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Competency Assessment Package

USAID HRH2030/Philippines: Human Resources for Health in 2030 in the Philippines

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Competency Review Report

USAID HRH2030/Philippines: Human Resources for Health in 2030 in the Philippines

Contents

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Abbreviations

ACGME	Accreditation Council for Graduate Medical Education
AE	Adverse Events
BON	Board of Nursing
CSC	Civil Service Commission
DAP	Development Academy of the Philippines
DSSM	Direct Sputum Smear Microscopy
DSTB	Drug-Sensitive Tuberculosis
EU	European Union
EU-PHSRC	European Union-Philippine Health Sector Reform Contract
FGD	Focus Group Discussion
GOCC	Government-Owned and Controlled Corporation
iDOTS	integrated Directly Observed Treatment, Short Course
KII	Key Informant Interview
LCP	Lung Center of the Philippies
LGU	Local Government Unit
KASAKA	*Kabalikat sa Kalusugan*
MDR TB	Multi-Drug Resistant Tuberculosis
NCR	National Capital Region
PAHRODF	Philippines/Australia Human Resource and Organisational Development Facility
PMDT	Programmatic Management of Drug Resistant Tuberculosis
PRC	Professional Regulation Commission
PSPI	Population Services Philippines Incorporated
PTSI	Philippine Tuberculosis Society Inc.
RHU	Rural Health Unit
SLBAI	*Samahang Lusog Baga* Inc.
STC	Satellite Treatment Center
TB	Tuberculosis
TC	Treatment Center
XDR TB	Extremely Drug Resistant TB

Executive Summary

Competency is a capacity that a person brings to the performance of a job role, manifesting a behavior that meets job demands within parameters of the organizational environment. These behaviors are observable, measurable, and demonstrate vital knowledge, skills, and attitudes that are translations of capacities deemed essential for organizational success. The main reason for the possession and acquisition of competencies in health care is to bring about desired organizational and population health results.

Based on this clear need, the expectation is that pre-service/academic institutions produce fit-for-work and ready-to-practice health workers. However, there is increasing recognition that health workers do not have the requisite skills to perform competently, both in terms of consistency and degree of engagement.

Due to this, USAID's HRH2030 Philippines project conduct a review of health worker competency assessment tools, the European Union-Philippine Health Sector Reform Contract (EU-PHSRC), the Development Academy of the Philippines (DAP) Certification Programs, and the International Labor Organization (ILO) study on National Nursing Core Competency Standards, that were developed for the Filippino context. The competency review was undertaken through: (1) desk review of existing competency frameworks developed under the stewardship of Department of Health's (DOH) Health Human Resources Development Bureau; (2) analysis of public sector job descriptions; (3) validation focus group discussions (FDG) with exemplar incumbents; (4) competency mapping; and (5) review of Civil Service Commission's PRIME-HR Competency model.

Overall, the review found that there is a rich environment for the implementation and institutionalization of a competency-based approach to assessing health worker performance. In addition, common themes in assessment/evaluation models indicate a Core, Organization, Leadership, and Technical Competency approach, but lack clinical competencies or a unifying framework. Also, it was found that while gaps exist in the CSC PRIME-HRH Model, though the model does provide a strong base to build on. Finally, focus Group Discussion results identify soft competencies to improve quality of care (specifically for TB).

This competency review will serve as the basis to inform the development of a competency assessment tool that can be used for appraising, assessing and evaluating the performance of a health care worker, which will be utilized by the DOH and USAID Implementing Partners to develop a fit-for-work and ready-for-practice health workforce.

Introduction

Competency is viewed as the ability to perform a work role according to a defined standard with reference to real working environments that includes a person's ability to demonstrate his or her cognitive knowledge, skills, and attitudes manifested in behaviors in a given situation.[1] It is a capacity that a person brings to the performance of his or her job role that manifests as behavior he observes in order to meet the demands of his or her job, within parameters of the organizational environment. These behaviors are observable and measurable. They also demonstrate the translation of vital knowledge, skills, and attitudes that are translations of capacities deemed essential for organizational success. The main reason for the possession and acquisition of competencies in health care is to bring about desired organizational and population health results. The concept of competency in healthcare is the foundation for the attainment of patient care outcomes. Ensuring that health care providers have the necessary skills to provide quality TB and FP/MCH care is critical in attaining tuberculosis (TB) and family Planning (FP)/ Maternal Child Health (MCH) goals.

The expectation is that pre-service/academic institutions produce fit-for-work and ready-to-practice health workers. No study has yet been done to determine whether this mandate is accomplished, or the degree to which it is realized in health care. However, anecdotal reports from hospitals and other health care institutions

[1] Franklin, N. & Melville P. (2015) Competency assessment tools: An exploration of the pedagogical issues facing competency assessment. Collegian 22(1), 25-31.

lamenting graduates' lack of requisite skills, abound. Furthermore, other studies indicate such as one conducted by the World Bank in 2017 in the Philippines indicate that 'missing' workforce skills may not be about technical acumen alone, but also socio-emotional skills, also known as "soft skills" or "behavioral skills."[2] In health care, and especially in TB and FP/MCH care, socio-emotional skills are as crucial as cognitive and technical skills in the attainment of clinical outcomes. In a very direct way, health workers' totality of skills influence patients' health-seeking behaviors, motivation to return and continue treatment, subject themselves for more treatment despite severe adverse reactions to therapy and show up at treatment centers despite the stigma that is attached to certain diseases, like TB. The same World Bank study report that the number of Philippine firms that report inadequate workforce skills rose by 30% in the past six years alone. In addition, two-thirds of employers report difficulty finding workers with an adequate work ethic or appropriate interpersonal and communications skills. Between 2009 and 2015, the share of employers that acknowledged having unfilled vacancies rose by 30% because of a lack of qualified candidates. Inadequate workforce skills are a major obstacle to operations and goal attainment.

Based on this clear need to develop a fit-for-work and ready-to-practice health workforce, USAID's HRH2030 Philippines project conduct a review of health worker competency assessment tools, the European Union-Philippine Health Sector Reform Contract (EU-PHSRC), the Development Academy of the Philippines (DAP) Certification Programs, and the International Labor Organization (ILO) study on National Nursing Core Competency Standards, that were developed for the Philippines context. The EU-PHSRC report documented the expected competencies for all positions at the Health Centers, and Regional Offices. Meanwhile, the DAP report established a benchmark competencies of physicians, nurses, and midwives deployed in Health Centers. Meanwhile, the "National Nursing Core Competency Standards" developed under the leadership of the Professional Regulation Commission (PRC) Board of Nursing (BON), and the nursing competencies identified in the "Nurse Certification Program" of the DOH were reviewed as a reference for nursing competencies. The three tools, although aimed at analyzing competencies in general, differed in approach and focus. The studies that were analyzed are different but consistent pieces of a knowledge mosaic aimed at favoring the accumulation of ideas, tools, and practices with the end-in-view of developing a common framework for identifying the required competencies for physicians, nurses, midwives and medical technologists.

There are two major outcomes from the application of a competency assessment: 1) Training needs and planning of trainings can be informed by evidence and 2) managers and decisions makers will understand the competency level of the workforce to provide quality health services. Subsequently, the need for harmonizing these approaches and developing a comprehensive tool that would measure TB and FP/MCH competencies and profiling the current workforce, is the impetus behind this analysis.

Methodology

The competency review was undertaken through: (1) desk review of existing competency frameworks developed under the stewardship of Department of Health's (DOH) Health Human Resources Development Bureau; (2) analysis of public sector job descriptions; (3) validation focus group discussions (FDG) with exemplar incumbents; (4) competency mapping; and (5) review of Civil Service Commission's PRIME-HR Competency model. Specifically, Boyatzis' definition of competency was adapted for this study which defines competency as "a capacity that exists in a person that leads to behavior that meets the job demands within parameters of the organizational environment, and that, in turn, brings about desired results."[3]

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[2] Acosta, P.A., Igarashi, T., Hamanaka, R.O., & Rutkowski, J. (2017). Developing socioemotional skills for the Philippines' labor market. The World Bank. Retrieved from http://documents.worldbank.org/curated/en/333521498727263689/pdf/ACS22716-REVISED-PUBLIC-Philippines-STEP-Book-2017.pdf

[3] Boyatzis, R.E. (1982). The competent manager: A model for effective performance. London: Wiley

1. **Desk review of existing competency frameworks** developed under the EU-PHSRC, DAP, National Nursing Core Competency Standards, CSC, and other DOH competency frameworks, standards, rubrics, and material. Other local and foreign references on competency mapping, generic health worker competencies, and specific TB and FP/MCH competencies were also consulted. The desk review aimed to gather what is already known in the area of health worker competencies.
2. **Analysis of public sector job descriptions.** Using the results of the comprehensive literature review, comparisons with the current public sector job descriptions based on CSC guidelines were analyzed. A sampling of private sector job descriptions was also included in the analysis. Additionally, to ensure that national competency standards in the four cadres were considered, PRC Boards were also consulted which resulted in the identification of national standards for nurses. None of the above frameworks indicate that national standards were identified for physicians, midwives, and medical technologists. Thus, professional organizations representing the four cadres were also consulted (see Annex A).[4]
3. **Validation focus group discussions (FGDs) with exemplar incumbents**. A series of FGDs were conducted among four cadres— physicians, nurses, medical technologists, and midwives—providing tuberculosis services in selected exemplar sites in Metro Manila. The FGDs were conducted at the Lung Center of the Philippines, Philippine Tuberculosis Society-*Kabalikat sa Kalusugan* (PTSI-KASAKA) and Dr. Elvira Lagrosa Health Center. One FGD was conducted with among members of the *Samahang Lusong Baga Association*, Inc to gather insights from TB patients. The FGD's collected and gathered health worker insights on desirable qualities competencies and qualities for high quality TB services (See Annex B and C).
4. **Competency mapping** for all cadres including competency standard comparisons among the four cadres, were mapped to the expected roles and responsibilities in TB and FP/MCH care as expressed by the job descriptions. A comprehensive listing of specific skills required for their job performance was created from the analysis of the identified roles and responsibility of the four cadres that relate to the delivery of TB and FP/MCH services (See Annex B and C).
5. A **review of the CSC PRIME-HR competency model** to be adapted by DOH was undertaken to determine and evaluate its comprehensiveness and appropriateness. A competency model is a framework that defines the skill, knowledge, attitude, and behavior requirements of a job that define successful performance.

Findings

This review was conducted to support the development of a competency assessment tool that can be used for appraising, assessing and evaluating the performance of a health care worker. The findings of this scoping activity are outlined below.

- *Common themes in assessment/evaluation models indicate a Core, Organization, Leadership, and Technical Competency approach, but lack clinical competencies or a unifying framework.*

Analysis of the current competency model indicate that the most common competency assessment/evaluation model used is the Core-Organizational-Leadership-Technical Competencies framework or other approaches with similar features. This was the framework used by the EU-PHRSC and the PAHRODF, when they assisted both the DOH and the CSC to build their competency and performance management systems. The model for the Philippine setting outlines 3 Core competencies, 6 organizational competencies, 26 technical competencies, and 7 leadership competencies. Table 1 below summarizes the competency model adapted by the CSC for its PRIME-HRH.

[4] Note that these specific reports are included to ensure faithful replication of methodologies and processes for capacity-building purposes

The DOH-HHRDB Learning and Development Division has commissioned several projects to develop a framework that will determine health worker competencies in the light of several contexts (i.e., rural health units, certification, performance evaluation). However, the review revealed that no unifying framework was used to anchor either the competency categories nor the proficiency levels. Competency categories or proficiency levels were labeled as levels (Level 1 to 3 or 1 to 5) or as skill acquisition levels as described by Dreyfus and Dreyfus.[5] The Competencies for the Rural Health Unit were categorized as basic, intermediate, advanced. The cross-cutting functions in the L & D Framework for RHUs identified five levels: Level 1(Beginner), Level 2 (Advanced Beginner), Level 3 (Competent), Level 4 (Proficient), and Level 5 (Expert).

In addition, while TB- and FP-specific competencies were identified, there were lacking in depth and ability to assess clinical capabilities. There were also lacking clinical competencies for the various cadres. While TB and FP competencies were identified for physicians and medical technologists, only TB specific competencies were identified for medical technologists and no specific TB and FP competencies were identified for nurses. In addition, overall, there are no assessment tools that are specific to a certain service delivery area, such as TB and FP/MCH-Focused. This finding is aligned with the DOH's thrust of providing integrated universal care through offering of essential packages, but also limit the ability of the competency rubrics to be operationalized. [6]

- *Gaps exist in the CSC PRIME-HRH Model, though the model does provide a strong base to build on.*

The CSC PRIME-HRH model allows for tracking performance of mission-critical competencies. The model also outlines competencies that provide the basis for recruitment, promotion, and incentives. The P.R.I.M.E. Framework developed by Pangaro, was first used to evaluate and meaningfully write about the performance of medical students, but now has widespread use as a simple, valid, and reliable way to write about performance.[7] [8] P.R.I.M.E. was developed due to the poor quality of written evaluations turned in by faculty on students' performance. The written narratives prior to the development of P.R.I.M.E. did not provide enough information on current performance and do not specify areas for focused attention in subsequent experiences that may present as opportunities for learning. P.R.I.M.E. classifies important observable learner behaviors and skills into five easily observed domains: professional, reporter, interpreter, manager, and educator. Even students can teach by locating appropriate teaching material, references, and relevant articles. They can also teach patients about health conditions.

Table 1 Competency Model CSC PRIME-HRH

CORE	ORGANIZATIONAL		LEADERSHIP		
Exemplifying Integrity	Demonstrating Personal Effectiveness	Championing and Applying Innovation	Managing Performance	Partnering and Networking	Coaching for Results
Delivering Service Excellence	Speaking Effectively	Planning and Delivering	Building Commitment	Thinking Strategically	
Solving Problems and Making Decisions	Writing Effectively	Managing Information	Developing People	Leading Change	

[5] Dreyfus, S. & Dreyfus, H. (1980). A five-stage model of the mental activities involved in directed skill acquisition. Washington, DC: Storming Media.

[6] There is a growing realization in the DOH that a system disconnect exists between training and implementation, as training is rolled out programmatically, but the implementation of these programs are carried out by a single frontline worker, for the most part. Thus, the health care workers at point-of-care are left to their own devices to integrate the knowledge and actualize them comprehensively.

[7] Pangaro, L. (1999). A new vocabulary and other innovations for improving descriptive in-training evaluations Academic Medicine, 74 (11), 1203-7 DOI: 10.1097/00001888-199911000-00012

[8] Although not in the original framework, "P" for professionalism was added to ensure "soft skills" were represented as an area of observation. "R" for reporter refers to the trainee's ability to obtain information from a patient or family interview, to review the medical record, and to report findings coherently in oral presentations, referrals, and also written notes. Interpreter is the "I" in P.R.I.M.E. This domain addresses how well the trainee interprets data collected from various sources (i.e., history, physical examination, medical record, lab and radiology studies) to prioritize the most urgent problems and formulate a well-reasoned differential diagnosis (for physicians) or an action plan (for nurses, midwives, and medtechs. "M" represents the manager role. Managing not only involves assessment, planning, intervention and evaluation, but also the aspect of the performance of procedures and time management. "E" represents the educator role, which includes the ability of the observed to self-direct his/her own learning, appropriately accept and respond to feedback, and the critical interpretation of the health care literature.

While this system has been adapted by the DOH, there is continuing work that needs to be done in refining the competency areas and knowledge, skills and attitudes indicators for DOH positions, particularly for the four identified cadres. To begin, extensive work in the areas of health worker competency assessment using this model has been done for midwives and nurses but not for physicians and medical technicians. Likewise, the model also does not outline the technical or clinical competencies required from the four cadres. To address the lack of clinical competencies, the DOH developed a Competency Catalogue for Regional Offices which outlines how competencies are structured. The Competency Catalogue presented an inventory of competencies following the CSC PRIME-HR model, thus clinical competencies are not included. In May 2016, the DOH contracted the Development Academy of the Philippines (DAP) to develop a framework patterned after the competency catalogue developed by People Dynamics which included rubrics for basic, intermediate, and advanced performance.[9] Other areas of this model requiring improvement include the observation that the competencies, as defined, may be too generic to be useful as a selection, performance, career planning or development tool for health care workers. Because of the complexity of the model, it is not easily translatable to a competency assessment tool. The review found that no competency assessment tools have been developed so far using CSC PRIME-HRH model. Thus, it's reliability and validity have not yet been ascertained.

In addition, the review of literature found that a list of job skills traditionally forms the basis for a competency assessment. Typically competency assessments focus how well a worker demonstrates observable proficiency in the expected abilities such as knowledge, skills, values and attitude required for the position she or he occupies, in relation to specified performance standards. Competency assessment tools—kept over time— are developed to keep track of workers' performance. These assessments serve as baseline information for tracking worker performance, providing coaching, acknowledging satisfactory and exemplary performance, targeting performance deficits, highlighting skills that require additional training or practice, and benchmarking employee performance across organizational norms. A review of existing competency models in different contexts suggest that an ideal competency tool must:

- Be user friendly – be easy for supervisors to observe and write about performance and be easy for health care workers to know what the expectations are
- Use simple language for describing not just behaviors, but micro-behaviors that workers are expected to practice on a daily basis with the end-goal of developing the competency to "add value" to the role, that all parties involved can remember
- Start with a self-assessment so that comparisons can be made and disparities in scores between the health care worker and his/her immediate supervisor are addressed
- Be short – must be completed in 10 minutes or less
- Have high validity and reliability and reflect the realities of the work environment

However, tools are only a means of capturing information and are not designed to change behavior. Behavior change resulting from learning may be most expediently moved by meaningful feedback.[10] Feedback that is timely, meaningful, and relevant, is an essential element of the learning process and has been shown to be the prime factor contributing to improved behavior.[11]

- *Focus Group Discussion results identify soft competencies to improve quality of care (specifically for TB).*

A series of FGDs were conducted among four cadres— physicians, nurses, medical technologists, and midwives— providing tuberculosis services in selected exemplar sites in Metro Manila. The FGDs were conducted at the Lung Center of the Philippines, Philippine Tuberculosis Society-*Kabalikat sa Kalusugan* (PTSI-KASAKA) and Dr. Elvira

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[9] Yapchiongco, L.R. & Tongco, M. (2019). Policy Brief on Competency Standards and Assessment. USAID HRH2030 Philippines.
[10] Loftin, R., Peng, B., MacGlashan, J., Littman, M.L., Taylor, M.E., Huang, J., & Roberts, D.L. (2016). Learning behaviors via human-delivered discrete feedback: modeling implicit feedback strategies to spped up learning. Retrieved from https://link.springer.com/article/10.1007/s10458-015-9283-7
[11] Hansen, M. (2018). Great at work: How top performers do less, work better and achieve more. NY: Simon and Schuster.

Lagrosa Health Center. One FGD was conducted with among members of the *Samahang Lusong Baga Association*, Inc to gather insights from TB patients. The FGD's collected and gathered health worker insights on desirable qualities competencies and qualities for high quality TB services. The results of the FGDs among TB exemplar incumbents corroborate the clinical competencies expected of the cadres, namely understanding and adeptness of programmatic management of TB. Qualities expected of health workers include capacity to provide compassionate care, dedication, sincerity, kindness and ability to multi-task between responsibilities. The summary of the findings from the FGDs and KIIs conducted among exemplars are outlined in Table 2, for use in the revision of non-clinical competency development activities.

Table 2. Summary of FGD Results

***Samahang Lusog Baga Association, Inc* (Organization of Healthy Lungs Association, Inc)**			
Cadres	**DESIRABLE QUALITIES**	**DESIRABLE COMPETENCIES**	**RECOMMENDATIONS / Additional respondent insights**
Physicians	• Caring • Kind • Understanding • Intelligent • Approachable • Humble • Thoughtful • Friendly • Helpful • Godly • Respectful • Hard-working • Loving • Beautiful • With common sense • With a sense of humor	• **Effective communicator**: can clearly explain the disease/diagnosis/treatment to the patients • Have enough clinical knowledge on how to treat the disease • Active learner: to know new methods to treat the disease • Interpersonal skills: treats patients not just as patients but as persons with feelings	Notable patient experiences: Exemplary caring: 1. Physician exuding caring beyond expectations throuugh caring communication; prompt referral to specialists and to TB DOTs center, if private physician; reaching out to patients through social media (FB, etc.), formation of support groups • Nurses: – Treated KI with compassion, and not just as a patient, exhibiting behaviors like greetimg her during her monthsary (of TB medication), encouraging her to continue her treatment; and reminding her to submit her sputum samples diligently for follow-up. • Nurses must be approachable, and exhibit the following behaviors: always ask patients how they are, actively following up with the patients even on Saturdays, asking about the presence of adverse symptoms from TB meds, commending if there are any improvements (e.g. weight gain), and to continue to take he meds despite the side effects
Nurses	• **Understanding** • **Hard-working** • **Kind** • **Values patients:** e.g. reminding the patients to always take their medicine • **Easy-going/happy to be with/friendly** • **Caring/helpful** • Approachable • Knows how to easily explain the disease/treatment to the patients • Gentle • Professional • Intelligent • Strict	• **With steady hands for injection of drugs** • **Interpersonal skills**: knows how to properly treat a patient • Can perform tasks that doctors cannot perform • Good counsellor	
Medical technologists	• Handles specimens with care • Efficient (releases results quickly)		
Midwives		• Capable of going house-to-house to check on children who needs immunization.	
Pharmacists	• Easy to ask for needed drugs • Highly aware if there are stock outs of drugs • Kind		

Lung Center of the Philippines				
Cadres	**DESIRABLE QUALITIES**	**DESIRABLE COMPETENCIES**	**Factors that facilitate retention in service**	**RECOMMENDATIONS / Additional respondent insights**
Physicians	• **Knowledgeable** • **Team player**: should not see oneself as the boss, but must be considerate on the needs of one's teammates • **Considerate**: do not make the patients feel as if they are less superior to you as their physician • **Sincere**: patients can feel if you are sincere when you show your concern to them • **Dedication:** if one has dedication, it enables you to continue on with your job, otherwise, it is easy to quit this kind of job.	• **Educated and well-versed on what you need to do** (PMDT patient management): how do you manage an MDR-TB patient? What are the latest treatment updates for MDR-TB? These must be considered if one wants to be competent. • **Assertive**: Not be afraid to speak up and be brave	• Provision of security of tenure and long-term benefits. Most important of all issues. All of them are PBSP-hired, and their contracts are only until 2020 (no long-term plan yet). Since the staff are PBSP-hired, turnaround rate for health workers is high. • Provision of better compensation, hazard pay, uniform allowance • Provide all needed supplies/equipment for protection of HRH: In their laboratory, the filter replacement of the P3 cabinet was delayed but the medtechs kept on working to avoid delay in their work. • Provide adequate training: The medtechs are requesting that the appropriate authorities aid them to be more proficient with the skills they need to perform their work with more confidence. • Support from management: LCP can be more inclusive with the PMDT team even if they are PBSP-hired. There is currently no LCP representative/liaison officer providing oversight to the PMDT team.	<u>Adequacy of pre-service training:</u> • The concepts for PMDT were not taught during their undergraduate years, even in medical school. • Medtechs raised that all techniques were new. Since LCP is a specialized laboratory procedure, all laboratory techniques that they are doing now were not taught in school. • Management and leadership skills were not taught in medtech courses, and these skills are necessary for their work now. • For physicians, the relevant skills for patient management were not taught in med school, but you get to learn these during your internship. • A deeper version of the therapeutic communication taught in nursing school is needed for nurses to be better equipped with counselling. <u>Conclusion</u> • The FGD revealed the demand for counselling skills among PMDT health workers with nurses expressing the need to be better equipped with counselling skills that is key to managing patients. • Interrupter tracing, where patients are visited in their homes/workplaces if they have
Nurses	• **Passion/compassion to serve** • **Knowledgeable:** on how to handle PMDT patients • **Learner:** with PMDT updates; never stop learning • **Versatile/Flexible**: on how to perform their tasks • **Patient:** one must have patience to continuously encourage the patients to take their medicine, and complete their treatment • **Understanding:** you must put yourself in the shoes of the patients so that you can understand what they are going through	• **Effective communicator:** one needs to effectively communicate the treatment, the disease, to the patients at their level of understanding • **Good counsellor:** counselling must be a two-way street; listen to the patients and talk to the patients. • **Good with the needed technical skills** • **With good management/organizational skills**		
Medical Technologists	• **Passion with a purpose** • **Integrity**: the character of the person affects the kind of work that he/she will produce. • **Teachable/willing to learn**	• **Technically competent**: all laboratory techniques that they are performing now are new (except DSSM), hence one needs to be well-versed with these techniques. • **Systematic**: with records, with laboratory tasks, logistics, supplies		

Lung Center of the Philippines				
Cadres	**DESIRABLE QUALITIES**	**DESIRABLE COMPETENCIES**	**Factors that facilitate retention in service**	**RECOMMENDATIONS / Additional respondent insights**
	• **Focused**: with the heavy load (both technical and administrative load) that they are managing in the laboratory, it is desirable for a PMDT medtech to be focused always, to ensure that everything is in order, and for a fast turnaround rate. • **Organized**: with their records, reports, lab tasks to avoid backlog in the laboratory,	• **Knows how to prioritize** • **Teachable**: easy to absorb new learnings, and transfer these to the other members of the team • With good time management: this is significant on their daily work activity		consecutively missed their direct observation treatment (DOT), entails a different skillset compared to the qualities and competencies a health worker must possess in the health facility.

Philippine Tuberculosis Society, Inc – Kabalikat sa Kalusugan (PTSI-KASAKA)			
Cadres	**DESIRABLE QUALITIES**	**DESIRABLE COMPETENCIES**	**RECOMMENDATIONS / Additional respondent insights**
Physicians	• **Compassionate**: A physician must show compassion to the patients, since they are already suffering from the adverse events of the drugs they take. • **"Cruel" only to be kind**: A physician must be cruel to some extent to the patients to ensure that they will take their medicine. • **Flexible**: A physician must be flexible with how they treat their patients, depending on their status (educated, uneducated), to ensure that the patients' needs are addressed.	• **Skilled in interpersonal communication/counselling** • **Clinically competent to manage MDR-TB patients**	Among the good practices for managing MDR-TB mentioned by respondents were: • **Flexible schedule of DOT**: The staff adjusts their clinic hours to cater to the patient's needs. Compared to other TCs, PTSI-KASAKA is not limited to dispensing medicine from 8:00 A.M. to 12 noon, but instead, considers the patient's availability. For example, if a patient needs to go to work by 8:00 A.M., then the TC staff will open the clinic by 5:30 A.M. The staff dispenses medicine and provides DOT even up to 7 P.M. if need be • **Strict quick turnaround for DSSM results**: In PTSI, the 24-hour rule for providing the results of DSSM is strictly enforced. • **Engages community authorities to trace patients**: During interrupter tracing, the staff seek out the help of barangay officials to trace the patients. • **Family counselling**: The staff at PTSI-KASAKA also provides counselling to the patient's family members to ensure that the support of the family is provided to the patients while on treatment.
Nurses	• **Approachable**: A nurse must be approachable so that the patients will be open to them, on what they feel, especially with the effects of the medicine they are taking. • **Friendly** • **Compassionate**	• **Clinically competent**: In terms of addressing the adverse events being experienced by the patients • **Skilled in interpersonal communication/counselling**	
Midwife	• **"Cool":** So that the patients will feel at ease; it will make the patients feel more comfortable. • **Patient** • **Always in a happy state**	• **Skilled in interpersonal communication/counselling**	

Philippine Tuberculosis Society, Inc – Kabalikat sa Kalusugan (PTSI-KASAKA)			
Cadres	**DESIRABLE QUALITIES**	**DESIRABLE COMPETENCIES**	**RECOMMENDATIONS / Additional respondent insights**
	• **Flexible/easily adjusts to cater to what the patient needs**		
Medical technologist	• **Efficient:** For a quick turnaround time for sample analyses • **Organized:** A medtech must not use any shortcuts in work • **Systematic:** To ensure efficiency in completing analyses • **Knows how to multi-task:** To ensure efficiency in completing analyses	• **With integrity:** In giving out the true results of the samples • **Strict:** In receiving specimens to be analyzed; this is to ensure of high quality results • **Aware of the value of one's work:** A medtech must realize the value of his work in relation to its contribution to a patients' treatment process	

Dr. Elvira Lagrosa Health Center				
CADRES	**DESIREABLE QUALITIES**	**DESIREABLE COMPETENCIES**	**Factors facilitating retention**	**RECOMMENDATIONS/ Additional Insights**
Physicians		• **Sweet attitude**: Dr. D was immersed at the Lung Center of the Philippines for a week, and in here, she saw how "sweet "the health workers were towards the patients. When pressed to describe "sweet" behavior she proffered the following: 1. Soothing and respectful tone of voice when addressing patients, 2. Establishing eye contact during conversations, 3. Social distance during conversation at 2 feet, 4. Holding patient's hands, or tapping shoulder during conversation. • **Love for and valuing the work**: • **Knowledgeable with the PMDT program**	• **Security of tenure**: Security of tenure is the most important reason for a health worker to be retained. There is a standing memorandum between PBSP and the LGU that the latter will absorb the staff in the near future. However, as per the nurses interviewed, the LGU prefers to hire their relatives. • **Provision of incentives**: To recognize the good work that is being done by the health workers. • **Provision of better facilities**: The current state of the STC's office discourages the workers to go to work every day.	Conclusions Despite the discouraging office situation at Lagrosa Health Center, the staff seemed dedicated to providing quality care to their MDR-TB patients. The health workers mentioned repeatedly that they wish that the PMDT management at the central level will also take care of the plight of the health workers, and not only the patients. It was also emphasized that the lack of tenured position drives the health workers to better opportunities, hence, this singular solution can make or break the human resource for health situation in PMDT centers, where majority of the health workers are hired by PBSP.
Nurses	• **Exemplifies team leadership** • **A team player/teamwork:** This, and team leadership, are needed to provide quality care service to the patients	• **Administratively competent**: A PMDT nurse must have financing skills, and data management skills • **Management skills**: In terms of managing the records		

	• **Shows sensitivity:** To gain the trust of the patients • **Patient with authority:** These two should be together • **Good listener/counsellor:** This is especially important for defaulters. • **Able to treat patients as friends** • **Trustworthy** • **Authoritative:** This is needed so that the patients will take their medicine • **Knows how to self-evaluate/reflect :** A nurse must know when to self-evaluate so that he/she will be made aware of the good approaches to use to a patient • **Knows interpersonal communication and counselling** • **Organized**	of the patients, and drugs • **Must know how to multi-task** • **Must be passionate to do the tasks**		

Conclusions and Recommendations

There is currently no standardized framework for providing health worker feedback and documenting competency assessment and performance evaluation. In addition, there are currently no competency assessment tools that assess for HRH's knowledge, skills and ability to provide TB- and FP/MCH-care used by the DOH. This finding is best understood in the light of the current thrust to move away from the programmatic approach to the integrated approach to care.

The CSC PRIME-HR Competency Model does capture the clinical aspects of that is unique to the work environment of DOH health human resources. While this model provides a good starting point in determining the organizational fit of the DOH HRH, it falls short of providing a basis for appraising the clinical/health service provision aspects that other DOH HRH perform. Specifically, there is currently a lack of clinical competencies that measure the knowledge, skills and attitudes of health workers to conduct clinical services. Finally, while some of the reviewed tools do note clinical competencies, they are out of date, need improvements to allow for measurement and should be linked to training outcome. In addition, it was confirmed trhough focus group discussions that while the CSC PRIME-HRM competencies are cross-cutting and span the five PRIME (Professional, Reporter, Interpreter, Manager, Educator) roles, the PRIME framework can still be used as the organizing framework for describing performance. Performance is the multi-dimensional manifestation of cognitive skills (both tacit and explicit knowledge and critical thinking), physical skills, and values/attitudes (demonstrated as socioemotional skills).

Recommendation

Modify the CSC PRIME-HR model design to reflect a unifying framework that contextualizes the competencies for the specific work that DOH HRH perform such that it reflects the clinical aspects of their work that encompass the treatment and prevention aspects of healthcare. The CSC personnel perform administrative and technical work; the DOH HRH perform clinical competencies in addition to administrative work.

For the clinical aspect, the comprehensive competency assessment tool that defines and measures the knowledge, skills and ability of primary health care workers in the provision of TB and FP/MCH care. The comprehensive assessment tool will prove useful in appraising the performance and strengthening the capacities of primary health care workers. The conduct of regular performance appraisals is important in facilitating quality improvement of health services and tracking progress of commitments to improved health outcomes. As such, clinical competencies refer to skills, ability, attitude and knowledge of health care workers that will allow them to fulfill their functions within their scope of practice. Clinical competencies should cover the abilities to assess, diagnose or support diagnosis, provide health education and promote healthy behaviors, implement a plan of treatment and care, and controlling and preventing diseases across the life stages of a patient. On the prevention side, the competencies include assessing, choosing the appropriate methods, case management and monitoring and evaluation. Specifically it is recommended: retaining the core, organizational, and leadership roles and adding clinical competencies that encompass the continuum of care provided to patients including health education and promotion of healthy behaviors, prevention and control of diseases and treatment or implementation of care. Disease management competencies include: 1) Assessing, Controlling, and Preventing Disease; 2) Diagnosing/Supporting Diagnosis; 3) Managing the Case; and 4) Monitoring and Evaluating. Prevention-focused competency categories include: 1) Assessing, 2) Choosing Appropriate Method/s, 3) Managing the Case, and 4) Monitoring and Evaluating. Ultimately the specific competency areas and the knowledge, skills and attitudes indicators that should be reflected when conducting the clinical service should be defined. See Table 3 for an initial Clinical Competency Framework.

Table 3. Clinical Competency Framework

TB Care-Specific Clinical Competencies					
	Competency	**Physician**	**Nurse**	**Midwife**	**MedTech**
TB 1	**Competency 1: ASSESSING, CONTROLLING, & PREVENTING DISEASE**				
TB 1.1.	Identifying individual and population risk factors for tuberculosis, including determinants of health	Yes	Yes	Yes with training	Yes with training
TB 1.2.	Collecting and documenting data for surveillance, reporting, and case management	Yes	Yes	Yes	Yes with training
TB 1.3.	Case finding through "any-one-of-four" symptom screening	Yes	Yes	Yes with training	Yes with training
TB 1.4.	Ascertaining patients' knowledge of TB and experiences that increase risk (i.e., impact, stigma, denial, fear)	Yes	Yes	Yes with training	Yes with training
TB 1.5.	Preventing infection	Yes	Yes	Yes	Yes
TB 2	**Competency 2: DIAGNOSING/ SUPPORTING DIAGNOSIS**				
2.1.	Performing relevant TB screening including TB health history and physical assessment, TST, sputum collection, CxR	Yes	Yes	Yes with training	Run the test
2.2.	Raising respiratory secretions (expectorated, induced sputum, gastric lavage)	Yes	Yes	Yes with training but gastric lavage outside of scope	Yes with training but induced sputum and gastric lavage outside of scope
TB 2.3.	Diagnosing TB promptly and accurately, and reducing diagnostic delay	Yes Medical Diagnosis	Yes Nursing Diagnosis	No	Run the test
TB 3	**Competency 3: MANAGING THE CASE**				
TB 3.1.	Using standardized treatment regimens of proven efficacy	Yes	Supported by protocol, under physician supervision; Refer when appropriate	Refer	No
TB 3.2.	Supervising intake of anti-TB drugs	Yes	Yes	Yes with training	No
TB	Detecting drug resistance	Yes	Yes;	Refer	No

TB Care-Specific Clinical Competencies					
Competency		**Physician**	**Nurse**	**Midwife**	**MedTech**
3.3.			Refer when appropriate		
TB 3.4.	Referring to next level and coordinating with local public health services and agencies	Yes	Yes	Yes	Yes
TB 3.5.	Patient/family counseling and education	Yes	Yes	Yes with training	Yes with training
TB 4	**Competency 4: MONITORING & EVALUATION**				
TB 4.1.	Monitoring adherence to the regimen	Yes	Yes	Yes with training	No
TB 4.2.	Reporting and retrieving defaulters within 2 days	Yes	Yes	Yes with training	No
TB 4.3.	Address factors leading to interruption or discontinuation of treatment (i.e., lost to follow up,	Yes	Yes	Yes with training	No
TB 4.4.	Managing adverse reactions	Yes	Yes per protocol; Refer when appropriate	Refer	No

FP Care-Specific Clinical Competencies					
Competency		Physician	Nurse	Midwife	MedTech
FP 1	**Competency 1: ASSESSING**				
FP 1.1.	Assessing client using the G-A-T-H-E-R Approach	Yes	Yes	Yes	Not applicable
FP 1.2.	Preventing infection	Yes	Yes	Yes	Yes
FP 1.3.	Observing informed choice and voluntarism	Yes	Yes	Yes	Not applicable
FP 1.4.	Conducts FP counseling with focus on modern methods and fertility awareness; observing the principles of informed choice; birth spacing; responsible parenthood and respect for life; and contraceptive provision	Yes	Yes	Yes	Not applicable
FP 2	**Competency 2: CHOOSING APPROPRIATE METHOD/S**				
FP 2.1.	Assisting clients in decision-making on appropriate FP method based on several client factors (risk factors, preferences, etc.)	Yes	Yes	Yes	No
FP 2.2.	Prescribing appropriate FP methods using the WHO MEC Wheel	Yes	Yes under protocol, refer when appropriate	Yes under protocol, refer when appropriate	No
FP 2.3.	Using FP methods for special populations (adolescents, women over 40, smokers, post-partum, breastfeeding)	Yes	Yes under protocol, refer when appropriate	Yes under protocol, refer when appropriate	No
FP 3	**Competency 3: MANAGING THE CASE**				
FP 3.1.	Providing different FP services (natural, artificial, IUD, OCP, condom, DMPA)	Yes	Yes with training	Yes with training	No
FP 3.2.	Providing surgical services for permanent sterilization where appropriate (BTL, NSV)	Perform when trained	Assist	Assist	No
FP 3.3.	Providing post-surgical care for patients who underwent permanent sterilization (wound care, administration of meds, etc.)	Yes	Yes	Yes	No
FP	Counseling client on LARC	Yes	Yes	Yes	No

FP Care-Specific Clinical Competencies					
Competency		Physician	Nurse	Midwife	MedTech
3.4.					
FP 3.5	Counseling client on FAB and LAM	Yes	Yes	Yes	No
FP 3.6.	Providing information on LAPM	Yes	Yea	Yes	No
FP 4	**Competency 4: MONITORING & EVALUATION**				
FP 4.1.	Monitoring patients for adverse reactions to FP use (weight, BP and others)	Yes	Yes	Yes	No
FP 4.2.	Managing patients with complications relating to FP use	Yes	Yes under protocol, refer when appropriate	Yes under protocol, refer when appropriate	No
FP 4.3.	Address factors leading to interruption or discontinuation of use of FP method	Yes	Yes	Yes	No

MCH Care-Specific Clinical Competencies					
Competency		Physician	Nurse	Midwife	MedTech
MCH 1	**Competency 1: ASSESSING**				
MCH 1.1.	Examining the abdomen during pregnancy	Yes	Yes	Yes	No
MCH 1.2.	Counseling during antenatal consultation on nutrition	Yes	Yes	Yes	No
MCH 1.3.	Counseling during antenatal consultation on exclusive breastfeeding	Yes	Yes	Yes	No
MCH 1.4.	Assisting the client to develop a birth and emergency plan	Yes	Yes	Yes	No
MCH 1.5.	Preventing infection	Yes	Yes	Yes	No
MCH 1.6.	Completion of partograph	Yes	Yes	Yes	No
MCH 2	**Competency 2: DIAGNOSING/ SUPPORTING DIAGNOSIS**				
MCH 2.1.	Performing the labor watch	Yes	Yes	Yes	No
MCH 2.2.	Diagnosing/assisting in diagnosing complications	Yes	Yes and refer	Yes and refer	No
MCH 3	**COMPETENCY 3: MANAGING THE CASE**				
MCH 3.1.	Delivery/ Assisting in Delivery	Yes	Yes	Yes	No
MCH 3.2.	Facilitating essential newborn care	Yes	Yes	Yes	No
MCH 3.3.	Performing routine newborn care	Yes	Yes	Yes	No
MCH 3.4.	Counseling for preventive care in the first 48 hours	Yes	Yes	Yes	No
MCH 3.5.	Counseling the mother about conditions of the breast before discharge from the facility	Yes	Yes	Yes	No
MCH 4	**Competency 4: MONITORING AND EVALUATION**				
MCH 4.1.	Monitoring for complications of pregnancy	Yes	Yes	Yes	No
MCH 4.2.	Monitoring for complications of delivery	Yes	Yes	Yes	No
MCH 4.3.	Monitoring for complications in the newborn	Yes	Yes	Yes	No
MCH 4.4.	Managing post-delivery complications in the mother	Yes	Yes	Yes	No
MCH 4.5.	Managing post-delivery complications in the newborn	Yes	Yes under protocol; refer when appropriate	Yes under protocol; refer when appropriate	No

The competencies that are threaded through the entire framework but are not specifically identified, are the socioemotional skills that must be possessed by anyone who aspires to work in health care. Socio-emotional skills, also known as "soft skills" or "noncognitive skills" are related to individual behavior, personality, attitude, and mindset. These skills include the relative capacity of individuals to 1) manage and recognize their emotions, 2) cope successfully with conflict, 3) navigate interpersonal problem solving, 4) understand and show empathy for others, 5) establish and maintain positive relationships, 6) make ethical and safe choices, 7) contribute constructively to their community, and 8) set and achieve positive goals.[12] In the traditional narrative, the evaluation is vague, which is typical of current practices.[13] In the merged write-up, evaluation as a developmental process is evident, the language is understandable to both the observed and provider of feedback, and the system allows one to chart and measure progress along a continuum. Real learning does not occur until people actually change what they do. Additionally, there is as much importance given to the socio-emotional skills relative to the cognitive and leadership competencies. There is also an objective assessment of the strengths, and areas that need to improve and a clear and helpful development and progression pathway. As a result of a merged framework and a common vocabulary for assessing competency or evaluating performance, an example of an enhanced health worker evaluation write-up should be developed as opposed to a traditional write-up. See Table 4 for a list of the identified socio-emotional skills, as well as a sample application in Table 5.

Table 4. Soft Skills Identified to complement CSC PRIME-HRM

Roles	Soft Skills	CSC PRIME-HRM
Professional – Does this health worker demonstrate professionalism?	• Reliability, Responsibility, Teamwork • Punctuality • Respect for Others • Appropriate Attire • Demeanor and Comportment	• Exemplifying Integrity (Core)
Reporter – Is this health worker a reliable and honest reporter?	• Interviewing • Physical Examination/ Assessment • Written Documentation • Oral presentations	• Speaking Effectively and Listening Actively (Organizational) • Writing Effectively (Organizational) • Building Collaborative, Inclusive Working Relationships (Leadership)
Interpreter – When given data, can the health worker interpret them?	• Problem prioritization • Interpreting clinical and other data	• Solving Problems and Making Decisions (Core)
Manager – Can the health worker manage self, patients, peers, a team?	• Management of individual patients/families • Management of a health care team • Formulate Plans (Therapeutic, Diagnostic, Administrative) • Demonstrate Risk/Benefit Decision Making • Proficient at procedures • Incorporates patient values into plans	• Deliver Service Excellence (Core) • Demonstrating Personal Effectiveness • Championing and Applying Innovation (Organizational) • Planning and Delivering (Organizational) • Thinking Strategically and Creatively (Leadership) • Managing Information (Organizational) • Creating and Nurturing a High Performing Organization (Leadership)
Educator – Does the health worker demonstrate educator qualities?	• Self-directed learning • Good response to feedback • Critical reading skills • Teaching Skills to peers and other team members	• Demonstrating Personal Effectiveness (Organizational) • Managing Performance and Coaching for Results (Leadership)

[12] Acosta, P., Igarashi, T., Olfindo, R., & Rutkowski, J. (2017). Developing socioemotional skills for the Philippines' labor market. The World Bank Group. Retrieved from http://documents.worldbank.org/curated/en/333521498727263689/pdf/ACS22716-REVISED-PUBLIC-Philippines-STEP-Book-2017.pdf

[13] Lye, P.S. (2001). A pleasure to work with – An analysis of written comments on student evaluations. Ambulatory Peds.

Table 5. Comparing a Traditional Performance Write-up with the Recommended Proposed Enhanced Write Up

Traditional Performance Write-Up Example	Recommended Proposed Enhanced Write-Up Example
Great job. No problems. Pleasant. Interested in learning. Performed as expected. Needs to work on prioritization. Will refer to Training.	She is at all times professional in her dealings with patients, families, and other members of the health team including ancillary support staff. She demonstrates wholehearted acceptance of TB patients and is empathetic about their situation. She shows no discriminatory behavior. She is a reliable reporter, although initially she seemed to want to embrace all the problems found in the review of systems. This improved greatly as she seems now able to focus and prioritize her histories much more effectively for the clinical setting. Her physical assessment skills are very good, reliable, and reproducible. Interpretive skills are good, and managerially, she always seems to be able to navigate the system to ensure that treatment, consultations, plans are coordinated and instituted. She is a motivated and highly engaged worker who is clearly reading about her cases and asking more questions of staff. Areas for improvement: focus histories and prioritize problems, relax a bit more when it comes to the unpredictability of patient flow/issues in the clinic, continue education as opportunities arise.

Finally, the enhanced CSC PRIME-HR which includes clinical competencies and other soft skills to provide feedback and document progress toward competency attainment as part of supportive supervision is divided into four parts:

- Core Competencies, define capabilities that distinguish an organization from others offering the same services and are often derived from the organization's values. The expectation is that, because it is core, all staff should aspire to become proficient in these core competencies
- Organizational Competencies, encompass those competencies required to manage oneself and the institution's operations. Organizational competencies involve coordinating personal development, aligning personal goals with organizational goals, and coordinating work both with internal groups and with external entities, and optimizing use of available resources.
- Leadership Competencies are leadership skills and behaviors that contribute to superior performance. Leadership attributes are identified by organizations and defined by distinctive attributes that create an advantage
- Technical/clinical competencies cover the abilities to assess, diagnose or support diagnosis, provide health education and promote healthy behaviors, implement a plan of treatment and care, and controlling and preventing diseases across the life stages of a patient. On the prevention side, the competencies include assessing, choosing the appropriate methods, case management and monitoring and evaluation.

Next Steps

Many lessons were learned about the current policy environment Based on this review, USAID's HRH2030 will develop a clinical competency assessment package which will include a clinical competency dictionary, clinical competency assessment tool, standard operating procedure for the application and implementation of the tool. It is recommended that these clinical competencies, when piloted and finalized, be both coupled with the PRIME framework and utilized as a stand alone tool for use by the Department of Health, local government stakeholders and USAID Implementing Partners when working to identify both training needs and planning of trainings and to better understand the competency level of the workforce to provide quality health services and respond to population health needs.

Annex A. Consolidated Competency Rubrics

Collection and review of available competency rubrics for physicians, nurses, medical technologists, and midwives

Department of Health

HRH2030/Philippines aimed to identify if there are any developed competency rubrics for the four mentioned cadres. HRH2030/Philippines consulted with the Learning and Development Division (LDD) under HHRDB to identify competency rubrics that DOH developed throughout the years. In addition, HRH2030/Philippines also inquired if there are any rubrics that other organizations developed and whether DOH formally recognizes these as official competency rubrics for the four cadres.

The competencies of 12 nurses type are applicable to those who are deployed in hospitals; however, one nursing rubrics was applicable for those deployed at Health Centers, i.e., Public Health Nursing[14]. Using the information for this type of nurse, HRH2030/Philippine created an Excel file to consolidate the qualities expected to be observed for each competency level, for each competency theme.

Further, the DOH shared the final reports of the European Union-Philippine Health Sector Reform Contract (EU-PHSRC), and the Development Academy of the Philippines (DAP). For the EU-PHSRC report, this listed the expected competencies[15] for all positions at the Health Centers, and Regional Offices for the four cadres. For the DAP report, the competencies of physicians, nurses, and midwives deployed in Health Centers were developed. The report did not include competencies for medical technologists.

Integrated Midwives Association of the Philippines

HRH2030/Philippines also consulted the Integrated Midwives Association of the Philippines (IMAP) to check if the organization developed any competency rubrics in the recent years. During the consultation meeting with Ms. Patricia Gomez, IMAP's Chief Executive Officer last June 5, 2018, HRH2030/Philippines learned that IMAP was involved in the development of the competency rubrics for midwives led by DAP, as commissioned by HHRDB-DOH.

Further, as per IMAP also developed their own competency rubrics, that is applicable for both public and private facilities, as an ERA (Education, Regulation, and Association) initiative. Education is led by the Association of Philippine Schools of Midwifery, Inc., Regulation by the Board of Midwifery, and Association by IMAP. IMAP initially discussed with DOH that they would marry the two rubrics together (DAP and IMAP rubrics) but this has yet to be done. In their development of the competency rubrics, IMAP conducted several FGDs, as part of their methodology. The competency rubrics from ERA is still at the final stage of development.

Philippine Association of Medical Technologists, Inc.

HRH2030/Philippines also consulted the Philippine Association of Medical Technologists, Inc (PAMET), to check if the organization developed any competency rubrics for their cadre. HRH2030/Philippines consulted with Mr. Rolando Puno, PAMET President, Dr. Leila Lany, Previous PAMET President, and Ms. Jacinta Cruz, PAMET member last June 13, 2018.

PAMET pointed out that there are numerous aspects of competencies for medical technologists (leadership, diagnostics, etc). As such, HRH2030 must define the specific scope of the competency mapping so PAMET can help develop the rubrics to measure the identified competency aspects.

PAMET recently conducted a competency assessment among its members. This project is internally funded by PAMET. The Department of Health has not provided any competency rubrics to PAMET, hence PAMET was left on its own to find their own competency tool for their assessment. Since there is no available rubrics to be used as the measurement tool, PAMET used the public health competencies in the laboratory, adapted from an assessment tool from the US. However, this competency tool only includes general competencies. The sample size for their

[14] The competency rubrics for Public Health Nursing is available at http://ejobs.doh.gov.ph/ncp-update/pdf/PHN/Competency%20Standards%20for%20the%20Public%20Health%20Nursing.pdf

[15] The competencies for physicians were differentiated for Medical Health Officers, versus Doctors to the Barrios (DTTBs).

assessment was n=494 and this count includes medical technologists in the public, and private sectors. The assessment is a self-awareness competency.

During the discussion, PAMET mentioned that the report of this competency assessment is still being finalized.

The summary of the availability of all competency rubrics from all these organizations are presented as follows.

Annex Table 1. Summary of competency rubrics developed by various organizations for physicians, nurses, medical technologists, and midwives

Cadres	Developing organization					
	Department of Health (no date)	European Union-Philippine Health Sector Reform Contract (2017)	Development Academy of the Philippines (no date)	Integrated Midwives Association of the Philippines (2018)	Philippine Association of Medical Technologists, Inc. (2018)	International Labour Office (2014)
Physicians	Not developed	Developed	Developed	N/A	N/A	Not developed
Nurses	Developed	Developed	Developed	N/A	N/A	Developed
Medical technologists	Not developed	Developed	Not developed	N/A	Not developed	Not developed
Midwives	Not developed	Developed	Developed	Currently being developed	N/A	Not developed

Using all the information gathered, HRH2030/Philippines analyzed the competency themes, to check the similarities and differences between the various types of rubrics. Further, the expected roles and functions of the cadres, in relation to TB and FP service delivery, were included in the analysis, to check if there are any competencies specific to these roles.

This file contains the consolidated competency reburics that were used during the review.

Annex A. Consolidated Competency Rubrics

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
A. CORE COMPETENCIES:	**A. CORE COMPETENCIES:**		
1. Exemplifying Integrity. Ability to establish and maintain social, ethical and organizational norms within the organization and towards clients in accordance to the Code of Conduct and Ethical Standards for Public Health Officials and Employees (RA 6713)	1. Exemplifying Integrity. Ability to establish and maintain social, ethical and organizational norms within the organization and towards clients in accordance to the Code of Conduct and Ethical Standards for Public Health Officials and Employees (RA 6713)		
2. Professionalism. Ability to exemplify high standards of professional behavior as a public servant, adhering to ethical as well as moral principles, values and standards of public office.	2. Professionalism. Ability to exemplify high standards of professional behavior as a public servant, adhering to ethical as well as moral principles, values and standards of public office.		
3. Service Excellence. Ability to recognize and create opportunities to meet and exceed the needs and expectations of both internal and external clients of the organization.	3. Service Excellence. Ability to recognize and create opportunities to meet and exceed the needs and expectations of both internal and external clients of the organization.		
B. ORGANIZATIONAL COMPETENCIES	**B. ORGANIZATIONAL COMPETENCIES**		

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
1. Effective Communication Skills. Ability to receive and convey ideas, instructions, information by using appropriate language, method and manner to ensure the audience understands the message and take necessary action.	1. Effective Communication Skills. Ability to receive and convey ideas, instructions, information by using appropriate language, method and manner to ensure the audience understands the message and take necessary action.		
2. Effective Interpersonal relations. Ability to develop and maintain effective relationships with others; notices and accurately interprets what others are feeling; shows understanding, tact, empathy, courtesy, concern and politeness.	2. Effective Interpersonal relations. Ability to develop and maintain effective relationships with others; notices and accurately interprets what others are feeling; shows understanding, tact, empathy, courtesy, concern and politeness.		
3. Organizational awareness and commitment. Ability to gain knowledge of DOH culture, systems, and pressures; understands the agenda and perspectives of others; recognizes and balances the interests of one's department with those of other departments and the Agency, as well as the impact of decisions on each.	3. Organizational awareness and commitment. Ability to gain knowledge of DOH culture, systems, and pressures; understands the agenda and perspectives of others; recognizes and balances the interests of one's department with those of other departments and the Agency, as well as the impact of decisions on each.		

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
4. Promoting innovation. Ability to develop new and creative insights into situations, and applies different and novel solutions to make improvements and/or adaptations to available resources.	4. Promoting innovation. Ability to develop new and creative insights into situations, and applies different and novel solutions to make improvements and/or adaptations to available resources.		
C. LEADERSHIP COMPETENCIES	**C. LEADERSHIP COMPETENCIES**		
1. Building collaborative and Inclusive Working Relationship. Ability to build a network of reciprocal, high trust, synergistic working relationship within the organization and across the government and relevant sectors. This involves the ability to leverage and maximize opportunities for strategic influencing within the organization and with external clients.	1. Building collaborative and Inclusive Working Relationship. Ability to build a network of reciprocal, high trust, synergistic working relationship within the organization and across the government and relevant sectors. This involves the ability to leverage and maximize opportunities for strategic influencing within the organization and with external clients.	**HEALTH REGULATION** 1. Advocacy for LGU support for health programs and agenda	
2. Leading change. Ability to generate enthusiasm and momentum for organizational change. It involves engaging and enabling groups to understand, accept and commit to the change agenda. It also includes advancing and sustaining change.	2. Leading change. Ability to generate enthusiasm and momentum for organizational change. It involves engaging and enabling groups to understand, accept and commit to the change agenda. It also includes advancing and sustaining change.	**HEALTH RESOURCES FOR HEALTH** 1. Organizational Development and HRH Management	

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
3. Managing performance and coaching for results. Ability to create an environment, which will nurture and sustain a performance-based coaching culture. Effectiveness of this competency also includes strong focus on developing people for current and future needs, managing talent, promoting the value of continuous learning and development.	3. Managing performance and coaching for results. Ability to create an environment, which will nurture and sustain a performance-based coaching culture. Effectiveness of this competency also includes strong focus on developing people for current and future needs, managing talent, promoting the value of continuous learning and development.		
4. Thinking strategically and creatively. Ability to "see the big picture", think multi-dimensionally, craft innovative solutions, identify connections between situations or things that are not obviously related, and come up with new ideas and different ways to enhance organizational effectiveness and responsiveness.	4. Thinking strategically and creatively. Ability to "see the big picture", think multi-dimensionally, craft innovative solutions, identify connections between situations or things that are not obviously related, and come up with new ideas and different ways to enhance organizational effectiveness and responsiveness.	**HEALTH GOVERNANCE** 1. Strategic planning	
D. TECHNICAL COMPETENCIES	**D. TECHNICAL COMPETENCIES**		

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
1. Achieving high standards. Ability to set standard of performance for self and others; assuming responsibility and accountability for successfully completing assignment of tasks; self-imposing standards of excellence rather than having standards imposed.			
2. Advocating Public health. Ability to promote and advance the advocacies, programs, policies, and regulations of the local health unit and/or DOH to individuals, interest groups, assigned communities, offices, media outlets, and other clients through various communication channels.	2. Advocating Public health. Ability to promote and advance the advocacies, programs, policies, and regulations of the local health unit and/or DOH to individuals, interest groups, assigned communities, offices, media outlets, and other clients through various communication channels.	**SERVICE DELIVERY** 3. Conduct of education and advocacy for health programs	
	5. Building relationship with clients. Ability to build client relationships and leverage coalition in the implementation of plans, programs, policies, and activities geared toward the achievement of strategic intents of DOH.	**HEALTH GOVERNANCE** 2. Stakeholder management	

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
6. Case management. Ability to coordinate and implement the assessment, planning, assignment and resolution of operational requirements including medical cases anchored on major roles of DOH; i.e. leadership and health enabler and capacity builder; and administrator of specific services.	6. Case management. Ability to coordinate and implement the assessment, planning, assignment and resolution of operational requirements including medical cases anchored on major roles of DOH; i.e. leadership and health enabler and capacity builder; and administrator of specific services.	**HEALTH GOVERNANCE** 3. Management of RHU Systems, Processes and Procedures	
	10. Computer literacy. Ability to efficiently utilize Information and Communication Technology (ICT) tools such as hardware, software and electronic communications for data entry, work processing, spread sheet, internet and other computer applications to enhance work productivity and quality of outputs.		
	20. Effective presentation/speaking skills. Ability to deliver effective presentations that are contextually applicable to the audience's particular needs.		

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
25. Implementing health policies and regulations. Ability to implement knowledge of laws, executive orders, agency rules, and implementing rules and regulations relevant to the line of work.	25. Implementing health policies and regulations. Ability to implement knowledge of laws, executive orders, agency rules, and implementing rules and regulations relevant to the line of work.	**HEALTH REGULATION** 2. Supervision of health policies/regulations implementation	
	26. Learning and development. Ability to build and maintain capabilities, skills and competencies of employees to help sustain organizational growth of DOH, thus achieving its overall goals and objectives.		
	35. Procurement planning and management. Ability to administer contract and other procurement requirements in compliance to RA; manages program and vendor/supplier relationships and monitors contract performance for the effective delivery of goods and services.	**HEALTH FINANCING** 4. Efficient purchasing of health goods and services	
	36. Project/program planning and management. Ability to plan, implement, monitor and evaluate projects/programs in order to achieve the set objectives within budget, time and quality limits. Ability to	**SERVICE DELIVERY** 2. Supervision of health programs implementation	

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
	manage human, financial, information technology and material resources.		
	39. Research and analysis. Ability to demonstrate knowledge and application of terminology, tools, tactics, principles for the successful implementation of a plan.	**HEALTH INFOSYSTEM** 3. Conduct of research and epidemiologic studies	
41. Respecting and caring for patients. Ability to establish a relationship of trust with patient by treating him/her with respect to his/her religious, cultural, or social background; respecting the right of patient to confidentiality and privacy.	41. Respecting and caring for patients. Ability to establish a relationship of trust with patient by treating him/her with respect to his/her religious, cultural, or social background; respecting the right of patient to confidentiality and privacy.		
42. Risk management. Ability to plan, develop, and implement measures that will avoid, overcome or compensate for elements of risk.	42. Risk management. Ability to plan, develop, and implement measures that will avoid, overcome or compensate for elements of risk.		

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
	45. Scientific review and management. Ability to plan and conduct scientific review activities to ensure an unbiased, informed review process, and successful programmatic outcomes.		
		SERVICE DELIVERY 1. Management of the health facility	
		HEALTH FINANCING 1. Management of the Health Budget	
		HEALTH FINANCING 2. Mobilization of external resources for the RHU	
		HEALTH FINANCING 3. Management and promotion of equitable Health Financing and health insurance	
		HEALTH REGULATION 3. Participation in the development of health policies	

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
		HEALTH INFOSYSTEM 1. Management of Databases and Health Information systems	
		HEALTH INFOSYSTEM 2. Supervision of RHU recording and Reporting System	
		HEALTH RESOURCES FOR HEALTH 2. Motivation of RHU staffs and other health workers	
		HEALTH RESOURCES FOR HEALTH 3. Conflict management	

		SERVICE DELIVERY 4. Clinical management	**Family Planning Competency-Based Training (DOH, no date)** **12 Modules** 1. Philippine Family Planning Program2. Human Reproductive Anatomy and Physiology3. FP Client Assessment4. Infection Prevention in FP Services5. Fertility-Awareness Based Methods6. Hormonal Contraceptive Methods7. Male Condom8. Long-Acting and Permanent Methods9. FP for Special Populations10.Counseling for FP11.Management of FP Clinic12.Action Planning

			(NTP, 2014 5th edition) • Organize planning and evaluation of TB control activities in DOTS facilities. • Ensure that all staff have been trained on TB DOTS. • Supervise staff to ensure proper implementation of NTP policies and guidelines. • Evaluate presumptive TB based on clinical and laboratory evidence. • Prescribe appropriate treatment. • Manage adverse reactions. • Provide continuous health education and counseling to all TB patients under treatment. • Refer TB patients to other health facilities if needed. • Encourage community and family support to TB control.

Physicians at Health Centers			
European Union-Philippine Health Sector Reform Contract		**Development Academy of the Philippines**	**Expected Roles and Functions for TB, and FP services**
DTTB	**MHO**	**MHO**	**Health workers**
			(NTP, 2014 5th edition) • Mobilize and utilize resources in the area for TB control. • Coordinate with the local chief executives to ensure funds and personnel are available for program implementation. • Coordinate with other TB stakeholders to ensure that all detected TB cases are reported and services provided are within the NTP policies and guidelines.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
A. Service Delivery	**A. Service Delivery**		
1. Assessment of Client	1. Assessment of Client		**A. CLIENT CARE** **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.2. Assesses with the client (individual, family, population group, and/or community) one's health status/competence.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.2. Assesses with the client (individual, family, population group, and/or community) one's health status/competence. 2.2.1. Develops the data gathering plan with the client, specifying methods and tools.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.2. Assesses with the client (individual, family, population group, and/or community) one's health status/competence. 2.2.2. Obtains assessment data utilizing appropriate data

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			gathering methods and tools guided by type of client and working setting requisites.
			A. CLIENT CARERESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.2.2. Assesses with the client (individual, family, population group, and/or community) one's health status/competence.2.2.3. Analyzes data gathered.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.2. Assesses with the client (individual, family, population group, and/or community) one's health status/competence. 2.2.4. Synthesizes data gathered.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.2. Assesses with the client (individual, family, population group, and/or community) one's health status/competence. 2.2.5. Specific client's status/conditions/problems to be addressed identifying reasons (etiology) for the existence of the condition or problem.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
2. Health Promotion andHealth Education	2. Health Promotion andHealth Education		**A. CLIENT CARERESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.**2.5. Provides health education using selected planning models to targeted clientele (individuals, family, population group or community).
			A. CLIENT CARE RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE. 2.5. Provides health education using selected planning models to targeted clientele (individuals, family, population group or community). 2.5.1. Determines the health education planning models appropriate to target clientele/expected objectives and outcomes.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.5. Provides health education using selected planning models to targeted clientele (individuals, family, population group or community). 2.5.2. Utilizes health education process to accomplish the plan to meet identified client's learning needs.
3. Management of Public Health Programs	3. Management of Public Health Programs	**D. TECHNICAL COMPETENCIES**36. Project/program planning and management. Ability to plan, implement, monitor and evaluate projects/programs in order to achieve the set objectives within budget, time and quality limits. Ability to manage human, financial, information technology and material resources.	**B. MANAGEMENT AND LEADERSHIPRESPONSIBILITY 3-DEMONSTRATES MANAGEMENT AND LEADERSHIP SKILLS TO DELIVER HEALTH PROGRAMS AND SERVICES TO SPECIFIC CLIENT GROUPS IN THE COMMUNITY SETTING**3.1. Applies management and leadership principles in providing direction to manage a community/village-based:3.1.1. health facility3.1.2. component of a health program or3.1.3. nursing service
4. Referral of Patients	4. Referral of Patients		
B. Health Financing	**B. Health Financing**		

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
1. Mobilizing Resources and managing finances (same as below)	1. Management of the use and availment of Social Health Insurance Program benefits		**RESPONSIBILITY 4-MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE** 4.4. Mobilizes resources for effective program implementation/service delivery.
2. Mobilizing Resources and managing finances (same as above)	2. Management of PFPR		
C. Health Regulation	**C. Health Regulation**		
1. Facilitation of licensing of the health facility	1. Facilitation of licensing of the health facility		
2. Implementation of health policies	2. Implementation of health policies		**B. MANAGEMENT AND LEADERSHIP RESPONSIBILITY 2-DEMONSTRATES ACCOUNTABILITY FOR SAFE NURSING PRACTICE.** 2.1. Participate in the development of policies and standards regarding safe nursing practice

Annex A. Consolidated Competency Rubrics

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
3. Monitoring of quality improvement	3. Monitoring of quality improvement		**B. MANAGEMENT AND LEADERSHIPRESPONSIBILITY 1-DEMONSTRATES MANAGEMENT AND LEADERSHIP SKILLS TO PROVIDE SAFE AND QUALITY CARE**1.4. Creates a safe environment of care through the use of quality assurance, continuous quality improvement and risk management strategies.
D. Health Governance	**D. Health Governance**		
1. Establishment of linkages among stakeholders	1. Establishment of linkages among stakeholders	**D. TECHNICAL COMPETENCIES** 5. Building relationship with clients. Ability to build client relationships and leverage coalition in the implementation of plans, programs, policies, and activities geared toward the achievement of strategic intents of DOH.	**RESPONSIBILITY 4-ESTABLISHES COLLABORATIVE RELATIONSHIP WITH COLLEAGUES AND OTHER MEMBERS OF THE TEAM TO ENHANCE NURSING AND OTHER HEALTH CARE SERVICES** 4.1. Ensures intra-agency, inter-agency, multidisciplinary and sectoral collaboration in the delivery of health care. **RESPONSIBILITY 6-UTILIZES APPROPRIATE MECHANISMS FOR NETWORKING, LINKAGE BUILDING AND REFERRALS** 6.3. Collaborates with government organizations, non-government organizations, and other socio-civic agencies to improve health care services, support enviroment protection policies and strategies, and safety and security mechanisms in the community.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
2. Monitoring of adherence to referral system	2. Monitoring of adherence to referral system		
3. Advocacy on adoption of health related laws/issuances/policies	3. Advocacy on adoption of health related laws/issuances/policies		**RESPONSIBILITY 5-PROMOTES PROFESSIONAL AND PERSONAL GROWTH AND DEVELOPMENT.** 5.3. Engages in advocacy activities to influence health and social care service policies and access to services.
			RESPONSIBILITY 6-UTILIZES APPROPRIATE MECHANISMS FOR NETWORKING, LINKAGE BUILDING AND REFERRALS 6.4. Engages in advocacy activities to deal with health related concerns and adopts policies that foster the growth and development of the nursing profession.
E. Records Management on Health Information Systems	**E. Health Infosystem**		**RESPONSIBILITY 3-MAINTAINS COMPLETE, ACCURATE AND UP-TO-DATE RECORDING AND REPORTING SYSTEM.**3.3. Implements system of informatics to support the delivery of health care.
F. Human Resources for Health (HRH) Developing the needed capacity of HRH involved in a particular health program	**F. Human Resources for Health (HRH) Developing the needed capacity of HRH involved in a particular health program**	**D. TECHNICAL COMPETENCIES** 26. Learning and development. Ability to build and maintain capabilities, skills and competencies of employees to help sustain organizational growth of DOH, thus achieving its overall goals and objectives.	**RESPONSIBILITY 4-**MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE 4.1. Coordinates the tasks/functions of other nursing personnel (midwifery, Barangay Health Worker and utility worker)
		A. CORE COMPETENCIES:	

Annex A. Consolidated Competency Rubrics

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
		1. Exemplifying Integrity. Ability to establish and maintain social, ethical and organizational norms within the organization and towards clients in accordance to the Code of Conduct and Ethical Standards for Public Health Officials and Employees (RA 6713)	
		2. Professionalism. Ability to exemplify high standards of professional behavior as a public servant, adhering to ethical as well as moral principles, values and standards of public office.	**RESPONSIBILITY 5-PROMOTES PROFESSIONAL AND PERSONAL GROWTH AND DEVELOPMENT.** 5.4. Models professional behavior.
		3. Service Excellence. Ability to recognize and create opportunities to meet and exceed the needs and expectations of both internal and external clients of the organization.	
		B. ORGANIZATIONAL COMPETENCIES	
		1. Effective Communication Skills. Ability to receive and convey ideas, instructions, information by using appropriate language, method and manner to ensure the audience	

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
		understands the message and take necessary action.	
		2. Effective Interpersonal relations. Ability to develop and maintain effective relationships with others; notices and accurately interprets what others are feeling; shows understanding, tact, empathy, courtesy, concern and politeness.	**B. MANAGEMENT AND LEADERSHIP RESPONSIBILITY 1-DEMONSTRATES MANAGEMENT AND LEADERSHIP SKILLS TO PROVIDE SAFE AND QUALITY CARE** 1.3. Maintains a harmonious and collegial relationship among members of the health team for effective, efficient and safe client care.
		3. Organizational awareness and commitment. Ability to gain knowledge of DOH culture, systems, and pressures; understands the agenda and perspectives of others; recognizes and balances the interests of one's department with those of other departments and the Agency, as well as the impact of decisions on each.	
		4. Promoting innovation. Ability to develop new and creative insights into situations, and applies different and novel solutions to make improvements and/or adaptations to available resources.	

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
		D. TECHNICAL COMPETENCIES 16. Data management. Ability to plan, develop, and implement data storage and retrieval systems by applying current DOH's data model/systems, standards and processes.	**RESPONSIBILITY 3-MAINTAINS COMPLETE, ACCURATE AND UP-TO-DATE RECORDING AND REPORTING SYSTEM.** 3.1. Ensures completeness, integrity, safety, accessibility and security of information.
		D. TECHNICAL COMPETENCIES21. Equipment, materials and supplies management. Ability to advise, review and coordinate the acquisition, loan, transfer and disposal of accountable property items per RA 9184 regulations and DOH property policies and procedures, and the DOH acquisition and property management process.	
		D. TECHNICAL COMPETENCIES 35. Procurement planning and management. Ability to administer contract and other procurement requirements in compliance to RA; manages program and vendor/supplier relationships and monitors contract	

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
		performance for the effective delivery of goods and services.	
		D. TECHNICAL COMPETENCIES 41. Respecting and caring for patients. Ability to establish a relationship of trust with patient by treating him/her with respect to his/her religious, cultural, or social background; respecting the right of patient to confidentiality and privacy.	**A. CLIENT CARE** **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.1. Ensures a working relationship with the client and/or support system based on trust respect and shared decision making.
		D. TECHNICAL COMPETENCIES 47. Technical consulting. Ability to provide expertise, technical guidance and training to ensure projects and operations are carried out effectively.	

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE RESPONSIBILITY 1-PRACTICES IN ACCORDANCE WITH LEGAL PRINCIPLES AND THE CODE OF ETHICS IN MAKING PERSONAL AND PROFESSIONAL JUDGEMENT 1.1 Adherence to ethico-legal considerations when providing safe, quality and professional nursing care.
			A. CLIENT CARE RESPONSIBILITY 1-PRACTICES IN ACCORDANCE WITH LEGAL PRINCIPLES AND THE CODE OF ETHICS IN MAKING PERSONAL AND PROFESSIONAL JUDGEMENT 1.2 Applies ethical reasoning and decision making process to address situations of ethical distress and moral dilemma.
			A. CLIENT CARERESPONSIBILITY 1-PRACTICES IN ACCORDANCE WITH LEGAL PRINCIPLES AND THE CODE OF ETHICS IN MAKING PERSONAL AND PROFESSIONAL JUDGEMENT1.3 Adheres to established norms of conduct based on the Philippine Nursing Law and other legal, regulatory and institutional requirements relevant to safe nursing practice.
			A. CLIENT CARE RESPONSIBILITY 1-PRACTICES IN ACCORDANCE WITH LEGAL PRINCIPLES AND THE CODE OF ETHICS IN MAKING PERSONAL AND PROFESSIONAL JUDGEMENT

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			1.4. Protects clients rights based on "Patient's Bill of Rights and Obligations"
			A. CLIENT CARE **RESPONSIBILITY 1-PRACTICES IN ACCORDANCE WITH LEGAL PRINCIPLES AND THE CODE OF ETHICS IN MAKING PERSONAL AND PROFESSIONAL JUDGEMENT** 1.5. Implements strategies/policies related to informed consent as it applies in multiple contexts.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.1.1. Establishes rapport with client and/or support system ensuring adequate information about each other as partners in a working relationship.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.**

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			2.1.2. Formulates with the client-partner the objectives and expectations of the nurse-client working relationship.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.1.3. Maintains shared decision-making and client's participatory capability throughout the nurse-client working relationship.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.1.4. Enhances client-partner's readiness for taking over/being-in-charge when objectives and expectations of the working relationship have been achieved.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE. 2.3. Formulates with the client a plan of care to address the health conditions, needs, problems and issues based on priorities.
			A. CLIENT CARE RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE. 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues.
			A. CLIENT CARERESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.1. Implements appropriate psychosocial/therapeutic interventions to render holistic nursing care in any setting.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.2. Provides appropriate evidence-based nursing care using participatory approach based on: variety of theories and standards relevant to health and healing research clinical practice client preferences client and staff safety customer care standards
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.2.4.3. Applies safety, principles, evidence based practice, infection control measures and appropriate protective devices consistently, when providing nursing care and preventing injury to clients, self, other health care workers and the public.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.4. Implements strategies related to the safe preparation and administration of medications based on institutional policies and protocol.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.5. Applies evidence-based practice on pain prevention and management of clients using pharmacologic and non-pharmacologic measures.
			A. CLIENT CARERESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.6. Implements safe, adequate, evidence-based care of clients

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			during the pre-, intra-, and post-diagnostic and treatment procedures.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.7. Implements safe and quality nursing interventions addressing health needs, problems and issues affecting pregnant woman during the peripartal phases and newborn from perinatal to neonatal stage.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.8. Applies appropriate and evidence-based nursing interventions for physiologic and related psychosocial needs of patients/clients to preserve physiologic integrity and prevent complications of problems of oxygenation (ventilation, transport, perfusion); fluid and electrolyte imbalance and acid-based imbalances; nutrition and metabolism; gastrointestinal (indigestion, digestion, absorption, elimination); urinary function, perception, coordination, and altered sensation; inflammation, infection, and immune responses; cellular aberration, altered generic conditions; and reproductive problems.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environmental protection and health resource generation use or access within the context of Primary Health Care.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARERESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environmental protection and health resource generation use or access within the context of Primary Health Care.2.4.9.1. Enhances family competence on health promotion, wellness, healthy lifestyle, health care, health resource access or use, and safe environment conducive to health maintenance among its members.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environmental protection and health resource generation use or access within the context of Primary Health Care. 2.4.9.2. Implements strategies/interventions to ensure health population/s in the school and work settings.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environmental protection and health resource generation use or access within the context of Primary Health Care. 2.4.9.3. Enhances the competencies of specific population groups to ensure wellness, health lifestyle/adaptation, disease prevention, management, rehabilitation and vulnerability reduction or prevention.

			A. CLIENT CARERESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environmental protection and health resource generation use or access within the context of Primary Health Care.2.4.9.4. Implements participatory and empowerment strategies for community competence to identify and collaborate effectively in addressing needs and problems related with health resource availability, access or use, environmental protection, safety and security.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.10. Implements interventions guided by prescribed context of specific health program/services.
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.11. Implements appropriate care to individuals, families, vulnerable groups and communities during the three phases of disaster situations, such as: 1) Pre-incident phase, 2) incident phase, and 3) Post incident phase

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE. 2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.12. Implements appropriate nursing interventions to help clients and support system address spiritual needs.
			A. CLIENT CARERESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues. 2.4.13. Manages client load to ensure health program/service coverage.
			A. CLIENT CARE RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE. 2.6. Evaluates with the client the health status/competence and/or process/expected outcomes of nurse-client working relationships.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			A. CLIENT CARE **RESPONSIBILITY 2-UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE.** 2.7. Document client's responses/nursing care services rendered and processes/outcomes of the nurse client working relationship.
			RESPONSIBILITY 3-MAINTAINS COMPLETE, ACCURATE AND UP-TO-DATE RECORDING AND REPORTING SYSTEM. 3.2. Adheres to protocol and principles of confidentiality in safekeeping and releasing of records and other information.
			RESPONSIBILITY 4-ESTABLISHES COLLABORATIVE RELATIONSHIP WITH COLEAGEUS AND OTHER MEMBERS OF THE TEAM TRO ENHANCE NURSING AND OTHER HEALTH CARE SERVICES 4.2. Implements strategic/approaches to enhance/support the capability of the client and care providers to participate in decision making by the inter-professional team.
			RESPONSIBILITY 5-PROMOTES PROFESSIONAL AND PERSONAL GROWTH AND DEVELOPMENT. 5.1. Assumes responsibility for lifelong learning, own personal development and maintenance of competence.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			RESPONSIBILITY 5-PROMOTES PROFESSIONAL AND PERSONAL GROWTH AND DEVELOPMENT. 5.2. Demonstrates continued competence and professional growth.
			B. MANAGEMENT AND LEADERSHIP RESPONSIBILITY 1-DEMONSTRATES MANAGEMENT AND LEADERSHIP SKILLS TO PROVIDE SAFE AND QUALITY CARE 1.1. Utilizes appropriate and efficient methods/strategies/tools to manage multiple nursing interventions for clients with comorbidities, complex and rapidly changing health status with consultations as needed.
			B. MANAGEMENT AND LEADERSHIP RESPONSIBILITY 1-DEMONSTRATES MANAGEMENT AND LEADERSHIP SKILLS TO PROVIDE SAFE AND QUALITY CARE 1.2. Coordinates care by organizing and prioritizing use of human, material, financial and other resources to achieve expected health outcomes.
			B. MANAGEMENT AND LEADERSHIP RESPONSIBILITY 2-DEMONSTRATES ACCOUNTABILITY FOR SAFE NURSING PRACTICE. 2.2. Organizes own workload demonstrating time management skills for meeting responsibilities and achieving outcomes.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			B. MANAGEMENT AND LEADERSHIPRESPONSIBILITY 2-DEMONSTRATES ACCOUNTABILITY FOR SAFE NURSING PRACTICE.2.3. Institutes appropriate corrective actions to prevent or minimize harm arising from adverse effects.
			B. MANAGEMENT AND LEADERSHIP RESPONSIBILITY 3-DEMONSTRATES MANAGEMENT AND LEADERSHIP SKILLS TO DELIVER HEALTH PROGRAMS AND SERVICES TO SPECIFIC CLIENT GROUPS IN THE COMMUNITY SETTING 3.2. Uses appropriate strategic/approaches to plan community health programs and nursing service.
			RESPONSIBILITY 4-MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE 4.2. Collaborates with other members of the health team in the implementation of programs and services.
			RESPONSIBILITY 4-MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE 4.3. Ensures adequate resources (e.g. human material) to effectively implement programs/services based on requirements, ration and standards.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			RESPONSIBILITY 4-MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE 4.5. Supervises the implementation of the nursing component of the health services/programs.
			RESPONSIBILITY 4-MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE 4.6. Ensures that all nursing personnel adhere to standards of safety, bioethical principles and evidence-based nursing practice.
			RESPONSIBILITY 4-MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE 4.7. Evaluates specific components of health programs and nursing services based on parameters/criteria.
			RESPONSIBILITY 4-MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE 4.8. Applies management and leadership principles to ensure a complete, accurate, and up-to-date documentation of activities

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			and outcomes of managing a community/village-based facility, component of a health program and/or nursing service.
			RESPONSIBILITY 4-MANAGES A COMMUNITY/VILLAGE BASED HEALTH FACILITY/COMPONENT OF A HEALTH PROGRAM OR A NURSING SERVICE 4.9. Maintains a positive practice of environment.
			RESPONSIBILITY 5-DEMONSTRATES ABILITY TO LEAD AND SUPERVISE NURSING SUPPORT STAFF 5.1. Applies principles of supervision for effective and efficient delivery of health programs and services.
			RESPONSIBILITY 5-DEMONSTRATES ABILITY TO LEAD AND SUPERVISE NURSING SUPPORT STAFF 5.2. Assesses supervisory needs of the nursing support staff.
			RESPONSIBILITY 5-DEMONSTRATES ABILITY TO LEAD AND SUPERVISE NURSING SUPPORT STAFF5.3. Participation in the planning and implementation of staff development activities to enhance performance of nursing support staff.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			RESPONSIBILITY 5-DEMONSTRATES ABILITY TO LEAD AND SUPERVISE NURSING SUPPORT STAFF 5.4. Monitors the performance of the nursing support staff.
			RESPONSIBILITY 5-DEMONSTRATES ABILITY TO LEAD AND SUPERVISE NURSING SUPPORT STAFF 5.5. Evaluates performance of nursing support staff using a standard evaluation tool.
			RESPONSIBILITY 5-DEMONSTRATES ABILITY TO LEAD AND SUPERVISE NURSING SUPPORT STAFF 5.6. Participates in improving policies and standards of nursing practice.
			RESPONSIBILITY 5-DEMONSTRATES ABILITY TO LEAD AND SUPERVISE NURSING SUPPORT STAFF 5.7. Disseminates policies, regulations, circulars and programs among nurses and nursing support staff.
			RESPONSIBILITY 5-DEMONSTRATES ABILITY TO LEAD AND SUPERVISE NURSING SUPPORT STAFF 5.8. Participates in developing polices and procedures relevant to human resource management.
			RESPONSIBILITY 6-UTILIZES APPROPRIATE MECHANISMS FOR NETWORKING, LINKAGE BUILDING AND REFERRALS 6.1. Applies principles of partnership and collaboration to improve delivery of health services.

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			RESPONSIBILITY 6-UTILIZES APPROPRIATE MECHANISMS FOR NETWORKING, LINKAGE BUILDING AND REFERRALS 6.2. Determines resources available for networking, linkage building, and referral necessary for improving delivery of health services.
			RESPONSIBILITY 6-UTILIZES APPROPRIATE MECHANISMS FOR NETWORKING, LINKAGE BUILDING AND REFERRALS 6.2. Determines resources available for networking, linkage building, and referral necessary for improving delivery of health services.
			C. RESEARCH **RESPONSIBILITY 1-ENGAGES IN NURSING OR HEALTH RELATED RESEARCH WITH OR UNDER THE SUPERVISION OF AN EXPERIENCED RESEARCHER** 1.1. Participates in preparing a research proposal complying with the ethical principles in nursing research
			C. RESEARCH **RESPONSIBILITY 1-ENGAGES IN NURSING OR HEALTH RELATED RESEARCH WITH OR UNDER THE SUPERVISION OF AN EXPERIENCED RESEARCHER** 2.2. Analyzes if the conceptual framework, the summary of review of related literature, research design, and data analysis

Nurses at Health Centers			
Department of Health Nurse Certification Program	Development Academy of the Philippines	European Union-Philippine Health Sector Reform Contract	International Labour Organization
			procedure are logically linked with the research purpose, problems/questions and hypothesis.

Medical Technologists at Health Centers	
European Union-Philippine Health Sector Reform Contract	**Expected Roles and Functions for TB, and FP services**
A. CORE COMPETENCIES:	
1. Exemplifying Integrity. Ability to establish and maintain social, ethical and organizational norms within the organization and towards clients in accordance to the Code of Conduct and Ethical Standards for Public Health Officials and Employees (RA 6713)	
2. Professionalism. Ability to exemplify high standards of professional behavior as a public servant, adhering to ethical as well as moral principles, values and standards of public office.	
3. Service Excellence. Ability to recognize and create opportunities to meet and exceed the needs and expectations of both internal and external clients of the organization.	
B. ORGANIZATIONAL COMPETENCIES	
1. Effective Communication Skills. Ability to receive and convey ideas, instructions, information by using appropriate language, method and manner to ensure the audience understands the message and take necessary action.	
2. Effective Interpersonal relations. Ability to develop and maintain effective relationships with others; notices and accurately interprets what others are feeling; shows understanding, tact, empathy, courtesy, concern and politeness.	
3. Organizational awareness and commitment. Ability to gain knowledge of DOH culture, systems, and pressures; understands the agenda and perspectives of others; recognizes and balances the interests of one's department with those of other departments and the Agency, as well as the impact of decisions on each.	
4. Promoting innovation. Ability to develop new and creative insights into situations, and applies different and novel solutions to make improvements and/or adaptations to available resources.	
D. TECHNICAL COMPETENCIES	

Medical Technologists at Health Centers	
European Union-Philippine Health Sector Reform Contract	**Expected Roles and Functions for TB, and FP services**
21. Equipment, materials and supplies management. Ability to advise, review and coordinate the acquisition, loan, transfer and disposal of accountable property items per RA 9184 regulations and DOH property policies and procedures, and the DOH acquisition and property management process.	
23. Government accounting and budgeting. Ability to perform bookkeeping, accounting, budgeting, and auditing processes in accordance to laws, principles, and practices of government/public financial management.	
24. Government and departmental policies and procedures. Ability to understand and apply knowledge of government and departmental statutes, regulations, policies, and procedures.	
25. Implementing health policies and regulations. Ability to implement knowledge of laws, executive orders, agency rules, and implementing rules and regulations relevant to the line of work.	
31. Operating medical machines, equipment and tools. Ability to operate and preserve medical machines, equipment, and tools to ensure reliability and availability for medical diagnosis, monitoring, and treatment of medical condition.	
38. Records management. Ability to establish a system of procedures in recording and safekeeping of documented information for ease of storage and retrieval.	
41. Respecting and caring for patients. Ability to establish a relationship of trust with patient by treating him/her with respect to his/her religious, cultural, or social background; respecting the right of patient to confidentiality and privacy.	
43. Safety awareness. Ability to identify and correct conditions that affect employee safety; upholding safety standards.	
47. Technical consulting. Ability to provide expertise, technical guidance and training to ensure projects and operations are carried out effectively.	
	(NTP, 2014 5th edition) • Do DSSM for diagnosis and follow-up. • Perform Xpert MTB/RIF examination as needed.

Medical Technologists at Health Centers	
European Union-Philippine Health Sector Reform Contract	**Expected Roles and Functions for TB, and FP services**
	• Perform HIV testing for TB patients as needed. • Inform the referring health worker or facility of the result of DSSM or Xpert MTB/RIF. • Maintain and update the NTP laboratory register. • Prepare quarterly report on laboratory services and submit to the nurse or physician. • Do internal quality control within the laboratory. • Prepare and submit quarterly laboratory supplies requirement to the nurse. • Store sputum smears for sampling of the provincial/city TB coordinators for blinded re-checking. • Ensure that microscope and Xpert MTB/RIF machine are properly maintained and functional.

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
SERVICE DELIVERY BLOCK		
A. Pregnancy care. The ability to apply professional midwifery practice in providing appropriate, timely and effective care for a woman and her baby before, during, and immediately after labor and delivery.		
1. Prenatal care		
2. Intrapartum care		
3. Immediate post-partum care for mothers		
4. Immediate post-partum care for the newborns		
5. Postpartum care		
B. Newborn care. The ability to apply professional midwifery practice in providing appropriate and effective essential care to the newborn after delivery.		

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
C. Reproductive Health and Family Planning. The ability to provide appropriate, timely and effective services on reproductive health, sexually transmitted infections, positive parenting and family planning.		**Family Planning Competency-Based Training (DOH, no date)** **12 Modules** 1. Philippine Family Planning Program 2. Human Reproductive Anatomy and Physiology 3. FP Client Assessment 4. Infection Prevention in FP Services 5. Fertility-Awareness Based Methods 6. Hormonal Contraceptive Methods 7. Male Condom 8. Long-Acting and Permanent Methods 9. FP for Special Populations 10.Counseling for FP 11.Management of FP Clinic 12.Action Planning
1. Pre-pregnancy		
2. Family Planning		
D. Child Health care. The ability to provide appropriate, timely and effective primary care to children under 5 years old.		
E. Primary Health Care. The ability to provide appropriate, timely and effective primary care services to the members of his/her covered barangays.		

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
F. Customer Service. The ability to provide quality health services to ensure client satisfaction all throughout the continuum of care.	**A. CORE COMPETENCIES:** 3. Service Excellence. Ability to recognize and create opportunities to meet and exceed the needs and expectations of both internal and external clients of the organization.	

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
		(NTP, 2014 5th edition) Under the supervision of the nurse, do the following: - Identify presumptive TB patients and ensure proper collection and transport of sputum specimen. - Refer all diagnosed TB patients to physician and nurse for clinical evaluation and initiation of treatment. - Maintain and update NTP treatment cards. • Implement DOT with treatment partners: - Provide continuous health education to patients. - Supervise intake of anti-TB drugs. - Collect sputum for follow-up examination. - Report and retrieve defaulters within 2 days. - Refer patients with adverse reactions to physician for evaluation and management. - Supervise and mentor treatment partners
G. Integrity and Professionalism. The ability to align and maintain social, ethical, and professional norms and expectations in all job-related activities.	**A. CORE COMPETENCIES:** 1. Exemplifying Integrity. Ability to establish and maintain social, ethical and organizational norms within the organization and towards clients in accordance to the	

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
	Code of Conduct and Ethical Standards for Public Health Officials and Employees (RA 6713)	
	A. CORE COMPETENCIES: 2. Professionalism. Ability to exemplify high standards of professional behavior as a public servant, adhering to ethical as well as moral principles, values and standards of public office.	
H. Resource Management. The ability to maximize resources for optimal use during service delivery.		
I. Attention to Communication. The ability to receiving and convery ideas, instructions and/or information by using appropriate language, method and manner to ensure that the audience understands the message to elicit the necessary action.	**D. TECHNICAL COMPETENCIES** 8. Communicating technical information. Ability to convey technical and medical information through written, oral, or visual means to audiences of varying levels of technical knowledge compliant with set standards with regard to scope, order, clarity, conciseness, stylem and terminology.	
J. Program/Project Management. The ability to plan, implement, monitor and evaluate of projects/tasks to achieve health goals and improve health outcomes within budget, time and quality limits.	**D. TECHNICAL COMPETENCIES** 6. Case management. Ability to coordinate and implement the assessment, planning, assignment and resolution of operational requirements including medical cases anchored on major roles of DOH; i.e. leadership and health enabler and capacity builder; and administrator of specific services.	
HUMAN RESOURCES FOR HEALTH BLOCK		

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
A. Community Organizing. The ability to coordinate, organize and develop leaders and people of the community to facilitate successful implementation of health programs and achievement of the desired health outcomes.		
B. Political Savvy. The ability to identify and understand the work of an organization and utilize the dynamics of power and decision-making to achieve objectives.	**B. ORGANIZATIONAL COMPETENCIES** 3. Organizational awareness and commitment. Ability to gain knowledge of DOH culture, systems, and pressures; understands the agenda and perspectives of others; recognizes and balances the interests of one's department with those of other departments and the Agency, as well as the impact of decisions on each.	
C. Attention to Communication. The ability to receive and convey ideas, instructions and/or information by using appropriate language, method and manner to ensure that the audience understands the message to elicit the necessary action.	**B. ORGANIZATIONAL COMPETENCIES** 1. Effective Communication Skills. Ability to receive and convey ideas, instructions, information by using appropriate language, method and manner to ensure the audience understands the message and take necessary action.	
D. Managing Health Human Resource. The ability to mentor and motivate barangay health workers and midwives, and **manage their conflicts** towards better work performance (same as below)	**D. TECHNICAL COMPETENCIES**12. **Conflict resolution.** Ability to manage and resolve disagreements and conflicts in a positive and constructive manner to minimize negative impact.	
D. Managing Health Human Resource. The ability to mentor and **motivate barangay health workers and midwives**, and manage their conflicts towards better work performance (same as above)		

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
	B. ORGANIZATIONAL COMPETENCIES 2. Effective Interpersonal relations. Ability to develop and maintain effective relationships with others; notices and accurately interprets what others are feeling; shows understanding, tact, empathy, courtesy, concern and politeness.	
HEALTH INFORMATION BLOCK		
A. Managing Health Data. The ability to identify, collect and organize health data.	**D. TECHNICAL COMPETENCIES** 38. Records management. Ability to establish a system of procedures in recording and safekeeping of documented information for ease of storage and retrieval.	
B. Teamwork. The ability to participate as a full member of a team and work productively towards achieving health goals and improving health outcomes.		
C. Analytical Thinking. The ability to use logical and systematic reasoning to understand, analyze and resolve problems.		
D. Technical Writing. The ability to compose technical documents (e.g. policies, proposals, reports, letters, memorandum, minutes of meetings, manuals, briefing materials etc.) in a clear, concise and coherent manner.		
HEALTH FINANCING BLOCK		
A. Teamwork. The ability to participate as a full member of a team and work productively towards achieving health goals and improving health outcomes.		
ACCESS TO MEDICINE AND TECHNOLOGY (OR REGULATION) BLOCK		

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
A. Teamwork. The ability to participate as a full member of a team and work productively towards achieving health goals and improving health outcomes.		
LEADERSHIP AND GOVERNANCE BLOCK		
A. Community Organizing. The ability to coordinate, organize and develop leaders and people of the community to facilitate successful implementation of health programs and achievement of the desired health outcomes.	**D. TECHNICAL COMPETENCIES** 30. Organizing communities. Ability to coordinate, organize, and develop the individuals and groups of different communities involved and/or affected in health-related projects in order to facilitate implementation and success of the said projects.	
B. Political Savvy. The ability to identify and understand the work of an organization and utilize the dynamics of power and decision-making to achieve objectives.		
C. Advocacy and Networking. The ability to advocate health programs and establish and **maintain relationships or linkages** with local leaders and other stakeholders to achieve the desired health outcomes (same as below)	**D. TECHNICAL COMPETENCIES** 5. **Building relationship with clients.** Ability to build client relationships and leverage coalition in the implementation of plans, programs, policies, and activities geared toward the achievement of strategic intents of DOH.	
C. Advocacy and Networking. The ability to **advocate health programs** and establish and maintain relationships or linkages with local leaders and other stakeholders to achieve the desired health outcomes (same as above)	**D. TECHNICAL COMPETENCIES** 2. **Advocating Public health.** Ability to promote and advance the advocacies, programs, policies, and regulations of the local health unit and/or DOH to individuals, interest groups, assigned communities, offices, media outlets, and other clients through various communication channels.	

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
D. Teamwork. The ability to participate as a full member of a team and work productively towards achieving health goals and improving health outcomes.	**D. TECHNICAL COMPETENCIES** 37. Providing support and services. Ability to provide support and services in order to meet the administrative requirements of the office.	
E. Problem Solving and Decision making. The ability to make alternative courses of action while exhibiting judgement based on realistic understanding issues.		
	B. ORGANIZATIONAL COMPETENCIES 4. Promoting innovation. Ability to develop new and creative insights into situations, and applies different and novel solutions to make improvements and/or adaptations to available resources.	
	D. TECHNICAL COMPETENCIES10. Computer literacy. Ability to efficiently utilize Information and Communication Technology (ICT) tools such as hardware, software and electronic communications for data entry, work processing, spread sheet, internet and other computer applications to enhance work productivity and quality of outputs.	
	D. TECHNICAL COMPETENCIES 14. Continuous learning. Proactively investigates new perspectives, approaches, and behaviors, and takes steps to evaluate and improve performance.	

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
	D. TECHNICAL COMPETENCIES 21. Equipment, materials and supplies management. Ability to advise, review and coordinate the acquisition, loan, transfer and disposal of accountable property items per RA 9184 regulations and DOH property policies and procedures, and the DOH acquisition and property management process.	
	D. TECHNICAL COMPETENCIES 23. Government accounting and budgeting. Ability to perform bookkeeping, accounting, budgeting, and auditing processes in accordance to laws, principles, and practices of government/public financial management.	
	D. TECHNICAL COMPETENCIES 24. Government and departmental policies and procedures. Ability to understand and apply knowledge of government and departmental statutes, regulations, policies, and procedures.	
	D. TECHNICAL COMPETENCIES 25. Implementing health policies and regulations. Ability to implement knowledge of laws, executive orders, agency rules, and implementing rules and regulations relevant to the line of work.	
	D. TECHNICAL COMPETENCIES 41. Respecting and caring for patients. Ability to establish a relationship of trust with patient by treating him/her with respect to his/her religious, cultural, or social background; respecting the right of patient to confidentiality and privacy.	

Midwives at Health Centers		
Development Academy of the Philippines (PDF copy of terminal report)	**European Union (PDF copy of terminal report)**	**Expected Roles and Functions for TB, and FP services**
	D. TECHNICAL COMPETENCIES 51. Workforce planning. Ability to understand and demonstrate knowledge of business strategy and human resource (HR) concepts, principles, and practices to effectively align the needs of DOH and its workforce and to design strategies that support leadership in planning for and obtaining the necessary resources to carry out its mission.	

Annex B. Competency mapping for the provision of tuberculosis services

Identification of health facilities to be visited

The first step in observing exemplar health workers providing tuberculosis services was the identification of exemplar health facilities in the country. Facilities were identified as exemplar by using two criteria: 1) their ability to achieve desired TB outcome results and 2) their reputation. The assumption was the exemplar status of the facility was a direct result of the outstanding work of the health workers stationed at these facilities.

To identify exemplar health facilities in terms of TB service provision, HRH2030/Philippines solicited the program expertise of Dr. Marietta Solante, the Programmatic Management of Drug Resistant Tuberculosis (PMDT) Medical Specialist at the Lung Center of the Philippines. Dr. Solante heads the training of all new health workers to be stationed at the PMDT Treatment Centers (TCs) all over the country, as well as the monitoring of these TCs. With the nature of her responsibilities for PMDT, it can be said that Dr. Solante has the knowledge to identify exemplar TCs in terms of MDR-TB service provision. As per Dr. Solante's definition of exemplar TCs, these are the health facilities with good program indicators, such as Treatment Success Rate, Defaulter Rate, and other cohort-related indicators.

From the Key Informant Interview with Dr. Solante, the exemplar TCs in the country (regardless of whether a TC is government-owned or privately-owned) are the following:

Annex Table 6. Exemplar Treatment Centers in the country based on program data, Dr. Marietta Solante, LCP PMDT Medical Specialist (n=18)

Name of Treatment Center	Location
Lung Center of the Philippines Treatment Center	National Capital Region
San Lazaro Hospital Treatment Center	National Capital Region
Tayuman Treatment Center (under the Philippine Tuberculosis Society Inc.)	National Capital Region
Kabalikat sa Kalusugan (under the Philippine Tuberculosis Society Inc.)	National Capital Region
Karuhan Satellite Treatment Center	National Capital Region
Marikina Cough Center Satellite Treatment Center	National Capital Region
Pawatag Satellite Treatment Center	National Capital Region
Tala Treatment Center (Dr. Jose N. Rodriguez Medical Hospital)	National Capital Region
Dr. Elvira Lagrosa Health Center	National Capital Region

Name of Treatment Center	Location
Bicol Medical Center	Bicol
Bicol Regional Training and Teaching Hospital	Bicol
Sorsogon Medical Mission Group Hospital	Bicol
Batac Satellite Treatment Center	Ilocos Norte
Dingras District Hospital	Ilocos Norte
Ilocos Training and Regional Medical Center	La Union
Panopdopan Hospital	Ifugao
Maria Reyna-Xavier University Hospital	Cagayan de Oro

Using the information provided by Dr. Solante, HRH2030/Philippines then chose select health facilities to be visited. The facilities were selected based on two criteria: 1) proximity/location, and 2) ownership/type. Using the first criterion, the facilities at the National Capital Region were prioritized for these visits. For the second criterion, HRH2030/Philippines decided to select publicly and privately-owned facilities. With this, PTSI-KASAKA was chosen as one of the facilities to be visited, being a privately-run health facility. For the publicly-owned facilities, HRH2030/Philippines decided to choose one DOH-retained facility, and one LGU-owned facility, to show the contrasting management situation in these types of facilities. For the former, the Lung Center of the Philippines, a DOH-retained, Government-Owned and Controlled Corporation (GOCC) was chosen; for the latter, Dr. Elvira Lagrosa Health Center was chosen (Pasay City owned health facility).

Activities conducted for identifying competencies for the provision of tuberculosis services

Prior to the start of the health facility visits, HRH2030/Philippines planned to conduct 1) Focus Group Discussions (FGDs) among the four cadres manning the health facilities; 2) Key Informant Interviews (KIIs); and 3) Direct Observation of health workers at their duty stations. These methodologies were deemed appropriate to identify the competencies required for a health worker to provide quality TB care to the patients. However, during the conduct of the FGDs, HRH2030/Philippines was made aware of another activity, i.e., 4) Interrupter tracing. Interrupter tracing was a routine activity being conducted by health workers at TCs, to ensure that patients who interrupted their treatment will go back to the program to complete their two year or nine months treatment. Since interrupter tracing will provide additional perspective on the needed competencies for the management of TB patients, HRH2030/Philippines decided to add this activity for the competency mapping.

With this, from August to September 2018, HRH2030/Philippines conducted five FGDs, two KIIs, one patient flow observation, and two interrupter tracing among the three PMDT sites selected. The activities conducted are summarized below:

Annex Table 7. Summary of conducted activities for tuberculosis competency mapping, Aug. 24-Sept. 12, 2018

NAME OF ORGANIZATION	Activities	Date
***Samahang Lusong Baga* Inc.**	FGD	Aug. 24, 2018
Treatment Center, Lung Center of the Philippines	Focus Group Discussions (2) Key Informant Interviews (2) Patient flow observation (1) Interrupter tracing (1)	Aug 28, 2018 Sept 5, 2018 Sept 3, 2018 Sept 12, 2018
Treatment Center, Philippine Tuberculosis Society Inc.-*Kabalikat sa Kalusugan* (PTSI-KASAKA)	Focus Group Discussion (1) Interrupter tracing (1)	Aug 29, 2018 Sept 6, 2018
Treatment Center, Dr. Elvira Lagrosa Health Center	Focus Group Discussion (1)	Aug 30, 2018

From these activities, a total of 30 patients and health workers were encountered. Patients were included in the identification of health worker competencies, since they are the ones who receive the TB care from these health workers. However, majority of the participants in this competency mapping were health workers, where nurses make up majority (37%) of those interviewed. The table below summarizes the participants in this competency mapping activity.

Classification	Frequency (%)
Patients	9 (3)
Physicians	4 (13.33)
Nurses	11 (36.67)
Medical technologists	4 (13.33)
Midwives	1 (3.33)
Nursing attendant	1 (3.33)

Documentation of conducted activities

The details of the FGDs, KIIS, and interrupter tracing activities are presented below:

Focus Group Discussion among select members of Samahang Lusog Baga Inc.
Aug. 24, 2018, 1:00 PM-4:30 PM
Serye Restaurant and Café, Quezon City

HRH2030/Philippines invited the members of the *Samahang Lusog* Baga Association, Inc. (SLBAI) to a Focus Group Discussion. The main objectives of this FGD was to discuss the desirable competencies, and qualities of health workers providing TB care from the patient perspective. The SLBAI members, including their adviser and co-founder, Dr. Vivian Lofranco, were gathered in Quezon City for this event.

Key Observations/Pertinent discussion points

A. The desirable qualities, and competencies among health workers providing PMDT services, were identified by the SLBAI members. Identification of these qualities, and competencies was through a workshop, wherein the participants were requested to write down the characteristics of health workers that either they observed, or they want to observe, among the PMDT health workers. The results of the workshop are as follows:

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1. The desirable **QUALITIES** for physicians are the following (those in bold letters were identified by multiple participants):

- **Caring**
- **Kind**
- **Understanding**
- **Intelligent**
- **Approachable**
- Humble
- Thoughtful
- Friendly
- Helpful
- Godly
- Respectful
- Hard-working
- Loving
- Beautiful
- With common sense
- With a sense of humor

2. For the most desirable **COMPETENCIES** among physicians, these are:

- **Effective communicator**: can clearly explain the disease/diagnosis/treatment to the patients
- Have enough clinical knowledge how to treat the disease
- Active learner: to know new methods to treat the disease
- Interpersonal skills: treats patients not just as patients but as a person with feelings

3. For nurses, the most desirable **QUALITIES** are:

- **Understanding**
- **Hard-working**
- **Kind**
- **Values patients:** e.g. reminding the patients to always take their medicine
- **Easy-going/happy to be with/friendly**
- **Caring/helpful**
- Approachable
- Knows how to easily explain the disease/treatment to the patients
- Gentle
- Professional
- Intelligent
- Strict

4. For the most desirable **COMPETENCIES** among nurses, these are:
- **With steady hands for injection of drugs**
- **Interpersonal skills**: knows how to properly treat a patient
- Can perform tasks that doctors cannot perform
- Good counsellor

5. For medical technologists, the participants were only able to identify the desirable **QUALITIES**:
- Handles specimens with care
- Efficient (releases results quickly)

6. The participants only identified one **COMPETENCY** for midwives, since they were not in contact with this cadre during their treatment. However this was not related to TB service quality:
- Capable of going house-to-house to check on children who needs immunization.

7. For pharmacists, the desirable **QUALITIES** are:
- Easy to ask for needed drugs
- Highly aware if there are stock outs of drugs
- Kind

8. The participants did not identify any desirable competency for medical technologists.

B. Dr. Borromeo also requested for the participants to tell their own story recalling an outstanding doctor, nurse, that they encountered when they were still a TB patient.

1. One of the participants (Ms. X) recalled her experience with an outstanding doctor (Dr. Caparas). Ms. X initially consulted with a private practitioner, and Ms. X was told to only come back when Ms. X experienced vomiting due to the TB medication. Ms. X felt that she was not receiving quality care from this doctor, thus she went to another private practitioner, Dr. Caparas. This doctor used to practice at the Lung Center of the Philippines, hence was familiar with the NTP TB case management. Ms. X experienced jaundice and thus, Dr. Caparas referred her to a DOTS facility, and encouraged Ms. X to continue with the treatment. Ms. X saw that Dr. Caparas cared about her, and not only cared about earning her money from her as a TB patient.
2. Ms. Y recalled her experience with three outstanding doctors at the Lung Center of the Philippines. Ms. Y can even reach out to her doctor thru Facebook (Dr. Rose Santiago) if Ms. Y needed helped. All three doctors still asked how she is until now, even if her treatment is already completed. Ms. Y also identified Dr. Lofranco as an outstanding doctor. Dr. Lofranco initiated forming a group among patients to help the patients encourage each other.
3. Ms. X recalled her experience with outstanding nurses at LCP. The nurses treated her with compassion, and not just as a patient. The nurses would greet her during her monthsary (of TB medication) to encourage her to continue her treatment; and the nurses would also remind her to submit her sputum diligently.
4. Ms. Z recalled her experience with an approachable nurse. This nurse would always ask the patients how they are, actively following up with the patients even on Saturdays. This nurse would always ask the patients if they are experiencing any adverse event with the TB medication. This nurse would also commend if there are any improvements in the patients (like if a patient gained weight), to continue encouraging the patients to continue with their medication.
5. Ms. A recalled a "cute" nurse who is genuinely concerned with her during her treatment. She appreciated this nurse not only because he is "cute" but also because she can see that he really cared about the patients during their treatment.

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Focus Group Discussion among select members from the Lung Center of the Philippines
Aug. 28, 2018, 1:30 PM-3:00 PM
Lung Center of the Philippines

HRH2030/Philippines visited the Programmatic Management of Drug Resistant Tuberculosis (PMDT) Treatment Center at the Lung Center of the Philippines (LCP) to conduct a Focus Group Discussion among the health workers. The main objectives of this FGD was to discuss the desirable competencies, and qualities of health workers providing TB care to ensure high quality TB services are provided to the patients. The PMDT-Treatment Center team at LCP was identified as one of the exemplar teams in the country (based on treatment outcomes) by the PMDT Training team led by Dr. Marietta Solante, PMDT Medical Specialist at LCP.

Key Observations/Pertinent discussion points

A. The health workers at the PMDT Treatment Center of LCP identified the desirable qualities, and competencies among health workers providing PMDT services. Identification of these qualities, and competencies was through a Focus Group Discussion, wherein the participants were requested to identify the qualities and competencies that are desirable in their own respective cadres. The identified qualities by cadre are as follows:

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– **Desirable qualities in the four cadres are the following:**

Physicians

1. **Knowledgeable**
2. **Team player**: should not see oneself as the boss, but must be considerate on the needs of one's teammates
3. **Considerate**: do not make the patients feel as if they are less superior to you as their physician
4. **Sincere**: patients can feel if you are sincere when you show your concern to them
5. **Dedication:** if one has dedication, it enables you to continue on with your job, otherwise, it is easy to quit this kind of job.
6. **Knowledgeable**
7. **Team player**: should not see oneself as the boss, but must be considerate on the needs of one's teammates
8. **Considerate**: do not make the patients feel as if they are less superior to you as their physician
9. **Sincere**: patients can feel if you are sincere when you show your concern to them
10. **Dedication:** if one has dedication, it enables you to continue on with your job, otherwise, it is easy to quit this kind of job.

Nurses

1. **Passion/compassion to serve**
2. **Knowledgeable:** on how to handle PMDT patients
3. **Learner:** with PMDT updates; never stop learning
4. **Versatile/Flexible**: on how to perform their tasks
5. **Patient:** one must have patience to continuously encourage the patients to take their medicine, and complete their treatment
6. **Understanding:** you must put yourself in the shoes of the patients so that you can understand what they are going through

Medical Technologists

1. **Passion with a purpose**

2. **Integrity**: the character of the person affects the kind of work that he/she will produce.
3. **Teachable/willing to learn**
4. **Focused**: with the heavy load (both technical and administrative load) that they are managing in the laboratory, it is desirable for a PMDT medtech to be focused always, to ensure that everything is in order, and for a fast turnaround rate.
5. **Organized**: with their records, reports, lab tasks to avoid backlog in the laboratory.

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B. Desirable competencies among the four cadres are the following:

Physicians

1. **Educated and well-versed on what you need to do** (PMDT patient management): how do you manage an MDR-TB patient? What are the latest treatment updates for MDR-TB? These must be considered if one wants to be competent.
2. **Assertive**: do not be afraid to speak up and be brave

Nurses

1. **Effective communicator:** one needs to effectively communicate the treatment, the disease, to the patients at their level of understanding
2. **Good counsellor:** counselling must be a two-way street; listen to the patients and talk to the patients.
3. **Good with the needed technical skills**
4. **With good management/organizational skills**

Medical Technologists

1. **Technically competent:** all laboratory techniques that they are performing now are new (except DSSM), hence one needs to be well-versed with these techniques.
2. **Systematic:** with records, with laboratory tasks, logistics, supplies
3. **Knows how to prioritize**
4. **Teachable:** easy to absorb new learnings, and transfer these to the other members of the team
5. **With good time management**: this is significant on their daily work activity

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C. The participants also discussed the adequacy of pre-service training they received that enabled them to be effective PMDT providers. The participants' insights are as follows:

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1. The concepts for PMDT were not taught during their undergraduate years, even in medical school.
2. For the medtechs, all techniques were new. Since LCP is a specialized laboratory, all laboratory techniques that they are doing now were not taught in school.
3. Management and leadership skills were not taught in medtech courses, and these skills are necessary for their work now.
4. For physicians, the relevant skills for patient management were not taught in med school, but you get to learn these during your internship.
5. A deeper version of the therapeutic communication taught in nursing school is needed for nurses to be better equipped with counselling. Counselling is an important skill in PMDT management since patients experience numerous adverse events during their treatment.

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D. The participants also identified the issues that can determine their willingness to stay and serve in the country as health workers. These issues are as follows:

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1. **Provide security of tenure**: Most important of all issues. All of them are PBSP-hired, and their contracts are only until 2020 (no long-term plan yet). Since the staff are PBSP-hired, turnaround rate for health workers is high.
2. **Provide better compensation**
3. **Provide long-term benefits**

4. **Provide hazard pay**
5. **Provide uniform allowance**
6. **Provide all needed supplies/equipment for protection of HRH**: In their laboratory, the filter replacement of the P3 cabinet was delayed but the medtechs kept on working as to avoid delay in their work.
7. **Provide adequate training**: The medtechs are requesting that the appropriate authorities aid them to be more proficient with the skills they need. This will then provide the medtechs with more confidence to do their work.
8. **Support from management**: LCP can be more inclusive with the PMDT team even if they are PBSP-hired. There is currently no LCP representative/liaison officer providing oversight to the PMDT team.

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E. Other matters discussed in the FGD were:

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1. HRH2030 requested to return on Sept. 3 to observe patient flow in the PMDT Treatment Center. Dr. T agreed to this request.
2. A general assembly among the current and completed MDR-TB patients is held every last Saturday of the month. HRH2030 requested to be present this event. The next general assembly is on Sept. 29, 2018. Dr. T welcomed HRH2030's presence on this date.
3. HRH2030 requested to participate during LCP's interrupter/default tracing. Mr. C will inform the HRH2030 team of the next scheduled date for this activity.

Recommendations and Conclusions

Based on the discussion in this group, one pertinent point that was emphasized was the importance of counselling skills among PMDT health workers. In addition to the importance of clinical knowledge, the health workers felt that they should also be equipped with counselling skills, given the nature of the MDR-TB treatment that they are providing. They assessed that they, as health workers, may encourage the patients more to complete the intensive TB treatment (before it was 2-3 years, now this is only for nine months) if they have been well-trained with counselling.

HRH2030 learned that the PMDT health workers are also involved in interrupter tracing, wherein the patients are visited in their homes/workplaces if they have consecutively missed their direct observation treatment (DOT). This activity entails a different skillset compared to the qualities and competencies a health worker must possess in the health facility. Thus, HRH2030 identified this activity as another potential source of competencies for documentation.

Focus Group Discussion among select members from Philippine Tuberculosis Society Inc.-*Kabalikat sa Kalusugan* (PTSI-KASAKA)

Aug 29, 2018; 9:00 A.M-2:00 P.M.

PTSI-KASAKA, Quezon City

HRH2030/Philippines visited the Programmatic Management of Drug Resistant Tuberculosis (PMDT) Treatment Center at PTSI-KASAKA to conduct a Focus Group Discussion among the health workers. The main objectives of this FGD was to discuss the desirable competencies, and qualities of health workers providing TB care to ensure high quality TB services are provided to the patients. The PMDT-Treatment Center (TC) team at PTSI-KASAKA was identified as one of the exemplar teams in the country (based on treatment outcomes) by the PMDT Training team led by Dr. Marietta Solante, PMDT Medical Specialist at LCP.

Key Observations/Pertinent discussion points

A. The facility visited is a private, non-government institution providing PMDT services, in accordance to the National Tuberculosis Control (NTP) guidelines. PTSI was founded in 1938, to primarily provide TB services to the underserved population. t

B. There were only two full-time staff assigned at the TC, Ms. M (Clinic Support Staff/Nursing Aide) and Dr. V (Physician). Both staff were hired by the Philippine Business for Social Progress (PBSP) under the Global Fund initiative, and hence, are project-based staff. The other staff that was stationed at the DOT, Ms. C, is an organic staff at PTSI. This additional nurse is being deployed from the roster of nurses from the PTSI hospital and is changed every six months. As per Ms. F, PTSI decided to rotate the permanent nurses so that they will learn the PMDT program. Another staff, Mr. R, a Nursing Attendant, also mans the TC. He provides support to DOT, and interrupter tracing. All in all, there are four health workers in direct contact with MDR-TB patients at the TC. In addition to these four staff, a medical technologist is assigned for MDR-TB sample analysis (DSSM and GeneXpert).

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C. The staff at PTSI-KASAKA identified their good practices for managing MDR-TB. These are as follows:

- **Flexible schedule of DOT**: The staff adjusts their clinic hours to cater to the patient's needs. Compared to other TCs, PTSI-KASAKA is not limited to dispensing medicine from 8:00 A.M. to 12 noon, but instead, considers the patient's availability. For example, if a patient needs to go to work by 8:00 A.M., then the TC staff will open the clinic by 5:30 A.M. The staff dispenses medicine and provides DOT even up to 7 P.M. if need be.
- **Strict quick turnaround for DSSM results**: In PTSI, the 24-hour rule for providing the results of DSSM is strictly enforced.
- **Engages community authorities to trace patients**: During interrupter tracing, the staff seek out the help of barangay officials to trace the patients.
- **Family counselling**: The staff at PTSI-KASAKA also provides counselling to the patient's family members to ensure that the support of the family is provided to the patients while on treatment.

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D. The staff were requested to identify the qualities among their cadres, which would enable them to be exemplar TB service providers. The responses of the participants are as follows:

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– **Physicians**

- **Compassionate**: A physician must show compassion to the patients, since they are already suffering from the adverse events of the drugs they take.
- **Cruel only to be kind**: A physician must be cruel to some extent to the patients to ensure that they will take their medicine.
- **Flexible**: A physician must be flexible with how they treat their patients, depending on their status (educated, uneducated), to ensure that the patients' needs are addressed.

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– **Nurses**

- **Approachable**: A nurse must be approachable so that the patients will be open to them, on what they feel, especially with the effects of the medicine they are taking.
- **Friendly**
- **Compassionate**

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– **Midwife**

- **Cool:** So that the patients will feel at ease; it will make the patients feel more comfortable.
- **Patient**
- **Always in a happy state**
- **Flexible/easily adjusts to cater to what the patient needs**

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– **Medical technologist**

- **Efficient:** For a quick turnaround time for sample analyses
- **Organized:** A medtech must not use any shortcuts in work
- **Systematic:** To ensure efficiency in completing analyses
- **Knows how to multi-task:** To ensure efficiency in completing analyses

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E. After identifying the qualities, the staff also identified the competencies that are desirable for PMDT providing health workers to possess, and these are:

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– **Physicians**

- **Skilled in interpersonal communication/counselling**
- **Clinically competent to manage MDR-TB patients**

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– **Nurses**

- **Clinically competent**: In terms of addressing the adverse events being experienced by the patients
- **Skilled in interpersonal communication/counselling**

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– **Midwife**

- **Skilled in interpersonal communication/counselling**

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– **Medical technologist**

- **With integrity:** In giving out the true results of the samples
- **Strict:** In receiving specimens to be analyzed; this is to ensure of high quality results
- **Aware of the value of one's work:** A medtech must realize the value of his work in relation to its contribution to a patients' treatment process

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F. The staff were asked for the possible reasons why the number of TB cases is still rising. Their professional opinion are as follows:

- Patients are usually lost to follow up due to their work schedule. One strategy used by the PTSI-KASAKA staff to address this is to give the medicine to the company nurse (DOT at the workplace).
- Patients choose to be functional at work over taking their medicine. After the patients take their drugs for the day, they are usually not functional for at least half a day because of the side effects they experience. If patients are given livelihood programs while taking their medicine, lost to follow up may be lessened.
- Patients stop their treatment because of the adverse events (AEs) they experience. Most common AEs are vomiting and nausea. Some experience mental disturbances due to cyclosporine. There were a few patients at PTSI-KASAKA that needed to be taken to the mental hospital because of this AE.
- Patients stop their treatment after they feel better, even if they are just halfway their treatment.

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G. The staff also identified the training they received to prepare them for PMDT service delivery. This included DSSM (for the medtech), clinical management of MDR-TB led by trainers from the International Union Against Tuberculosis and Lung Disease (IUTLD) sponsored by PBSP (for the physician), and interpersonal communication and counselling (for physicians) training sessions.

Recommendations and Conclusions

It is recommended that more Focus Group Discussions be conducted to obtain more information related to the qualities and competencies desired for a PMDT health worker to possess for MDR-TB service delivery.

Also, the staff of PTSI-KASAKA suggested that HRH2030 accompany them during interrupter tracing, so that the competencies needed for this type of activity may be included in the competency mapping.

The perspective of medical technologists is always different from the perspective of the other cadres of health workers (physicians, nurses, and midwives), hence, medtechs must always be represented in the FGDs. For the three cadres, they present similar qualities and competencies, and hence, their responses may be thematically analyzed together. This is because the three cadres are all involved with direct patient care, and medtechs are confined in the laboratory.

Pharmacists were once part of the PMDT team when there were a high number of patients at the TC. However, since MDR-TB patients were decentralized (referred to the health centers from the TCs), the number of patients decreased, thus there was no need for pharmacists to be present at the TCs.

The situation at PTSI-KASAKA is different from what was seen at the TC of LCP; for the former, permanent staff from the institution are involved in PMDT service delivery, while in the latter, only project-based staff are involved. Thus, it can be said that if Global Fund cease to provide funds for PMDT (personnel salary most importantly), PTSI-KASAKA may be predicted to still function and provide Tb services to MDR-TB patients, as the permanent staff here are slowly but surely being trained with PMDT.

Focus Group Discussion among select health workers from Dr. Elvira Lagrosa Health Center

Aug 30, 2018; 10:00 A.M-4:30 P.M.

Dr. Elvira Lagrosa Health Center, Pasay City

HRH2030/Philippines visited the Programmatic Management of Drug Resistant Tuberculosis (PMDT) Treatment Center at Dr. Elvira Lagrosa Health Center to conduct a Focus Group Discussion among the health workers. The main objectives of this FGD was to discuss the desirable competencies, and qualities of health workers providing TB care to ensure high quality TB services are provided to the patients. The PMDT-Satellite Treatment Center (STC) team at Lagrosa Health Center was identified as one of the exemplar teams in the country (based on treatment outcomes) by the PMDT Training team led by Dr. Marietta Solante, PMDT Medical Specialist at LCP.

Key Observations/Pertinent discussion points

A. **Establishment and ownership**: The STC at Lagrosa Health Center was established last 2011. Since this is a health center, management and ownership is with the local government unit of Pasay, unlike the other PMDT sites that were previously visited (Lung Center of the Philippines is a Government-Owned and Controlled Corporation, and PTSI-KASAKA is a privately-run health facility). By 2012, the health center provided screening services to the whole city of Pasay. Currently, Lagrosa Health Center caters to 25 barangays.

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B. **Treatment Success Rate:** As of 2016, the Treatment Success Rate (TSR) of this STC was 61%. Despite this relatively high TSR, it still fails to reach the World Health Organization (WHO) TSR target range of at least 75% up to 90%[16], and the Philippine target of 85% by 2022[17].

C. **Sufficiency of staff:** With the implementation of iDOTS (integrated Directly Observed Treatment, Short Course) starting in 2015, there are now less patients at Lagrosa Health Center. Currently, there are only 40 MDRT-TB patients receiving treatment at the health center (with four full-time staff: three PBSP-hired nurses, and one LGU-hired physician), compared to 60 patients back in 2012 (with one nurse, and one physician). As per Dr. Demdam, there is sufficient staff at the health center. Before, the nurse to patient ratio was 1:30, but the current ratio now is at 1:40.

D. **Project-based to plantilla staff**: The LGU may not absorb the PBSP-hired health workers due to the limited number of plantilla available. Also, any staff to be hired must be a registered voter in Pasay City.

E. **Referral partners**: Lagrosa Health Center receives referrals from San Juan de Dios, and Adventist Hospital, two privately-run hospitals in Pasay City.

F. **Diagnostic capacity**: The LGU hired one medical technologist when PBSP provided a GeneXpert machine. Currently, there are two GeneXpert machines in the facility. The cartridges are being provided by the Department of Health (DOH).

G. **Physical situation at the STC**: The PMDT health workers are staffed in a small, dilapidated office inside the health center compound. There have been three burglaries since 2015, but until now, the LGU has yet to improve the office. PBSP signified that they will donate a trailer van, however, due to security reasons, this suggestion was deemed impractical.

H. **Innovations**: At Lagrosa Health Center, they engaged community treatment partners to reduce defaulters. The community treatment partners are involved even in the injection of drugs of the patients. Further, the health center tap the barangay officials to find defaulters.

I. **Competencies**

– **Physicians**: Dr. D identified the necessary competencies for an MDR-TB providing physician. These competencies are:

- **Sweet attitude**: Dr. D was immersed at the Lung Center of the Philippines for a week, and in here, she saw how sweet the health workers were towards the patients. After her immersion, Dr. D carried this attitude with her, since she saw that being sweet was effective to hold the patients in the treatment course.
- **Love and value the work**: Dr. D indicated that she loves her work that is why she thinks she is doing a great job.
- **Knowledgeable with the PMDT program**

[16] Kibret et al. 2017. Treatment outcomes for multidrug-resistant tuberculosis under DOTS-Plus: a systematic review and meta-analysis of published studies. BMC Infectious Diseases of Poverty. Accessed from https://idpjournal.biomedcentral.com/articles/10.1186/s40249-016-0214-x

[17] Garfin, C. 2017. 24th PhilCAT Convention. 2017-2022 Philippine Strategic TB Elimination Plan: Phase 1(PhilSTEP 1). Accessed from https://www.philcat.org/PDFFiles/PhilSTEP1_PhilCAT_2017.pdf

– The two PBSP-hired nurses identified the competencies necessary for a PMDT nurse to possess, to be effective in the program. These competencies are:

– **Nurses**

- **Administratively competent**: A PMDT nurse must have financing skills, and data management skills
- **Management skills**: In terms of managing the records of the patients, and drugs
- **Must know how to multi-task**
- **Must be passionate to do the tasks**

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J. Qualities

– **Nurses**: The desirable qualities for a PMDT nurse are:

- **Exemplifies team leadership**
- **A team player/teamwork:** This, and team leadership, are needed to provide quality care service to the patients
- **Shows sensitivity:** To gain the trust of the patients
- **Patient with authority:** These two should be together
- **Good listener/counsellor:** This is especially important for defaulters. Patients open up to the health workers when the patients see the health workers listening to the other patients.
- **Able to treat patients as friends**
- **Trustworthy:** This, and the quality above, will enable the nurses to have a good relationship with the patients
- **Authoritative:** This is needed so that the patients will take their medicine
- **Knows how to self-evaluate:** A nurse must know when to self-evaluate so that he/she will be made aware of the good approaches to use to a patient
- **Knows intrapersonal communication and counselling**
- **Organized**

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K. Retention: The staff were asked how they can be retained as health workers in the facility. Their requests include:

- **Security of tenure**: Security of tenure is the most important reason for a health worker to be retained. There is a standing memorandum between PBSP and the LGU that the latter will absorb the staff in the near future. However, as per the nurses interviewed, the LGU prefers to hire their relatives.
- **Provision of incentives**: To recognize the good work that is being done by the health workers.
- **Provision of better facilities**: The current state of the STC's office discourages the workers to go to work every day.

Recommendations and Conclusions

Despite the discouraging office situation at Lagrosa Health Center, the staff seemed dedicated in providing quality care to their MDR-TB patients. The health workers mentioned repeatedly that they wish that the PMDT management at the central level will also take care of the plight of the health workers, and not only the patients. It was also emphasized that the lack of tenured position drives the health workers to better opportunities, hence, this singular solution can make or break the human resource for health situation in PMDT centers, where majority of the health workers are hired by PBSP.

Observation of Patient Flow at the Lung Center of the Philippines PMDT Treatment Center
Sept 3, 2018; 8:30 A.M-12:00 noon

Lung Center of the Philippines

HRH2030/Philippines visited the Programmatic Management of Drug Resistant Tuberculosis (PMDT) Treatment Center and the DOTS Center at the Lung Center of the Philippines (LCP) to observe patient flow. Notes from the observation will serve as inputs to develop the competency assessment tool, where the desirable competencies among health workers will be enumerated.

Key Observations/Pertinent discussion points

A. The health workers at the PMDT Treatment Center of LCP described the various stations (represented by the tents) that the patients will need to go through as they complete their treatment for multi drug resistant tuberculosis (MDR-TB). The stations are as follows:

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1. First tent: Screening station- where the potential MDR-TB patients consult the nurses. Time management is highly desirable here, since there are a lot of patients who are waiting for their turn, and all of them were requested not to eat prior to their submission of sputum sample (two hours prior to sputum collection). Hence, the nurse manning this station must be highly efficient. Also in this station, it is important that the nurses know how to effectively explain to the patients that once they tested positive for MDR-TB, they need to come back for treatment. Hence, counselling skills is highly important in this station. It is also important to convey to the patients that there is a high probability that they are infections, hence the need for the health workers to wear masks (N95 or N100 masks). It is imperative that this fact is explained to the patients without offending them.
2. Second tent: Positive station- where the positively identified MDR-TB patients take their drugs thru direct observation treatment (DOT). This is called the positive station since the patients who are here are those who still have positive sputum samples. There are two tents here: a) tent where the patients take their drugs; and b) tent where the patients receive their injection. In the second tent, there is a privacy panel where the patients and nurse can do the injection in case the patient wishes to receive the injection in their hip area. In this station, it is important for the nurses to emphasize that the drugs are free; this fact may help the patients see the positive side despite the fact they were diagnosed with MDR-TB. In addition, this is considered as the most crucial station of all, since the patients will experience the worst adverse events during their 3-4 months of treatment. Hence, the nurses must continuously encourage the patients to come back and take their drugs daily. Once the patients voice out the adverse events, the nurses must listen to the patients so that the appropriate management of the adverse events may be given to the patients (change of drug combination, referral to the PMDT physician or to a specialist, and others).
3. Third tent: Negative station- where the MDR-TB patients who seroconverted to negative sputum samples. This is where the patients take their drugs thru DOT. This is where the patients finish their treatment. Either the nurses, or volunteers (previous MDR-TB patients) man this tent. The volunteers provide a valuable contribution to this tent, since they provide a concrete evidence that MDR-TB can be cured; the volunteers also provide their past experience to the current patients, to encourage them to continue on with their treatment, despite the adverse events.
4. Fourth tent: Research station- where the research group of LCP is stationed to recruit potential research subjects. All patients recruited are MDR-TB patients.
5. Fifth tent: Drug-susceptible station- where the potentially drug-susceptible TB (DS-TB) patients consult. These patients usually come from referrals from the outpatient department, or from the specialists of LCP. If the patients have never been previously treated for TB, they are screened in the DS-TB station. Once their sputum samples are tested positive, they are referred to the health center nearest to their homes. If the patients have previously been treated for TB (either completed treatment, or defaulter), they are referred to the first tent, to be screened as potential MDR-TB patients.

B. The health workers only man the first to the fourth tents in the morning (8:00 A.M. to 12 noon), as all screening and treatments of MDR-TB patients are only done in the morning. For the fifth tent, the health workers man this from 8:00 A.M. until 4:00 P.M., since referrals from the OPD, and specialist clinics come until the afternoon.
C. After the PMDT nurses man the tents, they now complete the necessary forms (paper-based and electronic) for reporting purposes.
D. The PMDT DOT is manned every day, and even during holidays or typhoons.
E. The health workers at the PMDT created a private (for confidentiality purposes) Facebook group called Lung Center Survivors. This is where updates are shared to all members (socialization events such as Christmas parties, General assemblies, Halloween parties, Nutrition month cook outs, etc). Successful treatments are shared here to encourage the other patients.
F. The health workers from the PMDT and the DOTS come together every Wednesday for a Bible study group. This serves as their outlet to share their experiences, answered prayers, and issues. The participants indicated that this bible study group helps them be better health workers.

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Recommendations and Conclusions

The specific competencies per tent must be identified since the various tents call for different skills and competencies. Next step is an in-depth discussion of these competencies with the health workers manning these tents. HRH2030 will also observe the bible study group at LCP, to see how this activity helps them be more competent health workers as claimed by some of those who work at this site.

The health workers at LCP identified other health facilities that are good potential facilities to be visited by HRH2030. These are:

Exemplar health centers:

1. Gulod Health Center- contact is Ms. O (nurse)
2. Sauyo Health Center- contact Ms. N (nurse)

The skills and competencies of the health workers in these health centers will also be documented during the facility visits.

Health centers that face challenges in their TB services:

1. Culiat Health Center- even if this facility has been converted to an iDOTS (integrated DOTS facility, where MDR-TB patients are referred by Treatment Centers), the health workers are not accepting MDR-TB patients. System issues were identified as a potential flaw in this facility.
2. Bagbag Health Center- no system in place to handle MDR-TB patients
3. Apolonio Health Center- potential issue here are the patients

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Key Informant Interviews and Observation of LCP's Bible study group
Sept 5, 2018; 2:30 A.M-6:00 P.M.

Lung Center of the Philippines

HRH2030/Philippines visited the Programmatic Management of Drug Resistant Tuberculosis (PMDT) Treatment Center and the DOTS Center at the Lung Center of the Philippines (LCP) to conduct Key Informant Interviews

(KIIs) with two exemplar nurses from this facility. Information from these KIIs will serve as inputs to develop the competency assessment tool, where the desirable competencies among health workers will be enumerated.

Key Observations/Pertinent discussion points

A. Ms. D, a 10-year veteran nurse at the PMDT Treatment Center was interviewed to obtain in-depth information on the necessary skills and competencies to be an exemplar health worker. For a more systematic discussion, HRH2030 requested Ms. D to imagine that she is orienting a newly hired PMDT nurse. Ms. D then discussed the pertinent skills and competencies for each PMDT station. These are as follows:

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1. **Stage 0**:
   - Assess the readiness of the staff to handle MDR-TB patients. A new staff must understand that one must not contribute to the stigma towards TB patients, regardless if they are MDR-TB cases. With this, a new staff must understand when a mask is needed or not when attending to the patients.
   - The new staff must be oriented to the layout of the Treatment Center, so that the staff can clearly explain to the patients how patient flow works.
2. **Stage 1 at the First tent: Screening station**:
   - Health workers must be inviting/welcoming here so that the potential MDR-TB patients will feel at ease. Even if health workers are wearing a mask at this station, everyone is encouraged to smile to the patients.
   - A health worker must introduce oneself to the patients, including name and position, as some patients respect the health workers based on their position.
   - Quickly profile the patient so you can adjust how you should interact/talk to them (are they educated, or not?).
   - A health worker must be sensitive to the needs of the patients, since you need to come back to the health facility, especially if their sputum result is positive for MDR-TB. A health worker must act like a social worker at this station since you need to be concerned with the patients' concerns. Putting on this hat may make the difference for a patient to come back after the screening.
   - A health worker must be very patient at this point, carefully explaining the informed consent to the patients, and making them understand of the seriousness of the situation.
   - It is an advantage is a health worker knows another language (Cebuano, Ilocano etc) since some patients may better understand the explanations in their native languages.
   - In this station, it is also important to have a trained clinical eye; a health worker must not only assess if a patient has TB, but also HIV, or other diseases (diabetes for example). With this, HIV testing must also be conducted.
   - A health worker must have good interviewer skills at this point, especially for history taking. One must be very inquisitive to get all relevant health information from the patient; get more information beyond what is being asked in the patient form.
   - A health worker must be very sensitive, but still effective, when taking down sexual history of the patient. A health worker must strategize how to get this information from the patient, if a patient brought along a companion (especially spouses, and parents). Gently ask the companion to leave while the health worker asks the sexual history of the patient.
   - A health worker must be skilled in providing instructions to the patients. To make sure that the patients understood the instructions, ask the patients to repeat what has been explained to them. For sputum collection, a health worker may demonstrate how to properly get a sputum sample, to ensure high quality samples from the patients. Provide step-by-step instructions to limit misunderstanding.
   - If a patient cannot expel a sputum sample, a health worker must be very encouraging at this point. Give them other ways on how to expel sputum.
   - A health worker must have an understanding heart at this station; be considerate. Sputum collection must be done at least two hours after meal, if this is not the case, ask the patient to stay behind the line so they can still give their sputum sample that day. Do not ask them to come back the next day without strategizing the best possible solution for a patient to give their sample on the same day.

- To encourage a patient to return, a health worker must provide the proper counselling to the patients. Emphasize to the patients the importance of coming back to get the results. If the test is positive for MDR-TB, explain (sort of black mail the patient) that they cannot be given the medicine unless they return to the facility.

3. **Stage 2 at the Second tent: Positive station**:
   - Be very welcoming at this station since this is where the patients will start their treatment. A health worker must now show that they are not afraid of the patients because they have MDR-TB.
   - The health worker must properly counsel the patient of the importance of the treatment (including duration, and possible adverse events that they will experience). Proper counselling must be given, especially to the previously treated patients (DS-TB who were only treated for six months). The treatment difference of an MDR-TB patient from a DS-TB patient must be thoroughly explained to the patients.
   - A health worker must have an open-mind with the fast-changing treatment algorithms for PMDT (as there are always new algorithms provided by WHO). A health worker must always be willing to learn these new treatment guidelines.
   - A health worker must still have a good clinical eye at this point.
   - A health worker must have the proper counselling skills to explain to the patients why they are experiencing the adverse events, and how to encourage them to stay despite of all of these.
   - A health worker must have a peripheral vision to see if the patients are really taking the drugs or if they are keeping it in their pockets, or in their hands. A health worker must be very vigilant at this station.
   - A health worker must know how to properly admonish a patient if one is not taking their drugs; talk to the patient privately and not in front of the whole group as not to embarrass them. This will show the patient that they are still respected even if they did something wrong. However, be very strict with them regarding this issue to avoid repeated behavior. Ask the patient why they did what they did (pocketed their drugs for example) so that you can address the issue.
   - A health worker must have an attentive ear/a listening ear so that you will understand your patient, and hence, be able to help them to complete their treatment. Listen beyond their TB problems, even listen to their family problems, personal problems, to have a deeper understanding on why a patient acts the way they act.
   - If there are numerous new patients, a health worker is encouraged to conduct a group discussion. In this session, ask the patients for their expectations during the course of their treatment. Explain the house rules at the facility.
   - A general assembly (GA) is conducted once a month at LCP. The GA is an avenue to celebrate the graduation of patients from their treatment. Also, this is an avenue for the health workers to ask how the patients are. However, health workers must still ask the patients how they are every single day, when the patients come in for their DOT. During the GA, pastors/priests are invited to speak to the patients.
   - A health worker must always be encouraging at this station.
   - When receiving the injection, a health worker must be sensitive if a patient is experiencing pain in the injection site; be sensitive to the patient's needs. Be very gentle during the injection as not to traumatize the patient.
   - A health worker must know how to provide clear instructions (health teaching).
   - A health worker must have the skills for wholistic management of the patients (not just physical, but also social, and spiritual).
   - A health worker must thoroughly know the drugs they are giving to the patients, and the associated adverse events for each. This way, a health worker can easily address the adverse events as experienced by the patient.
   - A health worker must have the proper referral skills. For example, there are issues that should be managed by the PMDT physician, or a specialist.
   - A health worker must have good documentation skills. All information must be taken down and written in the patient records. One must be very detailed (walang labis, walang kulang).
   - To manage TB in children, a health worker must know how to administer the drugs that would enable the children to swallow it (pulverize the medicine, add honey, add this to the kid's food).

- It is helpful to have a kiddie corner where the children can play while DOT. This will help them be distracted with the medicine they need to ingest. Place books in the kiddie corner, or toys, or candies, or have a story telling time. Be innovative on how you can make the children stay for their DOT. Birthday celebration is another innovative way to encourage the children to come back for their DOT.
- Make small promises to the children so that they will come back (candies or treats for their next DOT).
- Health workers injecting the medicine to the children must have very skilled hands.
- Encourage a similar time for the children to come back for their DOT. If the children take their medicine together, this distracts them from the DOT since they play, and spend time together in the health facility.

4. **Stage 3 at the Third tent: Negative station**:
   - A health worker must continue to counsel the patients in this station- make the patients realize that even if they are feeling well, and have negative sputum readings, they still need to continue on with the treatment or else, the treatment will fail (sort of black mail the patients at this point, as a lot of patients stop their treatment when they reached this point).
   - A health worker must be vigilant to the overall health status of the patient (monitor sugar, creatinine level, or any other cell values that may be affected by the drugs).
   - A health worker must still be very observant and vigilant at this point to monitor is a patient is taking their drugs. An easy indicator for this is if the adverse events are exhibited by the patients (visual confirmation, not just thru patient accounts).
   - If a patient fail to take their drugs, check their things to look for the drugs. Indicate in their treatment cards that this patient is not taking his medicine, hence strict DOT is needed.
   - Once a patient has completed their treatment, a health worker must emphasize that the patients need to come back every six months to submit their sputum sample for monitoring purposes for two years. At this point, get all the contact details of the patient (personal number, home number, relatives' numbers).
5. Once patient management is done for the day (in the morning), a health worker must then go inside the LCP building to address administrative work. At this stage, the following skills and competencies are needed:
   - Time management: To ensure that all records are completed (paper-based and electronic-base reports).
   - Strategic: A health worker must be very strategic in order to finish everything.
   - Patient: At times, internet connection is very slow, and ITIS (Integrated TB Information System, the official database for all TB patients) is web-based.
   - Computer literate: For all records completion
   - Administrative skills
   - Multi-tasking skills
   - A health worker must know how to perform the tasks of their colleagues in the team.
   - A health worker must be willing to work beyond office hours to complete all needed work, especially to meet the deadlines.

B. Ms. m, a seven-year nurse both at the PMDT and DOTS center at LCP, is also a trainer for newly hired nurses. HRH2030 requested Ms. M to imagine that she is orienting a newly hired DOTS nurse. Ms. M then discussed the pertinent skills and competencies that a new nurse must learn. These are as follows:

- When Ms. M was a nurse at LCP, she were not aware of TB, and its management. Hence, if there is a new nurse to be stationed at the DOTS facility, one must deeply understand and realize the importance of DOTS so that this can easily be explained to the TB patients.
- A new nurse must be made aware of the drug regimen for TB, as mandated by NTP. This is not a common knowledge among non-DOTS nurses.
- A new nurse must understand the importance of counselling to DS-TB patients. A new nurse must see the relationship of DT-TB and MDR-TB; the latter potentially comes from the former, hence health workers must be very vigilant in treating DS-TB patients to avoid their conversion to MDR-TB. A nurse's role is to counsel the patients that proper treatment is needed as early as DS-TB treatment.
- A new nurse must understand and know the TB terms; these will equip the new nurses when they are now explaining TB to their patients. Use the Manual of Procedures of NTP to explain these terms.
- A new nurse must be skilled in Health Teaching to dispel TB myths among the patients.
- New nurses must be highly competent in explaining to patients how to get a proper sputum sample. The trainer must demonstrate the procedure for this.

- A new nurse must know the importance of checking the patient's vital signs to document the clinical status of the TB patient as one progresses with their treatment.
- A new nurse must understand the referral system from the wards to the DOTS Facility, to the health centers.
- A new nurse must thoroughly understand how TB is contracted, as to minimize stigma in the health facility.
- A new nurse must be passionate, especially with this kind of work (TB treatment).
- A DOTS team must be consistent with what they say or do with the patient so that the patients will not lose their trust with the program. A DOTS team must learn how to encourage one another.
- A new nurse must be oriented with DOTS based on their current knowledge; orientation may be for one to three hours depending on what the nurse already knows. Hence, orientation must be individualized. This strategy is more personal, and more customized. Group training is also a good way to train nurses since competition between the trainees are usually observed. This way, the nurses are motivated to do their best since there are other participants to compete with.

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C. Ms. M also identified pertinent qualities for a new trainer to possess, or techniques that can make one an effective trainer. These are:
- Ms. M indicated that a trainer need not judge the non-DOTS nurses if they are not well-equipped for DOTS service delivery. This is because DOTS was not included in their pre-service training as nurses.
- To make new nurses more competent, use role playing during training.
- Ms. M uses shadowing technique to teach her students. She would ask the trainees to observe her while she manages the TB patients so that the trainees can see firsthand how to perform the tasks at a DOTS facility. During a shadowing activity, Ms. de Mesa will encourage the trainees to manage TB patients that can easily be managed, so that she can check how a trainee will handle a particular case.
- A trainer must always be humble at all times.
- A trainer must have a mindset that he/she will show the trainees during the course of the training session, on how it is to be a great nurse.

D. Ms. M emphasized the importance of faith and prayer in their work. These two drives her passion to provide services to the TB patients. Faith and prayer also help her realize that she needs to be humble at all times. Ms. de Mesa then welcomed HRH2030 to their bible study group, which was headed by a pastor. During the discussion, the group read various passages in the bible, shared their answered prayers, and enumerated their prayer requests. The bible study ended with a prayer, lifting everyone's concerns to the Lord.

Recommendations and Conclusions

Specific skills and competencies per station/tent were identified in the conducted KII. These specific skills and competencies must be captured and reflected in the competency assessment tool being developed by HRH2030.

Counselling was again identified as a crucial skill that a health worker providing TB services must possess. This has been repeatedly mentioned in the previous FGDs.

Additional FGDs, and KIIs must be conducted in DOTS facilities, in different set ups. All FGDs and KIIs conducted are in high access areas (and highly urbanized areas), hence, different skillset and competencies may be needed in different settings, such as in island group or mountainous-located health centers.

Interrupter tracing with the health workers from the Philippine Tuberculosis Society Inc.
Sept 6, 2018; 9:00 A.M-2:00 P.M.

PTSI-KASAKA, Lucky Chinatown Mall, Barangay Maria Clara, Manila, Bernardo Health Center, Quezon City, Tatalon Health Center

HRH2030/Philippines aims to observe and document how interrupter tracing is conducted by PMDT facilities. Interrupter tracing is defined as the tracking the whereabouts of a patient who fail to follow up with the health facility as scheduled. Management of interrupter depends on the length of interruption of treatment, results of smear, and length of treatment, as shown in the table[18] below:

Table No. 17 - Management of Cases Who Interrupted Treatment

Length of Interruption	Do DSSM if >1 Month Interruption	How long has patient been treated?	Disposition
Less than 1 month	Continue treatment and prolong to compensate		
	Negative DSSM	Continue treatment and prolong to compensate	
More than 1 month	Positive DSSM	Less than 5 months	Continue treatment and prolong to compensate
		More than 5 months	Classify as "Treatment Failed"
More than 2 months	Classify as "Lost to Follow-up"		

Key

Observations/Pertinent discussion points

A. There were two patients to be traced last Sept 6. The first patient (Patient J) already interrupted his treatment before. The health workers at PTSI-KASAKA previously visited him at Lucky Chinatown Mall in Binondo, and after this tracing activity, Patient J continued his treatment. However, after a few weeks, the patient fail to show up for his DOT again.

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– On Sept 6, the team from PTSI-KASAKA (a midwife, and a nursing attendant), together with three representatives from HRH2030, ventured out to Lucky Chinatown Mall in hope of catching Patient J during his work hours. At 10:00 A.M., the team reached the mall, but Patient J was not in his work station. Patient J serves as an attendant for a go-kart service, which caters to children. Patient J's coworker told the team that Patient J should come in that day, however, by 10:30 A.M., Patient J has yet to report to work. The team requested for the coworker to call Patient J to ask if he is still coming to work, but Patient J was not answering his phone. The team also tried to contact Patient J but to no avail. The team decided to visit Patient J at his home, which is located in Barangay Maria Clara, a few minutes from Lucky Chinatown mall.

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– On the way to Barangay Maria Clara, Ms. N, the midwife, who is serving as the clinic support staff at the PMDT-Satellite Treatment Center of PTSI-KASAKA, called Patient J's father, who lives in Las Piñas. Ms. N explained to the patient's father that his son has interrupted his treatment again, and that there is a team currently looking for him to bring him his medicine. The father promised that he will talk to his son to continue on with his treatment.

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– The team reached Barangay Maria Clara, and asked a few people in the neighborhood where Patient J lives. After a few tries, the team located Patient J's house. Patient J's mother was the first one to talk to the team, and Ms. N explained to the mother that Patient J interrupted his treatment again. The mother knew that Patient J

[18] Manual of Procedures. 5th edition. 2014. National Tuberculosis Control Program. Philippines: Department of Health. Accessed from https://www.philhealth.gov.ph/partners/providers/pdf/NTCP_MoP2014.pdf

discontinued his treatment, and she volunteered to get his medicine from PTSI-KASAKA every day, just so he will continue taking his medicine. However, Patient J was not responsive to this idea. The mother told the team that his son came home late the night before, and that he is still sleeping. The mother woke Patient J so that he can personally talk to the team.

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– Patient J went down to talk to the team, and Mr. B, the nursing attendant from PTSI-KASAKA, gave him a mask, and requested Patient J to wear it. During the discussion with the team, a young girl, about three years of age, was in the living room as well. The young girl was Patient J's niece. Ms. N asked Patient J is he still wants to continue on with his treatment, but he was not responsive. Ms. N and Mr. B tried to encourage him to complete his treatment, so that he will be completely cured from MDR-TB. They even pointed out that if Patient J will not continue on with his treatment, he might infect his young niece, who apparently lives with him. During the whole discussion, Patient J was not responsive to the team. The patient's mother, however, encouraged him to continue on with his treatment.

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– It was agreed by the team, the patient's mother, and Patient J (with less enthusiasm), that the mother will go to PTSI-KASAKA to get his medicine, and she will act as his treatment partner. Ms. N and Mr. B told the mother that she needs to directly see if Patient J will take his medicine every day; if not, then the mother should reflect that he did not take his medicine for the day. Patient J wrote a promissory note that he will take his medicine daily under the supervision of his mother. His mother also wrote that she will observe her son take his drugs every day, and to submit his sputum sample to PTSI-KASAKA. Patient J's medicine for the day was left with his mother.

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– Just as the team was about to leave the house, Patient J was playing around with his niece, kissing her in her cheek and neck, while not wearing his mask.

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– During this house visit, the team observed that there were about four adults living in the house, in addition to Patient J, and one child. However, Patient J only indicated that he is living with two adults in his current address, as Ms. N remembers from Patient J's file. This has an implication to contact tracing- people who have been exposed to a TB patient (especially living with a TB patient for three months or so), and therefore, must be screened and tested for TB. HRH2030 inquired if the household members living with Patient J were already screened for TB, and she said that none of them has ever came in at PTSI-KASAKA to be screened.

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B. The second patient (Patient V) to be traced was a vagrant living in a park near Bernardo Health Center in Quezon City. Patient V only took his medicine for two days, then disappeared. Patient V was referred to Bernardo Health Center since he lives a few steps from the health center, with PTSI-KASAKA supplying his medicine to the health center. Ms. N told HRH2030 that Patient V appears to have a mental disorder and this theory was shared by Mr. B.

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– When the team arrived at the health center, the health center nurse. Ms. M, told the team that she was also looking for Patient V a few days ago (Sept 3), however, Ms. M was not able to locate Patient V. The team, together with Ms. M, went out to the park to look for Patient V. The team asked for the other vagrants living in the park if they knew Patient V, but none of them can answer definitively. The team then walked around and beyond the park, until they reached Quezon City Jail. Ms. M suggested that the team ask if the vagrant was pickup up and placed inside the jail, however, since there were new inmates being transported into the jail, the team fail to inquire with the proper authorities.

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– Ms. M suggested that Patient V, as a vagrant, may have wandered to another park, and therefore, may be considered soon as Lost to Follow up.

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C. Additional activity for the day was the delivery of medicine for an MDR-TB patient referred to Tatalon Health Center. Ms. N told the team that her referred patient was continuously taking his medicine, and that we needed to deliver his medicine before 2 P.M., the designated time for TB patients to take their medicine at the health center. After the delivery, the team parted ways.

Recommendations and Conclusions

As HRH2030 observes the health workers from PTSI-KASAKA, pertinent qualities needed for interrupter tracing include:

1. Resourcefulness: Use every resource to contact the interrupter. Route the communication to any authoritative figure in the patient's life (parents), and even involve the barangay officials if need be.
2. Patience: To trace the patients even if they are interrupting their treatment over and over again
3. Concerned with patient confidentiality: While looking for Patient J, PTSI-KASAKA's health workers were careful not to mention that the patient has MDR-TB. This was also true when the team was looking for Patient V.

It was also noted that while health workers aim to trace interrupter patients, there is no policy to support the health workers to compel the patients to finish their treatment. Even if the patients can be traced, how can they be made to go back to their treatment? The PTSI-KASAKA health workers were debating whether to tell Patient J's employers that he has MDR-TB to compel him to go back to DOT, however, they decided not to do it, since previous experience with this approach, resulted to a patient threatening to kill himself if the health workers reach out to his employee. Thus, as noble as interrupter tracing is, this may still be all in vain, if the supporting policy will not be given to the health workers.

Interrupter tracing with the health workers from the Lung Center of the Philippines
Sept 12, 2018; 1:00 PM-4:00 P.M.

Lung Center of the Philippines, Barangay Bagong Pag-asa, Baesa Health Center

HRH2030/Philippines aims to observe and document how interrupter tracing is conducted by PMDT facilities. Interrupter tracing is defined as the tracking the whereabouts of a patient who fail to follow up with the health facility as scheduled. Management of interrupter depends on the length of interruption of treatment, results of smear, and length of treatment, as shown in the table[19] below:

[19] Manual of Procedures. 5th edition. 2014. National Tuberculosis Control Program. Philippines: Department of Health. Accessed from https://www.philhealth.gov.ph/partners/providers/pdf/NTCP_MoP2014.pdf

Table No. 17 - Management of Cases Who Interrupted Treatment

Length of Interruption	Do DSSM if >1 Month Interruption	How long has patient been treated?	Disposition
Less than 1 month	Continue treatment and prolong to compensate		
	Negative DSSM	Continue treatment and prolong to compensate	
More than 1 month	Positive DSSM	Less than 5 months	Continue treatment and prolong to compensate
		More than 5 months	Classify as "Treatment Failed"
More than 2 months	Classify as "Lost to Follow-up"		

Key

Observations/Pertinent discussion points

A. There were three patients to be traced last Sept 12. The first patient (Patient F) was a 75-year-old, female patient living in Barangay Bagong Pagasa, Road 1. Her last medicine intake was last Aug 13, as per LCP's records. After the team left LCP, the first stop was to Baesa Health Center, to let the health center know that LCP will be conducting interrupter tracing that day. Also, the LCP staff requested for the Barangay Health Worker (BHW) to accompany the team to the house of the interrupter patient.

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– After the courtesy call, LCP, HRH2030/Philippines, and the BHW proceeded to the house of Patient F. The patient was at home at that time. The patient is living in a small room, with no proper ventilation, with her adult son. The son recently tested negative for TB via GeneXpert testing.

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– Patient F told the team that she stopped taking the medicine since she experienced dizziness. Patient F consulted a private physician for her dizziness. The private physician told the patient to have her brain scanned MRI to determine the cause of her dizziness. The patient failed to tell the physician that she is currently taking MDR-TB drugs, and her dizziness is an adverse event of the drugs.

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– The LCP team explained to the patient that she has MDR-TB, and her dizziness is due to the drugs she is taking. The LCP patiently explained to her again that if she discontinues her medication, she is highly infectious to others, especially to her son who is living with her. The patient insisted that she is not sick, quoting the private physician that she saw for her dizziness. She kept on pointing to her head that her test results were clear, hence, she is not sick. The LCP team told Patient F that when she was dizzy, she should have proceeded to the treatment center at LCP since the health workers there know her condition. The LCP team reminded the patient that they are open even during the weekend. After the discussion, Patient F was still not convinced that she has TB and that she needs treatment, still quoting what the private physician told her.

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– The LCP team asked the son if he believes that her mother has TB. He said that he believes that she is still sick and needs anti-TB medication. The LCP team emphasized to the son that he needs to help the LCP staff help his mother so that she will be convinced to go back to treatment. The son requested if he can just retrieve the drugs from LCP so that his mother can just take her medicine at home. The LCP team told the son that this is not possible, since Patient F needs to be injected, hence, she needs to go to LCP. At this point, Patient F requested if she can just go to LCP every Sundays. The LCP team explained to her that her anti-TB drugs must be taken every single day, and not just during the weekend.

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– It was agreed that the patient will go to Barangay Bagong Pagasa Health Center from Monday to Friday, then to LCP every Saturday and Sunday (since health centers are closed during weekends). The LCP team explained to Patient F and her son that they will be writing to the barangay to request for a vehicle to take Patient F to LCP during her weekend treatment. This way, Patient F does not have to incur costs for this. It was also agreed that Patient F's schedule to be transported to LCP is every 8-9 AM during the weekend.

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The LCP staff reminded the patient's son that his mother should not be cooking or doing the laundry. The son promised that he is taking care of this. The LCP team also emphasized that her mother's treatment needs the support of their whole family, for it to be successful.

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– The LCP team also emphasized that they will change Patient F's regimen to exclude the medicine that makes her dizzy. This was to encourage the patient to continue taking her medication. With the LCP team is a previous MDR-TB patient, Jimbo. He shared his experience with Patient F, encouraging her to continue her medication even if she is experiencing adverse events. He shared that his hearing was slightly affected by the anti-TB drugs, but nonetheless, he continued to take the drugs until he completed the regimen.

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– At the end of the visit, the patient was still not convinced that she has MDR-TB. The LCP team told the son to bring her TB results to the private physician, so she can tell the patient that she is sick. The patient told the visiting team that she will finish her BP medicine first, then her anti-dizziness medicine, before anything else.

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– After the home visit, the team proceeded back to the health center. The staff, including the BHW, were not aware that Patient F has MDR-TB. The LCP told the health center that Patient F only took her medicine for a month then stopped. The LCP staff endorsed Patient F's medicine to the midwife at Barangay Bagong Pagasa Health Center, and the schedule of the patient's treatment (weekdays at Barangay Bagong Pagasa Health Center, and weekends at LCP). After endorsing the medicine at the health center, the team proceeded to the Barangay Captain's office. The team discussed Patient's F condition to the barangay team. The Barangay Captain agreed to take Patient F to LCP every weekend, on the condition that the BHW will accompany the patient. He also requested that the patient signs a waiver indicating that the barangay is not responsible if any untoward event will happen to the patient while in transit. The Barangay Captain indicated that he wants to talk to the family of the patient so that these conditions are clear. It was agreed that LCP will write the request letter to Barangay Bagong Pagasa Health Center and the Barangay, to formalize the request.

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– This ended the interrupter tracing for this one patient.

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B. The second patient (Patient A) lives in Mendez Road, Quezon City. This is under the jurisdiction of Baesa Health Center. The team proceeded to the health center to tell the health workers here that LCP will be conducting interrupter tracing to one of their patients. The patient was last seen at LCP last Aug 16. The team was accompanied by a BHW to the house of Patient A. The patient was home when the team reached her address. The patient lives with three children (around three to four years old), and her 100-year-old mother.

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– The patient told the team that she stopped taking her medicine since she was down with the flu for the past two weeks, and because the drugs affected her hearing. Also, she said that she has no money left to go to LCP. Since

the patient is done with her injectables, the LCP team suggested that she identifies a treatment partner, so she can just take her medicine at home. Or, she can ride with another MDR-TB patient, who owns a tricycle.

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– The team encouraged the patient to continue her treatment since she will finish her regimen in the next few weeks. The LCP team gave her medicine for the day, and Patient A took the medicine in front of the team. The LCP team also told the patient that she needs to submit her sputum sample, and that if this will yield negative results, she can already stop her treatment.

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– The patient agreed that she will ride with another MDR-TB patient to finish her treatment, and to submit her sputum sample. The team left the patient, satisfied with this interrupter tracing.

C. The third patient (Patient B) lives in Barangay Island, still under the jurisdiction of Baesa Health Center. The patient lives with her partner, and three children. Her partner recently graduated from the MDR-TB program, and this is where they met. The LCP asked why she stopped her treatment. Patient B told the team that she is currently two months pregnant. By this time, she told the team that she also has yet to receive prenatal care from the health center. The BHW told the team that she did not know that Patient B is pregnant, hence, they were not able to include her for prenatal services under the health center.

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– The LCP nurse called Dr. T, the PMDT physician at LCP, to consult Patient's B situation. Prior to her being pregnant, the LCP team knew that she was resistant to the injectable drug. With her being pregnant, the team must carefully design her anti-TB drug regimen, to ensure that the drugs will be effective to the patient, but at the same time, be safe to the fetus.

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– The LCP team told the patient that one of her options is to be a defaulter (she is formally categorized as a defaulter by Sept 20, since this will mark her 2nd month of not taking her medication). After her first trimester, Patient B can continue on with her medication, since this at this time, her medicine is relatively safer to the fetus. The LCP team told the patient to talk with her partner, so they can decide on this together, and that a decision must be reached by Saturday.

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– After this visit, the team proceeded back to Baesa Health Center, and updated the health workers of the situation of the two interrupters, and the agreements.

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– This marked the end of the interrupter tracing with the health workers from the Lung Center of the Philippines.

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Recommendations and Conclusions

As HRH2030/Philippines observed the health workers from LCP, pertinent qualities needed for interrupter tracing include:

4. Collaborative: The LCP included all important actors for the interrupter tracing activity to be successful, including the local health workers, and the barangay officials.
5. Methodical: The LCP staff has a step-by-step plan on how to do the interrupter tracing, from the first stop prior to the house visits, other offices that need to be visited, and lastly, the endorsement of the patients back to the health center.

6. Bringing a complete team: LCP brought their nurses, and a member of the patient group *Samahang Lusog Baga* Inc. Having a previous MDR-TB patient with the interrupter tracing team adds a personal touch to this activity.
7. Authoritative: The LCP team asserted their authority to convince the patients to go back to their treatment. They spoke with authority, but still with visible concern.
8. Patience: When the patient refuses to believe that she has TB, the LCP team repeatedly explained her conditions, even if the conversation dragged on for half an hour. The LCP team did not waiver in their explanation, just to convince the patient that she needed the anti-TB drugs.

Annex C. Competency mapping for the provision of tuberculosis services

Identification of health facilities to be visited

HRH2030/Philippines identified a private FP-providing organization, the Population Services Philippines Incorporated (PSPI), as a resource group to identify FP competencies needed for health workers. This group was selected for an FGD due to: 1) its proximity (PSPI office is in Pasay City); 2) ownership (private organization); and 3) reach (PSPI has clinics in nine regions the country). HRH2030/Philippines contacted PSPI's Interim Community Director, Dr. Marilen Danguilan, for an FGD with PSPI's health workers, and this was conducted last Aug. 23, 2018. To date, only one FGD for FP-related competencies was conducted.

Documentation of conducted activities

The details of the FGDs, and KIIS are presented below:

Focus Group Discussion among select members of Population Services Philippines Incorporated (PSPI)
Aug. 23, 2018, 10:45 AM-1:00 PM
PSPI Building, Pasay City

HRH2030/Philippines conducted a Focus Group Discussion among select members of PSPI, a privately-run organization providing family planning services in select sites in the country. This FGD was conducted to identify the competencies desirable for health workers to possess, to provide quality FP services.

Key Observations/Pertinent discussion points

A. Brief background of PSPI

1. PSPI was founded in 1990 funded by Marie Stopes International (UK-based organization).
2. Initially, there was no formal training of trainers, not until DOH required all FP trainers to be formally trained in Jose Fabella Memorial Hospital (a DOH-retained hospital) back in 2015.
3. PSPI was formally accredited by DOH as a training institution back in 2017. Only seven organizations were given this accreditation.
4. All training materials that PSPI are using came from DOH.
5. PSPI used to run nine FP-providing and birthing home clinics in nine regions. These clinics are all PhilHealth accredited.
6. However, since PSPI's funding ran out, all clinics are now closed. Operations of the whole PSPI system will be completely discontinued by November 2018.
7. In addition to using DOH materials, PSPI is also using monitoring protocol developed by MSI.

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B. Competencies of a health worker providing FP services

1. **Accessible**: The trainers establish rapport with their trainees. They make technical words/concepts simpler as not to overload the trainees.
2. **Flexibility**: The trainers are sensitive to what the trainees need; there is no need to go back to the basic topics if the health workers were already trained in these specific areas. The trainers individualize the training according to the needs of the trainees.
3. **Clinically competent**: The trainers were all FP service providers before they became trainers, hence the they have in-depth knowledge on how to provide these services. This then gives the trainers the background, and most importantly, the credibility to lead the training sessions.

4. **Experience**: Most of the trainers have been doing the training for a decade now, some of them for over 20 years.
5. **Brand association**: PSPI carries the MSI name, hence they rise to the high level of expectations associated with this organization.
1. **Communication/Transfer of knowledge skills**: The trainers know how to prepare good training materials (may it be electronic or paper-based visuals). The trainers use the vernacular language of the trainees, making the topics easier to understand. The PSPI staff were trained in John Robert Powers to enhance their public speaking skills. They also underwent personality training.
6. **Confidence**: The trainers are confident while delivering the training sessions; this can be associated with the years of experience they acquired as trainers.

FEBRUARY 2020

Competency Assessment Standard Operating Procedure

USAID HRH2030/Philippines: Human Resources for Health in 2030 in the Philippines

How to Conduct Competency-based Health Worker Assessment for improved TB and FP/MCH services

A guide for conducting facility-based competency assessment

1. Introduction

Background

Human resources for health form the foundation of an efficient and resilient health system. In the Philippines, significant variations in quality of healthcare service is attributed to uneven capacity of local government units to finance the delivery of quality primary care services, which include Tuberculosis (TB) and Family Planning/Maternal Child Health (FP/MCH) services and manage and develop local health workforce. The fragmented distribution of a confident, fit-for-work and fit-for-practice workforce across the country directly impacts equitable distribution of quality health services among Filipino communities and the Philippines ability to fulfill national and global commitments to improve key health outcomes.

The passing of Republic 11223 or Universal Health Act through its guarantee of delivering quality primary care services to underserved and marginalized Filipinos provides an opportunity for strengthening health workforce planning and management. Section 23 of the UHC outlines Department of Health's mandate to provide policies and strategies for "appropriate reassessment of the health workforce according to changing population health needs" through the National Health Human Resource Masterplan.[1] The master plan identifies strategies for equitable distribution of health workers and promotion of a fit-for-work and fit-for-practice workforce. Such strategies include the development of measures to assess health worker primary care clinical competencies (including TB and FP/MCH).

When looking under the umbrella of primary care services, reports from hospitals, health facilities and other healthcare institutions indicate that a significant portion of health care providers lack the requisite knowledge and skills to deliver quality health services. This was observed in the delivery of priority health programs such as FP and TB services. For instance, the Department of Health notes how the low uptake of family planning services in the Philippines--two in every 10 married Filipinas wishing to postpone their next birth or stop childbearing are not using a family planning method—is linked to limited access to quality family planning service.[2] This is corroborated by other findings in the 2017 National Demographic Health Survey (NDHS) which report that among women aged 15-49 who are not using contraception, only 14 per cent of them who visited a health facility discussed family planning with a health provider.[3] This is despite the guarantee to universal access to family planning information in all public health facilities outlined in the Responsible Planning and Reproductive Health Law (RA 10354).

[1] 2019, Republic of the Philippines, Implementing Rules and Regulations of the Universal Health Care Act (RA 11223)
[2] 2017 National Demographic Health Survey
[3] in the 12 months preceding the survey

Meanwhile, the National Tuberculosis Prevalence Survey in 2016 report showed that the gap between the estimated number of TB cases and those found and notified to the National Tuberculosis Program indicate poor adherence of health providers to national TB guidelines. Furthermore, results from series of focus group discussion among health workers in TB exemplar sites in 2018 report that health workers were not confident in fulfilling their job functions because they did not receive ample preparation during pre-service education.[4]

Developing practice-ready health workforce
Results from USAID HRH2030/Philippines rapid review of national policies relating to health human resource management indicate DOH and stakeholder efforts to establish mechanisms and measures to assess and strengthen health workforce in the country. For instance, DOH has undertaken policy issuances for assessing and managing health workforce competencies and development of competency frameworks and performance management measures such as:

- AO 2006-0031 entitled "Guidelines for operationalizing the Competency-based Human Resources for Health Management and Development (HRHMD) Systems;
- AO 2014-044: "Guidelines for the Installation of HRH Management and Development Systems for Health and Allied Health Professionals Employed within a Service Delivery Network, including the Assessment and Monitoring of Clinical Competencies, Baseline Competencies and Standards"; and
- DOH Competency Catalog for Regional Offices and Rural Health Units, 2017

Likewise, competency assessment is also considered as part of a government employee's evaluation as prescribed by Civil Service Commission's Strategic (CSC) Performance Management System (SPMS) Performance Review and Evaluation system. Moreover, the CSC also adds that an employee shall be assessed according his or her strengths in order to identify competency-related performance gaps and the opportunities to address these gaps, career paths and alternatives.

Literature review on health workforce planning and management indicate sparing efforts to establish competency-based health workforce assessments. However, there is little evidence to ascertain whether these initiatives have been implemented or not. Moreover, the DOH Competency Catalog does not account for the expected clinical competencies of health workers at the service delivery level. In addition, while DOH public health nurse and midwifery certification programs have identified competencies for certification, these assessments are undertaken voluntarily by health workers rather than as an established regular performance management measure of the health facility or local health office. Neither do their results used for workforce planning to respond to population health needs[5].

Overall, the review found that there is a rich environment for the implementation and institutionalization of a competency-based approach to assessing health worker performance. In addition, common themes in assessment/evaluation models indicate a Core, Organization, Leadership, and Technical Competency approach, but lack clinical competencies or a unifying framework. Also, it was found that while gaps exist in the CSC PRIME-HRH Model, the model does provide a strong base to build on. Finally, focus Group Discussion results identify soft competencies to improve quality of care (specifically for TB).

2. What is competency-based assessment?

Competency and competency-based health worker assessments
Different organizations and institutions have proposed varied definitions of the word competency. In general competency refers to demonstration of acquired skills, knowledge and attitudes in performing a specific task or activity. Within the context of quality improvement of health services, we shall refer to **competency** as the

[4] 2018, HRH 2030, "Development of a Proposed Competency Assessment Tool for Physicians, Nurses, Medical Technologists, and Midwives for the Effective Provision of Tuberculosis and Family Planning Services" (unpublished).
[5] 2019, HRH 2030, "Rapid Review and Update of HRH Competency Standards and Assessment Policies" (unpublished).

set of related knowledge, skills and attitudes required to successfully perform critical work functions according to established performance outcomes and quality standards, including performing effectively on different occasions and unexpected contexts. Competencies can be measured and assessed to ensure their acquisition. Competencies can be assembled like building blocks to facilitate progressive development. The identification and use of competencies in health human resource management and planning supports good performance, establishing standards and accountability mechanisms, quality improvement of services and managing health workers' performance and continuing professional development.

Competency assessment is defined as any system for measuring and documenting personnel competency. Competency assessments is a means to identify problems with employee performance and to correct these issues before they affect patient care[6]. The regular or periodic conduct of competency-based health worker assessment ensures that the delivery of services correspond to the guaranteed quality of care expected at both private and public facilities. Because it is conducted at regular intervals during an employee's tenure, assessments of competencies allow for the systematic identification of performance gaps that may be addressed either through supportive supervision, mentoring, coaching or task-specific training.

Competency-based health worker assessments focuses on the measurement of health worker's knowledge, skills and attitudes needed to perform a procedure, task or activity under different occasions and unexpected contexts. It also entails the observation of the practice and demonstration of skills associated with minimum standards of quality care. It is also considered as key element for conducting supportive supervision visits and performance review and evaluation as outlined in the CSC's Strategic Performance Management Review and Evaluation.

Once established in the health facility, competency-based health worker assessments shall be undertaken by clinical supervisors, provincial/regional training coordinators and/or municipal health officers, depending on the protocols and guidelines of the facility's human resource management system. The aggregate results of the competency assessment in a health facility may be shared with the provincial and regional health office to inform workforce planning, improvement of health services and identifying continuing professional development. Supervising personnel or assessors shall also be responsible for facilitating interventions to ensure that performance gaps are addressed.

Rationale for measuring health workforce competency

Measuring health worker competencies allows program managers, local health leaders and decision-makers understand the capacity of their workforce to provide quality health services at their facility. Understanding the level of health workforce's competency provides basis for evidence-based workforce planning and management for a fit-for-practice and fit-for-work primary care workforce. Results from the competency-based health worker assessments can help primary care health facilities:

- determine baseline competency of its health workforce
- ensure delivery of quality services and positive TB and FP/MCH outcomes
- Identify performance gaps among health workers to guide human resource managers, supervisors or program managers in setting appropriate training interventions

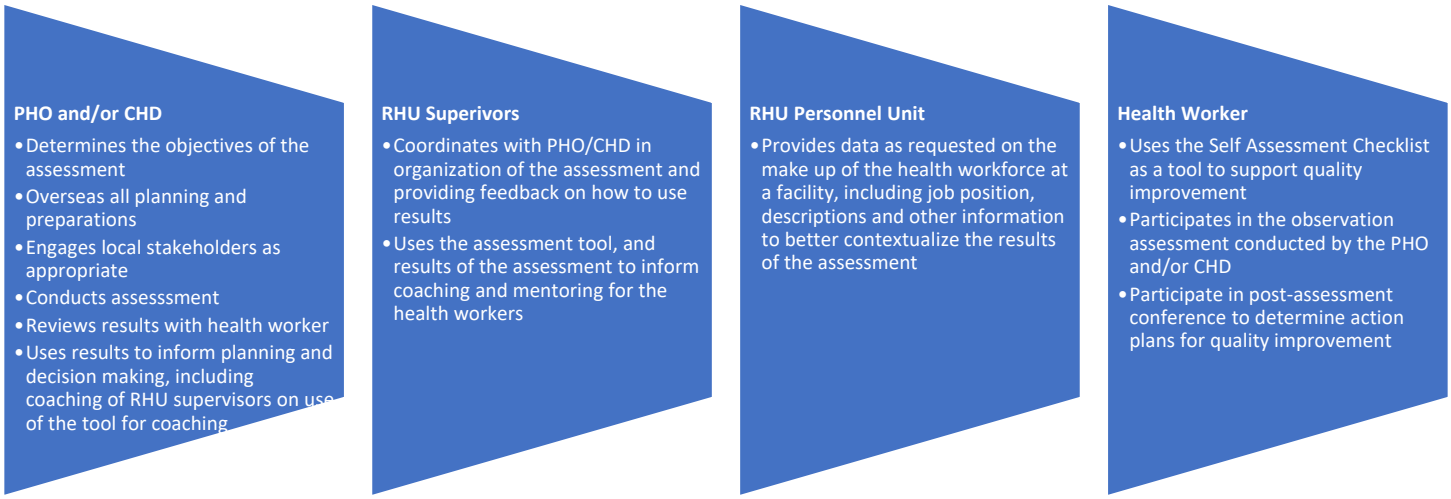
Regular and periodic review of health worker competencies is key in ensuring the quality of health services at the health facility or within the health care provider network. It also provides opportunity to update standards of care and capabilities of the health workforce since 'what it means to be competent' for a service/intervention may change according to population health needs, health sector priorities, health outcomes and even, clinical technologies.

Primary health care facilities that intend to carry out competency-based health worker assessments are encouraged to collaborate with their regional DOH offices, training institutions and local health offices to receive the appropriate support needed and enact accountability flow.

[6] 2005, World Health Organization. "Laboratory Quality Management System – Information on Competency"

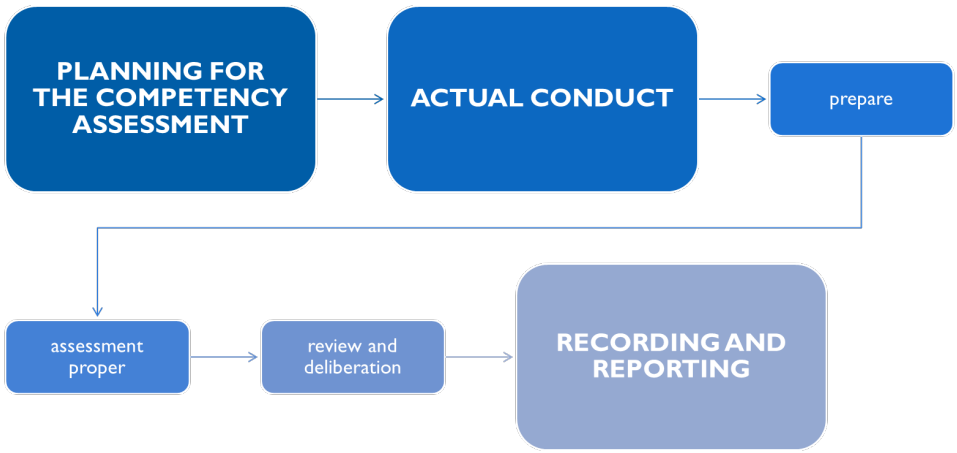
3. Who should participate in a competency assessment?

There are different perspectives and stakeholders that should be engaged in a competency assessment. These include Provincial Health Officers (PHOs), Regional Health Office Center for Health Development (CHD), supervisors of the health worker, representatives from the personnel unit of the health facility and the health workers themselves. Overall, the competency-based health worker assessments should be conducted by the PHO or CHD, though the tool can be used by supervisors of health workers to provide coaching and mentoring. In addition, the tool can be used by the health workers themselves during their own voluntary self-review or in preparation for the PHO led assessment. It shall be conducted by PHO or CHD assessors who have been oriented with the use of Competency Dictionary and Competency Assessment Tools. After the assessment by the PHO or CHD, results will be used by the PHO and CHD to inform the action plan for the health worker, with aggregate results used to inform the planning of trainings for the Province or Region and the immediate supervisor using the results for training and mentoring.



4. Overall Competency Assessment Process

The below flow demonstrates the overall competency assessment process. The areas of **Planning for the Competency Assessment**, **Actual Conduct** and **Recording and Reporting** are documented in detail below.



5. Planning for competency assessment activity in the health facility

Provincial Health Officers are advised to undertake the following steps before scheduling a competency assessment activity:

a. Conduct a brief facility orientation and briefing on the TB and FP/MCH Clinical Competency Dictionary and Assessment Tools with the personnel unit, supervisors and health workers at the facility. This briefing and orientation session will provide all involved in the process with the opportunity to: appreciate the value of the competency assessment to their professional development, familiarize themselves with the assessment tools that will be used during the assessment. In addition, the workshop will help the PHO, supervisors and the health worker determine how to utilize findings of the competency assessment in improving essential TB and FP/MCH services at the primary care level. Furthermore, tools should be used not only to evaluate the competence of providers but also identify appropriate learning interventions and professional development.

b. Determine whether health workers have undertaken the fundamental and basic courses on the provision of essential FP/MCH and TB services.

c. Ensure that facilities have adequate infrastructure to provide essential TB and FP/MCH services. Minimum requirements for these services are: (1) private place for counselling, (2) an adequate number of instruments and logistics to provide service, (3) available information, education, and communication (IEC) materials and job aids, (4) an identified referral protocol and (5) demand generation activities

d. Review the TB and FP/MCH service delivery accomplishments and statistics of the facility to better understand the workload of the facility.

e. Determine the frequency of the competency assessment. The frequency of the competency-based health worker assessments should be determined based on the specific needs and resources of the community or facility. DOH's Administrative Order (A.O) 2014-044 prescribes the conduct of performance evaluation twice a year in health facilities. Competency assessment activities can be integrated in the performance review initiatives, during supportive supervision visits or even regular mentoring or self-review/reflection as a strategy for establishing the practice and encouraging behavior change. Likewise, the conduct of competency assessments may be scheduled in line with staff development planning and review, such as planning for trainings.[7]

[7] 2014, Philippines, Department of Health, "Administrative Order No. 2014-0044: Guidelines for the Installation of Human resources for Health Management and Development Systems for Health and Allied Health Professionals Employed Within a Service Delivery Network, Including the Assessment and Monitoring of Clinical Competencies, Baseline Competencies and Standards."

6. Conduct of Competency Assessment

This section discusses the conduct of competency-based health worker assessment including the preparatory and actual steps to be undertaken during the competency assessment activity.

Remember!

It is important that PHO, CHD, supervisors, health managers and health workers appreciate competency assessment activities as means for quality improvement, workforce planning, career management, and improving health outcomes and not as a punitive measure of performance management. Both supervisors and health workers are encouraged to keep a positive and open attitude towards assessment activities.

Competency assessment activities shall assess health workers on the following areas:

- FP counseling and service provision
- Adherence to principles of Informed Consent and Voluntarism
- Provision of prenatal, labor and delivery and postpartum care
- Screening, diagnosing, provision and managing treatment for drug-sensitive and drug-resistant Tuberculosis
- Provision of patient-centered care

Competency assessments should be considered as an activity that is:

- Driven by evidence: this means the assessment of health worker clinical competencies are supported by validated health facility data such as those collected for the Field Health Service Information System (FHSIS).
- Cognizant of the enabling factors for service provision, such that work environments, infrastructure, supply chain and commodities are considered during the assessment activity
- Results-oriented: assessment focuses on the results of processes and program outcomes. This also entails provision of feedback and updates to providers, and reports to the concerned
- Focused on quality improvement of health services at the facility and, ultimately, of within the healthcare provider network. Assessors or clinical supervisors are advised to impress upon health workers undergoing assessment the value of individual assessment in improving quality of services, addressing client/patient satisfaction and promoting positive health-seeking behavior
- Health worker-focused as periodic competency assessments promotes standardized provider performance based on established standards of practice, professional norm, health sector priorities, population health needs and most-updated clinical evidences.

Below are the recommended steps for health worker competency-based assessments. Since competency assessment require ample time and resources, PHO, CHD, health managers, clinical supervisors and program managers intending to carry out these activities are advised to adapt the procedures according to their capacities, population health needs, health provider capacities and needs, and local health priorities.

PREPARATORY

The preparatory phase for competency assessment should be undertaken during the annual planning session of the local health office or health facility. Doing so allows both clinical supervisors and health workers ample time to prepare and health managers to allocate needed resources. Planning for competency-based health worker assessment includes identifying appropriate tools and methods for competency assessment, roles and

responsibilities, performance goals and schedules to be followed. Facilities should also have adequate infrastructure, regular provision of TB and FP/MCH services, and steady client load.

Suggested actions to be completed during this phase are:

1. **Determine the assessment team and identify the workers** who will undertake the competency assessment. Ideally, each health worker should be assessed while on the job using the Supervisor Observation Tools (See Annex B) and given feedback in a timely manner.

2. **Develop clear objectives** for competency-based health worker. These objectives should be based on the health worker's career development, health workforce needs of the facility, performance goals and overall population health needs of the community. This is important to do to understand how the data will be used. Sample objectives include (but are not limited to):
    - To determine the skills gaps and subsequently training needs for the Province or Region
        - For example, if the training plan for the year is being developed, a competency assessment could help decision makers prioritize what trainings are needed.
    - To measure health worker performance on an individual and aggregate scale
        - For example, if there is a need to understand the individual performance of a health worker for various decision-making needs, the assessment could help analyze in what areas the health worker needs capacity strengthening. This could be aggregated to identify trends within the Region or Province.
    - To identify strengths and weaknesses in current trainings or retention of skills post-training
        - While the competency assessment is not a replacement for post-training evaluation, it could serve as a way for decision makers and managers to assess what is working and what is not working with their current trainings, as well as identify what skills health workers are retaining or not retaining.

3. **Determine the scoring technique** that is appropriate for your context. While the overall process for scoring is described below, it is imperative that those involved in the training planning reflect on their objectives of the assessment the determination of scoring technique. The technique will be different based on how the results are intended to be used. Here are some examples of how the scoring technique could be implemented:
    - To determine the skills gaps and subsequently training needs for the Province or Region
        - Planners could look at aggregate results for each competency area to determine where the critical areas of training are needed. For example, if the average aggregate score for the Provision of Prenatal Care competency area is less than 50%, than a training on this area might need to be prioritized.
    - To measure health worker performance on an individual and aggregate scale
        - Similar to the above, if decision makers are seeing that across all competency areas, health workers are scoring 74%-50%, then perhaps efforts should be invested in coaching and mentoring of the health workforce.
    - To identify strengths and weaknesses in current trainings or retention of skills post-training
        - If trainers are seeing health workers scoring "0" or "Not Done" on any of the skills indicators under the competency area, then the content of the training may need to be reviewed and revised.

4. **Organize the competency assessment activity** according to the following tasks:

    - Review the TB and FP/MCH Competency Dictionary (see Annex A). Because health facilities and communities face different challenges and priorities, managers and supervisors are encouraged to examine the inventory of TB and FP/MCH competencies and identify skill indicators that are most relevant to them

- Review existing monthly reports and findings from previous evaluation activities, if applicable.[8] Understand which services need strengthening and identify the relevant and corresponding competency area. Draft clear objectives for the assessment based on the facility's and population health needs.

- Determine the date and time of the or period of the assessment, items or equipment and materials and staff compliment that need to be prepared.

- Provide the health workers with the Self-Assessment Checklist (See Annex B) as a way to sensitize the health workers on the content of the up.

ACTUAL ASSESSMENT/ASSESSMENT PROPER

The health worker competency assessment shall be carried out through use of the Observation Tool and Self Assessment Checklist.

During the assessment period:

1. Health workers will be asked to accomplish the self-assessment checklist. Health workers will be asked to objectively appraise their performance against the listed TB and FP/MCH clinical competencies. The self-assessment checklist captures the health worker's perspective on the quality of TB and/or FP/MCH services she is providing and should be used more as a checklist to sensitize the health worker to the next steps with the Observation Assessment tool.
    a. The self-assessment checklist will be completed using the following steps:

Step #	Action
1	The health worker will review each task/indicator
2	Then, they will reflect on their activities
3	They will then check the column if you do this task/indicator or if you do not do this tasks/indicator
4	Overall, they will use this Checklist as a way to reflect on their activities and workload and prepare for the upcoming competency assessment

2. The PHO/CHD is advised to identify the date and time to conduct his/her observation. She/he must ensure the availability of clients so that provision of the guaranteed primary care services are observed in actual job environment. Both the PHO/CHD and the health worker will ensure that patients are well-appraised of the situation and their right to privacy is duly maintained.

3. The PHO/CHD will use the Observation Tool to assess the health worker's performance of competencies for TB and FP/MCH care. The observation tool contains the questions that are identical to the questions found in the Health Worker Self-Assessment Checklist tool.
    a. The scoring for the Observation Tool is as follows:

Score	Description	Action
2	Task done	No immediate action, continuous regular monitoring and supervision
1	Task done but needs improvement	Enhanced coaching, mentoring, supportive supervision on entire competency area Coordination of opportunities for lectures/readings to learn more
0	Task not done	Review of the health worker current position, actual activities/role, training/education background. Recommendation of specific trainings/orientations/refreshers

[8] Health workers coming from the DOH Deployment Program, for example undergo annual Performance Evaluations which can give an indication of the baseline competencies of the health worker

b. Once the individual competency areas have been scored, an aggregate score can be determined that supports planning for next steps:

Aggregate Competency Area Score	Action
75% and above	Passes competency area
50-74%	Coaching and mentoring needed for the competency area
49% and below	Training needed with supportive supervision for the competency area

REVIEW AND DELIBERATION

After the conduct of the competency assessment, the PHO/CHD and health worker will convene to review and deliberate the results of the assessment. This review and deliberation will be a conversation to determine how the PHO/CHD, supervisor and health worker can work together to help enhance the health workers skills set in the areas identified. They will look at both the health workers self-assessment check list and the PHO/CHDs observation assessment tool. This should be taken as an opportunity to address performance gaps and provide further feedback on the health worker's performance, as well as for the health worker to provide feedback and insight on their capacity building needs. The supervisor will then assist the health worker in identifying training opportunities that the health worker can participate in, such as eLearning, and coaching/mentoring needs that could be supported by the health workers supervisor. This deliberation will be integrated into an action plan.

7. Planning for next steps

In addition to the individual health worker's action plan, the PHO/CHD will be responsible for consolidating and aggregating the competency assessment results of the health workers in their area to determine next steps based on the defined objectives of the assessment.

PHO/CHD are advised to:

- Keep record of the results of health worker competency assessment
- Take note of major gap(s) in the service delivery or performance identified during the assessment. Draft staff learning and development plan to address the competency gaps of health workers in their Province and Region to strengthen their capacity to provide quality TB and FP/MCH services. Likewise, the results may also be used as additional basis for improving planning and management of staff.
- Assess adequacy of facility supplies, equipment and commodities; job aids; and IEC materials necessary to provide quality TB care services and comprehensive FP information and services to the community. Facility administrators and local program managers are advised to follow through with equipment and supply problems in a timely manner.
- Communicate and relay the aggregate results with the Health Human Resources Development Bureau and national health program offices. Communicating and sharing the aggregate results to other stakeholders will demonstrate the effectiveness of competency assessment activities in establishing accountability mechanisms, strengthening health worker capacities and, ultimately ensuring quality improvement of primary care services.

FEBRUARY 2020

Process Map: Competency Assessment, eLearning and Post Training Evaluation

USAID HRH2030/Philippines: Human Resources for Health in 2030 in the Philippines

Process Map: Competency Assessment, eLearning and Post Training Evaluation

Ensuring a fit to work and fit for practice workforce through competency-based health workforce development

Background

Human resources for health form the foundation of an efficient and resilient health system. In the Philippines, significant variations in quality of healthcare service is attributed to uneven capacity of local government units to manage both the delivery of quality primary care services, which includes Family Planning & Maternal Child Health (FP/MCH) and Tuberculosis (TB) services, and the local health workforce. This fragmented distribution of a confident, fit-for-work and fit-for-practice workforce across the country directly impacts equitable distribution of quality health services among Filipino communities and the Philippines ability to fulfill national and global commitments to improve key health outcomes.

The passing of Republic Act 11223 or Universal Health Care Act provides an opportunity for strengthening the delivery of primary care services to the underserved and marginalized. The UHC ensures a "whole-of-society approach to health…centered on the needs and preferences of individuals, families and communities while addressing the broader health determinants".[1] The UHC law also outlines improvements for health human resources management through the formulation and implementation of a National Health Human Resource Masterplan that will "provide policies and strategies for the appropriate generation, recruitment, retraining, regulation, retention and reassessment of health workforce based on population needs." Such strategies include the development of clinical competencies and competency assessment measures for primary care services (including TB and FP/MCH).

The periodic and regular review of health worker knowledge, skills and attitudes in providing integrated primary care services as exemplified by TB and FP/MCH clinical services is critical in aligning health workforce competencies with health sector needs. But assessment cannot be done in silo; the results of routine competency assessments identify

[1] 27 February 2019, WHO Fact Sheet Primary Health Care, retrieved from < https://www.who.int/news-room/fact-sheets/detail/primary-health-care>

learning needs, which can be matched with the learning outcomes of competency-based eLearning, and then followed with post-training evaluation to ensure that a practice-ready and work-ready primary care workforce is developed and maintained. In this project, work on FP /MCH and TB competency was accomplished to demonstrate the application of the proposed competency assessment tool.

Purpose of the Process Map

The purpose of this Process Map is to guide those using the competency assessment and eLearning developed by the Human Resources for Health in 2030 (HRH2030) Project, funded by USAID, and those implementing post-training evaluation to better understand how these three key components to health workforce development can build on each other and interact. This process map should be used as a reference when planning your health workforce development programs. The following describes the roles and responsibilities of each of the components.

- **Competency Assessment:** A competency assessment is a system for measuring and documenting personnel competency, to identify problems with employee performance and to correct these issues. The regular or periodic conduct this assessment ensures that the delivery of services correspond to the guaranteed quality of care expected at both private and public facilities. Also, this assessment allows for the systematic identification of performance gaps that may be addressed either through supportive supervision, mentoring, coaching or task-specific training. The assessment focuses on the measurement of health worker's knowledge, skills and attitudes needed to perform a procedure, task or activity under different occasions and unexpected contexts. It also entails the observation of the practice and demonstration of skills associated with minimum standards of quality care. USAID's HRH2030 developed a competency assessment package that provides Regional and National Level trainers and decision makers with the tools to assess the FP/MCH and TB skill set of the health workforce. It can also be used by managers as a coaching/mentoring guide and health workers as a tool for self-review.

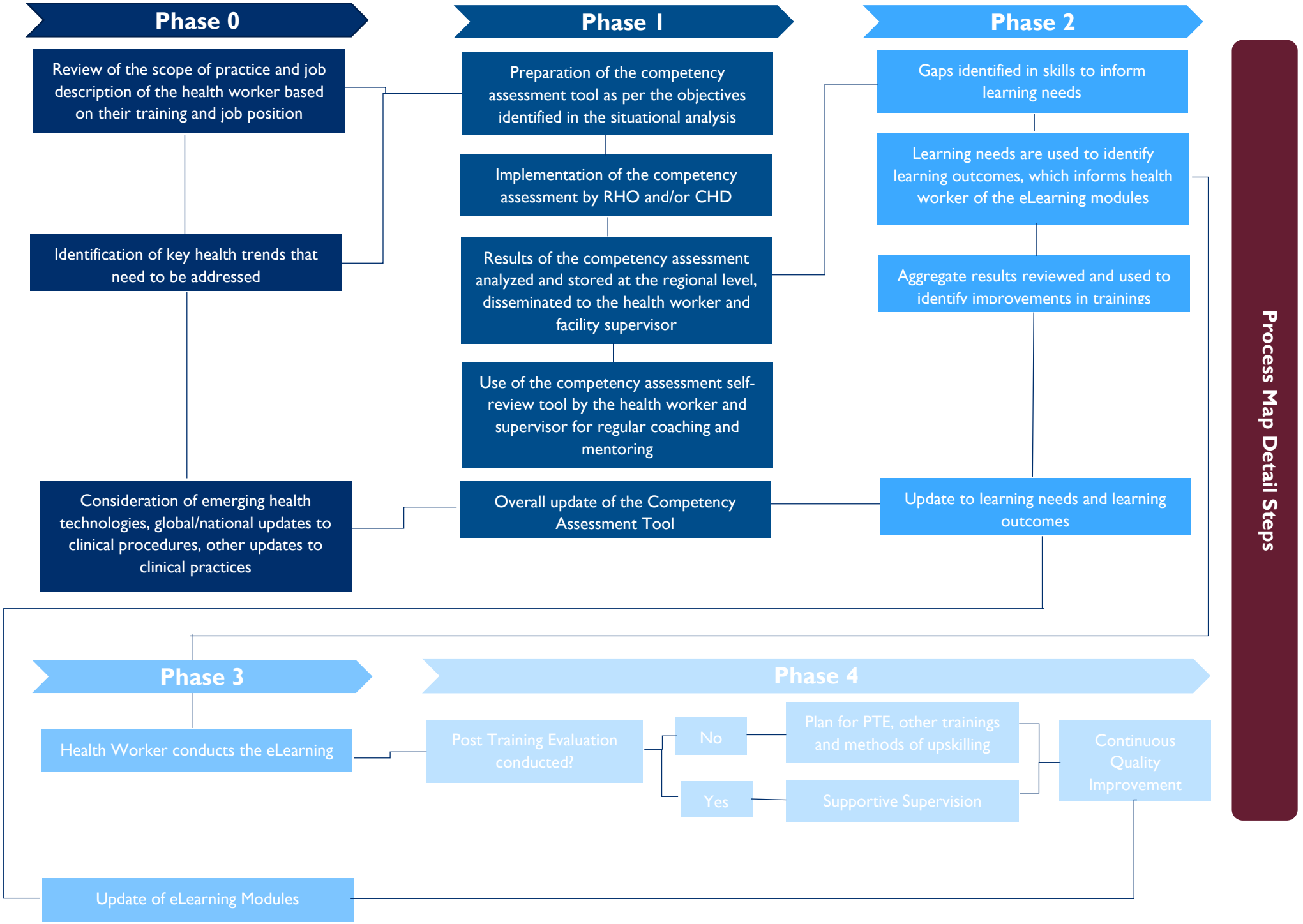
- **eLearning:** eLearning provides health workers with access to competency-based training to enhance the knowledge, skills, and attitudes of the health workforce. Through eLearning, health workers can not only reduce their time away from the clinic, but also increase availability and access to participation in evidence-based training that improves behavior change and self-efficacy. USAID's HRH supported the development of several FP/MCH and TB eLearning modules, which will be available on the Department of Health Academy (https://academy.doh.gov.ph/).
- **Post Training Evaluation:** Post Training Evaluation (PTE) is an integral part of any training program as it determines and assists the learners to integrate the knowledge and skills, they acquired during the course to their job of providing health services. To benefit from this approach, it is recommended that PTE be conducted one to two months after training (the optimal time for identifying challenges in the learners' environment and implementing strategies to overcome these challenges after eLearning). During the process, the trained health service provider is coached towards being able to integrate his/her learnings given existing working environment. After this period, integration will be difficult as mistakes would have become practice and thus, difficult to reverse while long periods of non-practice of the learned concepts and skills would have been lost and unlearned. Due to this, it is critical that PTE take place after a health worker undertakes eLearning. USAID's HRH2030 created a PTE checklist and toolkit which compiles the various PTE guidance documents developed by the DOH and other stakeholders for reference by stakeholders when conducting post training follow up.

Process Map

Process Map Overview

Provides an overview and example of how competency assessment, eLearning and PTE can be integrated for health workforce development.

Phase 0 Situational Analysis	Phase 1 Competency Assessment	Phase 2 Learning Needs	Phase 3 eLearning Training	Phase 4 Post-Training Evaluation
To begin, an analysis of the situation must occur. This starts by first examining the scope of practice and job description of the health worker type and position. Then, key health trends must be identified, as well as emerging health trends, new technologies and updated clinical guidelines. This will inform the knowledge, skills, and attitudes required of the health workers to then inform the objectives of the competency assessment.	Based on the objectives identified, the competency assessment is tailored and subsequently conducted with results analyzed. Emerging health trends, updates to clinical procedures and practices are used to inform updates to the competency assessment tool.	With analyzed results, gaps in skills are identified using the identified scale (see USAID's HRH2030 Competency Assessment SOP). If it is identified that a health worker needs training, then learning outcomes are identified, which reflect the various eLearning modules. At an aggregate level, this data is used to plan for the upcoming training cycle and/or to examine if there are any quality issues with past trainings.	Health workers complete the eLearning identified. eLearning are updated and key health trends must be identified, as well as emerging health trends, new technologies and updated clinical guidelines.	After the health worker conducts the eLearning, PTE is conducted to assist the health worker in integrating the knowledge and skills into their work. After Post Training Evaluation, regular supportive supervision occurs. If PTE does not occur, a plan is made for the evaluation to be conducted and/or other trainings or methods of upskilling are identified for continuous quality improvement.
The Family Planning Program has recently recognized a decrease in new acceptors; thus, you would like to understand which midwives may need additional training.	The Region Health Officer conducted the FP Competency Assessment for all midwives in the Region to identify which of the Competency Areas were lacking.	A majority of midwives are scoring 0 on the FP Counseling Competency Area. The skills indicators listed in the FP Counseling Competency Area align with the learning outcomes in Competency Based Family Planning Training 1	Midwives complete the FP Counseling Module on the DOH Academy's Competency Based Family Planning Training 1	After 2-3 months, PTE is conducted with midwives on FP Counseling. The PTE not only evaluates if the midwife is conducting FP counseling properly but provides coaching and support on how to fully integrate learnings.


Phase 0
Review of the scope of practice and job description of the health worker based on their training and job position
Identification of key health trends that need to be addressed
Consideration of emerging health technologies, global/national updates to clinical procedures, other updates to clinical practices
Phase 1
Preparation of the competency assessment tool as per the objectives identified in the situational analysis
Implementation of the competency assessment by RHO and/or CHD
Results of the competency assessment analyzed and stored at the regional level, disseminated to the health worker and facility supervisor
Use of the competency assessment self-review tool by the health worker and supervisor for regular coaching and mentoring
Overall update of the Competency Assessment Tool
Phase 2
Gaps identified in skills to inform learning needs
Learning needs are used to identify learning outcomes, which informs health worker of the eLearning modules
Aggregate results reviewed and used to identify improvements in trainings
Update to learning needs and learning outcomes
Process Map Detail Steps
Phase 3
Health Worker conducts the eLearning
Update of eLearning Modules
Phase 4
Post Training Evaluation conducted?
No
Yes
Plan for PTE, other trainings and methods of upskilling
Supportive Supervision
Continuous Quality Improvement

Flow of Component Elements Competencies, eLearning Trainings and PTE

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