# Strengthening Local Governance for Health (HealthGov) Project

## Operational Plan
October 1, 2010 to September 30, 2011

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# List of Acronyms

| | |
|---|---|
| A2Z | Micronutrient and Child Blindness Project |
| AIP | Annual Investment Plan |
| AO | Administrative Order |
| AOP | Annual Operational Plan |
| ARMM | Autonomous Region in Muslim Mindanao |
| BCC | behavior change communication |
| BDR | benefit delivery ratio |
| BHS | *Barangay* Health Station |
| CA | cooperating agency |
| CBMS | Community-based Monitoring System |
| CHD | Center for Health Development |
| CHITS | Community Health Information Tracking System |
| CHLSS | Community Health and Living Standards Survey |
| CHO | City Health Office |
| CO | central office |
| CQI | Continuing Quality Improvement |
| CSR+ | contraceptive self-reliance plus |
| DILG | Department of the Interior and Local Government |
| DOH | Department of Health |
| DOH Reps | DOH Representatives |
| DSWD | Department of Social Work and Development |
| EMR | electronic medical records |
| EPI | Expanded Program on Immunization |
| F1 | FOURmula ONE |
| FHSIS | Field Health Services Information System |
| FIC | fully immunized child |
| FLSW | freelance female sex workers |
| FP | family planning |
| FPCBT | Family Planning Competency-based Training |
| FPCMS | Family Planning Commodity Monitoring System |
| FSW | female sex worker |
| GAD | Gender and Development |
| GO | government organizations |
| GOLD | Governance and Local Democracy |
| GP | *Garantisadong Pambata* |
| GRP | Government of the Republic of the Philippines |
| HealthGov | Strengthening Local Governance for Health Project |
| HealthPRO | Health Promotion and Communication Project |
| HIS | Health Information System |
| HIV/AIDS | human immunodeficiency virus/acquired immunodeficiency syndrome |
| HPDP | Health Policy Development Project |
| ICV | informed choice and voluntarism |
| IDU | injecting drug user |
| IHBSS | Integrated HIV Behavioral and Serologic Surveillance |

| | |
|---|---|
| ILHZ | inter-local health zone |
| IPC/C | inter-personal communication/counseling |
| ISFP | Integrated Strategic and Financial Plan |
| IUD | intrauterine device |
| JAC | Joint Appraisal Committee |
| JSI\|DELIVER | John Snow Inc. USAID \| DELIVER Project |
| LAC | Local AIDS Council |
| LCE | local chief executive |
| LFC | Local Finance Committee |
| LGU | local government unit |
| LRA | local replicating agency |
| LRP | local response plan |
| LSS | Life Saving Skills |
| LTAP | local technical assistance provider |
| M&E | monitoring and evaluation |
| MARP | most-at-risk population |
| MCH | maternal and child health |
| ME3 | Monitoring and Evaluation for Equity and Effectiveness |
| MHO | Municipal Health Office/Officer |
| MIPH | Municipal Investment Plan for Health |
| MNCHN | maternal, newborn and child health and nutrition |
| MSM | males having sex with males |
| MSW | male sex workers |
| NASPCP | National AIDS/STI Prevention and Control Program |
| NCDPC | National Center for Disease Prevention and Control |
| NEC | National Epidemiology Center |
| NFPP | National Family Planning Program |
| NGO | non-government organization |
| NHIP | National Health Insurance Program |
| NHTS | National Household Targeting System |
| PFM | Public Finance Management |
| PHIC/PhilHealth | Philippine Health Insurance Corporation |
| PHN | public health nurse |
| PHO | Provincial Health Office/Officer |
| PHTL | Provincial Health Team Leader |
| PIPH | Province-wide Investment Plan for Health |
| PIR | Program Implementation Review |
| PMT | Proxy Means Test |
| PNAC | Philippine National AIDS Council |
| PRISM | Private Sector Mobilization for Family Health Project |
| PSEP | Public Service Excellence Program |
| QAPC | Quality Assurance Partnership Committee |
| QCHL SaMaCKA | Quezon City Health and Lifestyle Spa, Massage Clinics, Clubs, and KTV Association |
| RAV | Rapid Assessment of Vulnerabilities |
| RCBI | Region-wide Capacity Building Initiative |
| RFSW | registered female sex workers |
| RHU | Rural Health Unit |
| RICT | Regional Implementation and Coordination Team |

| | |
|---|---|
| SBMR | Standards Based Management-Recognition |
| SDExH | Service Delivery Excellence in Health |
| SDIR | Service Delivery Implementation Review |
| SDM | Standard Days Method |
| SHC | Social Hygiene Clinic |
| SHIELD | Sustainable Health Initiatives through Empowerment and Local Development Project |
| SIMS | Stock and Inventory Management System |
| SO3 | Strategic Objective |
| SP | *Sangguniang Panlalawigan* |
| SOCOPA | South Cotabato Purse Seiners Association |
| STI | Sexually Transmitted Infection |
| TA | technical assistance |
| TB | tuberculosis |
| TB LINC | Linking Initiatives and Networking to Control Tuberculosis Project |
| TOT | training of trainers |
| TWG | Technical Working Group |
| USAID | United States Agency for International Development |
| WAH | Wireless Access for Health |

# 1 Introduction

HealthGov is United States Agency for International Development's (USAID) project in health designed to strengthen LGUs' commitment to and support for public health services and their capacity to plan, provide, manage, and finance quality health services sustainably, particularly family planning (FP) and maternal, newborn, child health and nutrition (MNCHN), tuberculosis (TB) control, and HIV/AIDS prevention services.

HealthGov works with national and local government counterparts, other USAID-supported projects, and major stakeholders on four key activity areas, which correspond to the results framework of USAID's SO3: *Improved Family Health Sustainably Achieved*:

- ***Strengthening LGU management systems (IR 1.1)***: (1) integrating health planning and budgeting functions into the overall local government system; (2) improving management systems, including inter-local health zone (ILHZ) management, planning and budgeting, financial management, drug/commodity logistics and procurement, and the use of self-assessment techniques and health management information systems (HMIS) to diagnose priority problems; and (3) institutionalizing multi-stakeholder coordination mechanisms at the provincial level for participatory planning, leveraging resources, and sharing best practices.

- ***Improving and expanding LGU financing for health (IR 1.2)***: (1) integrating LGU priorities into multi-year health investment plans and forging national and local partnerships to sustain HIV/AIDS surveillance and prevention activities; (2) promoting performance-based decision-making among LGUs; (3) diversifying the LGUs' financial base; and (4) completing market segmentation.

- ***Improving service provider performance (IR 1.3)***: (1) improving human resource management; (2) enhancing health service quality assurance systems; (3) strengthening health provider training systems; and (4) improving LGU response to TB, HIV/AIDS, and other infectious diseases.

- ***Increasing advocacy for health (IR 1.4)***: (1) enhancing LGU officials' and leaders' commitment to health by providing advocacy tools and training; (2) increasing the capacity of health providers and civil society champions to develop and deliver effective health advocacy messages to local government officials and decision-makers; (3) intensifying civil society advocacy and participation with training and grants; and (4) strengthening partnerships between health providers and civil society to promote supportive policies and priority health programs, and expand opportunities where information is shared and consensus is built.

In the preparation of the Year 4 Plan in August 2009, and in revising the operational plan for Year 4 and Year 5 last February 2010, HealthGov took into account the broad strategies for accelerating improvements in family health performance indicators related to CA efforts identified in USAID SO3 Mid-Term Program-Level Assessment and SO3 Mid-Term Project-Level Assessment conducted in February 2009. These priority strategies include the following:

- Integration, addressing missed opportunities, and generating demand (FP);
- Implementation of MNCHN strategy (MCH);

- Focus on low performers and improving drug supply (TB);
- Addressing prevalence spike among MARPs (HIV/AIDS); and
- Improving data management and financing (health systems).

To identify specific priority TA interventions within these USAID's broad strategies, HealthGov undertook an internal review of its past interventions. Preliminary findings suggested areas that needed to be intensified and accelerated. Furthermore, HealthGov took into account the DOH initiatives in mobilizing the Centers for Health Development (CHD) as regional centers to assist LGUs, and the USAID continuing strategy to strengthen inter-CA collaboration.

The internal review, which was completed in May, provided further guidance in prioritizing technical assistance activities for Year 5. The internal review found that the pace of coverage of some HealthGov activities was faster, while others were slower, but that all activities implemented by HealthGov were within the scope of the RFA/Cooperative Agreement. A few activities were also developed to respond to pressing priorities of DOH and USAID, while a few others were modified to:

a) Provide greater focus. For example, the Public Finance Management (PFM) activity was adapted to focus on the management of revenues from PhilHealth for investment in health services expansion and quality improvements; improve access, custody, and utilization of DOH MNCHN grants; and integrate health planning into LGU planning and budgeting processes to ensure that LGU financial commitments in PIPH/AOP were budgeted for;

b) Leverage other partners' resources for TA product development (e.g., National Health Accounts). HealthGov focused on providing needed technical advice on the choice of consultants and resource persons for DOH-sponsored NHA training; and/or

c) Emphasize the strengthening of existing institutions rather than establishing new ones. For example, HealthGov's TA focused on making existing ILHZs become a focal institution for the implementation of PIPH.

A few TA interventions were also not pursued as a result of lack of demand from LGUs (cost recovery measures, hospital autonomy), or because they were beyond the capacity of HealthGov to effect changes in existing civil service laws (e.g., staffing levels and other HRH issues of LGU health services).

The findings also pointed to certain activities that needed to be:

a) Institutionalized in both DOH and LGUs (e.g., ICV, continuing quality improvement);

b) Intensified (i.e., covering more municipalities) and completed (i.e., TA to cover activities beyond planning to include policy development and monitoring of actual service provision);

c) Accelerated (e.g., logistics management and health information system improvements); and

d) Modified to achieve greater focus (e.g., financing).

Finally, HealthGov continued to take account of the DOH initiatives in mobilizing the CHD as centers to assist LGUs, considered the national government's renewed concern regarding universal coverage and access to health care, and the need for greater inter-CA collaboration. In Year 5, HealthGov will work in expansion sites in Eastern Visayas, namely, Western Samar and Leyte, together with the Cities of Ormoc and Tacloban.

Based on the above considerations, the priorities for Year 5 include the following categories:

1. Improving service delivery

    - FP/CSR/MNCHN plan implementation;
    - Integrating FP into EPI and maximizing use of MNCHN services;
    - Capability building of providers including training on FP-CBT and PHN facilitative supervision;
    - HIV/AIDS local action plan implementation;
    - Institutionalizing service delivery improvement tools (continuing quality improvement with community participation, ICV compliance monitoring and reporting);

2. Sustaining financing and local policy support

    - Local NHIP implementation;
    - Accessing and utilizing DOH MNCHN grants;

3. System strengthening

    - Strengthening health information system (data quality check and utilization of FP current users data and other MNCHN indicators; health sector reform implementation reviews, local data generation for health, electronic medical record system);
    - Integrating enhanced health plan into LGU planning and budgeting processes;
    - Improving logistics management system (nationwide FP commodity monitoring system, stock inventory management system for LGU facilities); and

4. Continuing advocacy with and orientation of newly elected officials (NEO).

In the development, delivery, and documentation of TA, the following strategy will be adopted:

- For TA products that are developed and ready for nationwide roll out by DOH and CHD, intensify capability building for the CHD to develop and deliver TA to LGUs (FP/CSR/MNCHN planning and implementation; data quality check and utilization; Family Planning Commodity Monitoring System; and access, custody, and utilization of MNCHN grants);
- For TA products under development and refinement with DOH/CHD and LGUs, demonstrate, on a pilot basis, in selected LGUs and CHD (SIMS; local NHIP implementation using the BDR approach; HIV/AIDS local action planning, implementation, and monitoring and evaluation);

- For TA products that have been tested, facilitate adoption by DOH and LGUs (continuing quality improvement with community participation, or SDExH; health sector reform implementation review or SDIR; ICV compliance monitoring and reporting); and
- For TA products that have produced results, accelerate documentation and showcase LGU innovative practices.

# 2 Priorities for Year 5

## 2.1 Improving service delivery

***FP/CSR/MNCHN planning, implementation, and monitoring***

The purpose of assisting LGUs formulate a consolidated CSR+ plan is to help them bring together various elements of the local FP program, including the need to secure the availability of FP commodities into a coherent program that would result in improved FP service delivery, which is a critical component of the MNCHN strategy. The LGUs can use the CSR+ plan as an advocacy tool for the development of a policy that would help ensure sustained commitment of the LGU to FP/CSR. By ensuring that key FP program elements identified in the FP/MNCHN performance grants are included in the plan, the CSR+ planning activity supports the FP/MNCHN performance grants initiative. In short, the CSR+ TA activity will assist LGUs focus on its FP program, ensure commitment and sustainability through local policy, and access external resources to fund FP/MNCHN activities. HealthGov will provide TA in collaboration with TB LINC, A2Z, and HealthPRO.

To speed up technical assistance to these provinces, as well as to build the capability of the CHD and PHOs, HealthGov and other CAs will support the conduct of a CHD-sponsored Training of Trainers. Training will include the entire CSR TA continuum and processes, which include current users data quality check, commodity forecasting, plan formulation, policy development, and monitoring and tracking of policy implementation. In Year 4, HealthGov has adopted this approach in Region 2, with CHD 2 sponsoring such TOT. The TOT also resulted in the formulation of a Joint CHD-PHO Action Plan on CSR+/ MNCHN Planning and Implementation for each of their respective provinces. In Year 5, HealthGov and the other CAs will likewise support the CHD-led TOT to be conducted in priority regions (3, 9, 11, and CARAGA).

As a pre-condition for CSR+/MNCHN planning, all provinces must undertake data quality check (DQC) of current users data to be used for forecasting FP commodities. In Luzon, this activity will be conducted in all provinces, except Tarlac, which has completed the activity in Year 4. Subsequent TA for CSR+/MNCHN planning will be provided to Cagayan and Bulacan. Albay will update its CSR+/MNCHN plan based on data quality checked current users data. Upon consultation with the provinces concerned, CSR/MNCHN activities for Nueva Ecija, Pangasinan, Isabela, and Tarlac will include only data quality check and updating, commodity forecasting, and inclusion of budgetary requirements of forecasted commodities in their respective AIPs.

In Visayas, all provinces will update their CSR+/MNCHN plans, principally the forecasts of FP commodities based on DQC current users data. Aklan, Capiz, and Negros Oriental will still conduct their DQC: Bohol and Negros Occidental have completed the activity in Year 4. In Eastern Visayas, both Leyte and Western Samar will undertake data quality check, forecasting, and planning up to development of policy.

In Northwestern Mindanao, all provinces have earlier conducted current users data quality check using the tool developed for Sarangani. A review and check based on updated quidelines will be done by these provinces, with the exception of Zamboanga del Norte, which has already done so in Year 4, to ensure quality data is consistent with new

DOH guidelines. Revised forecasts will be done, if deemed necessary, and policy development and tracking will follow.

Finally, in Southern Mindanao, priority provinces include Agusan del Norte, Davao del Sur, and South Cotabato. Compostela Valley will complete its CSR+/MNCHN activity with the passage of an ordinance. Sarangani has completed its CSR+/MNCHN plan, and policy and tracking activities at the end of Year 4.

***Integrating FP into EPI and maximizing use of MNCHN services***

A comparison of the 2003 and 2008 NDHS results revealed that the CPR for modern methods has remained stagnant at 34%, and facility-based deliveries (FBD) and deliveries attended by skilled birth attendants (SBA) have increased minimally from 38% to 44% and from 60% to 62%, respectively. To contribute to the increase in the CPR, FBD, and SBA, the project developed and implemented the service delivery strategy of integrating FP into EPI and maximizing the utilization of existing MNCHN services and facilities. The encouraging results of the use of individually-delivered referral messages linking FP to EPI services and maximizing utilization of MNCHN services in Polomolok led to expansion in other sites (Cagayan, Isabela, Tarlac, Albay, Aklan, Bohol, Negros Oriental, Negros Occidental, Misamis Occidental, Misamis Oriental, Bukidnon, and Zamboanga del Norte). To date, 40 C/MLGUs from 13 of the 25 HealthGov provinces are in various stages of implementation.

Initial observations in the expansion sites revealed that supervision has not been systematically implemented, hence, documentation of progress and performance needs improving. To address this, HealthGov developed a monitoring tool for tracking the progress of implementation of the key action points and to document changes in the performance indicators. These include indicators for family planning services (new acceptors and current users), and maternal and child health services (4 quality ante-natal care, facility-based deliveries, deliveries by skilled birth attendants, fully immunized child (FIC), and exclusive breastfeeding, among others).

In Year 5, the project will continue to provide technical assistance and capacitate the CHD and PHOs through the conduct of training of trainers to enable them to expand the coverage of the strategy to other LGUs with at least 85% FIC performance coverage in 234 municipalities and 17 cities in 24 provinces. Inter-CA collaboration will be strengthened by ensuring that the strategy is presented and discussed in the Inter-CA TWG to arrive at an operational implementation arrangement at the national, regional, and field levels. Inter-CA collaboration will also be fostered by defining the roles of the CAs. For instance, HealthPRO will a) develop focused and localized messages that will be used and disseminated by the community health teams; b) its local replicating agents (LRAs) to include in the training on organizing/conducting mothers' classes the CHTs in LGUs implementing the intervention; c) prioritize capacity building of service providers in IPC/C; and d) assist LGUs develop localized messages that will be used during FP IPC/C sessions. PRISM2 will help in establishing a public-private FP and birthing facility referral network and mechanism, and in developing a mechanism for recording and reporting private sector performance to the public sector reporting system. HPDP will harmonize the strategy with the Family Health Book initiative implemented in Compostela Valley and incorporate the strategy in the MNCHN Manual of Operations.

### *Capacity building for FP/MNCHN providers*

In improving service providers' performance in Family Health Programs, HealthGov has developed a guide on the different training courses on MNCHN, FP, TB, and sexually transmitted infections (STI)/HIV/AIDS. The guide includes information on the objectives and content of the training course, the duration, the participants, and criteria for the selection of facilitators and trainers. HealthGov will provide the LGUs with the guide to help them in developing their annual training plan. In collaboration with the DOH at the national level, manuals on Family Planning Competency Based Training (FPCBT) Levels 1 and 2, and PHN Supportive Supervision were revised and Regional TOTs were conducted nationwide and in Luzon, respectively. In Year 4, the DOH and PHOs initiated the conduct of roll out trainings for LGU service providers, for completion in Year 5. Furthermore, in Year 5, HealthGov will develop a database design for the LGU's Health Human Resource training profile for downloading to all 23 provinces that had completed SDIR.

### *Local action for HIV/AIDS prevention and control*

USAID's technical assistance to the Philippine Government with regard to HIV/AIDS is to help maintain low HIV prevalence status – that is, less than 3 percent among the most at-risk populations (MARPs) and less than 1 percent among the general population. This will be realized in close collaboration with the Department of Health (DOH) at the central and regional levels, through focused TA delivery by the USAID cooperating agencies (CAs) in 11 HIV/AIDS high-risk cities, namely, Angeles, Pasay, Quezon, Bacolod, Iloilo, Cebu, Lapu-Lapu, Mandaue, Davao, General Santos, and Zamboanga.

In Year 4, in response to the need for new initiatives, HealthGov, together with the concerned DOH-Centers for Health Development (CHD) and USAID Cooperating Agencies (HealthPRO, PRISM2, and HPDP), assisted key stakeholders in the pilot cities of Quezon, Davao, General Santos, and Metro Cebu (Cities of Cebu, Lapu-Lapu, and Mandaue) to identify actionable HIV/AIDS prevention and control interventions. This local response planning approach aimed to engage LGUs to implement local responses with much more sustained intensity, wider coverage, and more strategic approaches than were usually implemented. The following are the major activities conducted:

- Through a workshop and on-site meetings, assisted health officers at DOH-CHD and City Health Offices (CHOs) of the pilot cities in updating their information on emerging trends in HIV/AIDS and their understanding of the local drivers of the HIV/AIDS epidemic. Likewise, they were assisted in identifying effective HIV/AIDS prevention and control strategies.
- Through interviews with informants who could "influence" the local chief executives (LCEs), determined the "local action space" in relation to implementation of recommended technical interventions to respond to the HIV/AIDS epidemic in the pilot cities. The specific interventions and operational steps for implementation were likewise validated with the LCEs.
- Through a stakeholders' meeting, specified the operational steps to implement specific intervention modes that are within the "local action space", identified advocacy, financing, and other support from the LCEs, DOH-CHD, and other partners for the implementation of approved interventions, and developed a system for monitoring the implementation of the approved interventions.

For Year 5, technical assistance will focus on:

- Monitoring the implementation of the STI/HIV/AIDS local response plan of the Cities of Quezon, Davao, General Santos, and Metro Cebu (Cebu, Mandaue, Lapu-Lapu) and documenting the local response planning approach to serve as input to the development of a process guide to be used by DOH in replicating the approach in other LGUs; and
- Improving service delivery by supporting private sector partnership with the Davao City Chamber of Commerce and Industry to plan, implement, monitor, and evaluate STI/HIV/AIDS prevention and control activities in the workplace, specifically the call centers. An output of this technical assistance is the development of an implementation guide and manual for setting up a workplace STI/HIV/AIDS prevention and control program that LGUs may adopt for local use.

***Institutionalizing service delivery improvement tools (SDExH, SDIR, ICV)***

Continuing quality improvement with community participation (SDExH with QAPC)

SDExH is an approach to continuous quality improvement in health care services with the main goal of contributing to better health outcomes by improving the quality of health services. It is an integration of the local Public Service Excellence Program (PSEP) implemented under the USAID-funded project Governance and Local Democracy (GOLD) and the internationally implemented Standards Based Management-Recognition (SBMR) approach of Jhpiego. These two quality assurance approaches have been proven and tested to be viable in achieving results. PSEP is a planned change effort to improve frontline services through customer-centered interventions in the behavior of service providers; coverage and scope of services; and installation of systems and processes. SBMR promotes innovative approaches to improving performance and quality at the facility level in low resource settings adopting national and international standards.

The design, development, and pilot implementation of SDExH began in April 2007 and ended in January 2008. From conceptualization to the conduct of subsequent action steps in implementing the SDExH, the DOH-National Center for Disease Prevention and Control has been the lead in the systematic process of molding the SDExH technical assistance package.

In Year 4, HealthGov expanded SDExH implementation to the following areas:

- 4 municipalities and 1 district hospital in Bailan Inter-Local Health Zone, Capiz;
- 3 municipalities, 1 city, and 3 government hospitals in Ozamiz ILHZ, Misamis Occidental
- 3 municipalities and 1 district hospital in Sta. Bayabas ILHZ, Negros Oriental
- 6 municipalities and the Compostela Valley Provincial Hospital in COMMMONN ILHZ, Compostela Valley;
- 3 municipalities and 1 district hospital in JOLLIPOGUI ILHZ, Albay; and
- 3 municipalities and I district hospital in BueNasCar ILHZ in Agusan del Norte.

In Year 5, work will focus on completing the last phases of the module in the last three ILHZs identified above. In addition, SDExH will be introduced in Bulacan in response to the LGU's request made in Year 4. However, the PHO opted to start its implementation

in October 2010 when the political environment would have stabilized. SDExH implementation has been included in the 2010 Provincial AIP.

It is worth noting that as early as Year 3, the DOH-NCDPC has presented SDExH to the DOH-Sectoral Management Team Cluster for nationwide adoption but the Cluster has put its decision on hold pending the conduct of a study on all continuing quality improvement initiatives of the department. A committee was created to perform the task but it was never convened. Consequently, the project will continue to find SDExH's niche in the overall DOH quality assurance program. Thus, in Year 5, the project will undertake the following activities: (1) present to the DOH-NCDPC Family Health Cluster program managers and technical staff the SDExH local service standards on the delivery of FP, and maternal and child health services at primary health facilities for review in terms of consistency with existing DOH policies and standards and secure their approval for its adoption; (2) provide technical assistance to DOH-NCDPC to facilitate approval and adoption of SDExH; (3) enhance the SDExH module to incorporate the elements of the Quality Assurance Partnership Committee as a result of the Health Systems 20/20 Project in Compostela Valley Provincial Hospital and the Oroquieta City and Lopez Jaena health facilities, thereby, ensuring the participation of the community in the delivery of quality health services; and 4) advocate for the institutionalization of SDExH within the DOH system through the issuance of an AO.

<u>ICV compliance monitoring and reporting</u>

Since its start in 2006, HealthGov has provided technical assistance to the Department of Health (DOH) in ICV compliance monitoring and reporting. It has designed an ICV Orientation Training Program that has capacitated the regional health offices and PHOs with trainers on ICV. The HealthGov field staff has worked closely with these trained FP Coordinators and Trainers to roll out the orientation training in ICV compliance monitoring among service delivery sites and FP clients.

HealthGov has used a two-way approach to ensure ICV compliance monitoring in the field. First, it set up and implemented an in-house project compliance monitoring mechanism on USAID family planning legislative and policy requirements as reflected in the Tiahrt Amendment and PD-3. Second, the project supported the establishment of a nationwide ICV compliance monitoring mechanism within the DOH by building capacities at the sub-national level.

In Year 4, the conduct of ICV compliance monitoring and reporting by the CHD and PHO has been rather slow. There were reported possible vulnerabilities in some municipalities, which suggest that there are practices at the LGUs that constrain informed choice and voluntary decision-making. Hence, compliance with ICV remains a concern and the need to conduct regular and systematic monitoring of health facilities to ensure ICV compliance is imperative.

In Year 5, HealthGov will continue to implement activities that will create or increase awareness on ICV policies and principles among in-house staff, DOH FP program managers/coordinators, other stakeholders, and service providers. HealthGov will do this through: a) the dissemination of the ICV policies during the conduct of orientation on Integrating FP to EPI services and maximizing MNCHN services, FP CBT Level 1 and Level 2 orientation/training, and FP/CSR+/MNCHN planning workshops; and b) the

conduct of inter-CA orientation for newly hired staff or refresher course for existing project staff on FP Policy Requirements and Compliance Monitoring.

HealthGov will also strengthen its work with the DOH at the national level for wider ICV compliance monitoring and reporting across the country. The project will continue to work with DOH-NCDPC and the CHD to conduct actual monitoring and reporting of the ICV policy requirements for facility, clinic, and hospital staff and cover the rest of the provinces and municipalities.

To ensure that all health facilities in all 25 provinces will be monitored, the following strategies will be adopted:

1. Sessions will be added during SDIR (internal assessment) and SDExH (mentoring and coaching) to allow the conduct of interviews with service providers and clients;
2. ICV compliance monitoring will be conducted during FPCBT Level I training and the Data Quality Check practicum;
3. Project staff will integrate ICV compliance monitoring during field visits to ensure wide coverage of facilities, service providers, and clients; and
4. The rest of the municipalities in the project sites that have not been monitored for ICV compliance will be identified and monitoring for these municipalities will be scheduled.

The final draft of the Administrative Order on the implementation of ICV has been submitted to DOH for approval. HealthGov will support the implementation of the approved AO through the installation of an ICV compliance monitoring and reporting system within the DOH, CHD, and the LGU service delivery outlets, thus, ensuring adherence to policy requirements.

Meanwhile, HealthGov will task its regional teams to oversee and facilitate the monitoring of the municipalities in the 25 provinces and take a more pro-active stance in determining non-compliance with the ICV policy requirements. Documentation and reporting of monitoring activities will be included in the quarterly reports submitted to USAID.

At the local level, HealthGov will provide assistance in formulating local policies that will ensure the strict implementation of ICV policies, especially the elimination of targets and incentives. These policies will be formulated in line with the development of the FP/CSR+/ MNCHN Plan of the LGU.

## 2.2 Sustaining financing and local policy support

### *Local NHIP implementation*

In Year 4, with technical assistance from USAID cooperating agencies, which pooled their resources to provide consultants and in-house resource persons, the Department of Health (DOH) and the Philippine Health Insurance Corporation (PhilHealth), completed the review of the delivery of the National Health Insurance Program (NHIP) benefits. The PhilHealth Benefit Delivery Review used the benefit delivery ratio (BDR) approach to measure the extent of actual delivery of NHIP benefits to the ultimate beneficiaries. It captures the combined and cumulative effects of PhilHealth operations from enrollment,

accreditation, benefit availment, and benefit payment to support health care expenditures.

The review yielded a national average BDR of around eight (8) percent. Results of the review showed that the NHIP was able to enroll and make eligible to claim only 53 out of every 100 Filipinos, and of those enrolled, only 22 availed of the services from accredited facilities. Of those who availed those benefits, only the equivalent of eight (8) secured full financial protection from NHIP.

Given the results of the BDR study, the DOH decided to make the measurement and monitoring of the BDR as the primary basis for DOH support to monitor NHIP implementation in provinces and cities. As provided for in DOH Department Order No. 2010 -0156, "all DOH central offices and CHD shall learn to use and apply the principles and methods of the BDR approach" in working with PhilHealth and LGUs implementing the NHIP.

In Year 5, HealthGov, in collaboration with HPDP and PRISM2, will a) develop TA tools for local NHIP implementation, including custody and management of facility revenues derived from PhilHealth benefit payments for investment in health service expansion and quality improvements through policy support; b) assist DOH in a nationwide CHD orientation as provided for in the DO 2010-0156 for national roll-out, starting with priority CHDs 8, 9, 1, 2, and CARAGA; c) assist priority CHDs to engage the respective provinces in the development of an NHIP implementation plan based on the BDR approach, with attention to HealthGov provinces, i.e., Leyte, Western Samar, Zamboanga del Norte, Zamboanga del Sur, Pangasinan, Cagayan, and Agusan del Norte; d) in collaboration with CHDs 6 and 7, which have had orientation on BDR, assist Aklan, Bohol, Capiz, and Negros Occidental in developing their respective NHIP implementation plans; and e) assist Sarangani and South Cotabato update their NHIP implementation plan based on the BDR approach and available data on indigent households.,

***Accessing and utilizing the DOH MNCHN grants***

Since the establishment of the 2008 FP Grant, HealthGov has provided the following TA to improve access to and utilization of the DOH grant facility, now known as the MNCHN grants. In Year 5, HealthGov in collaboration with HPDP will:

- Support the CHD and PHOs in understanding the operational details of the grant facility, including the criteria for accessing the grant and its utilization;
- Support the CHD and PHOs in allocating the 2010 grant and tracking its utilization --- develop the automated tool reflecting the criteria identified in the Department Order;
- Incorporate under the FP/CSR/MNCHN Plan the MNCHN interventions, focusing on the critical components of the MNCHN strategy; and
- Provide technical backstop support to the CHD in providing TA to LGUs in the development and implementation of relevant policies, MOA, and plan to access the MNCHN grant.

## 2.3 Systems strengthening and governance

***Integrating enhanced health plan into the LGU planning and budgeting processes***

In the past four years, HealthGov has assisted the CHD and LGUs in the preparation of Province-wide Investment Plan for Health (PIPH) and Annual Operational Plan (AOP) in response to DOH priorities when it wanted nationwide implementation of PIPH/AOP as basis of LGU, DOH, and donor investments in health at the local level. HealthGov participated in the inter-CA development of PIPH Guidelines and assessment tools led by HPDP, and led inter-CA teams in assisting LGUs in the preparation, review, and post-JAC finalization of PIPH/AOPs. The PIPH/AOPs served as an advocacy tool to bring in commitment of stakeholders (e.g., Albay Health Fest, August 13, 2010).

An innovation HealthGov introduced at the start in the preparation of PIPH/AOPs was the involvement of municipal and component city LGUs in the preparation of the PIPH. Individual LGU needs and priorities are reflected in the PIPH.

However, all these years, the DOH-sponsored PIPH/AOP process has not been synchronized with the LGU planning and budgeting process. The DOH schedules the preparation of PIPH/AOP after the LGU planning and budgeting process has been completed. As a result, in most cases, LGU financial commitments contained in the PIPH/AOP are not funded from local budgets.

There is an excellent opportunity to demonstrate the integration of the DOH-sponsored PIPH/AOP process with the LGU planning and budgeting process after the May 2010 elections in view of the fact that the new administration will be preparing their Comprehensive Development Plan-Executive-Legislative Agenda (CDP-ELA). In Year 5, HealthGov will demonstrate this integration in selected sites, which are characterized by a supportive CHD and active partnership between planning and health offices at the province and municipal/city levels. These include South Cotabato, Sarangani, Agusan del Norte, Zamboanga del Norte, Zamboanga del Sur, Misamis Oriental and Misamis Occidental (both municipality/city and province); and Aklan, Capiz, Negros Occidental and Bohol (province only). HealthGov will work with HPDP to assist DOH to develop a policy to integrate and synchronize PIPH/AOP activities with the LGU planning and budgeting processes along the lines indicated in the Joint Memorandum Circular of DILG, NEDA, DBM, and DOF.

***Strengthening health information system (HIS)***

In Year 4, HealthGov's work on HIS strengthening took various forms: data quality check and utilization, local data generation for health and living standards (useful for client classification), and innovations in data recording and reporting (electronic medical record system) piloted in Tarlac in collaboration with Qualcomm. The first one is nationwide in scope, while the second and third apply to selected areas as demonstration sites.

<u>Data quality check and utilization</u>

In Year 4, the nationwide CHD orientation and training in FP current users data quality check and utilization (forecasting FP commodity requirements for planning and budgeting) covered 10 CHDs (3, 4A, 5, 6, 7, 8, 9, 10, ARMM, NCR). Actual data quality has been conducted in Tarlac, Zamboanga del Norte, South Cotabato, Negros Occidental, and Bohol. In Year 5, HealthGov will cover the remaining CHDs, and in collaboration with these CHDs, FP data quality check will be undertaken in all the remaining HealthGov provinces. HealthGov will also provide backstop support to CHDs

in providing TA to the rest of their respective provinces, so that data quality will be achieved uniformly across the nation and to institutionalize routine data quality check through issuance of DOH guidelines. HealthGov will work closely with HPDP to engage DOH in developing and issuing such guidelines for FP and for the other MNCHN indicators described below.

The data quality check guide and tool for the other MNCHN indicators (ANC, SBA, FBD, FIC, and VAC), have also been developed. Consultations with DOH-NCDPC will be done to solicit support and to identify the CHD and project provinces that will be involved in the pilot implementation. Either CHD 3 or CHD 8 will serve as the pilot implementation region for the region-wide orientation training of CHD Program Coordinators, selected DOH Representatives, and PHO technical staff. The project will continue to support DOH-NCDPC in the conduct of the region-wide orientation as resource persons and facilitators. Coaching and mentoring on the use and implementation of the data quality check guide and tool during the pre-SDIR data cleaning phase will be provided by project staff to CHD program coordinators and PHO technical staff to ensure that "cleaned" data are analyzed and appropriate interventions are developed. In Year 5, this TA will be provided to nine (9) provinces (and their component LGUs), namely, Pangasinan, Tarlac, Aklan, Leyte, Western Samar, Zamboanga Sibugay (demonstration site for integration into SDIR process), Zamboanga del Norte, South Cotabato, and Sarangani.

Experiences in the region-wide orientation training and data cleaning will be documented to enhance the consolidated guidelines/tools, which will be submitted to DOH for review and adoption as supplemental guidelines in improving the quality of public health data of LGUs.

<u>Local data generation: Community Health and Living Standards Survey (CHLSS)</u>

The CHLSS was designed to help LGUs generate local data for identifying unmet needs for family health services and identifying households eligible for public subsidies. The technical, operational, and resource requirements to conduct a complete enumeration of households, processing, and analysis precludes even this simplified system to be implemented by all provinces. Only provinces that have the will, commitment, resources, organization, and the appreciation of its need can be candidate provinces for advocating the use of CHLSS. In Year 3 and Year 4, three provinces - Misamis Occidental, South Cotabato and Negros Oriental - adopted the CHLSS together with the municipality of Polangui, Albay. All have completed the CHLSS and data analysis, and they have started using the data for planning and program implementation.

In Year 5, HealthGov will assist General Santos City, Pangasinan, and Capiz in response to their request for assistance, the latter two to update the Living Standards Survey, the precursor of CHLSS, that they had conducted under the LEAD Project. In the case of General Santos City, this would be an opportunity to work with a city in generating local data for addressing urban health issues as well as other concerns such as focused targeting and greater equity in delivery of services, and improvement of city health services to serve a larger catchment area of neighboring provinces.

The core questionnaire, interviewer and supervisor manuals, and coding manual have been prepared. Further work will be done to complete the analysis manual. This manual will include the following: a) guide to classification of households based on a Living Standards Index for determining households eligible for public subsidies; b) use of

selected indicators to apply DSWD NHTS proxy means test; c) estimation of FP/MNCHN indicators of unmet needs, which can also help validate FHSIS data; and d) use of data to address local development issues such as monitoring of local achievement of MDG goals, education, infrastructure, agriculture, employment, and livelihood. The CHLSS tool will be packaged and, through DOH and CHD, offered to LGUs as an option for local data generation for health and development.

Electronic medical recording and health information system (Wireless Access for Health (WAH)

HealthGov's support to the WAH project in Tarlac is lodged within its technical assistance to improve existing health information systems at the LGU level. In addition to Tarlac, HealthGov will assist CHD 3 in developing its strategy to expand WAH, particularly the use of the Community Health Information Tracking System (CHITS) electronic medical records (EMR), to other provinces in the region. WAH is designed to improve health care by reducing the time required for monthly reporting of FHSIS data and by improving access to accurate and relevant patient information.

The first objective of the WAH scale up strategy is to get the CHITS EMR system to all RHUs in the four original pilot LGUs in Tarlac, namely, Victoria, Paniqui, Gerona, and Moncada. The next will be to roll out to at least 10 additional RHUs in Tarlac over the next 12 months. For this, HealthGov will assist the PHO develop advocacy materials to be used during presentations to the local chief executives of other municipalities who have signified interest to adopt CHITS EMR and participate in the WAH network. HealthGov, in coordination with CHD 3 and the PHO, will also assist in providing technical assistance to the four pilot RHUs in the analysis and use of the data that have been generated from the CHITS EMR.

Apart from assisting in developing the WAH expansion strategy, HealthGov will work very closely with CHD 3 in ensuring that quality check and cleaning of family planning current users, MNCHN, and TB data are conducted prior to the installation of the CHITS EMR. HealthGov, together with the other stakeholders, particularly CHD 3, will also facilitate a dialogue among partners to lay the groundwork for ensuring that the initiative can continue without financial support from Qualcomm, which provided major financial assistance to the pilot project.

Enhanced health sector reform implementation review (SDIR)

The Service Delivery Implementation Review (SDIR) was developed as a management tool to monitor, review, and assess program performance. Its major feature is the flexibility to include core program indicators, which allows the review/analysis of several public health programs and areas at a time. This feature enables LGUs to identify and prioritize health programs and areas. Over the life of the HealthGov project, the SDIR tool evolved to address increasing needs, i.e., to provide data quality check guide for the core set of indicators that corresponds to the indicators of the LGU Scorecard; to provide data for determining critical interventions in priority areas as input to PIPH/AOP formulation; to provide data for accessing DOH-MNCHN grants; and to provide additional information on specific concerns such as health situation in IPs and GIDAs, PhilHealth enrollment, client utilization of services, and hospital operations, among others. All HealthGov provinces have used the tool in generating inputs for the PIPH/AOP formulation process.

In Year 5, activities will mainly involve packaging the tool incorporating the latest enhancements, and adding it as part of the PIR toolkit of DOH and LGUs.

***Improving logistics management system (FP commodity monitoring system; stock inventory management system)***

In Year 4, HealthGov commissioned a study on logistics management in 23 project sites. The study revealed three major gaps, i.e., the need to monitor the availability of FP supplies, the need to improve the LGUs' stock and inventory management system, and the need to establish a logistics management information system. Together with JSI|DELIVER, HealthGov and concerned CHDs validated the findings in selected provinces. As a result of this validation, HealthGov and JSI|DELIVER developed tools for the FP Commodity Monitoring System (FPCMS) and the Stock Inventory Management System (SIMS). The development of these tools also benefited from the inputs of HPDP, PRISM2, SHIELD, A2Z, and TB LINC during a series of technical consultation meetings.

Family Planning Commodity Monitoring System (FPCMS)

The FPCMS will be used to assess the availability of family planning commodities in the main health centers, hospitals, PHOs, and CHD. It can be used by the CHD for monitoring the provinces, and by the provinces for monitoring the municipalities. It can also support staff in improving their ability to manage and monitor family planning commodities.

In Year 4, HealthGov, in collaboration with JSI|DELIVER, developed quarterly and annual monitoring tools after a series of technical consultations with DOH-NCDPC, development partners, other CAs, and LGUs. HealthGov conducted the LGU consultation in Tarlac in June 2010 to generate inputs for refining the design of the tools for monitoring FP commodities. The annual tool includes questions that will allow the DOH, CHD, and even LGUs to assess how LGUs respond to the CSR initiative, e.g., questions on budget, procurement, subsidy to the poor, etc.

The DOH-NCDPC has decided to implement nationwide the commodity availability segment of the FPCMS to obtain information that would guide decisions regarding DOH distribution of contraceptives to LGUs, either from supplies to be procured by DOH or supplies donated by partners. The DOH Central Office will aggregate the data from municipalities obtained by the DOH Reps. As of September 30, a total of 1,037 facilities 761 out of 1,605 municipalities have submitted reports. The results show the following percentages of facilities with the specified stocks: condom, 38%; COC, 63%; progestin only, 22%; IUD, 44% and injectibles, 60%. HealthGov sites follow a similar pattern. It is expected that the submissions will be completed in October and DOH will use the results to guide decisions regarding FP commodity assistance to LGUs.

In Year 5, HealthGov will assist DOH in conducting a nationwide CHD Training of Trainers for routine implementation of the FPCMS, i.e., the regular quarterly and annual monitoring in all regions. The DOH-NCDPC was able to obtain clearance from the DOH-Health Human Resource Development Bureau (HHRDB) for the conduct of said training despite the DOH moratorium on the conduct of trainings. HealthGov will provide DOH TA support in implementing their rollout plan for FPCMS in all LGUs.

Stock inventory management system (SIMS)

The SIMS, will help LGUs track expendable commodities in health facilities, especially drugs and medical supplies. It will help organize and update records for quantities received; quantities dispensed to clients; quantities issued to midwives or *Barangay* Health Stations (BHSs); and quantities in stock. This system operates only within the health units and does not require any new reports. For units that are already making logistics reports to specific programs such as TB or EPI, this system will facilitate the generation of information necessary for filling out their forms.

The SIMS tool includes instructions and forms for undertaking the following tasks: receiving drugs and medical supplies; safe storage; dispensing to patients; issuing to midwives and BHSs; carrying out physical inventories; ordering new stock; reporting on stock; and keeping track of drug expiration dates.

In Year 4, as was done with the development of the FPCMS tool, the development of the SIMS tool involved a series of technical consultations with DOH-NCDPC, development partners, other CAs, and LGUs. The LGU consultation was conducted with representatives from the CHD 8, the Provincial Health Office of Leyte, and local government officials and health workers of one Inter-local Health Zone (ILHZ) in Leyte.

In Year 5, TA activities will involve piloting of the SIMS in seven (7) provinces: Cagayan (all municipalities), Tarlac (four municipalities of WAH, electronic version), Capiz (all municipalities, electronic version), Leyte (one city and 4 municipalities), Zamboanga del Norte (5 municipalities and one city), Agusan del Norte (all municipalities and one city), and Sarangani (all municipalities). The pilot test will last for three months, followed by capability building of the CHD through Training of Trainers (TOT) in the provision of technical assistance to LGUs. The CHD will fund the conduct of the TOT. HealthGov will provide resource persons and other technical support.

## 2.4 Continuing advocacy with and orientation of newly elected officials (NEO)

HealthGov's support to newly-elected local officials aims to: a) facilitate the integration of health investment plans, i.e., PIPH/AOP, LGU acceleration plans, etc. in the LGU development plans and budgets at the beginning of the term of newly-elected local officials, and b) foster linkages between and among the CHD; regional DILG and its field offices in the provinces, municipalities, and cities; LGU health staff; LGU planning officers; as well as local LGU leagues and CSOs in building support of local leaders for health.

To make this operational, HealthGov's TA follows two tracks: 1) integrating health in the DILG NEO program, and 2) continuing support to CHD/PHO advocacy initiatives directed at NEOs.

Integrating health into the DILG NEO Program

Operating in the context of *Building a Corps of Good Governance Champions*, the DILG NEO Program runs for three years, with the key components implemented through the Local Government Academy, DILG field offices in the regions, provinces, cities, and municipalities, the various LGU leagues, and other development partners. The DILG

NEO Program provides the best opportunity for jumpstarting and sustaining advocacy for health among newly elected and re-elected local officials.

Following the election in May 2010 in Year 4, HealthGov provided TA to integrate health into the DILG NEO Program in the different provinces at varying stages of engagements with CHD/PHO and DILG partners. This will continue into Year 5 to cover all 25 provinces.

Component 1: Ensuring Smooth Transition: Assist PHO/MHO compile and package investment plans and related materials (PIPH, AOPs, ISFP, TB Action Plans, CSR plans and ordinances, SDIR results) to be made available to Transition Team

Component 2: Laying the Foundation

*Track 1A*: My First 100 Days: Assist PHO/MHO in orienting officials on key health messages developed by DOH with assistance from USAID CAs: investing in health; investing in FP/MNCHN, TB, and HIV/AIDS

*Track 1B*: Knowing my LGU: Assist PHO/MHO in organizing information on state of local governance for health as input to defining term-based agenda (inclusion of LGU Scorecard in Local Governance Performance Management System); provincial fact sheets that reflect status of family health concerns and suggested actions for the NEOs; summarize health agenda in PIPH and AOP

*Track 2*: Fine Tuning my Competencies: Assist PHO/MHO in collaboration with local LGU leagues (LPP, LMP and LCP) to include LGU experiences and innovations in health development with attention to family health

Component 3: Provincial Alliance-Building. Assist PHO/MHO to disseminate and secure support for the implementation of term-based health agenda among other stakeholders based on experience in inter-LGU cooperation (ILHZ) and public-private collaboration (LGU-NGO; LGU-private sector) work with USAID CAs

Component 4: Sharpening the Saw: Assist in institutionalizing LGU application of TA products and tools developed by DOH/CHD with USAID CA assistance (PIPH, AOP, CSR, SDIR) in the LGU Capacity Development Program of the DILG-LGA.

<u>Support to CHD and PHO advocacy initiatives</u>

In Year 4, HealthGov provided TA support to the CHD, in particular, CHD 1 and CHD 3, in the conduct of their sponsored health fora, orientations, and courtesy meetings with and presentations to newly elected and re-elected local officials. Such support will continue into Year 5 and will be expanded to cover CHD 6, 10, 11, 12, and CARAGA. Likewise, HealthGov in collaboration with other CAs provided technical assistance to the PHO of the Province of Albay in the conduct of the Provincial Health Summit on August 12, 2010. The summit intended to forge cohesive partnerships among the province, cities, municipalities, other government agencies, civil society, and the private sector to implement fully the province's PIPH/AOP. HealthGov provided TA in the preparation of the provincial health situation and provincial directions, media brief, the draft MOU of the local governments, and the documentation of innovative LGU practices in health sector

development. In Year 5, HealthGov will continue to support PHO-initiated activities in all provinces in collaboration with other CAs.

## 2.5 Special Project: TA priorities in Region 8 (Eastern Visayas)

In 2010, two additional provinces (Northern Leyte and Western Samar) and two cities (Ormoc and Tacloban) in Eastern Visayas were added as HealthGov areas. Given the limited time available before HealthGov ends, it was important to fast-track key TA to the provinces and cities through CHD 8 and the PHOs. The focus of HealthGov's activities in Eastern Visayas is to strengthen the capability of CHD 8 to assist LGUs and help them implement local health sector reforms that will promote the achievement of USAID's family health goals. In the case of the Province of Leyte and the City of Ormoc, HealthGov's efforts will also complement the assistance provided by JICA, which is to strengthen maternal and child health services.

The major TA priorities identified for Eastern Visayas in Year 5 are the following:

1. Improving service delivery

    - FP/CSR/MNCHN plan implementation, including ICV compliance monitoring and reporting;
    - Integrating FP into EPI and maximizing use of MNCHN services;

2. Sustaining financing and local policy support

    - Local NHIP implementation;
    - Accessing and utilizing the DOH MNCHN grants;

3. System strengthening

    - Strengthening health information system with attention to data quality check and utilization of FP current users data and other MNCHN indicators;
    - Improving logistics management system (nationwide FP commodity monitoring system; stock inventory management system for LGU facilities); and
    - Continuing advocacy with and orientation of newly elected officials (NEO).

## 2.6 Documentation and dissemination of TA processes, outputs, and results

Over the past four years, HealthGov has developed, introduced, and implemented a number of TA interventions to help selected LGUs enhance the management and delivery of health services to their constituents. Also, there have been several lessons learned in the course of implementing HealthGov's technical assistance packages that, if documented and shared, may benefit other LGUs interested in adopting or applying them in their respective localities. On the other hand, implementing project sites may be encouraged to adopt these interventions on a continuing basis and provide the necessary funds to sustain them and, hopefully, to scale up implementation.

For Year 5, HealthGov's communications strategy will be directed at achieving the following objectives: 1) to inform all stakeholders of what HealthGov is and what it has done (project initiatives, accomplishments/results); 2) to gain wider acceptance for HealthGov's products (TA processes and tools) among key partners to ensure institutionalization and sustainability; and 3) to encourage adoption/replication and scaling up of successful interventions (LGU experiences in adopting the tools and processes, and corresponding results, as well as LGU innovations). The specific target audiences include USAID, DOH/CHD, PhilHealth, LGUs, particularly LCEs, policy-makers, health workers, planners, etc., LTAPs, NGOs/CSOs, and other funding agencies. In this regard, the following will be undertaken:

***Purposive documentation*.** In addition to the regular project reports, Weekly Highlights, and Program/Project Briefers being prepared by HealthGov, three other types of documents will be produced, namely, 1) guides and manuals, 2) technical notes, and 3) success stories or emerging/potential best practices.

The how-to guides or manuals will detail the processes and the tools used in implementing the major TA interventions introduced by the project. The series of Technical Notes will provide a detailed account of how a specific intervention has been used or applied in selected project sites, the subsequent insights and learning generated, the results and impact realized, and suggested modifications, if any. The success stories will feature LGU-initiated innovations related to governance, health financing, regulation, and service delivery, specifically in such program areas as FP, MNCHN, TB, and HIV/AIDS. Focus will be on innovative strategies that were initiated either in response to HealthGov's TA or to facilitate the implementation of a specific TA intervention.

***Packaging and dissemination of information materials***. The resulting products will be used for advocacy purposes, i.e., as promotional and marketing tools for the interventions to gain wider acceptance. They are also intended as technical resource materials to facilitate adoption and replication of the interventions by interested parties. These will be disseminated or shared through any or a combination of the following: a) national and regional conferences of the League of Municipalities/Provinces, b) special health events, c) local and international workshops and meetings, and d) electronic media, among others. In this regard, efforts will also focus on the development of a project website.

Toward the end of Year 5, HealthGov and other relevant CAs will organize a series of inter-CA regional dissemination fora to showcase all their major TA products and interventions, as well as the LGU-initiated innovations. Representatives from various stakeholder groups, particularly the LGUs, will be invited to these fora.

# 3 Summary of TA interventions, by province

The succeeding matrix summarizes the major TA interventions to be implemented by the Project at the LGU level in Year 5 to improve family health outcomes. Further details are contained in Annexes A (National) and B (Regional/Provincial/HIV/AIDS).

**Summary of Priority TA Interventions by Province per Region for Year 5**

| TECHNICAL ASSISTANCE | LUZON | | | | | | | | | | | | | | | | | | | | | REGIONAL TOTAL (LUZON) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ALBAY | | | BULACAN | | | CAGAYAN | | | ISABELA | | | NUEVA ECIJA | | | PANGASINAN | | | TARLAC | | | | | |
| | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| **I. Improving Service Delivery** | | | | | | | | | | | | | | | | | | | | | | | | |
| 1A. Contraceptive Self-Reliance+/Maternal, Newborn, Child Health and Nutrition (CSR+/MNCHN) | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Data Quality Check (DQC) for Family Planning (FP) + Forecasting of FP Commodities + integration to AOP | 1 | 3 | 15 | 1 | 3 | 21 | 1 | 1 | 28 | 1 | 2 | 35 | 1 | - | 14 | 1 | 3 | 44 | - | - | - | **6** | **12** | **157** |
| b. CSR+/MNCHN Planning | 1 | 3 | 15 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | **2** | **3** | **15** |
| c. CSR+/MNCHN Plan + Policy | - | - | 9 | - | - | - | 1 | 1 | 28 | - | - | - | - | - | - | - | - | - | - | - | - | **1** | **1** | **37** |
| d. CSR+ MNCHN + Policy + Policy tracking | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 1B. Informed Choice & Voluntarism (ICV) Compliance Monitoring/Reporting | 1 | 3 | 15 | 1 | 3 | 21 | 1 | 1 | 28 | 1 | 2 | 35 | 1 | 5 | 27 | 1 | 3 | 44 | 1 | 1 | 17 | **7** | **18** | **187** |
| 1C. Functional Literacy | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 4 | **1** | - | **4** |
| 2. Integration of FP into the Expanded Program on Immunization (EPI) + Maximizing Use of Existing MNCHN Services + Evaluation | 1 | - | 9 | 1 | - | 10 | 1 | - | 5 | 1 | - | 6 | 1 | 1 | 8 | 1 | 1 | 4 | 1 | 1 | 5 | **7** | **3** | **47** |
| 3. Provincial database of health human resource capability profile | - | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | - | - | - | 1 | - | - | **5** | - | - |
| 4. Service Delivery Excellence in Health (SDExH) | 1 | - | 3 | 1 | 1 | 3 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | **2** | **1** | **6** |
| **II. Sustaining financing and local policy support** | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. National Health Insurance Program (NHIP) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| a. Local NHIP implementation plan | - | - | - | - | - | - | 1 | 1 | 28 | - | - | - | - | - | - | 1 | 3 | 44 | - | - | - | **2** | **4** | **72** |
| b. Enrollment | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| c. Accreditation | - | 3 | 6 | - | - | 3 | - | - | 5 | - | - | 7 | - | - | 10 | - | 1 | 10 | - | - | 5 | - | **4** | **46** |
| d. PHIC fund management | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 10 | - | - | - | - | **1** | **10** |
| 6. MNCHN grants access and utilization | 1 | 3 | 15 | 1 | 3 | 21 | 1 | 1 | 28 | 1 | 2 | 35 | 1 | 5 | 27 | 1 | 3 | 44 | 1 | 1 | 17 | **7** | **18** | **187** |
| 7. Integration of PIPH/AOP with LGU planning and budgeting processes + Comprehensive Development Plan (CDP) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **III. Systems strengthening** | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Data Quality Check of other MNCHN indicators | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 4 | 44 | 1 | 1 | 17 | **2** | **5** | **61** |
| 9. Family Planning Commodity Monitoring System (FPCMS) | 1 | 3 | 15 | 1 | 3 | 21 | 1 | 1 | 28 | 1 | 2 | 35 | 1 | 5 | 27 | 1 | 3 | 44 | 1 | 1 | 17 | **7** | **18** | **187** |
| 10. Stock and Inventory Management System (SIMS) | - | - | - | - | - | - | 1 | 1 | 28 | - | - | - | - | - | - | - | - | - | 1 | - | 4 | **2** | **1** | **32** |
| **IV. Continuing advocacy with and orientation of newly elected officials (NEO)** | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Support to Advocacy to NEO | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | **7** | - | - |

Legend: **-** Not applicable

**Summary of Priority TA Interventions by Province per Region for Year 5**

| TECHNICAL ASSISTANCE | VISAYAS | | | | | | | | | | | | | | | REGIONAL TOTAL (VISAYAS) | | | EASTERN VISAYAS | | | | | | REGIONAL TOTAL (EASTERN VISAYAS) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AKLAN | | | BOHOL | | | CAPIZ | | | NEGROS OCCIDENTAL | | | NEGROS ORIENTAL | | | | | | NORTHERN LEYTE | | | WESTERN SAMAR | | | | | |
| | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| **I. Improving Service Delivery** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1A. Contraceptive Self-Reliance+/Maternal, Newborn, Child Health and Nutrition (CSR+/MNCHN) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Data Quality Check (DQC) for Family Planning (FP) + Forecasting of FP Commodities + integration to AOP | 1 | - | 17 | - | - | - | 1 | 1 | 16 | - | - | - | 1 | 6 | 19 | **3** | **7** | **52** | 1 | 2 | 40 | 1 | 1 | 25 | **2** | **3** | **65** |
| b. CSR+/MNCHN Planning | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 2 | 40 | 1 | 1 | 25 | **2** | **3** | **65** |
| c. CSR+/MNCHN Plan + Policy | 1 | - | 9 | - | 1 | 25 | - | 1 | 15 | 1 | 8 | 12 | - | 4 | 11 | **2** | **14** | **72** | 1 | 2 | - | 1 | 1 | - | **2** | **3** | - |
| d. CSR+ MNCHN + Policy + Policy tracking | 1 | - | 2 | 1 | - | 10 | 1 | - | 8 | 1 | - | 2 | - | - | - | **4** | - | **22** | - | - | - | - | - | - | - | - | - |
| 1B. Informed Choice & Voluntarism (ICV) Compliance Monitoring/Reporting | 1 | - | 17 | 1 | 1 | 47 | 1 | 1 | 16 | 1 | 12 | 19 | 1 | 6 | 19 | **5** | **20** | **118** | 1 | 2 | 40 | 1 | 1 | 25 | **2** | **3** | **65** |
| 1C. Functional Literacy | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 2. Integration of FP into the Expanded Program on Immunization (EPI) + Maximizing Use of Existing MNCHN Services + Evaluation | 1 | - | 10 | 1 | - | 25 | 1 | - | 7 | 1 | 11 | 14 | 1 | 2 | 12 | **5** | **13** | **68** | 1 | - | 23 | - | - | - | **1** | - | **23** |
| 3. Provincial database of health human resource capability profile | - | - | - | 1 | - | - | - | - | - | 1 | - | - | 1 | - | - | **3** | - | - | - | - | - | - | - | - | - | - | - |
| 4. Service Delivery Excellence in Health (SDExH) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **II. Sustaining financing and local policy support** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. National Health Insurance Program (NHIP) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| a. Local NHIP implementation plan | 1 | - | - | 1 | - | 13 | 1 | 1 | 16 | 1 | - | - | - | - | - | **4** | **1** | **29** | 1 | 2 | 40 | 1 | 1 | 25 | **2** | **3** | **65** |
| b. Enrollment | - | - | 5 | - | - | - | - | - | - | - | 4 | 7 | - | - | - | - | **4** | **12** | - | - | - | - | - | - | - | - | - |
| c. Accreditation | - | - | 5 | - | - | 13 | - | - | - | - | 4 | 7 | 1 | - | 6 | **1** | **4** | **31** | - | - | 18 | - | - | - | - | - | **18** |
| d. PHIC fund management | - | - | 5 | - | - | 13 | - | - | - | 1 | 4 | 7 | - | - | - | **1** | **4** | **25** | - | - | - | - | - | - | - | - | - |
| 6. MNCHN grants access and utilization | 1 | - | 17 | 1 | 1 | 47 | 1 | 1 | 16 | 1 | 12 | 19 | 1 | 6 | 19 | **5** | **20** | **118** | 1 | 2 | 40 | 1 | 1 | 25 | **2** | **3** | **65** |
| 7. Integration of PIPH/AOP with LGU planning and budgeting processes + Comprehensive Development Plan (CDP) | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | - | - | - | **4** | - | - | - | - | - | - | - | - | - | - | - |
| **III. Systems strengthening** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Data Quality Check of other MNCHN indicators | 1 | - | 17 | - | - | - | - | - | - | - | - | - | - | - | - | **1** | - | **17** | 1 | 2 | 40 | 1 | 1 | 25 | **2** | **3** | **65** |
| 9. Family Planning Commodity Monitoring System (FPCMS) | 1 | - | 17 | 1 | 1 | 47 | 1 | 1 | 16 | 1 | 12 | 19 | 1 | 6 | 19 | **5** | **20** | **118** | 1 | 2 | 40 | 1 | 1 | 25 | **2** | **3** | **65** |
| 10. Stock and Inventory Management System (SIMS) | - | - | - | - | - | - | 1 | 1 | 16 | - | - | - | - | - | - | **1** | **1** | **16** | 1 | 1 | 4 | - | - | - | **1** | **1** | **4** |
| **IV. Continuing advocacy with and orientation of newly elected officials (NEO)** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Support to Advocacy to NEO | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | **5** | - | - | 1 | - | - | 1 | - | - | **2** | - | - |

Legend: **-** Not applicable

**Summary of Priority TA Interventions by Province per Region for Year 5**

| TECHNICAL ASSISTANCE | NORTHERN-WESTERN MINDANAO | | | | | | | | | | | | | | | | | | REGIONAL TOTAL (NORTHERN-WESTERN MINDANAO) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | BUKIDNON | | | MISAMIS OCCIDENTAL | | | MISAMIS ORIENTAL | | | ZAMBOANGA DEL NOR | | | ZAMBOANGA DEL SUR | | | ZAMBOANGA SIBUGAY | | | | | |
| | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| **I. Improving Service Delivery** | | | | | | | | | | | | | | | | | | | | | |
| 1A. Contraceptive Self-Reliance+/Maternal, Newborn, Child Health and Nutrition (CSR+/MNCHN) | | | | | | | | | | | | | | | | | | | | | |
| a. Data Quality Check (DQC) for Family Planning (FP) + Forecasting of FP Commodities + integration to AOP | 1 | - | - | 1 | - | - | 1 | - | - | - | - | - | 1 | - | - | 1 | - | - | **5** | - | - |
| b. CSR+/MNCHN Planning | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 16 | **1** | - | **16** |
| c. CSR+/MNCHN Plan + Policy | 1 | 2 | 8 | 1 | 1 | 6 | 1 | 1 | 11 | - | - | - | - | - | - | 1 | - | 4 | **4** | **4** | **29** |
| d. CSR+ MNCHN + Policy + Policy tracking | - | - | 10 | - | 1 | 6 | - | 1 | 10 | - | - | 19 | 1 | - | 25 | 1 | - | 4 | **2** | **2** | **74** |
| 1B. Informed Choice & Voluntarism (ICV) Compliance Monitoring/Reporting | 1 | 2 | 20 | 1 | 3 | 14 | 1 | 2 | 23 | 1 | 2 | 25 | 1 | 1 | 26 | 1 | - | 16 | **6** | **10** | **124** |
| 1C. Functional Literacy | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 2. Integration of FP into the Expanded Program on Immunization (EPI) + Maximizing Use of Existing MNCHN Services + Evaluation | - | - | 10 | - | - | 9 | 1 | - | 14 | - | - | 12 | 1 | - | 10 | 1 | - | 9 | **3** | - | **64** |
| 3. Provincial database of health human resource capability profile | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | - | 1 | - | - | **2** | - | - |
| 4. Service Delivery Excellence in Health (SDExH) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **II. Sustaining financing and local policy support** | | | | | | | | | | | | | | | | | | | | | |
| 5. National Health Insurance Program (NHIP) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| a. Local NHIP implementation plan | - | - | - | - | - | - | - | - | - | 1 | 2 | 25 | 1 | 1 | 26 | - | - | - | **2** | **3** | **51** |
| b. Enrollment | - | - | - | 1 | 1 | 7 | - | - | - | - | - | - | - | - | - | - | - | - | **1** | **1** | **7** |
| c. Accreditation | - | - | - | - | 1 | 7 | 1 | - | 4 | - | - | - | - | - | 10 | - | - | - | **1** | **1** | **21** |
| d. PHIC fund management | - | - | - | 1 | 1 | 7 | - | - | - | - | - | - | - | - | - | - | - | - | **1** | **1** | **7** |
| 6. MNCHN grants access and utilization | 1 | 2 | 20 | 1 | 3 | 14 | 1 | 2 | 23 | 1 | 2 | 25 | 1 | 1 | 26 | 1 | - | - | **6** | **10** | **108** |
| 7. Integration of PIPH/AOP with LGU planning and budgeting processes + Comprehensive Development Plan (CDP) | - | - | - | 1 | 3 | 14 | 1 | 2 | 23 | 1 | 2 | 25 | 1 | 1 | 26 | - | - | - | **4** | **8** | **88** |
| **III. Systems strengthening** | | | | | | | | | | | | | | | | | | | | | |
| 8. Data Quality Check of other MNCHN indicators | - | - | - | - | - | - | - | - | - | 1 | 2 | 25 | - | - | - | 1 | - | 16 | **2** | **2** | **41** |
| 9. Family Planning Commodity Monitoring System (FPCMS) | 1 | 2 | 20 | 1 | 3 | 14 | 1 | 2 | 23 | 1 | 2 | 25 | 1 | 1 | 26 | 1 | - | 16 | **6** | **10** | **124** |
| 10. Stock and Inventory Management System (SIMS) | - | - | - | - | - | - | - | - | - | 1 | 1 | 5 | - | - | - | - | - | - | **1** | **1** | **5** |
| **IV. Continuing advocacy with and orientation of newly elected officials (NEO)** | | | | | | | | | | | | | | | | | | | | | |
| 11. Support to Advocacy to NEO | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | **6** | - | - |

Legend: **-** Not applicable

**Summary of Priority TA Interventions by Province per Region for Year 5**

| TECHNICAL ASSISTANCE | SOUTHERN MINDANAO | | | | | | | | | | | | | | | REGIONAL TOTAL (SOUTHERN MINDANAO) | | | GRAND TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AGUSAN DEL NORTE | | | COMPOSTELA VALLEY | | | DAVAO DEL SUR | | | SARANGANI | | | SOUTH COTABATO | | | | | | | | |
| | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| **I. Improving Service Delivery** | | | | | | | | | | | | | | | | | | | | | |
| 1A. Contraceptive Self-Reliance+/Maternal, Newborn, Child Health and Nutrition (CSR+/MNCHN) | | | | | | | | | | | | | | | | | | | | | |
| a. Data Quality Check (DQC) for Family Planning (FP) + Forecasting of FP Commodities + integration to AOP | 1 | 1 | 10 | - | - | - | 1 | 1 | 14 | - | - | - | - | - | - | **2** | **2** | **24** | **18** | **24** | **298** |
| b. CSR+/MNCHN Planning | - | - | - | - | - | - | 1 | 1 | 14 | - | - | - | 1 | 1 | 10 | **2** | **2** | **24** | **7** | **8** | **120** |
| c. CSR+/MNCHN Plan + Policy | 1 | 1 | 10 | 1 | - | - | - | - | - | - | - | - | - | - | - | **2** | **1** | **10** | **11** | **23** | **148** |
| d. CSR+ MNCHN + Policy + Policy tracking | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | **6** | **2** | **96** |
| 1B. Informed Choice & Voluntarism (ICV) Compliance Monitoring/Reporting | 1 | 1 | 10 | 1 | - | 11 | 1 | 1 | 14 | 1 | - | 7 | 1 | 1 | 10 | **5** | **3** | **52** | **25** | **54** | **546** |
| 1C. Functional Literacy | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | **1** | - | **4** |
| 2. Integration of FP into the Expanded Program on Immunization (EPI) + Maximizing Use of Existing MNCHN Services + Evaluation | 1 | - | 5 | 1 | - | 8 | 1 | - | 4 | 1 | - | 7 | 1 | 1 | 8 | **5** | **1** | **32** | **21** | **17** | **234** |
| 3. Provincial database of health human resource capability profile | 1 | - | - | - | - | - | - | - | - | 1 | - | - | - | - | - | **2** | - | - | **12** | - | - |
| 4. Service Delivery Excellence in Health (SDExH) | 1 | - | 3 | - | - | 6 | - | - | - | - | - | - | - | - | - | **1** | - | **9** | **3** | **1** | **15** |
| **II. Sustaining financing and local policy support** | | | | | | | | | | | | | | | | | | | | | |
| 5. National Health Insurance Program (NHIP) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| a. Local NHIP implementation plan | 1 | 1 | 10 | - | - | - | - | - | - | 1 | - | 7 | 1 | 1 | 10 | **3** | **2** | **27** | **13** | **13** | **244** |
| b. Enrollment | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | **1** | **5** | **19** |
| c. Accreditation | - | 1 | 10 | - | - | 11 | - | - | - | - | - | 7 | 1 | 1 | 10 | **1** | **2** | **38** | **3** | **11** | **154** |
| d. PHIC fund management | 1 | 1 | 10 | 1 | - | 11 | - | - | - | - | - | - | - | - | - | **2** | **1** | **21** | **4** | **7** | **63** |
| 6. MNCHN grants access and utilization | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | **5** | - | - | **25** | **51** | **478** |
| 7. Integration of PIPH/AOP with LGU planning and budgeting processes + Comprehensive Development Plan (CDP) | 1 | 1 | 10 | - | - | - | - | - | - | 1 | - | 7 | 1 | 1 | 10 | **3** | **2** | **27** | **11** | **10** | **115** |
| **III. Systems strengthening** | | | | | | | | | | | | | | | | | | | | | |
| 8. Data Quality Check of other MNCHN indicators | - | - | - | - | - | - | - | - | - | 1 | - | 7 | 1 | 1 | 10 | **2** | **1** | **17** | **9** | **11** | **201** |
| 9. Family Planning Commodity Monitoring System (FPCMS) | 1 | 1 | 10 | 1 | - | 11 | 1 | 1 | 14 | 1 | - | 7 | 1 | 1 | 10 | **5** | **3** | **52** | **25** | **54** | **546** |
| 10. Stock and Inventory Management System (SIMS) | 1 | 1 | 10 | - | - | - | - | - | - | 1 | - | 7 | - | - | - | **2** | **1** | **17** | **7** | **5** | **74** |
| **IV. Continuing advocacy with and orientation of newly elected officials (NEO)** | | | | | | | | | | | | | | | | | | | | | |
| 11. Support to Advocacy to NEO | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | 1 | - | - | **5** | - | - | **25** | - | - |

Legend: **-** Not applicable

# 4 Monitoring and evaluation

## 4.1 Summary of performance targets and milestones

HealthGov developed a well-defined set of performance indicators as quantitative and qualitative measures of project performance. These include policy outputs and health systems improvements at the LGU level. It should be noted that not all performance indicators apply to all the LGUs covered by the project since the project design requires that TA interventions and activities be driven by the needs and priorities of LGUs as reflected in their respective provincial TA plans.

Over the last four years, the project has made significant strides in responding to the technical assistance needs of the LGUs. However, some resulting milestones accomplished for these various TA need to be synchronized with what have been set as performance targets in the PMEP and what needs to be reported. To address this, some minor changes have been made to the set of milestones and indicators without necessarily affecting the overall intent of the project.

The following table summarizes HealthGov's Year 5 performance targets set against the baseline data, cumulative accomplishment as of end of Year 4, and the end-of-project (EOP) targets.

**Table 1. Baseline, results, and performance targets**

| Indicator | | Baseline | | Cumulative Results (June 2010) | | Year 5 Target | | End of Project Target | |
|---|---|---|---|---|---|---|---|---|---|
| | | P | M/C | P | M/C | P | M/C | P | M/C |
| **IR1.1 Key management systems to sustain delivery improved** | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | 5 | | 23 | | - | | 23 | |
| 1.1B | CSR implementation plan | 11 | 164 | 18 | 359 | 5 | 64 | 23 | 400 |
| 1.1C | No. of LGUs with improved data management | 5 | 132 | 16 | 290 | 25 | 590 | 23 | 530 |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | 0 | 0 | 3 | 44 | | 1 | 3 | 45 |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | 0 | 0 | 0 | 0 | 25 | 590 | 23 | 530 |
| 1.1F | No of LGUs with health related policies passed as of the current year | 3 | 46 | 20 | 209 | 4 | 14 | 23 | 290 |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | 4 | 69 | 9 | 212 | 1 | 16 | 10 | 220 |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | 18 | | 530 | | - | | 530 |
| **IR1.2 LGU financing for key health programs improved** | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | 3 | 17 | 15 | 140 | 4 | 70 | 16 | 200 |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | 3 | 11 | 8 | 59 | 13 | 257 | 16 | 200 |

| Indicator | | Baseline | | Cumulative Results (June 2010) | | Year 5 Target | | End of Project Target | |
|---|---|---|---|---|---|---|---|---|---|
| | | P | M/C | P | M/C | P | M/C | P | M/C |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | 5 | 41 | 10 | 161 | 11 | 135 | 16 | 200 |
| **IR1.3 Performance among service providers improved** | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | 6 | | 20 | | 3 | | 23 | |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | 0 | 0 | 4 | 12 | 3 | 16 | 7 | 37 |
| 1.3C | Number of LGUs conducting an annual enhanced Program Implementation Review | 10 | 185 | 23 | 530 | - | - | 23 | 530 |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | 3 | | 23 | | 2 | | 25 | |
| **IR1.4 Advocacy for the financing and delivery of health services at the local level increased** | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | 3 | 56 | 10 | 108 | 9 | 64 | 16 | 200 |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | 6 | 56 | 16 | 133 | 15 | 232 | 16 | 200 |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | 56 | | 174 | | 94 | | 200 |

*Note: To date, targets and results are still subject to validation at the end of FY4.*
** Includes the two project areas - Northern Leyte and Western Samar*

Of the eighteen performance indicators, HealthGov has achieved the end-of-project (EOP) targets for four (4) indicators – PIPH, SDIR, LGU provision of inputs to deliberations at the provincial level, and ICV compliance and monitoring. Interventions to keep up to speed the accomplishment of targets for other performance indicators that are lagging behind, especially those related to CSR implementation, local NHIP implementation, and logistics management have been identified. In Year 5, these technical interventions and activities, which are detailed under Section 2 (Priorities for Year 5) of this plan, have been prioritized to meet these targets.

The individual Provincial Operational Plans expound on the quarterly milestones to achieve the remaining targets at the end of Year 5. Details of the HealthGov performance milestones, per province, for Year 5, which is the last year of project implementation, are provided in Annex C**.**

## 4.2 HealthGov Project Monitoring and Evaluation Plan

### Progress to date on the implementation of the PMEP

The HealthGov M&E Plan, submitted to USAID in Year 4, was updated with the approval of the Year 4 annual work plan. The following were accomplished during the same year:

- The project team members were re-oriented on the performance indicators and corresponding project data management protocols, tools, and processes. Specific data sources, relevant reporting forms, frequency of collection, including specific data collection responsibilities were reiterated.

- The quarterly progress reports included the progress of the accomplishment of the project performance indicators by tracking the indicative milestones accomplished during the quarter.

- The prescribed data capture forms and reporting forms were utilized in reporting project data and performance indicators.

- Internal data audit of field offices was conducted..

- The Project Management Information System (PMIS) was simplified and improved to increase usage among HealthGov staff and to effect the utilization of a centralized database for project reporting.

**Year 5 planned M&E activities**

In Year 5, M&E activities will focus on updating and completing the project data repository, while continuously performing the following:

- ***Synchronizing the PMEP and project reporting.*** In light of the remaining project life, it will be ensured that reporting of project performance is consistent with the targets set in the PMEP. This is necessary in order to accurately reflect what the project wants to achieve at the end of the project.

- ***Ensuring the implementation of the data management system (DMS) and corresponding data quality system (DQS) mechanisms and controls***. The installation of the DMS and DQS at all reporting levels enables the collection, storage/retrieval, analysis, reporting, and utilization of a set of valid, reliable, and precise project data. The PMG, team leaders, and regional coordinators will play a significant role in the DMS compliance by project team members, in particular, observing data quality controls and mechanisms.

- ***Conducting field monitoring and internal audit of project data.*** The last year of project implementation entails more close-out TA activities that require closer monitoring. This activity will allow timely response to identified data limitations. The routine field monitoring comes with a monitoring tool/guide and a data quality assessment tool, which is used for self-assessment and monitoring of data quality improvement, supervision, and strengthening of data management and reporting systems. Field monitoring will be conducted by both project management and designated field staff as identified in the PMEP.

- ***Utilization of the PMIS in data collection and reporting.*** The PMIS is a DQS mechanism that ensures the use of a consistent set of data across the different levels

of implementation and reporting. The PMIS will continue to serve as the source of information for progress made, to date, on the project's performance milestones and indicators.

- ***Inter-CA M&E TWG activities***. The inter-CA TWG meetings provide the venue for giving feedback, as well as getting feedback from other CAs regarding the implementation of their respective M&E activities, data collection and analysis of OP data, and identification of appropriate TA to project partners. The TWG is also responsible for the annual consolidation of the OP indicators for submission to USAID Washington. HealthGov will continue to actively participate in the M&E TWG meetings and related activities.

The quarterly milestones for the M&E activities for Year 5 are as follows:

| M&E Tasks/ Quarterly Milestones | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| 1. Synchronization of PMEP and project reporting | | | | |
| • Quarterly milestones reported against the performance indicators | x | x | x | x |
| 2. Installation of the DMS and the corresponding DQS mechanisms and controls | | | | |
| • Project data collected, processed, stored, analyzed, utilized, and disseminated | x | x | x | x |
| 3. Internal audit of project data and routine conduct of field monitoring | | | | |
| • Quarterly DQA reports for the project indicators | | x | x | x |
| 4. Utilization of PMIS in data collection and reporting | | | | |
| • Project data completed and updated | x | x | x | x |
| • Project reports, outputs, and pertinent documents consolidated and centralized | x | x | x | X |
| • Project data retrieved from PMIS by project key players at all levels for use in the preparation of project progress reports | x | x | x | x |
| 5. Inter-CA M&E TWG activities | | | | |
| • Consolidated OP reports and plans | | | | x |

## 4.3 Linking HealthGov TA interventions and the M&E System

The HealthGov M&E system makes possible the management of project data to inform project staff, LGU, DOH, and other stakeholders on HealthGov's project interventions and the extent to which services and health outcomes in HealthGov-supported LGUs are being improved and expanded. The system allows for the planning of appropriate TA and other relevant intervention activities.

The sub-systems of the HealthGov M&E system, in particular, data collection, processing (including verification and data quality check), analysis, and utilization, including routine data quality assessment, are mainstreamed in HealthGov's TA activities related to data management, e.g. PIPH and AOP planning, CSR planning, SDIR, ICV monitoring and compliance, financing, and PME, among others.

Improving the use of data for planning, budgeting, and advocacy is an important HealthGov TA activity. In particular, for TA areas where data utilization for decision-making is critical, decision-makers are bound to demand for better and more reliable data. Routine data quality assessment and regular data quality checks and verification ensure that reliable, valid, impartial, precise, and timely data are available.

# 6 Close-out plan

## 6.1 Program/technical

All technical activities will end on June 30, 2011. However, the documentation and packaging of identified technical products will commence as early as August 2010. These products will come in the form of guides/manuals, Technical Notes, and success stories. All these are expected to be finished by March 2011 in time for the scheduled series of regional dissemination fora in April-May 2011. The fora will be organized and conducted in collaboration with other USAID Cooperating Agencies that are also closing out in September 2011.

Preparation of the final quarterly report (July-September 2011) will start in July 2011 for submission by end of September 2011. Similarly, the compilation and analysis of data for the end-of-project report will be initiated as early as April 2011 for submission to RTI NC in September 2011. RTI NC will finalize and submit the report to USAID within 90 days after project close-out as stipulated in the Cooperative Agreement.

Starting July 2011, project files will be checked to ensure that all project deliverables such as annual work plans, quarterly reports, and the PMEP are all accounted for. The same will be done for all project publications.

## 6.2 Finance and administration

The close out activities for finance and administrative support are contained in a close out plan that includes three (3) phases of demobilization. The first phase will be implemented on March 31, 2011, the second phase on June 30, 2011, and the third phase is the final close out ending on September 30, 2011. Phases 1 and 2 will implement downsizing of both regional and national staff, to include separation of some subcontractor personnel, and complete office closure of the regional offices in Visayas, Northwestern Mindanao, and Southern Mindanao. Phase 3 will cover the close out of all in-country project operations.

Preparations for the closure will start as soon as Y5 sets in. Notifications of project closure will be sent out to partners, subcontractors, and consultants, as well as to the local government agencies for registration closures.

**Close-out of Regional Operations**

Complete office closure shall take effect in the regions by June 30, 2010. Office lease will be terminated and premises vacated on June 30, 2011. The remaining key staff will continue to work in counterpart offices.

<u>Personnel</u>

All project staff whose contracts will need to be terminated in March and June 2011 will be notified as early as three months prior to their termination. The employee kits for distribution to outgoing staff will be prepared to include certification of employment and

certification of contribution to statutory social government agencies such as Social Security System (SSS), Home Development Mutual Fund (HDMF), and Philippine Health Insurance Corporation (PHIC). Duly signed BIR Form 2316 will also be included in the kit. Each staff will be given severance pay in accordance with the project's policy on the provision of employee fringe benefits.

Property Disposition

The disposition of both non-expendable and expendable properties in the regions shall be completed on June 30, 2011. These properties shall be subjected to a final physical inventory 60 days prior to actual disposition. The project will seek USAID approval for the list of proposed recipients. Actual disposition and/or delivery to recipients shall have started by June 15, 2011 and finished by June 30, 2011.

Finance and Banking

The regional bank accounts shall be maintained and continued to be managed by the Regional Coordinators who will be assisted by the bookkeepers until September 2011. Closure of the bank accounts as well as the submission of final expense reports will be advised later.

Technical Reports, Financial and Administrative Files

All reports and files will be listed and organized and sent to national office for review. The regional files from the final inventory list will be sent to the national office for storage and eventually shipped to RTI NC together with the national files.

**Final Close Out of all In-Country Project Operations**

The leased office for the national staff in Ortigas, Pasig will be completely closed on September 30, 2011. Notifications will be sent to the LGUs on the cessation of business operations of the project. The same will be done for the Bureau of Internal Revenue (BIR), Securities and Exchange Commission (SEC), and Department of Labor and Employment (DOLE). Other government agencies like SSS, HDMF, and PHIC will also be notified.

Personnel

HealthGov will submit to the Department of Labor and Employment the list of employees who ended employment with RTI. All staff will be notified in advance of their end dates as amendment to their existing contracts. Outgoing staff will receive severance pays and employee kits to include certifications and other pertinent documents as previously enumerated.

Property Disposition

The disposition of both non-expendable and expendable properties at the national office will be completed on September 30, 2011. These properties will be subjected to a final physical inventory 60 days prior to actual disposition. The project will prepare a disposition plan and seek USAID approval for its implementation, including the

identification of proposed recipients. Actual disposition and/or delivery to recipients will have started beginning September 15 and finished by September 30, 2011.

Finance and Banking

The two (2) RTI bank accounts, one dollar savings account and one peso current account, will be reconciled and closed. Any remaining funds will be returned to RTI NC. In September, the remaining balances of the regional bank accounts should be returned to the national office bank account.

Technical Reports, Financial, and Administrative Files

A complete list of files with complete description and table of contents will be prepared and sent to RTI headquarters in North Carolina for review. The actual files of the final approved list shall be shipped back to RTI.

For complete guidance, a close- out checklist will be provided to the regional offices and all staff in the national office at the start of Y5. This will be tracked and filled out as each task or activity is completed.

| Item # | ACTION ITEM | 12-months timeline to closedown on September 30, 2011 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct '10 | Nov '10 | Dec '10 | Jan '11 | Feb '11 | Mar '11 | Apr '11 | May '11 | Jun '11 | Jul '11 | Aug '11 | Sept '11 |
| A | **Notifications** | | | | | | | | | | | | |
| | Notify Donor and in-country contact of impending closeout. | | | | | | | | | | | | |
| | Notify the appropriate Government Agencies (National, Local) | | | | | | | | | | | | |
| | Notify all office staff of project closeout. | | | | | | | | | | | | |
| | Notify all current implementing agencies of closeout. | | | | | | | | | | | | |
| | Notify other partners or contractors of closeout | | | | | | | | | | | | |
| | Notify the appropriate registering entities: SEC, BIR, SSS, Philhealth, Pag-Ibig, DOLE, Local Government | | | | | | | | | | | | |
| | Notify Suppliers and Servicing company: PLDT, SMART, Travel Agencies etc. | | | | | | | | | | | | |
| | Notify Web Content Manager for Information Programs that project is closing. | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| B | **Closeout Action Items related to Contracting - Implementing Agencies, Subagreements, Task Orders, Partners** | | | | | | | | | | | | |
| | Send closeout letter 90 days prior to project end date outlining responsibilities and informing all recipients that they must retain project records for three years. | | | | | | | | | | | | |
| | Complete burn rate/pipeline analysis for all subagreements. | | | | | | | | | | | | |
| | Review subagreement spreadsheet to verify status (financial, start/end date, balance remaining, etc.) prior to amending any of the agreements. | | | | | | | | | | | | |
| | Check that all required deliverables in the agreement have been submitted per agreement (ex - narrative reports, final reports, etc). | | | | | | | | | | | | |
| | Ensure that all monthly/quarterly Financial Reports have been submitted. | | | | | | | | | | | | |
| | Ensure reclassification request is submitted to reflect no more than 10% exceeds each contract line item. | | | | | | | | | | | | |
| | Closeout amendment prepared, sent and received back signed (as needed). | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| C | **Finance and Administration** | | | | | | | | | | | | |
| | **ACCOUNTING** | | | | | | | | | | | | |
| | If RTI presence remain In-country, change set of signatories. | | | | | | | | | | | | |
| | Provide final VAT information for the year to vendors | | | | | | | | | | | | |
| | If applicable, make final payments and terminate contracts for equipment, vehicle, and services and return rented items. | | | | | | | | | | | | |
| | Liquidate petty cash account. Deposit balance in local currency account. | | | | | | | | | | | | |
| | Ensure that all remaining funds are returned to National Office bank account and Regional Revolving Operational Fund bank accounts are closed with supporting closure letters received and signed by the bank. | | | | | | | | | | | | |
| | Obtain final bank statements from National and regions showing zero balance. | | | | | | | | | | | | |
| | EnsureNational and regional accounts book balances have zeroed out. | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

| Item # | ACTION ITEM | 12-months timeline to closedown on September 30, 2011 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct '10 | Nov '10 | Dec '10 | Jan '11 | Feb '11 | Mar '11 | Apr '11 | May '11 | Jun '11 | Jul '11 | Aug '11 | Sept '11 |
| | **FILES** | | | | | | | | | | | | |
| | Conduct an inventory of accounting files (including Cost share files) | | | | | | | | | | | | |
| | Conduct Inventory of Admin files | | | | | | | | | | | | |
| | Prepare Disposition Plan of files, effect shipment to RTI NC or store in warehouse | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | **LEASES - (office spaces and/or Expatriate)** | | | | | | | | | | | | |
| | **National Office** | | | | | | | | | | | | |
| | Review lease for end-of-term notification and other requirements and notify landlord. | | | | | | | | | | | | |
| | Review other terms such as refunds on pre-paid, security deposit, etc. | | | | | | | | | | | | |
| | Conduct a walk through with landlord and obtain, in writing, an agreement of any necessary repairs. | | | | | | | | | | | | |
| | Arrange for repairs, complete, and get signed statement from landlord that premises are repaired as requested. | | | | | | | | | | | | |
| | review registration business of the office | | | | | | | | | | | | |
| | Return keys to landlord. | | | | | | | | | | | | |
| | **Regional Offices (Visayas, Northwestern Mindanao, Southern Mindanao)** | | | | | | | | | | | | |
| | Review lease for end-of-term notification and other requirements and notify landlord. | | | | | | | | | | | | |
| | Review other terms such as refunds on pre-paid, security deposit, etc. | | | | | | | | | | | | |
| | Conduct a walk through with landlord and obtain, in writing, an agreement of any necessary repairs. | | | | | | | | | | | | |
| | Arrange for repairs, complete, and get signed statement from landlord that premises are repaired as requested. | | | | | | | | | | | | |
| | review registration business of the office | | | | | | | | | | | | |
| | Return keys to landlord. | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | **NON-EXPENDABLE PROPERTIES (NXP) AND EXPENDABLE PROPERTIES (XP)** | | | | | | | | | | | | |
| | **National Office** | | | | | | | | | | | | |
| | Produce Property Inventory List from RAMs | | | | | | | | | | | | |
| | Conduct end-use check and Update Inventory of Non-Expendable Properties at the National office and regional offices | | | | | | | | | | | | |
| | Conduct end-use check and update Inventory of Expendable Properties at the National office and regional offices | | | | | | | | | | | | |
| | Submission of Proposed Disposition Plan to USAID | | | | | | | | | | | | |
| | Consult with donor/local mission about disposition plans. | | | | | | | | | | | | |
| | Revision of Disposition Plan per USAID advice. | | | | | | | | | | | | |
| | Make arrangements for transfer: contact movers, process PO and schedule deliveries. | | | | | | | | | | | | |
| | Transfer/Delivery of Properties to Recipients | | | | | | | | | | | | |
| | List of basic office equipments for the skeletal force for the last two weeks prior to Sept. 31, 2011 | | | | | | | | | | | | |
| | Disposition of last batch of furniture and equipment. | | | | | | | | | | | | |

| Item # | ACTION ITEM | 12-months timeline to closedown on September 30, 2011 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct '10 | Nov '10 | Dec '10 | Jan '11 | Feb '11 | Mar '11 | Apr '11 | May '11 | Jun '11 | Jul '11 | Aug '11 | Sept '11 |
| | **Regional Offices (Visayas, Northwestern Mindanao, Southern Mindanao)** | | | | | | | | | | | | |
| | Produce Property Inventory List from RAMs | | | | | | | | | | | | |
| | Conduct end-use check and Update Inventory of Non-Expendable Properties at the National office and regional offices | | | | | | | | | | | | |
| | Conduct end-use check and update Inventory of Expendable Properties at the National office and regional offices | | | | | | | | | | | | |
| | Submission of Proposed Disposition Plan to USAID | | | | | | | | | | | | |
| | Consult with donor/local mission about disposition plans. | | | | | | | | | | | | |
| | Revision of Disposition Plan per USAID advice. | | | | | | | | | | | | |
| | Make arrangements for transfer: contact movers, process PO and schedule deliveries. | | | | | | | | | | | | |
| | Transfer/Delivery of Properties to Recipients | | | | | | | | | | | | |
| | List of basic office equipments for the skeletal force for the last two weeks prior to Sept. 31, 2011 | | | | | | | | | | | | |
| | Disposition of last batch of furniture and equipment. | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | **COMPUTERS** | | | | | | | | | | | | |
| | Copy all files to be archived onto a CD-Rom and send to RTI NC or Regional Office if RTI will no longer have a presence in-country. | | | | | | | | | | | | |
| | Copy all files to be archived onto a CD-Rom and store in-country if RTI presence in-country will continue. A copy of CD Rom will be sent to RTI as reference documents. | | | | | | | | | | | | |
| | Delete all files on computers and make sure the hard drive is completely clean. Seek IT professional assistance to verify this. | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | **VEHICLES** | | | | | | | | | | | | |
| | Compile list of all vehicles with registration #s, mileage, age. | | | | | | | | | | | | |
| | Ensure that donor approval of NXP disposition includes vehicles. (Please refer to the NXP section above.) | | | | | | | | | | | | |
| | Organize for transfer of vehicle titles | | | | | | | | | | | | |
| | Terminate vehicle insurance. | | | | | | | | | | | | |
| | Ensure vehicle insurance policy; maintenance logs; vehicle usage logs are on file and endorsed to recipients. | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| D | **Storing/Shipping Files and Records** | | | | | | | | | | | | |
| | Complete project files | | | | | | | | | | | | |
| | Arrange for storing of files in-country if there is another project after current one closes. | | | | | | | | | | | | |
| | Dispose of remaining records appropriately with regard to confidentiality and privacy. | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

| Item # | ACTION ITEM | 12-months timeline to closedown on September 30, 2011 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct '10 | Nov '10 | Dec '10 | Jan '11 | Feb '11 | Mar '11 | Apr '11 | May '11 | Jun '11 | Jul '11 | Aug '11 | Sept '11 |
| E | **Human Resource Issues (c/o Human Resource Manager)** | | | | | | | | | | | | |
| | Confirm with local counsel the length of time payroll and personnel files need to be retained. | | | | | | | | | | | | |
| | Create Severance Letter and review final version with HR/NC (needs to include confirmation of close-out of program, position title and length of service and provide the dates for which severance is calculated, and date of final payment). | | | | | | | | | | | | |
| | Confirm that there is no borrowed property (laptops, cellular phones, portable printers, etc.). Include this as a line item on the separation checklist. | | | | | | | | | | | | |
| | Calculate and print out document for each employee outlining all payments due: annual leave/severance/pension/13th month/retirement/etc. The document must be approved by COP and RTI NC prior to releasing final payment. | | | | | | | | | | | | |
| | Distribute Employee Kits (Certifications: Employment, contributions to SSS, Philhealth, etc.) | | | | | | | | | | | | |
| | Finalize tax withholdings and remit to government (Annualization with severance and final pays | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| F | **Program/Technical Tasks** | | | | | | | | | | | | |
| | Document project initiatives and results, including LGU innovations. | | | | | | | | | | | | |
| | Package TA products. | | | | | | | | | | | | |
| | Hold dissemination fora/workshops with other Cooperating Agencies and stakeholders | | | | | | | | | | | | |
| | Prepare and submit final Quarterly Report. | | | | | | | | | | | | |
| | Compile and analyze data for end-of-project report. | | | | | | | | | | | | |
| | Check if all deliverables have been submitted. | | | | | | | | | | | | |
| | Check if all deliverables are on file (annual work plans, quarterly reports, PMEP) | | | | | | | | | | | | |
| | Check if project publications are on file. | | | | | | | | | | | | |

# Annex A
# Operational Plans: National

# Health Programs

**Priority TA Interventions and Activities**
**HEALTH PROGRAMS**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **Data quality check for MNCHN indicators** | Quality data | 1. Enhance and finalize the data quality guide and assessment tools | | | | | | | | | | | | | | | | |
| | | 2. Develop SOW for STTA to design TOT and conduct TOT for CHD and PHO | | | | | | | | | | | | | | | | |
| | 35 trained trainers | 3. Training of trainers for pilot CHD and PHO | | | | | | | | | | | | | | 9 | | |
| | | 4. Monitoring and documenting LGU data cleaning | | | | | | | | | | | | | | | | |
| | | 5. Presentation of documentation of data cleaning and data quality check guide to DOH-NCDPC | | | | | | | | | | | | | | | | |
| | | 6. Incorporating the data quality check guide and tools in the SDIR Manual | | | | | | | | | | | | | | | | |
| **Enhancement of SDExH manual** | Approved clinical standards for FP/MNCHN and TB Programs | 1. Presentation of revised FP/MNCHN and TB clinical standards to DOH-NCDPC program managers for approval and adoption | Resource person, facilitator | | | | | | | | | | | | | | | |
| | | 2. Revision of SDExH manual to incoporate QAPC process guide | Technical writer | | | | | | | | | | | | | | | |
| | DOH approved Manual | 3. Finalization of SDExH manual and submission of the manual to USAID and DOH for approval | In-house lay-outing, style editing and packaging | | | | | | | | | | | | | | | |
| **Continuing implementation of SDExH installation in project sites** | Installation of SDExH in 4 provinces that will champion SDExH as CQI | 1. Phase 2 interval coaching and mentoring | | | | | | | | | | | | | | | | |
| | | (a) CoMMMoNN ILHZ, Compostela Valley | Resource person and facilitator | | | | | | | | | | | | | | 6 | |
| | | (b) JOLLIPOGUI ILHZ, Albay | Resource person and facilitator | | | | | | | | | | | | | 1 | 3 | 2 |
| | | (c) BueNasCar ILHZ, Agusan del Norte | Resource person and facilitator | | | | | | | | | | | | | 1 | 3 | |
| | | (d) Angat, Doña Remedios Trinidad, San Rafael, Bulacan and San Jose Del Monte City | | | | | | | | | | | | | | 1 | 3 | 1 |

| TA Intervention (1) | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | DOH approval of SDExH as CQI | 2. Completion of the Phase 3 training and showcase/ demonstrate SDExH implementation | Resource person and technical guidance in the preparation of presentation | | | | | | | | | | | | | | | |
| | | (a) CoMMMoNN ILHZ, Compostela Valley (35 pax) | | | | | | | | | | | | | | 1 | 6 | |
| | | (b) JOLLIPOGUI ILHZ, Albay (60 pax) | | | | | | | | | | | | | | 1 | 3 | |
| | | (c) BueNasCar ILHZ, Agusan del Norte (35 pax) | | | | | | | | | | | | | | 1 | 3 | |
| | | (d) Angat, Doña Remedios Trinidad, San Rafael, Bulacan and San Jose Del Monte City | | | | | | | | | | | | | | 1 | 3 | 1 |
| **Institutionalization of ICV compliance monitoring and reporting** | | | | | | | | | | | | | | | | | | |
| 1. Establishing ICV compliance monitoring and reporting system | Local policy for implementing ICV compliance monitoring and reporting | Provision of guidance to LGUs in policy formulation on ICV compliance monitoring and reporting | Resource person and technical guidance | | | | | | | | | | | | | 25 | | |
| 2. Dissemination/ implementation of the approved AO | ICV compliance monitoring and reporting action plan with the CHD/PHO/PHTL | Meeting/action planning with the CHD/PHO/PHTL on the implementation of AO specifically on monitoring and reporting | Resource person and technical guidance | | | | | | | | | | | | | 25 | | |
| | Established monitoring and reporting system from LGUs, PHOs/PHTO and CHD | Follow through of the implementation of the action plan to ensure that ICV compliance monitoring system is functional | Resource person and technical guidance | | | | | | | | | | | | | 25 | | |
| | | Track and document ICV compliance monitoring reports per LGU per province with CHD/PHO | Technical guidance | | | | | | | | | | | | | 25 | 586 | 54 |
| | | Provide assistance to LGUs and CHDs in the documentation and reporting of monitoring activities | Technical guidance | | | | | | | | | | | | | 25 | | |

| TA Intervention (1) | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 3. Supporting preventive actions to ensure ICV compliance | Staff updated/oriented on ICV policy requirements | Dissemination of ICV policies during conduct of orientation on Integrating FP to EPI, FP-CBT level 1 and 2 trainings and during FP-CSR+ planning workshops | Resource person and technical guidance | | | | | | | | | | | | | | | |
| | | Conduct of in-house updates and/or refresher course on ICV policy requirements | Resource person and technical guidance | | | | | | | | | | | | | | | |
| | Service providers, facilities and clients monitored | Conduct of ICV compliance monitoring for service providers and clients during field visits for SDExH coaching and mentoring visits, SDIR internal assessments, and other field activity monitoring visits | Technical guidance | | | | | | | | | | | | | 25 | 586 | 54 |
| Supporting DOH in the development of corrective measures for any vulnerability/violation | Corrective measures developed | Assist DOH in conduct of in-depth investigation of vunerabilities | Technical guidance | | | | | | | | | | | | | | | |
| | | Provide technical guidance to DOH-NCDPC in identifying/developing corrective measures for appropriate vulnerabilities identified and documented | Technical guidance | | | | | | | | | | | | | | | |
| | | Monitor implementation of corrective measures at the LGU level | | | | | | | | | | | | | | | | |

# Policy and Health Systems

**Priority TA Interventions and Activities**
**POLICY AND HEALTH SYSTEMS**
**October 1, 2010 to September 30, 2011**

| TA Intervention | Expected Output/Result or Milestone* (2) | Activities | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **Logistics management** | | | | | | | | | | | | | | | | | | |
| **Family planning and commodity monitoring system (FPCMS) implementation** | | | | | | | | | | | | | | | | | | |
| 1. Institutionalization of FPCMS: formulation and implementation DOH policy or guideline or directive from NCDPC for the routine implementation of the FPCMS in all regions and all provinces | DOH policy or guideline for the implementation of FPCMS finalized and issued for implementation | 1-a. Conduct technical consultation meetings with the DOH and Logistics Management TWG, in close collaboration with HPDP to support and coordinate the drafting, finalization and implementation of the DOH policy/ memo on the routine implementation of FPCM | Technical resource persons, meeting costs | | | | | | | | | | | | | | | |
| | | 1-b. Generate necessary technical support materials and provide technical inputs for the drafting and finalization of the policy, including the sharing of experiences and lessons learned in the initial implementation of the tools | Technical resource persons, meeting costs | | | | | | | | | | | | | | | |
| | | 1-c. Finalize theCHD- LGU Guide for FPCMS impementation | Technical resource persons, materials reproduction | | | | | | | | | | | | | | | |
| | | 1-d. Conduct training for HealthGov field staff and LTAP (as necessary), with specific focus on monitoring implementation of FPCMS | Technical resource person, travel | | | | | | | | | | | | | | | |
| 2. Capacity building of CHDs/ PHO in the conduct of training/orientation for FPCMS in HealthGov-supported provinces, in support of the CHD action plan | | 2-a. Participate as technical resource for the conduct of the National Training in FPCMS | Technical resource person, travel | | | | | | | | | | | | | | | |
| | DOH Reps, Provincial FP Coordinator trained and prepared for the conduct of FPCMS; Municipal staff oriented and prepared for the data needs for the FPCMS routine monitoring | 2-b. Participate technical resource for regional orientation/training for the province (as necessary) | Technical resource persons, materials reproduction, travel | | | | | | | | | | | | | 25 | 546 | 54 |
| 3. Monitoring TA implementation | | 3-a. Support the field staff in monitoring TA implementation, specifically, in terms of assessing<br><br>(i) whether CHDs are able to generate results of stock availability quarterly in each province (and other relevant info based on FPCMS);<br><br>(ii) whether LGU | Technical resource person, travel | | | | | | | | | | | | | 25 | | |

| TA Intervention | Expected Output/Result or Milestone* (2) | Activities | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 4. Engagement of an STTA to support TA implementation | | 4-a. Prepare the technical SOWs, and engage STTA to provide TA support in TA tools refinement and TA implementation | STTA | | | | | | | | | | | | | | | |
| 5. Documentation of TA accomplishments | | 5-a. Document TA accomplishments and success stories in coordination with the communications team | Technical resource person | | | | | | | | | | | | | | | |
| **Stock and Inventory Management System(SIMS) Implementation** | | | | | | | | | | | | | | | | | | |
| 1. Development of the Stock and Inventory Management (SIMS) Tools, enhancement and refinement of the tools for implementation; and pre-testing in selected HealthGov provinces and selected municipalities | | 1-a Prepare training materials and tools including simulation documents for the training-workshop exercise for the pilot LGUs | Technical resource person | | | | | | | | | | | | | 7 | | |
| | | 1-b Develop the complete design and the user's guide for SIMS in consultation with the DOH and CHD8 and CARAGA | Technical resource person, travel | | | | | | | | | | | | | | | |
| | | 1-c Conduct training for the health personnel of Leyte (Leyte Gulf ILHZ:Tanauan, Tolosa, Dulag, Palo, Baybay City + Tacloban City), including the formulation of action plan for SIMs implementation, adoption and institutionalization | Technical resource person, travel, workshop technical materials | | | | | | | | | | | | | 1 | 4 | 1 |
| | | 1-d Conduct technical consultation meetings with selected pilot LGUs and CHDs for SIM implementation | Technical resource person, travel | | | | | | | | | | | | | 6 | | |
| | | 1-e Conduct traning for the health personnel of the selected pilot LGUs in Luzon, Visayas and Mindanao including the formulation of action plan for SIMS implementation, adoption and institutionalization | Technical resource person, travel, workshop technical materials | | | | | | | | | | | | | 6 | | |
| | | 1-f Monitoring of implementation of the pre-testing of SIMS implementation in close coordination with the HealthGov field staff | Technical resource person, travel | | | | | | | | | | | | | 7 | | |
| | | 1-g Documentation of the results of the pre-testing | Technical resource person, STTA | | | | | | | | | | | | | 7 | | |

| TA Intervention | Expected Output/Result or Milestone* (2) | Activities | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 2. Formulation of the roll-out plan for the national implementation of SIMs | | 2-a. Present the results of the 3-month pre-testing activity to concerned CHD, DOH and USAID CA partners and use these results for the refinements and finalization of the tool | Technical resource person, travel | | | | | | | | | | | | | | | |
| | | 2-b. Formulate the roll-out plan with the DOH and USAID CAs (including the conduct of regional TOT) | Technical resource person, travel | | | | | | | | | | | | | | | |
| | | 2-c. Implement the roll-out plan with the DOH | Technical resource person, travel | | | | | | | | | | | | | | | |
| 3. Capacity building of CHDs and PHOs on Stock and Inventory Management System (SIMS) implementation | TOT on SIMS conducted<br><br>Enhanced capacities of CHDs and PHOs on stock and inventory management systems<br><br>Action plan for regional/province-wide re-echoing/ training formulated and SIMS implementation formulated | 3-a Based on the results of the pilot-testing, refine training materials and tools, including simulation documents for the training-workshop exercise for the pilot LGUs for the conduct of National TOT in SIMS | Technical resource person, travel | | | | | | | | | | | | | | | |
| | | 3-b Conduct national TOT in SIMS | Technical resource person, travel | | | | | | | | | | | | | | | |
| | | 3-c Document joint CHD-PHO action plan for re-echo/training for the provinces and implementation of the SIMS | Technical resource person, travel | | | | | | | | | | | | | | | |
| 4. Institutionalization of SIMS | DOH policy on the implementation of SIMS drafted, finalized, issued and implemented in all regions and all provinces | 4-a Coordinate with HPDP and DOH-NCDPC on the formulation of the official DOH guidelines/policy for the implementation of the SIMS to be integrated as part of the quarterly monitoring activities of the DOH Reps/PHTL and provincial FP Coordinators | Technical resource person, travel | | | | | | | | | | | | | | | |
| 5. Monitoring of TA implementation | | 5-a Monitor implementation of TA, in close coordination with the field staff by documenting the following:<br>- number of LGUs utilizing SIMS (able to monitor stocks) and using the results of such in the planning and policy decisions | Technical resource person, travel | | | | | | | | | | | | | 13 | 244 | 13 |
| 6. Engagement of an STTA to support TA implementation | | 6-a. Prepare the technical SOWs, and engage STTA to provide TA support in TA tools enhancement and implementation | | | | | | | | | | | | | | | | |
| 7. Documentation of TA accomplishments | | 7-a. Document TA accomplishments and success stories in coordination with the Communications Team | | | | | | | | | | | | | | | | |

| TA Intervention | Expected Output/Result or Milestone* (2) | Activities | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **FP Data Quality Improvement** | | | | | | | | | | | | | | | | | | |
| 1. Capacity building of CHDs and PHOs on FP Data Quality Improvement | CHD and PHO staff capacitated on FP Data Quality Improvement<br><br>Joint CHD-PHO action plan formulated for FP data quality improvement and updating for all regions/provinces finalized | 1-a Update training materials and tools including simulation documents for the training-workshop exercise for the pilot LGUs and develop the guide for FP Data Quality Improvement | Technical resource person, travel | | | | | | | | | | | | | 18 | 298 | 24 |
| | | 1-b Conduct FP data quality check and FP commodity forecasting | | | | | | | | | | | | | | | | |
| 2. Institutionalization of FP data quality improvement and monitoring of TA implementation | | 2-a - Support CHDs and PHO in implementing the joint action plan formulated and submitted to the DOH | Technical resource person, travel | | | | | | | | | | | | | | | |
| Provide direct TA support to provinces as needed (4 provinces) | | 2-b. .Monitor the results of the TA implementation by documenting the following in each of the 25 HealthGov-supported LGUs:<br>- old data (prior to DQI TA) and cleaned/updated data<br>- CPR (before and after)<br>- forecast of FP commodities using corrected data<br>- | Technical resource person, travel | | | | | | | | | | | | | | | |
| 3. Finalization of the guide to FP Data Quality Improvement | | 3-a. In collaboration with the Communications Team, finalize the guide to FP data quality improvement | Technical resource person | | | | | | | | | | | | | | | |
| 4. Engagement of an STTA to support TA implementation | | 4-a. Prepare the technical SOWs, and engage STTA to provide TA support in TA tools enhancement and implementation | | | | | | | | | | | | | | | | |
| 5. Documentation of TA accomplishments | | 5-a. Document TA accomplishments and success stories in coordination with the communications team | | | | | | | | | | | | | | | | |
| **MNCHN Implementation** | | | | | | | | | | | | | | | | | | |
| 1. Finalize the MNCHN Allocation Tools in consultation with the DOH | | 1-a.Develop and enhance the 2010 MNCHN allocation tool (CHD to provinces and provinces to municipality/city) to support CHDs and PHOs in allocating the 2010 grants | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| | | 1-b. Pre-test the 2010 MNCHN allocation tool in 4 regions; share experiences of other provinces in downloading the tool, including development of sub-MOA for the allocation and monitoring of utilization | Technical resource person, travel | | | | | | | | | | | | | | | |

| TA Intervention | Expected Output/Result or Milestone* (2) | Activities | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 2. In coordination with HPDP, support DOH-NCDPC in finalizing the different options for the allocation tool (province to municipalities) | | 2-a. Present the results of the pre-testing of MNHCN allocation tools option to DOH-NCDPC for comments/enhancement/clearance and for roll-out | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| Option 3 - Conduct orientation in 25 Healthgov provinces | | 2-b. .Roll-out TA support to all 25 provinces on 2010 MNCHN allocation tools | Technical resource person, travel | | | | | | | | | | | | | 25 | 478 | 51 |
| | | 3-a. In coordination with HPDP and DOH, formulate the expected key contents of the LGU EO or equivalent policies (full support and describing administrative arrangements for the province-wide or city-wide implementation of MNCHN strategy including the coo | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| 3.Support CHDs in providing TA to LGU for the (a) development and implementation of policies/MOA/plan to access the MNCHN grants; and in (b) facilitation of access to the grants by completing the grants requirements | | 3-b. Conduct of MNCHN policy writeshop<br>Support LGUs in ensuring that the following MNCHN criteria are met:<br><br>Certification from or Memorandum of Agreement (MOA) with PhilHealth on enrollment of indigents in the LGU showing at least enrollment of 20% of ind | Technical resource person, travel | | | | | | | | | | | | | | | |
| | | a) establishment of service delivery network which provides package of services for each life cycle,<br>b) ensuring availability of safe blood supply<br>c) ensuring availability of family health commodities,<br>d) setting up communication and transportation faci | | | | | | | | | | | | | | | | |
| | | 4-a. Monitor MNCHN Grants (a) access and (b) utilization in coordination with the field staff | | | | | | | | | | | | | | 25 | 478 | 51 |
| 4. Monitoring of TA Implementation | | 5-a. Document TA accomplishments and success stories in coordination with the Communications Team | | | | | | | | | | | | | | | | |

| TA Intervention | Expected Output/Result or Milestone* (2) | Activities | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **5. Documentation of TA accomplishments** | | | | | | | | | | | | | | | | | | |
| **Local NHIP implementation using the BDR approach within the universal health care framework** | | | | | | | | | | | | | | | | | | |
| 1. Conduct orientation on BDR approach to local NHIP implementation (in support of family health improvements) | | 1-a. Prepare the technical orientation materials for refinement and customization to region and provinces | Technical resource person, meeting costs, travel | | | | | | | | | | | | | | | |
| | | 1-b. Pre-test the technical materials, references and presentations in Region 8 and other selected regions | Technical resource person, meeting costs, travel | | | | | | | | | | | | | | | |
| | | 1-c. Conduct of national TOT (all regions) in NHIP planning using the BDR approach | Technical resource person, meeting costs, travel | | | | | | | | | | | | | | | |
| 2. Develop and pre-test investment and planning tools tools, to support successful local NHIP implementation | | 2-a. Develop and pre-test all investment and planning tools in support of the following key steps in local NHIP implementation;<br>- increasing coverage of the poor<br>- improving access to outpatient care<br>- improving access to inpatient care and implementing | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| | | 2-b. Customize investment modules by region/by province | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| | | 3-a. Support LGUs in drafting key contents of the MOA between PhilHealth and participating LGUs | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| 3. Formulate policy development module – issues and options for policy development including management of reimbursements and capitation funds | | 3-b. Support LGUs in drafting key contents of the MOA between participating LGUs:<br><br>Distribution and use of capitation funds to participating LGUs; guidelines for use in health sector<br><br>Use and sharing of reimbursement funds to participating LGUs; guidelin | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| | | 3-d. Support LGUs in drafting key contents of the local policy (ordinances) on key decision areas:<br><br>Management of funds (reimbursements and capitation)<br><br>Cost shares in implementing a means test tool other than PhilHealth FDSF | Technical resource person, meeting costs | | | | | | | | | | | | | | | |

| TA Intervention | Expected Output/Result or Milestone* (2) | Activities | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 4. Develop the management module – discussion of management structures for implementation | | 4-a Support LGUs in setting up overall management and coordination structures: creation of TWG, coordination with PhilHealth and DOH/CHD regarding the monitoring and reporting system | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| | | 4-b Provide technical guidance to CHD/PHO in monitoring the following indicators (to include among others, depending on the gaps identified):<br><br>Increased coverage of population, proper identification of the poor, health promotion and behavior change commu | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| 5. Conduct of CHD/provincial orientation and training on tools<br>support province-wide NHIP plan formulation | | 5-a. Finalize orientation materials and investment and planning tools to support province-wide formulation of the NHIP Plans<br><br>5-b. Conduct training-orientation to selected CHDs/provinces and provide technical guidance to target provinces in finalizing and | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| 6. Support the field staff in monitoring LGUs on the adoption of the BDR approach in local NHIP plans | | 6-a. Colloborate with the field operations staff in monitoring of the following indicators:<br>- number of LGUs with:<br>- increased and sustained public sector investments for health (LGUs with NHIP investment plans)<br>- increased PHIC coverage of the poor | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| 7. Engagement of an STTA to support TA implementation | | 7-a. Prepare the technical SOWs, and engage STTA to provide TA support in TA tools enhancement and implementation | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| 8. Documentation of TA accomplishments | | 8-a. Document TA accomplishments and success stories in coordination with the Communications Team | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| **CSR+ MNCHN planning and policy development and implementation** | | | | | | | | | | | | | | | | | | |
| 1. Build CHD/PHO capacities in the formulation, implementation and tracking CSR+/MNCHN plans and policies<br><br>1a. Support province-wide development of the plan and policies | | 1-aTrain CHDs and PHOs in the updated CSR+ tools and support provinces to formulate their CSR+/MNCHN plans as inputs to the AOP 2011-2015 (4 batches) | Technical resource person, meeting costs | | | | | | | | | | | | | | | |
| | | 1-b. Conduct of CSR+ plan and policy writeshop | Technical resource person, meeting costs | | | | | | | | | | | | | 11 | 129 | 33 |
| | | 1-c Documentation of TA accomplishments | | | | | | | | | | | | | | | | |

# Documentation and Dissemination of HealthGov TA Products

## Documentation and Dissemination Plan
## October 1, 2010 – September 30, 2010

| Activities | Responsible Staff | Oct '10 | Nov '10 | Dec '10 | Jan '11 | Feb '11 | Mar '11 | Apr '11 | May '11 | Jun '11 | Jul '11 | Aug '11 | Sep '11 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **A. Documentation** | | | | | | | | | | | | | |
| • Development/Finalization of guides/manuals | | | | | | | | | | | | | |
| • Preparation of Technical Notes | | | | | | | | | | | | | |
| • Documentation of success stories | | | | | | | | | | | | | |
| **B. Packaging** | | | | | | | | | | | | | |
| • Technical editing | Specialists, Tess, STTA | | | | | | | | | | | | |
| • Copy editing/lay-out, cover design (Guides & Manuals) | STTA | | | | | | | | | | | | |
| • Template design (Technical Notes & Success Stories) | STTA | | | | | | | | | | | | |
| • Printing | Success stories | | | | | | | | | | | | |
| | Technical Notes | | | | | | | | | | | | |
| | Guides | | | | | | | | | | | | |
| • E-book (digital publication in CD or DVD) | STTA | | | | | | | | | | | | |
| • Website development | | | | | | | | | | | | | |
| **C. Dissemination** | | | | | | | | | | | | | |
| • Inter-CA Regional Dissemination Fora | Tess, RCs | | | | | | | | | | | | |
| • LMP National Convention/Island Conferences | Tess, RCs | | | | | | | | | | | | |
| • LPP Convention | Tess | | | | | | | | | | | | |
| • RTI COPs' Annual Meeting | Alex | | | | | | | | | | | | |
| • Special Health Events | Pinay, Abie | | | | | | | | | | | | |
| • RICT Meetings | RCs | | | | | | | | | | | | |

| Activities | Responsible Staff | Oct '10 | Nov '10 | Dec '10 | Jan '11 | Feb '11 | Mar '11 | Apr '11 | May '11 | Jun '11 | Jul '11 | Aug '11 | Sep '11 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| • FIMO's Development Partners' Meetings | Alex | | | | | | | | | | | | |
| • Uploading in the project /USAID website | Abie | | | | | | | | | | | | |
| • Feature articles for the DOH's *HealthBeat* Magazine | Tess | | | | | | | | | | | | |
| • Articles for the USAID Weekly Highlights | Tess | | | | | | | | | | | | |
| • Articles for inclusion in RTI's *the brIDGe* Project Supplement | Tess | | | | | | | | | | | | |

# Annex B
# Operational Plans: Regional/Provincial/HIV-AIDS

# Luzon

## Luzon

HealthGov supports 7 provinces in four regions in Luzon: Pangasinan in Region 1; Cagayan and Isabela in Region 2; Bulacan, Tarlac, and Nueva Ecija in Region 3; and Albay in Region 5.

In the past four years of operation, the handle approach was used in implementing the TA interventions acting as a focal point that brings together the various TA elements of service delivery, financing, regulation, and governance to contribute to the achievement of SO3 outcomes. In Albay, the implementation of the various TA in the different F1 reform instruments emphasized their role in responding to emergency and recovery situations. In Pangasinan, Tarlac, and Isabela, the implementation of the PhilHealth Sponsored Program handle pooled together the various elements related to PhilHealth (identification of the poor, enrollment, accreditation, policy development) as well as what PhilHealth coverage should provide, i.e., better health services both those financed by PhilHealth and those by LGUs. In Cagayan however, the handle worked on facility rationalization (hospital-public health nexus), financing, and policy development as inputs to better health services while in Nueva Ecija, improvement in the data and information management system was the entry point for undertaking evidence-based planning (facility rationalization). Lastly in Bulacan, the public-private partnerships and multi-sectoral alliances for public health became avenues to deliver quality health care services.

In 2009, the handle approach was enhanced to include the implementation of the Regional Capacity Building Initiative (RCBI) that put forward the role of the CHD as the main technical support unit of DOH in assisting LGUs for F1 implementation. Since then, HealthGov's overall approach to TA delivery is to collaborate with CHD/PHTOs and build their capacities as main TA providers to LGUs.

The Governors of Bulacan and Isabela, who are first-termers, have both identified health as one of their priority provincial thrusts. The five other remaining provincial governors are well-versed with their health situation and are committed to implement the health programs contained in their annual operational plan.

Looking back at health operations, two main issues stood out: inadequate health information system and insufficient enabling policies on FP/MNCHN services.

Most of the performance indicators (ANC, SBA, FBD, CPR, VAC, FIC, and TB CDR/CR) have shown improvements. However, the veracity of the data collected, submitted, and used by the CHD/LGUs has been questioned. Of late, it has been proven that the subject data are indeed not reliable. The FP current users data quality checks (DQC) conducted have shown a wide % difference in the number of FP current users, forecast, and CPR. In Tarlac, the DQC for FP current users has shown a 10% to 75% difference between the cleaned data and the reported data, a 15%-80% difference in FP commodity forecast, and a 10%-77% difference in CPR. Moreover, the FHSIS data submitted by the RHUs also showed discrepancies. The coverage of DPT3 antigen is lower than the FIC coverage in some provinces. There are a number of midwives that need to be retrained on how to estimate age of gestation (AOG), mechanism of natality reporting, and TCL data transfer to monthly tables/reports.

In like manner, enabling policies in support of MNCHN services need to be approved and implemented to ensure MNCHN services and commodities are available to clients, particularly the poor. Currently, there is a dearth of enabling policies in Luzon. It would be most useful to intensify

advocacy among LCEs and policy-makers for the passage of enabling policies using evidence-based data (i.e. cleaned FHSIS data) to support the needs of the LGUs.

In Year 5, in collaboration with other USAID cooperating agencies and in partnership with the CHD/PHTOs, HealthGov will build on the gains achieved in the past four years of operations, while addressing the above issues and strengthening existing structures and systems that will enhance provision of quality health care through adequate funding support.

Specifically, HealthGov will capacitate the CHD/PHTOs as primary TA providers of the provinces. The following TA support will be provided:

- For CSR+, the focus is on generating correct and reliable data and forecasts for planning and policy development. Data quality checks on FHSIS data, particularly on FP/MNCHN, to strengthen the overall health information system will be undertaken. The cleaned data will be used as inputs in the provincial implementation reviews and AOP preparation/formulation. Likewise, through the CHD, the Family Planning Commodity Monitoring System (FPCMS) will be downloaded to the LGUs for adoption using developed tools and guidelines. AOP development will be mainstreamed in the LGU budget cycle. Avenues to plan and discuss AOP integration into AIP will be facilitated among the PHOs/MHOs/LFCs, with CHD as lead organizer.
- For NHIP, the approach is to make the CHD and provinces understand the BDR approach. Orientation trainings with CHD/DOH Representatives as trainers/facilitators will be provided to the PHO/MHOs. Likewise, the CHD through the DOH Representatives will fast track the accreditation of health facilities. Coordination meetings with PhilHealth and MHOs will be arranged. Plans for the utilization of reimbursements and capitation funds will be formulated to ensure that these will be re-invested in health.
- Continuing assistance will be provided to LGUs in accessing and utilizing the MNCHN grant facility through conduct of follow-through/feedback meetings to discuss status of fund utilization, particularly on proper and timely liquidation of the grant funds.
- TA will be provided in integrating FP in EPI/MCH activities in model LGUs as well as expansion LGUs. In line with maximizing MNCHN services, expansion of existing women's health teams or *barangay* health teams will be undertaken to mobilize communities in accessing MNCHN services.
- Support will be provided in the implementation of SDExH in Albay and Bulacan as demonstration sites for continuous quality improvement in health care services.
- Assistance will also give priority to the implementation of a HIV/AIDS local response plan in Quezon City.
- CHD/PHOs will be assisted in tracking ICV compliance in all LGUs.
- Consultation meetings with CHD/provinces will be held to discuss the TA provided in support of the implementation of the AOPs and on how to further enhance these using project-developed guides and tools.
- Coordinate and organize, through the CHD, a regional dissemination forum to inform the partners about USAID-CAs' technical assistance and the corresponding guides and tools developed. Initiatives that worked will be showcased for possible replication or scaling up.

## Albay

The Province of Albay is located in the Bicol peninsula about 460 km. South of Manila, composed of 15 municipalities and 3 component cities, including Legazpi City, its capital. Based on the August 2007 census, Albay's total population is 1,190,823, which makes it among the most populous province in the country. There are 208,640 households in the province with an average size of 5.22 persons, significantly higher than the national average of 4.99.

**The health situation: trends in SO3 indicators**

The FHSIS 2009 data showed that only Vitamin A coverage (103%) and TB case detection rate (86%) were able to meet the national performance standards. The provincial performance in all three key health programs-- maternal care, child care and TB did not reach the national standards for 2009 (FHSIS 2009 Report).

Performance indicators for maternal care are steadily below the national standards but with a slightly increasing trend from 2006-2008. In 2009, however, increase was very significant on the following indicators: pregnant women with 4 ante-natal visits (40% in 2006 to 49% in 2008 and 74% in 2009); skilled birth attendant (44% in 2006 to 54% in 2008 and 62% in 2009); and, in facility-based delivery (14% in 2006 to 21% in 2008, and 35% in 2009).

The poor maternal care services of the LGUs is attributed largely to limited outreach activities for direct service delivery, health promotion and education, pregnancy tracking, referrals to health facilities resulting to low percentage of pregnant women getting access for pre-natal, natal and post- natal care. Coupled with ill-equipped public health facilities and inadequate logistical and manpower resources for maternal care, the low to no budget allocation for the delivery of maternal health services resulted in a very low demand for such services.

The FP supply shortage has also put the provincial CPR at a declining trend. The CPR declined by 9% points from 2006 to 2009 because many LGUs still do not buy FP commodities; while those very few that were able to purchase their own commodities, supply has always been inadequate. Furthermore, the MNCHN grant money that was intended for procurement of FP commodities was only distributed in December 2009 to January 2010. LGU CSR+ plans have not been fully implemented mainly because of a lack of a CSR policy or mandate to back up its operationalization. However, it is observed that even those LGUs with already approved policies still struggle with issues of low budget allocation for health and for procurement of FP commodities.

The performance indicators of the province in child care service delivery is relatively doing well particularly along the indicator for DPT3 which revealed an upward trend from 80% in 2006 to 85% in 2009 and in FIC at 74% in 2006 to 86% in 2009. The steady supply of immunization commodities from the DOH was seen to have contributed to this increasing trend. More so, the proportion of under-five children with diarrhea seen and treated with ORT is quite high and increasing (from 2006-2008 at 81% to 99%) as well as the indicators for under-five children with pneumonia seen and treated with antibiotics. Current data shows that both indicators went down in 2009.

Although still above the national standards, the performance indicators for the implementation of TB prevention and control program are on a downward trend. This can be seen in the TB case detection rate which went down by 3% points for the period of 2006-2008 and TB cure rate from 91% in 2006 and 74% in 2009. Based on the results of the data cleaning and validation in 2007,

there was an apparent confusion between service providers in understanding the protocols and definitions of a TB cured patient. Thus, the high cure rate reported in 2006 was questioned as this may have been a result of over-reporting.

The table below shows the status of program performance from 2006-2009 against the national performance standards.

**Table 1. Selected health indicators (2006- 2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 43 | 38 | 33 | 29 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 40 | 41 | 49 | 74 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 49 | 52 | 54 | 62 | 80 |
| 4 | Percent of facility-based deliveries | 16 | 19 | 25 | 35 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 66 | 65 | 82 | 85 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 74 | 76 | 78 | 86 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 86 | 82 | 96 | 103 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 81 | 94 | 99 | 81 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 82 | 94 | 99 | 81 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 90 | 87 | 86 | 87 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 123 | 139 | 130 | 127 | 99 |
| 12 | TB cure rate (%) | 91 | 76 | 74 | 74 | 85 |

**The response: TA interventions and results**

HealthGov's technical assistance for the province was generally aimed to assist and build the capacity of LGUs to develop and implement measures in order to achieve better health outcomes for the province. All technical assistance was implemented, in collaboration and partnership with the PHO, DOH Reps, LGUs and CHD.

In Year 1, technical assistance was focused on assisting the province in developing its five-year Province-Wide Investment Plan for Health (PIPH) as well as the Investment Plan for Health of its component LGUs. These plans served as a blueprint for improving the province's and LGUs health status. In addition, a review of the service delivery performance using the SDIR tool was conducted to generate a baseline data for its service delivery and as a guide in the formulation of the MIPH and PIPH.

In Year 2, however, technical assistance provided to the province shifted from preparing the PIPH operational plan for 2008--which happened mid-way of the year to drafting a provincial catch-up plan. HealthGov facilitated the implementation of the catch-up plan--a set of tactical measures to catch-up on the implementation of its 2008 AOP--- through the delivery of the following TA packages:

- HealthGov facilitated the review of the provincial CSR+ plan developed through the LEAD Project and the development of an enhanced Commodity Self-Reliance plan and policy. In recognition of the very low contraceptive prevalence rate across all LGUs, the CSR implementation status per LGU was also assessed which led to the drafting of local CSR+ plans and policies. To date, 3 LGUs have already passed a local CSR+ policy (Polangui, Daraga and Malinao). With the perceived strong opposition of the Catholic Church and some local officials to modern methods of Family Planning, the submission of the provincial CSR+ policy to the Sanggunian Panlalawigan was deferred. The provincial health office in turn localized the approach and advocated for the passage of CSR policies at the municipal level with the incorporation of CSR+ implementation activities into the LGUs AOP to ensure that CSR related activities were funded and implemented. Continuing technical assistance is being provided to the LGUs in terms of updating their CSR+ plan and policy in the light of the ongoing FP data cleaning e.g. updating commodity forecast and integrating new developments in the implementation of the CSR+ plans.
- Activities priming the LGUs for CHLSS implementation were also conducted. These included an orientation of the provincial and municipal LGUs including a few LHBs on the need to have a segmentation of its social insurance clients. It aimed to address two major issues: over-enrollment of PhilHealth beneficiaries and the need to determine the unmet needs of clients for various health services. Supposedly, the intent was a province-wide CHLSS but due to funding constraints, the province decided to pilot the implementation of CHLSS in the municipality of Polangui in 2009. HealthGov‘s assistance dealt on the drafting of the CHLSS tool, training of enumerators, data encoders, and data management, provision of the statistical software and doing preliminary data analysis. The data are now available for use by the LGU for planning, identification of PHIC beneficiaries and to reach out clients with unmet needs in the municipality.
- Technical assistance on RHU facility assessment in preparation for accreditation for the Maternal Benefit Package of the PHIC was also provided. The objective was to assist LGUs to improve their health financing and resulted in 2 LGUs acquiring MCP accreditation in 2009 and 4 more LGUs with pending application for accreditation.
- A profile of all LDCs/LSBs in the province was drawn through scanning local development councils and local special bodies. ICV monitoring for select RHUs and BHS was also included in the catch up plan.

For Years 3 and 4, HealthGov’s assistance became more focused and directed towards mainstreaming the MNCHN strategy in the LGUs because of its poor over-all service delivery performance. The aim was to strengthen LGU response in improving the quality of service delivery for MNCHN programs and eventually raise the performance level of service delivery for MNCHN. The TA was categorized into: (a) conduct of purposive advocacy activities to local officials using the results of the SDIR, and the promotion of the MNCHN framework wherein the LHBs were used as venues; (b) assistance in developing MNCHN plan using the provincial AOP as its reference to component LGUs.

This approach triggered the harmonization of the program direction for MNCHN between the provincial and municipal/city governments. This initiative was later cascaded to the barangay level as some MHOs and CHOs were able to conduct their own advocacies to their respective barangay captains. The intervention facilitated more pro-active responses at the ground level such as the construction of more BHS equipped with a birthing facility using their barangay IRA. The municipality of Oas as an example responded to this initiative and has already drafted their respective barangay MNCHN plans.

Other interventions provided were geared to beef up improvements in MNCHN service delivery performance and continuous improvement of MNCHN health services. The following TA interventions facilitated more concrete actions from the province that resulted in the improvement of service delivery performance indicators noted in 2009:

- The Service Delivery Excellence in Health approach was implemented in three (3) LGUs within an Inter-Local Health Zone, namely: Polangui, Oas and Guinobatan. Local health personnel underwent the SDExH training program and were introduced to the concepts, tools and process in SDExH implementation. The implementation of their Service Implementation Plan (SIP) is on going in all three (3) pilot LGUs but at varying levels. PHO program coordinators and DOH reps were also trained so they can provide technical assistance to LGUs in SDExH implementation. Clients were able to observe this early, the improvements in the quality of service delivery and a more positive attitude of health service providers in these LGUs.
- The Integration of Family Planning into EPI and Maximization of MNCHN services was introduced in two (2) LGUs--Oas and Daraga as a measure to improve FP program implementation and consequently increase their CPR. The implementation of this strategy will be expanded to cover other LGUs with low CPR but whose FIC is high. The expansion phase shall be implemented in Year 5.
- Inspired by their Training on Life Saving Skills, trained RHMs are now actively practicing their newly-acquired skills in their respective health facilities. One even had to convince her MHO to open its lying-in clinic 24-hours daily. Furthermore, small increments or increases in facility-based delivery and delivery by skilled birth attendant were noted in their facilities.
- The project's assistance to municipal and city governments in preparing their own annual operations plan using their MIPH as reference was used to leverage funds from their respective LCEs. As a result, all 18 LGUs were able to develop their MIPH annual operations plan. In addition, the 2009 SDIR was able to generate a barangay level baseline data for health service delivery performance.

Aside from the above, there were other TA/interventions provided to the province which focused on improving data quality particularly on the FP current users. Technical assistance was provided in the harmonization of health planning with the local development planning and budgeting process. HealthGov also helped LGUs improve health financing through accessing of the MNCHN grant and the maximization of PhilHealth financing through accreditation for the Maternity Care Package.

Technical support was also provided in terms of helping LGUs operationalize their AOPs through the following interventions:

- Budget advocacy and improving capacities of MHOs in managing AOP implementation which also included building capacities on understanding budget execution and public finance management,
- Mobilizing NGOs and other stakeholders to support AOP operationalization and determining specific areas for collaboration and possible public-private partnership engagement between the LGUs and NGOs/CSOs and private sector. Conduct of the successful First Albay Health Fest, which was an initiative of the provincial government to rally LCEs behind to support PIPH/AOP implementation. A Memorandum of Agreement declaring the support and commitment of provincial and municipal/LGUs to work together especially on critical aspects of the AOP was one of the highlights of the event. Likewise, other stakeholders signed the Declaration of Support to the AOP implementation.

**Remaining gaps and challenges**

For Year 5, HealthGov in collaboration with other CAs and in partnership with CHD and national agencies needs to build on the immediate gains of the project interventions towards more measurable family health outcomes for the LGUs. In order to further the institutionalization of HealthGov TA/interventions from Year 1, critical activities should be undertaken particularly in the following areas:

- Improvement of health management information system through data quality and utilization for planning and decision making, e.g. FP current users, FHSIS data for use as inputs for better planning;
- Formulation of a sustainable health financing strategy through mainstreaming the PIPH/AOP into the LGUs CDP/ELA and LDIP/AIP, maximization and utilization of the PHIC health financing scheme, and access and utilization of the MNCHN grant;
- Establishment of systems for continuing quality health service delivery in public health facilities; and,
- Maximization of MNCHN services to deliver quality family health services.

**Year 5 priority interventions and expected results**

As a response to these challenges, the following technical assistance will be implemented with due consideration of the limited resources and time constraints of the project for Year 5:

A. Support to improving service delivery in family health:

- Updating of the municipal/city/provincial CSR+ plans and FP commodity forecast with an installed logistics management monitoring system for FP commodities;
- Advocacy for the passage of CSR+ policy to back up the implementation of the CSR+ plans and the purchase of FP commodities;
- Monitoring and documenting FP integration to EPI and Maximization of MNCHN services for possible LGU initiated scale-up in other municipalities of the province;
- Installation of the provincial health human resources database;
- Coordination with CHD 5 for implementation of ICV Monitoring;
- Coaching and monitoring LGUs' compliance of requirements for MNCHN grant accessing, and monitoring utilization of the grant money;
- Completion of SDExH piloting, and coaching and monitoring of SIP implementation

B. Strengthening family health program support through financing and governance:

- Completion of the CHLSS implementation report ( write up on the municipal profile, generation of data in tables and graphs); and,
- Promotion of MCP accreditation, and monitoring of LGU MCP compliance.
- TOT in FPCMS and monitoring its implementation
- Assist the province in the presentation of priority health agenda for the NEO Program

At the end of Year 5, HealthGov's technical assistance package is expected to achieve the following milestones and results:

- Province and 9 LGUs with approved CSR/MNCHN Ordinance/Resolution, allocating funds annually and procuring CSR+ commodities, and CSR+ implementation plan operationalized
- Province with a monitoring system for ICV compliance
- 5 LGUs with a continuing service delivery quality improvement system in place at their RHUs and BHSs
- Province and 18 LGUs conducting an annual enhanced Program Implementation Review
- 1 LGU implementing a client classification system for identifying the poor
- Province with improved logistics management for essential drugs and commodities
- 9 LGUs with increased number of accredited health facilities for MCP
- Civil society providing inputs to the health sector program or budget deliberations at the municipal level

**Priority TA Interventions and Activities**
**ALBAY**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to MNCHN Strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ planning and policy | 1.1C.d | 30 health personnel trained in FP CU data cleaning | Training of PHO FP program coordinator, DOH Reps and Municipal FP Coordinator in FP current users data cleaning, forecasting of FP commodity and enhancement of CSR+ plan of LGUs | Resource person and facilitator<br><br>FP current users validation instrument<br><br>Training design | | **M15 C3** | | | | | | | | | | | | 15 | 3 |
| | 1.1C.b | Quality of FP CU data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | Workshop on validation of FP current users, revision of FP commodity forecast and enhancement of CSR+ plan of LGUs | Monitoring and supervision | | | **P1 M15 C3** | | | | | | | | | | 1 | 15 | 3 |
| | 1.1C.a<br><br>1.1B.b | Cleaned FP CU data used in updating in forecasting FP commodities<br><br>Updated CSR+ plan and policy | | | | | **P1 M15 C3** | | | | | | | | | | 1 | 15 | 3 |
| | 1.1B.d | 9 LGUs with CSR+ policy approved | Incorporate the drafting of CSR+ policy as one of the activities/outputs for the training of the LGUs SB Chair on Health | In-house TA | | | | | | | **M9** | | | | | | | 9 | |
| 2. Integration of FP into EPI, post-partum FP, and maximizing utilization of MNCHN services; and social mobilization for improving FIC and Vitamin A supplementation | 1.3A.d | Service providers trained in Integration of FP/EPI and postpartum services and maximizing utilization of MNCHN services | Orientation of PHO/PHTO and CHOs/MHOs on FP integration and maximization of MNCHN services to roll-out sites | Resource person/technical inputs, facilitator, FP integration guide | | **M7 C2** | | | | | | | | | | | | 7 | 2 |
| | 1.4Cc | LGUs/NGOs/CSOs partnership established in planning for integration of FP/EPI and maximizing utilization of MNCHN services | On-site orientation training of CHOs/MHOs/PHNs/RHMs in integration of FP/EPI and maximizing utilization of MNCHN services per LGU | Coach PHO/PHTL | | **M7 C2** | | | | | | | | | | | | | |
| 3. ICV compliance and monitoring | 1.3D.a | 7 DOH Reps trained in ICV monitoring | Training of DOH Reps in ICV compliance monitoring | Resource person, facilitator | **P1** | | | | | | | | | | | | 1 | | |
| | 1.3D.c | ICV compliance of FP/RH service delivery sites monitored and reported | Meeting to discuss and prepare ICV compliance monitoring of the province | Monitoring provincial ICV compliance | | | | **M4 C2** | | | **M5 C1** | | | **M6** | | | | 15 | 3 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **B. Continuing quality improvement (CQI) in family health service delivery** | | | | | | | | | | | | | | | | | | | |
| 1. SDExH with community participation | 1.3B.b<br>1.3B.c<br>1.3B.d | 3 phases of SDExH training completed<br>Service improvement plan implemented<br>LGUs implementing SDExH recognized and awarded | SDExH training and service improvement planning (3 phases) - modelling and rolling-out phase | Resource person, facilitator, manuals | | **P1 C2** | | | | | | | | **M3** | | | 1 | 3 | 2 |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on benefit delivery approach | 1.2C.b | 9 LGUs with accredited health facility for MCP | Field visit to monitor MCP compliance of LGUs | Coach | | | | | | **C3** | **M6** | | | | | | | 6 | 3 |
| 2. Accessing and managing DOH MNCHN grants | 1.2A.b | MNCHN grant accessed | Coaching and monitoring of PHO/MHOs on the completion of the required documents for the MNCHN grant for 2009 and 2010<br>Monitor LGUs accessing the MNCHN grant | Coaching and monitoring<br>Grant allocation tool | | **P1 M15 C3** | | | | | | | | | | | 1 | 15 | 3 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Data management | | CHLSS data analysis completed, made available and ready to use | Completion of CHLSS in Polangui as model<br>Writing up and packaging the data analysis for presentation to the PHO, Polangui local officials and MDG committee | Cost-share for the write-up of the LGU profile using the CHLSS results | | **P1** | | | | | | | | | | | 1 | | |
| | | Community Health component of CHLSS included in the CBMS | Meetings with the provincial MDG committee to include the community health component in the CBMS tool to be used by the province | Resource person, CHLSS initial results | | | | | | | | | | | | | | | |
| 2. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | TOT in FP commodity monitoring system (FPCMS) for CHD 5 and PHO technical staff conducted | | | | **P1** | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitor the Provincial Health Office in its implementation of FPCMS | Coach PHO/PHTL | | | | | | | | | **M15 C3** | | | | | 15 | 3 |
| **C. Advocacy to newly-elected local officials (NEOs)** | 1.4B.c | Priority health agenda presented to leagues of LCEs<br>• Priority health policies approved, e.g. CSR+ policy, support to facility-based delivery<br>• Procurement of CSR+ commodity<br>• Estabishment/reactivation of *BnBs* | Health fora, consultative meetings, dialogues with LMP, *Liga ng mga Barangay*, ABC presidents, League of Councilors conducted | | **P1** | | | | | | | | | **1** | | | 1 | | |

## Bulacan

Bulacan is a first class province and part of the Metro Luzon Urban Beltway Super Region—a development approach of the government focused on investing in tourism-related projects for a cluster or group of provinces. The province is composed of 569 *barangays*, 21 municipalities, and 3 component cities. The current population according to the 2007 Census is 3,121,765 with a high annual population growth rate of 3.36 percent.

**The health situation: trends in SO3 indicators**

The province achieved minimal increments in improving maternal health care from 2006 to 2009 as seen through its performance indicators. The trends in vital health outcomes like Maternal Mortality Ratio and Infant Mortality Rate went down slowly from MMR of 57 per 100,000 LB to 52 per 100,000 LB and IMR of 4.5 per 100,000 in the past four years.

The proportion of births attended by skilled birth attendants has surpassed the national standards of 80% in 2009. While FBD had small increments from 33 % in 2006 to 38% in 2009, this is still low when compared to the national standard. On the antenatal visits coverage, it ranged from a low 44% in Dona Remedios Trinidad to a high 99 % coverage in San Meycauyan City with a provincial average of 85 percent. The CPR of Bulacan declined from 47% to 42% still way below the national benchmark of 60 percent. At the municipal level, the municipality of Pandi recorded the lowest CPR at 9% while Bulacan posted the highest at 55%.

For child care, the indicators from 2006 to 2009 are declining or variable. The performance accomplishments on DPT3, FIC and children below 5 years old with diarrhea treated with ORS and Vitamin A coverage among under-five declined from 2006 to 2009. The provincial 2009 FIC coverage of 84 % is 11 percentage points below the 95% national average. Across LGUs, FIC coverage ranged from 60% to 105 % with Marilao having the lowest coverage while City of San Jose del Monte topping the performance. Seventeen (17) out of twenty-four (24) LGUs had 85% below FIC coverage. The performance coverage for children with pneumonia seen and treated with antibiotics increased from 94 % to 96%, coverage ranged from 71% to 100%, with 16 LGUs with 100% coverage and only two (2) LGUs with below 80% coverage namely Pulilan and Balagtas.

TB ranks fifth among the leading causes of mortality and eighth among the leading causes of morbidity in 2009. From 2006 to 2008, provincial case detection rate slightly increased from 63% to 64% but it went down to 55 % in 2009 while cure rate slightly decreased from 82% to 80% and increased in 2009 by one percentage point (81%). The performance indicators for child health and TB control and prevention either fluctuated or remained static.

On health financing, there is low PhilHealth enrollment among informal and low income groups. Only 47% or 27 out of 57 RHUs are OPB accredited, 13 TB DOTS accredited and only one health facility that is MCP accredited. The guidelines on the use of PHIC reimbursement needs to be reviewed as utilization of capitation was said to be at the discretion of the LCEs.

Table 1 below shows the status of program performance from 2006-2009 against the national performance standards.

**Table 1. Selected health indicators (2006- 2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 47 | 42 | 42 | 42 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 85 | 86 | 87 | 85 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 91 | 93 | 93 | 94 | 80 |
| 4 | Percent of Facility-based Deliveries | 33 | 30 | 34 | 38 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 87 | 86 | 86 | 84.5 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 83 | 89 | 86 | 84 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 91 | 88 | 97 | 77 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 60 | 54 | 53 | 56.3 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 97 | 100 | 94 | 90 | 100 |
| 10 | Case Detection Rate (per 100,000 population) | 63 | 64 | 63 | 55 | 76 |
| 11 | Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 83 | 85 | 82 | 72 | 99 |
| 12 | Cure Rate | 82 | 81 | 80 | 81 | 85 |

**The response: TA interventions and results**

In Year 1 of the project, scoping missions and data-gathering were undertaken to understand the health program situation of the province. Advocacy and orientation on the project was conducted with various provincial stakeholders (LGUs, NGOs, CSOs) in partnership with the regional agencies primarily the CHD. The SDIR was undertaken from May through July of this year as an immediate response in order to identify municipalities that are weighing down the provincial health indicator average and determine important activities to address the gap.

Based on the results of the SDIR, the province adopted the theme “Achieving the Performance Standards at the Local Level.” The theme underscores the important role that municipalities and civil society, as evidenced by the immediate mobilization of the BKB play in “turning the reds into greens” or bringing under-delivering areas up to standard. In that context, four (4) clusters of interventions were anticipated namely: a) establishing the MIPH/PIPH preparation process, and the resulting document as the principal basis for guiding the effort of “turning the reds into greens”; b) SDIR, CSR+ planning, assessment and monitoring; c) developing CSO-NGOs, through the BKB, as active partners of the LGU in health work; d) build the capacity of Bulacan LGUs to promote awareness of local health programs and favorable health-seeking behavior; and, e) control of Avian Influenza. The province has also completed the development of their PIPH, MIPHs and AOPs.

From this, Bulacan has already made headway in strengthening multi-sectoral alliances in support of public health. With assistance from HealthGov, a provincial Executive Order (EO) on “Engaging Private Sector Participation to Improve Bulacan Health Outcomes” was launched and a Private Health Desk was created as a unit of the PHO tasked among others, to provide services to the private sector in the form of training and orientations on public health issues.

Preparatory discussions on how to increase the private sector's role in promoting public health was also undertaken which involved 17 small and medium-scale industries, 11 private midwives, and 10 NGOs and civil society groups. As a follow-up, capability building in advocacy, service delivery, and M&E for non-government stakeholders will be provided to enable them to effectively support public health programs.

HealthGov also coordinated the rollout of the FPCBT Training of Trainers by CHD 3. Aside from an additional two (2) provincial trainers, eight (8) Municipal FP service providers were trained on FP CBT Level 1 from a total 7 municipalities in the province. To date, there are 17 midwives in the province already trained in LSS through the HealthGov project. The trained midwives are applying the new skills in their respective RHUs, like suturing, IV insertion, and partograph.

In collaboration with DOH, HealthGov facilitated the Training of Trainers in PHN Supportive Supervision where one PHO supervising nurse was trained and rollout of this training to Municipal and City level is expected to be undertaken by year 5 by the PHO and CHD 3.

The province has been tailing in terms of its Philhealth accreditation of health facilities, specifically on MCP. To date, only the RHU of Bustos is MCP accredited despite the training because of the expressed difficulty in complying with the requirements for the MCP accreditation specifically the facility upgrading.

Together with HealthPRO, HealthGov assisted the PHO in developing the concept of KAISA Project—a package of MNCHN services which include FP integration into EPI and maximizing utilization of MNCHN services, CSR+, ICV compliance monitoring, MDR, MNCHN financing, and organization of community health teams in low performing LGUS.

The KAISA project was launched at the province with assistance from USAID last December 2009 and was attended by about 350 participants/partners from 10 LGUs. Representatives from the NGOs/CSOs/private sector, provincial government offices with CHD 3, and Provincial BHW Federation also attended the launching. Seventy-nine (79) couples and their children availed of the various services such as: general health check-up, responsible parenthood and breastfeeding counseling, health education on care of children, women and adolescent reproductive health, pre-marriage counseling and birth planning. To date, activities of KAISA is monitored and implemented through a Multi-sectoral TWG whose members had been nominated from its partners.

On ICV compliance monitoring and reporting, after the Regional Training of Trainers on ICV compliance monitoring and reporting, CHD 3 and the PHTO has been continuously monitoring ICV compliance of health workers and health facilities. For this reporting period, 6 facilities were visited and monitored. No violation was noted in all the 6 facilities.

With regards to grant support to NGOs for the implementation of the MNCHN strategy, the PHO and NGOs were oriented on the Fixed Obligation Grant guidelines of the project. These orientations were done during the *Bantay Kalusugan ng Bulacan* (BKB) annual assembly and during the meeting coordinated by the Private Health Desk of the PHO, which was attended by five (5) NGOs, namely, BKB, Integrated Midwives Association of the Philippines (IMAP), Family Planning Organization of the Philippines (FPOP), International Community Care Foundation for Asia, and Rotary International District. The draft concept paper on *Barangay* Advocacy for MNCHN in five (5) low-performing LGUs of Bulacan was also presented during the assembly for review, comments, and enhancement.

The BKB representative reiterated its support and commitment in helping the province and the RHUs/LGUs deliver quality health services to Bulakeños. In keeping with this commitment, BKB has just recently donated four (4) boxes of medical supplies for distribution to priority hospitals and RHUs, in addition to the PhP1.7M worth of medical supplies and equipment donated earlier in February. Among the medical equipment that BKB distributed to the RHUs and hospitals were OB examining beds, microscopes, and ECG machine. This is in support of MIPH/PIPH implementation, particularly in facilitating the PhilHealth accreditation of health facilities. It is worth noting that the BKB was organized through the technical assistance of HealthGov in the province.

The project likewise supported other USAID CAs in the conduct of other critical service delivery initiatives, which include, among others, the following: a) development of the strategic communication plans for FP, Vitamin A, vector-borne diseases, TB control, AI, and MCH (with HealthPRO); b) conduct of the World TB Day and Lung Month celebration, which promoted the *'ubokabularyo"* / cough manners (TB LINC); d) conduct of pre-organization meetings and strategic planning for engaging support of private sector and NGOs in line with the establishment of the Private Health Desk at the Provincial Public Health Office; and e) conduct of *Garantisadong Pambata* planning (A2Z and HealthPRO).

HealthGov provided support to the province in accessing the P1.4 FP/MNCHN grant facility by conducting technical orientations on the grant, facilitating the MOA signing process, and providing the tool for allocating the grant funds (or commodities) to component LGUs. The province procured FP commodities and distributed to the LGUs.

Likewise, HealthGov provided technical assistance to the RHUs in the conduct of their PIR which include internal assessment of the C/LGU performance against the NOH in preparation for the province-wide PIR and 2011 AOP preparation. To date, the province, with technical support from HealthGov and other CAs, has an approved 2010 provincial AOPs giving attention to private sector engagement and participation to improve health outcomes. It also focuses on the 22 M/CLGU acceleration plans which were translated as their 2011 AOP and 2011 AIP.

Support to Continuing Quality Improvement of FP/MNCHN Services through the SDExH Module was presented during the Health Manager's meeting. Four (4) LGUs namely Angat, San Rafael, Dona Remedios Trinidad in Baliwag ILHZ and the City of San Jose del Monte agreed to introduce SDExH as Continuing Quality Improvement (CQI) in their health facilities to improve health care services this coming months. A facilitator's training for PHO and DOH will also be conducted.

The project supported TB LINC in its initiative to assist in the development of a Municipal Executive Order declaring implementation of NTP and the organization and strengthening of *Barangay* TB Patrol in 14 *barangays* in the municipality of Paombong.

**Remaining gaps and challenges**

The quality of family health data and indicators still needs to be checked and validated to aid in planning, forecasting, budget allocation and prioritization of the Family health program. In addition, the varying levels of FP/MNCHN program implementation across the province may have compromised the high-risk groups of children and women in some LGUs. More so, because of the piece-meal appreciation of social insurance for the poor as seen by the low PhilHealth enrollment among informal, low income group, inappropriate utilization of capitation funds and non accreditation of most of government health facilities. Non–integration of priority

investments in health in local plans in some C/MLGUs have also resulted in limited budget for health from local funds.

**Year 5 technical assistance and milestones**

HealthGov and other CAs' TA will support the province-wide direction for health development in 2011 adopting the handle *"Local Government Units of Bulacan Leading the Multi-sectoral Alliances in support of Public Health."* The priority Technical Assistance for the province of Bulacan would be in the following areas:

A. Support to improving service delivery in family health:

- FP/CSR/MNCHN plan, policy, and capability building
- Data Quality check/cleaning /utilization (FP Current users data and other MNCHN indicators in support to CSR+ plan updating
- Scaling-up of MNCHN integration and maximizing utilization of existing MNCHN services
- ICV compliance monitoring and reporting
- MNCHN grant access, custody, utilization and reporting
- CQI thru SDExH with community participation

B. Strengthening family health program support through financing and governance

- Local BDR approach to NHIP implementation
- Orientation of Newly Elected Officials
- TOT in FPCMS and monitoring of its implementation
- Presentation of priority PPAs to NEOs

At the end of Year 5, HealthGov's technical assistance to the province will contribute towards the increase in health performance for FP/MNCHN health outcome indicators that will result to the following milestones:

- Province and 24 LGUs are using corrected data in the forecasting of FP/MNCHN requirements and integrated in the AOP/AIP
- 10 LGUs implementing action plans to accelerate SO3 performance through FP Integration into EPI and PP and maximizing utilization of MNCHN services
- 1 Province implementing ICV compliance monitoring and reporting
- 9 LGUs assisted in the compliance of health facility PHIC accreditation
- 5 RHUs implementing continuous CQI and its service improvement plans
- Investment plans for health especially on Family Health Programs and PHIC are integrated and synchronized in CDP and LGU budget cycle

**Priority TA Interventions and Activities**
**BULACAN**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN Strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ planning | 1.1C.d | PHO, PHTL trained in DQC of FP current users | Meeting, orientation and planning with PHO/PHTL on data quality check of FP current users and its roll-out to C/MLGU | Resource Person | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1C. b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | Training of CHOs/MHOs/PHNs in FP data quality check and in forecasting | | | **M7 C3** | **M7** | **P1 M7** | | | | | | | | | 1 | 21 | 3 |
| | 1.1B.b | CSR+ plan updated | Follow through workshop on 10 LGU CSR+ Plans specifically on forecasting for Vitamin A, TB and FP using cleaned data (reforcasted CSR+ requirements will be used in AOP/AIP ) | Develop the design, resource person/facilitator, fund support | | | **P1** | **P1** | **P1** | | | | | | | | 1 | | |
| 2. Integration of FP into EPI, postpartum FP and maximizing utilization of existing MNCHN services | 1.3A.d | Service providers trained in integration of FP/EPI and maximizing utilization of MNCHN services | Service providers trained in integration of FP/EPI and maximizing utilization of existing MNCHN services and facilities | Resource person/facilitators | **P1 M10** | | | | | | | | | | | | 1 | 10 | |
| | | | Conduct one day training, orientation and planning on integrating FP/EPI and maximizing utilization of existing MNCHN services and facilities for RHU personnel (MHOs/RHP, all PHNs and all RHMs) in 10 LGUs including NGOs/CSOs | Resouce person/facilitators | **M5** | **M5** | | | | | | | | | | | | 10 | |
| 3. Capacity building acivities on FP and MNCHN | 1.3A.a | Database on service providers' capability profile established | Consultative meeting with PHO/PHTO for database on capability profile of service providers and implementation of AOP training plan | Resource person and faciltator | | **P1** | | | | | | | | | | | 1 | | |
| 4. ICV compliance monitoring | 1.3D c | ICV compliance of FP/RH service delivery sites monitored and reported | Quarterly meetings with PHO, PHTO to discuss results of ICV compliance monitoring (integrated in other meetings with the PHO) | Monitoring and coaching | **M7 C1** | | | **M7 C1** | | | **M7 C1** | | | | | | 1 | 21 | 3 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **B. Continuing quality improvement (CQI) in family health service delivery** | | | | | | | | | | | | | | | | | | | |
| 1. SDExH+ community participation | 1.3B.a | SDExH has been mandated for 4 LGUs | Facilitators trained in the modeling of SDExH in selected municipalities in the province (CHD/PHO/PHTO/selected MHOs) | Resource person | **M4** | | | | | | | | | | | | | 4 | |
| | 1.3B.c | 4 LGUs where Service Improvement Plan has been implemented | Monitoring of SDExH implementation | Monitoring and coaching | | | | | **M4** | **M4** | **M4** | **M4** | | | | | | 4 | |
| | 1.3B.b | Training completed (3 phases) in 4 LGUs (pilot areas) | Implementation of SDExH Phase 3; Recognition of achievements and awarding | Resource person and facilitator; training manual | | | | | | | | **P1 M4** | | | | | 1 | 4 | |
| | 1.3B.d | LGUs implementing SDExH recognized and awarded (i.e. incentives for good performance of service providers) | | | | | | | | | | **M4** | | | | | | 4 | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local Implementation of NHIP based on benefit delivery approach | 1.2 C a | Application for accreditation filed (renewal for OPB and TB DOTS and new application for MCP) | Coach MHOs in completing the documentary requirements of PhilHealth accreditation of RHU for MCP and renewal for OPB and TB DOTS | Facilitator | | | **M3** | | | | | | | | | | | 3 | |
| | 1.2 C b | Facilities accredited by PhilHealth (for OPB, TB DOTS and MCP) | Facilitate coordination with PHIC and MHOs to fast track MCP accreditation and renewal | Coach; Facilitator | | | | **M3** | | | | | | | | | | 3 | |
| 2. Accessing and managing DOH MNCHN grants facility | 1.2A.a | MNCHN grant accessed | LGU orientation and planning to access the 2009 and 2010 MNCHN grant facility (Provincial LFC, MHOs and LFCs)<br><br>Monitor the completion of requirements to access MNCHN grant, implementation and utilization of the MNCHN grant | Resource person and facilitator | **M21 C3** | | **P1 M10 C3** | | **P1 M11** | | | | | | | | 1 | 21 | 3 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | TOT in FP commodity monitoring system (FPCMS) for CHD 5 and PHO technical staff conducted | | | | **P1** | | | | | | | | | | | 1 | |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitor implementation of FPCMS by the Provincial Health Office | Coach PHO/PHTL | | | | | | | | | **P1 M15** | | | | | 1 | 15 |
| **C. Advocacy to newly-elected local officials (NEOs)** | 1.4B.c | Priority PPAs presented to NEOs | Meetings with the PHO, PPDO to finalize list of priority PPAs and advocacy to NEOs for its inclusion to AIP 2011 | Coach PHO/PHTL | **P1** | | | | | | | | | | | | 1 | | |

## Cagayan

Cagayan is a first class province in Cagayan Valley, with 28 municipalities and one city divided into three congressional districts. It has 820 barangays. Tuguegarao City is the provincial capital, regional seat, and center of business, trade, and education. It has a land area of 144.80 square kilometers and a population of 1,072,571 as of 2007. It has two primary hospitals and 31 rural health units. It is classified as F44 province.

**The health situation: trends in SO3 indicators**

In the past four years (2006-2009), the performance of Cagayan remained below the national standards and has been fluctuating. In 2009, there was a dramatic decline in the number of maternal deaths from nine (9) in 2008 to five (5) in 2009. This maybe due to the provincial MDR team organized in 2009 that had been conducting regular maternal death reviews and instituting actions to improve maternal services.

Data from 2006 to 2009 showed fluctuations although the province has significantly decreased maternal deaths by half. This accomplishment is attributed to the good seeking behavior of pregnant women who have been accessing the services of skilled birth attendants (SBA). The SBA increased from 71% in 2006 to 78% in 2009. Although the increased SBA connotes higher trust in health service providers, facility based deliveries (FBD) is still low. The 2009 data shows that 70% of deliveries are still home based deliveries. The cultural and traditional practice of delivering at home still prevails. The Municipality of Gattaran achieved the national standard for facility-based deliveries - from 23% in 2007; the proportion significantly rose to 76% in 2008. In Solana, a women's health team has been organized. It is also in Solana that there is a standby ambulance/vehicle and personnel on-call for 24 hours to bring a mother about to give birth to the nearest health facility. This strategy contributed to the improved accomplishment in facility based delivery from 8% in 2007 to 23% in 2008. The presence of a Pregnancy Watch Board that is regularly updated is the strategy employed by certain municipalities to keep track and monitor the condition of pregnant women in the LGU. This was done in Gattaran and is successfully replicated in Tuguegarao City. There are 20 birthing clinics spread across the province. The facility in Sto. Niño is a BEmONC facility while Sta. Praxedes is the lone PhilHealth MCP-accredited facility in the province.

Contraceptive prevalence rate declined from 45% in 2006 to 42% in 2007 but increased to 46% in 2008 and 49% in 2009. Eleven (11) LGUs attained CPR over 60%. The increase in performance is attributed to the availability of commodities from UNFPA through the League of Municipalities of the Philippines and the active campaign of health workers on the importance of birth spacing and family planning. In 2006, total MLGU expenditure for contraceptives was P903, 814 by 14 municipalities. In 2007, 12 municipal LGUs had a budget for contraceptives (Pills and DMPA vials) with an aggregate total of P2.1 million. At the provincial level, the Governor has approved the budget of more than P400, 000 for FP advocacy under the PPO Budget. The PHO was able to include in its budget P250, 000 for the procurement of FP commodities. Despite these efforts, there remains inadequate supply of FP commodities as most LGU funds are prioritized for other programs. The MNCHN grant from the DOH amounting to P3.2 million was used by the province to procure FP commodities and these were distributed to all the LGUs based on the distribution scheme recommended by the AMHOP.

In terms of child care indicators, the data on Fully Immunized Child (FIC) shows fluctuating trends. Moreover, from 2006 to 2009, FIC is always below the national standard of 95%. The difference ranged between 11-19% points. For Vitamin A, the province has 73% coverage in

2006 and 76% in 2009 registering a 3% point increase. Again, the vitamin A coverage (VAC) did not meet the national standard of 95%, despite the commendable "*ligtas buntis*" program of the province. It was observed that "*ligtas buntis"* or pregnancy watch board was not maximized by VAC. In fact, babies of expectant mothers included in the pregnancy watch board were not recipients of Vitamin A. It is evident that Maternal Neonatal Child Health and Nutrition program is not taken on its entirety but on a per program basis. The direct connection of the programs to one another is not yet defined resulting to non-continuity of health services from mother and child. As a result, there were quite a number of missed opportunities in the delivery of public health services to both mother and child. This may also be the reason why infant mortality rate (IMR) remains high. The data show fluctuating trends with the latest rising from 4.66 per 1000 live births in 2008 to 5.49 per 1000 live births in 2009.

The implementation of the Tuberculosis Control and Prevention Program in the province slightly improved with CDR at 67% and CR at 85% in 2009. TB ranks ninth among the leading causes of mortality in the province. There are only 6 (of the 31 RHU facilities) TB DOTS accredited facilities. The table below further illustrates the trends in selected health indicators.

**Table 1. Selected health indicators (2006- 2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 45 | 42 | 46 | 49 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 60 | 48 | 66 | 69 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 74 | 72 | 75 | 76 | 80 |
| 4 | Percent of Facility-based Deliveries | 24 | 23 | 26 | 31 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 74 | 81 | 78 | 81 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 84 | 78 | 76 | 79 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 73 | 71 | 72 | 76 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 24 | 22 | 23 | 100 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 96 | 92 | 99 | 100 | 100 |
| 10 | Case Detection Rate (per 100,000 population) | 71 | 65 | 65 | 67 | 70 |
| 11 | Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 105 | 101 | 88 | 89 | 99 |
| 12 | Cure Rate | 86 | 85 | 85 | 85 | 85 |

**The response: TA interventions and results**

Presented with the health situation, HealthGov's TA interventions focused on strengthening financing and governance to be able to support the continuous delivery of health services. The maternal health situation was addressed by building the capacities of the health workers to provide quality health care services to clients. Likewise, commodities were made available through access to financing scheme outside of IRA.

The CHD with the support of the project conducted the first batch of FPCBT comprised of 30 service providers from 10 LGUs. The health workers trained plan to echo the training to other health workers in their respective RHUs during their regular staff meeting to be able to improve access to FP services for clients with unmet needs on FP. The project, in partnership with the CHD and PHO also facilitated the training in DSSM of 13 microscopists to help the RHUs improve their TB case detection. Technical assistance was also provided in the conduct of TB Rapid Appraisal in three LGUs which led to the development of action plans to improve TB implementation in these municipalities.

In addition, HealthGov facilitated the training of 10 CHD/MHO/Provincial Veterinary Office (PVO) staff in AI and provided hands-on TA to two *barangays* of Aparri in CBEWS installation. The training included the development of community AI action plans. As a result, the *Barangay* Captain of Bukig, Aparri issued an EO creating its *Barangay* AI Task Force. A few months after the CBEWS installation, the monitoring team, composed of the PVO, Municipal Government of Aparri, and HealthGov, acknowledged the efforts of the *Barangay* AI Task Force in tracking and tracing of persons infected with flu virus as an early warning system for AH1N1 in the *barangay.*

The FP integration into EPI and Post Partum Services and Maximizing Utilization of existing MNCHN Services was modeled in Penablanca last March. The action points formulated by the municipal health office are now being implemented in the RHUs of the municipality. To track its implementation, the FP-EPI monitoring tool was collaboratively developed by MHO, DOH Reps and HealthGov. The tool was used in monitoring the implementation of the initiative and showed that from the 409 client counseled on FP, 99 (25%) registered as new FP acceptors. The monitoring visits also surfaced the need to add other variables in the monitoring such as current users, type of FP of choice by current and new FP users. Likewise, the TCL should be updated every month. The tool is currently undergoing revision/modification.

HealthGov also assisted the province to access the PhP1.8M grant from the DOH, which was utilized to purchase FP commodities. These commodities were distributed to the different LGUs in the province. Discussions with and orientation of the PHO on the grant helped in ensuring the LGU purchase of commodities. Similarly, the requirements for domains 2 and 3 for the 2009 MNCHN grant had been completed and are now with the finance people (budget officer and accountant) of the province for their signatures.

To help strengthen the management information system of the province, a core of trainers for Cagayan (composed of the regional FP/FHSIS coordinators, PHTL, DOH Reps and selected PHO technical staff-provincial FP/FHSIS coordinators) were trained in FP Current User Data Validation. Likewise, the PHN and the RHM of all the RHUs of Cagayan were also trained. Didactic and hands-on sessions on FP data cleaning (using the self assessment tool and review of TCLs) and FP commodity forecasting were conducted. The FP data cleaning at the LGU level are on-going. There were 2 municipalities that completed FPCU data cleaning FP commodity re-forecasting.

The technical assistance extended to the province resulted in the completion of the PIPH and 28 municipal investment plans for health. The formulation of the PIPH enabled the province and its component LGUs to come together, assess their current situation and draft a 5-year plan for health. The PIPH identified critical interventions that the province needs to implement to achieve MDG and attain better health outcomes. Resource requirements have been identified to fund the interventions, though LGU commitments have not yet been finalized. The PIPH and MIPH made possible the allocation of resources by the province and the municipalities for the implementation of health services, including the improvement of RHUs and hospital facilities. These documents

also served as guide to LCEs and policy and development planners in developing and implementing health programs focusing on reforms in the next five years. The PIPH was presented for JAC review in September 2009 and was concurred with minor revisions. The 2009 and 2010 AOPs had been approved by JAC.

In preparation to the 2011 AOP, HealthGov collaborated with CHD2-F1 team and provided training in the SDIR process and tools to the forty (40) DOH Reps identified facilitators. The facilitators trained will lead the municipal F1 internal reviews or the MF1IR in every municipality of the province. Likewise, to better support the undertaking, HealthGov together with CHD2 conducted a one-day orientation to all MHO (29 MHOs) on MF1IR/internal assessment of health program implementation. The activity equipped the MHOs with appropriate knowledge and skills to assess their health situation and formulate respective acceleration plans to respond to their health needs/gaps to ultimately achieve better health outcomes. The internal assessments had been completed and the draft acceleration plans will be used in the province wide SDIR/RF1IR.

**Remaining gaps and challenges**

A review of the performance of the province for the last four years showed the following gaps:

- Poor health information system. Data varies as per data source. The TCL is not regularly updated and validated. Reports still include clients that may need to be weeded out. There is a need to do data quality check to be able to determine actual performance. Other factors include underreporting and poor recording. The PHNs are unable to supervise properly the midwives and are unable to do regular monitoring. There is also a problem on the understanding of the formula for computing the accomplishments. Late submission of reports by the MLGUs to the province has also been a perennial problem. Tuguegarao City, on the other hand, does not submit reports to the province in the past, thus, provincial data does not include the city, which approximately accounts for 15% of the population. It was only on the second quarter of 2010 that that Tuguegarao submitted its report to the province.

- Lack of drugs, medicines, and supplies. With the phase-out of donated FP commodities, not all LGUs are able to procure regularly. Add to this the non-regular procurement of other essential drugs and medicines. The province, with its limited budget, is also unable to augment completely the logistic needs of the LGUs. Supply for Vitamin A and Iron remains insufficient. Stock outs have been noted in some municipalities. Some municipalities procured TB drugs but this is not sustained.

- Ill-equipped health facilities. Of the 31 RHUs, only one is MCP-accredited and six are TB DOTS-accredited.

- Limited outreach activities due to lack of health manpower and logistics.

**Year 5 priority interventions and expected results**

The LGUs have limited financial resources allocated for health, and thus need to efficiently manage these resources to improve health outcomes. To ensure that appropriations are properly utilized, it is necessary to make LGU resources more focused and efficient. In the same manner, the Year 5 technical assistance to the province will be purposive to the priority TA needs warranted by the province.

HealthGov will work with CHD2 in providing the technical assistance requirements of the province. To achieve wider scope at the shortest possible time, teams of trainers will be capacitated on specific TA packages (i.e. FHSIS data cleaning, SIMS, etc.) to be able to download to the M/CLGUs. Regular feedback meetings will be conducted to know the progress and identify measures for implementation gaps. To better appreciate the TA interventions, demonstration sites/LGUs will be selected to model the TA interventions. The CHD and PHO will implement/roll these to other LGUs.

HealthGov will likewise provide technical assistance in improving service delivery through the following:

- Support to improving service delivery in family health

  - CSR+ planning, CSR+ policy development;
  - Enhanced support to the Integration of FP into EPI, post-partum FP, and maximizing utilization of MNCHN services; and social mobilization for MNCHN;
  - Established provincial database on service providers capability profile
  - ICV compliance monitoring

B. Strengthening family health program support through financing and governance

- Support to improving the management information system of the province through quality data check of FP/MNCHN data/indicators as bases for sound decisions and interventions;
- Accessing and managing DOH MNCHN grants facility;
- Capacity building of LGUs on NHIP benefit delivery rate approach and monitoring of facilities accreditation;
- Training of health workers to install and use FPCMS and SIMS
- Presentation of priority PPAs to NEOs.

The TA interventions will contribute in achieving better health outcomes. Specifically, the following will be accomplished:

- PIPH/AOP integrated in LGU planning process (PIPH to CDP; AOP to CDP/AIP)
- CSR plan approved for implementation
- Improved data management system through regular cleaning/updating of FP/MCHN data and analysis of data generated using SDIR tools
- FP commodity monitoring system installed
- Access and utilization of external funds for health care
- Continuing delivery of quality health care through trained health workers

**Priority TA Interventions and Activities**
**CAGAYAN**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, monitoring and evaluation) | 1.1Cb | Quality of FP current users data derived from FHSIS checked and vaildated for accuracy in collection, computation and reporting | Monitor data quality check for FP current users at the LGU level to be conducted by trained DOH and PHO staff | Coach PHO/PHTL/DOH Reps/MHOs | **M17 C1** | **M11** | | | | | | | | | | | | 28 | 1 |
| | | Action plan to conduct the CSR+ planning<br><br>CSR+ TWG organized | Provincial orientation cum planning on CSR+ assessment, planning and implementation including data quiality check (PHO, PHTO, AMHOP and NGO) | Resource person, facilitator | | | | | | | | | | | | | | | |
| | 1.1B.a | Provincial CSR+ plan formulated | CSR planning workshop and output integration into AOP | Resource person and facilitator | | | **P1** | | | | | | | | | | 1 | | |
| | 1.1B.d (1.1F.b) | CSR+ policy approved | Monitor the CSR+ plan implementation/policy approval | Monitoring/coaching | | | | | **P1 M9 C1** | | | | | | | | 1 | 9 | 1 |
| 2. Integration of FP into EPI, post-partum FP, and maximizing utilization of MNCHN services; and social mobilization for MNCHN | | Progress report and documentation | Monthly monitoring of the implementation of key actions points on integration of FP/EPI, Postpartum FP (Penablanca) | Coaching | **M1** | | | | | | | | | | | | | | |
| | 1.3Ad | Service providers trained in integration of FP/EPI and maximizing utilization of MNCHN services<br><br>Action points to implement FP into EPI and maximizing utilization of MNCHN services | Monitor the roll-out training in integration of FP into EPI and maximizing utilization of MNCHN services in Lallo ILHZ | Resource person<br><br>Coach PHO/PHTL | **P1 M2** | **M3** | | | | | | | | | | | 1 | 5 | |
| | 1.4C.c | LGU-NGOs/CSOs partnership established for planning, budgeting, implementation, monitoring, policy | One day advocacy and consultation meeting with public-private providers on FP/MNCHN within Lallo ILHZ (MHOs/DOH Reps and heads of public/private FP and MNCHN providers and facilities, including birthing and designated BEmONC/CEmONC facilities) | Meeting design, Resource person, facilitator<br><br>Coach PHO | | | **C5** | | | | | | | | | | | 5 | |
| 3. Capacity building acivities on FP, TB and MNCHN | 1.3A.d | Database on service providers' capability profile established | Updating of human resource capability profile | Training modules, resource person/facilitator | **P1** | | | | | | | | | | | | 1 | | |
| 4. ICV compliance monitoring | 1.3D.b | Local action plan for ICV compliance monitoring | Consultative meeting with PHO and PHTO to formulate province-wide action plan for ICV monitoring and reporting compliance of LGUs | Resource person and facilitator | | **P1** | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.3D c | ICV compliance of FP/RH service delivery sites monitored and reported | Quarterly meetings with PHO, PHTO to discuss results of ICV compliance monitoring (integrated in other meetings with the PHO) | Monitoring and coaching | | M9 C1 | | M10 | | M9 | | | | | | | 1 | 28 | 1 |
| **II. Strengthening family health program support: financing, policy, and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on benefit delivery approach | 1.2B.a | TOT in local NHIP implementation conducted | Orientation of provincial TWG for NHIP (including PHO/NHIP point person/ coordinator) on NHIP benefit delivery approach | Resource person<br><br>Guide in preparing report | | | | | P1 | | | | | | | | 1 | | |
| | 1.2B.b | Local NHIP implementation plan prepared/updated | Formulation of local NHIP implementation plans | | | | | | | | | | P1 M28 C1 | | | | 1 | 28 | 1 |
| | 1.2 C.a | Application for accreditation filed (renewal for OPB and TB DOTS and new application for MCP) | Coach MHOs in completing the documentary requirements of PhilHealth accreditation of RHU for MCP and renewal for OPB and TB DOTS | Facilitator<br><br>Coach PHO during meeting with MHOs | | M5 | | | | | | | | | | | | 5 | |
| | 1.2 C.b | Facilities accredited by PhilHealth (for OPB, TB DOTS and MCP) | Facilitate coordination with PHIC and MHOs to fast track MCP accreditation and renewal | Coach, facilitator | | M5 | | | | | | | | | | | | 5 | |
| 2. Accessing and managing DOH MNCHN grants facility | 1.2A.b | MNCHN grant accessed | LGU orientation and planning to access the 2009 and 2010 MNCHN grant facility (Provincial LFC, MHOs and LFCs)<br><br>Monitor the completion of requirements to access MNCHN grant, implementation and utilization of the MNCHN grant | Resource person and facilitator<br><br>Monitoring and coaching | | | P1 M28 C1 | | | | | | | | | | 1 | 28 | 1 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Coordinate with DOH on the conduct of training in FPCMS for MHOs/PHNs | Coach CHD/PHO trainer | | | P1 | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring too | Monitor implementation of FPCMS | Coach PHO/PHTL | | | | P1 M28 C1 | M10 | M10 | | | | | | | 1 | 28 | 1 |
| | 1.1E.c | TOT in stocks and inventory management system (SIMS) conducted | - Training of LGU health personnel in SIMS | Support CHD/PHO/PHTL | | | | | P1 | | | | | | | | 1 | | |
| | 1.1E.d | Inventory management tool for essential drugs and commodities adopted | - On-site visits to selected LGUs to monitor progress of application | Coach | | | | | | | M28 C1 | | | | | | | 28 | 1 |
| **C. Advocacy to newly-elected local officials (NEOs)** | 1.4B.c | Priority PPAs presented to NEOs | Coordinative meetings with DILG to integrate PIPH in CDP especially Family Health Programs and PHIC<br><br>Meetings with the PHO, PPDO to finalize list of priority PPAs and advocacy to PPDO for its inclusion to AIP 2011 | | P1 | | | | | | | | | | | | 1 | | |

## Isabela

The province of Isabela is the most populous province in Northern Luzon with a total population of 1,511,400 as of 2009 and the second largest province in the Philippines with a total land area of 10,665, square kilometer, which comprises 31% of the Philippine territory. It is a first class province composed of 35 municipalities, 2 cities (1 independent and 1 component), and 1,055 *barangays* within its 4 congressional districts.

**The health situation: trends in SO3 indicators**

The performance of the province of Isabela in maternal, family planning, child care and TB prevention and control is mixed with progress made in some indicators and a noted decline in other indicators for selected programs (See Table 1).

In terms of maternal and newborn health, all three indicators: percent of pregnant women with at least four ANC, percent of births attended by SBA, and percent of FBD improved from 2006 to 2009. However, all indicators remained below the national standards. In general, there is still a strong preference for home deliveries because of the following: a) poor awareness among clients about the importance of delivering in facilities; b) limited number of birthing facilities; c) absence of a CEmONC-accredited facility ready to respond to emergency cases; d) inadequate training of personnel on recommended skills such as Life-Saving Skills and Obstetric Emergencies for BEmONC facilities; e) poor tracking of early pregnancies by midwives; f) weak LCE support in equipping and upgrading health facilities to become MCP-accredited facilities; and g) no supportive policy for facility-based delivery among the 36 MLGUs.

Likewise, the CPR has been fluctuating from 51 to 52 for the period 2006-2009 with the rate remaining at 52%. The 2009 CPR, however, is higher compared to the FHSIS average of 36% but it is still 12 percentage points short of the MDG target of 64. The PHO remains firm on her stand to promote only NFP and the province has not procured any FP commodities. The finding of the on-going FP-current users (FPCU) data cleaning pointed to a decrease in FP CU that would correspondingly decrease the CPR. It was observed that women beyond 49 years of age and mothers practicing LAM even beyond the prescribed period are still included in the FP CU. Compounding this is the unreported FPCU getting FP services/commodities from private sectors.

All indicators improved for child health and nutrition. The most notable improvement is on the cases of child pneumonia treated with antibiotics and diarrhea cases treated with ORT which reached the national standard at 100% in 2009. DPT3 coverage is lower than the FIC coverage putting the indicators in question. There is a need to conduct data quality check because of the wide variation (6-16 percentage point difference) between these DPT3 and FIC performance indicators. Some contributory factors to the low FIC and VAC performance are inadequate budget allotment for child health, irregular interventions provided by the health providers in preventing potential dropouts and inadequate education and information on the importance of immunization of mothers. Lack of manpower, weak supervision and monitoring, lack of knowledge and skills among staff especially the newly hired ones, low staff morale, limited staff mobility because of absence of traveling allowance and transportation to conduct REB hampers the identification of the marginalized and location of missed children by the RHU staff. The proportion of under-5 year old children given Vitamin A slightly increased from 82% in 2008 to 83% in 2009. The performance is still below the national standard of 95.

TB remains to be the sixth leading cause of death in the province. The case notification rate had been fluctuating for the past 4 years. A 5 point percent increase was noted in CNR from 84 per 100,000 in 2006 to 89 per 100,000 in 2009. The CDR also registered a 5 point percent increase from 56 per 100,000 in 2006 to 61 per 100,000 in 2009. The CR has also been fluctuating with a 2 point percent decrease from 87 per 100,000 in 2006 to 85 per 100,000 in 2009. The low performance in TB can be attributed to the following: a) TB program is not a priority program of the LGU; b) lack of commitment of some health workers due to lack of recognition and incentives from the LGU; c) untrained new health workers on TB DOTS; d) work overload due to lack of manpower/13 RHUs without medical technologists/fast turnover of staff; e) inadequate monitoring and supervision at the *barangay* level; f) new BHWs as treatment partners are not oriented on the NTP policies and guidelines; g) lack of staff training, h) lack of IEC, and i) interrupted supply of drugs, reagents, and cups. From the 39 RHUs, there are only 17 TBDOTS (43%) accredited health facilities.

**Table 1. Selected health indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 51 | 52 | 51 | 52 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 67 | 65 | 69 | 71 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 80 | 82 | 83 | 83 | 80 |
| 4 | Percent of Facility-based Deliveries | 18 | 15 | 22 | 27 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 86 | 70 | 71 | 74 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 80 | 86 | 79 | 81 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 83 | 82 | 82 | 83 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 42 | 41 | 41 | 100 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 80 | 99 | 100 | 100 | 100 |
| 10 | Case Detection Rate (per 100,000 population) | 56 | 59 | 59 | 61 | 70 |
| 11 | Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 84 | 94 | 87 | 89 | 99 |
| 12 | Cure Rate | 87 | 81 | 84 | 85 | 85 |

### The response: TA interventions and results

For the period of four years, the project supported the province of Isabela in implementing local health sector reforms focused on the four reform areas: service delivery, financing, regulation, and governance. The significant technical assistance of HealthGov and results to date in collaboration and partnership with the PHO/LGUs, CHD and DOH Reps are the following:

The technical assistance provided by HealthGov in support of service delivery resulted in 26 key health personnel trained in FPCBT, 10 in Life Saving Skills, 30 in TB DOTS, and 10 in DSSM and other health interventions. AI-CBEWS training for two pilot municipalities: Cauayan and Cabagan have also been completed. A TB Rapid Appraisal and planning was facilitated for health service providers of the identified three low-performing MLGUs (Alicia, Echague, and

Jones) while the integration of FP into EPI and postpartum services were implemented in Benito Soliven.

A core of trainers from the province participated in the Training of Trainers for data cleaning of the FP current users. The province has started to roll-out data cleaning and has completed cleaning the FP current users data in 4 LGUs (Cauayan City, Santiago City, Maconacon and Divilacan). Likewise, FP commodity forecasting was also taught to the LGU nurses and midwives.

A major health reform initiative in the area of health care financing is the province's efforts on the enrolment of the poor under PhilHealth Sponsored Program within the first term of its new governor. In 2007, the province allotted about P45 million to cover the premium subsidies of the estimated number of enrolment by the provincial government, municipal LGUs and congressional sponsorship at 155,246 families or 242% of the estimated number of indigents. This means that even the non-poor have been enrolled in the PhilHealth Sponsored Program and thus duplication of enrollment of the poor families occurred. Hence, technical assistance in client segmentation through CHLSS orientation was provided which resulted in the drafting of the province-wide CHLSS implementation plan and in finalizing the CHLSS survey instrument. However, after some time, the governor opted to put on-hold all of the CHLSS-related activities until after May 10 election as these may be misconstrued as election-related activities.

Special arrangements were made with PhilHealth on the capitation fund received from the Sponsored Program wherein the referral facilities for the indigents enrolled by the province are the district and provincial hospitals. Thus, capitation funds were funneled to the provincial and district hospitals.

In terms of health facilities accreditation with PHIC, 4 RHUs are now accredited for MCP, 17 for TB DOTS and 16 for OPB. As a result of the facility rationalization plan, 4 RHUs plan to establish birthing centers while 18 LGUs plan to avail of the 3 in 1 accreditation with PhilHealth.`

Technical assistance was also provided to the province in accessing the MNCHN grant (orientation and MOA signing) and preparing the grant utilization plan. The province has received 3.1 M and has opted to use the fund grant for training of health workers and for purchase of obstetric equipment for RHUs. With the assistance of HealthGov, the province of Isabela was able to access the 2008 FP/MNCHN grant. The project assisted the province in completing the documentary requirements to facilitate the release of the grant fund. For the 2009 MNCHN grant, the province encountered difficulty in having the Governor sign the SLA. The SLA will now be signed by the new Governor.

In support to improving the health planning system, HealthGov assisted the province in the preparation and finalization of their annual operation plans. HealthGov assisted the province in finalizing their 2009 AOP. The conduct of SDIR will include concerns related to PhilHealth enrolment and client utilization. The 2010 AOP has been submitted to CHD2 for approval. Eighteen (18) municipalities were assisted in completing their respective 2010 AOPs. Preparations for 2011 AOP had been initiated. Internal assessments had been completed which resulted in 34 (out of the 37) LGUs with 2011 acceleration plans. The 2011 province wide SDIR and AOP had also been completed. The provincial and municipal AOPs are now being consolidated and finalized.

For effective advocacy and partnership building, HealthGov supported the profiling of CSOs/NGOs and LHBs both in the province and municipalities. The CSO/NGO forum on HSR

conducted in Year 2 was participated in by about 25 organizations with orientation sessions on the HSR/F1 framework and illustrations on the provincial health situation. Six of the CSOs/NGOs members met with the Provincial Health Board as formalized by an Executive Order. The PHB members were oriented on their roles and functions in terms of policymaking and direction setting.

**Remaining gaps and challenges**

Though maternal health indicators are improving, there are still inadequate maternal and child health facilities in the province that are accessible to clients. Most of these are not yet MCP-accredited thus unqualified to avail of PhilHealth maternal benefit fund reimbursements. LGUs also are passive in supporting the upgrading of their facilities to be accredited as BEmONC, TB DOTS, MCP, and OPB.

Making the situation even worse is the apparent biases of provincial leaders against modern artificial methods of family planning. Their strong preference on NFP blocks support to the procurement of artificial FP commodities regardless of the source of funds (including the MNCHN grant). Records also show that almost half of the LGUs have allotted inadequate budget to fund MNCHN programs.

There is also a lack of appreciation on the part of health providers on the importance of recording and reporting accurate data. These were reflected in the submission of incomplete, invalidated, and unanalyzed data. This was exacerbated by the presence of untrained health providers, specifically on LSS, FP-CBT, NSV and BTL.

**Year 5 priority interventions and expected results**

HealthGov will continue providing technical assistance to the province of Isabela to strengthen and improve key LGU health systems based on the priority TA packages to accelerate improvements. These packages of technical assistance will be anchored on the provincial handle, “Improving Health Outcomes through Strategic MNCHN Interventions.”

To achieve this, HealthGov’s technical assistance in year 5 will focus on:

A. Support to improving service delivery in family health

- CSR plan updating and FP commodity forecasting in all LGUs
- FP current users data validation/cleaning in all LGUs
- Utilization of commodity forecasts in SDIR and AOP preparation
- Modeling of integration of FP in EPI and maximizing use of MCH services and mapping of existing providers and facilities
- Establish database of service providers capability profile using SDIR results
- Local action planning for ICV compliance monitoring

B. Strengthening family health program support: financing, policy and governance

- Orientation of MHOs on the BDR approach with emphasis on accreditation, claims and fund management
- Accreditation of health facilities for OPB, MCP and TB DOTS

- Continuing technical assistance to the province in completing requirements to access MNCHN grant for 2009 and 2010 including development of guidelines in the allocation and utilization of the grant at the province and LGU levels
- FHSIS data quality check for FP/MNCHN indicators in all LGUs as inputs for SDIR and AOP formulation
- TOT of PHO logistics management team on FPCMS and tracking of action plan implementation of FPCMS
- Priority PPAs presented to NEOs

At the end of Year 5, HealthGov's technical assistance packages are expected to achieve the following milestones and results:

- LGUs with cleaned and updated FP current users
- LGUs with FP commodity forecasts as inputs in SDIR/AOP
- 15 LGUs with map of existing providers / facilitators and key action points for integrating FP in EPI and postpartum FP and maximizing use of MNCHN services
- 1 ICV provincial team formed and monitoring plan formulated
- ICV monitoring report for 37 LGUs
- 37 LGUs accessing external financing for health outside IRA; MNCHN grant accessed and utilized
- 37 LGUs/MHOs trained and implementing FP commodity management system
- Provincial NHIP / PHIC action plan for accreditation and enrolment of indigent families formulated
- 13 RHUs PhilHealth MCP accredited
- Health personnel trained in FHSIS data cleaning
- MNCHN (FHSIS) data validated and cleaned

**Priority TA Interventions and Activities**
**ISABELA**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN Strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy and monitoring and evaluation), in collaboration with other CAs | 1.1C.d | Personnel trained in data custody of health-related data (e.g. FHSIS DQC) used for planning and decision-making | Meeting, orientation and planning with PHO/PHTL on data quality check of FP current users and its roll-out to C/MLGUs<br><br>Training of CHOs/MHOs/PHNs in FP data quality check and in forecasting | Resource person<br><br>Coach | **P1 C2** | | | | | | | | | | | | 1 | | 2 |
| | 1.1Cb | Quality of FP current users derived from FHSIS checked and validated for accuracy in collection, computation and reporting | Monitoring and coaching in the conduct of DQC of FP current users | Coach | | **P1 C2** | | | | | | | | | | | 1 | | 2 |
| | 1.1B.b (1.1C.a) | CSR+ plan updated (forecasting requirements updated using clean FP CU data) | CSR+ plan updating using cleaned data (reforecasted CSR+ requirements will be used in AOP/AIP) | Resource person/coach | | | **P1** | | | | | | | | | | 1 | | |
| 2. Integration of FP into EPI and maximizing utilization of MNCHN services, and social mobilization for Vitamin A and EPI, in collaboration with HealthPRO and A2Z | 1.3Ad | Service providers trained in integration of FP/EPI and maximizing utilization of MNCHN services | Orientation training cum planning for PHO technical staff, PHTO (PHTL and DOH Reps), and for MHOs on integrating FP to EPI and maximizing utilization of existing MNCHN services and facilities | Resource person/facilitators | **P1 M6** | | | | | | | | | | | | 1 | 6 | |
| 3. Capacity-building of FP/MNCHN providers | 1.3A.a | Database on service providers' capability profile established | Consultation meeting with PHTO/PHO on the need to establish a database of health human resource capability profile using SDIR data<br><br>Review and schedule of training in FP/MNCHN | Coach, design | **P1** | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 4. ICV compliance and monitoring | 1.3D.b | Local action plan for ICV compliance monitoring | Consultative meeting with PHO and PHTO to formulate province-wide action plan for ICV monitoring and reporting compliance of LGUs | Facilitator, resource person | | **P1** | | | | | | | | | | | 1 | | |
| | 1.3D c | ICV compliance of FP/RH service delivery sites monitored and reported | Meetings with PHO, PHTO to discuss results of ICV compliance monitoring (integrated in other meetings with the PHO) | Resource person, mentoring and coaching, monitoring tool, reporting forms | | **M12** | | **M11 C2** | | **M12** | | | | | | | | 35 | 2 |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on benefit delivery approach | 1.2C.a | Application for accreditation filed (renewal for OPB and TB DOTS and new application for MCP) | - Assist PHO in coaching the MHOs to complete the documentary requirements of PhilHealth accreditation of RHU for MCP and renewal for OPB and TB DOTS | Facilitator | | **M7** | | | | | | | | | | | | 7 | |
| | 1.2C.b | Facilities accredited by PhilHealth (for OPB, TB DOTS and MCP) | Facilitate coordination with PHIC and MHOs to fast track MCP accreditation and renewal of 7 LGUs in Roxas ILHZ | Coach, facilitator | | | | **M7** | | | | | | | | | | 7 | |
| 2. Accessing and managing DOH MNCHN grant | 1.2A.b | MNCHN grant accessed by LGUs | Orientation on the 2010 MNCHN grant facility<br><br>Monitor the completion of MNCHN grant facility requirements, implementation and utilization | Support resource person, facilitator<br><br>Technical guidance as resource person | **P1** | **M25** | | **M10 C2** | | | | | | | | | 1 | 35 | 2 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | TOT of PHO logistics management team | | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitor implementation of FPCMS | | | | **M20** | | | **M15 C1** | | | | | | | 1 | 35 | 1 |
| **C. Advocacy to newly-elected local officials (NEOs)** | 1.4B.c | Priority PPAs presented to NEOs | Continuing discussion with DILG on integration of health in CDP<br><br>Meetings with the PHO, PPDO to finalize list of priority PPAs and advocacy to NEO for its inclusion to AIP 2011 | Resource person and facilitator; advocacy materials | **P1** | | | | | | | | | | | | 1 | | |

## Nueva Ecija

Nueva Ecija is a first class province located in Central Luzon Region (Region 3) composed of 849 barangays, 27 municipalities and 5 cities grouped into 4 congressional districts. Based on 2000 census, the projected population for 2010 is 1,969,100. The total number of households in 2000 was 340,158 with each household having five members on the average, meaning that the province accounts for some 21 percent of the total number of families in Central Luzon.

**The health situation: trends in SO3 indicators**

The health situation in Nueva Ecija showed increasing trends in maternal care (increased ANC. SBD, FBD) and child care (FIC, VAC, diarrhea cases treated with ORT, and pneumonia cases treated with antibiotics) performance indicators although still below the national targets. This is largely because of poor health facilities, inadequate supply of drugs and medicines, fast turn-over of health workers and a fragmented health service delivery system caused by partisan politics. LCEs also showed low support to reproductive health programs which included supplies and activities for prenatal services, facility-based deliveries, postpartum care, and support to MCP accreditation of birthing facilities. There were also insufficient medical supplies for the administration of EPI services which indirectly affected the indicators for fully immunized children.

The antenatal care shows a 33 percentage point improvement from 2008 to 2009. But despite the improvement, there were six (6) maternal deaths reported all occurring in hospitals. Taking into consideration that there is no maternal death reporting system to review and report maternal deaths in the province, the data may still be under reported. Although facility based deliveries are in the upward trend, pregnant women preferred to deliver at home often assisted by health professionals and skilled birth attendants due to poor access and high cost of deliveries in health facilities.

The CPR data fluctuated from 2006-2009. The three (3) point percentage increase from 2006 to 2009 (33% to 36%) is still questionable because of the FP current users data cleaning/validation results which showed a decrease in FP current users and CPR by almost 50% after data cleaning. In the data cleaning conducted in San Jose Nueva Ecija alone, the CPR decreased from 91 to 59 percent. The province has completed FP current users data cleaning in all 28 RHUs. The summary results are being consolidated to date.

Similarly, the child health indicators showed increasing coverage but still below national benchmarks. The following factors contributed to the low FIC coverage: a) inability of health workers to cover geographically isolated *barangays* contributing to the high number of missed children in EPI; b) lack of logistical support during tracking of defaulters; c) inadequate medical supplies to support the administration of EPI; and, d) lack of EPI program monitoring. There is also an inconsistency in the DPT3 and FIC data of 2009. The DPT coverage is lower by 2 point percentage than the FIC coverage. There is a need to conduct data quality check because of the variation between these two performance indicators.

In TB, the low TB cure rate was due to the high number of defaulters, deaths and transferred-out patients and poor patient follow-up for sputum examinations. The PHO and RHUs lack the capacity to analyze TB program data for planning and advocacy for support, monitoring and supervision. There are also no policies supportive of TB prevention such LGU support for mobilization of treatment partners and community smearing sites for case finding. The TB program in the province is however, supported by a functional provincial external quality

assessment system, adequate TB data banking due to electronic TB register and adequate supply and distribution of CAT I and CAT II drugs.

Summing up, the major reasons for not meeting the national benchmarks are the following: lack of information and dissemination activities to increase awareness and information of the community on MNCHN and TB activities and the need to conduct BCC activities to influence the community to avail of RHU health services and programs; lack of referral system in medical, obstetrical, and surgical emergencies between health facilities, and in public health programs between referral hospitals and RHUs using the inter-local health zones; and poor monitoring and supervision of PHO and PHTO program managers which reflect weak managerial skills and insufficient technical competencies of rural health personnel as implementers and main providers of health programs. This was compounded by a low enrollment among indigent families in PhilHealth and most facilities are not accredited for PhilHealth packages such as OPB, MCP, and TB DOTS.

On the point of view of governance, the problem is on the absence of policies and resolutions in support of child immunization, facility-based deliveries, and FP services. The monitoring and evaluation system in support of program implementation and PIPH/AOP implementation are not in place as well. There is limited and low budget allocation for health in almost all LGUs in the province. In addition, the supplies of affordable medicines are not readily available and accessible to the *barangay* level due to a small number of functional *BnBs*, with only 209 out of the targeted 338 *BnBs* established.

**Table1. Selected health indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 33 | 47 | 32 | 36 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 64 | 63 | 63 | 76 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 98 | 85 | 93 | 92 | 80 |
| 4 | Percent of Facility-based Deliveries | 10 | 22 | 25 | 55 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 83 | 79 | 86 | 86 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 77 | 75 | 80 | 88 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 82 | 77 | 81 | 93 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 36 | 42 | 39 | 41 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 100 | 96 | 76 | 90 | 100 |
| 10 | Case Detection Rate (per 100,000 population) | 69 | 58 | 50 | 81 | 76 |
| 11 | Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 69 | 73 | 60 | 108 | 99 |
| 12 | Cure Rate | 83 | 80 | 77 | 85 | 85 |

**The response: TA interventions and results**

In response to the health situation, the project focused its technical assistance on strengthening support to service delivery, governance and financing. The four years of implementation resulted in the following:

In improving service delivery, the project considered both the supply and demand interventions. On the supply side, the capacities of health workers were upgraded: FPCBT was conducted by DOH Central Office that included one participant from the PHO and rolled out to eight newly hired health workers coming from 5 LGUs; LSS training for 2 midwives in Ilocos Training and Medical Center on early recognition of obstetrical emergencies, suturing, IV insertions, and IE examinations; and PHN supervision training for 1 trainer and rolled out to PHO program managers and DOH Reps. The two midwives trained on LSS reported applying the newly acquired skills to pregnant clients particularly during deliveries. However, their facilities have not been MCP accredited as they still lack the standard physical lay-out as well as the equipment and medical supplies (i.e. delivery table, ambu bag, Kelly pad, oxygen tank/gauge, etc.) required by PhilHealth.

To ensure the reliability of FP current users' data, a training of trainers in FP current users' data quality check and updating was conducted to 21 health workers from Nueva Ecija. The training teams had initiated the data cleaning at the LGU level and had completed 18 MLGUs. The FP coordinator is consolidating the data findings to date.

HealthGov also assisted the province in accessing the 2008 MNCHN/FP performance awards amounting to PhP3.2M. The province has utilized the PhP2.8M for the purchase of FP commodities, Vitamin A, iron tablets, IEC materials, equipment, supplies and trainings.

Technical assistance was provided in capacitating the health providers in enhancing public health system reviews through the adoption of the SDIR tools and in the conduct of internal assessment at the RHU level, as well as the external assessment at the PHO and PHTO levels. HealthGov further provided technical support to the province in conducting SDIR in hospital setting. The assessments were jointly conducted by the CHD, PHO, and HealthGov. The outputs resulted in the formulation of acceleration plans for the health programs and were utilized in the formulation of PIPH. The annual operation plans for 2009 and 2010 had been JAC reviewed and approved and are now being implemented by the province.

**Remaining gaps and challenges**

The results of the technical assistance are promising but two major issues still need to be addressed. Foremost are the enormous data gaps in the FHSIS reports submitted by the municipalities. Most of the available data showed underreporting and reports from five (5) component cities were not completed/updated. Likewise, review of the municipal and provincial data showed inconsistencies in the different health program indicators. Data management was poor in RHUs and BHS levels. It was also apparent that program coordinators at the PHO and the PHNs at the different municipalities lack skills in information management (especially data analysis). Supervision in data collection and reporting to rural nurses and midwives as well as TCL checking and updating are no longer done. Another issue is the implementation of selective public health interventions to include access to and utilization of MNCHN grant to fill the gaps in FP and MCH service delivery.

**Year 5 priority interventions and expected results**

To address these gaps, Year 5 technical assistance will focus on the continuous generation of quality health data for effective decision making and interventions and securing financial support for the health programs from the provincial and city/municipal LGUs. The province will continue its FPCU data cleaning in all its C/MLGUs to ensure that the data used for forecasting are correct and reliable. The cleaned FP current users and FP commodity forecast will be used in the 2012 AOP preparation and formulation. Similarly, data quality check on the MNCHN data from FHSIS will also be conducted. A set of training teams composed of the PHTO/DOH Representatives and selected provincial coordinators (FP and MCH coordinators) will be trained to teach all the RHUs on the FHSIS – MNCHN DQC. The outputs of the DQC will be the bases for the 2012 AOP preparation/formulation.

The Year 5 technical assistance will also include enhancement of MNCHN activities such as integrating FP in EPI and maximizing MNCHN services, ICV compliance monitoring through trained DOH Reps, and access and utilization of MNCHN grant in support to MNCHN activities. The PHO and MHOs will also be coordinated to fast track accreditation of health facilities.

HealthGov will work through the Center for Health Development (CHD) in capacitating the province to be able to address its health gaps and concerns. Training of trainers consisting of PHTL, DOH Reps and selected PHO will be employed to cover more LGUs/RHUs more swiftly. To better appreciate the TA, modeling and demonstration sites will be used as showcases for the technical assistance/intervention provided. Advocacy meetings with CHD/province will be conducted to advocate for the engagement of LTAPs/STTAs by the CHD/province to download the technical assistance packages more quickly in more LGUs.

The technical assistance for Year 5 will strengthen the health information system so that the province can have accurate and reliable health data as the bases for sound decisions/actions and interventions. More importantly, the health interventions provided and accessed will be responsive to needs of clients.

Specifically, the major activities and expected results for Year 5 are summarized below:

A. Support to improving service delivery in family health

- Consolidation of the cleaned FPCU data and FP commodity forecast in all C/MLGUs for use in provincial 2012 AOP formulation
- Follow through on LGU CSR + Plan specifically on forecasting for Vitamin A, TB and FP using cleaned data (reforecasted CSR + requirements will be used in AOP/AIP )
- Orientation training and planning on Integrating FP to EPI and PP Services and Maximizing Utilization of Existing MNCHN Services and Facilities for RHU personnel (MHOs/RHPs, all PHNs and all RHMs including NGOs/CSOs) in 9 LGUs
- Consultation meeting with Public-Private health providers to establish referral mechanism and mobilization of communities to access MNCHN services
- Setting up the database on capability profile of service providers and implementation of AOP training plan
- Quarterly ICV compliance monitoring covering all LGUs
- LGU Orientation and planning to access the 2009 and 2010 MNCHN grant facility (Provincial LFC, MHOs and LFCs) and tracking of completion of requirements to access MNCHN grant and its utilization

B. Strengthening family health program support through financing and governance

- Meeting with MHOs to discuss completion of requirements for PhilHealth accreditation (OPB, MCP, TBDOTS)
- TOT in FPCMS and tracking of FPCMS in all C/MLGUs

At the end of Year 5, the following are the milestones which are expected to be achieved:

- RHUs trained in data custody of health-related data - FHSIS DQC used for planning and decision-making
- Quality of FP current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting
- Quality of other family health performance indicators derived from FHSIS (i.e., SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting
- Provincial CSR + plan (FP /MNCHN requirements updated)
- Providers trained in FP, FP-EPI integration and maximizing utilization of MNCHN services using training design
- Key action points in the implementation of integrating FP on MCH & maximizing utilization of MNCHN services in 8 priority LGUs developed
- Service providers of the 8 priority LGUs trained in Integration of FP/EPI and PP and maximizing utilization of MNCHN services;
- LGU-NGO/CSO partnerships established for planning and mobilization
- Provincial health human resource database set up
- ICV compliance of FP-RH service delivery sites monitored and reported
- LGUs accessed and utilized MNCHN grant

**Priority TA Interventions and Activities**
**NUEVA ECIJA**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN Strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy and monitoring and evaluation) | 1.1C d | Personnel trained in data custody of health-related data - FHSIS DQC used for planning and decision-making | Training of CHOs/MHOs/PHNs of the remaining 14 LGUs in FP data quality check and in forecasting of FP/MNCHN requirements | Resource Person | **P1 M14** | | | | | | | | | | | | 1 | 14 | |
| | 1.1C.b | Quality of FP current users data derived from FHSIS checked and vaildated for accuracy in collection, computation and reporting | Monitoring and coaching in the conduct of DQC and forecasting of FP/MNCHN requirements of priority LGUs | Resource person | **M3** | **M4** | **M1 C1** | | | | | | | | | | 1 | 14 | 1 |
| | 1.1B.b 1.1C.a | CSR+ plan (FP/MNCHN requirements) updated using clean FP CU data | Follow-through workshop on 9 LGU CSR+ plan specifically on forecasting for Vitamin A, TB and FP using cleaned data (reforecasted CSR+ requirements will be used in AOP/AIP) | Develop the design, resource person/facilitator, fund support | | **M4** | **M4 C1** | | | | | | | | | | | 8 | 1 |
| 2. Integration of FP into EPI and maximizing utilization of existing MNCHN services | 1.3A.d | Providers trained in FP/EPI integration and maximizing utilization of MNCHN services<br><br>Key action points in the implementation of integrating FP on MCH and maximizing utilization of MNCHN services in priority LGUs developed | Orientation training cum planning for PHO technical staff, PHTO (PHTL and DOH Reps), and MHOs in integrating FP to EPI and maximizing utilization of existing MNCHN services and facilities | Resource person/facilitators | **P1** | | | | | | | | | | | | 1 | | |
| | 1.3Ad | Service providers trained in Integration of FP/EPI and maximizing utilization of MNCHN services<br><br>Key action points on integrating FP in MCH and maximizing utilization of MNCHN services in priority LGUs developed | Conduct one-day orientation training and planning on integrating FP to EPI and maximizing utilization of existing MNCHN services and facilities for RHU personnel (MHOs/RHPs, all PHNs and all RHMs including NGOs/CSOs) in 9 LGUs | Resouce person/facilitators | **M4** | **M4 C1** | | | | | | | | | | | | 8 | 1 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.4C.b | LGU-NGOs/CSOs partnerships established for planning and mobilization | Consultation meeting with public-private health providers to establish referral mechanism and mobilization of communities to access MNCHN services | Coaching | | | **P1 M8 C1** | | | | | | | | | | 1 | 8 | 1 |
| 3. Capacity building activities on FP and MNCHN | 1.3A.a | Database on service providers' capability profile established | Consultative meeting with PHO/PHTO for database on capability profile of service providers and implementation of AOP training plan | Resource person and faciltator | | **P1** | | | | | | | | | | | 1 | | |
| 4. ICV compliance monitoring | 1.3D c | ICV compliance of FP/RH service delivery sites monitored and reported | Quarterly meetings with PHO, PHTO to discuss results of ICV compliance monitoring covering all LGUs (integrated in other meetings with the PHO) | Monitoring and coaching | **P1 M10** | | | **M10 C2** | | | **M7 C3** | | | | | | 1 | 27 | 5 |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local Implementation of NHIP based on benefit delivery approach | 1.2 C.a | Application for accreditation filed (renewal for OPB and TB DOTS and new application for MCP) | Meeting with PHO/MHOs to discuss preparation and completion of documentary requirements of PhilHealth accreditation of RHU for MCP and OPB and TB DOTS | Facilitator | | | **M10** | | | | | | | | | | | 10 | |
| | 1.2 C.b | Facilities accredited by PhilHealth (for OPB, TB DOTS and MCP) | Facilitate coordination meeting with PHIC and MHOs to fast track PhilHealth accreditation | Facilitator | | | | **M10** | | | | | | | | | | 10 | |
| 2. Accessing and managing DOH MNCHN grants facility | 1.2A.a | MNCHN grant accessed | LGU orientation and planning to access the 2009 and 2010 MNCHN grant facility (Provincial LFC, MHOs and LFCs) | Resource person and facilitator | **P1 M27 C5** | | | | | | | | | | | | 1 | 27 | 5 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | TOT of PHO logistics management team | Support CHD 3 in conducting the training | | **P1** | | | | | | | | | | | 1 | | |
| | 1.1Eb | FPCMS tool adopted | Monitoring/tracking of action plan of FPCMS | Advocate to CHD/PHO to implement FPCMS | | **M27 C5** | | | | | | | | | | | | 27 | 5 |
| **C. Advocacy to newly-elected local officials (NEOs)** | 1.4B.c | Priority health agenda presented by PHO/DILG to NEOs | Coordinative meetings with DILG to discuss the integration of the executive and legislative agenda of the AOP into the LGU's ELA | Monitoring, coaching | **P1** | | | | | | | | | | | | 1 | | |

## Pangasinan

The Province of Pangasinan in Ilocos Region (Region 1) has 44 municipalities, 1 chartered and 3 component cities. According to the latest census, its population is at 2,645,395 with 477,819 households and is the third biggest province in population size. The total population is projected to rise to 3,039,500 in 2010. The average population growth rate is 2.41%; generally a very young population with 39% in the 0-14 age range, 56% in the 15-64 age range and only 5% belonging to the 65 years old and over group.

### The health situation: trends in SO3 indicators

A review of the health indicators of the province showed that almost all of the health indicators improved in 2009 except two of the maternal health indicators, the CPR and four antenatal visits which showed decreasing trend from 2006 to 2009. On the other hand, deliveries attended by skilled birth attendants remained constant while facility-based deliveries manifested an increasing trend.

The CPR baseline of the province in 2006 (which includes both the modern and natural methods) has dropped dramatically in 2007 and 2008 and significantly increased in 2009 to be at par with the baseline data of 56%. However, if only modern methods are counted, the coverage in 2009 is only 32% which is still way below the national standards. The main reason for a decreased CPR is the lack of FP commodities because majority of LGUs no longer procure due to religious conviction of the local chief executives. There were a lot of clients who dropped out from their particular FP method because of the lack of free commodities from the health centers. Non-integration of reports from private FP providers into the provincial accomplishment report also contributed to the decrease. The increase in CPR in 2009 was the result of the procurement / distribution of commodities to LGUs through the MNCHN grant of the Department of Health.

The province still lags behind the national standards for pregnant women with at least four ANC visits and facility-based deliveries. Its ante-natal care performance has been stable at 78% in 2007 and 2008 but dropped to 70% in 2009 while its facility-based deliveries showed an increasing trend from 13% in 2006 to 24% in 2008 and 30% in 2009. The increase in facility-based deliveries is due to the continuous advocacy of health personnel including the Governor, who has become a champion for MNCHN and advocates that all pregnant women should deliver in health facilities. In support of MNCHN the Provincial Government has ensured that all hospitals of the province are MCP accredited and that BEmONC facilities are established in priority LGUs. To support this reform, the ambulance network of the province was also improved so that pregnant women needing referrals can be easily transported and receive proper care. There was also an increase in the number of MCP accredited RHUs from 1 to 4. These are the RHUs of Infanta, Basista, Mangaldan and Binalonan. The identified hindering factors especially in the antenatal care coverage include the lack of active follow-up of RHU personnel (the lack of TEV and/or logistics support to follow-up clients) busy working moms and poor health seeking behavior of clients. The province though has good performance and surpassed the national standard on deliveries by skilled birth attendance from 90% to 92 % with most deliveries attended by midwives.

All five (5) child health and nutrition indicators improved from 2006 to 2009. FIC coverage has steadily increased from a level of 63% in 2006 to 89% in 2009; however, this is still below the national standard of 95 percent. Likewise, DPT3 coverage also increased from 79% in 2006 to 87% in 2008, which was maintained in 2009. Based on these health performance indicators of

the province, there is a need to sustain increasing performance in fully immunized children and DPT3 coverage so that it becomes at par with the national standards / targets. The province will need to identify the implementation strategies that moved these indicators and, at the same time, address issues that are hindering performance in the LGUs through the conduct of regular service delivery implementation review.

Similarly, the 2008 Vitamin A coverage among 6-59 months old (99%) surpassed the national target of 95%, but, five (5) municipalities still have coverage below 85%. Diarrhea cases treated with ORT improved from 30% in 2008 to 47% in 2009. The proportion of cases of child pneumonia treated with antibiotics has steadily increased from 85% in 2006 to 98% in 2009.

In terms of TB prevention and control program, the performance of the province in the past years has greatly improved both in case detection as well as in TB cure rate. The province utilizes the TB Register instead of the FHSIS report because the TB register includes the performance of all the hospitals as well as the PPMD DOTS centers in the province.

Both the CDR / CNR and TB cure rates of the province are already above the national standards. The problem with the untimely and erratic delivery of TB supplies and commodities especially in 2008 and the improvements in TB assessments, recording and reporting contributed to the drop in CDR in 2007. Itinerant teams were mobilized, private physicians were engaged and oriented on TB-DOTS, and barangay management councils were organized to help improve case detection and cure rates. In most cases, the increase in the cure rate was attributed to the improvement in the follow-up sputum of enrolled TB clients.

Inasmuch as the province is one of the highest in terms of PhilHealth enrollment of indigents, with 106,512 enrolled families as of November 2009, minimal benefit payments were received by the provincial government. In 2008, reimbursements for TB DOTS amounted to PhP163, 000 and this came from only from eight of the 31 TB DOTS-accredited facilities. For out-patient benefits, only three of the 23 OPB-accredited facilities received reimbursements. On the other hand, private sector claims accounted for 70% of total hospital reimbursements, with the hospitals in Dagupan City getting 48% of the share.

The province utilizes the living standard survey (LSS) in identifying the poor for enrolment of indigents to PHIC. The last LSS was conducted in 2005 and is due to be conducted this 2010. The provincial government has decided to enhance the tool with technical assistance from HealthGov prior to the conduct of the survey by 4$^{th}$ quarter of 2010.

A crucial complement to the implementation of the PhilHealth sponsored program is the accreditation of health facilities. The number of accredited facilities increased from 29 in 2007 to 39 RHUs in 2009. In 2007, there was no health facility accredited for MCP. As of July 2009, three RHUs have been accredited for MCP and two RHUs have their MCP accreditation under process. To date, there are already 4 MCP accredited RHUs. The number of RHUs accredited as TB DOTS centers increased from 19 in 2007 to 29 in 2009.

**Table 1. Selected health indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 56 | 45 | 45 | 57 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 71 | 78 | 78 | 70 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 90 | 90 | 92 | 91 | 80 |
| 4 | Percent of Facility-based Deliveries | 13 | 18 | 24 | 30 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 79 | 81 | 87 | 87 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 63 | 78 | 84 | 89 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 90 | 83 | 99 | 99 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 32 | 25 | 30 | 47 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 85 | 94 | 95 | 98 | 100 |
| 10 | Case Detection Rate (per 100,000 population) | 74 | 70 | 68 | 71 | 76 |
| 11 | Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 97 | 92 | 89 | 93 | 99 |
| 12 | Cure Rate | 86 | 84 | 86 | 91 | 85 |

**The response: TA interventions and results**

In response to the above-cited health situation, HealthGov packaged a set of technical assistance that aimed to assist and capacitate LGUs to develop and implement measures to overcome the gaps that hinder them to achieve better health outcomes for the province. This set of technical assistance was implemented, in collaboration and partnership with the PHO, DOH Reps, LGUs and CHD, to wit:

In Year 1, technical assistance extended by HealthGov were: a) an orientation session to LGU program managers and partners on the ongoing living standard index (LSI) and the framework of Community Health Living Standard Survey (CHLSS) as an integrated tool to identify the poor program recipients of health programs; b) Conduct of orientation on Service Delivery Implementation Review, including a review of the Commodity Self Reliance (CSR+) program; c) Orientation on the Informed Choice and Volunteerism principles and processes; and, d) Forum on the Health Sector Reform/FI among Civil Society Organizations / Non-Government Organizations in preparation for their sustained engagement with the LGU.

The technical assistance in Year 2 includes Conduct of Health Service Delivery Implementation Review (SDIR), Technical Assistance on PhilHealth accreditation for OPB and MCP, Support to Capacity Building on MNCHN, Support to Advocacy on TB Prevention and Control and Support to Advocacy on Enhancing LGU-PHO-CHD-NGO/CSO Partnership in LGU Special/ Coordinating/Development Bodies.

Together with CHD 1, other CAs, and EC, HealthGov/USAID assisted the province in the conduct of the Provincial Health Summit. The summit provided a venue for LCEs to better understand health sector reform; sharing of experience of peers (among LCEs) in their

implementation of practices that work particularly in maternal and child health, tuberculosis control, inter-local health zone collaboration and local implementation of the “Asin” Law (use of iodized salt); and formalizing the partnership between the province, the LGUs, the donors, national and regional government agencies, private sector and non-governmental organizations / civil society, which was formalized through the signing of pledge of commitment. The second part of the health summit was devoted to the health sector and other partners and together they formulated the acceleration plan per ILHZ to identified health gaps.

In Year 3, the major areas of technical assistance in Pangasinan included: a) support to the implementation of the PhilHealth Sponsored Program which is primarily the handle of the technical assistance in the province, b) support to the implementation of PIPH and 2009 AOP with attention to key SO3 interventions, c) support to the preparation of 2010 AOP with input from acceleration plans developed from the harmonized LGU scorecard – SDIR and Planning Workshop, and d) support to the province in accessing the MNCHN grant facility, and finalization of the procurement and allocation list for the MNCHN grant.

Through the provincial PhilHealth technical working group, HealthGov provided inputs in designing the Pangasinan PhilHealth study as well as assisted the TWG in the completion of reports. This became inputs to the province-wide action plan for PhilHealth Sponsored Program which aimed to ensure better access of the poor to public health services and increase utilization of MNCHN and TB program services.

HealthGov supported the 2009 and 2010 AOP development and implementation by facilitating the harmonized LGU scorecard-SDIR. This involved processes of reviewing the implementation of preventive and curative health care services, which resulted in the preparation of municipal and ILHZ acceleration plans that are focused on improving performance of LGUs with low program accomplishments. The province’s 2010 AOP was developed based on the ILHZ acceleration plans. The ILHZ acceleration plans served as guide of the province as it strengthens the ILHZ offices as a small manageable network of health service providers. The CSR+ plan was also reviewed.

Assistance in enhancing the competency of FP service providers was given through the FPCBT training among 47 RHMs and PHNs from C/MLGUs. The training improved the competence of service providers which will redound to increased FP service coverage. To increase demand and utilization, an orientation on the integration of FP in EPI/PP was provided to 24 RHM participants of the second batch of FPCBT. HealthGov also assisted the province in monitoring RHUs for ICV compliance to ensure quality of FP services. No violations were noted for all the 10 facilities monitored.

Cognizant of the active participation of NGOs in the province, HealthGov provided assistance to the PHO in engaging NGOs in the conduct of advocacy activities in four priority municipalities which the province identified.

Major accomplishments in Year 4 were the review of the 2007, 2008 and 2009 AOPs including disbursement of funds and the orientation of the provincial and municipal/city heath officers on integrating health in the DILG NEO Program. The training of trainers for FP data cleaning and quality check, the review and enhancement of the living standard survey and the presentation of the PhilHealth study conducted to the governor and the municipal / city mayors will be completed by the next quarter.

**Remaining gaps and challenges**

Although most of the information in the table 1 above showed improvements, there were reasons to believe that there are data gaps. Quarterly FHSIS reports submitted by RHUs do not tally with the annual report that they also submit. The coverage of DPT3 antigen is lower than the coverage of the fully immunized children. The health data also implies that there are a lot of missed opportunities. If mothers are now encouraged to deliver in health facilities, behavior change communication should also focus in promoting antenatal care, family planning and child immunization.

There is still a need to intensify advocacy to LCEs to allocate funds and pass enabling policies to ensure that MNCHN commodities are available especially for the poor. Forecasting of commodities using clean/validated data of family planning current users and other MNCHN indicators will help convince LCEs to appropriate funds to cover unmet needs for family planning, immunization, micronutrient supplementation and TB control. This is an area where non-government organizations and civil society can really push for specific LGU action. The Provincial Government and the Provincial Health Office have strong partnership with the Pangasinan Federation of NGOs (PFNGO), which is composed of more than 200 member NGOs all over Pangasinan. PFNGO was also signatory to the Pledge of Commitment in 2008, during the 2nd Pangasinan Health Summit.

**Years 5 priority interventions and expected results**

HealthGov's technical assistance for Year 5 is aimed at building on the gains for the past four years and maximizing existing government structures and systems in order to sustain and institutionalize these gains.

Specifically, HealthGov TA intervention is aimed to capacitate LGUs to:

- Improve the quality of their health data, e.g. FP current users, FHSIS data for use as inputs for better planning;
- Ensure a sustainable health financing strategy through the maximization and utilization of the PHIC health financing scheme, and the accessing and utilization of the MNCHN grant;
- Establishment of systems for continuing quality health service delivery in public health facilities, and the maximization of MNCHN services to deliver quality health services

Responding to these objectives, the following activities/TAs will be implemented with its corresponding milestones and expected results:

A. Support to improving service delivery in family health

- Validation of FP current users; training in ICV monitoring; updating of the municipal/city/provincial CSR+ plans and FP commodity forecast; advocacy for passage of CSR+ policy; and coaching, monitoring and documenting FP integration to EPI and Maximization of MNCHN services; installation of monitoring logistics management system for FP commodities
- Coaching and monitoring LGUs' compliance of requirements for MNCHN grant accessing, and monitoring utilization of the grant money; TOT in FHSIS data quality check for PHO staff and DOH reps

B. Strengthening family health program support through financing and governance

- Facilitate/provide technical inputs to the review of PIPH 2006-2010 and development of 2011-2015 PIPH
- Orientation on NHIP-BDR, formulating the NHIP enrolment plan, tracking of NHIP-BDR plan implementation, and promotion of MCP accreditation
- Presentation of priority health agenda for NEOs

At the end of Year 5, HealthGov's technical assistance package is expected to achieve the following milestones and results:

- CSR+ plans approved and province-wide CSR+ plan formulated;
- 1 ICV provincial team formed and monitoring plan formulated with ICV monitoring report for 44 municipalities and 3 cities;
- 1 province, 44 municipal and 3 city LGUs accessing external financing for health outside IRA; MNCHN grant accessed and utilized;
- CHD 1 and LGU (44 LGUs, 3 cities and 1 province) trained in logistics management of FP commodities (Stock and Inventory Management System);
- 1 Provincial NHIP/PHIC action plan for accreditation and enrolment of indigent families formulated;
- 11 RHUs PhilHealth MCP accredited,
- 30 health personnel trained as trainers in FHSIS data cleaning;
- FP current users and other MNCHN (FHSIS) data validated and cleaned in 44 municipalities and 3 cities;
- Priority health agenda presented to NEOs

**Priority TA Interventions and Activities**
**PANGASINAN**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN Strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.d | 30 health personnel trained as trainer in FHSIS data cleaning | TOT in FHSIS data cleaning and action planning to conduct DQC, SDIR and AOP formulation | Resource person/facilitator<br><br>Training materials | | | | **P1** | | | | | | | | | 1 | | |
| | 1.1C.b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | LGU DQC/CSR assessment | Coaching and mentoring | | **M44 C3** | | | | | | | | | | | | 44 | 3 |
| | 1.3A.d | CSR TWG and ICV monitoring teams organized<br><br>Action plan to roll out CSR assessment and DQC formulated<br><br>30 facilitators trained in CSR | Provincial orientation/TOT (including DQC and ICV compliance monitoring) | Activity design<br><br>Resource person and facilitator | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1C.a | CSR commodity forecasting updated using cleaned FP CU data | Commmodity forecasting | Resource person and facilitator (Palaris, Pilgrims) | | | **M44 C3** | | | | | | | | | | | 44 | 3 |
| 2. Integration of FP in EPI and maximizing utilization of MNCHN services and social mobilization for Vitamin A and EPI, in collaboration with HealthPRO and A2Z | 1.3A.d | Providers trained in integration of FP/EPI and maximizing utilization of MNCHN services | Roll-out of integration of FP/EPI and maximizing utilization of MNCHN services in 2 LGUs | Technical oversight | **M2 C1** | | | | | | | | | | | | 1 | 1 | 1 |
| | | Progress reports<br><br>FP integration documented | Monitoring and documentation of FP integration and maximizing utilization of MNCHN services | Monitoring; process documentation | | **M3** | | **M3** | | **M3** | | | | | | | | 3 | |
| 3. ICV compliance monitoring | 1.3D.d | ICV compliance included in CSR policy | Reconstituion of ICV monitoring team and reorientation | Resource person, co-facilitator | | **P1** | | | | | | | | | | | 1 | | |
| | 1.3D.b | ICV team organized and trained<br><br>Monitoring plan formulated | ICV monitoring plan formulation | Resource person/Facilitator | | **P1** | | | | | | | | | | | 1 | | |
| | 1.3D.d | ICV compliance monitoring and reporting locally mandated/CSR ordinance policy updated to include ICV compliance monitoring | ICV monitoring and reporting | Monitoring, coaching | | | | | | | | **P1 M44 C3** | | | | | 1 | 44 | 3 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on benefit delivery approach | | | Conduct of BDR orientation | Resource person, facilitator | | | | | | | | | | | | | 1 | 44 | 3 |
| | 1.2B.a | Local NHIP implementation plan prepared/updated | NHIP enrolment plan formulation | Resource person/facilitator | | **P1** | | | | | | | | | | | 1 | | |
| | 1.2C.b | Health facilities accredited | Accreditation of health facilities by PHIC | Monitoring, coaching | | | | | | | | | **P1 M10 C1** | | | | 1 | 10 | 1 |
| | 1.2A.c | Local policy for fund management of PhilHealth reimbursements and capitation fund for re-investments in health developed | Monitoring NHIP plan implementation | Monitoring, coaching | | | | | | | | | **P1 M10 C1** | | | | 1 | 10 | 1 |
| 2. Accessing and managing DOH MNCHN grant | 1.2A.a | MNCHN grant accessed | Monitor accessing, utilization and tracking of MNCHN grants (2009-2010) | Monitoring and coaching | | | | | | | | | | | | | 1 | 44 | 3 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Data management | 1.1C.d | DOH Reps, MHOs and PHNs trained in data quality and validation tools and guide | Orientation training of MHOs, PHNs, and DOH Reps on data quality tools/guide for selected MNCHN and TB indicators | Training design, modules, resource persons/facilitators<br><br>Supplies and materials | | **P1 M44 C3** | | | | | | | | | | | 1 | 44 | 3 |
| | 1.1C.c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | Assist PHO and PHTL in implementing action plan on data quality and validation at field level i.e. coaching RHU staff in data quality check of selected MNCHN indicators + EPIR internal assessment | Provincial TA team as resource persons and facilitator<br><br>In-house staff - resource person and facilitators | | **P1** | | | | | | | | | | | 1 | | |
| 2. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Training of CHD/Provincial trainers in FPCMS | National governance team as trainers | | **P1** | | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | Meetings to discuss progress of FPCMS implementation | Support CHD/PHO | | | | | | **M44 C3** | | | | | | | | 44 | 3 |
| **C. Advocacy to newly-elected local officials (NEOs)** | 1.4B.c | Priority health agenda presented to NEOs | Meetings with the PHO, PPDO to finalize list of priority PPAs and advocacy to NEOs for its inclusion to AIP 2011 | Monitoring, coaching | | **P1** | | | | | | | | | | | 1 | | |

## TARLAC

Tarlac is a first class province located in Central Luzon (Region 3). The province is composed of 511 barangays, 17 municipalities and 1 city grouped into three congressional districts. Based on the 2000 census, its projected population for 2010 is 1,279,700. The province is landlocked with boundaries defined by the province of Pangasinan on the north, Nueva Ecija on the east, Pampanga on the south and Zambales on the west.

**The health situation: trends in SO3 indicators**

Generally, the performance of the province in terms of the implementation of MNCHN programs is fair compared to the national standards. This could be attributed to the excellent health program management by PHO and PHTO, adequate budgetary allocation for health from LCEs and adequate health manpower support to the implementation of health programs.

The performance of Tarlac in three key programs, maternal, childcare and TB control and prevention is steadily but moderately increasing. In general, from among the 12 health indicators, 8 (67%) indicators improved/increased.

The reported CPR of the province increased from 34% in 2008 to 38% in 2009. There were eleven (11) LGUs with CPR above the reported provincial rate in 2009. However, seven (7) LGUs still remain below the provincial rate (Bamban, Capas, Concepcion, Paniqui, Ramos, San Manuel and Tarlac City).

The data quality check for FP current users' data in Tarlac for LGUs has just been completed. The results showed a decrease in the number of FP current users and CPR by as much as 50% from the previously reported data in almost all the LGUs. Among the critical factors contributing to low performance were: a) insufficient provincial/municipal budget for purchase of FP commodities, health promotion activities and logistical support (TEV, vehicle and vehicle maintenance) due to low priority of most LCEs; b) lack of provincial and municipal approved CSR policy; c) inadequate training/capacity building opportunities for RHU personnel on FP program.

With regard to maternal care indicators, Tarlac showed increases in deliveries attended by skilled attendants as well as facility-based deliveries. There was a 2% point increase on deliveries attended by skilled attendants (from 90% in 2008 to 92% in 2009) and 8% point increase in facility-based deliveries (from 35% in 2008 to 43% in 2009). Although there was an improvement, it still falls short from the national standard of 70%. Home deliveries predominate at 54% of all deliveries, most of which were attended by midwives. The increase in FBD from 35% in 2008 to 43% in 2009 however could be attributed to the adequate presence of facilities including 4 public hospitals, 15 private hospitals, 38 RHUs (8 are birthing facilities) and 198 BHS for the entire province, where only few far-flung barangays exist.

In addition, the province's maternal mortality rate was lower in 2009 at 43/100,000 live births or 9 deaths compared to 46/100,000 live births or 13 deaths in 2008. These deaths however, could be under-reported since the data is very much lower than national average of 162; all the more because of the absence of a systematic maternal death reporting and review occurring in the province. Likewise, there are no health promotion activities to improve health-seeking behavior of mothers for pre-natal check-up and facility-based deliveries.

For child care, most of the indicators from 2006 to 2009 fluctuated. The performance accomplishments on DPT3 and FIC showed slight improvements. It is to be noted that FIC registered at 96% and DPT3 coverage at 91%. Considering the 5 point percent difference, there is a need to review the data to ensure their validity. There were 12 or 67% (from the 18 LGUs) that reached/exceeded national average while six (6) more LGUs needs follow through to catch up in terms of performance indicators. The performance coverage for Vitamin A supplementation, children below 5 years old with diarrhea treated with ORT and children with pneumonia seen and treated with antibiotics decreased. The Vitamin A coverage for children 6-59 months for April 2009 GP was 6 point percent lower (92% in 2009 and 98% in 2008). The coverage was pulled down by the low VAC in the seven municipalities (Anao, La Paz, San Clemente, San Manuel, Paniqui, Bamban and Capas). Antibiotics and ORT supplies were also inadequate to treat the children with diarrhea and pneumonia, thus only 97% and 52% of children with pneumonia were given antibiotics and ORT respectively. Among the leading causes of mortality in Tarlac, TB ranks sixth. The case detection rate slightly increased from 51% in 2008 to 56% in 2009 with six (6) LGUs having CDR above 70 percent. The TB cure rate dropped from 85% in 2008 to 75% in 2009 because of inadequate supply of drugs. The low TB cure rate was due to the high number of defaulters, deaths and transferred-out patients and poor patient follow-up for sputum examinations. There is a need to strengthen case-holding activities by ensuring the capability of health workers to treat patients, community participation and greater LGU support to hire and mobilize treatment partners. The increasing CDR is attributed to the availability of drugs and logistics, good TB data management through electronic TB Register and implementation of quality assurance system.

**Table 1. Selected health indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 44 | 35 | 34 | 38 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 58 | 82 | 82 | 75 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 81 | 64 | 90 | 92 | 80 |
| 4 | Percent of Facility-based deliveries | 37 | 34 | 35 | 43 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 65 | 87 | 91 | 92 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 68 | 96 | 92 | 96 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 96 | 86 | 98 | 92 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 43 | 62 | 62 | 52 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 69 | 95 | 100 | 97 | 100 |
| 10 | Case Detection Rate (per 100,000 population) | 95 | 43 | 51 | 56 | 76 |
| 11 | Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 71 | 75 | 67 | 75 | 99 |
| 12 | Cure Rate | 42 | 95 | 85 | 75 | 85 |

**The response: TA interventions and results**

Assistance in improving service delivery and service utilization includes training of eight (8) PHNs/MHNs in newborn screening and PHO/MHOs in TB Rapid Appraisal. USAID CAs, led by HealthGov, assisted the PHO in organizing the celebration of World TB day in the province and in selected LGUs. The activity was a TB awareness campaign for the indigenous people (IP), particularly the Aeta community in Capas which included a presentation-discussion on the TB program for the Aeta community, distribution of IEC materials, demonstration of herbal medicine preparation, and pulmonary clinic services. As an off shoot of the celebration, a Training of Trainers on TB program was held for five RHU staff, seven NGO members, and one NCIP nurse. The new trainers in turn conducted awareness raising activities to the target IP communities.

In response to the need of building for well trained RHU personnel, the FPCBT training was conducted through the DOH Central Office. This was participated by the Provincial FP Coordinator who was tasked to roll out the training to fellow health workers. There were eight (8) RHMs trained in LSS from the municipalities with birthing clinics groomed to be MCP-accredited. The LSS training capacitated the RHMs in early diagnosis of emergency obstetrical cases, IE and suturing. In addition, 22 health service providers and three (3) PHO technical staff were trained on newborn screening through the collaborative efforts of HealthGov and CHD3. HealthGov facilitated as well, the training of trainers for PHN supportive supervision and roll-out trainings for the FP-CBT of four health workers from Bamban, Sta. Ignacia, Paniqui and Gerona.

The strategy on integrating FP in EPI and maximizing existing MNCHN services was modeled in two (2) municipalities (Paniqui and Camiling) and respective plans of action were developed after the orientation. The RHU personnel were also provided with the list of existing FP and MNCHN facilities that they may use as referral facilities for FP and MCH services like bilateral tubal ligation and caesarian section. The Trained RHU personnel were able to cascade the strategy to their respected BHWs and the three key FP messages are now being discussed to mothers during EPI day in their respective barangay.

HealthGov together with HealthPRO assisted the province in conceptualizing and organizing an advocacy event aimed to solicit support on FP and EPI for women from various sectors. The event was in line with the celebration of the World Population Day and Population and Development (POPDEV) week. The event was celebrated in collaboration with the PHO, Provincial Population Office, PPDO and Health Advocates of Tarlac (HAT).

In terms of data quality check, a training of trainers was conducted to teach the PHO and PHO technical staff in generating reliable data at various levels. After the training, the trainers went from one RHU to another to upload the FP current users' data cleaning tools to public health nurses and midwives. They were able to provide assistance in the assessment and validation of FHSIS reports on FP current users and review the TCL records on family planning and forecasting of FP commodities.

The FP data quality check conducted showed discrepancies between the reported data of the RHU to the PHO and actual TCL/ FP service records. One of the discrepancies in the records of the midwives was the failure to include the following in the dropped-out FP clients list: a) those who did not come back for resupply of a FP commodity; b) those whose ages were above the women of reproductive age (WRA) 15-49 years old; and, c) those who did not fulfill criteria of being recorded as current user in a particular FP method.

As a result of the updated FP current users' data, the CPR for the entire province decreased. This has subsequently reduced the number of FP commodity forecasting requirements. The PHO and the PHTO have agreed to work together to improve CPR and among the immediate next steps identified were the ff: a) regular updating of the FP current users data; b) identifying priority MNCHN activities to maximize use of the MNCHN grant; c) CSR planning and d) intensifying integration of FP into MCH service delivery to include roll-out to other LGUs.

Meanwhile, HealthGov continued its support to the Wireless Access for Health (WAH) piloted in four (4) RHUs in Tarlac using the Community Health Tracking-Electronic Medical Record System (CHITS-EMR) to improve access to accurate and comprehensive patient information required in FHSIS reporting. HealthGov's TA support included capacitating the rural health workers (midwives and nurses) on data cleaning with their respective FP current users' data that accurately adjusted the number of current FP users, CPR and FP commodity forecast. HealthGov also coordinated with WAH staff, Tarlac PHO and CHD3 the preparations for the media launch and scaling up of the initiative in the entire province of Tarlac and in the roll out of the initiative to other LGUs within the region.

In collaboration with CHD3, a total of 109 participants (all MHOs/PHNs of Tarlac, local budget officers and IT persons and PHOs and FHSIS coordinators of the provinces of Nueva Ecija, Bulacan, Bataan, Pampanga and Zambales) were provided with appropriate orientation on WAH, highlighting its benefits, lessons learned from the pilot sites and costing for installation. The demonstration of the Community Health Information Tracking System-Electronic Medical Records System (CHITS-EMR) generated interest from among the participants. As a result, the CHD 3 was further motivated to pursue piloting the WAH in all the provinces of the region.

HealthGov in collaboration with CHD3 and Tarlac PHO facilitated a one-day forum on the scale-up of WAH where representatives from the 7 provinces of the region and WAH stakeholders attended. The following commitments were generated after the forum: a province wide implementation in Tarlac and piloting in selected LGUs in all the provinces of CHD3; road show and advocacy of WAH in all CHD provinces to obtain LGU's acceptance and support; and specific commitment from project partners like capacity building at reduced costs, continuing enhancement of CHITS modules, 3G technology availability; connectivity at discounted rates; assistance on data cleaning; provision of full time WAH IT staff. The geographic expansion will be pursued on the last quarter of the year. Advocacy to LCEs will be conducted in the pre-selected pilot LGUs. For the media launch of WAH, HealthGov assisted in conceptualizing/drafting of the communication plan, key messages, brochures and other public relations materials. During the launch, USAID reaffirmed its commitment to help systematize health data recording in the Philippines.

In terms of health financing, assistance was provided in the completion of requirements for accessing the DOH FP/MNCHN performance grant. HealthGov assisted the province in fast tracking the requirements for the release of the 2008 MNCHN grant, particularly the preparation of the work and financial plan and MOA between the province and CHD3. The province received the PhP1, 373,325 MNCHN grant and purchased FP commodities worth PhP1.3M that were distributed its 18 component LGUs. The fund was only enough to provide approximately 5%-10% of their total current users. The PHO had submitted the fund utilization report for this grant.

HealthGov also conducted an orientation on resource mobilization, grant access, cost recovery schemes and expenditure tracking to 33 participants of the province coming from the provincial finance committee, PHO, PHTO, Chiefs of hospitals of the district hospitals and selected MHOs.

The financial commitments of the province to the implementation of the approved PIPH and AOP were discussed with focus on the financial structure of the PIPH/AOP, challenges to PIPH implementation and other internal and external sources of funding.

The CHD together with the USAID CAs provided technical assistance to the province during its annual operational planning workshop. The 2009 and 2010 AOPs had been approved by JAC. The total cost of investments for five (5) years amounted to P4.98B where almost 50% of the budget was allotted to facility upgrading including the conversion of district hospitals into BEmONC or CEmONC facilities. Around 25% was allotted for the operations of public health programs (10% for maternal health, 5% for child health).

Technical assistance in implementing the Health Sector Reform at the local level was provided by the CHD 3 to their provinces through the RCBI. This initiative was carried out to harmonize the TA needs and plans of the CHD, PHO, and LGUs. The workshop was conducted to validate the TA needs of the province and formulate CHD support plan to meet these TA needs. Among the TA identified by the province were the following: a) expansion of NHIP Coverage to include TA on all the cycles of Philhealth components like identification of true indigents, cleaning of enrollees, advocacy to LCEs to increase enrolment, enrollment of indigents, clients availing services and utilization of reimbursement and capitation; b) CSR Assessment and Planning; and, c) development of a policy tracking tool to monitor the enforcement of health related laws.

**Remaining gaps and challenges**

In the course of TA provision, the province's challenge is sustaining the interventions to address maternal care. Although the maternal deaths decreased for 2009, this maybe under reported and should be subjected to data cleaning/validation. The current interventions and health seeking behaviors of mothers need to be enhanced.

NHIP implementation also needs to be reviewed. The province needs to identify the real poor and increase its present enrolment and accredited facilities to maximize Philhealth benefits. More importantly, the Philhealth members need to be informed on the services that they can avail of, the accredited facilities they can go to and the process of claiming reimbursements. The province also needs to be informed on how the capitation and reimbursements will be plowed back to health programs.

There is also the continuing need to track the implementation of AOP. The tracking may be linked to improved health data management at the local level. The data collection, updating, analysis, reporting and utilization must be reviewed and improved. The capacities of the PHNs and RHMs on data management need to be enhanced.

**Year 5 technical assistance**

In response to the health situation and identified needs of the province, the Year 5 priority technical assistance will include the following:

A. Support to improving service delivery in family health:

- Tracking the status of FP integration modeling implementation and orientation of roll-out sites

- Facilitating the development of a database profile of the training capacities of health service providers and the implementation of the provincial training plan through coordinative meetings with the PHO and PHTO.
- Institutionalizing ICV compliance monitoring;
- Facilitating the LGU Action plans drafting that will ensure compliance with the requirements for MNCHN grants.
- Building the capacities of PHO, PHTO, /MHOs on implementing a Functional Literacy Program for Aetas using the Parent Functional Literacy on MCH / FP / TB). Such training is expected to pave the way for the formulation of an action plan for its implementation by the LGUs.

B. Strengthening family health program support through financing and governance

1. Conducting an orientation on logistics management tool for LGU adoption

- Facilitating the AOP integration into the ELA and AIP using the orientation for newly elected officials as venue to generate support for its implementation on the ground and presentation of priority health agenda to NEOs

As a project close-out activity, HealthGov will document best practices that may evolve in the course of project implementation in the province and these shall be highlighted and presented in a province-wide alliance workshop that the provincial LGU will organize.

At the end of year 5 project implementation, the following milestones and outputs are expected to be achieved:

- Province and priority LGUs with improved logistics management for essential drugs and commodities
- Province with a database on service provider's capacity profile established
- Province-wide training plan prepared
- Trainings in FP Integration, Logistics Management, MNCHN grant accessing, SDIR/AOP formulation conducted
- 15 trained facilitators in Functional Literacy
- Province and priority LGUs conducting an annual enhanced PIR
- Province and 18 LGUs with a monitoring system for ICV compliance
- Province/M/C LGUs with increased public sector investments for health
- Expenditure tracking installed for MNCHN
- AOP for municipalities and city formulated and integrated into AIP/ELA
- Province and 18 LGUs with improved data management with respect to FHSIS
- Health performance (SO3) FHSIS data used for planning and decision-making

**Priority TA Interventions and Activities**
**TARLAC**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to strengthening service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. ICV Compliance monitoring and reporting system | 1.3D.c | ICV compliance of FP/RH service delivery sites monitored and reported | Monitor implementation of action plan for ICV monitoring and reporting compliance of LGUs | Monitoring and coaching | | | | **M6 C1** | | | **M6** | | | **M5** | | | | 17 | 1 |
| 2. Integration of FP into EPI and maximizing utilization of existing MNCHN services | | Integration of FP/EPI and maximizing utilization of MNCHN services modelled in 2 LGUs (Camiling and Paniqui) | Continuing tracking of implementation of key action points | Monitoring and coaching | **M2** | | | | | | | | | | | | | 2 | |
| | 1.3A.d | Key action points on integration of FP/EPI and maximizing utilization of MNCHN services in 6 roll-out LGUs<br><br>Service providers trained in integration of FP/EPI and maximizing utilization of MNCHN services | Orientation of MHOs/PHNs/RHMs in roll-out sites on FP integration | Resource person/facilitator | | **M5 C1** | | | | | | | | | | | | 5 | 1 |
| 3. Capacity building acivities on FP, TB and MNCHN | | Agreement on setting up health human resource database at the provincial level | Consultative meeting with PHO/PHTO for database on capability profile of service providers and implementation of AOP training plan | Resource person and facilitator | | | | | | | | | | | | | 1 | | |
| | 1.3A.a | Established database on capability profile of service providers<br><br>Annual training plan prepared | Meeting to proritize service providers for training in FP/MNCHN/TB and develop training plan for 2011 AOP using database | Coach PHO | **P1** | | | | | | | | | | | | 1 | | |
| | **Functional Literacy for Aetas** | | | | | | | | | | | | | | | | | | |
| 4.a Functional literacy for Aetas | | Action plan for implementation of functional literacy formulated (Capas, Bamban, San Jose, San Manuel) | Orientation/meeting with PHO/PHTO/MHOs/NGOs on Functional Literacy for Aetas to improve FP/MNCHN service delivery | Resource person | **P1 M4** | | | | | | | | | | | | 1 | 4 | |
| | 1.3A.d | 15 trained facilitators in Functional Literacy to improve FP/MNCHN service delivery | Training of facilitators for Functional Literacy | Resource person, STTA (functional literacy training) | **P1 M4** | | | | | | | | | | | | 1 | 4 | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| A. Local implementation of NHIP based on benefit delivery approach | | Action plan for strengthening PHIC benefit delivery package (particularly on enrolment/facility development plans) | Orientation of PHO/DOH Reps/MHOs in PhilHealth Benefit Delivery Approach, PHIC operational issues in local implementation, province-wide planning and monitoring | Facility assessment tool, resource person | | | | | | | | | | | | | | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.2C.a<br><br><br>1.2C.b | 5 Application for accreditation filed (3 OPB, 1 MCP, 1 TB DOTS)<br><br>Number of facilities accredited | Monitor compliance of LGUs to requirements and application to PHIC facility accreditation | | | | | | **M5** | | | | | | | | | 5 | |
| D. Accessing and managing DOH MNCHN grants facility | 1.2A.a | MNCHN grant accessed and utilized | LGU orientation and planning to access the 2009 and 2010 MNCHN grant facility (provincial LFC, MHOs and LFCs) | Resource person and facilitator | **M17 C1** | | | | | | | | | | | | 1 | 17 | 1 |
| | | | Monitor the completion of requirements to access MNCHN grant, implementation and utilization of the MNCHN grant | Monitoring and coaching | | | | | | | | **M17 C1** | | | | | | 17 | 1 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Data management | | Action plan to assist LGUs conduct their internal assessments/completed DQC | Orientation training of PHO/PHTL/DOH Reps/ MHOs in SDIR and action planning to complete DQC, conduct SDIR, AOP fromulation and AIP integration | SDIR process design, resource person | | | | | | | | | | | | | | | |
| | 1.3C.a<br><br>1.1.C.c | Pre-SDIR conducted by LGUs<br><br>Quality of other family health performance indicators derived from FHSIS (i.e., SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | Internal assessment of LGUs/DQC of all FHSIS data | Monitoring of LGU internal assessment | **M17 C1** | | | | | | | | | | | | | 17 | 1 |
| Wireless Access for Health (WAH) expansion | <br><br>1.1C.a | Province-wide implementation of WAH<br><br>WAH-generated (local) data utilized in planning and decision-making | Tracking of WAH roll-out plan in 13 LGUs and implementation in 4 pilot sites | Technical inputs | | | | | | | | **M17 C1** | | | | | | 17 | 1 |
| 3. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Orientation of MHOs/CHOs on FPCMS | | | | | **P1** | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitoring/tracking of action plan of FPCMS | | | | | | | | | **P1 M17 C1** | | | | | 1 | 17 | 1 |
| | 1.1E.c | TOT in stocks and inventory management system (SIMS) conducted | - Training of LGU health personnel in SIMS | Support CHD/PHO/PHTL | | | | | | | | | | | | | 1 | | |
| | 1.1E.d | Inventory management tool for essential drugs and commodities adopted | - On-site visits to selected LGUs to monitor progress of application | Coach | | | | | | | **M4** | | | | | | | 4 | |
| **C. Advocacy to newly-elected local officials (NEOs)** | 1.4B.c | Priority health agenda presented by PHO/DILG to NEOs | Coordinative meetings with DILG to discuss the integration of the executive and legislative agenda of the AOP into the LGU's ELA | Monitoring, coaching | **P1** | | | | | | | | | | | | 1 | | |

# Visayas

## Visayas

The Visayas regional cluster is composed of five provinces and five HIV/AIDS high-risk cities under two CHDs. CHD 6 covers the Provinces of Capiz, Aklan, and Negros Occidental, while Negros Oriental and Bohol belong to CHD 7. The five HIV/AIDS high-risk cities are Bacolod and Iloilo (CHD 6), and Cebu, Lapu-Lapu, and Mandaue (CHD 7). Four other USAID CAs, namely, TB LINC, HealthPRO, A2Z, and PRISM 2 are also covering these provinces.

The regional and provincial operations in Year 5 will concentrate on the *consolidation and completion* of TA interventions, which the team has progressively worked on since the first year. These are TA interventions that will contribute to the improvement of service delivery in health *(CSR+ policy advocacy/tracking, ICV, MNCHN grants access/utilization, FP-EPI integration, selected capability building, SDExH)* and strengthening family health program support to financing, governance, and regulation *(NHIP, PIR/SDIR/F1IR-AOP-AIP-PME, logistics management, LGU data management, NEO advocacy, and CHLSS in Negros Oriental only)*. More importantly, TA delivery will be entrenched in the CHD's overall TA delivery system, consistent with the DOH-RCBI framework. The regional TA delivery strategies in the Visayas will still be anchored on two key points: a) support to provinces and to an increased number of LGUs and ILHZs in the implementation of their PIPH/AOP interventions that will contribute to the achievement of common key health indicators in the LGU scorecard and USAID SO3; and b) support to RCBI by strengthening capacities of CHD technical staff (including DOH Reps) as main TA provider, building local capacities of PHO technical staff, and expanding availability, building capacity, and engagement of LTAPs for major TA areas in the region/provinces.

In Year 4, the Visayas region purposively worked on the full integration of HealthGov's TA interventions in the CHD's overall TA delivery system. This was achieved through the inclusion of HealthGov's TA interventions in the CHD's annual work and financial plans (WFP). HealthGov, in close collaboration with other USAID CAs, assisted CHD 6 and 7 in the formulation of regional TA support plans and/or TA-specific action plans for integration in their 2010 Work and Financial Plan (WFP). These served as guideposts in planning for and delivering the TA to provinces in Year 4. The same process, which was improved based on initial learning, will be undergone by the CHDs as they formulate their regional TA support plan/2011 WFP. This also indicated a more positive environment at both CHD, where the RD/ARD leadership was a key factor. The remaining challenge is how this can become a CHD-wide way of doing things – from identification, to planning, to TA delivery, up to results monitoring.

Thus, in Year 5, TA interventions at the regional level will primarily focus on providing support to the CHD in operationalizing RCBI in the region/provinces.

- *Formulation of CHD-CA TA-specific action plans.* This includes TA interventions that will be started in Year 5 such as logistics management (FPCMS, SIMS) and 2012 AOP-AIP formulation.
- *Delivery of TA in the region/provinces based on the agreed upon regional TA support plans or CHD-CA TA-specific action plans.* Among the major ones are on: CSR, FP-EPI, ICV, MNCHN grant, NHIP-BDR, PIR/F1IR-AOP-AIP-PME, FPCMS, SIMS, LGU data management, and NEO advocacy.
- *RCBI management structure strengthening in the regions.* Both CHD have RCBI TWGs headed by the RD/ARD, and HealthGov/other CAs are members. Formed during the early part of Year 4, the TWGs serve as venue for CHD to plan with health partners and discuss implementation progress of regional TA support plans and other concerns.
- *LTAP engagement, capacity building, and management.* This will include assistance to CHD/PHO in local contracting of TAPs, including development of SOW, selection/screening

and reviewing TAP proposals, regional /provincial orientation, and technical monitoring and supervision of TAPs. The project's current LTAPs, engaged in Year 4 and whose contracts will spill over in Year 5, are for CSR policy advocacy and tracking (all provinces), local NHIP using BDR approach (Negros Occidental, Aklan, and Bohol), FP-EPI integration/maximizing utilization of MNCHN services (Aklan, Negros Occidental, Bohol), and AOP-AIP-PME (varying levels in all five provinces).

At the provincial level, in line with the *consolidation and completion* direction of the region this year, the project will see the completion or scaling up of TA in the provinces. HealthGov will continue to collaborate with other USAID CAs in all these processes and major activities. Aside from the regular CAs meetings organized by HealthGov in the region, other venues are available where the group can discuss TA status/progress in the provinces, plan for synchronized TA delivery, and update each other on new developments. These are the RCBI TWG meetings (monthly for CHD 6 and quarterly for CHD 7) and, at times, the quarterly RICT meetings.

Another major undertaking for Y5 will be the documentation of experiences in the region, provinces, and selected LGUs. In Year 4, the region has started documenting at least two emerging best practices or TA interventions in selected LGUs that show potentials for success. These stories/documentation topics are on a) CSR and NHIP implementation in Aklan; b) ILHZ strengthening and leveraging public sector resources with private sector in Negros Occidental; c) CHLSS and SDExH in Negros Oriental; d) SDIR/F1IR institutionalization in Capiz; and e) public-private sector partnership and utilization of SDIR results in Bohol. These will be used by the CHDs/PHOs/LGUs as advocacy materials in any fora or venue to generate support for health priorities among newly-elected officials. More stories will be documented this year. In this regard, TA in documentation will be provided to the CHDs, PHOs, and LGUs. All these materials will be the region's share in the project's compendium which will be disseminated to the local partners.

## Aklan

The province of Aklan in Western Visayas is composed of 17 municipalities with a population of 547,091(projected based on 2000 NSO). It is categorized by DOH as an F44 province. The province has formulated its PIPH in 2008 with technical assistance from HealthGov, other USAID CAs and CHD 6. This was approved by JAC in September 2009 and the corresponding 2009 AOP and 2010 AOP was also approved by JAC with "A" ratings.

**The Health Situation: Trends in SO3 Indicators**

The 2006 provincial health data were below the national performance standard in terms of maternal and child health as indicated in the table. These indicators include CPR, 4ANC, SBA, FBD, DPT3, FIC, CDD treated with ORT and Vitamin A coverage. On the other hand, TB case detection and cure rate are above performance standard at the province level but there are LGUs that are below performance standard.

In the program implementation review using the SDIR tools and processes developed by HealthGov, results showed that major reasons for low performance are attributed to the lack of budget support by the province and LGUs in the implementation of health programs. This resulted to poor quality services due to the lack of equipment, dilapidated health facilities, untrained health providers, limited health promotion activities at the LGU level, lack of a comprehensive health plan, poor data management and non-functional referral and drug procurement system. Furthermore, misconceptions and lack of knowledge on the benefits of programs such as family planning, immunization, prenatal care, delivery at the health facility and skilled workers were also cited as reasons. Specific for CPR, reasons are due to poor FP data recording and reporting, lack of free commodities for indigents despite the 16 Municipalities (except Malay) having formulated its CSR plans in 2006. But the PHO has no status report on its implementation.

One major reason cited in the province was the low budget allocation by LGUs which is approximately 5-8% health budget out of the total LGU budget. This is also due to the limited resources of the province being a 2$^{nd}$ class province and with municipalities which are mostly 4$^{th}$ class and are Internal Revenue Allotment (IRA) dependent. Benefits from PHIC as seen by the province and LGUs will augment its health budget. In fact, the province has a high enrolment (50,354 or 53% of total household in 2007) on PHIC indigent sponsored program. However, there are limited RHUs accredited for PHIC with only 7/17 TB DOTS, 8/17 OPB and 1 MCP. There is also lack of policy in to ensure utilization of capitation and reimbursements for health programs/services and sustainability of indigent enrolment.

Data shows that trends are increasing on ANC, SBAs, FBDs, FIC and Vitamin A coverage from 2006 to 2009 province-wide although it is still below the national performance standard. However at the municipal level, performance varies. For TB, the CDR is decreasing but it is still within the national performance standard. The two indicators that decreased are TB cure rate and family planning CPR. CPR province-wide has decreased by 9% from 2008 to 2009. At the LGU level, in 2009 almost all LGUs have decreased its performance except for Numancia, Balete and Nabas. Only two LGUs (Batan -69% and Kalibo -67%) have achieved the MDG performance standard of 64%. The decrease in performance is due to the data validation/reconciliation undertaken by the PHO using the FHSIS guide. Initial results showed that there was over reporting on LAM current users. However, there is a need to enhance process on current users data quality check using

the updated guide. Furthermore, misconceptions on the side effects of family planning and lack of system to include private providers report were also cited.

In the hope to increase its health budget, the province and LGUs have sustained its high enrolment in the PhilHealth Sponsored Program at 56% of the total HH in 2008. In terms of facility accreditation, as of end of 2009, all RHUs (17/17) are OPB and TB DOTS accredited. However, no RHU was accredited on MCP for 2009. There are five RHUs (Numancia, Malay, Nabas, New Washington, and Batan) working for MCP accreditation. The province has received a total of PhP35,051,279.87 reimbursements and PhP15, 216, 77.11 capitation fund from PHIC for 2008. The funds were utilized by the province in the upgrading of hospital services and LGUs in the improvement of health facilities and procurement of laboratory supplies.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 42 | 47 | 47 | 38 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 61 | 65 | 66 | 66 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 66 | 71 | 77 | 79 | 80 |
| 4 | Percent of facility-based deliveries | 21 | 29 | 39 | 48 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 77 | 75 | 78 | 83 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 80 | 79 | 83 | 83 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 86 | 80 | 83 | 90 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 20 | 19 | 21 | 40 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 99 | 100 | 100 | 100 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 108 | 70 | 76 | 81 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 81 | 98 | 97 | 105 | 99 |
| 12 | TB cure rate (%) | 92 | 88 | 68 | 78 | 85 |

## The Response: TA Interventions and Results

HealthGov's TA interventions in Years 1 and 2 was assisting the province/LGUs better understand their performance on key health indicators, utilizing processes and tools of SDIR and rapid assessment on LGU CSR implementation. The information derived from these served as baseline in the MIPH, consolidated at the ILHZ level and eventually the PIPH. The PIPH, approved by DOH/JAC in September 2009, was initially formulated with TA from HealthGov and other CAs and by CHD 6 at the latter part. The province-wide rapid assessment on LGUs CSR implementation was followed with TA on the formulation of CSR plans, resulting to 17 M/LGU and province-wide CSR plans in 2008.

With the formulation of PIPH, the availability of resources to implement the plan poses a big challenge, particularly in securing provincial and municipal counterpart. The insufficient budget is attributed to the limited resources of the province and the municipalities. In the continuing

consultations with the PHO and selected ILHZ/LGU, it was agreed that HealthGov's TA interventions will focus on improving health care financing in the province and priority ILHZs (Southwest Aklan and Northwest Aklan) to ensure sufficient resources for priority public health programs that will contribute to the increase in CPR and to improve health outcomes. The TA interventions revolved around:

1. Support to improving service delivery in family health through strengthening CSR response by LGUs province-wide, with TA/interventions ranging from assessment, plan updating, FP data clean up, re-forecast, CSR policy/budget support for FP commodity procurement, FP-EPI integration/maximizing MNCHN utilization including setting up referrals to private, ICV compliance monitoring, logistics management FPCMS and SIMS; and;
2. Strengthening systems particularly health planning and financing, specifically on PIPH/AOP formulation, MNCHN grants accessing and local NHIP implementation. The TA/interventions would include investment/AOP/NHIP planning, LGU health management information system, province AOP integration to AIP, PME, MNCHN grant accessing and utilization, NHIP local implementation assessment, plan approval, policy/budget support for plan implementation specifically on NHIP -- attention to enrolment, accreditation, improving capacity to claim, and management of funds as re-investment for public health.

From this point until Year 4, HealthGov's TA provision in collaboration and partnership with the PHO, DOH Reps, LGUs and CHD went full blast, resulting in the following major outputs:

<u>CSR/MNCHN</u>

- Province-wide and 17 LGU plans formulated/updated with 15/17 LGUs allocated budget in 2009 amounting to PhP969, 000. The province-wide CSR plan was integrated in the AOP.
- 8 LGUs of SWAILHZ and NAILHZ passed ordinances/resolutions in support to CSR plan with budget allocation ranging from Php25, 000 to Php100, 000 per municipality.
- Ibajay RHU with increased in FP new acceptors resulting from the training of health personnel on FP-EPI integration and maximizing MNCHN services
- 25 health personnel trained on ICV and have monitored only 12 out of 17 RHUs with no vulnerability noted
- Province accessed the PhP1.2M FP/RH grant of 2008, utilized in the purchase of FP commodities and drugs/supplies for permanent methods, CSR/MNCHN TWG meetings and Implementation Review

<u>Health planning and financing</u>

- PIPH approved by JAC review for 2009-2013 with estimated budget of PhP1.1B
- 2009 and 2010 AOPs approved with "A" rating, 2009 budget released amounting to PhP25.7M which was utilized in the upgrading of Boracay and DRSTMH Provincial Hospital;
- 5 LGUs from SWAILHZ with NHIP plans, formulated based on assessment results and with LGU-specific focus on either expanding and/or sustaining enrolment of the poor, accreditation, management of capitation funds/reimbursements, and improving ability to claim reimbursements;
- Five LGU resolutions were passed approving the LGU NHIP plan with budget allocation

- 17/17 of the RHUs are TB DOTS-accredited and are OPB-accredited; 5 are on the process for MCP accreditation

HealthGov's overall approach to TA delivery has been to closely collaborate and coordinate with CHD/PHTO and build capacities of PHO/PHTO/selected ILHZ/LGU as TA providers to LGUs. Keeping abreast with and in support of the DOH's RCBI policy issuance, the project engaged and capacitated local TA providers (LTAP) in CSR policy advocacy and NHIP planning/policy starting in 2009. This also enabled HealthGov to reach more cities/municipalities, increase the awareness of and motivate NGO-LTAPs to actively participate in health-related government processes, and promote LGU-NGO partnerships and collaboration that can be sustained even beyond the project life.

**Year 5 Priority Interventions and Expected Results**

Building on the accomplishments for the past three and a half years, the USAID CAs particularly HealthGov for the remaining year of the project will consolidate and complete TA interventions that have been started and/or strengthening of the existing TA interventions. These include key LGU health systems and priority program areas (i.e., MNCHN, PhilHealth) that will contribute towards increase in performance on MNCHN and TB indicators.

Particularly, the following TA interventions will address the remaining gaps identified by the province and the LGUs:

<u>CSR/MNCHN</u>

- Roll out of policy advocacy to expand to the remaining nine LGUs in the province to ensure full implementation of CSR and to comply with the MNCHN facility grant requirements;
- Training on FP current user's data quality check
- Training on FP commodity monitoring system to ensure availability of FP commodity for the clients;
- Sustain ICV monitoring to ensure delivery of quality FP services through mobilizing the Province MNCHN TWG to completely monitor the 17 facilities and clients;
- Assist the province in preparing the province-wide annual training plan; Training of health providers on data quality check on selected MNCHN indicators derived from the FHSIS to improve health data as basis in planning and advocacy and action planning in preparation for the AOP 2012;
- Assist the province in completing the documentary requirements to access the MNCHN 2010 grant amounting to Php 4 million and in the development of guidelines for its allocation and utilization to ensure budget support for MNCHN program and services which will contribute to increase in MNCHN indicators.

<u>Health planning and financing</u>

- Advocacy support to the PHO/ILHZs in integrating the province-wide 2011 AOP in the AIP to ensure budget counterpart from the LGUs and subsequently in the CDP/ELA of the LGUs ;
- Continuing technical assistance to the province and SWAILHZ to track enrollment of the sponsored program and informal sectors, policy advocacy for the management of PHIC capitation and reimbursement, accreditation of health facilities for MCP and renewal for TB DOTS and OPB, and planning for its expansion to other ILHZs/LGUs; and

- Intensify campaign for increased utilization of health services in PhilHealth-accredited facilities through the engaged local NGOs, POs, and private sector.
- TOT on Local NHIP implementation
- Continuing advocacy to NEOs on health

At the end of Year 5, HealthGov's technical assistance to the province will contribute towards the increase in health performance for MNCHN/FP health outcome indicators, resulting from:

- Province and 17 LGUs with approved CSR/MNCHN Ordinance/Resolution allocating funds annually and procuring MNCHN related commodities;
- Province and 17 LGUs accessed MNCHN grants and utilized in the procurement of FP/MNCHN commodities, training of health personnel, implementation of services and monitoring;
- Province adopted and utilizing an FP monitoring and commodity system tool;
- SWAILHZ LGUs have sustained 100% enrolment of their indigent household to PHIC sponsored program;
- SWAILHZ LGUs have additional 100 individuals enrolled from the informal sectors
- Five additional RHUs accredited for MCP
- Sustained accreditation of facilities in the province for 17/17 TB DOTS and 17/17 OPB
- 80 % of the capitation funds and reimbursement utilized in the capacity building of health personnel and upgrading of health services

Rounding up all these is the documentation of all "success stories" or interventions that are potential/emerging best practices. Documentation was started last quarter of Year 4, with two materials – 1) LGU support to CSR in South West Aklan ILHZ; and 2) local NHIP implementation in SWAILHZ – linking with micro-finance institutions for a multi-payer scheme. These are prepared in time for the PHO/CHD use as an advocacy material during CHD-led or DILG-led fora with new LCEs in September 2010. As the project moves on to its last year, more success stories will be documented for local use. The primary intent is for intended audience, specifically LCE/decision makers, to invest on a certain health approach/intervention as this will contribute to improved health outcomes.

**Priority TA Interventions and Activities**
**AKLAN**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C b | Quality of family planning user's data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | 1. Reforecast commodity requirements using clean FP data<br><br>a. Follow-on meetings with the PHO/PHTL/DOH Reps/FP Coordinator to discuss progress of all LGUs FP data clean-up | Coach | | | **M17** | | | | | | | | | | | 17 | |
| | 1.1C.a<br><br>1.1B b | Cleaned FP current users data used in updating CSR plans<br><br>CSR+ plan updated | b. Workshop on province/LGU CSR plans specifically on forecasting for Vitamin A, TB and FP using cleaned data (note: reforcasted CSR+ requirements will be integrated in the AOP/AIP) | Develop the design, resource person/ facilitator, fund support | | | **P1 M17** | | | | | | | | | | 1 | 17 | |
| | | | 2. Expansion of policy advocacy province-level and remaining 9 LGUs<br><br>a. Action planning with PHO, PHTL/DOH Reps on expanding their CSR policy advocacy support to 9 LGUs | Facilitate, coach | | | | | | | | | | | | | | | |
| | 1.4C.a<br><br>1.1B.c (1.1Fa) | NGO/CSO participated in CSR policy development<br><br>CSR policy crafted with broad stakeholders participation and support | b. 1-Day orientation of 9 LGUs MHO, SB Health, FP Coordinator, NGO/CSO to draft CSR policy ordinance and agree on next steps per LGU to consult community and secure policy approval | Facilitator, resource person, orientation design, meeting cost | | **P1 M9** | | | | | | | | | | | 1 | 9 | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.1B.e | CSR (CSR+) plan and policy implementation tracked | 3. Track CSR policy implementation of 8 LGUs (first batch) to include utilization of CSR budget in the procurement of commodities for the poor and other provisions<br><br>a. Meeting with PHO/PHTL/DOH Reps to customize tracking tool and orient them on its use | Resource person, tracking tool<br><br>Coach<br><br>Facilitator | | | **M1** | | | **M1** | | | | | | | | 2 | |
| | | | c. Meeting with the PHO/PHTL to review the results, analyze and come up with recommendations to improve CSR+ implementation | | | | | | | | | | | | | | | | |
| 2. Integration of FP/EPI, postpartum FP and maximizing utilization of MNCHN services (FP, ANC, SBA and FBD) | 1.3 A d | Providers trained in FP/EPI integration and maximizing utilization of MNCHN services | 1. Monitor the orientation/training and planning of 10 LGUs - M/CHOs, PHNs, RHMs, NGO/CSO in FP-EPI integration and maximizing utilization of MNCHN services | Resource person, facilitator, orientation design, materials, meeting cost | | | **M10** | | | | | | | | | | | 10 | |
| | | Progress reports | 2. On-site visits (2 LGUs), together with PHO/DOH Reps, to monitor progress, initial results (records of referrals of services for FP, MNCHN) | Resource person, coach | | | | | | | | | | | | | | | |
| | 1.4C c | LGU-NGO/CSO partnership established for implementation of integration of FP-EPI and maximizing utilization of MNCHN services | 3. Periodic meetings with PHO, PHTO, LGUs to discuss progress, including documentation of results, review of records and referral of services for FP and MNCHN | Facilitator, resource person, monitoring tool and templates | | | | | | **M10** | | | | | | | | **10** | |
| | 1.4A.b | Public fora with NGO/CSO participation conducted to present/share results to stakeholders | 4. One day province-level meeting to present/share results to stakeholders | Activity design, facilitator/ resource person; fund support | | | | | | | **P1** | | | | | | 1 | | |
| 3. Capacity building activities on FP, TB and MNCHN | 1.3 A b | Province-wide annual training plan prepared | 1. Meetings with PHO/PHTO to update annual training plan as sub-plan to the AOP 2011 based on updated database on service providers' capability profile | | **P1** | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 4. ICV compliance monitoring and reporting system | 1.3D c | ICV compliance of FP/RH service delivery sites monitored and reported | Quarterly meetings with the provincial ICV compliance monitoring team to discuss findings, review/analyze consolidated reports | Coach | | | M5 | | | M5 | | M7 | | | | | | 17 | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Implementation of NHIP based on benefit delivery approach in SWAILHZ | 1.2B.a | TOT in Local NHIP implementation (BDR) | BDR Orientation | Resource person, tools/templates, orientation design | | | M5 | | | | | | | | | | | 5 | |
| | 1.2 C.a | Application for accreditation filed (renewal for OPB and TB DOTS and new application for MCP) | Facility accreditation | Coach/resource person<br><br>TB LINC for TA and training for TB DOTS accreditation | | | M5 | | | | | | | | | | | 5 | |
| | 1.2C.b | Facilities accredited by PhilHealth (for OPB, TB DOTS and MCP) | | Facilitator | | | | | | M5 | | | | | | | | 5 | |
| | 1.2A.c (1.1F.a) | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed | One-day orientation/planning to draft policy for management of PHIC reimbursement and capitation funds | Resource person, fund support | | | M5 | | | | | | | | | | | 5 | |
| | 1.1F.b<br><br>1.1G.b | Policies approved<br><br>LGUs collaborated in implementing NHIP plans | Meeting with the ILHZ Board to generate support and approval of policy/guidelines on the management and utilization of PHIC funds | Resource person, fund support | | | | | | M5 | | | | | | | | 5 | |
| 2. 2009/2010 MNCHN grants facility | 1.2A.b | MNCHN grant accessed | 1. Meeting with PHO MCH cluster coordinators to review and consolidate requirements for 2010 MNCHN grant for submission to CHD 6 | Facilitator, MNCHN grant templates | | | | | | | | | | | | | | | |
| | | | 2. One-day orientation of PHO, DOH Reps, LGUs on the MNCHN grant utilization tracking tool and planning for its use | Resource person, facilitator, tools/templates | | | | | | | | | | | | | | | |
| | | | 3. Meetings with PHO, CHD/PHTO to discuss results of tracking | Coach | | | P1<br>M17 | | | | | | | | | | 1 | 17 | |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. 2011 AOP/CDP-ELA integration | 1.1A.h | AOPs (PIPH) prepared and integrated into CDP-ELA and AIP | a. Meetings with the PHO, PPDO to finalize list of priority PPAs and advocacy to PPDO for its inclusion to AIP 2011<br><br>b. Meetings with the PHO, PPDO, LFC, PLGOO for the inclusion of PIPH/Provincial AOP 2011 into the CDP-ELA | Facilitator, STTA | | P1 | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Data management | 1.1 C.d | Personnel trained in DQI of MNCHN indicators (SBA, FBD, FIC, DPT3, EBF, among others) | Data quality check of other MNCHN indicators<br><br>a. Orientation training of PHO technical staff, DOH Reps, MHOs, NGO and CSO in DQC on FHSIS indicators | Resource person, tools | | | | | **P1 M17** | | | | | | | | 1 | 17 | |
| | 1.1C.c | Quality of other family health performance indicators derived from FHSIS (i.e. SBA, FBD, 4ANC, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | b. On-site visit to LGUs (at least 2), together with PHO/PHTO, to provide follow on TA in FHSIS DQI | Coach | | | | | | | **P1 M17** | | | | | | 1 | 17 | |
| 2. Logistics management | 1.1E a | TOT in FP commodity monitoring system (FPCMS) conducted | a. Training of trainers in FPCMS for PHO/DOH Reps and on SIMS for C/MHO/PHN | Facilitator, tools/templates, STTA | | | **P1** | | | | | | | | | | 1 | | |
| | 1.1E b | FP commodity monitoring system tool adopted | b. Meetings with PHO, PHTL to review LGU reports on FPCMS and utilize data for planning logistics procurement in the AOP | Facilitator, templates | | | | | | **P1 M17** | | | | | | | 1 | 17 | |
| **D. Advocacy to newly elected local chief executives/ other local officials** | 1.4B.c | Best practice documents presented/shared to the NEOs | Document best practice and prepare presentation material for sharing to the province-wide alliance building | STTA | | | | | | **P1** | | | | | | | 1 | | |

## Bohol

Bohol is the 10th largest island in the country, a major tourist destination, located in Central Visayas with a population of 1.23 million distributed in 47 municipalities and one city. It is a first class province, de-listed in 2005 from the poorest 20 provinces.

Bohol was the last province engaged by HealthGov in 2007 and never had USAID projects on health sector reform in the immediate past five years prior to the engagement except for PRISM that focused on the private sector.

**The Health Situation: Trends in SO3 Indicators**

The trend and comparative data of selected SO3 indicators from 2006 to 2009 below indicated persistent problem on services for maternal, neonatal and child care with low quality ANC, FBD, FIC, micronutrient supplementation and children with diarrhea treated with ORT. Performance are increasing in trend (except for Vitamin A supplementation) but still below national standards. Deliveries by skilled birth attendants have achieved performance standards, though majority of women still prefer home deliveries.

Data management of the Field Health Service Information System (FHSIS) is also a nagging problem because of the absence of periodic data quality check but with the introduction of the assessment tools on Service Delivery Implementation Review (SDIR), improvement in data collection and analysis was triggered. Maternal death reporting was improved from 30/100,000lb in 2006 to 72/100,000lb. Deaths in the hospitals of Tagbilaran City are now collected and reported by the respective municipality where it came from. The 17 maternal deaths in 2009 came from 14 municipalities and most commonly occurring in four (4) municipalities of Catigbian, Mabini, Ubay and CPG since 2006. These areas are noted to have low access to birthing facilities and service providers, difficult terrain and transportation facilities that usually result to delayed referrals of complicated deliveries. RHMs in Ubay are covering an average of 6000 population a ratio more than the standard of at least 2500 per RHM. Though majority of the municipalities (87%) have deliveries by skilled birth attendants more than the national standards of 80%, there are also six (6) municipalities with more than 30% deliveries attended by traditional birth attendants. The improvement of facility based deliveries by 29% in 2009 over that of 2008 are from 15 municipalities who reached national standard of 70% and five municipalities that have significantly increased facility based deliveries by 12-90%. These include the municipalities of Duero, Alicia, Candijay, Mabini, Ubay 1 and Sevilla. Duero started to increase facility based deliveries after MCP accreditation. HealthGov assisted the RHU to comply for accreditation by training one RHM on LSS. The rest of the facilities have recently implemented lying–in clinics and RHUs like Talibon and Carmen established birthing centers at the BHS. The reporting of the IMAP clinics of services rendered for maternal care likewise contributed to the improvement of FBD coverage. There are nine (9) IMAP clinics that are MCP accredited.

There is a decreasing trend in IMR but the data most likely are still under-reported. Child immunization increased from 75% in 2008 to 80% in 2009 but only three municipalities (Tagbilaran City, Dauis, and Dimiao) achieved the national standards with more than 100% performance. These are highly populated and accessible areas. Extremely low FIC between 50-60% are from Anda, Sikatuna, Loon and Jagna. Children given Vitamin A has decreased from the 2006 level of 87% to 73% in 2009 mainly due to lack of social preparation despite social mobilization planning conducted prior to GP. In a recent data quality check it has been found out

that there are existing problems in FSHIS data recording and reporting that has generally affected performance of most program due to under reporting.

CPR has increased to 33% (2009), but still very low compared to the national average. In 2009 majority of the municipalities (70%) have increased CPR and two municipalities, Inabanga and Talibon reached the national standard. Both municipalities allocated funds for the procurement of commodities and Talibon MHO is an active provider of NSV. The CSR planning and policy advocacy has encouraged 19 LGUs to allocate funds and procure commodities. The FP grant has helped augment the lack of FP commodities at the local level. Likewise, the intervention on FP-EPI in Dauis has also increased the demand for FP services of the municipality increasing the CPR from 35 % in 2008 to 58% in 2009.

TB Cure Rate and case detection rate has gone down in 2009. There are 26 LGUs (62%) with low case detection rate below 70% standard (includes Tagbilaran City) and five (5) municipalities with low cure rate. The situation is highly affected by the lack of Medical Technologists since half of the RHUs do not have permanent Med Techs and the province-paid Medical Technologist visits only once or twice a week and covers only ¾ of the LGUs. The worst will happen if the provincial rationalization plan will push thru and all provincial med technologists will be recalled and assigned in the hospitals.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 27 | 28 | 30 | 33 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 56 | 54 | 55 | 56 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 85 | 85 | 94 | 91 | 80 |
| 4 | Percent of facility-based deliveries | 26 | 25 | 34 | 53 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 70 | 65 | 67 | 67 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 73 | 66 | 75 | 80 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 87 | 88 | 74 | 73 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 48 | 44 | 41 | 52 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 100 | 100 | 100 | 99 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 67 | 65 | 65 | 65 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 89 | 84 | 85 | 86 | 99 |
| 12 | TB cure rate (%) | 90 | 91 | 91 | 84 | 85 |

The overall percentage of families in 2009 enrolled in PhilHealth is 233,395HHs or 102 percent. Sponsored program enrolment has increased from 63,254 HHs in 2008 to 92,714 HHs in 2009 implemented in three modes: a) 50-50 cost share between the province and municipality; b) purely municipality; and, c) purely province. Total sponsored program enrolment exceeded by 167% of the 25% indigent household estimate of PhilHealth. Despite the high coverage, there are still pockets of indigent not covered by municipalities like Panglao. There is therefore a need

to align and rationalize enrolment, accreditation and fund management of capitation and reimbursements to impact on better health services and outcomes. To date, accredited facilities increased to 36 OPB, 26 TB-DOTS and four (4) MCP public facilities of Carmen, Talibon, Duero and Calape. The project has assisted Duero and Calape thru the LSS training of RHMs.

**The Response: TA interventions and results**

On the initial engagement of the province in 2007, it was observed that the interplay of health sector reform components are not actively implemented to include local health systems assessment and planning, monitoring, financing, Inter-LGU partnership, contraceptive self-reliance and functional provincial health board, strengthening data management as inputs to planning and advocacy for policy support. Therefore in the last four years, HealthGov has continuously worked towards strengthening LGU health systems in planning, monitoring, improving the performance of service providers, contraceptive self reliance strategy and increasing advocacy for health. In all of these activities and technical assistance, the project has established stronger partnerships with the DOH, CHDs, local governments, NGOs, and other USAID cooperating agencies (CAs) to ensure effective delivery of project interventions, maximize resources and sustained implementation.

In the 3rd quarter of 4, HealthGov has taken the initial step in modeling the processes in the engagement of local assistance partners (LTAPS) together with CHD to ensure replication after the project ended. HealthGov's experience in engaging the services of TAPs to expand the availability of technical resources at the local level is an essential input to the CHDs mandate in responding to LGUs need for technical assistance.

Among the more notable contributions of the project in the past four years are: a) Strengthening health planning and monitoring systems thru the introduction of the SDIR tools harmonized with the LGU Scorecard in the assessment of FOURmula 1 implementation prior to the province wide investment planning for health (PIPH) b) TA in the development of local investment plans and the yearly Annual Operations Plan (AOP) for health to ensure financing for priority health interventions; c) development of a service delivery-centered assessment tool to guide the identification of program gaps and formulation of strategic interventions in public health and hospitals; d) enhancement of the contraceptive self-reliance (CSR) strategy and relevant tools to ensure the availability of FP commodities to reduce unmet needs for FP; e) Modeling the engagement of LTAPS for CSR policy advocacy to ensure availability of technical assistance at the local level at all times; f) Modeling integration of FP and EPI services to mothers and children to increase demand for FP services to reduce FP unmet needs; g)Facilitate accessing, allocating, and utilizing the DOH's grant facility for maternal, newborn, and child health and nutrition (MNCHN); and, h) With CHD 7, developed data quality check tools to improve accuracy of FHSIS data collection and reporting.

To date, the province of Bohol has enjoyed the benefits of the following gains among others:

- Reactivated the Provincial Health Board (PHB) that has remained dormant for three years. It became the venue where the mandate to plan the PIPH was first discussed.
- Program Implementation Review (PIR) was revived by providing tools on the harmonized SDIR / LGU Scorecard to identify gaps and developed appropriate interventions to improve service delivery in 48 LGUs that formulated the acceleration plans. Before HealthGov engagement, the province had no program implementation review in the last two years.

- Supported the formulation of a province wide investment plan for health PIPH; and 48 AOPs updated yearly.
- Assisted in the formulation of CSR plans after the first SDIR in 2007 and facilitated the integration of CSR budget in the municipal AIPs of 2008. A full blown technical assistance in updating 24 municipal CSR plans followed. These has resulted to 19 municipalities providing budget for FP commodities amounting to a total of PhP2.5M. The Province was also assisted to access the FP grant in the amount of PhP2.3M to augment the LGU funds for FP commodities.
- Engaged LTAP to do CSR policy advocacy together with CHD/LGU partners in 9 municipalities and mobilized two other municipalities to passed CSR ordinance. NGOs and civil society were given the opportunity to input and participate in the policy decision making. To date there are 10 municipalities with CSR ordinance.
- Supported 22 RHMs to train in Life Saving Skills (LSS) from identified facilities ready for MCP accreditation. From among those trained, 2 RHUs (Duero and Calape) have qualified for MCP accreditation.
- Oriented a hundred service providers on ICV initially during SDIR and organized a planning workshop to monitor ICV compliance province wide among 18 DOH representatives, PHO staff and IMAP clinic managers. To date, there are 16 municipalities and 8 IMAP clinics monitored for ICV compliance with no known vulnerability.
- Modeled the FP-EPI integration of services in Dauis that showed marked increase in the FP new acceptor especially in the barangay Totolan. The municipality has increased CPR from 38% in 2008 to 58% in 2009.
- Mentored the province to access the MNCHN grant for 2009 and 2010 thru the identification of the prioritized activities to support for the grant and the development of the provincial MNCHN plan.
- Assisted the province in forging partnerships with local NGOs and civil society organizations (CSOs).
- Mentored the CHD in the development of SOW and identifying potential LTAPS on the NHIP Benefit delivery approach technical assistance for Bohol.
- Engaged STTA to document best practice in the province.

**Remaining Gaps and Challenges**

Building on the gains and current status of TA provision in the province there is a need to continue strengthening data management of FSHIS by building the capacity of PHO and DOH rep in the use of data quality check tools to generate quality data that can be used in planning and decision making to improve ANC, FBD, CPR, FP especially in the forecasting of commodity requirement for MNCHN. To ensure sustainability of the PIPH, major TA in integrating the plans at the local level in the Executive Legislative Agenda of the LGUs, partnering with other national agencies (DILG, DOH) in advocacy for health is equally important to pursue. Rationalizing implementation of NHIP thru the BDR and emphasizing the benefit of accreditation and fund management to improve service delivery performance in MNCHN and TB.

Tracking MNCHN/CSR fund utilization to cover for the major components and interventions in providing the continuum of care is a must, together with advocacy on policy support in the form of LGU issuances (EO, resolutions and ordinances.) Remaining CSR plans need to be updated and likewise approved, and budget allocation ensured. ICV compliance monitoring for the remaining 36 LGUs also needs to be addressed.

The experience of the municipality of Dauis in increasing CPR thru the integration of FP-EPI services should be scaled up to create an impact provincewide by capacitating PHO and DOH representatives to include the cost of interventions in the MNCHN grant. It is also critical to ensure that the supply side meets the increased demand for FP commodities so there is a need to capacitate partners in FP commodity monitoring system for planning and institutionalize logistics management in order to ensure the availability of commodities at service delivery points.

**Year 5 Priority Interventions and Expected Results**

Given the limited resources and time constraints, HealthGov's TA interventions for Year 5 will focus on:
A. Support to improving service delivery in family health:

- LGU CSR+ plan updating and re-forecasting, utilizing cleaned FP current users data, including MNCHN and TB;
- Capacitating PHO and DOH Reps on policy development for MNCHN/ CSR+
- Scaling up the interventions of FP integration into EPI and maximizing MNCHN services and facilities province wide
- Institutionalizing ICV compliance monitoring

B. Strengthening family health program support through financing and governance:

- Continuing TA in data quality check for other FHSIS indicators, including analysis and utilization thru the leadership of the PHO and CHD.
- Facilitating access to and tracking utilization of the 2010 MNCHN grant;
- Installing the FP Commodity Monitoring System;
- AOP Preparation and integration into the CDP-ELA and AIP; and
- Continuing TA support for advocacy to NEOs

At the end of Year 5, HealthGov's technical assistance to the province will contribute towards the increase in health performance for MNCHN/FP health outcome indicators, resulting from:

- Province and 48 LGUs with updated CSR plans
- Province and 48 LGUs with approved CSR/MNCHN Ordinance/Resolution allocating funds annually and procuring MNCHN related commodities
- Province and 48 LGUs compliant to ICV guidelines and protocols
- Province adopted and utilizing an FP monitoring and commodity system tool
- Province with guidelines on the adoption by 48 LGUs of a stock and inventory management system for local level facilities
- Province and 48 LGUs accessed MNCHN grants and utilized in the procurement of FP/MNCHN commodities, training of health personnel, implementation of services and monitoring
- FP-EPI integration of services implemented in 25 LGUs
- Province with approved NHIP plan, which includes enrolment, facility accreditation and fund utilization plan
- Province with institutionalized planning system ensuring data quality check used of harmonized SDIR/LGU Scorecard prior to the development of 2012 AOP and the integration of the PIPH/ AOP into the ELA of the LGUs

Given the fact that tools in assessment and planning, CSR strategy, modeling interventions in integration of FP-EPI services and data quality check in FP, tools in ICV compliance monitoring and processes in the engagement of LTAPS for CSR advocacy are available, and with limited time remaining, the project expects to see by the end of Year 5, a provincial leadership that will utilize the developed HealthGov tools and products to improve its health outcomes. The full implementation of the CSR+ strategy including ICV and the sustained adoption of the FP-EPI integration strategy are foreseen to increase the very low CPR. A more focused utilization of the MNCHN grant to areas with high risk for maternal and infant mortality is an utmost consideration. By project end, the province would have also adopted, on a sustainable basis, the SDIR process and tools for improved planning, thus, ensuring the preparation of more responsive health plans.

**Priority TA Interventions and Activities**
**BOHOL**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN Strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.a | FP commodity reforecasted using cleaned data | Reforecast of commodity requirements using clean FP data | Facilitator, resource person, tools, design | **M25 C1** | | | | | | | | | | | | | 25 | 1 |
| | 1.4C c<br><br>1.1B.c (1.1F.a) | NGO/CSO participated in CSR policy development<br><br>CSR Policy crafted with broad stakeholders participation and support | Expansion of policy advocacy at the province-level in remaining 26 LGUs | Facilitator, resource person, tools, design | | | **M25 C1** | | | | | | | | | | | 25 | 1 |
| | 1.1B.e | CSR plan and policy implementation tracked | Tracking utilization of CSR budget in the 10 LGUs with CSR ordinance | | | **P1 M10** | | | **P1 M10** | | | | | | | | 1 | 10 | |
| | | | Adoption of FP commodity monitoring system (FPCMS) at the province level | | | | | | | | | | | | | | | | |
| 2. Integration of FP into EPI, post partum FP, and maximizing utilization of MNCHN services; social mobilization for improving FIC, Vitamin A supplementation | 1.3Ad | Service providers trained in integration of FP/EPI and maximizing utilization of MNCHN services | Orientation training of RHU personnel in integration of FP/EPI and maximizing utilization of MNCHN services | Trainer and facilitator, design, materials, fund support | **P1 M25** | | | | | | | | | | | | 1 | 25 | |
| | 1.4 C c | LGU-NGO/CSO partnership established for implementation of integration of FP-EPI and maximizing utilization of MNCHN services | FP-EPI integration action plan implementation | Coach PHO/DOH Reps; monitoring of implementation (on-site visits) | | | **M3** | | **M3** | | | | | | | | | 3 | |
| | 1.4A.b | Public forum to present results to stakeholders with NGO/CSO participation conducted | One day province-level meeting to present/share results to stakeholders | Activity design, facilitator/resource person; fund support | | | | | | | **P1** | | | | | | 1 | | |
| 3. Capacity building of FP-MNCNH providers | 1.3A.a | Database on service providers' capability profile established | Planning meeting with PHO program coordinators and PHTO to update training and service providers' capability profile database | Coach, resource person | **P1** | | | | | | | | | | | | 1 | | |
| 4. Institutionalization of ICV compliance monitoring in the province | 1.3D d | ICV compliance monitoring and reporting locally mandated (note: This will be integrated into the MNCHN/CSR Provincial Ordinance) | Meetings with PHO/PHTO, SP Health to draft EO on regular ICV compliance monitoring and formation of the ICV compliance monitoring team | Coach/mentor | **P1** | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.3D.c | ICV compliance of FP/RH service delivery facilities monitored and reported | Meetings to discuss findings and recommendations of the ICV compliance monitoring | Coach | **M5** | **M5** | **M5** | **M5** | **M5** | **M5** | **M5** | **M5** | **M7 1C** | | | | 1 | 47 | 1 |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on BDR approach | 1.2B.a | TOT in local NHIP implementation conducted | Orientation/meeting with PHO, LGUs on NHIP/BDR and development of the tool on local NHIP implementation status and planning for its conduct | Resource person, tools, designs | | **P1 M13** | | | | | | | | | | | 1 | 13 | |
| | 1.1G a | LGUs collaborated in planning (ILHZ planning for NHIP) | Writeshop on NHIP plan formulation with 13 LGUs (ILHZ), NGO, private sector, NGO representative of LHB | Resource person, tools, designs, STTA | | | **P1 M13** | | | | | | | | | | 1 | 13 | |
| | 1.4C b | NGO/CSO participated in the NHIP planning | Follow-on meetings (some on-site) to assist ILHZ/LGUs complete NHIP plans and plan to secure approval and budget | Resource person, tools, designs, STTA | | | **M7** | | **M6** | | | | | | | | 1 | 13 | |
| | 1.2B.c | LGUs with PHIC enrolment plan prepared and approved | Advocacy support to generate/secure approval of the NHIP plans | Resource person, tools, designs, STTA | | | | | | **P1 M13** | | | | | | | 1 | 13 | |
| | 1.2C.a | Application for accreditation filed (renewal for OPB and TB DOTS and new application for MCP) | Meetings with the MHOs to guide them complete the documentary requirements of PhilHealth accreditation of RHU for MCP and renewal for OPB and TB DOTS | Coach/resource person; TB LINC for TA and training for TB DOTS accreditation | | **M3** | | **M5** | | **M5** | | | | | | | | 13 | |
| | 1.2C.b | Facilities accredited by PhilHealth (for OPB, TB DOTS and MCP) | Coordinate with PHIC and MHOs to fast track MCP accreditation and renewal on TB DOTS and OPB of the 5 LGUs | Facilitator | | **M3** | | **M5** | | **M5** | | | | | | | | 13 | |
| | 1.2A.b (1.1F.a) | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and/or implemented | One-day orientation/planning to draft policy for utilization of PhilHealth funds | Resource person, fund support, STTA | | | | **P1 M13** | | | | | | | | | 1 | 13 | |
| | | | Meetings with provincial NHIP TWG to discuss progress of action plan implementation | | | | | | | **M13** | | | | | | | | 13 | |
| 2. Accessing and managing DOH MNCHN grants | 1.2A b | MNCHN grant accessed | 1. Meeting with PHO MCH cluster coordinators/PHTL/ DOH Reps to review and consolidate requirements for domains 2 and 3 of the 2010 MNCHN grant for submission to CHD 6 | Facilitator, MNCHN grant templates | **P1** | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | | | 2. One-day orientation of PHO, DOH Reps, LGUs on the MNCHN grant utilization tracking tool and planning for its use | Resource person, facilitator, tools/templates | | P1 | | | | | | | | | | | 1 | | |
| | | | 3. Meetings with PHO, CHD/PHTO to discuss results of tracking | Coach | | | | | P1 M47 C1 | | | | | | | | 1 | 47 | 1 |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide PIPH/AOP preparation | 1.1A.e | AOP formulated | Follow-on meetings with PHO, PHTO, LGUs on progress of C/M AOP 2012 completion | Facilitator, STTA | | | | | | | | P1 | | | | | 1 | | |
| | 1.1A.h | AOPs (PIPH) prepared and integrated into CDP-ELA and AIP | Monitor integration of priority health agenda (PIPH/AOP) into the the LGU CDP-ELA | Facilitator | | | | | | | | | P1 | | | | 1 | | |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | a. Training of trainers in FPCMS for PHO/DOH Reps and MHOs | Facilitator, tools/templates, STTA | | P1 | | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | b. Meetings with PHO, PHTL/DOH Reps to review LGU reports on FPCMS and utilize data for planning logistics procurement in the AOP | Facilitator, templates | | | | | | | P1 M47 C1 | | | | | | 1 | 47 | 1 |
| **C. Advocacy to newly elected local chief executives/ other local officials** | 1.4B.c | Advocacy materials on priority health agenda as contained in the PIPH/AOP 2011 to be included in the LGU development agenda (ELA) presented during the health summit | Province-wide orientation of newly elected officials such as Mayors, Vice-Mayors, Governor and Vice-Governor (can be integrated into the planned Health Summit of the province) | All CAs as Resource persons<br><br>Advocacy materials/design<br><br>Fund support | P1 | | | | | | | | | | | | 1 | | |

## Capiz

The Province of Capiz is one of the F1 convergence sites in the Visayas. The province has a total population of 708,468 (projected based on NSO 2000) spread in 16 municipalities and one city. They have implemented its PIPH starting in 2007-2010 with funding support from the European Commission for its health facility upgrading and capacity building of health personnel and technical assistance from USAID.

**The Health Situation: Trends in SO3 Indicators**

USAID and other funding agencies have been assisting the province on health reforms. This resulted in the installation of health systems such as essential drug management, health passport program and setting up of PopShops in all 17 LGUs.

Results of the PIR using the SDIR tool, revealed that in 2006, health performance of the province for maternal and child health services are below national standards. Low MCH program performance was greatly affected by demand-side factors which translated into low utilization of MCH services. Despite having 17 RHUs with PopShops, CPR is low in some LGUs because the poor would often prefer free FP commodities. This is compounded by the underutilization of the provincial budget allocation for FP commodities with only 46% utilization (i.e., of the total allocated amount of PhP799, 607 only PhP365, 088 was utilized).

Furthermore, non-achievement of indicators were also attributed to the lack of facilities, equipment, medicines and supplies at the RHU level, low staff morale and poor motivation due to non-full implementation of the benefits enshrined in the Magna Carta for Health Workers.

The province's health performance on selected indicators is mostly decreasing in trend from 2007 to 2009 as indicated in Table 1. However, significant increase is noted in facility-based deliveries and births attended by skilled birth attendants.

On CPR, data from the FHSIS showed an increase from 52% in 2008 to 53% in 2009. Only two LGUs (Roxas City - 82% and Dumalag - 65%) have achieved the MDG performance standard of 64% in 2009. It can be noted that Pilar and Maayon under Bailan ILHZ have increased its performance. This can be attributed to the implementation of the clinical standards indicated in their Service Improvement Plan for SDExH and activities indicated in their CSR plans.

Provincial performance for 2009 on MCH is improving especially for SBA and FBD. Antenatal care of pregnant women showed a decreasing trend from 47% in 2007 to 39% in 2009. Program reviews revealed that it may also be attributed to the irregular hours of prenatal check up at the BHS level because in 15 LGUs, one midwife is handling two to three *barangays*. There is an increasing trend in deliveries at health facilities (from 47% in 2007 to 67% in 2008). On child health, almost all LGUs have decreased its accomplishment except for Maayon that increased by 3% from 77% in 2008 to 80% in 2009 and President Roxas which maintained its performance to 50% for 2008 and 2009. This can be attributed to the implementation of defaulter tracking as part of the implementation of clinical standards on FIC under SDExH. The irregular schedule of immunization in far-flung areas, high population projection and non-integration of maternal and child care services were cited as reasons. The trend in Vitamin A coverage is improving from 78% in 2007 to 89% in 2009. Zinc supplementation for diarrheal cases has not yet been implemented province-wide.

TB performance has consistently achieved national standards for TB CR and CDR due to a well-managed TB program at all levels, and the active participation of the communities and the private sector in the PPMD. All LGUs (17) are accredited for TB DOTS.

In support to service delivery, PHIC benefits are seen as source of funds to augment health budget. As of October 2009, PhilHealth report shows that the province has already exceeded its target of enrolling 61,940 households which is equivalent to 48% of the total household. In 2008, claims availed by sponsored members and their dependents amounted to P24.4 million of which P20.9 million was availed of within the Province of Capiz and P3.4 million was availed of in other provinces in Western Visayas. Nineteen health facilities were PhilHealth-certified TB DOTS Centers (15 RHUs, CHO, Camp Peralta Station, and two private facilities). As of July 2009, all 16 RHUs and CHO sustained their PhilHealth OPB accreditation; likewise, 10 health facilities were accredited for MCP and NBS. From 23 in 2008, the number of *BnBs* already operating with special license as of July 2009 rose to 72.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 48 | 56 | 52 | 53 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 47 | 47 | 43 | 39 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 66 | 71 | 72 | 73 | 80 |
| 4 | Percent of facility-based deliveries | 37 | 47 | 61 | 67 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 70 | 61 | 80 | 75 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 74 | 69 | 81 | 76 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 86 | 78 | 90 | 89 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 8 | 14 | 13 | 56 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 100 | 100 | 98 | 99 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 85 | 78 | 91 | 89 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 113 | 104 | 121 | 102 | 99 |
| 12 | TB cure rate (%) | 91 | 91 | 90 | 93 | 85 |

### The Response: TA interventions and results

HealthGov's TA intervention in Years 1 and 2 was assisting the province/LGUs better understand their performance on key health indicators, utilizing the processes and tools of SDIR and rapid assessment on LGU CSR implementation. The information derived from these, served as input to the finalization of the PIPH, AOPs and CSR. It is then that the province and LGUs realized that despite foreign assistance, their health indices are still low compared to the national performance standard. With the assistance of EC, the LGUs have allocated budget for the upgrading of their health facilities and capacity building of their personnel. USAID CAs then will focus in increasing utilization of health services for maternal and child health and family planning focused on the two low-performing ILHZs (CDD and Bailan) and two low-performing LGUs

(Jamindan and Tapaz). The following are the TA interventions that HealthGov will extend to the Province in consultation with the PHO and PHTL:

1. Support to improving service delivery in family health through strengthening CSR response by LGUs province-wide, with TA interventions ranging from assessment, plan updating, FP data clean up, re-forecast, CSR policy/budget support for FP commodity procurement, FP-EPI integration/maximizing MNCHN services utilization, mobilizing community leaders to support MNCHN, ICV compliance monitoring, logistics management, FPCMS and SIMS;

2. Support to continuing quality improvement in family health service delivery using the processes and tools on Service Delivery Excellence in Health (SDExH). The TA interventions include support in the piloting in one ILHZ and expansion to other ILHZ; and

3. Strengthening systems particularly health planning and financing, specifically on PIPH/AOP formulation, MNCHN grants accessing and local NHIP planning. The TA/interventions would include investment/AOP/NHIP planning, LGU health management information system, Provincial AOP integration to AIP, PME, MNCHN grant accessing and utilization, NHIP local implementation assessment and action planning with attention to enrolment, accreditation, improving capacity to claim, and management of funds as re-investment for public health.

HealthGov's significant technical assistance and results to date in collaboration and partnership with the PHO, DOH Reps, LGUs and CHD are the following:

The province and 17 LGU CSR plans have been formulated/updated with 16 LGUs (except Mambusao) with an allocated budget in 2009 amounting to P1.2 million in 2009. The province-wide CSR plan have also been integrated in the AOP. In addition, eight (8) LGUs (Dumarao, Ivisan, Jamindan, Tapaz, Maayon, Pilar, Panay and Pontevedra) have already passed CSR ordinances in support to CSR plan implementation with budget allocation.

The PHO, DOH Reps and health personnel of the 7 RHUs was oriented on FP-EPI Integration and maximizing MNCHN services. Capacity building for the organized ICV compliance monitoring team was done. The team has monitored 17 LGUs to date and no vulnerabilities have been noted.

The province was able to access the MNCHN grant facility of 2008 and 2009 amounting to Php 960 thousand and Php 1.02 M, respectively. The MNCHN 2008 grant was utilized in the procurement of pills which were distributed to the 17 LGUs during the last quarter of 2009. The commodity will be distributed to the poor clients using a scheme of buy-1-take-3. The 2009 MNCHN grant will be utilized and allocated for the procurement of injectables and zinc, organization of community health teams, and capacity building related to MNCHN.

In terms of continuing quality improvement in health facilities, the province piloted SDExH in Bailan ILHZ and all 75 health personnel were trained on three phases of SDExH. Remarkable changes were observed in terms of work ethics, work environment, and attitude of the staff that became friendlier and more accommodating. There were also improved service provisions specifically tracking of EPI defaulters.

HealthGov's technical assistance enabled the province and LGUs to institutionalize and customize the use of SDIR tool into F1-IR. The results of the F1-IR were utilized as basis in the

identification of interventions in PIPH and AOPs. It also served as tool in tracking/monitoring progress of performance on a quarterly basis to accelerate performance to achieve national standards. The province has formulated its PIPH 2011-2014 and AOP of 2011. In Year 5, HealthGov will continue to support the province in the preparation of the 2012 AOP.

With regard to the province's response to emerging and re-emerging diseases, seven (7) high risk LGUs have formulated the AI preparedness plan, organized a task force and passed ordinances in 2008. The province also allocated Php 400,000 annually for AI activities and installed the Community-Based Early Warning System (CBEWS) in Barangay Talon, Roxas City which regularly conducts simulated AI preparedness exercises in Roxas City.

The province has also institutionalized and customized SDIR tool into F-1 implementation conducted regularly as basis for the AOP preparation and to track progress of health performance. Their PIPH (2011-2014) and AOP for 2011 has been formulated and approved. In addition, the Capiz Integrated Health Services Development Council, which served as the expanded Provincial Health Board (PHB) and Local Implementation and Coordinating Team (LICT) of the province, was reactivated.

TA ensured sustained good performance in TB and to prevent occurrence of MDR which included the orientation of private pharmacies on TB DOTS, and IPC training for the TB task force by HealthPRO. Capiz performs relatively well in terms of standard in TB indicators. TA provided was to ensure sustained good performance and to prevent occurrence of MDR and this included the orientation of private pharmacies on TB DOTS, and IPC training for the TB task force by HealthPRO. Towards the end of Year 4, TB LINC partnered with the province and will continue to provide technical assistance until Year 5.

HealthGov's overall approach to TA delivery has been to closely collaborate and coordinate with CHD/PHTO and build capacities of PHO/PHTO/selected ILHZ/LGU as TA providers to LGUs. Keeping abreast with and in support of the DOH's RCBI policy issuance, the project engaged and capacitated local TA providers (LTAP) in CSR policy advocacy and NHIP planning/policy starting in 2009. This also enabled HealthGov to reach more cities/municipalities, increase the awareness of and motivate NGO-LTAPs to actively participate in health-related government processes, and promote LGU-NGO partnerships and collaboration that can be sustained even beyond the project life.

**Remaining Gaps and Challenges**

Series of PIRs(latest was in July 2010), showed that low performance across MNCHN are due to low client utilization and lack of full implementation of health support systems.

Among the remaining challenges that need to be addressed are:

*On CPR*: aside from poor FP data management-related gaps, absence of CSR policies in more than half of M/CLGUs, leading to insufficient budget for FP commodities and interventions, need to re-forecast the commodity requirements using the validated data;

*On ANC, SBA, and FBD*: preference of mothers on *hilots*; and lack of implementation of policy/ordinance supportive of MNCHN strategy and limited utilization of existing birthing facilities (public);

*On FIC and Vitamin A*: high population projections/sudden change in targets, limited LGU support, lack of defaulter tracking, inadequate supervision of RHMs by PHN, underreporting; and

*On TB*: non-reporting by private physicians of patients who have initiated TB treatment, patients not coming back after the end of treatment, and hospitals not implementing the TB DOTS protocol.

**Year 5 priority interventions and expected results**

Building on the accomplishments for the past three years, the USAID CAs particularly HealthGov for the remaining year of the project will consolidate and complete TA interventions that have been started and/or strengthening of the existing TA interventions. More specifically, technical assistance will contribute towards achieving increase in performance on MNCHN and TB indicators.

In support to improving service delivery in family health, HealthGov will provide follow on technical assistance on policy advocacy to expand to the remaining nine (9) LGUs in the province to ensure full implementation of CSR and to comply with the MNCHN facility grant requirements. Furthermore, in collaboration with DOH and CHD, a data quality check will be conducted and results will served as basis in the reforecast of FP commodity requirements for another five years. Mobilize community health teams in the implementation of pregnancy tracking, birth planning, and referrals in Tapaz. Follow on assistance will be provided to monitor progress of implementation and documentation of results on FP EPI integration while continuing assistance to sustain monitoring of ICV compliance will still be provided together with the assistance to the province in accessing the 2010 MNCHN grant. In addition, a post-training follow up for Bailan ILHZ on their Service Improvement Plan implementation as well as the expansion of SDExH in another ILHZ or hospital will be undertaken.

With regard to strengthening family health program support, HealthGov will continue to support the province in the preparation of the 2012 AOP, determine status of NHIP implementation and planning based on benefit delivery approach at the province level and strengthen stock inventory and management systems of essential drugs.

The intermediate outputs/results of these interventions are as follows:

*Improving service delivery in family health through CSR*

- Province/17 LGUs with updated CSR plans/FP commodity forecast based on quality-checked FP data;
- 7 LGUs adopting the strategy of FP-EPI integration and maximizing utilization of MNCHN services;
- Provincial action plan to secure approved CSR ordinances, with multi-sector participation, in 9 LGUs;
- 9 LGU CSR ordinances crafted with multi-sector participation;
- 2009 and 2010 MNCHN grants accessed by the province/LGUs;
- ICV compliance monitoring of the 17 RHUs

*Strengthening health planning and financing*

- Provincial 2011 AOP formulated and integrated into 2011 AIP;
- Provincial 2009 and 2010 FHSIS data quality-checked;
- TOT in NHIP implementation; assessment and formulation of action plan using the BDR approach
- Provincial action plan to expand TA provision in NHIP planning and policy/budget approval to four other ILHZs;
- FPCMS adopted in the province/LGUs;
- Province and LGUs trained and implementing SIMS;
- Continuing advocacy to NEOs

Rounding up all these is the documentation of all "success stories" or interventions that are potential/emerging best practices. Documentation was started last quarter of Year 4, with two materials – 1) institutionalization of SDIR/F1-IR in the province-wide planning process; and 2) SDExH in Bailan ILHZ. These are prepared in time for the PHO/CHD use as an advocacy material during CHD-led or DILG-led fora with new LCEs in September 2010. As the project moves on to its last year, more success stories will be documented for local use. The primary intent is for intended audience, specifically LCE/decision makers, to invest on a certain health approach/intervention as this will contribute to improved health outcomes.

**Priority TA Interventions and Activities**
**CAPIZ**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.d | Providers trained in FP DQC and forecasting of FP commodity requirement | TOT of PHO/PHTO in FP data quality improvement and forecasting of FP commodity requirement | Facilitator, resource person, tools/templates | **P1 M16 C1** | | | | | | | | | | | | 1 | 16 | 1 |
| | 1.1C b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | On-site FP data clean up<br><br>Meeting with the FP Coordinator/DOH Reps to discuss results of all LGUs FP data clean up | Coach | | **P1 M16 C1** | | | | | | | | | | | | 16 | 1 |
| | 1.1C.a | Clean FP CU data used for CSR plan updating | FP commodity re-forecasting | Resource person/facilitator, tools/templates | | | **P1 M16 C1** | | | | | | | | | | 1 | 16 | 1 |
| | 1.1B.d (1.1F.b) | CSR (CSR+) policy approved | Completion of CSR policy support to LGUs with Y4 LTAP | Y4 LTAP | | | **M7** | | | | | | | | | | | 7 | |
| | 1.1B.c 1.1F.b 1.4c.a | CSR policies crafted with broad stakeholders participation and support | Expansion of policy advocacy at the province-level and in remaining 9 LGUs | Facilitator, coach, orientation design | **M8 C1** | | | | | | | | | | | | | 8 | 1 |
| | 1.1B.e | CSR (CSR+) plan and policy implementation tracked | Tracking CSR policy implementation<br><br>- meeting with PHO/DOH Reps/LGUs to customize tracking tool and orient them on its use | Resource person/facilitator | | | | **P1** | | | | | | | | | 1 | | |
| | | | - quarter meeting with the PHO to review the results, analyze and come up with recommendations to improve CSR+ implementation | Facilitator | | | | | | **P1 M8** | | | | | | | 1 | 8 | |
| 2. Integration of FP/EPI and maximizing utilization of MNCHN services (FP, ANC, SBA and FBD) | 1.3Ad<br><br>1.4Cc | Service providers trained in integration of FP/EPI and maximizing utilization of MNCHN services<br><br>LGU-NGO/CSO partnerships established for planning, budgeting, implementation of integration of FP/EPI and maximizing utilization of MNCHN services | 1. Periodic meetings with PHO/PHTL/LGUs, to discuss implementation status/progress, including documentation of LGU results, review of records and referrals of services for FP and MNCHN | Facilitator, resource person, monitoring tool and templates, | | | | | | **M7** | | | | | | | | **7** | |
| | 1.4A.b | Public fora with NGO/CSO participation conducted | 2. One-day province level meeting to present/share results to stakeholders | Activity design, facilitator/resource person, fund support | | | | | | | | | **P1** | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 3. Modeling of community participation/mobilization in a low-performing LGU of Tapaz with GIDA and Ips | 1.4C.c | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGOs/CSOs inputs | Continuing implementation of planned activities in support of MNCHN services in Tapaz LGU<br>- on-site/*barangay* meetings of CHT in the GIDA *barangays* of Roxas 8, Cristina, Daan Norte, Nayawan, Agcococ, Camburanan, Artuz, Libertad, and Candelaria | Coach, Y4 FOG | | | **M1** | | | | | | | | | | | | 1 | |
| | 1.4A.b | Public fora with NGOs/CSOs participation conducted | - Meetings to provide feedback on experiences/results of the barangay level advocacy - including documentation | Coach, FOG | | **M1** | | | | | | | | | | | | 1 | |
| 4. Capacity building acivities on FP, TB and MNCHN | 1.3A b | Formulated training plan based on updated database of service providers' profile | 1. Meetings with PHO/PHTO and PHO to update database on service providers' capability profile (SDIR form) and annual training plan as sub-plan to the AOP 2011 | | **P1** | | | | | | | | | | | | 1 | | |
| 5. ICV compliance monitoring | 1.3.D.c | ICV compliance of FP/RH service delivery sites monitored and reported | Quarterly meetings with the provincial ICV compliance monitoring team to discuss findings, review/analyze consolidated report | Coach | | | **M5** | | | **M5** | | **M6 C1** | | | | | 1 | 16 | 1 |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on benefit delivery approach | 1.2B.a | TOT in local NHIP implementation conducted | Orientation of PHO, PHTO, PPDO, DSWD, PHIC MHOs/DOH Reps on NHIP Benefit Delivery Rate and options for client segmentation including CHLSS; NHIP assessment tool | Resource person, counterpart funds for meals; NHIP materials including assessment tool | **P1** | | | | | | | | | | | | 1 | | |
| | 1.2 Bb | Local NHIP implementation plan formulated | Formulation of a province-wide NHIP plan | Counterpart funds for meals, resource person | | **P1 M16 C1** | | | | | | | | | | | 1 | 16 | 1 |
| | 1.1H.a | Provincial NHIP implementation plan formulated with LGU inputs | | | | **P1 M16 C1** | | | | | | | | | | | 1 | 16 | 1 |
| 2. 2009/2010 MNCHN grants access and utilization | 1.2 A.b | MNCHN grant accessed | Meetings with MNCHN TWG to consolidate data required in domains 2 and 3 and other requirements for 2010 MNCHN grant for submission to CHD 6 | Facilitator, MNCHN grant templates | | | **P1 M16 C1** | | | | | | | | | | 1 | 16 | 1 |
| | | | One-day orientation of PHO, DOH Reps, LGUs on the MNCHN grant utilization tracking system | Resource person, facilitator, tools/templates | | | **P1 C1 M16** | | | | | | | | | | 1 | 16 | 1 |
| | | | Monitoring by PHO/PHTO of the LGUs' MNCHN grant facility utilization using the approved tracking tools | Coach | | | | | | **P1 C1 M17** | | | | | | | 1 | 16 | 1 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide PIPH/AOP preparation, implementation and M&E | 1.1A d | Plan (PIPH) completed | PIPH 2011-2015 finalization and integration in the PDIP and MTDP<br><br>-Small group meetings with the PHO to finalize PIPH 2011-2015 and identification of PPAs for inclusion to the Provincial Development and Investment Plan (PDIP-MTDP) | All CAs as resource person | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1 A h | PIPH 2011-2014 integrated in the Province-wide Medium Term Development Plan/Provincial Development Investment Plan | - Meeting between PHO and PPDO to integrate the updated PIPH 2011-2015 in the Provincial Medium Term Development Plan | Facilitator, resource person | | **P1** | | | | | | | | | | | 1 | | |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | - Training of Trainors in FPCMS for PHO and DOH Reps | Facilitator, tools/templates, STTA | | | **P1** | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | - Advocate to the PHO to issue a provincial guidelines/resolution adopting the FPCMS and for adoption by the LGUs | Facilitator, templates, STTA | | | | | | **P1 C1 M16** | | | | | | | 1 | 16 | 1 |
| | 1.1E.c | TOT in stocks and inventory management system (SIMS) conducted | - Training of LGU health personnel in SIMS | Support CHD/PHO/PHTL | | | | | **P1** | | | | | | | | 1 | | |
| | 1.1E.d | Inventory management tool for essential drugs and commodities adopted | - On-site visits to selected LGUs to monitor progress of application | Coach | | | | | **M5** | **M5** | **M6 C1** | | | | | | | 16 | 1 |
| | | | - meetings with the PHO, PHTO to discuss progress/status of SIMS implementation | Facilitator, coach | | | | | | | **P1 M16 C1** | | | | | | 1 | 16 | 1 |
| **D. Advocacy to newly elected local chief executives/ other local officials** | 1.4B.c | Best practice in health presented and shared to NEOs | Document best practice and prepare presentation material for sharing to the province-wide alliance building and other fora | STTA | | | | | | **P1** | | | | | | | 1 | | |

## Negros Occidental

The Province of Negros Occidental in Western Visayas (Region 6) has a total population of 2.37 million distributed across 12 component cities and 19 municipalities. Its population grows at an average of 1.44 percent per year based on the 2007 Census of Population. Categorized by DOH as an F44 province, HealthGov and other USAID CAs provided TA to the province in 2007 in the formulation of its PIPH. The PIPH passed the JAC review in September 2009 and the succeeding Annual Operations Plan for 2009 and 2010 both passed with "A" ratings.

**The Health Situation: Trends in SO3 Indicators**

At the time when USAID, through its cooperating agencies, initiated its technical assistance package in 2007, the province was still grappling with low CPR, 4 ANC, SBA, FBD, children received DPT3, FIC, CDD treated with ORT, and Vitamin A supplementation (Table 1); although at varying degrees across LGUs and ILHZs. Only the TB indicators exhibited a favorable performance, with only three (3) and eight (8) LGUs posting a CDR and CR lower than the national standards, respectively.

Utilizing HealthGov's SDIR processes and tools, the initial activity focused on identifying the reasons for the province's relatively poor performance in the above indicators. For CPR, these ranged mostly from insufficient budget for FP interventions and commodities, absence of reliable commodity forecasts, out of stock donated FP commodities, absence of enabling provincial and municipal policies, lack of trained RHU personnel in FP and post-training follow-up, lack of network of FP service providers, limited health promotions, poor monitoring, and poor FP data recording and reporting. For maternal indicators (4ANC, SBA and FBD), the reasons were client misconceptions on ante-natal care and safe deliveries, mothers' preference for *"hilots"*, absence of birthing facilities in far-flung areas, lack of MCP-accredited facilities, and insufficient pregnancy tracking and birth planning by RHU personnel. Meanwhile, in spite of health promotion, social preparation/ community mobilization, utilization of the REB strategy, master-listing and defaulters' follow-up, availability of supplies, and airing of GP messages, FIC and Vitamin A indicators remained below standards. The good performance for the TB indicators were mainly due to LCE support, availability of drugs/logistics, accessible DOTS-accredited facilities with trained staff complement, implementation of a quality assurance system, trained personnel, and active client master-listing/follow-up.

The underlying reasons accounting for the above findings include the following: a) health planning was not systematically done, i.e., each program held an independent PIR, health plan preparation did not coincide with the LGU budget cycle and the resulting plans were not integrated into the AIP/LDIP; b) data management, analysis, and utilization were poor; c) there were insufficient LGU funds to finance priority health programs; d) lack of birthing facilities nor MCP-accredited; e) there were no provincial/municipal ordinances mandating CSR implementation; and f) NHIP implementation was weak in terms of enrolment, facility accreditation, fund (capitation and reimbursements) management.

The province continued to perform below standards for the next three years (2008-2010); however, most indicators have started to exhibit positive trends. An exception is the set of TB indicators, which consistently met standards since 2007 (although at a declining rate). All others had an upward trend, except in 2009 for CPR, 4 ANC, DPT3, and FIC -- which all dipped. The decline in the 2009 CPR data is the result of a province-wide validation done for data on FP current users, with the PHO utilizing the existing FHSIS guidelines coupled with HealthGov's tool on FP DQC and the change in population reference. Only the 2009 FP data was validated.

Among the major findings of the FHSIS data validation were absence of/incomplete TCL, difficulty of RHMs in filling out the TCL and using new CU computation, non-reporting of clients by private facilities, and poor use of records to follow up drop-outs. As a result, the province had difficulty in "cleaning" the 2006-2008 data and, thus, left them as they are. After the DQC, the CPR dropped to 30% in 2009 from a high of 39% in 2008. The 2009 CPR is now deemed more reliable.

While the indicators have shown improvements at the provincial level, ILHZ- and municipal-level performance varies. For instance, in 2009, among the six ILHZs in the province, D'BESTCA showed improvements across all LGU members, while in South Negros; three of the LGU members had low performance in almost all health indicators. The Midland ILHZ showed significant increases for all indicators, especially for FBD and SBA, which is mainly attributed to the enforcement of ordinances requiring mothers to give birth in facilities, and attended by SBAs.

**Table 1 Selected health indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 35 | 34 | 39 | 30 | 64 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 54 | 55 | 54 | 50 | 85 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 59 | 65 | 68 | 72 | 80 |
| 4 | Percent of facility-based deliveries | 40 | 45 | 55 | 61 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 25 | 43 | 86 | 78 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 79 | 81 | 89 | 83 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 89 | 86 | 88 | 91 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 11 | 26 | 23 | 95 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 99 | 96 | 99 | 99 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 110 | 113 | 109 | 103 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 145 | 147 | 145 | 136 | 99 |
| 12 | TB cure rate (%) | 90 | 91 | 89 | 89 | 85 |

### The Response: TA interventions and results

Jumpstarting the TA interventions in Years 1 and 2 was helping the province and municipalities better understand their performance on key health indicators utilizing the SDIR processes and tools, rapid assessment of LGU CSR implementation, and the participatory action research (by HealthPRO),which validated demand-related factors such as client preferences, misconceptions, and health-seeking behaviors. The information derived from these served as baseline data for the formulation of the M/CIPH, which were consolidated at the ILHZ level, and, eventually, at the provincial level, to form the PIPH. The PIPH, whose formulation was initiated in 2007 with TA from HealthGov, other CAs, and the CHD, was finally approved by DOH/JAC in September 2009. The province-wide rapid assessment of LGUs' CSR implementation was followed with TA in the formulation of CSR plans, resulting in 31 M/CLGU CSR plans developed in 2008.

The PIPH includes two critical strategic interventions that are envisioned to increase the province's CPR and sustain the upward trend in ANC, SBA, and FBD. In consultation with the PHO and selected ILHZs/LGUs, it was agreed that HealthGov's TA will adopt a zonal approach to its technical assistance in order to assist the province close the variance in the health outcomes of the ILHZs and will revolve around:

1. Improving service delivery in family health by strengthening LGU response to CSR province-wide, with TA interventions ranging from assessment, plan updating, FP data quality check, re-forecasting, CSR policy/budget support for FP commodity procurement, FP-EPI integration/maximizing MNCHN utilization, including setting up referrals to private providers, ICV compliance monitoring, logistics management (FPCMS and SIMS), private to public reporting of performance; and

2. Strengthening systems, particularly health planning and financing, specifically for PIPH/AOP formulation, MNCHN grants accessing, and local NHIP implementation, with TA interventions ranging from investment/AOP/NHIP planning; improving LGU health management information system; integrating the provincial AOP into the AIP; installing PME; facilitating MNCHN grant accessing and utilization; facilitating NHIP local implementation assessment, plan approval, policy/budget support for plan implementation – with attention to enrolment, facility accreditation, improving capacity to claim, and management of funds to ensure re-investment in public health.

From this point until Year 4, HealthGov's TA provision was intensified, resulting in the following major outputs:

<u>On CSR</u>

- 1 Province-wide and 31 M/CLGU CSR plans updated to include other MNCHN commodities and services;
- 10 city/municipal CSR ordinances passed, with inputs from community consultations/ public hearing (DBESTCA, MIDLAND ILHZs) with allocated budget of PhP1,450,447;
- FP data/CPR for 2009 of all LGUs validated and will be used to re-forecast commodity requirements;

FP new acceptors during the months of November and December 2009 increased in the model site (La Carlota City) for FP-EPI integration especially in 7 barangays (Ayungon, Batuan, Cubay, Haguimit, La Granja and Poblacion 1 and 2). The total new acceptors for the month of December 2009 were 125 compared to 76 in December of 2008. Sustained increases were recorded during the 1st Quarter of 2010 especially during the month of February with 105 (vs. 91 in 2009) and March with 144 (vs. 104 in 2009).

- Provincial guidelines on MNCHN grant allocation, distribution, and utilization were approved
  - 26 LGUs with utilization report for the PhP3.9 million 2008 MNCHN grant following the guidelines of 70% for purchase of FP commodities, 20% for training, and 10% for surgical sterilization
  - 2009 MNCHN grant requirements for domain 1 completed with partial release of PhP 1.5 million to the province

- Two PHO staff capacitated as trainers and 8 RHMs trained in FPCBT level 1 and 5 RHMs trained in FP-CBT level 2.

- Agreement among PHO, selected LGUs, and private FP practitioners (Well-family Midwife Clinic network) forged for the integration of accomplishments of the private sector in FP and selected MCH programs with the public sector – an initiative of CHD 6, modeled in the province and TA started by HealthGov in collaboration with PRISM2;
- Provincial ICV compliance monitoring plan formulated by PHO/PHTO but not fully implemented

<u>On health planning and financing</u>

- 2009 and 2010 AOPs approved with "A" rating;
- PIR/SDIR conducted province-wide and by ILHZ annually since 2007, in preparation for AOP formulation;
- 11 LGUs from D'BESTCA and Midland ILHZs with NHIP plans, formulated based on assessment results and with LGU-specific focus on either expanding and/or sustaining enrolment of the poor, accreditation, management of capitation funds/reimbursements, and improving ability to claim reimbursements;
- 9/11 NHIP plans approved and endorsed by the local health boards and 4 were approved by the local *Sanggunian*;
- Commitment of micro-finance institutions (MFI) to enroll 2,000 members from the informal sector on a 50:50 sharing on premium payment scheme with the LGUs generated;
- 13/31 health facilities in the province are already MCP-accredited, 7 of these received LSS training support, which is a PHIC requirement for accreditation;
- 28/31 are TB DOTS-accredited and 28/31 are OPB-accredited; and
- Partnership with private sector to leverage resources for the upgrading of a BHS in La Carlota City (Midland) into a birthing and MCP-ready facility.

HealthGov likewise responded to the province and ILHZs' request for specific TA interventions that were deemed necessary at some point. The results of the TA provided are as follows:

- One NGO (NEDF) accredited and elected as the NGO member of the Provincial Health Board, through advocacy actions of HealthGov;
- Province and DBESTCA ILHZ (with high number of maternal deaths) with organized MDR Team, legalized thru the issuance of an Executive Order and ILHZ Council policy in support of MDR. TA focused on policy development, formation of MDR team, capacity building for PHO/PHTO/ILHZ on the MDR processes and tools, and advocacy actions. Included in the 2010 AOP is the province's plan to expand to the five ILHZs, and
- Two community-based early warning system (CBEWS) for avian influenza installed in the high risk cities of Bago and Himamaylan. TA included capacity building and policy development.

HealthGov's overall approach to TA delivery has been to closely collaborate and coordinate with CHD/PHTO and build capacities of PHO/PHTO/selected ILHZ/LGU as TA providers to LGUs. Keeping abreast with and in support of the DOH's RCBI policy issuance, the project engaged and capacitated local TA providers (LTAP) in CSR policy advocacy and NHIP planning/policy starting in 2009. This also enabled HealthGov to reach more cities/municipalities, increase the awareness of and motivate NGO-LTAPs to actively participate in health-related government processes, and promote LGU-NGO partnerships and collaboration that can be sustained even beyond the project life.

**Remaining gaps and challenges**

Based on the series of PIRs conducted (latest was in May 2010), LGUs were noted to have significant improvements. Low performance across SO3 indicators continues to persist due to the same reasons cited earlier. On FIC, 6 LGUs accomplished more than 90% while 10 LGUs surpassed the 95% performance standards on Vitamin A supplementation. Two LGUs (Hinoba-an & La Carlota) reached the performance standards of providing 4 quality antenatal care to mothers. LGUs with high percentage of deliveries attended by skilled birth attendants reached 12 while 11 LGUs with high percentage of facility-based deliveries.

Among the remaining challenges that need to be addressed are:

*On CPR*: aside from poor FP data management-related gaps, absence of CSR policies in more than half of M/CLGUs, leading to insufficient budget for FP commodities and interventions; need to re-forecast the commodity requirements using the validated data;

*On ANC, SBA, and FBD*: poor health-seeking behavior of women, for instance, continued reliance / preference of mothers on TBAs; limited LGU support for facility upgrading and implementation of policy/ordinance and non- maximizing the utilization of existing birthing facilities both private and public;

*On FIC and Vitamin A*: high population projections/sudden change in targets, limited LGU support, poor recording, inadequate supervision of RHMs by PHN, underreporting; and

*On TB*: non-reporting by private physicians of patients who have initiated TB treatment, patients not coming back after the end of treatment, some health workers' negative attitude due to inadequate understanding of the TB program, absence of microscopy technicians in some LGUs.

**Year 5 priority interventions and expected results**

In view of the foregoing, TA in Year 5, will focus on further improving CPR and sustaining increases in ANC, SBA, and FBD. This will entail consolidating and completing the technical interventions on service delivery and health systems improvement, specifically on planning and financing.

To improve service delivery in family health through CSR, HealthGov will provide continuing TA in plan updating/re-forecasting using "cleaned" FP data; policy advocacy (20 M/CLGUs); MNCHN grant accessing and utilization; tracking CSR ordinance implementation (10 LGUs); logistics management, particularly in setting up the FPCMS and SIMS; ICV compliance monitoring; and adoption of the FP-EPI integration strategy (25 LGUs). These are all directed at effecting improvements in the province's CPR. In addition, the project and other CAs specifically, PRISM 2 and HealthPRO will provide TA to 25 LGUs in implementing strategy on maximizing utilization of existing MNCHN service providers both public and private to contribute to improvement on ANC, SBA and FBD.

In line with strengthening planning and health financing, HealthGov will continue to provide TA in the implementation of the NHIP, using the BDR approach, in D'BESTCA and Midland LGUs, specifically in tracking increase in enrolment, facility accreditation, MFI commitments, and policy issuance on management of PHIC funds; 2011 AOP formulation and its integration into the 2011 AIP; and installation of PME at the provincial level. All these interventions are expected to

contribute to increase the resources available for the sustained implementation of quality health services and, consequently, improve family health outcomes as evidenced by the positive trends in the SO3 indicators.

The intermediate outputs/results of these interventions are as follows:

*Improving service delivery in family health through CSR*

- 25 LGUs adopting the strategy of FP-EPI integration and maximizing utilization of MNCHN services;
- 1 BHS in La Carlota City upgraded to birthing/MCP-ready facility resulting from public-private partnership;
- Province/2 LGUs with updated CSR plans/FP commodity forecast based on quality-checked FP data;
- Province establishing a database on service providers capability profile
- Provincial policy on ICV compliance monitoring and installation of the system province-wide

*Strengthening health planning and financing*

- Provincial 2011 AOP formulated and integrated into 2011 AIP and CDP/ELA;
- Provincial 2009 and 2010 FHSIS data quality-checked;
- FPCMS adopted in the province/LGUs;
- SIMS adopted by PHO;
- 2009 and 2010 MNCHN grants accessed by the province/LGUs;
- Enrolment of the poor, based on the NHIP plans of 11 LGUs in D'BESTCA and Midland ILHZs;
- Increase in the number of MCP-accredited facilities;
- Local/ILHZ action plan to draft policy on NHIP funds utilization for public health;
- Presentation of success stories and continuous advocacy with NEOs

Priority will also be given to the documentation of all "success stories" or interventions that are potential/emerging best practices. Documentation was initiated in the last quarter of Year 4, for two materials – 1) ILHZ approach to improving health outcomes – D'BESTCA experience; and 2) leveraging public resources with private sector to improve health facilities in La Carlota City. These were prepared in time for the CHD-/DILG-led fora with new LCEs in September 2010. As the project moves on to its last year, more success stories will be documented for advocacy purposes. The primary intent is for the intended audience, specifically LCEs and other local decision-makers, to invest in relevant health approaches/interventions that will contribute to improved health outcomes.

**Priority TA Interventions and Activities**
**NEGROS OCCIDENTAL**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.a<br><br>1.1B.c (1.1F.a)<br><br>1.4C.a | FP/RH commodities re-forecasted using clean FP data<br><br>CSR policy crafted with broad stakeholders participation and support<br><br>NGOs/CSOs participated in CSR policy development | Reforecast commodity requirements using clean FP data<br><br>Meeting/orientation of 20 LGUs MHOs, SB Health, FP Coordinator<br><br>NGOs/CSOs to draft CSR policy ordinance and agree on next steps per LGU to consult community and secure policy approval | Facilitator, coach | | **M12 C8** | | | | | | | | | | | | 12 | 8 |
| | 1.1B.e | CSR (CSR+) plan and policy implementation tracked | Tracking CSR policy implementation | Coach | | **P1 M2** | | | | | | | | | | | 1 | 2 | |
| | | | Meeting with the PHO/PHTL to review the results, analyze and come up with recommendations to improve CSR+ implementation | Facilitator | | | | | | | | | | | | | | | |
| 2. Integration of FP into EPI and maximizing utilization of MNCHN services; and social mobilization for improving FIC, Vitamin A | 1.3Ad<br><br>1.4Cc | Service providers trained in integration of FP/EPI and maximizing utilization of MNCHN services<br><br>LGU-NGO/CSO partnerships established for planning, budgeting, implementation of integration of FP/EPI and maximizing utilization of MNCHN services | Orientation training cum planning on FP-EPI integration and maximizing utilization of MNCHN services | Resource person, facilitator, orientation design, materials, meeting cost<br><br>HealthPRO - tie up with IPC/C, LRA SOW<br><br>PRISM 2 - collaborate on referrals to private sector | **P1 M14 C11** | | | | | | | | | | | | 1 | 14 | 11 |
| | 1.4C.b | Public private partnership established for implementation of MNCHN referral mechanism | Modelling public-private partnership in mobilizing communities to maximize MNCHN services in *Barangay* Ayungon, La Carlota City (FOG Budget)<br><br>- Meetings with CHO, PHO and private sector to discuss progress and document results | Facilitator, Y4 FOG | | | **C1** | | | | | | | | | | | | 1 |
| | 1.4B.b | Best practice results of mechanism presented to LHB/LDC | - Provincial level meeting to present results | Facilitator | | | **P1** | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 3. Capacity-building activities for FP/ MNCHN providers | 1.3A a | Database on service providers' capability profile established | 1. Planning meeting with PHO program coordinators and PHTO to update training and service providers' capability profile database | Template, coach | | | | | | **P1** | | | | | | | 1 | | |
| 4. ICV compliance and monitoring | 1.3D c | ICV compliance of FP/RH service delivery sites monitored and reported | Quarterly meetings with PHO, PHTO to discuss results of ICV compliance monitoring | Facilitator | | | **M7 C4** | | | **M6 C4** | | | **M6 C4** | | | | | 19 | 12 |
| | 1.3D.d | ICV compliance monitoring and reporting locally mandated/CSR ordinance policy updated to include a section on ICV compliance monitoring | Meetings with SP on Health to advocate incorporation of ICV in the provincial MNCHN/CSR ordinance | Facilitator, materials | | | | | | **P1** | | | | | | | 1 | | |
| **II. Strengthening health management systems, planning, and data management and inter-LGU cooperation in D'BESTCA and Midland ILHZ** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP (BDR) | 1.2B.c | Local NHIP implementation plan implemented<br><br>- Increased proportion of the poor enrolled | Enrollment<br>- Meetings with PHO, DOH Reps to discuss progress of their continued advocacy to LCEs and MFIs to implement enrolment plan and targets<br><br>- Enrolment of the poor (including those enrolled by MFIs) | Coach | | | | **M7 C4** | | | | | | | | | | 7 | 4 |
| | 1.2C b | Application for accreditation and renewal of accreditation for TB DOTS, OPB and MCP filed | Facility accreditation<br>- Meetings with M/CHOs to guide them in completing requirements for accreditation and renewal of accreditation for OPB, TB DOTS and MCP | Resource person, facilitator | | | **C2 M3** | | | **C1 M2** | | | **C1 M2** | | | | | 7 | 4 |
| | 1.2C.b | Facilities accredited by PHIC | - Advocacy support to M/CHOs for PHIC to fastrack accreditation/renewal of accreditation of facilities | Facilitator | | | **C2 M3** | | | **C1 M2** | | | **C1 M2** | | | | | 7 | 4 |
| | 1.2A.b | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and/or implemented | Management of PHIC reimbursement and capitation funds<br>- One-day orientation/planning to draft policy for utilization of PhilHealth funds | Resource person, fund support | | **P1 M7 C4** | | | | | | | | | | | 1 | 7 | 4 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide PIPH/AOP preparation, implementation and M&E | 1.1A d | Plan (PIPH) completed | PIPH 2011-2015 finalization and integration in the PDIP and MTDP<br><br>-Small group meetings with the PHO to finalize PIPH 2011-2015 and identification of PPAs for inclusion to the Provincial Development and Investment Plan (PDIP-MTDP) | All CAs as resource person | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1 A h | PIPH 2011-2014 integrated in the Province-wide Medium Term Development Plan/Provincial Development Investment Plan | - Meeting between PHO and PPDO to integrate the updated PIPH 2011-2015 in the Provincial Medium Term Development Plan | Facilitator, resource person | | **P1** | | | | | | | | | | | 1 | | |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | - Training of Trainors in FPCMS for PHO and DOH Reps | Facilitator, tools/templates, STTA | | | **P1** | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | - Advocate to the PHO to issue a provincial guidelines/resolution adopting the FPCMS and for adoption by the LGUs | Facilitator, templates, STTA | | | | | | **P1 C1 M16** | | | | | | | 1 | 16 | 1 |
| | 1.1E.c | TOT in stocks and inventory management system (SIMS) conducted | - Training of LGU health personnel in SIMS | Support CHD/PHO/PHTL | | | | | **P1** | | | | | | | | 1 | | |
| | 1.1E.d | Inventory management tool for essential drugs and commodities adopted | - On-site visits to selected LGUs to monitor progress of application | Coach | | | | | **M5** | **M5** | **M6 C1** | | | | | | | 16 | 1 |
| | | | - meetings with the PHO, PHTO to discuss progress/status of SIMS implementation | Facilitator, coach | | | | | | | **P1 M16 C1** | | | | | | 1 | 16 | 1 |
| **D. Advocacy to newly elected local chief executives/ other local officials** | 1.4B.c | Best practice in health presented and shared to NEOs | Document best practice and prepare presentation material for sharing to the province-wide alliance building and other fora | STTA | | | | | | **P1** | | | | | | | 1 | | |

## Negros Oriental

The province of Negros Oriental is one of the original F1 provinces in Central Visayas and was on its first year of PIPH implementation when HealthGov started its technical assistance to the province in 2007. It has a population of 1,231,904 (2007 census) distributed in 6 cities and 19 municipalities.

### The Health Situation: Trends in SO3 indicators

In 2007, when the USAID through its cooperating agencies, started its technical assistance support in the province, the province's health indicators showed varying levels. Except for TB cure rate, all other maternal and child health indicators such as CPR, 4ANC, SBA, FBD, children received DPT3, FIC, CDD treated with ORT, and Vitamin A supplementation (Table 1), are below the performance standards.

Negros Oriental is one of the provinces where the HealthGov's SDIR tool was utilized to determine the causes of low performance. The province has been a recipient of various programs and services supported by both local and international organizations. Based on the SDIR results, low CPR is primarily caused by insufficient budget for the purchase of FP commodities and services; stock-out of donated FP commodities; absence of post training follow-ups; limited health promotion activities and poor FP data recording. For maternal indicators (FBD, SBA and ANC), the reasons were irregular visits by RHMs in far flung barangays especially those with difficult terrain, non residency of some midwives in the barangays, misconception of mothers on antenatal care and poor tracking of AP defaulters, preference to *"hilots"* by mothers due to financial constraints, and only one RHU is MCP accredited. Cure rate was high due to the availability of TB drugs and the utilization of treatment partners who does the regular follow-ups of the patients who have started the medication.

Other reasons include: a) insufficient budget for health; b) absence of ordinances in support of ensuring mothers to give birth to facilities and attended by skilled birth attendants and in support of CSR implementation; c) poor data collection, management, analysis and utilization; d) Only one RHU is MCP accredited e) low enrolment to PHIC due to a number of local health insurance evolving in the province and poor health planning system that does not coincide with the LGU planning and budgeting cycle.

In 2009, the provincial health performance for some SO3 indicators showed some improvements from 2006 although they still fall below the national standards. CPR, SBAs, FIC and TB cure rate indicators however decreased by a few percentage.

CPR performance has been decreasing since 2006 but this time the decrease is greatly affected by the change in population base used in 2009. Other factors still include prevailing myths and misconceptions about FP and religious conviction of couples, irregular access to free commodities especially the poor; and defaulters are not regularly followed up by the RHM especially those covering more than one *barangay*. The performance of the province for ANC has generally decreased with several LGUs exceeding the national performance standard. Some of the reasons cited still include, mothers' preference for "*hilots"* and no proper tracking of pregnant women by RHMs.

Deliveries by SBAs showed an increasing trend from 58 in 2006 to 64 in 2009. Similarly, FBDs also showed an increasing trend from 28% in 2006 to 45% in 2009 but still below the national

standard of 70%. Promoting facility-based deliveries supported with policy requiring all births to be delivered in health facilities (Bacong and Amlan) are among the major factors that contributed to increasing performance. Low performance may be attributed to unavailability of vehicle to transport mothers in labor to nearest birthing facility and/or to a higher level of facility in emergency cases.

FIC showed an increasing trend from 73% in 2006 to 83% in 2009 but low compared to 86% in 2008.This is also still below the national standard of 95%. Contributory factors to the increase include the adoption of team approach in conducting immunization, adoption of the REB strategy, and close supervision of RHMs among others. Irregular immunization schedules in far-flung *barangays* due to peace and order problems, poor defaulters follow-up, irregular *barangay* visits due to high transportation costs, competing activities of the different health programs, lack of social mobilization activities, and lack of monitoring and supportive supervision are some of the factors that contributed to the bottom three low performing LGUs of Bacong, Valencia, and Zamboanguita.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 52 | 47 | 47 | 44 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 60 | 43 | 37 | 48 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 58 | 57 | 71 | 64 | 80 |
| 4 | Percent of facility-based deliveries | 28 | 33 | 45 | 45 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 69 | 68 | 75 | 80 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 73 | 81 | 86 | 83 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 82 | 73 | 82 | ND | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 85 | 72 | 77 | ND | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 98 | 90 | 99 | ND | 100 |
| 10 | TB case detection rate (per 100,000 population) | 70 | 78 | 79 | 78 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 94 | 104 | 104 | 102 | 99 |
| 12 | TB cure rate (%) | 88 | 90 | 88 | 86 | 85 |

ND-no data

### The Response: TA interventions and results

TA interventions in Years 1 and 2 were based on the result of the initial consultations with the PHO and the province's PIPH. The province's PIPH and funding was already approved when HealthGov started its intervention in the province. To jumpstart, one of the major interventions was the conduct of rapid LGU CSR Assessment which was used as input in the formulation of the provincial and LGU level CSR plans as sub-plan to the PIPH.

Given the availability of resources, current trend in the province's health performance and based on the PIPH and in consultation with the local partners, it was agreed that the TA will focus on the strengthening of provincial government influence on improving health outcomes on MCH, FP and TB province-wide, and will revolve around:

- Improving service delivery in family health by strengthening LGU response to CSR province-wide, with TA interventions ranging from assessment, plan updating, FP data quality check, re-forecasting, CSR policy/budget support for FP commodity procurement, FP-EPI integration/maximizing MNCHN utilization, ICV compliance monitoring, and logistics management (FPCMS and SIMS) and;
- Strengthening systems, particularly health planning and financing, AOP formulation, MNCHN grants accessing, service delivery improvement (SDExH) and CHLSS implementation, with TA interventions ranging from investment/AOP planning; improving LGU data management; integrating the provincial AOP into the AIP; installing PME; facilitating MNCHN grant accessing and utilization; and facilitating conduct of CHLSS.

Taking off from the above plan, HealthGov's TA provision until Year 4 in collaboration and partnership with the PHO, CHD7, PHTO, and LGUs, resulted in the following major outputs:

<u>On CSR</u>

- 21 LGUs and provincial CSR plan formulated and approved with forecasted commodity requirements
- 12/21 allocated budget for FP commodities procurement
- 7/25 LGUs with passed CSR ordinances with community participation and budget allocation amounting to P3, 456,447.
- Creation of the provincial CSR Task Force with defined roles and function
- Approval of the IRR for the provincial CSR Ordinance
- FP DQC conducted in all LGUs
- Provincial allocation of P1.0 million pesos for the commodities and training
- Increase in the number of new acceptors in 2009 due to the implementation of the FP-EPI Integration strategy in Tanjay City. CPR increased from 46% in 2008 to 52% in 2009 even after the FP data cleaning by the PHO
- On-going ICV monitoring conducted by the DOHReps especially in La Libertad

<u>On health planning and financing</u>

- 2009 AOP approved with "A" rating
- SDExH installed in Metropolitan (4LGUs and 1 provincial hospital) and Sta. BayaBas (3 LGUs & 1 Dist. Hospital) ILHZ as roll-out site. Post training follow up conducted in Sta. Bayabas, Bayawan District hospital, Bayawan and Basay
- CHLSS completed in 17/25 LGUs; processed results were turned-over to the province where guidelines for its utilization will be formulated by the province thru the SP on Health.
- Additional one RHU was accredited as MCP (amounting to a total of 2 MCP accredited RHUs)
- Trained 10 RHMs as a requirement for MCP accreditation
- Training in data management conducted enabling participants to manipulate CHLSS data and information

- Institutionalized and customized the use of SDIR tool into regular provincial PIR; used as a tool in tracking/monitoring progress of performance on a quarterly basis to accelerate performance to achieve national standards.

TA intervention on the installation of CBEWS in high risk LGU of Tanjay and Bais City for Avian Influenza was also implemented. All TA interventions in the province were implemented in close collaboration with CHD7, PHTO, PHO and the LGUs. This is in line with developing capabilities of local partners as TA providers who will sustain interventions even beyond project life. To reach more cities and municipalities, and promote LGU-NGO partnerships on health, the project also engaged and capacitated local TA providers (LTAP) in CSR policy advocacy starting in 2009.

**Remaining gaps and challenges**

Although low performance across SO3 indicators continues to persist over the years, there are also LGUs where significant improvements have already been noted. LGUs in Metropolitan ILHZ showed increasing performance in FBD with only Dauin showing performance below 70% while all LGUs performed above 80% for deliveries attended by SBAs. For 4 ANC visits, LGUs of Basay and Jimalalud showed exemplary performance. Zamboanguita showed a consistent increase in FBD, SBA and AP visits. Basay and Mabinay II reached the 95% FIC.

Among the challenges that need to be addressed are:

*On CPR*: Need to reforecast requirements based on the cleaned FP data as basis for budget request and advocacy to the LCEs, absence of CSR/MNCHN policies in more than half of the LGUs leading to insufficient budget for FP commodities and services; signing of the approved IRR for the provincial CSR ordinance to ensure availability and release of the P1M budget for CSR.

*On ANC, SBA and FBD:* Not all LGUs have passed an ordinance for facility-based deliveries and attended by SBAs; only 2 RHUs are MCP accredited; poor health seeking behavior of mothers as continued reliance to "*hilots"* is still reported, RHMs are not implementing pregnancy tracking and birth planning, and poor LGU support to ensure that vehicle to transport mothers to the facility during deliveries (except in Bacong) and upgrading of facilities.

*On FIC and Vitamin A:* change in population projection, poor recording, reporting and follow-up of defaulters, and inadequate PHN supervision; and

*On TB*: Only 14/25 RHUs are TB-DOTS accredited; non-reporting of private physicians of patients who have initiated TB treatment; misconceptions on TB protocols and absence of medical technologists or microscopists in some LGUs.

**Year 5 Priority Interventions and Expected Results:**

In view of the foregoing, TA in Year 5 will focus on further improving CPR, and ensuring/sustaining increases in FBD, SBA, ANC and FIC. This will entail consolidating and completing the technical interventions on service delivery, and health systems improvement, specifically on planning and utilization of CHLSS results for increased NHIP enrolment.

In support to improving service delivery in family health, HealthGov will continue to provide assistance to the province in accessing the 2010 MNCHN grant in Year 5 as well as provide assistance in policy advocacy to the remaining 15 M/CLGUs in the passage of CSR/MNCHN

policy supporting CSR plan implementation. Based on the validated data and updated LGU CSR+ plans, assistance will be provided in re-forecasting FP commodity requirements as well as the establishment of an FP commodity monitoring system at the province level and all LGUs. Monitoring and documentation of the implementation of the FP-EPI integration strategy in 14 LGUs will be undertaken.

In terms of strengthening family health program support, HealthGov will continue to provide assistance in ensuring that CHLSS results are utilized for planning and LCE decision making. Likewise, the project will continue to support the province in the finalization of its PIPH and the preparation of the 2012 AOP.

The intermediate outputs/results of these interventions are as follows:

*Improving service delivery in family health through CSR*

- Remaining 15 LGUs with CSR/MNCHN Ordinance/Resolution crafted with budget allocation for the procurement of MNCHN related commodities
- Province and 25 LGUs compliant to ICV guidelines and protocols
- 14 LGUs adopting the strategy of FP-EPI integration and maximizing utilization of MNCHN services;
- Preparation of the annual training plan as part of the AIP

*Strengthening health planning and financing*

- Province with 2011-2015 PIPH and AOPs approved by DOH/CHD
- Province adopted and utilizing an FP monitoring and commodity system tool
- FPCMS adopted in the province;
- Province trained in SIMS
- Province and 25 LGUs accessed MNCHN grants and utilized in the procurement of FP/MNCHN commodities, training of health personnel, implementation of services and monitoring
- Province utilizing CHLSS results in identifying the poor for its sponsored program and responding to unmet needs of various health programs
- Continuous advocacy to the NEOs

Priority will also be given to the documentation of all “success stories” or interventions that are potential/emerging best practices. Documentation was initiated in the last quarter of Year 4, for two materials – 1) Quality improvement in the municipalities of Valencia and Bacong; and 2) CHLSS as a means in identifying the poor. This will be utilized during advocacy with the LCEs and other local decision-makers, to invest in relevant health approaches/interventions that will contribute to improved health outcomes.

**Priority TA Interventions and Activities**
**NEGROS ORIENTAL**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR plan implementation | 1.1Cb | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | FP data clean up | Facilitator, coach | **M19 C6** | | | | | | | | | | | | | 19 | 6 |
| | 1.4C c<br><br>1.1.B.c (1.1F.a) | NGOs/CSOs participated in CSR policy development<br><br>CSR policy crafted with broad stakeholders participation and support | 1-Day orientation of PHO/MHOs, SB Health, NGOs/CSOs to draft policy ordinance, agree on steps to consult community and secure ordinance approval | Facilitator, coach | | | **M11 C4** | | | | | | | | | | | 11 | 4 |
| 2. Integration of FP into EPI, post-partum FP, and maximizing utilization of MNCHN services (FP, ANC, SBA and FBD) | 1.4C c | LGU-NGOs/CSOs partnership established for implementation of integration of FP-EPI and maximizing utilization of MNCHN services | 1. Orientation and planning with PHO, DOH Reps, M/CHOs, NGOs/CSOs on FP-EPI integration and maximizing utilization of MNCHN services | Resource person, facilitator, orientation design, materials | **M12 C2** | | | | | | | | | | | | | 12 | 2 |
| | 1.3A.d | Providers trained in FP, FP-EPI integration and maximizing utilization using updated training design | | | **M12 C2** | | | | | | | | | | | | 1 | 12 | 2 |
| | | Progress reports on the implementation of action plans to accelerate FP/MNCHN performance | 2. Periodic meetings with PHO, PHTO, LGUs to discuss progress, including documentation of results, review of records and referral of services for FP and MNCHN | Facilitator, resource person, monitoring tool and templates | | | **M6 C1** | | | | **M6 C1** | | | | | | | | |
| | 1.4A.b | Public fora with NGO/CSO participation to present/share results to stakeholders conducted | 3. One day province-level meeting to present/share results to stakeholders | Activity design, facilitator/resource person; fund support | | | | | | | | **P1** | | | | | 1 | | |
| 3. Capacity-building of FP/MNCHN providers | 1.3A a<br><br>1.3A b | Database on service providers' capability profile established<br><br>Annual training plan prepared as part of the AOP | 1. Consultative meetings with PHO/ PHTO to update database of service providers' capability profile (output of SDIR) and use this as basis to develop the annual training plan in the AOP and its implementation | Coach, resource person | **P1** | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 4. ICV compliance and monitoring | 1.3D c | ICV compliance of FP/RH service delivery sites monitored and reported | Quarterly meetings with local team composed of PHO/PHTL and FP program coordinator to discuss findings, review/analyze consolidated ICV compliance monitoring reports | Coach | | | **M6 C2** | | | **M6 C2** | | | **M7 C2** | | | | | 19 | 6 |
| | 1.3D d | ICV compliance monitoring and reporting locally mandated/CSR ordinance policy updated to include a section on ICV compliance monitoring | Advocacy to Governor to issue policy on ICV compliance monitoring thru the CSR task force | Coach | **P1** | | | | | | | | | | | | 1 | | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1.Local NHIP implementation and facility accreditation | 1.1D.a | CHLSS adopted to identify the indigent PHIC enrollees | a. Coordinate with the PHIC, PHO, DSWD, and DOH Reps to discuss progress in the implementation of NHIP plan particularly on the use of CHLSS results for enrolment of indigent, management of PhilHealth reimbursement/capitation funds | Resource person | | | **P1 M6** | | | | | | | | | | 1 | 6 | |
| | 1.2C.a | Application for accreditation filed | b. Consultative meetings with MHOs to guide them in fast tracking facility upgrading and completing documentary requirements and filing for MCP accreditation | Resource person | | | **M3** | | | **M3 C1** | | | | | | | | 6 | 1 |
| | 1.2C.b | Facilities accredited by PhilHealth | | | | | | | | **M3** | | | | | | | | 6 | 1 |
| 2. 2009 MNCHN grants facility | 1.2A.a | MNCHN grant accessed | 1. Meeting with PHO MCH cluster coordinators to review and consolidate requirements for domains 2 and 3 of the 2010 MNCHN grant for submission to CHD 7 | Technical inputs as resource person; allocation tool/criteria; technical guidance on how to access and utilize the grant | **P1** | | | | | | | | | | | | 1 | | |
| | | | 2. One-day orientation of PHO, DOH Reps, LGUs on the MNCHN grant utilization tracking tool and plan for its use | Resource person, facilitator, tools/ templates | **P1** | | | | | | | | | | | | 1 | | |
| | | | 3. Meetings with PHO, CHD/PHTO to discuss results of tracking | Facilitator, resource person, meeting cost | | | **P1 M19 C6** | | | | | | | | | | 1 | 19 | 6 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1.LGU data management system improvement | 1.1F.b | Policy on data use and management approved | CHLSS - Meetings with SP Health, PHO to finalize provincial policy on CHLSS data use and management | Resource person | | **P1** | | | | | | | | | | | 1 | | |
| 2. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Training of trainers in FPCMS for PHO/DOH Reps and in SIMS for C/MHOs/PHNs | Facilitator, tools/templates, STTA | | | | **P1** | | | | | | | | | 1 | | |
| | 1.1E b | FP commodity monitoring system tool adopted | Meetings with PHO, PHTL to review LGU reports on FPCMS and utilize data for planning logistics procurement in the AOP | Facilitator, templates | | | | | | **P1 M19 C6** | | | | | | | 1 | 19 | 6 |
| **C. Advocacy to newly elected local chief executives/ other local officials** | 1.4B.c | Best practice shared and presented to the NEOs | Document best practice and prepare presentation material for sharing to the province-wide alliance workshop | Y4 STTA | | | | | | **P1** | | | | | | | 1 | | |

# Region 8

## Eastern Visayas

Region 8, also known as Eastern Visayas Region is located in the eastern part of the country. It has two main islands: Leyte and Samar connected by San Juanico Bridge, the second longest bridge in Southeast Asia. It has 23,229 square kilometers of land, making it the fourth largest region in the country. The Region has approximately 3.9 million inhabitants, of which 1.72 million are in Leyte Island. The region has six (6) provinces and five (5) cities: Leyte, Samar, Northern Samar, Eastern Samar, Southern Leyte and Biliran provinces and the cities of Tacloban, Ormoc and Baybay in Leyte and Catbalogan and Calbayog in Western Samar. The poverty household rate of the region is 41% (national average: 27%), which is the fifth highest in the country.

Based on the survey report of JICA, the MMR in the region is 137 per 100,000 live births in 2007. CHD 8's Annual Report of 2008, however, showed an MMR of 0.85 per 1000 live births. The main reasons for maternal death are as follows: bleeding caused by failure of placental detachment or placenta abruption; puerperal hemorrhage; eclampsia; sepsis; and bleeding caused by ectopic pregnancy and uterine prolapse. The IMR and the Neonatal Mortality Rate (NMR) in the region are 28.7 per 1,000 live births and 14.5 per 1,000 live births, respectively. These figures are much higher than the national average of 24.1 per 1,000 live births for IMR and 13.2 per 1,000 live births for NMR. The reasons for infant deaths include pneumonia, congenital anomaly, sepsis (principally neonatal sepsis), dehydration, premature diseases, and the Respiratory Distress Syndrome (RDS). The high maternal and infant mortality rates are considered to be related to the socio-cultural background of risky Filipino women's pregnancies which are closely-spaced births, and pregnancies at too young or too old an age. Moreover, 55% of deliveries in the Eastern Visayas region are assisted by Traditional Birth Attendants (TBAs) or relatives. Thus, only a limited number of deliveries are assisted by Skilled Health Professionals (SHP) such as doctors, nurses and midwives. Such current situation seems to contribute to high maternal and infant mortality due to delays in detecting abnormality, and providing proper treatment and handling complications. Of the estimated 138,584 pregnant women in 2008, 66.9% had 4 or more prenatal visits in public health facilities and others could have gone to private practitioners, hospitals and traditional birth attendants or none at all. Eastern Samar and Northern Samar have shown better performance, since they have functional Basic Emergency Obstetric and Newborn Care facilities with the support of UNICEF under the Sixth Country Programme for Children (CPC VI) Program.

The Expanded Program on Immunization accomplishment in 2008 was 82.07% for fully immunized children. No province or city was able to reach the target coverage of 95%, which further decreased to 77.89% in 2009. Efforts in tracking defaulters should be given attention this year.

The FPS 2006 reported a 31.1% CPR for the region. The Regional 2008 data was 32% and all provinces have higher CPR with a range of 42% to 75% except Northern and Western Samar with 14.9% and 12%, respectively. There is also an observed disparity in the regional data with the provincial/city data. Among the regions in the Visayas, Region 8 has the lowest CPR which declined to 28% in 2008 from 31.8% in 2003, below the national average of 34%.

## Northern Leyte

The Province of Northern Leyte occupies the largest land area (46,695 sq.km.) among all the provinces in the region with 40 municipalities, 3 cities, 1,393 barangays, and 301,253 households. Its population of 1,505,224 (2009) is the largest among the provinces and accounts for 33.78% of the region's population with a population density of 260 persons per sq.km. Tacloban City, the Province' capital city, has the highest population density of 2,211 persons per sq.km. There are 22 municipalities that are categorized as 5$^{th}$ class and 7 municipalities that are categorized as 6$^{th}$ class, with 5 congressional districts. The Provincial Governor is a young executive who is a health champion and has a heart for women's health and well-being. At the provincial health office, the PHO II who is in charge of hospital operations is very supportive to public health and gives the Assistant PHO, who is dynamic and cooperative, the full authority on public health service delivery implementation. However, the Assistant PHO has not been delegating the tasks that the Technical Chief is supposed to do and leaves her uninformed of other technical matters and concerns.

**The Health Situation: trends in SO3 indicators**

Based on the province's 2009 FHSIS Report, its Infant Mortality Rate (IMR) is 7.56/1000 LB or 229 infant deaths. This is an increase from the 195 cases or 6.07/1000 LB in 2008. Maternal death cases decreased from 17 in 2008 to 12 cases in 2009. Basic intervention activities for maternal and child health program has led to an increase of the facility-based deliveries from 33% in 2008 to 41.4% in 2009, while skilled-birth attendants also increased from 77.51% (2008) to 79.47 (2009). However, ANC had a very slight increase from 43.59% to 44.99%. These indicators are below the national performance standard.

The number of Fully Immunized Children (FIC) has also decreased from 96.89% in 2008 to 85.65% in 2009 which did not reach the target coverage of 95%. Non-tracking defaulters are also one of the reasons of the decrease; thus, the province has to exert a lot of effort to reach a high coverage for child immunization.

Contraceptive Prevalence Rate (CPR) is low compared to the national performance standard at 44.99% in 2009, which slightly increased from 43.59% in 2008. However, this is still higher, as compared to the regional CPR of 32%. The CPR of Tacloban and Ormoc Cities also showed higher rates compared to the provincial and the regional data at 80.21% and 46.13%, respectively.

TB cure rate is 85% in 2008 but decreased to 81% in 2009, while case detection rate is 71% in 2008, which increased to 80% in 2009. With the assistance of Global Fund, 3 Private-Public Mix DOTS (PPMD) Units were initiated in the Cities of Ormoc, Baybay and Tacloban. In Tacloban City, there are 2 private-initiated PPMD units.

Health facilities of the province include: 45 Main Health Centers, 285 Barangay Health Stations, 3 City Health Offices, 13 government hospitals (1 provincial hospital, 8 district hospitals, 4 community hospitals and 1 mental hospital) and 6 private infirmary clinics. In terms of health manpower, there are 46 Municipal Health Officers, 57 Public Health Nurses, 288 Rural Health Midwives, 32 Dentists, 51 Rural Sanitary Inspectors, 46 Medical Technologists and 5,283 Barangay Health Workers. The province has a total health budget allocation of Php 268, 755,896 which is an increase of 10.12% from the 2009 budget of Php 274, 578,776 and a 5.8% from 2008 budget of Php 264, 799,619.

The Province identified its indigents through the “means test” of PhilHealth and CBMS. The Province initiated an increase in the enrolment of indigents from 45% in 2008 to 74.5% in 2009, with a budget of Php 17M. The target for 2010 is 85% enrolment.

**Priority TA Interventions and Activities**
**NORTHERN LEYTE (CITIES OF TACLOBAN AND ORMOC)**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ plan assessment/updating and policy development | 1.1.C.b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy, collection and reporting | Data quality improvement of FP current users | Support CHD/PHO in monitoring on-site DQC | | | | **P1 M40 C2** | | | | | | | | | | | | **1** | **40** | **2** |
| | 1.1C.a<br><br>1.1B.b | Cleaned FP CU used for forecasting FP commodities<br><br>LGU CSR plan updated | CSR+ plan and policy updating workshop using FP CU cleaned data for forecasting FP commodity requirements;<br><br>Forecasted requirements will be integrated in the 2011 AOP/AIP | Support CHD/PHO in providing TA | | | | **P1** | | | | | | | | | | | | **1** | | |
| | (1.1F.a)<br>1.4A.b<br>1.4C.a | Policy/ordinance with broad stakeholders participation and support formulated | CSR policy advocacy with broadstakeholders' participation | Support CHD/PHO in providing TA | | | | | **P1 C2** | | | | | | | | | | | **1** | | **2** |
| | 1.1Bd<br>(1.1F.b) | CSR policy approved | Monitor advocacy activities of MHOs/DOH Reps | Support CHD/PHO in monitoring | | | | | | | | | | **P1 C2** | | | | | | **1** | | **2** |
| 2. ICV compliance monitoring and reporting | 1.3D.a | Personnel trained in ICV compliance monitoring | a) Orientation to PHO/MHOs/DOH Reps on ICV Compliance Monitoring and Reporting | Resource person, guide in the preparation of the presentation material<br><br>Coach for any potential vulnerability | | | **P1 M40 C2** | | | | | | | | | | | | | **1** | **40** | **2** |
| | 1.3Dc | ICV compliance of service delivery sites monitored and reported | b) Implementation of the provincial ICV compliance monitoring plan | Coach CHD in the follow up of the ICV compliance monitoring | | | | | | | | | | | | **P1 M40 C2** | | | | **1** | **40** | **2** |
| | | | c) Quarterly reporting by the ICV monitoring team on the findings of ICV compliance monitoring during PHO regular meeting | Coach PHO in consolidating reports and analyzing findings | | | | | | | | | | | | **P1** | | | | **1** | | |
| 3. Integration of FP into EPI and maximizing utilization of MNCHN services | 1.3A.d | CHD/PHO/DOH Reps/MHOs/PHNs trained in integration of FP/EPI and maximizing utilization of MNCHN services and developed action plan | - Orientation/training of facilitators for the integration and action planning on FP/EPI and maximizing utilization of MNCHN services in 15 sites | Trainer and facilitator, design, materials, and LTAP fund support | | | | **P1 M23** | | | | | | | | | | | | **1** | **23** | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | P | M | C |
| | 1.3A.d | Providers trained in integration of FP in EPI and maximizing utilization of MNCHN services | -Orientation training cum planning with service providers on FP-EPI integration of services and maximizing utilization of MNCHN services and establishing FP, ANC, SBA and FBD baseline data and documenting progress/results | Trainer and facilitator<br><br>Training design/materials | | | | M9 | M14 | | | | | | | | | | | | 23 | |
| | | Report of findings and recommendations to improve implementation | Meetings with DOH Reps/PHO/Program coordinators on the progress of the implementation of the MNCHN strategies | Monitoring tool and templates, coaching; fund support | | | | | | | | | | | | | | | | | 15 | |
| | 1.4A.b<br>1.4B.b | Documentation of results on FP acceptors, ANC, SBA and FBD presented | - Province-level sharing of results | Activity design, facilitator/resource person; LTAP fund support | | | | | | | | | | | | | | | | 1 | | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | | | | |
| 1. BDR/Local NHIP Implementation | | Agreements on the key activities to implement BDR in the province | a) Consultative meeting with PHIC/CHD/PHO in planning for strengthening NHIP in the province | Support CHD/PHIC in planning for strengthening NHIP implementation in the province | | | | | | | | | | | | | | | | | | |
| | 1.2B.a | TOT in local NHIP implementation conducted | b) Orientation training cum planning of key P/M/C LGU officials on PhilHealth BDR and rapid assessment on policy and operation issues of local NHIP implementation specifically focus on enrolment, accreditation, management of capitation and reimbursement | Support CHD/PHIC in providing TA<br><br>Technical guides, NHIP toolkit, resource persons<br><br>Design, training materials and modules | | | P1 | | | | | | | | | | | | | 1 | | |
| | | NHIP assessment result consolidated | d) Small-group meetings with PHO, CHD/PHTO, PHIC to consolidate, analyze assessment results | Counterpart funds for meals, resource person | | | | | | | | | | | | | | | | | | |
| | | Key action points agreed | c) Follow on meetings with the CHD, PHO, PPDO, DSWD and PHIC to determine the status of PHIC implementation in the province | Support CHD/PHO | | | | | | | | | | | | | | | | | | |
| | 1.2B.b | Province-wide NHIP plan formulated | e) Province-wide planning for NHIP strengthening local implementation of NHIP | Support CHD/PHO in organizing and providing TA to the LGUs in developing a NHIP plan<br><br>Counterpart funds for meals, resource person | | | | | | | | | | | P1 | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
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| | | | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | P | M | C |
| | 1.2C.a | Application for accreditation of facilities for MCP, OPB and/or TB DOTS filed | Facility accreditation by PhilHealth | | | | | | | M3 | M3 | M3 | M3 | M3 | M3 | | | | | | 18 | |
| | 1.2C.b | Facilities accredited by PhilHealth | | | | | | | | | M2 | M2 | M2 | M1 | M1 | M1 | | | | | 9 | |
| 2. 2010 MNCHN grants facility | 1.2A.b | MNCHN grants accessed | a) Provincial orientation for MLGUs on MNCHN grant facility guidelines and determining allocation of the MNCHN grants to the LGUs | Support CHD in the orientation and LGU allocation guide | | | P1 M40 C2 | | | | | | | | | | | | | 1 | 40 | 2 |
| | | | b) Consolidation of the data required for submission to CHD 8 based on the assessment done in the municipalities and MNCHN grant guidelines | Coaching | | | | | | | | | | | | | | | | | | |
| | | | c) Monitoring the MNCHN grant facility access and utilization by the LGUs using the approved guidelines | Coaching | | | | | | | P1 C2 | M8 | M8 | M8 | M8 | M8 | | | | 1 | 40 | 2 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | | | | |
| 1. Data quality check for all FHSIS indicators including FP current users data | 1.1C.d | Personnel trained in data custody of health-related data - FHSIS DQC for FHSIS indicators | a) Orientation training on other MNCHN indicators/FP-DQC and CSR assessment and action planning for updating CSR+ plans policy using cleaned FP CU data | Resource person, facilitator<br><br>Support CHD in conducting the training | | | P1 M40 C2 | | | | | | | | | | | | | 1 | 40 | 2 |
| | 1.1.C.c | Quality of other MNCHN indicators derived from FHSIS checked and validated for accuracy, collection and reporting | b) Data quality check for FP current users/other MNCHN indicators and CSR assessment on-site | Support CHD/PHO in monitoring on-site DQC | | | | P1 M40 C2 | | | | | | | | | | | | 1 | 40 | 2 |
| | | Consolidated corrected LGU data and provincial data | c) Meeting with PHO/FP coordinator /PHTL/DOH Reps to discuss and consolidate results of all checked LGUs FP/other MNCHN data and assessment results | Resource person, facilitator<br><br>Templates for consolidation | | | | | | | | | | | | | | | | | | |
| | | Agreement to use data for planning for AOP | d) Advocacy meeting with the PHO on the use of cleaned data on FP/MNCHN indicators for AOP planning | Support CHD in meeting with PHO | | | | | | | | | | | | | | | | | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | P | M | C |
| 2. Logistics management | | Stock and inventory tools pre-tested in selected municipalities and 1city in the province;<br><br>Action plan for the 3-month pre-testing of tool developed and implemented | Testing of the SIMS tools in selected facilities in the province | Resource person for orientation, mentoring, coaching during training and source of fund | | | | | | | | | | | | | | | | 1 | 4 | 1 |
| | 1.1E.c | TOT in stocks and inventory management system (SIMS) conducted | b) Conduct of training for the CHD/RHU staff of the pilot sites | | | | P1 M4 C1 | | | | | | | | | | | | | 1 | 4 | 1 |
| | 1.1E.d | Inventory management tool for essential drugs and commodities adopted | c) Roll out to municipalities of the SIMS | | | | | | | | | | M4 C1 | | | | | | | | 4 | 1 |
| | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | c) TOT in FPCMS for CHD/PHO logistics management team | | | | | | | | P1 | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | e) FP commodity availability monitored quarterly | | | | | | | | | | | | | M40 C2 | | | | | 40 | 2 |
| **B Support to advocacy to newly elected local chief executives and other local officials** | 1.4B.c | Priority health agenda, as contained in the PIPH/AOP 2011 presented to NEOs | a) Meeting with CHD/PHO/PHTO and DILG re the NEO program focusing on component 3 (Alliance Building) and ensuring health integrated in the PDP-ELA | Technical support<br><br>Advocacy tool<br><br>Coaching | | | P1 | | | | | | | | | | | | | 1 | | |
| | | | b) Development of advocacy tool during the MNCHN Orientation to LCEs | | | | | | | | | | | | | | | | | | | |
| | | | b) Coach PHO/PHTO present and discuss health situation/AOP/MNCHN plan to PHB for endorsement to Provincial *Sanggunian* and come up with MNCHN policy | | | | | | | | | | | | | | | | | 1 | | |

## Western Samar

The province of Western Samar is a 2nd class province and the 2nd poorest in the region with a poverty incidence of 45.9 percent. It is composed of 24 municipalities- 5 mainland, 13 coastal, and 6 islands (with 9 geographically isolated and disadvantaged towns), 2 component cities and 954 barangays. In these 9 GIDA towns, majority has no access to health services either because there is no health center or is dilapidated. Even the provision of basic preventive health services, such as immunization, antenatal care, and follow-up on communicable diseases like TB, remains a big challenge. In emergency cases, the lack of established emergency transportation facilities contributes to the delay in seeking medical care. The province has a total population of 806,000 with 124,246 households. Catbalogan City is the capital of the province.

The provincial leadership is headed by a young lady governor who took over the reins from her mother, who is now a Congresswoman. It is hoped that she will give her support for health, which was not evident during her mother's administration. At the PHO level, the technical chief is more aggressive compared to the PHO II. She is supported by the Provincial FP Coordinator who is equally diligent and serious with her tasks and functions.

**The Health Situation: trends in SO3 indicators**

Based on the province's 2009 FHSIS Report, its Infant Mortality Rate (IMR) of 6.15/1000 LB is lower than the national and regional figures - which may be a case of underreporting. There were 18 neonatal deaths reported, figures higher than the past year. Majority of these deaths came from the Municipality of Daram, one of the GIDA towns in the province. Non-facility based deliveries and deliveries attended by unskilled birth attendants were attributed to these deaths.

Deaths related to pregnancy and child birth have significantly increased at a rate of 171/100,000 LB in 2009 from 109/100,000 LB in 2007. Common causes of maternal deaths are associated with complications and high-risk pregnancy and childbirth. About 12% of the total births were delivered at health facilities which do not have adequate health services nor capable of providing basic and emergency obstetric and neonatal care. However, 60% of these deliveries were attended by skilled birth attendants.

Non-communicable diseases like cardio pulmonary arrest, hypertension, cerebrovascular diseases, cardio vascular accident, bronchial asthma and diabetes except for pneumonia are the major causes of deaths. On the other hand, majority of the ten leading causes of illness includes pneumonia, URTI, bronchitis, and diarrhea.

The number of Fully Immunized Children (FIC) has increased from 59% in 2008 to 64% in 2009. There are still a huge number of eligible children who missed the opportunity of receiving the required vaccine. The poor coverage in immunization is caused by the irregular visit of health personnel to the barangay and poor tracking of defaulters.

Contraceptive Prevalence Rate (CPR) is very low at 12%, which showed no improvements for the past 3 years. This is due to the lack of contraceptive supplies and lack of support of the LGUs in providing these commodities and the religious beliefs of a number of couples was also identified as one of the factors. In addition to this, newly hired health workers have not been trained on Family Planning counselling and Basic FP and 90% of the Barangay Health Stations do not have the equipments/facility to do IUD insertion. Clients who are also buying FP supplies from pharmacies/other commercial outlets are not monitored.

TB cure rate is 81 percent while case detection rate is 42 percent. Non-availability of medical technologists in the RHUs, non-functional TB microscopist and detailing some of the field medical technologist to the Samar Provincial Hospital and poor follow up of patients under treatment are viewed to have contributed to the low performance. The TB DOTS Committee reviews x-ray results for further assessment and management of TB cases, however, the committee lacks a radiologist.

In support to MNCHN implementation, some health personnel and community based workers in the province were called for training on Community-Managed Maternal and Newborn Care (CMMNC), Maternal Death Review, Integrated Management of Childhood Illnesses, Maternal Neonatal and Tetanus Elimination and Promotion on Good Nutrition. Support groups like infant and Young Child Feeding (IYCF) and Women's Health Teams were also organized and activated.

Health promotion activities in the province were continuously carried out utilizing print, radio and TV. LGUs' also embarked on community based IEC activities such as the conduct of Responsible Parenting Movement (RPM) classes, session on "*Pabasa sa Nutrisyon*", Breastfeeding counselling and Food handler's classes. These activities are aimed at creating public awareness on health and develop positive health behaviour.

The Province has 2 City Health Offices, 5 Main Health Centers, 24 Rural Health Units, 136 Barangay Health Stations, 6 functional public hospitals and 3 private hospitals. Of these facilities, 11 RHUs are PhilHealth accredited for Out-Patient Benefit Package, 2 for MCP, 3 for TB DOTS and 6 are Sentrong Sigla Phase 2 certified. The Samar Provincial Hospital located in the capital city is the core referral hospital and is the only PhilHealth-accredited hospital. However, its capitation fund and users' fees are not maximized since it reverts to the general fund. Moreover, drug management system in all hospitals is beset with problems related to procurement process. The average hospital bed occupancy rate of all hospitals is only 67%. The poor utilization of hospital services is caused by lack of health personnel especially doctors and nurses and inadequate medical supplies and equipment. These deficiencies have resulted to downgrading of the licenses of 3 hospitals by the DOH.

In terms of health manpower, there are 22 Public Health Physicians, 19 Public Health Dentists, 44 Public Health Nurses, 145 Rural Health Midwives and 22 Medical Technologists. Five Medical Technologists and nine Public Health Dentists are province paid, deployed as manpower augmentation to Rural Health Units who cover more than one municipality. However, population ratio of these doctors, dentists and nurses are below the national standard set by DOH. There are 11 towns with no assigned MHOs and 4 towns with no assigned PHNs. This problem is compounded by lack of transportation facilities in several towns which makes it doubly difficult for the RHU staff to deliver the health services as well as for clients to access health services.

The province has a total health budget allocation of Php 138, 933,227.00 which accounts for 22% of the total budget of the province. However, a very minimal amount is allocated for public health (10%) and the rest goes to hospital operation. On average, government hospitals allocate 78% of their budgets for personal services and 22% for MOOE.

As of 2009, a total of 61,729 households were enrolled in the National Health Insurance Program (NHIP). Only 16% of indigent families from 11 LGUs are enrolled and three LGUs are still processing its application. Reimbursements and capitation are significant sources of health financing. Accredited facilities at the municipal and city levels received reimbursements and

capitation funds which are utilized to renovate its health facilities, purchase equipment, medicines and other supplies. They are also given as additional incentives for health service providers.

**HealthGov's Response and TA Interventions in the Provinces of Northern Leyte (including the Cities of Ormoc and Tacloban) and Western Samar**

Given the above challenges in the region, priority technical assistance will focus on supporting CHD and PHOs in MNCHN, particularly in the provinces of North Leyte and Western Samar and the Cities of Ormoc and Tacloban, which represents 62.8% of the region's total number of women of reproductive age and represents 57.4% of the region's total estimated number of annual deliveries and newborns. The JICA project focusing on Strengthening Maternal and Child Health services in the province of North Leyte and the City of Ormoc will be closely coordinated by HealthGov and other CAs. With a very dynamic CHD8 Regional Director and technical staff, we can move forward these priority TA interventions and hopefully improve the SO3 indicators.

HealthGov, in support of the priority strategies for the four LGUs in health, as spelled out in its PIPH/AOP 2010, and in collaboration with CHD/DOHReps, and PHO will provide the following TA interventions in Year1:

A. Support to improving service delivery in family health

- Data Quality Check for all FHSIS indicators and FP Current Users data - to ensure validity and reliability of all data generated. This will be used for planning and decision-making at all levels;
- CSR+ planning and policy development and approval – to ensure that there is access to FP commodities and services especially for the poor;
- ICV Compliance Monitoring and Reporting - provide guidance to LGUs in ensuring quality standards in FP thru ICV compliance monitoring;
- FP-EPI Integration/Post partum services - integration of services that target the same population, which will be implemented in 15 LGUs in the Province of North Leyte, which has over 85% FIC;
- Support to LGUs in accessing the 2010 MNCHN Grants Facility, a performance-based grant, which can also be utilized in accordance with the approved MNCHN plan of the province;

B. Strengthening family health program through financing, policy and governance

- BDR/Local NHIP Implementation – the Benefit Delivery Ratio Approach measures the extent that NHIP benefits are actually delivered and has reached its target beneficiaries; it captures the effects of PHIC operation from enrolment, accreditation, benefit availment and payment to support health care costs incurred;
- Logistics Management – this involves two components: FP Commodity Monitoring System to assess the availability of FP commodities in the CHDs, PHOs, RHUs, and Hospitals and the Stock Inventory Management System to track expendable commodities in health facilities, particularly drugs and medical supplies;
- Support to CHD in advocacy activities to newly elected local chief executives and other local officials - to deepen the understanding of the LCEs on health sector reform and generate support for health.

**Priority TA Interventions and Activities**
**WESTERN SAMAR**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN Strategy** | | | | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ planning and policy development and approval | 1.1C.b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | a) FP data on-site clean up | Support CHD as resource person for training, mentoring, coaching<br><br>Source of fund | | | | **P1 M25 C1** | | | | | | | | | | | | 1 | 25 | 1 |
| | | Provincial team oriented on CSR+ | b) Orient PHO/PHTL/DOH Reps on CSR planning processes and implementation | Support CHD as resource person for training, mentoring, coaching<br><br>Source of fund | | | | | | | | | | | | | | | | | | |
| | 1.1B.a (1.1C.a) | CSR+ plans formulated with 5-year forecasting with policy support using clean FP CU data | c) CSR+ planning workshop using FP CU cleaned data for forecasting FP, Vitamin A and TB commodity requirements; Forecasted requirements will be integrated in the 2011 AOP/AIP | Support CHD in facilitating planning workshop<br><br>Resource person | | | | **P1** | | | | | | | | | | | | 1 | | |
| 2. ICV compliance monitoring and reporting | 1.3D.a<br><br>1.3D.b | Personnel trained in ICV compliance and monitoring<br><br>ICV compliance monitoring plan developed | a) Orientation training of PHO/MHOs on ICV Compliance Monitoring and Reporting | Resource person, guide in the preparation of the presentation material<br><br>Coach for any potential vulnerability | | | **P1 M25 C1** | | | | | | | | | | | | | 1 | 25 | 1 |
| | 1.3D.c | ICV compliance of service delivery sites monitored and reported | b). Implementation of the provincial ICV compliance monitoring plan | | | | | **P1 M1 C1** | **M3** | **M3** | **M3** | **M3** | **M3** | **M3** | **M3** | **M3** | | | | 1 | 25 | 1 |
| | 1.4B.b | Provincial consolidation of ICV reports presented to LDC/LHB | c) Quarterly reporting by the ICV monitoring team on the findings of ICV compliance monitoring during PHO regular meeting | | | | | | | **P1** | | | **P1** | | | **P1** | | | | 1 | | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | | | | |
| 1. BDR/Local NHIP implementation | | Key action points and schedule agreed by partners | a) Consultative meetings with PHO, CHD/PHTO, PPDO, PHIC to determine sets of action to enhance NHIP local implementation | Resource person, NHIP materials including assessment tool | | | | | | | | | | | | | | | | 1 | | |
| | | Finalization of assessment tools | b) Follow on meeting with the CHD/PHO, PPDO, DSWD and PHIC to determine the status of PHIC implementation in the province and come up with NHIP assessment tool | Support CHD in facilitating meetings | | | | | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | P | M | C |
| | | Assessment report | c) Province-wide assessment of NHIP implementation | Technical guidance, coaching and mentoring | | | | | | | | | | | | | | | | 1 | | |
| | | NHIP assessment result consolidated and analyzed | d) Small-group meetings with PHO, CHD/PHTO, PHIC to consolidate, analyse assessment results | Counterpart funds for meals, resource person | | | | | | | | | | | | | | | | 1 | | |
| | 1.2B.b | Local NHIP implementation plan formulated | e) Province-wide orientation on NHIP Benefits Delivery Approach, presentation of assessment results and province-wide planning for NHIP local implementation | Counterpart funds for meals, resource person | | | | | | P1 | | | | | | | | | | 1 | | |
| 2. 2010 MNCHN grants facility | 1.2A.b | MNCHN grants accessed | a) Provincial orientation on MNCHN grant facility guidelines to the M-LGUs and use of the allocation tool in determining allocation of the MNCHN grants to the LGUs<br><br>b) Consolidation of the data required for submission to CHD 8 based on the assessment don | Support CHD in providing TA to the province/LGUs including LGU allocation guide<br><br>Coaching | | | P1 | P1 | P1 | P1 | | | | | | | | | | | | |
| | | | c) Monitoring the MNCHN grant facility utilization by the LGUs using the approved guidelines | Coaching | | | | | | | P1 C2 | M6 | M5 | M5 | M5 | M5 | | | | 1 | 25 | 1 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | | | | |
| 1. Data quality check for all FHSIS indicators and FP current users data | 1.1C.d | Personnel trained in data custody and management of health-related data (FHSIS DQC) used for planning and decision-making data | a) Orientation and assessment/data cleaning workshop for city/municipal health personnel | Resource person for orientation, mentoring, coaching during on-site data cleaning and source of fund | | | | P1 M25 C1 | | | | | | | | | | | | 1 | 25 | 1 |
| | 1.1C.c | Quality of other family health data derived from FHSIS (SBA, FIC, among others) checked and validated for accuracy in collection, computation and reporting | b) Other MNCHN data on-site clean-up | | | | | | P1 M25 C1 | | | | | | | | | | | 1 | 25 | 1 |
| | | Consolidated corrected FHSIS data by LGU and province | c) Meeting with PHO/FP coordinator/PHTL/DOH Reps to discuss and consolidate results of all LGUs FP data clean up | Coach CHD/PHO | | | | | | | | | | | | | | | | | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | P | M | C |
| 2. Logistics management | 1.1C.d | CHD technical staff oriented on data generation | a) Orientation to CHD 8 technical staff on data generation | | | | | | P1 | | | | | | | | | | | 1 | | |
| | 1.1Ea | TOT in FP commodity monitoring | c) TOT in FPCMS for CHD/PHO logistics management team | Resource person for orientation, mentoring, coaching during training and source of fund | | | | | | | P1 | | | | | | | | | 1 | | |
| | 1.1Eb | FPCMS tool adopted | e) FP commodity availability monitored quarterly | | | | | | | | | | P1 M25 C1 | | | | | | | 1 | 25 | 1 |
| **C. Support to advocacy to NEO and other local officials** | 1.4B.c | Priority health agenda, as contained in the PIPH/AOP 2011, presented to NEOs | a) Meeting with CHD/PHO/PHTO and DILG re the NEO program focusing on component 3 (Alliance Building) and ensuring health integrated in the PDP-ELA | Technical support<br><br>Advocacy tools | | | P1 | | | | | | | | | | | | | 1 | | |
| | 1.1F.b | Resolution on MNCHN policy issued by PHB | b) Coach PHO/PHTO present and discuss health situation/AOP/MNCHN plan to PHB for endorsement to Provincial *Sanggunian* and come up with MNCHN policy | | | | | | | P1 | | | | | | | | | | 1 | | |

# Northwestern Mindanao

## Northwestern Mindanao

HealthGov provides technical assistance (TA) to six provinces in northwestern Mindanao – three in Region 9 (Zamboanga del Norte, Zamboanga del Sur, and Sibugay) and three in Region 10 (Bukidnon, Misamis Occidental, and Misamis Oriental). The TA provided in the province for the past four years of the project, was geared towards increasing the SO3 indicators and improving public health outcomes through improved service delivery and strengthening family health programs support in governance, policy, and financing. The following table summarizes the performance of the six USAID-assisted provinces in the region.

### Regional Health Situation

The health picture of the six provinces, 10 cities, and 124 municipalities with a total projected population in 2010 (based on 2007 census) of 5,654,172 showed modest increases in the SO3 indicators in 2009. Bukidnon ranked first in CPR (53%), Zamboanga del Norte in 4ANC (79%), and Misamis Occidental in SBA (79%) and FBD (31%). Zamboanga Sibugay was lowest in all four indicators (24%, 42%, 33%, and 8%, respectively. Not one province was able to reach the national standards for all the maternal health indicators.

On the other hand, it was Zamboanga Sibugay that posted the highest accomplishment for Vitamin A coverage (99%) during GP and for child with diarrhea given ORT (53%). Only Zamboanga del Norte reached the national target for FIC and DPT3, while only Zamboanga Sibugay, Zamboanga Norte, and Misamis Occidental reached the national standard for Vitamin A coverage. For the indicator child with pneumonia given antibiotics, all provinces had more than 95% accomplishment.

In TB control, the best performing province is Misamis Occidental having shown consistently high accomplishments for four years. The lowest performing provinces are Bukidnon and Zamboanga del Norte, having consistently performed below the national standards. For CDR, 4 provinces passed the 70% target. For cure rate, only Misamis Occidental and Misamis Oriental achieved more than 85%.

### The Response: Regional Approaches

**RCBI implementation.** HealthGov's assistance to CHD 9 and 10 at the start of the project focused on mentoring/coaching of CHD management on the tools, guides, processes, and mechanisms developed by the project. The F1 regionalization workshop held at the start of Y4, with strong inter-CA support, gave impetus to the two CHD to lead the implementation of the health sector reforms. This also caused a paradigm shift among most CHD managers regarding their role as TA providers to the LGUs. With HealthGov's TA, CHD 10 was able to craft its support plan to the LGUs and implemented the identified activities during the year. These activities included training of the DOH Reps; training in referral system for hospital personnel; and training in FHSIS, including making population projections, for selected provincial staff. For CHD 9, the joint meeting with the USAID CAs re-affirmed their commitment to take leadership in undertaking health development reforms in governance, financing, and service delivery. Both CHD took the lead in the conduct and funding of these activities.

HealthGov's TA in the region during the early years of the project focused on improving LGU management systems in the areas of investment planning; CSR planning; installing a classification system for identifying the poor and advocacy for increased PhilHealth coverage of the poor; conduct of annual enhanced program implementation review (SDIR); and inter-LGU

collaboration. Being F1 roll out sites, all three provinces in Region 9 was assisted in the development of their PIPH (2008-2012) and AOP. TA was provided in close coordination with CHD 9 from plan development, to technical review, until enhancement and final approval utilizing the tools, guidelines, and modules developed by the project. On the other hand, HealthGov assisted Bukidnon and Misamis Oriental (Region 10) in the development of their MIPH. Both are F44 provinces and were required by DOH to develop their PIPH (2010-2014) in 2009.

HealthGov introduced the tools for enhanced program implementation review and oriented the health personnel in both regions in the conduct of the Service Delivery Implementation Review (SDIR). In the area of health financing, advocacy for increased PhilHealth coverage of the poor was also undertaken in all provinces. Misamis Occidental became a pilot province for the Community Health and Living Standards Survey (CHLSS), which is a tool for identifying the “true poor”.

Other TA packages were added like the SDExH for continuing service delivery quality improvement; ICV compliance; improving data management, including FP current users data cleaning and utilization; increasing financing through PhilHealth and MNCHN grants; and policy development. Towards the end of Year 3 until Year 4, the region also focused on improving service delivery and providing support to FP/ MNCHN through capability building of health workers on FP, MCH, and TB; FP integration in EPI and maximizing MNCHN services and facilities to increase SO3 indicators; and CSR+ planning and policy approval.

The SDExH was first introduced in the Oroquieta Inter-local Health Zone in the Province of Misamis Occidental, particularly in four RHUs, the CHO, and in the Misamis Occidental Provincial Hospital. The initiative was well received and appreciated by both health providers and clients, as evidenced by increased client satisfaction in all pilot health facilities. The intervention was later rolled out in Years 3 and 4 in the Ozamiz ILHZ, which consists of one CHO, three RHUs, and three government hospitals using provincial government funds. Currently, the Quality Assurance Partnership Committees of Health Systems 20/20 (another RTI project) were already integrated in the Quality Health Improvement Teams of the SDExH in Lopez Jaena and Oroquieta City.

In support of the FP/MNCHN strategy and as a response to the very low CPR in the Zamboanga Peninsula provinces, CSR+ was initiated in Year 3 in the Provinces of Zamboanga del Norte, Zamboanga del Sur, and Zamboanga Sibugay. These three provinces conducted their CSR forecasting and planning in Year 3, followed by policy development in Year 4. CSR+ policies were passed and approved by many LGUs. Zamboanga del Sur has an approved CSR ordinance and there are already 45 approved municipal CSR policies in Zamboanga del Norte and Zamboanga del Sur. Tracking of policy implementation has also been done in 24 municipalities.

FP integration in EPI and maximizing MNCHN services and facilities were modeled in Misamis Oriental in Year 3. This was rolled out in the 13 municipalities of the province with more than 85% FIC. In Year 4, these were started in Zamboanga del Norte, where a total of nine municipalities have already formulated and implemented their action plan to accelerate improvements in the SO3 indicators – CPR, SBA, 4ANC, and FBD. In the same year, the initiatives were rolled out in eight municipalities in Bukidnon and one in Misamis Occidental. More municipalities will be covered before the end of Year 4.

In response to the perennial problem of inconsistent and incorrect data, and in support of improving data management, the FP Current Users (CU) data quality check (DQC) was initiated in Zamboanga del Norte in Year 3. This intervention which consists of data cleaning and utilization was done to have a sound basis for CSR+ forecasting. The lessons learned in implementing DQC in the province were used as bases in enhancing the DQC process when it was later replicated in Misamis Oriental, Misamis Occidental, and Bukidnon.

All the provinces were assisted in accessing the 2008 and 2009 MNCHN grants facility. Zamboanga del Sur made cash transfers to its city and municipal LGUs utilizing its 2008 MNCHN grant. On the other hand, Zamboanga del Norte transferred a portion of its 2009 grant after the LGUs have developed their local policy based on the domains and guidelines provided and utilizing the provincial allocation tool developed by HealthGov.

ICV compliance monitoring was introduced to all provinces starting Year 1. A total of 26 health facilities in Misamis Oriental, Bukidnon, Zamboanga del Norte, and Zamboanga del Sur were covered and all the facilities showed compliance with the ICV policies.

In addition, all six provinces were supported in the conduct of their FPCBT by providing the resource persons/facilitators, manuals, pelvic models, and WHO-MEC wheels. As a result, there are now many newly-hired personnel who are able to provide FP services. In Zamboanga del Norte, TB DOTS training was provided to 121 health personnel and 108 community workers to help improve TB case finding and treatment. The province has the lowest performance in TB control and prevention among the Zamboanga peninsula provinces.

By the end of Year 4, it is expected that Misamis Oriental, Misamis Occidental, and Bukidnon would have formulated their CSR+ plan based on “cleaned” FP current users data. All provinces of Zamboanga peninsula would have also finished their data cleaning for a more accurate re-forecasting of commodity requirements and CSR+ plan updating. To contribute to improving CPR, FP integration in EPI and maximizing MNCHN services would have been scaled up in the region to cover at least more than 50% of the targeted 83 LGUs by the end of Year 4. Corollary to this, the FOGs for Zamboanga del Norte and Misamis Occidental, which will assist LGUs in mobilizing and increasing community participation, would have to be engaged by then. To ensure that commodities will be available to clients when they need them, it is also expected that all the LGUs would have received their 2009 MNCHN grant by then and have fast-tracked its utilization.

By the end of Year 4, the CHLSS results of the 15 LGUs would have been presented to the local officials and health personnel for utilization in the local NHIP implementation. With the assistance of the LTAPs, the SDIR process in all of the six provinces would have been conducted, including the data quality check of other FHSIS indicators. It is also expected that all LGUs would have had the capacity to formulate their acceleration plan and annual training plan, as well as to establish a database of the capability profile of health personnel. Towards the end of Year 4, it is also expected that with the STTAs engaged to support the NEO program, the LGUs would have been assisted in the preparation and presentation of their health agenda to the newly-elected and newly-minted LCEs and officials.

The political environment in this part of Mindanao has changed with the installation of two new Governors in Zamboanga peninsula and also two new Governors in northern Mindanao. The change in political leadership augurs well for three provinces, i.e., Zamboanga Sibugay, Bukidnon, and Misamis Occidental. For instance, the new Governor of Zamboanga Sibugay has already designated an OIC PHO, which is critical in moving the TA packages in the province.

The newly-elected Governor of Bukidnon is more inclined to give priority to public health programs unlike his predecessor who focused on hospital operations, while Misamis Occidental's new Governor is the wife of the former Health Secretary.

**TA Interventions for Year 5**

- CSR+ policy development and approval based on the CSR+ plans – this will be done in Bukidnon, Misamis Oriental, Misamis Occidental and Zamboanga Sibugay and will be pursued with broad stakeholders participation;
- CSR+ policy tracking in all provinces will be sustained by the PHO and DOH Reps;
- Institutionalization of ICV compliance monitoring
  - policy on ICV monitoring and reporting will form part of the CSR+ policy in the six provinces
  - regular conduct of ICV monitoring and reporting by PHO staff/DOH Reps;
- Scaling up of FP-EPI integration/maximizing utilization of MNCHN services in the remaining municipalities which cannot be covered by EO Year 4: Zamboanga Norte (12), Sibugay (9), Zamboanga Sur (10), Bukidnon (10), Misamis Occidental (9); Misamis Oriental (14)
- Formulation and approval of MNCHN policies (SBA/FBD) through FOG which started in Y4 (Zamboanga del Norte and Misamis Occidental);
- Monitoring and documentation of the results of FP-EPI integration in all mLGUs covered in the six provinces;
- MNCHN policy formulation for LGUs to meet the criteria for accessing MNCHN grants (Misamis Occidental, Misamis Oriental, and Bukidnon);
- Monitoring and reporting of MNCHN grant utilization (6 provinces);
- Local BDR approach to NHIP with focus on accreditation of facilities and utilization of reimbursements (Zamboanga del Norte, and Zamboanga del Sur); PHIC enrollment, facilities accreditation and PHIC fund Management (Misamis Occidental) and accreditation of health facilities in Misamis Oriental and Zamboanga del Sur.
- Capability building for LGU staff on CHLSS data custody and management (Misamis Occidental);
- Institutionalization of SDIR process and continuing data quality check and utilization (6 provinces);
- Integration of LGU health plans in the CDP-ELA and/or AIP during LGU planning and budgeting process;
- PIPH (Misamis Occidental) and AOP formulation (5 provinces) and monitoring of AOP implementation through PME;
- Establishment of FP commodity monitoring system in the PHO in all 6 provinces and Establishment of stock and inventory management system for Zamboanga del Norte
- Advocacy support to the NEO program.

Milestones to be achieved by EO of Year 5:

- PIPH/CIPH/MIPH integrated into the CDP-ELA;
- AOPs integrated into AIP during the LGU budgeting process;
- PME for AOP monitoring adopted;
- CSR policies approved;
- Health-related policies crafted and approved with broad stakeholders participation and support;
- LGUs with action plan implemented to accelerate performance to address SO3 concerns;
- Provinces with a monitoring system for ICV compliance;

- Quality of family health performance indicators derived form FHSIS checked and validated for accuracy in collection, computation, and reporting;
- Annual acceleration plans formulated by LGUs;
- Logistics management in LGUs improved through the establishment of a FP commodity monitoring system and an inventory system for essential drugs and commodities;
- LGUs collaborating with each other in systems development and implementation (planning, M&E, logistics management);
- External financing for health (e.g. MNCHN grant) utilized to increase public sector investments in health;
- Plan for management of PhilHealth reimbursements and capitation fund for re-investment in health implemented;
- LGUs with increased PHIC coverage for the poor using CHLSS tool;
- LGUs with increased number of accredited health facilities by PhilHealth;
- Province-wide training program for service providers in FP/ MCH implemented; and
- Continuing service quality improvement system of LGU implemented.

**Sustainability Mechanisms**

- Capacitate the CHD/PHO program managers, including DOH Reps through ToTs and orientation on the TA products;
- Plan, together with CHD/PHO management, for the conduct of all roll out activities;
- Discuss with the CHD the mechanism to harmonize TA tools and processes to better capacitate the CHD staff / DOH Reps and to enable them to take the lead in providing TA to the LGUs;
- Conduct joint monitoring activities, including policy tracking and documentation of results of FP-EPI integration and maximizing MNCHN services;
- Provide regular feedback on project activities through attendance in RICT meetings and PHO conferences;
- Assist PHOs in providing feedback to the LCEs through dialogue meetings or progress reports utilizing the presentation materials developed by the STTA for the NEO program;
- Conduct monthly meetings with LGU partners to monitor progress and to jointly identify solutions to issues and concerns;
- Negotiate for cost-sharing in the implementation of the remaining TA packages;
- Ensure creativity and flexibility in responding to the emerging needs of the CHD to sustain harmonious and effective partnership;
- Continue inter-CA collaboration and coordination; and
- Plan jointly with LGU partners for the turn-over and exit conference.

## Bukidnon

Bukidnon has 2 component cities and 20 municipalities. Based on 2007 census, its estimated population reached 1,190,284 comprising 30.12% of the regional total. Bukidnon has a distinct peculiarity: 40% of its populace is composed of IPs whose cultural practices and geographical inaccessibility to health facilities are regarded as contributory factors to the province's low performance in maternal and child health, TB control, and family planning.

**The Health Situation: Trends in SO3 Indicators**

An assessment of the health situation of the province revealed poor health condition of the marginalized communities particularly the Indigenous Peoples. This poor health state of the province is evident in the following specific realities: high maternal deaths totaling to 81 over the four-year period and the highest in the region; low and decreasing performance in family planning, ante-natal care, FBD, DPT3, ORT, and TB control. Deliveries by SBA is increasing but still below the national objective. Only FIC, Vit. A coverage and child pneumonia indicators met the NOH standards in 2009. However, the data in VAC needs to be checked as it is exceedingly high as well as the FIC if compared to DPT3. Although the PLGU have covered all the indigents under the sponsored program and the M/CLGUs have many accredited facilities, there seems to be an inefficient utilization of PhilHealth accredited facilities in some areas and its reimbursements is not plowed back to improve the services in the health facilities.

Utilizing HealthGov's SDIR tools and processes, the reasons for the low performances were determined and analyzed. The low CPR was attributed to most of the LGUs' failure to sustain its initial efforts in allocating a substantial amount of budget for the procurement of FP commodities in 2009. Other contributing factors include lack of follow up of FP clients and lack of trained personnel on FP-CBT.

Maternal health indicators such as FBD, ANC4 and SBA were also below national standards due to poor health seeking behavior of women especially the IPs who rely on TBAs services due to: a) cultural practices and poverty; b) inadequate information among pre-pregnant women on maternal health; c) lack of birthing facilities in most IP communities; d) geographically inaccessible barangays; e) weak pregnancy tracking and birth planning; and, f) poor enforcement of the Provincial *Hilot* Ordinance.

Except for diarrhea cases given oresol, the province performed well in child health programs in 2009. Bukidnon met its NOH target in FIC coverage while both GP Vitamin A supplementation and child pneumonia performance indicators overshot its targets. Factors that contributed to the high FIC performance are: updated master listing practiced in all government health facilities; implementation of the REB strategy; spot mapping with priority areas identified; regular immunization schedule; outreach activities conducted with LGU support; BHWs followed-up "missed" children thru their mothers; quarterly PIR being done with data validation; and annual recognition of good performing barangays is being done in some LGUs.

TB performance indicators were also considered very low and still the lowest in the region. This was attributed to poor health seeking behavior of TB symptomatic due to social stigma and problems in geographical access. The cure rate was also low due to poor compliance to treatment regimen and lack of monitoring and supervision.

In health financing, the provincial leadership has prioritized hospital operations. The province is popular for its universal coverage for the social health insurance program for more than five

years. In 2009, a total of 159,074 families were enrolled in PhilHealth or 223% coverage. However, the capitation fund goes directly to the province which is used to maintain the operations of the provincial hospital and the 14 PHSs that provide curative services to the indigent members who do not need to be hospitalized. The existence of the PHSs however competes with the RHU services and in a way lowers the performance of the RHUs. PSP members go to the PHSs since services are provided to them free of charge, drugs as well as supplies are readily available.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 44 | 62 | 60 | 51 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 70 | 70 | 79 | 71 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 54 | 52 | 57 | 63 | 80 |
| 4 | Percent of facility-based deliveries | 17 | 24 | 29 | 16 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 67 | 92 | 96 | 92 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 93 | 90 | 105 | 95 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 89 | 89 | 95 | 103 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 98 | 93 | 97 | 91 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 97 | 94 | 99 | 102 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 47 | 49 | 58 | 57 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 74 | 78 | 77 | 83 | 99 |
| 12 | TB cure rate (%) | 74 | 78 | 73 | 82 | 85 |

### The Response: TA interventions and Results

In response to the observed weaknesses in the PHO management structures and the provincial leadership's bias to hospital services, HealthGov assisted Bukidnon in its public health planning processes. In 2007, the province pioneered the development of the C/MIPH, using the results of the municipal/city level SDIR. This health planning process was backed up by an LMP resolution legitimizing the C/MIPH and adoption of the 2008 AIPs for Health. Still using the SDIR results and the LGU acceleration plans, TA was provided in the crafting of the 2008 municipal and city AOPs that outlines the PPAs to promote pubic health. In 2009, HealthGov supported the province in the formulation of their PIPH being part of the F44 provinces. The 2009 and 2010 AOPs reflected the municipal and city health priorities and targets they were also able to formulate their own AOPs with HealthGov's assistance. All of these health plans were concurred by JAC with "A" rating. In the full cycle of these health planning processes, partnerships were built between and among LGU health staff, USAID CAs, private sector, and the NGO/CSOs, and community groups.

By way of legislation, a major breakthrough at the start of the project in the province was the formulation of the LMP 7-point Agenda for Health in 2008 specifically on: 1) enhanced referral

system; 2) synchronized planning and budgeting; 3) province-wide TB strategy; 4) improved FP services; 5) improved nutrition services; 6) strengthened IEC; and 7) improved management information system all of which aptly captures ongoing USAID support to the province.

In support of the provincial health plans and in strengthening local governance for health, Bukidnon pioneered the development of the Participatory Monitoring and Evaluation (PME) system that was legitimized through an LMP resolution in 2008. This further supports the emerging role of the PHO in "health systems management" that re-establishes its relevance in the overall health care delivery system of the Province. This TA resulted in the identification and understanding of the roles and functions of the PHO in the areas of health information and enhanced data management, monitoring and supervision for AOP implementation, provision of technical guidance and support to RHUs/CHOs; and resource mobilization and management. In years 2 to 3, this intervention was developed and pursued to support the efforts in improving the program management of the province.

In Year 4, a consultative meeting to establish community feedback mechanisms as part of PME was conducted, followed by a consultative workshop to sum up the experiences in the pilot installation of PME in Bukidnon as resource material for the development of a tool kit/guide. The PME tool was piloted in Malaybalay and Valencia Cities, and in Year 4 in Maramag, and now in its final stages of province-wide installation.

In consonance with the DOH's call through AO 158 for a multi-sectoral effort to ensure the country's self-sufficiency in FP services and commodities to eliminate unmet needs of the poor was recognized as an intervention for health development by the LGUs of Bukidnon as early as 2004 (during the previous USAID health project). Through the LEAD for Health Project, CSR budgets were mostly in place and have become part of the regular budget allocation of most LGUs. The province generally sustained its CSR budget and continuously procured commodities in 2007 - 2008. Thus, the province exceeds the national target for CPR despite the withdrawal of donor support and the only province in the region to attain a more than 60% CPR. The formulation and adoption of 20 municipal and two city investment plans for health by the LMP in Bukidnon resulted in a PhP10.7M budget for CSR commodities in 20 LGUs in 2008. During that year, 20 municipalities were monitored to have established a procurement system to ensure availability of commodities at the RHU level, while seven LGUs formulated CSR policies for collection of users' fees including cost recovery scheme.

However, during the crafting of the PIPH in 2009, some LGUs have identified inadequate commodities and thus, the need to update their CSR plans. Efforts to support the province in this endeavor are the province-wide CSR assessment prior to their CSR plus plans updating. As a prerequisite to this, support was provided in the FP CU data quality check to ensure validity and reliability of the current users (CU) data as a sound basis for the CSR forecasting and planning. TA was provided in building the capacity of health implementers in FP–CU DQC at the PHO technical staff level, FHSIS Coordinators/PHNs as lead personnel responsible in DQC; and the RHMs who were trained using the by ILHZ approach.

Also in support to the FP program as an intervention to reduce high maternal deaths in the province, HealthGov introduced the intervention on integrating FP into EPI services and maximizing utilization of MNCHN services. It is expected that after the CU data cleaning, the CPR would be decreased and the LGUs need to adopt strategies to increase their new acceptors. The conduct of the modeling and roll out of the two interventions was also done by ILHZ approach. PHO was mentored in preparing action plan to roll out this activity in other LGUs

with an FIC of 85% after the modeling. There were 6 LGUs in the Central ILHZ that were started in early 2010 and currently a total of 8 LGUs has already been implementing the action plans to improve the SO3 indicators.

In order to ensure quality of care for FP services, the principles and concepts of Informed Choice and Voluntarism (ICV) was shared to the PHO staff and DOH Reps. As a result, ICV compliance monitoring was conducted in more than 50% of the service delivery sites in the province, mostly facilitated by the DOH Reps with HealthGov and PHO support.

The project also assisted the province access external funds to finance the MNCHN. In 2008, TA was provided to the LMP-Bukidnon, as the recipient of the grant, in forging a MOA between CHD 10 and the LMP for the downloading of MNCHN grant of PhP1.4M from CHD 10. As a follow-through activity, TA was extended in formulating the allocation and distribution of said grant to ensure procurement and distribution of FP commodities and other essential drugs. The LMP equally allocated and distributed FP commodities for the 20 municipalities and two cities. For the 2009 grant, the provincial government is now the recipient of the grant which was released in the amount of 2,382,820.20. Mentoring was made for the proper utilization of the grant facility in order to improve their health indicators based on the domains.

Also in Year 4, TA was provided to come up with culturally-sensitive interventions related to MCH, FP, TB, and micronutrient. HealthGov conducted a special study on the health practices and needs of seven (7) identified IP municipalities - Talakag, Pangantucan, Impasug-ong, Cabanglasan, San Fernando, Quezon and Kitaotao. The ensuing conduct of service delivery implementation review (SDIR) in these seven (7) municipalities incorporated the results of the study on the health practices and health needs of the IPs and in the drafting of culturally-sensitive 2011 AOPs. The results of this TA was used to assist health implementers incorporate into their acceleration plans the findings of the study on the special health needs of IPs in order to be responsive to the needs of these communities and address the cultural gaps and barriers.

**Remaining Gaps and Challenges**

Cutting across all these performance indicators is the concern on the quality and accuracy of data. For example, in maternal deaths, provincial health officials believe that many deaths were not accounted for. Initial findings of the ongoing WHO-funded survey on Reproductive Age Mortality Studies (RAMOS): Community-based Case Control Study on the Risk Factors of Maternal Mortality in Bukidnon revealed that 14 more maternal deaths were unregistered in 2008. This doubles the 2008 FHSIS reported maternal death figure from 14 to 28 deaths.

Data quality check also needs to be undertaken for FP CU and other MNCHN indicators. There are performance indicators that exceeded 100%. Some of these are the provincial GP Vitamin A (103% coverage in 2009) and child pneumonia treated with antibiotics (102% in 2009). This same pattern is also shown in most of the municipal FHSIS reports.

To address the perennial problem of the capability building needs of the health personnel, the health human resource training profile database system of M/CLGUs initially established in 2008 needs to be updated in Year 5.

**Year 5 Priority Interventions and Expected Results**

In Year 5, the focus of TA interventions will focus on further improving key interventions in CPR, TB, and maternal and child health; and sustaining performance in FIC, Vit. A. This will entail consolidating and completing technical interventions on service delivery, health systems improvement specifically planning, and management information system and logistics systems.

A. Support to improving service delivery in family health

- Province and at least ten (10) of the 22 M/CLGUs are targeted to have crafted their policies with broad stakeholder participation and support. Community concerns on FP/MNCHN shall be presented and discussed by NGO/CSO partners to LHB/ LDC. The PHO technical staff and PHTO shall be oriented on the CSR + policy tracking tool.
- Ten (10) additional municipalities piloted for the FP integration activities to increase CPR and improve maternal health performance
- Institutionalization of ICV compliance monitoring through the formulation of a Provincial ICV compliance monitoring plan. Also, ICV compliance monitoring and reporting will be included as a section in the provincial locally mandated CSR ordinance policy.
- Accessing the 2010 MNCHN grant

B. Strengthening family health program support: financing, policy and governance

- Training for the PHO logistics team shall be conducted on FP commodity monitoring and inventory management as well as tool adoption and institutionalization province-wide as an inventory management system for essential drugs and commodities.
- Conduct data quality improvement capacity building for PHO and DOH reps on MNCHN or family health indicators derived from FHSIS which shall be checked and validated for accuracy in collection, computation and reporting in all LGUs.
- Formulation of the provincial CDP-ELA for Health and advocacy to the NEOs and other local officials.
- Advocacy support to the NEO program at the provincial level

At the end of Year 5, it is expected that the province shall have improved province-wide results in FP, MCH and TB control through stronger program management practices, strengthened health information system, and culturally appropriate and client-sensitive interventions.

**Priority TA Interventions and Activities**
**BUKIDNON**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.b | Quality of provincial aggregate of cleaned FP CU validated for accuracy vis-à-vis the submitted reports to PHO | Meeting with FHSIS coordinator/DOH Reps to discuss results of all LGUs FP data clean-up<br><br>Review and consolidate corrected data for provincial level | Coach PHO/PHTO | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1B.c (1.1F.a, 1.4A.b) | Policies crafted with broad stakeholder participation and support | Advocacy meetings to LHBs/LMP and with wide participation of NGOs/CSOs | Resource person/facilitator, tools/templates | | **P1 M5** | **M3 C2** | | | | | | | | | | 1 | 8 | 2 |
| | 1.1B.d (1.1F.b) | CSR+ policy approved | Monitor the approval of CSR+ policies at the provincial/city/municipal levels | Mentoring/coaching | | | **P1 C2** | **M4** | **M4** | | | | | | | | 1 | 8 | 2 |
| | | | Orientation of PHO technical staff and PHTO on the policy tracking tool | Resource person, tools, fund support | | | | | **P1** | | | | | | | | 1 | | |
| | 1.1B.e | CSR+ plan and policy implementation tracked | CSR+ policy tracking | Coaching, monitoring | | | | | | **M4** | **M3** | **M3** | | | | | | 10 | |
| 2. Integration of FP into EPI and maximizing utilization of MNCHN services and facilities | 1.3A.d | Providers trained in FP, FP/EPI integration and maximizing utilization of MNCHN services, TB, HIV/AIDS, MNCHN and/or AI control using updated training design/modules | Consultative meeting and orientation of the MNCHN program coordinators and PHTL/DOH Reps on the use of the monitoring tool to track increase performance in CPR, ANC, SBA and FBD | Monitoring tool, facilitator | | **M10** | | | | | | | | | | | | 10 | |
| | | | Mentor/coach PHO and RHU/CHO staff in implementing their plans (including the need to involve civil society in the plannning, monitoring and implementation) | Tools, coaching | **M5** | | **M5** | | | | | | | | | | | 10 | |
| 3. ICV compliance monitoring institutionalization | 1.3D.b | Provincial ICV compliance monitoring plan developed | Consultative meeting with PHO/PHTO on the principles and concepts of ICV compliance monitoring and to formulate the ICV compliance monitoring plan | Facilitator, resource person, hand-outs, tools | | **P1** | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.3D.c | ICV compliance of FP/RH service delivery sites monitored and reported | Monitoring visits to RHUs/CHOs for the conduct of KII to service providers and clients utilizing ICV monitoring tools | Mentoring and coaching | | | | **M8** | | **M8** | | **M4 C2** | | | | | | 20 | 2 |
| | 1.3D.d | ICV compliance monitoring and reporting included as a section in the locally mandated CSR ordinance policy | Meetings and dialogue with SP Chair on Health and lobbying for the approval | Coaching, resource person | | | **P1** | | | | | | | | | | 1 | | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Accessing and managing DOH MNCHN grant facility | 1.2A.a | MNCHN grant accessed | Consultative meeting with MHOs/CHOs on the policy for the allocation of grants to the component LGUs to meet criteria/guidelines of 2010 MNCHN grant facility | Resource person/facilitator, provincial allocation tool | | | **P1** | | | | | | | | | | 1 | | |
| | | | Monitoring the utilization of the grant (if utilized to augment investments in health) | Coaching | | **M8** | **C2** | | **M12** | | | | | | | | | 20 | 2 |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| A. Improving logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Training of PHO team/DOH Reps/MHOs/CHOs and action planning on FP commodity monitoring system | Resource person/facilitator, tools/templates | | | **P1** | **P1 M20 C2** | | | | | | | | | 1 | 20 | 2 |
| | 1.1E.b | FP commodity monitoring tool adopted | Meetings with PHO, PHTL to review LGU reports on FPCMS and utilize data for planning logistics/ procurement in the AOP | Coach PHO/PHTL | | | | | | | | **P1 M20 C2** | | | | | 1 | 20 | 2 |
| B. Improving data management system | 1.1C.d | Personnel trained in FHSIS DQC used for planning and decision-making data | Orientation training in FHSIS DQC and action planning on DQC, SDIR and AOP formulation for PHO/PHTO and MHOs/CHOs/DOH Reps | Resource person, tools, fund support | **P1 M20 C2** | | | | | | | | | | | | 1 | 20 | 2 |
| **C. Advocacy to newly elected officials (NEOs)** | 1.1F.a | ELA for Health<br><br>LMP resolution to support FP/MNCHN interventions in AOP | Advocacy forum for presentation of draft health agenda based on consolidated actions | Resource person - STTA, presentation materials, facilitator, funding support | **P1** | | | | | | | | | | | | 1 | | |
| | 1.4A.b | Advocacy forum to strengthen LGU health systems conducted | | | **P1** | | | | | | | | | | | | 1 | | |

## Misamis Occidental

The Province of Misamis Occidental in Region 10 has a total population of 545,386 (NSO, 2007) spread over in 14 municipalities and 3 cities. It is categorized as a F1 Province by DOH and often serves as a model LGU in Region 10 in effecting health sector reforms for a quality and sustained health service programs. With technical support from HealthGov, USAID CAs and other donor supported programs like the EC Program and the Phil.-Australia Local Sustainability Program (PALS) in close coordination with CHD 10, Misamis Occidental has shown improvements in its overall health planning process; applying a system to respond immediately to unmet health needs and continuing quality improvement for health service delivery at the ILHZ and RHU levels.

**The Health Situation: Trends in SO3 Indicators**

When USAID through HealthGov started its TA interventions in 2006, the province in general experienced low performance in most SO3 indicators but had exhibited a good performance in Vitamin A supplementation, TB Case Detection, Case Notification and Cure Rates. It had achieved the national standards set for TB indicators by the Department of Health. While on VAC, it had 5% lower than the national standard.

Among the lowest SO3 indicators were the facility based delivery, children treated with ORT, fully immunized children and DPT3. Other health indicators which were also low but already achieved more than half of the national standard were CPR, 4ANC, SBA and children treated with antibiotics (See Table 1).

Over the last four years, Misamis Occidental demonstrated significant improvements in most of the SO3 health indicators. An increasing trend from 2006 to 2009 can be observed for skilled birth attendants and fully immunized children. Two health indicators (VAC and TB) have already reached the 2015 National MDG targets. Maternal and infant mortality have also been significantly reduced in 2009 compared to 2008. From the total of 8 reported deaths in 2008, it was reduced to 2 deaths in 2009. From 99 reported infant deaths in 2008, it reduced to 40 reported infant deaths in 2009.

Performance on FBD, DPT3 and children with pneumonia given antibiotics have also improved from 2006 to 2008 but slightly declined in 2009. Children with diarrhea given ORT and TB Cure Rate have also improved from 2006 to 2007 but dropped in 2008 and went up again in 2009. While TB Detection Rate, Cure Rate and VAC have consistently increased in 2006, 2008 and 2009 but declined in 2007. However, CPR showed no improvement of performance from 2006 to 2007. It had slight increase in 2008 but had performed the same in 2009.

While the province in general showed improvements on some of the health indicators, they are still below the MDG National Standard set by the Department of Health. To determine the underlying causes of the low performance, HealthGov in partnership with the PHO conducted a provincial assessment following SDIR processes and tools. Among the factors cited included the following:

Related to service delivery is the inadequate information dissemination with respect to utilization of prenatal and postnatal services and the use of health facilities and skilled birth attendants. Most clients also preferred home deliveries due to trust and established strong relationship with TBAs; expensive fees for SBAs and inaccessibility in some hard-to-reach areas to the health

facilities. Irregular services were also noted in some barangay health stations due to lack of health personnel, commodities, equipment, and facilities.

In the aspect of governance, there was a need to improve local health planning; data management and utilization; and implementation of an effective monitoring system. Data recording, reporting, analysis and utilization were poor. Identified and prioritized programs and health interventions were not based on the real needs of the constituents. More so, health planning was not synchronized with the LGU's planning and budgeting cycle which resulted to non-integration of health plans to LGU annual investment plan. There was also a need to improve the monitoring and evaluation system at the Provincial and Municipal levels to ensure effective implementation of health plans.

Financing support for health personnel, health programs, equipment and facilities was insufficient. There were a number of health facilities with lack of personnel to provide the quality care and services. The province and the municipal LGUs needed to maximize benefits from PHIC accreditation by increasing the number of their accredited facilities. Implementation of the PhilHealth Sponsored Program was needed improvement to increase accreditation and correspondingly the appropriate utilization of capitation funds and reimbursements that will flow back for the improvement of the health facilities. In addition, there was virtual absence of local policies and resolutions to support CSR, breastfeeding, family planning and MNCHN policies like ICV, FBD, and SBA which were also identified as contributing factors of low performance.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 51 | 51 | 55 | 51 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 56 | 60 | 60 | 69 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 52 | 53 | 68 | 79 | 80 |
| 4 | Percent of facility-based deliveries | 9 | 17 | 36 | 31 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 46 | 75 | 86 | 82 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 42 | 44 | 82 | 85 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 90 | 83 | 91 | 95 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 24 | 31 | 23 | 83 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 70 | 99 | 98 | 92 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 88 | 70 | 81 | 108 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 152 | 92 | 116 | 142 | 99 |

## The Response: TA Interventions and Results

To contribute to the improvement of the low performance of the province on the above mentioned indicators, USAID through HealthGov and other CAs pursued TA packages that helped improve the SO3 indicators. From Years 1 to 2, HealthGov assisted the province in the

formulation of the Annual Operation Plan (AOP) of PIPH using the SDIR analysis framework. This TA resulted to an improved provincial plan with in-depth analysis of the health situation by LGU and the reasons for low or high accomplishments of the program performance coverage; identified gaps and critical interventions; and prioritized investments based on priority needs and targets. In Year 3 HealthGov also assisted the province in the formulation of AOP and in the integration to the LGU's annual investment plan (AIP).

In Year 3, HealthGov supported the pilot testing of the Service Delivery Excellence in Health (SDExH) in Oroquieta Inter Local Health Zone (ILHZ) composed of Oroquieta City and the municipalities of Aloran, Jimenez, Lopez Jaena and Panaon and their referral hospital, the Misamis Occidental Provincial Hospital. The health service providers of these health facilities were trained on the three (3) phases of SDEX aimed to reorient their perspectives as local health manager and health care providers towards quality improvement on health care service delivery and to contribute to the improvement of health outcomes. SDEXH resulted to the following: (1) improvement/expansion of facilities for TB and maternal care; (2) achievements of most of the service standards in the Out-Patient Department and MCH services of the participating municipalities. Particularly in Lopez Jaena, the RHU developed the "Customers' Satisfaction Manual" as a guide in monitoring and constant improvement of their health service quality. With the encouraging results and the positive response of the pilot LGUs the PHO replicated SDExH using the provincial government funds in the Ozamiz ILHZ comprising of 3 Hospitals (MHARSGEN, SM LAO and Tudela Municipal Hospital), 3 RHUs and the CHO of Ozamiz City. Integrating the Quality Assurance Partnership Committee (QAPC) of Health Systems 20/20 to the Quality Health Improvement Team (QHIT) in Oroquieta City Health Office and Lopez Jaena RHU as a link to SDExH was done in Year 4.

Also from Year 3 up to Year 4, HealthGov assisted the province in establishing the Community Health and Living Standards Survey (CHLSS), which is a more responsive, client oriented and health focused survey tool. Except the cities of Tangub and Ozamiz, all 14 municipalities and the city of Oroquieta adopted CHLSS as survey tool. CHLSS was designed to gather health needs at the household level and living standards indicators to measure poverty at the municipal, city and provincial levels. The initial analysis and results of CHLSS were used by a number of municipalities particularly Sapang Dalaga, Calamba, Concepcion, Baliangao, Plaridel, Lopez Jaena, Jimenez, Panaon, Clarin and Bonifacio for determining coverage of the PhilHealth sponsored program. The data was also used by the PHO in cross-matching from the list of indigent families already sponsored by the Provincial Government. The community health data were also immediately utilized by some RHUs to provide services on identified unmet needs. Some RHUs referred to the household lists needing immediate health actions (i.e. pregnant women not seeking prenatal care, TB symptomatic, HH with no access to potable water, under-five children not given Vitamin A, etc). For instance, in Sapang Dalaga, patients identified as TB symptomatics were immediately followed-up for sputum collection and thereby increased their Case Detection Rate (CDR) from 51% to 115% in 2008. The provincial government's cost share to this TA package amounted to 1.8 M pesos.

Another TA in Year 4 was on CSR plus plan implementation. Through a LTAP, HealthGov assisted the province and the 14 municipalities and 3 cities on CSR + assessment and planning to address the low CPR performance. HealthGov also assisted the province and the 17 LGUs on appropriate data quality check/current users validation and came up with accurate and reliable data which were used by C/RHUs in forecasting of commodities and in identifying appropriate interventions. The results of the CSR + assessment indicated that only two municipalities (Plaridel and Jimenez) have allocated budget for 2009 for family planning commodities. No one among 17 LGUs had passed an ordinance for Commodity Self-Reliance.

In relation to the NHIP implementation, two RHUs (Lopez Jaena and Plaridel applied for PhilHealth accreditation during Year 4 which were approved and making them the first two government facilities in the province that are accredited for MCP.

Another TA package undertaken in Year 4 to help improve the LGUs performance on family planning was the FP Integration into EPI and Maximizing MNCHN Services. HealthGov piloted and oriented the health workers at the municipality of Jimenez on the principles and approaches of the strategy resulted to the formulation of key action points for the Integration of FP messages into EPI services of Jimenez RHU and for Maximizing utilization of RHU/CHO, BHS, public and private hospitals and clinics for FP and MNCHN services of the PHO and RHU Jimenez.

To enhance the capacities of PHTL/DOH reps, local health workers, local planners and health legislators in ensuring integration of the annual operations plan for health in the annual investment plan (AIP) and CDP ELA, HealthGov also assisted the provincial and municipal governments on the proper conduct of program implementation review, data quality check and analysis thru the use of SDIR tools harmonized with the LGU score card as well on the processes of health budgeting and annual investment planning.

HealthGov has also been providing TA to the PHO, MHOs, and PHTLs/DOH Reps in the advocacy of health concerns in the DILG Program for newly-elected officials (NEO). Orientation to the PHO, DOH Reps on the NEO program and the importance of the participation of MHOs to participate actively in the formulation of the LGUs comprehensive development agenda-executive legislative agenda and deliberately integrate their priority issues, health programs and projects in the LGU plans was done.

**Remaining Gaps and Challenges**

Based on the 2009 health data of Misamis Occidental, performance on CPR has not improved since 2006. This can be attributed to the lack of commodities, the absence of CSR policies for sufficient budgetary allocation for family planning commodities and the inadequate information and advocacy to potential FP users and women with unmeet needs. There is a need to pursue in Year 5 the policy development for CSR + in order to ensure funding support to FP/MNCHN. The province would have finished by end of Year 4 the data cleaning of the Current Users as well as the CSR+ planning and FP commodity forecasting. In addition, there is also a need for TA to complement the CSR + intervention that would result to increase demand for FP/MNCHN services. Thus, the roll out of the two interventions on FP integration and maximizing MNCHN services and facilities to the 8 municipalities with high FIC coverage will be scaled up in Year 5.

Although other health data such as 4 ANC, FBD, DPT3 and FIC have significantly improved since 2006, they are still below the MDG National Standards set by DOH. Therefore, equally important TA package still needs to be pursued which relates to strengthening the family health support for financing, policy and governance. Upon the completion of the SDIR process at the end of Year 4 and after the formulation of the LGUs' acceleration plans to improve their performance, there is a need for the health plans to be integrated in the CDP-ELA of the LGUs especially that the health planning is synchronized with the planning and budget cycle of the LGUs. This is the gap of the planning process in the previous years and the challenge for Year 5 is to truly integrate the health plans (PIPH/CIPH/MIPH) to the comprehensive development

plan and / or their AOPs to the LGU investment plans in order to say that health is part of the LGU priority agenda and to ensure commitment and support for its implementation.

Remaining challenges in the province is on the utilization of the CHLSS data results for enrolling the "true poor" to the PhilHealth Sponsored Program. After the presentation of the survey results to local officials, health officers and LGU planners, it is imperative that they have to be influenced in utilizing the data for decision making that will redound to the improvement of the local NHIP implementation in terms of enrollment and utilization of services by the members. Subsequently, there is also a need to motivate more LGUs to work for the accreditation of their facilities to MCP since there are only 2 accredited facilities in the province. To ensure more funds to finance FP/MNCHN, the continuing TA on MNCHN grant facility accessing and utilization will still needs to be done in Year 5.

**Year 5 Priority Interventions and Expected Results**

For Year 5, the TA interventions will focus in the completion of the TA and ensuring the sustainability of technical assistance which have been provided in the previous years.

HealthGov will continue to provide TA on CSR policy development to ensure that the 3 cities and 14 municipalities of the province will have approved CSR policies that will contain adequate budget for commodities particularly for the poor. Other TA interventions to be provided to the province are - FP Integration into EPI and maximizing MNCHN services; ICV compliance monitoring; and FP logistics management particularly on FPCMS and SIMS.

HealthGov will also provide TA to the provincial and municipal LGUs in the formulation of 2011 AOP formulation and in ensuring that the provincial and municipal health plans are mainstreamed and integrated in the LGU Annual Investment Plans and CDP-ELA. This TA is necessary to ensure that the priority issues and concerns are provided with necessary technical, policy and budgetary support. HealthGov will continue to assist the provincial and municipal LGUs on improving data recording, reporting and management.

Below are the specific TA interventions and the corresponding milestones:

A. Support to improving service delivery in family health:

- CSR+ policy development and tracking its implementation
- FP integration into EPI and maximizing MNCHN services
- ICV compliance monitoring institutionalization
- Accessing and managing FP/MNCHN Grants

B. Strengthening family health program support through financing and governance:

- AOP (PIPH) prepared and integrated into CDP/ELA
- PME management plan finalized and adopted for AOP
- Improved CHLSS data custody and management
- Local BDR Approach for financing to NHIP, policy implementation and monitoring; accreditation of facilities and fund management
- FP Commodity Management System
- Continuing Advocacy to NEOs

Expected to be achieved by the end of Year 5 are the following outputs/results:

- Approved CSR Ordinances crafted with CSOs/NGOs participation
- CSR policy implementation tracking
- Action plans to accelerate performance of FP and MNCHN
- Increased civil society participation in improving MNCHN services
- ICV compliance monitoring plan developed and provincial policy formulated
- MNCHN grant utilized and reported
- Sustained implementation of service implementation plan in SDExH areas
- 2012 AOP Integrated in 2012 Annual Investment Plan
- PME for AOP adopted
- Quality of family health performance indicators derived from FHSIS checked and validated
- CHLSS results used to identify the poor
- Increased enrollment of indigent/poor based from PHIC enrollment plan
- Application for accreditation filed (renewal for OPB and TB DOTS and new application for MCP)
- Facilities accredited by PhilHealth (for OPB, TB DOTS and MCP)
- Provincial FP Commodity Monitoring System
- Stock Inventory Management System of essential drugs and commodities adopted by LGUs

**Priority TA Interventions and Activities**
**MISAMIS OCCIDENTAL**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Improving service delivery in family planning** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.b | Quality of provincial aggregate of cleaned FP CU validated for accuracy vis-à-vis the submitted reports to PHO | Meeting with FHSIS coordinator/DOH Reps to discuss results of all LGUs FP data clean-up<br><br>Review and consolidate corrected data for provincial level | Coach PHO/PHTO | **P1** | | | | | | | | | | | | 1 | | |
| | | Action plan for CSR policy development | a) Meeting/planning with PHO staff/DOH Reps for the conduct of the CSR+ writeshop and the next steps until approval | Facilitator, mentoring | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1B.c (1.1F.a) | Draft CSR+ policies crafted* | b) Consultative meeting for CSR+ policy development for MHOs/SB Chair on Health and LHB-NGO members | Resource person/facilitator, funding support | | **P1 M6 C1** | | | | | | | | | | | 1 | 6 | 1 |
| | | | c) Follow up assistance in finalizing the draft of the provincial/municipal CSR+ ordinance ensuring cost recovery scheme and subsidy for the poor | Support CHD/PHO in monitoring the finalization of CSR policy | | **P1 M6 C1** | | | | | | | | | | | 1 | 6 | 1 |
| | 1.1B.d (1.1F.b) 1.4.C.a | Approved CSR ordinances with NGOs/CSOs participation* | d) Follow-up and monitoring the approval of CSR ordinances | Coaching, coordination | | | **P1** | **M3** | **M3 C1** | | | | | | | | 1 | 6 | 1 |
| | | Status of CSR+ implementation | e) Meeting with PHO/PHTL/ DOH Reps on the status of implementation of CSR+ plans | Support CHD/PHO in assessing status of CSR plan implementation | | | | | | | | | **P1** | | | | 1 | | |
| | 1.1B.e | CSR+ plan and policy implementation tracked | f) Orient PHO staff/DOH Reps on effective use of CSR tracking tool | Resource person, tools, activity design | | | | **P1** | | | | | | | | | 1 | | |
| | | | g) Guide PHO staff/DOH Reps on CSR policy tracking during on-site visits (to ride on the ICV monitoring) | Mentoring and coaching | | | | **M3** | | **M2** | | **M1 C1** | | | | | | 6 | 1 |
| 2. FP Integration in EPI and maximizing MNCHN services | 1.3A.d | Service providers trained in integration of FP/EPI and maximizing utilization of MNHCN services | a) On-site orientation training cum planning of RHU personnel on the two interventions on FP integration in EPI and maximizing utilization of MNCHN services | Resource person, facilitator, training design and materials | **M4** | **P1 M4** | | | | | | | | | | | 1 | 8 | |
| | | | b) Orientation of PHO/PHTO personnel on the tool and design for the monitoring of the results of FP Integration in EPI and maximizing MNCHN services | Resource person, tools and design | | | **P1** | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | | Progress reports on the implementation of the MNCHN strategies | c) Monitoring of the progress of the MNCHN indicators and results of the interventions | Mentoring and coaching | | | | | **M3** | **M2** | **M2** | **M2** | | | | | | 9 | |
| | | Documentation report of the implementation of MNCHN strategies | d) Documentation of results and sharing of good practices | Coaching | | | | | | | | | | | | | | | |
| 3. ICV compliance monitoring institutionalization | 1.3Db | ICV compliance monitoring plan developed* | a) Consultative meeting with PHO/PHTO to develop action plan on ICV compliance monitoring and to incorportae policy on ICV compliance monitoring in the provincial CSR ordinance | Technical inputs as resource person; monitoring tool reporting forms | | **P1** | | | | | | | | | | | 1 | | |
| | 1.3 Dd | ICV compliance monitoring locally mandated* | b) Monitor the approval of ICV policy incorporated in the provincial CSR+ ordinance as one of the sections | Mentoring and coaching | | | **P1** | | | | | | | | | | 1 | | |
| | 1.3Dc | ICV compliance of FP/RH service delivery sites monitored and reported* | c) Monitor ICV compliance monitoring activites of LGUs with PHO staff and DOH Reps | Coaching | | | | **M5** | | **M5** | | **M4 C3** | | | | | | 14 | 3 |
| **II. Strengthening program support for financing, regulation and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local BDR approach financing to NHIP, policy, implementation and results of monitoring | 1.1D.a | CHLSS adopted as means test tool to identify the poor | Orientation to PHO, MHOs/LGUs on: a) PHIC universal coverage using CHLSS data result and the local BDR approach in financing NHIP, policy and implementation with focus on identification of indigent households, accreditation of facilities, and management o | Resource Person | | | | | | **P1 M7 C1** | | | | | | | 1 | 7 | 1 |
| | 1.2A.c | Local Policy for management of Philhealth reimbursement and capitation for reinvestment in health developed and/or implemented | | Resource Person | | | | | | **P1 M7 C1** | | | | | | | 1 | 7 | 1 |
| | 1.2 C.a | Application for accreditation filed* (renewal for OPB and TB DOTS and new application for MCP) | b) Meeting with the MHOs to guide them on the complete documentary requirements of PhilHealth accreditation of RHU for MCP and renewal for OPB and TB DOTS | Coach/resource person | | | | **M7 C1** | | | | | | | | | | 7 | 1 |
| | 1.2 C b | Facilities accredited by PhilHealth (for OPB, TB DOTS and MCP)* | c) Coordinate with PHIC and MHOs to fast track MCP accreditation and renewal on TB DOTS and OPB of the 5 LGUs | Facilitator | | | | | | | **M7 C1** | | | | | | | 7 | 1 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | | Status report of enrolment/ accreditation | d) Tracking of NHIP plan implementation and policy development for use of PHIC funds | Support CHD/PHO in coordination tracking of implementation | | | | | | | | | | | | | | 7 | 1 |
| 2. Accessing and managing FP/MNCHN grants | 1.2A.b | MNCHN grant accessed | a) Attendance to PHO meeting to discuss progress on the compliance to requirements of the 2010 MNCHN grant facility | Facilitation, coordination | | | **P1** | | | | | | | | | | 1 | | |
| | | | b) Monitoring by PHO/DOH Rep on the 2009 and 2010 MNCHN grant facility utilization by the LGUs using the approved guidelines | Mentoring and coaching | | | **M5** | | **C3** | | **M5** | | **M4** | | | | | 14 | 3 |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide AOP formulation | 1.1A.h | AOP (PIPH) prepared and integrated into CDP/ELA* | Workshop with the LGU planning officers and members of the Local Finance Committee (LFC) | Resource person, facilitator, activity design, tools and templates | **P1 M14 C3** | | | | | | | | | | | | 1 | 14 | 3 |
| | | Agreed PPAs for integration into CDP-ELAH | Meeting of Provincial/ Municipal Development Councils and LFC to integrate PPAs into the CDP-ELA | Mentoring and coaching | | **P1 M14 C3** | | | | | | | | | | | 1 | 14 | 3 |
| | | Approval of the CDP-ELA/AIP by the SP/SB with the PPAs for health integrated in the plan | Monitoring of the integration of the PPAs of the PIPH/AOP to the CDP-ELA or the AIP by the LFC | Coaching | | **P1 M14 C3** | | | | | | | | | | | 1 | 14 | 3 |
| | | PME management plan finalized | a) Consultation planning with PHO, PPDO, MHO Reps and provincial DOH Rep finalizing the PME management plan | Resource person, coaching and mentoring | | **P1** | | | | | | | | | | | 1 | | |
| | 1.1A.g | PME for AOP adopted* | b) Follow up meetings to discuss implementation of PME | Advocacy and coordination | | | **P1** | | | **P1** | | | **P1** | | | | 1 | | |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. CHLSS | 1.1C.d | Personnel trained in data custody and management of health-related data (CHLSS) used for planning and decision-making data | Orientation/training local planners in CHLSS data updating, custody and management | Resource person | | **P1 M14 C1** | | | | | | | | | | | 1 | 14 | 1 |
| 2. FP commodity monitoring system | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | a) TOT in FPCMS for the PHO logistics management team | Resource person/facilitator, training design and materials | | | | | | **P1** | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | b) Quarterly monitoring and timely response to gaps | Coaching | | | | | | | | | **P1 M14 C1** | | | | 1 | 14 | 1 |
| **D. Advocacy to newly elected officials (NEOs)** | 1.4C.a | NGOs/CSOs have participated in PIPH, CSR, SDIR, SDExH and other events | a) Continuous advocacy meetings to MHOs/LHBs to participate in component 3 of the NEO program | Resource person, mentoring, coordination | | | **M5 C1** | | | | | | | | | | | 5 | 1 |
| | 1.4B.c | Good practice documented and presented to NEOs | b) Assist PHOs/MHOs in the documentation and dissemination of good practices of LGUs on health | | | | **P1** | | | | | | | | | | 1 | | |

## Misamis Oriental

Misamis Oriental is divided into five ILHZs originally formed as economic zones but is now moving to integrate health into their cluster plans. The province is home to several large private industrial companies and there are NGOs/CSOs that are interested in supporting the implementation of public health programs.

With minimal improvements in maternal care, skilled birth deliveries, child care, and TB control programs during the period 2006 to 2008; the provincial government actively pursued the strengthening of public health programs to respond to MDG commitments. The provincial government implemented the PhilHealth Sponsored Program as the single insurer; it has embarked on strengthening the 5 ILHZs and the reorganization of the PHO to strengthen its technical leadership to public health and hospital operations; as well mobilized many private sector like large private companies and local NGOs/Costs for their active engagement/involvement with the health programs and activities initiated by the provincial administration.

**The Health Situation: Trends in SO3 Indicators**

The province's selected health performance indicators from 2006 to 2008 have generally improved but some indicators decreased in 2009 such as ANC 4, FBD, and children with diarrhea given ORT. The CPR has not shown improvement through the years. SBA has increased but the FBD performance reduced. A reduction in Vitamin A coverage was also observed but this is due to improvement in reporting after the correction of data. It is noted in the previous year's submission has been exceedingly high and maybe faulty. Data on the immunization performance is a plateau in two years although if compared to the baseline, there has been marked improvement. Only child pneumonia and the 3 TB indicators (CDR, CNR and Cure Rate) exceeded the NOH target.

CPR performance was low which can be attributed by health workers to high population projections, although they also pointed out the inadequate supply of free contraceptives in all LGUs after the full termination of donor assistance in 2007. The province formulated their CSR (+) plan in 2005 which contained the detailed and comprehensive set of measures to be undertaken by the province to ensure the continued provision of Family Planning services and commodities. However, the commitments made at the provincial and municipal levels were not fulfilled hence the need to review the CSR (+) plan to ensure that CPR is sustained if not increased in the province.

Most of the maternal care indicators are low that contributed to the increasing trend in maternal deaths of the province, with eight deaths reported in 2008 and 2009. On ANC, there is inadequate supply of iron and Vitamin A supplements for pregnant and postpartum women. Low FBD performance is due to financial constraints; geographical distance; poor access to birthing facilities; and cultural biases on the part of the clients. Low SBA performance is attributed to: (1) poor health seeking behavior of pregnant mothers because of inadequate knowledge about safe motherhood; (2) lack of birth planning and tracking; (3) lack of training of newly-hired health personnel; (4) inadequate birthing facilities; and (5) lack of support from some LCEs in implementing policies on MCH programs. Also, the health personnel failed to mobilize community groups like the women's health team to support clients and help advocate safe motherhood.

Low performance in some child health indicators such children given ORT are due to lack of available ORS, and lack of training of health workers on Integrated Management of Childhood Illnesses. In particular, low FIC is attributed to high population growth projection set by NSO (as claimed by the health personnel); lack of knowledge of the parents on the benefits of immunization; poor access to health services because of geographic distance; and failure of health personnel to reach the far-flung areas because of multi-tasking and inadequate travelling allowance.

On health financing, except for two municipalities, the province is the single payor in the PhilHealth Sponsored Program (PSP) and thus, gets the entire capitation fund. Twenty-percent of the capitation funds are allocated to the MLGUs in form of drugs and medicines. However, the C/MLGUs with their facilities accredited for TB-DOTS or MCP are still getting the benefits from the increased enrollment through re-imbursements after the utilization of their facilities by PhilHealth members.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 41 | 40 | 44 | 43 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 60 | 65 | 74 | 71 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 69 | 67 | 67 | 73 | 80 |
| 4 | Percent of facility-based deliveries | 35 | 35 | 38 | 30 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 75 | 78 | 88 | 89 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 80 | 81 | 90 | 90 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 145 | 138 | 139 | 94 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 97 | 100 | 98 | 72 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 99 | 99 | 99 | 100 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 66 | 67 | 67 | 70 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 85 | 87 | 87 | 108 | 99 |
| 12 | TB cure rate (%) | 92 | 90 | 86 | 89 | 85 |

## The Response: TA Interventions and Results

In Year 1, activities were focused on laying the ground work for the project implementation. HealthGov assisted the PHO in appraising the functionality of 5 ILHZs in responding to cross-border health concerns and issues such as referral system, personnel sharing, disease-free zone initiatives, disease surveillance, planning, and monitoring and evaluation. Support from the NGO/CSO and community was sought through a provincial partnership-building workshop that drew the commitment of the NGOs and CSOs to support the NGO/Private Sector representative in the Provincial Development Council and the Local Health Board (LHB) in championing health issues. A meeting with Oro Chamber of Commerce, the organization of the private sector in the

province, was initiated to explore the possibility of collaboration to support ILHZ initiatives. As a result, the health personnel have slowly changed their perspective in involving the private sector rather than mobilize only the public organizations in implementing health activities and interventions.

To improve performance in low-performing indicators, HealthGov assisted the province in developing the capacities of LGUs with the CHD in conducting comprehensive and participatory planning process through the development of C/MIPH and PIPH. The technical guide and tools have led to the realization of the MHOs and PHO that health programs have to be planned out based on the health situation of the area. The development of a comprehensive MIPH that became the basis of developing the PIPH was an experiential learning for both municipal and provincial health providers.

TA also revolved around the formulation and implementation of the ClaJaViTa and MisOrET ILHZ sub-plans. Modified SDIRs were conducted in the ClaJaViTa and MisOrET to address the ILHZ issues as a follow-through to the province-wide SDIR. The modification included review and assessment of zone performance in the health programs, project and activities, health capability and health service delivery quality, including financing, governance and regulation.

To address low performance in selected indicators, HealthGov assisted the province in formulating its PIPH for 2009 to 2013, and its AOPs for 2009 and 2010 that were all concurred by JAC with an “A” rating. Overall, the entire PIPH exercise helped the key stakeholders in health in Misamis Oriental better understand the analytical framework of the health sector reform, their roles as catalysts, and how to better coordinate the whole planning process at various levels of local governance. In the 1st quarter of Year 4, the League of Municipalities of the Philippines (LMP), Misamis Oriental Chapter, an active inter-LGU group, committed to support the PIPH and the harmonization and implementation of investment plans for health.

As part of implementing selective interventions in their PIPH/AOP and to address the province’s low CPR and maternal health indicators on FBD and SBA, HealthGov piloted in the municipality of Tagoloan the strategy of Integration of Family Planning in EPI services and maximizing utilization of MNCHN services in the last quarter of 2009. A total of 120 active BHWs and RHU personnel were oriented on these interventions in the 1st quarter of Year 4. An FP-EPI monitoring tool was administered in the third quarter of Year 4. Results showed an 18.22% increase in new FP acceptors comparing the August to December 2009 versus the same period in 2010. There was also a 45% increase in new FP acceptors from January to March in 2009 as against the same period in 2010. Another key result of this TA is a draft municipal ordinance supporting the MNCHN strategy which is due for approval by the SB.

In the 3rd quarter of Year 4, this TA package was rolled out in 13 LGUs whose FIC coverage were 85% above through a composite team coming from the PHO with almost 300 health implementers (MHOs, PHNs, RHMs and BHWs) capacitated and actions points prepared on how to integrate FP into EPI; maximizing utilization of MNCHN services and mapping out existing facilities, birthing capability and FP service providers. Commitments were likewise generated from the RHU staff in implementing the action plans for their health centers and to be monitored by their respective MHOs and PHNs.

Also in support to FP performance and in support to the concern on lack of trained personnel on FP, HealthGov supported the PHO in the roll out of FP-CBT level I and II utilizing the MNCHN grant. A total of 30 RHMS/PHNs were trained representing 16 LGUs in the province. With these

trained health personnel, better FP services can be provided to clients in IUD insertion and other FP methods, thereby also helping the province boost up its CPR performance.

Support to MCP and TB DOTS accreditation was provided to near-ready MCP and TB DOTS facilities. In the 3rd quarter of Year 4, HealthGov advocated and worked with the PHTL and PHO in increasing the number of MCP and TB-DOTS health facilities in to help the province address its low maternal and TB performance. Pre-assessment on-site field visits were conducted in 7 RHUs with coaching done to the MHOs in ascertaining the lacking PhilHealth requirements and mentored them on how these can be complied with. Towards the end of Year 4, RHU-Gitagum was accredited as MCP while Claveria was accredited as TB DOTS.

HealthGov, through a LTAP completed the FP CU Data Quality Check (DQC) and CSR assessment in all 25 M/CLGUs. DQC results showed a 34% reduction in the 2009 FP CU data. The by city/municipality assessment on the CSR + implementation showed that almost all LGUs have no policy and 15 of the 25 LGUs have allocated budget for FP but only 5 have utilized the funds for CY 2007 – 2009.

In response, to the existing LGU conditions, the project assisted the LGUs craft their CSR + plans after the series of planning workshops which included forecasting activities utilizing the FP CU cleaned dat. The LGUs used the cleaned FP CU 2009 data as the baseline of their forecasting FP commodities and service requirements.

Also in Year 4, HealthGov started activities to implement interventions to engage private sector partners in improving MNCHN performance and coverage that is piloted in the CLAJAVITA ILHZ. This TA will contribute to increasing the accomplishments in low performing municipalities of CLAJAVITA, and will support the establishment of network of facilities and service providers by improving health data reporting and management, coordination of service delivery provision, and strengthen referral systems.

Technical support was provided to the province in accessing the MNCHN grant facility from the DOH-CHD. The province is set to receive PhP1, 680,023 for the 2009 AOP and PhP5,040,069 for the implementation of their 2010 AOP. HealthGov also oriented the DOH Reps on ICV in two occasions that resulted to the commitment of the DOH Reps to conduct of annual ICV monitoring in all health facilities (BHSs, RHUs). The MHOs and PHNs in the 25 LGUs were also oriented by the CHD on the guiding principles of Family Planning Program and Informed Choice and Voluntarism. This TA further resulted to compliance to the policy on no targets and quota for the health providers and for the health providers to provide complete information on FP methods to clients. In Year 4, a total of 13 service delivery sites were monitored by the DOH Reps, PHO staff and HealthGov.

**Remaining Gaps and Challenges**

With the completion of the municipal and provincial CSR+ plans, there is a need to back this up with corresponding legislation such as the drafting of the CSR + policy with NGOs/CSOs participating in policy development and approval. Also equally important is the adoption and institutionalization of a provincial FP Commodity Monitoring System (FPCMS). There is also a need to supervise the implementation of the FOG on the establishment of LGU-NGO/CSO partnership in CLAJAVITA for planning, budgeting, implementation, monitoring (e.g. maximizing use of MNCHN services, public-private partnership referral mechanism, etc.)

The implementation of FP/ EPI integration and maximizing utilization of MNCHN services' action points and results of 14 LGUs in the province using the developed monitoring tool for this integration should be monitored as well as in the institutionalization of ICV compliance monitoring by inclusion of provision in the CSR+ policy and the formulation of a monitoring plan to ensure full coverage by Year 5.

Assistance to the Province and the 25 M/CLGUs in accessing, judicious utilization and the timely reporting of external funding (MNCHN) to finance health reforms in the province needs to be continued as well as the support to the PHO in preparing other requirements for the full access of MNCHN funds for their AOP 2009 and 2010.

There is a need to continuously improve data system by sustaining FP CU DQC in all LGUs. DQC also need to be conducted in other MNCHN indicators to ensure quality health performance indicators derived from checked and validated FHSIS. Support in the formulation and approval of the 2011 AOP and its integration of the health plans in the LGU budgeting processes via the CDP/ELA should also be given.

On NHIP implementation, HealthGov needs to sustain its TA in helping the near MCP and TB DOTS RHUs qualify for PhilHealth accreditation in order to utilize the PhilHealth reimbursement for improving delivery of public health services. Assistance also needs to be provided in helping existing PhilHealth accredited facilities in managing their reimbursement funds.

**Year 5 Priority Interventions and Expected Results**

Among the major TA/interventions that HealthGov will provide in Misamis Oriental in Year 5 are:

A. Support to improving service delivery in family health:

- CSR plus policy development
- Monitoring the results of FP in EPI, post-partum, and maximizing MNCHN services in the Province and 14 RHUs already trained and implementing these interventions
- Public forum with NGO/CSO participation conducted
- HealthGov through an FOG will also push for the installation of PPP in ClaJaViTa ILHZ geared towards establishing a network of facilities and service providers to expand service delivery, enhance data management and improve referral systems for FP/MNCHN/TB.
- Formulation of an ICV monitoring plan with the PHO/CHD and integrating ICV compliance monitoring policy in the provincial CSR + ordinance. Support will also be provided for ICV on-site monitoring.
- Orientation of health implementers on the MNCHN guidelines, utilization, and tracking system. TA will also be provided in the formulation of key contents of LGU policy on 2010 MNCHN grant to support LGUs to meet the set criteria and in monitoring the utilization of the 2010 MNCHN grant facility.

B. Strengthening family health program support through financing and governance:

- Accreditation of health facilities for MCP and TB DOTS accreditation/renewal as well as management of PHIC capitation and reimbursement funds based on benefit delivery approach.

- Finalization of the 2011 AOP and more importantly in the integration of their health plans in the CDP-ELA LGU AIPs after formulating their plans following the SDIR process.
- Capacitating PHO logistics team on FP Commodity Monitoring Systems (FPCMS)
- Assisting the PHO present health agenda to the NEOs to solicit support for public health programs.

At the end of Year 5, HealthGov's technical assistance to the province will contribute towards the increase in health performance for MNCHN/FP health outcome indicators that will result to the following milestones:

- Province and 12 M/CLGUs with drafting CSR + policy with NGO/CSO participating in CSR policy development
- Province and 12 M/CLGUs with CSR+ policy approved
- LGU-NGO/CSO partnership established in CLAJAVITA for planning, budgeting, implementation, monitoring (e.g. maximizing use of MNCHN services, public-private partnership referral mechanism, etc.)
- 14 M/CLGUs with action plans implemented to accelerate performance of SO3 concerns
- 1 Provincial ICV monitoring plan developed
- Provincial policy on ICV compliance monitoring locally mandated
- 25 FP-RH service delivery sites monitored and reported for ICV compliance
- Province and 25 M/CLGUs accessed external funding (MNCHN) to finance health
- Province and 25 M/CLGUs utilized MNCHN grant facility to finance health programs
- facilities accredited by PhilHealth
- 2011 province-wide AOP formulated and approved
- Province and 25 M/CLGUs with quality health performance indicators derived from checked and validated FHSIS
- Province with improved data management system
- Provincial FP Commodity Monitoring System tool adopted

**Priority TA Interventions and Activities**
**MISAMIS ORIENTAL**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **1. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1.CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.b | Quality of provincial aggregate of cleaned FP CU validated for accuracy vis-à-vis the sumbitted reports to PHO | Meeting with FHSIS coordinator/DOH Reps to discuss results of all LGUs FP data clean-up<br><br>Review and consolidate corrected data for provincial level | Coach PHO/PHTO | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1B.c (1.1F.a)<br><br>1.4C.a | Draft CSR+ policy<br><br>NGOs/CSOs participating in CSR+ policy development | CSR+ policy writeshop for MHOs, SB Chair on Health, DOH Reps and with NGOs/CSOs participation to:<br>• Develop CSR+ policy<br>• Formulate action plan to finalize CSR+ policy and its approval | Resource person, training materials, tools/template | **P1 M11 C1** | | | | | | | | | | | | 1 | 11 | 1 |
| | 1.1F.a | Policies finalized with broad stakeholders participation* | Consultation meetings by the P/C/MLGUs with NGOs/CSOs/private sector involvement for cost recovery scheme, safety net for the poor, and other CSR+ criteria | Mentoring, activity design | | | **P1 M11 C1** | | | | | | | | | | 1 | 11 | 1 |
| | 1.1B.d (1.1F.b) | CSR+ policy approved* | Monitor approval of CSR+ provincial/city/municipal policies | Coordination | | | | | **P1 M11 C1** | | | | | | | | 1 | 11 | 1 |
| | 1.1B.e | CSR+ plan and policy implementation tracked | Meeting with PHO program coordinators/DOH Reps for orientation on the CSR tracking tool | Resource person, tools and guide | | | | **P1** | | | | | | | | | 1 | | |
| | | | Follow-up meetings with PHO/DOH Reps on the status of local policy implementation | Tracking tool, resource person | | | | | **M3** | **M3** | **M3** | **M1 C1** | | | | | | 10 | 1 |
| 2. Integration of FP in EPI and maximizing MNCHN services and facilities | 1.4C.c | LGU-NGOs/CSOs partnership established to expand service delivery and improve referral system for MNCHN, FP and TB | Consultative meetings/workshop involving P/MLGUs, NGOs/private service providers, private companies within the CLAJAVITA ILHZ as part of the PHO establishing a network of facilities and service providers to expand service delivery and improve referral sys | Resource person, funding support- FOG | | **M4** | | | | | | | | | | | | 4 | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.1G.c | LGUs signed MOU detailing areas of collaboration such as referral system, financing, M&E, among others | MOU signing between LGU/RHU and private companies for the installation of Public-Private Partnerships for FP/MNCHN in ClaJaViTa ILHZ | Template, tools, funding support - FOG | | **M4** | | | | | | | | | | | | 4 | |
| | 1.3A.d | No. of people trained in FP-EPI integration and maximizing utilization of MNCHN services | Orient DOH Reps/PHO program coordinators on monitoring tool to track progress on the integration of FP/EPI and maximizing utilization of MNCHN services | Resource person, tools, template | **P1 M14** | | | | | | | | | | | | 1 | 14 | |
| | | | Regular meetings with DOH Reps and PHO staff to assess and monitor the implementation and progress of the indicators (CPR, ANC, SBA, FBD) | Facilitator, monitoring tool and templates<br><br>Coach | | | | | | | | | | | | | | | |
| | | | Review of results and documentation of the promising practices | Mentoring, resource person, supplies and materials | | | | | **M7** | | | **M7** | | | | | | | 14 |
| | 1.4A.b | Public forum with NGO/CSO participation conducted | 1 province-wide presentation of results of promising practices | | | | | | | | | **P1** | | | | | 1 | | |
| 2. ICV compliance monitoring | 1.3D.b | Provincial ICV monitoring plan developed* | Consultative meeting with PHO staff/PHTL to formulate ICV monitoring plan (to ride on other meetings in same month) | Coaching, facilitator | **P1** | | | | | | | | | | | | 1 | | |
| | | ICV compliance monitoring locally mandated* | Consultative meeting with PHO/PHTL to integrate the ICV compliance monitoring policy in the draft provincial CSR+ ordinance | Coaching | | **P1** | | | | | | | | | | | 1 | | |
| | 1.3D.d | ICV compliance of FP/RH service dleivery sites monitored and reported* | Support on-site monitoring of DOH Reps/PHO staff of ICV compliance by LGUs | Mentoring, coaching, monitoring tools, forms | | **M4** | **M3** | **C1 M3** | **M3** | **M4** | **M3** | **C1 M3** | | | | | | 23 | 2 |
| | | | Consolidation of ICV compliance monitoring reports and submission on a quarterly basis | Coaching | | | | | | | | | **P1** | | | | 1 | | |
| **II. Strengthening family health program support, financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on benefit delivery approach | 1.2B.a | TOT in local NHIP implementation (BDR) | With PhilHealth regional staff and DOH Reps, conduct orientation-training in PHIC accreditation (OPB, MCP, TB DOTS, NBS) and reimbursement | Coaching, tools, facilitator, coordination | **P1** | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.2C.a | Application for facility accreditation by PhilHealth filed | With PHO technical staff and DOH Reps, coach MHOs and PHNs in self assessment and in complying with requirements for renewal or new accreditation (OPB, DOTS, MCP) | Coaching and mentoring | | **M2** | **M1** | **M1** | | | | | | | | | | 4 | |
| | | | Filing of application for PhilHealth accreditation and approval of PHIC | Coordination | | | | | **M2** | **M2** | | | | | | | | 4 | |
| | 1.2C | Facilities accredited by PhilHealth* | Approval for accreditation by PhilHealth | Coordination | | | | | | | | **M2** | **M2** | | | | | 4 | |
| 2. Accessing and managing DOH MNCHN grants | 1.2A.b | MNCHN grant accessed | One-day orientation of PHO, DOH Reps, MHOs, PHNs on the MNCHN guidelines, utilization, and tracking system | Resource person, tools, template | **P1 M23 C2** | | | | | | | | | | | | 1 | 23 | 2 |
| | | | Consultation meeting with the P/C/MLGUs for formulation of key contents of LGU policy on 2010 MNCHN grant to meet the set criteria of the CHD | Resource person, provincial allocation tool | **M23 C2** | | | | | | | | | | | | | 23 | 2 |
| | | | Monitoring the utilization of the 2010 MNCHN grant facility | Coaching | | | | **M8** | | **M8** | | | **P1 M7 C2** | | | | 1 | 23 | 2 |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide PIPH/AOP preparation, implementation and M&E | 1.1A.h | AOP (PIPH) prepared and integrated into CDP-ELA* | Workshop with the LGU planning officers and members of the Local Finance Committee (LFC) on the integration of PPAs of PIPH/AOP into the CDP-ELAH | Resource person, facilitator, activity design, tools and templates<br><br>LTAP | **P1 M23 C2** | | | | | | | | | | | | 1 | 23 | 2 |
| | | | Meetings by the local health boards to discuss the importance of the PPAs/ interventions for endorsement of the LHB to the LFC and Provincial/Municipal/City Development Councils | Facilitator, mentoring<br><br>LTAP | | **P1 M23 C2** | | | | | | | | | | | 1 | 23 | 2 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | | | Meeting of Provincial/Municipal Development Councils and LFC to integrate PPAs into the CDP-ELA | Resource person, facilitator, coaching<br><br>LTAP | | **P1 M23 C2** | | | | | | | | | | | 1 | 23 | 2 |
| | | | Monitoring of the integration of the PPAs of the PIPH/AOP to the CDP-ELA or the AIP by the LFC | Coordination<br><br>LTAP | | **P1 M23 C2** | | | | | | | | | | | 1 | 23 | 2 |
| | | | Approval of the CDP-ELA/AIP by the SP/SB with the PPAs for health integrated in the plan | Coaching and mentoring<br><br>LTAP | | **P1 M23 C2** | | | | | | | | | | | 1 | 23 | 2 |
| | 1.1A.e | 2011 province-wide AOP formulated and approved | Finalization of 2011 AOP based on JAC comments | Resource person, tools/templates<br><br>LTAP | **P1** | | | | | | | | | | | | 1 | | |
| | | | Orientation workshop on PME guides and tools for PHO technical staff, MHOs, DOH Reps, and NGOs/CSOs | Resource person/facilitators, PME tools/guide, supplies, funding support- LTAP | | **P1** | | | | | | | | | | | 1 | | |
| | | | On-site PME visits by the PHO team and DOH Reps to monitor implementation of PPAs in their AOPs | Coach PLGU/PHO/NGO partners in monitoring - LTAP | | | **C2 M5** | | **M6** | | **M6** | | **M6** | | | | | 23 | 2 |
| | | | **2012 AOP formulation** | | | | | | | | | | | | | | | | |
| | | Action plan to conduct DQC, SDIR, AOP formulation and AIP integration | Advocacy meeting cum planning of PHO program coordinators, DOH Reps and MHOs on DQC, SDIR, AOP formulation and AIP integration | Resource person, supplies and materials | | | | **P1** | | | | | | | | | 1 | | |
| | | Progress reports | Follow-up meetings with PHO/PHTL/DOH Reps in the status of implementation of the action plan (improved data management system, Pre-SDIR, Provincial SDIR, 2012 AOP formulation) | Mentoring and coaching | | | | | | | | **P1** | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.1A.e<br>1.1A.h | 2012 AOP finalized and integrated into AIP and LGU budgeting process* | Assist the PHO in the technical review of the 2011 AOP and define province-wide directions for 2012 AOP<br><br>Meeting with the LFC for the integration of PPAs in the LGU AIP | Mentoring and coaching; provision of tools | | | | | | | | | **P1** | | | | 1 | | |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | TOT in FPCMS for the PHO logistics management team | Resource speaker, supplies and materials, training modules | | | | | | **P1** | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | Meeting with PHO/PHTO to discuss progress and status of FPCMS implementation and identify recommendations for improvement | Resource speaker, supplies and materials, training modules | | | | **P1 M23 C2** | | | | | | | | | 1 | 23 | 2 |
| **D. Advocacy to newly elected local officials (NEOs)** | 1.4B.a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGOs/CSOs representation completed | Meeting with PHO/PHTL and NGO partners to fill-out LHB inventory forms and policy scanning of provincial and municipal LGUs on policies related to FP, MNCHN, TB, among others | Mentoring, coaching, resource person - STTA | **P1** | | | | | | | | | | | | 1 | | |
| | 1.4B.c | Best practice in health of LGUs presented to NEOs | Sharing of best practices of LGUs during LMP meetings, PCL, etc. as a form of peer-based learning | Resource person - STTA presentation materials | | **P1** | | | | | | | | | | | 1 | | |
| | | Validated political mapping | Meeting with PHO/PHTL, NGO partners for identifying LCEs and proposed actions who are supportive to FP/MNCHN, TB, HIV/AIDS | Mentoring | | **P1** | | | | | | | | | | | 1 | | |

## Zamboanga del Norte

Zamboanga del Norte having a population of 934,973 in 2009 is identified as one of the poorest provinces in the whole country with the poverty incidence rate of 65% in 2003. It is composed of twenty-five (25) Municipalities and two (2) Cities, Dipolog City and Dapitan City. The governor, whose 8-point agenda includes: support to health, housing and food sufficiency, duly supports the development of M / PIPH as a roadmap in the implementation of health interventions and as basis for funding support by the DOH and other development partners.

**The Health Situation: Trends in SO3 Indicators**

The status of the major health indicators of Zamboanga del Norte are summed up in the table below (see Table 1). A review of the health situation revealed low performance in maternal and child health indicators from 2006 – 2008; however, although still below the national standards, improvements were seen in 2009 accomplishments. ANC4 has increased from 55% in 2008 to 79%, SBAs by 2% and FBD by 5% which could be attributed to the increasing awareness of mothers on the importance of early and regular prenatal check- ups as a result of community mobilization and advocacies conducted in the province. Increasing LGU support to health interventions was also observed in most municipalities as seen in the upgraded health facilities and hiring of additional health personnel. Likewise, the growing commitment of health workers to comply with DOH AO 2008-0029 has caused increased deliveries in birthing facilities. However, there is still a need to maximize existing MNCHN services in order to provide efficient services to the clients and accomplish improved health performance indicators.

CPR was drastically reduced from 38% in 2008 to 31% in 2009 in spite of the provision of additional commodities amounting to 3M out of the 2008 MNCHN grant allocation. This is due to the CU data cleaning done in most municipalities in the last quarter of 2009. The CU data cleaning is a HG initiated activity. In spite of HG support in the development of CSR ordinance, only 19 municipal ordinances were passed and approved. There are still five (5) ordinances being processed, three (3) which are considered as gray areas because their LCEs duly oppose the crafting of the CSR ordinance. FP promotion still needs to be strengthened and the awareness on ICV compliance should be emphasized among partners as a way to create awareness and understanding FP in the context of quality of care.

Only the child health indicators like FIC and DPT3 have met the national target. This could be attributed to the improved services of the health providers ensuring that REB strategy is implemented municipality wide, availability of vaccines and needles and syringes and the increasing awareness of mothers on the importance of immunization. Community participation is also observed during immunization schedules. Child pneumonia treated with antibiotics has also met the target. It is noted that antibiotics are available in most health facilities. However, child indicators like Vitamin A coverage and treatment of diarrheal cases with ORT fall short below the national standard. Inadequacy of *oresol* or *oretabs* was noted in many health facilities.

TB case finding, CNR and CDR were greatly reduced except for cure rate which has sustained accomplishment but are nonetheless below the national standard.

The accreditation of facilities did not complement the increasing of PhilHealth enrollment under the sponsored program. PHIC enrollment for indigents accounts for only 36% of the population. Of the total 27 health facilities in the province, 22 health facilities are already Sentrong Sigla Level 2 Phase 1 certified. These SS RHUs have greater advantage in acquiring PHIC

accreditation. However, for 2009 only 15 municipalities have OPB accredited facilities (Dipolog City, Dapitan City, Jose Dalman, Katipunan, Liloy, Mutia, Pinan, Polanco, Salug, Siayan, Sindangan, Tampilisan, Godod, Roxas and Salug. TB-DOTS accredited were only the government hospital of Dr. Jose Rizal Memorial Hospital – PPMD unit) and only Tampilisan RHU became MCP accredited.

The Provincial government has been providing support to public health programs from its 20% development fund. It started with 5M in 2004 and doubled to 10M in 2005. For 2009 however, funding support to public health programs was reduced to 4.5M. More provincial fund support has been allocated to the indigent program and hospital improvements. The provincial government has become dependent on the grants received by the province to support public health services and reported that the PHO could not consume the funds allocated for their activities.

In the recently conducted CU data cleaning, erroneous recording was evident. There is still a need to improve data management in the province as well in cities and municipalities. Other indicators also need to be reviewed to come up with a realistic, accurate and realizable data which is relevant for planning and legislative purposes.

Monitoring and supervision at all levels has not been regularly conducted and if done, particularly that of the provincial team, it is programmatic in nature. Record review and updating of records and reports which is supposed to be part of M/E is not done routinely. No feedback on monitoring has been established.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 42 | 40 | 38 | 31 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 58 | 60 | 55 | 79 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 62 | 67 | 66 | 68 | 80 |
| 4 | Percent of facility-based deliveries | 18 | 20 | 21 | 26 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 63 | 78 | 80 | 97 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 60 | 82 | 94 | 95 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 96 | 77 | 88 | 88 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 48 | 41 | 44 | 42 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 99 | 97 | 96 | 99 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 55 | 55 | 59 | 46 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 78 | 80 | 89 | 66 | 99 |
| 12 | TB cure rate (%) | 68 | 75 | 75 | 77 | 85 |

**The Response: TA Interventions and Results**

The province being one of the 21 F1 roll-out sites completed its PIPH with USAID assistance and passed JAC review in April, 2007. As major TA provider, USAID CAs continuously assists the province in the implementation and monitoring of various health interventions as contained in the PIPH / AOP.

Technical assistance to the province in Years 1-4 focused on the formulation and enhancement of the municipal and provincial investment plans for health and preparation of the 2008-2010 Annual Operational Plans in collaboration with CHD 9. Part of the technical assistance was assisting the provincial and municipal planners in utilizing the SDIR tools to generate a comprehensive situational analysis in order to come up with strategic interventions to answer gaps and issues in health program implementation. As a result, the Municipal and Provincial Local Government Units have started to invest more in health, thus, increasing their budgets for health and funding for programs, projects and activities were observed to be more strategic and rationalized.

During the consultation meetings and workshops with municipal planners and implementers, PHIC enrollment and accreditation were also discussed and pursued. Consequently, 23 / 27 M-LGUs have pursued PHIC universal coverage and three municipalities (Jose Dalman, Rizal and Godod) already implemented universal coverage. Accreditation however is taking a slow pace but yearly increasing with 15 facilities OPB accredited, additional 3 facilities (Polanco, Mutia, and Dapitan CHO) were TB DOTS accredited in 1st quarter of 2010 making a total of 4 TB DOTS accredited facilities and Dipolog CHO birthing home was also MCP accredited in the March 2010, making it to a total of 2 MCP accredited facilities in the province.

HealthGov supported the 27 municipalities / cities and the province in the development of the CSR implementation plans and commodity forecasting and budgeting to strengthen its Family Planning program and local CSR response. With this, HealthGov's TA in CSR has generated increased commitment and support from LCEs in 2009. A total of 2.5M was appropriated for CSR implementation with 1.1M coming from the provincial government. For 2010, a total of about 5M was allocated for CSR commodities by the provincial and municipal LGUs. To further strengthen the province-wide FP/CSR implementation, HealthGov assisted the conduct of workshops on CSR policy development to ensure the increase in investments for health particularly on FP /MNCHN and safety nets for the poor. This resulted in 19 municipal CSR ordinances passed and approved. To ensure that LGU commitments as stipulated in the approved ordinances are efficiently and effectively implemented and expected results are duly achieved, a tool has been generated to track the specific commitments of the LGUs. This tool will track the regular and annual allocation of CSR budget, provision of subsidy to the poor/indigents, cost recovery scheme to non-poor, program management system including the setting up of CSR TWG, commodity procurement and distribution procedures, identification mechanism of poor and non poor, and monitoring and reporting system on the management of funds and the utilization of commodities. Policy tracking has already been conducted in 12 municipalities. In addition, a provincial CSR TWG was also formed and tasked to oversee the implementation of CSR in the province. HealthGov also conducted capacity building activities for the PHO and PHTO staff on ICV compliance to ensure that clients of FP and MCH programs are provided complete and correct information on family planning methods. This resulted to the conduct of ICV compliance monitoring for service providers and clients.

The project assisted the province in accessing the MNCHN grant facility through the conduct of an orientation on how to comply with documentary requirements. The 2008 MNCHN grant was a

welcome support in the amount of 3.4M of which 90% of the grant was utilized for the procurement of FP commodities and the remaining 10% was utilized for PHO operations and technical support activities e.g., trainings and workshops. The 2009 MNCHN grant facility was received in May 2010 in the amount of 4M. With HealthGov's TA and utilizing the provincial allocation tool, it was agreed by the PHO and the field health implementers that 1M of the grant will be used for the bulk purchase of FP commodities, 10% for the operational expenses of the PHO and the remaining amount will be cash transferred to the municipalities based on the DOH performance- based award scheme.

Municipalities were encouraged to strategize in order to improve FP coverage and to address the reduction of CPR as a result of CU validation. To date, nine (9) municipalities are already implementing the strategy of integrating FP messages into EPI and maximizing the utilization of existing MNCHN services and facilities. This strategy will be rolled out to the other municipalities in Year 5.

The province is a non-TB LINC area and is classified as low, low province having low CDR and low Cure Rate. In response to the request of the Provincial Government through the PHO, HealthGov with TB LINC supported the training of the remaining seven (7) untrained field health personnel and 19 hospital staff on TB DOTS providers training. This is in preparation for the installation of the TB DOTS clinic in government-owned hospitals.

For Year 3, Health Gov's TA for the province revolved around the handle "Mobilizing Lando BIBO and ILHZ to improve public health outcomes". The major technical assistance provided to the province included technical support to the PHO/RHU/CHO and community based organization (Lando BIBO) partnership for mobilizing communities for TB control and maximizing of MNCHN services. Moreover, a 2-day orientation workshop for Lando BIBO workers and selected BHWs was conducted by HealthPRO with A2Z to give them a broader understanding of *Garantisadong Pambata* and increase their skills in communicating to clients. As a result, Lando BIBO has supported the mobilization of barangays in the conduct of *Garantisadong Pambata* which have contributed to the reported increase from 59% in April 2008 to 88% in 2009.

In order to improve data management, HealthGov capacitated the provincial and municipal service providers in doing FP CU validation / data cleaning. As a result, FP CU in 27 facilities were corrected resulting to a dropped of over 10% of the CU data. On the other hand, a Data Validating Team is currently organized to regularly review FHSIS records including FP data.

**Remaining Gaps and Challenges**

With continuous and regular data cleaning, it is expected that CPR will reduce or will exhibit a slow increase. It is a big challenge for the provincial health office staff to identify measures that would accelerate their FP performance and improve MNCHN services. It is but worthy to roll out the strategy of FP integration to most of the municipalities and utilize existing resources in the community like the BHWs, community partners and BHTs in health information dissemination and strengthen coordination with partners and other FP service providers. Fast tracking of the remaining seven (7) municipalities without CSR ordinances will have to be done to ensure continued support to FP/CSR. Likewise, the conduct of regular policy tracking to the 19 municipalities with already approved ordinances will be supported. In addition, as a way of ensuring availability of FP commodity, PHO must adopt a FP commodity management system.

There is a need for the health officers to integrate their health plans to the comprehensive development plan of the LGU in order to ensure funding support for the FP/MNCHN and TB programs. In Year 4, the PHO and CHOs/RHUs were assisted through the SDIR process to mainstream an in-depth analysis of the health situation in the development of their annual operational plan. Part of the LGU planning and budgeting process prior to the preparation of the Annual Investment Program (AIP) is the updating, assessment and analysis of the prevailing situation. In Year 5, HealthGov will assist the health officers in the integration of the health plans in the CDP-ELA /AIP of the LGU so that the investment requirements into the provincial, city and municipal health plans will be funded. This can only be done if the AOP planning is synchronized with local planning and budget cycle.
Supervision and monitoring has always been irregularly and inefficiently conducted in the past. This is one area which still needs to be improved. Supposedly, field implementers need to be regularly supervised by capable supervisors. For many years, training on supervision and monitoring has not been conducted. There is a need to prioritize this area of work so they can fund the conduct of the training from their MNCHN grant. Along this line, HealthGov will also introduce PME on AOP for adoption.

**Year 5 Priority Interventions and Expected Results**

Upon consideration of the prevailing conditions of the province, the priority TA in Year 5 will focus on improving CPR and sustaining increases in ANC, SBA, and FBD. This will entail consolidating and completing the technical interventions on service delivery like the FP integration in EPI and maximizing utilization of MNCHN services and health systems improvement, specifically on planning and financing.

To improve service delivery in family health through CSR, HealthGov will provide continuing TA in policy advocacy for the remaining LGUs without ordinance; MNCHN grant accessing and utilization; tracking CSR ordinance implementation (19 LGUs); logistics management, particularly in setting up the FPCMS and SIMS; and ICV compliance monitoring; and adoption of the FP-EPI integration strategy (25 LGUs).

In line with strengthening the LGU's planning systems and health financing, HealthGov will assist the province and municipalities integrate their health plans to the LGU investment planning like specifically in CDP-ELA and/or AIP; increase facility accreditation, and installation of PME at the provincial level. All these interventions hope to support the improvements in service delivery and will redound to increase in the health indicators.

A. Support to improving service delivery in family health

- Local CSR + policy implementation and tracking
- Monitoring the results of the interventions on FP integration and maximizing MNCHN services in municipalities covered Y4
- Institutionalization of the ICV compliance monitoring
- Access and Managing of MNCHN grants

B. Strengthening family health program support – financing, policy and governance

- Orientation meeting to MHOs and PHNs, MBOs, PHO and PHTO staff on benefit delivery approach in local NHIP implementation / assessment / accreditation
- Data quality improvement of other family health data derived from FHSIS

- Logistics Management by adopting FP commodity monitoring system province-wide; SIMS tool for EDCs tested
- Integration of the LGU health plans (PIPH/AOP/acceleration plans) to the CDP-ELA of the LGU and/or AIP
- Adoption of PME for AOP activity monitoring
- Continuing advocacy to NEO to support SO3 programs in financing and regulations

Expected to be achieved by the end of Year 5 are the following outputs/results:

- Implementation of CSR policies in 19 municipalities with tracking results
- 12 Municipal Action plan developed and implemented to accelerate performance and address SO3 concerns
- 12 LGU / NGO partnership established for implementation of MNCHN / FP strategy
- 20 Health providers trained in FP, MNCHN using updated training design/modules
- 27 ICV compliance of FP-PH service delivery sites monitored and reported
- 27 LGU implementation plan prepared encompassing enrolment, accreditation of facility, utilization, availing of benefits and fund management.
- 18 (OPB), 3 LGUs accredited for MCP, 5 for TB DOTS
- 1P/27 M/C-LCEs oriented on NHIP framework and concept and committed their support to NHIP implementation
- PHO logistics team and MHO/PHNs trained on logistics management in FPCMS
- LGUs' health plans integrated in the CDP-ELA/ AIP
- PME adopted by the PHO
- NEOs including oriented on local health situation, MNCHN, FP/CSR, PhilHealth BDR and commitment of support to health generated

Towards the end of the project life, the documentation of promising practices initiated by the LGUs including the results of their initiatives and lessons learned will be made in order to capture the highlights of the gains of the health interventions and share this to other LGUs in Mindanao.

**Priority TA Interventions and Activities**
**ZAMBOANGA DEL NORTE**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. Local CSR+ policy development, implementation and tracking | | PHO program coordinators/DOH Reps oriented on CSR policy tracking tool | Meeting with PHO program coordinators/DOH Reps for orientation on the CSR policy tracking tool | Resource person, tracking tool, mentoring | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1B.e | CSR+ plan and policy implementation tracked | Conduct of continuing CSR+ policy tracking integrated in the routine monitoring | Mentoring and coaching | | **M7** | | **M4** | | **M4** | | **M4** | | | | | | 19 | |
| | 1.4B.c | Community concerns and feedback on CSR policy/plan implementation presented and discussed by NGOs/CSOs to LHB/LDC | Feedback meetings to LCEs, LHBs, PHO, SP of policy tracking results | Mentoring and coaching | **M3** | | **M4** | | **M4** | | **M4** | | **M4** | | | | | 19 | |
| 2. FP integration in EPI and maximizing utilization of MNCHN services and facilities | 1.3A.d | Providers trained in integration of FP/EPI and maximizng utilization of MNCHN services*<br><br>Action plan for the roll-out of integration of FP/EPI and maximizing utilization of MNCHN services formulated to accelerate performance and address SO3 concerns* | Orientation training cum planning with the PHO technical staff, PHTL/DOH Reps and MHOs of selected sites for the roll-out of the interventions on FP integration and maximizing MNCHN which includes tasking and cost sharing | Resource person | **P1** | | | | | | | | | | | | 1 | | |
| | 1.3Ad | Service providers trained in integration of FP/EPI and maximizing utilization of MNHCN services | Conduct of orientation/training cum planning for RHUs not covered in Y4 for the two interventions: FP integration in EPI and maximizing MNCHN services and facilities | Resource person/facilitator, funding support | **M3** | **M9** | | | | | | | | | | | | 12 | |
| | 1.4C.a | Mechanism for community consultations such as community meetings, *barangay* leadership forum established* | Advocacy/dialogues on MNCHN with the ABCs/*barangay* officials and *Barangay* Health Teams in 10 *barangays* in Siayan and Katipunan and 4 more municipalities (to be identified with partner agencies) | Resource person, funding support -FOG/STTA | **M6** | | | | | | | | | | | | | 6 | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.4Cb | Multi-stakeholders partnership established in developing emergency communition system, transport system and walking blood donors' network | Consultation meetings with multi-stakeholders for the establishment of facility mapping with service providers, strengthening referral systems and advocacy for LGU support | Facilitator, mentoring/coaching, funding support - FOG | | M3 | M3 | | | | | | | | | | | 6 | |
| | 1.4.B.c | LHB/LDC meetings held and health issues are discussed and deliberated with inputs from NGOs/CSOs | Meetings with the members of LHBs (NGOs and SBs on Health) to advocate for policy and budgetary support for MNCHN and the new roles of TBAs | Coaching, FOG | | M3 | M3 | | | | | | | | | | | 6 | |
| | 1.1F.a | Policies crafted with broad stakeholders participation* | Drafting of MNCHN policies and advocate for the approval of FP/MNCHN policies | Coaching/mentoring, funding support - FOG | | M2 | M2 | M2 | | | | | | | | | | 6 | |
| | 1.1F.b | Municipal policies in promoting facility-based deliveries crafted and approved with broad stakeholders participation | Passage and approval of municipal ordinances in Siayan and Katipunan and 4 more municipalities to support the maximizing MNCHN services and facilities specifically in promoting facility-based deliveries | Coordination, coaching, FOG | | | M2 | M2 | M2 | | | | | | | | | 6 | |
| | | Progress monitoring results | Periodic meetings with MHOs and staff to discuss implementation status/progress of the small grants | Mentoring and coaching | | | | | | | | | | | | | | | |
| 3. ICV compliance monitoring | 1.3D.b | Provincial ICV compliance monitoring plan developed* | Meeting with PHO/PHTO for the formulation of the ICV compliance monitoring plan | Resource person, coaching | | P1 | | | | | | | | | | | 1 | | |
| | 1.3D.d | ICV compliance monitoring and reporting locally mandated* | Advocacy meeting with Governor and SP for the issuance of policy (Executive Order) to institutionalize ICV compliance monitoring | Resource person | | | P1 | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.3D.c | ICV compliance of FP/RH service delivery sites monitored and reported* | Conduct of ICV monitoring by PHO/DOH Reps using the developed tools thru KII of service providers and FP clients | Mentoring/coaching, forms | **M4** | **M4** | **M4** | **M4** | **M3** | **M3** | **M3** | **C2** | | | | | | 25 | 2 |
| | | ICV compliance quarterly reports completed* | Quarterly consolidation and submission of reports | Coaching | | | **12** | | | **10** | | | **M3 C2** | | | | | 25 | 2 |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on Benefit Delivery Approach | 1.2B.a | Key personnel trained in BDR | Orientation meeting for MHOs and PHNs, MBOs, PHO and PHTO staff on NHIP framework and concept and the benefit delivery approach in local NHIP implementation/assessment/ accreditation and action planning to assess NHIP implementation and plan for accreditat | Resource person<br><br>Tools/design | **P1 M25 C2** | | | | | | | | | | | | 1 | 25 | 2 |
| 2. Accessing and managing DOH MNCHN grant facility | | Documentation for MNCHN grant requirements | Support PHO in complying with requirements for the release of 2010 MNCHN grant facility | Coaching | | | **P1** | | | | | | | | | | 1 | | |
| | 1.2A.b | MNCHN grant accessed | Monitoring the utilization of the 2010 MNCHN grant facility | Coaching/mentoring, funding support - FOG | | | | **M5** | **M5** | **P1 M5** | **M5** | **M5 C2** | | | | | 1 | 25 | 2 |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide SDIR/AOP formulation, implementation, and M&E | | Draft PPAs for integration into the CDP | Workshop with the LGU planning officers and members of the Local Finance Committee (LFC) | Resource person, facilitator, activity design, tools and templates | **P1 M25 C2** | | | | | | | | | | | | 1 | 25 | 2 |
| | 1.4B.b<br><br>1.1F.b | LHB meetings held to discuss and deliberate health issues<br><br>LHB resolution endorsing the PPAs for integration in the CDP-ELA | Local Health Board meetings to discuss the importance of the PPAs/ interventions for endorsement of the LHB to the LFC and municipal/city/province development councils with NGOs actively participating in the discussion | Facilitator | | **P1 M25 C2** | | | | | | | | | | | 1 | 25 | 2 |
| | 1.1Ah | AOP (PIPH) prepared and integrated into CDP-ELA | Monitoring of the integration of the PPAs of the PIPH/AOP to the CDP-ELA or the AIP by the LFC | Facilitator, mentoring/coaching, funding support | | **P1 M25 C2** | | | | | | | | | | | 1 | 25 | 2 |
| | | | Approval of the CDP-ELA/AIP by the SP/SB with the PPAs for health integrated in the plan | Coaching | | **P1 M25 C2** | | | | | | | | | | | 1 | 25 | 2 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | | Action plan for DQC, SDIR, AOP formulation and AIP integration formulated | Meeting with PHO technical staff, DOH Reps on the conduct of annual PIR using SDIR tools and including:<br><br>• FHSIS data quality check<br>• Guide in completing natality and mortality reporting<br>• Integrate private sector data<br><br>2012 AOP | Resource person/facilitator, tools, supplies and materials | | | | | **P1** | | | | | | | | 1 | | |
| | | Progress reports on the DQC, SDIR activities, AOP formulation and AIP integration | Monitor implementation of action plan | Support CHD in monitoring implementation of action plan | | | | | | | | | | | | | | | |
| | 1.1A.g | PME for AOP adopted | Meeting with PHO program coordinators and DOH Reps for orientation on the PME guide/toolkit | Resource person/facilitator, funding support - LTAP | **P1** | | | | | | | | | | | | 1 | | |
| | | | Province-wide orientation/training cum planning on the use of PME tool/guide for AOP activity monitoring in support of LGU score card | Resource person/facilitator, coaching | | **P1 M25 C2** | | | | | | | | | | | 1 | 25 | 2 |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Data management improvement | 1.1C.c | Quality of other family health data derived for FHSIS (SBA, FIC, among others) checked and validated for accuracy in collection, computation and reporting | Data quality check for other MNCHN data derived from FHSIS | Resource person/facilitator, coaching<br><br>DQC tools | | | **P1 M8** | | | **M8** | | | **M9 C2** | | | | 1 | 25 | 2 |
| 2. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Training of PHO logistics management team in FP commodity monitoring system (FPCMS) | Resource person/facilitator, mentoring | | | **P1** | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitor implementation of FP commodity monitoring | Coaching provincial logistics team and DOH Reps | | | | | **M8** | **M8** | **M9 C2** | | | | | | | 25 | 2 |
| | 1.1E.c | TOT in SIMS conducted | Monitor the implementation of FPCMS/SIMS in the province | | | | | | | | **P1** | | | | | | 1 | | |
| | 1.1E.d | SIMS tools for EDCs tested and adopted | Monitor the implementation of SIMS in the province | Technical guide/tools, resource persons and facilitators<br><br>Coaching | | | | | **M2** | **M2** | **M1 C1** | | | | | | | 5 | 1 |
| **D. Advocacy to newly elected officials** | 1.4B.c | Priority health agenda contained in the 2011 AOP is presented as priority in the CDP-ELA to NEOs | Continuing advocacy to NEOs in support to SO3 programs in financing and regulation | Resource person - STTA in Year 4 | | **P1** | | | | | | | | | | | 1 | | |

## Zamboanga del Sur

Zamboanga del Sur is a highly politically-charged province in Zamboanga peninsula composed of 26 municipal LGUs and 1 component city with a population of 949,925. While Zamboanga del Sur is First Class in terms of income classification, the province still belongs to the poorest 40 provinces (ranked 38th) in the country. Thus, access to quality health care and services by its poor and disadvantaged constituents remain a challenge. The presence of insurgent, separatist and bandit groups in the province creates an uncertain situation. The incidents of violence and other crimes are relatively high. The province is highly militarized and the potential for hostilities is high. These and other factors contributed to the low performance were painstakingly studied and analyzed during the PIPH development process. In the province and in majority of the mLGUs, capability to manage and steer the health sector reforms is wanting. Most of the rural health units are still dependent on funding for health from external sources while the municipal, district and provincial hospitals are still dependent on the Internal Revenue Allotment (IRA) and loans. Appropriate interventions were formulated in their AOPs of 2009 and 2010 to address the different health gaps and problems identified.

**The Health Situation: Trends in SO3 Indicators**

The province's selected health performance indicators from 2006 to 2009 has generally increased in trends--4ANC, SBA, FBD, DPT3, FIC, Child with diarrhea given ORT, and Child with pneumonia given antibiotics. However, no significant increase was noted in CPR, vitamin A coverage, and TB cure rate. Similarly, TB case finding indicators such as CDR and cure rate also decreased in 2009. Only the indicators for children sick with diarrhea and pneumonia and TB case finding reached the national targets (See table1).

CPR has been consistently very low in the last four years because of inadequate/lack of commodities in most health facilities. The FBD is also consistently very low because of the following: a) inadequate birthing facilities; b) non-residence of midwives in their place of assignment; c) untrained health personnel on maternal and newborn services; d) preference for TBA during deliveries because of poverty and difficult access (distance and terrain) to MN health services; and, e) fear of giving birth in birthing facilities due to cultural biases, thus prefer home deliveries (Muslim households). The ante-natal care and deliveries by skilled birth attendants are also below the national targets. The reasons cited for this low performance were: a) failure to seek prenatal check up because of the poor access to health facility; b) lack of information/advocacy for prenatal services; and, c) strong traditional beliefs which influence health seeking behavior and preference for TBAs over medical and allied personnel. In general, non-prioritization of most MLGUs on MN and child nutrition services is evidenced by inadequate logistics for MNCHN services such as Vitamin A, Oral Rehydration Salt for children with diarrhea, ferrous sulfate with folic acid and supplies for safe deliveries and newborn care. On top of these, the limited supervision and monitoring on program implementation by the PHO greatly affected the program. This is however attributed to the lack of funds for mobility and lack of competence on supervision by PHO program coordinators. There is a significant increase, however, in child with pneumonia given antibiotics. In TB prevention and control, the case notification rate of the province for the last two years has been increasing and as been the only performance indicator among the SO3 indicators which are above the national benchmarks. The provincial cure rate remained below the 85% national benchmark.

The data management of the province also needs improvement. The FHSIS reports are not fully used to monitor health activities, planning, budgeting and in formulating policies. Data analysis is not done on a regular basis by most health program coordinators. Furthermore, the issue on the lack of mobilization funds to do monitoring, facilitative and technical supervision support to MLGUs remains a problem especially with the present administration, as the travel of the PHO is curtailed. While there are MIPHs, the absence of a purposive M&E made it difficult for the province to determine the extent of LGU implementation. It also failed to provide the enabling mechanism and support to the C/MLGU in tracking the improvements of their health situation.

PhilHealth accredited RHUs are also inadequate. For 2009, out of the 28 RHU/CHO, there are only 11 MCP accredited facilities, 13 TB-DOTS accredited facilities and 24 OPB accredited facilities. Most field health personnel have been trained on BEMONC by the DOH and they are waiting for the funding support from DOH for their infrastructure and equipment before they convert their facilities to lying-in facilities. During the past year and even at present after the election, the PHO management is affected by a highly political situation leading to the low morale of health providers.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 42 | 39 | 36 | 37 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 71 | 77 | 69 | 76 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 48 | 61 | 59 | 70 | 80 |
| 4 | Percent of facility-based deliveries | 21 | 16 | 14 | 21 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 59 | 73 | 75 | 88 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 87 | 84 | 89 | 92 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 97 | 71 | 82 | 82 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 30 | 31 | 41 | 51 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 27 | 24 | 40 | 96 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 72 | 75 | 92 | 83 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 92 | 116 | 120 | 111 | 99 |
| 12 | TB cure rate (%) | 77 | 80 | 79 | 78 | 85 |

### The Response: TA interventions and Results

HealthGov's technical assistance to the province in Years 1 and 2 centered on developing the capacities of LGUs to conduct a comprehensive and participatory planning process for the development of MIPH, PIPH and province-wide AOPs. Part of the technical processes was generating health information through the use of SDIR tools. The results of which were used in analyzing their local health situation. There were two (2) key health issues identified during the development of health investment plans – the capacity of the LGUs to provide quality service

delivery in public health and the their capability to finance the resource requirements. Related issues were also identified like the out of pocket burden of the poor, limited services to the hard to reach areas, and lack of motivation among health workers. Thus, technical assistance was also provided to the province in the development and implementation of a scheme to enroll the indigents in the province under the PhilHealth's Sponsored Program wherein the province adopted the multi-payor scheme. Initially, the Sponsored Program started in 2000 with an initial enrollment of 5% of the total eligible population. The coverage rose to 18% in June 2008. With the implementation of the multi-payor scheme which was started in the second quarter of 2008, the enrollment was increased. By the end of 2009, the province was able to enroll 39,611 out of 92,216 households (43% of the target) with an increase of almost 140% from the previous year. In 2010, the province was awarded by PhilHealth as one of the provinces with universal coverage (>85% of the indigents enrolled). The number of accredited facilities also increased to 24 from 10 OPB, 13 from 1 TB-DOTS and 11 from 5 MCP accredited facilities.

The project assisted the province in the MIPH development of its municipalities in 2008 basically outlining both the immediate actions to be made and some indicative activities to be conducted in the future. These MIPH served as inputs to the development of PIPH. However, it was noted that many of the MIPH were not translated into municipal AOPs. The province formulated their PIPH and AOP in 2008 which was concurred by JAC with "A" rating. Thereafter, the province received start-up funds of PhP2M (October 2008) to implement the initial activities contained in the AOP. CBEWS were also installed for AI in six vulnerable communities.

In terms of MNCHN grant access and utilization, the province was able to receive a MNCHN grant close to PhP 1.5M for 2008. With TA from HealthGov, the grant has been transferred in cash to the city and municipal LGUs applying the distribution criteria used by DOH. Recently, CHD 9 has just released the 2009 MNCHN grant facility to the province in the amount of almost 2 M and is now awaiting the approval for disbursement of funds by the newly-elected Governor.

With HealthGov's TA, the provincial, city and municipal LGUs were able to formulate their CSR plus policies in mid-2009 and the enactment of local policies started thereafter. In Years 3 and 4, most the local policies in support of the CSR + plans were passed and approved in 25 LGUs, including that of the provincial government. In Year 4, the tracking for the implementation of these policies has also been started in half of these municipalities. Some of the findings noted were the lack of logistics management system for the commodities available in the RHUs like the absence of recording of the stocks received, and no distribution list being maintained by the PHN/RHM. The inadequate funding requirement for CSR + was also noted in most LGUs because the CSR + plans formulated were not integrated into the LGU planning and budgeting process. Thus, there is a need for the health planning to be in synch with that of the LGU backed up by a reliable local data. Currently, the province is now being provided with TA in improving data quality the FP current users data validation/cleaning which will be used as a sound basis for the CSR re-forecasting and plan updating during the beginning of Year 5. With the FP data system improvement, it is expected that LGUs will be able to internally better allocate adequate funds to procure the FP/MNCHN commodities.

Before the end of Year 4, assistance was given through another cycle of health planning and budgeting process using the SDIR tools and processes. It starts with thorough situational analysis by LGUs of its health situations and includes data cleaning of other FHSIS family health indicators. Mentoring and coaching of program coordinators and MHOs/PHNs on data quality check and utilization of data is also conducted as part of the TA support in improving the LGU data management system. One of the outputs of the SDIR process is the capability profile database that will be established in the PHO. An annual training plan will also be made in order

to rationalize and develop the health human resource. For this year also, aside from providing TA in the plan preparation, the assistance would also include the integration of LGU health plans to the LGU CDP-ELA /AIP in order to ensure funding support for the FP/MNCHN programs. This TA continuum will conclude with the orientation and adoption by the LGU on the participatory monitoring and evaluation tool. This will enable the staff to keep track of their formulated plans.

With the on-going data cleaning of the FP current users data and the expected reduction of the already low CPR, TA for the two interventions on FP integration into EPI and maximizing MNCHN services has just been started with the orientation of the PHO technical staff and the DOH reps. The 10 municipalities targeted are those with more than 85% FIC and the modeling of these interventions and subsequent roll out will start this September and will be continued until the first quarter of Year 5. In order to promote the policies on informed choice and voluntarism and ensure quality of care for FP, the orientation of the PHO program managers as well as the DOH Reps has also been done.

The political climate brought about by the currently concluded elections affected the performance of the PHO organization starting in January 2010. The implementation of HealthGov's TA activities (i.e. support to improving local NHIP implementation, assist PHO and selected RHUs in improving FP-MNCHN performance with the two interventions of FP integration and maximizing MNCHN) were stalled because of the change in technical leadership and capacity of the Provincial Health Office to coordinate and manage the field health operations of the PIPH/AOP implementation. The former PHO II and her Chief Technical are now assigned at the hospital and the appointed OIC PHO II is a hospital person who is the Chief of Hospital of Zamboanga del Sur Medical Center. The local election period also affected the already politically charged set up in the province and has greatly affected the confidence in the capacity of the current provincial health department to bring changes in terms of health outcomes.

After the newly elected officials were installed, the Governor's priority was to change other heads of offices including the Provincial Administrator – who is one of our strong link persons inside the Governor's office. Furthermore, the newly-elected Governor is not motivated to improve health outcomes and build strong ties with CHD 9.

Given this situation, it is recommended for CHD and the CAs and other development partners to strategize on how to advocate to the present Governor and make him support the health development agenda. There is also a need to identify other entry points i.e. Mayors, newly designated heads of offices, NGO leaders. Currently the TA on the advocacy to the local officials in support of the NEO (newly-elected officials) program of DILG through an engagement of a STTA is very welcomed by the OIC PHO as this assistance is needed in the light of the current change in the political landscape.

**Remaining Gaps and Challenges**

In order to adequately provide funding support for the procurement of commodities essential to MNCHN programs, there is a need to re-forecast FP commodities based on cleaned FP data. This will be done in Year 5. This priority TA intervention will take place in a synchronized manner as another important TA on integration of the health plans with the LGU plans will be undertaken. This important step in local health planning will ensure the allocation of required funds from the LGU so that plans will be implemented. Capacity building activities will be conducted for the PHO/CHO/MHO and the DOH reps in Year 5 to assist them in influencing local planners and officials to integrate health priorities in the CDP-ELA through resource leveraging and lobbying for health programs, human resource concerns, and capacity

development needs. By influencing the LGU to prioritize health projects and activities, this will contribute to produce improvements in health indicators and outcomes. Likewise, the important PPAs from the AOPs will be identified and integrated into the AIPs. Along with this, FP commodity monitoring systems and stock inventory to improve the logistics management system of the P/MLGUs will be provided in Year 5.

Aside from ensuring the supply side of FP/MNCHN strategy, the demand side needs to be assisted in pursuing FP integration in EPI and maximizing MNCHN services in the remaining municipalities. Together with this, FP quality care must be ensured and sustained by institutionalizing ICV compliance monitoring.

To ensure that health investments will be available, continuing assistance needs to be provided in accessing and utilizing the MNCHN grants facility. The mLGUs will also be provided continuing TA in the PhilHealth accreditation of health facilities including the proper utilization of PhilHealth reimbursements.

In the remaining life of project, it would be prudent to focus on support to PHO and selected RHUs in improving service delivery capacities that would redound to increased service performance.

**Year 5 Priority Interventions and Expected Results**

HealthGov's TA interventions for Year 5 will focus on completing the TA activities that were committed in the PIPH/AOP and which were started in Year 4, namely:

A. Support to improving service delivery in family health

- Support to re-forecasting of FP commodities and tracking for the policy and CSR plan implementation
- FP integration in EPI and maximizing of MNCHN services and facilities
- Data base on service providers' capability profile established
- ICV compliance monitoring
- Support to managing the utilization of the 2009 MNCHN grants facility and accessing for the 2010 grant

B. Strengthening family health program support – financing, policy and governance

- Local implementation of NHIP based on BDR approach focusing on accreditation and the TA for the utilization of the PhilHealth reimbursements
- Quality of family panning CU derived from FHSIS checked and validated
- Logistics Management which includes FP commodity monitoring to the LGUs by the PHO
- Integration of the LGU health plans (PIPH/AOP/acceleration plans) to the CDP-ELA of the P/C/MLGUs and/or AIPs
- Adoption of PME for AOP activity monitoring
- Continuing support for advocacy to NEOs

HealthGov expects to achieve the following outputs/results by the end of Year 5:

- 1P/25 M/C LGU updated their CSR + plans and policy approval in at least half of these LGUs

- 10 M/C LGUs implementing action plans on integration of FP and maximizing utilization of MNCHN services to increase FP-MNCHN program performance (CPR, SBA, FBD)
- PHO with data base on health providers capacity profile, and 2011 annual training plan formulated
- ICV compliance monitoring system installed at the PHO
- PLGU thru the PHO have managed the utilization of the 2009 and 2010 DOH MNCHN grant – funding used to implement AOP activities on FP, MNCHN including procurement of commodities
- PhilHealth accreditation in more health facilities using BDR approach
- Existing PhilHealth accredited facilities acquired renewal on OPB, DOTS, MCP
- PHO logistics team and MHO/PHNs trained on logistics management in FPCMS
- PME adopted by the PHO
- 1 province 27 LGUs' health plans integrated in the CDP-ELA/ AIP
- NEOs including LHB-LFC oriented on local health situation, MNCHN, FP/CSR, PhilHealth BDR and commitment of support to health generated

**Priority TA Interventions and Activities**
**ZAMBOANGA DEL SUR**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **1. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.a | Quality of provincial aggregate of cleaned FP CU validated for accuracy vis-à-vis the sumbitted reports to PHO | Re-forecasting using clean FP current users data | Coach PHO/PHTO | **P1 M26 C1** | | | | | | | | | | | | 1 | 26 | 1 |
| | | CSR+ requirements provided with budget by the LGU | Consultation meetings with LFC members for the integration of the budgetary requirements of CSR+ in the LGU AIP based on updated commodity forecast | Coaching, forecasting tool, funding support | | | | | | | | | | | | | | | |
| | | Policy tracking tool used in monitoring implementation | Orientation of the MNCHN Coordinators/DOH Reps on the use of CSR policy tracking tool | Resource person, tool, funding suppport | | **P1** | | | | | | | | | | | 1 | | |
| | 1.1B.e | CSR+ plan and policy implementation tracked | Regular policy tracking with on-site visits integrated to the technical staff and DOH Reps' monitoring activities | Mentoring, forms | | **P1 M7** | | **M7** | | **M7** | | **M4** | | | | | 1 | 25 | |
| 2. FP integration in EPI and maximizing utilization of MNCHN services and facilities | 1.3Ad | Service providers trained in integration of FP/EPI and maximizing the utilization of MNCHN services* | Orientation/training of RHU staff in FP integration to EPI and maximizing MNCHN services and facilities in the remaining targetted RHUs | Resource person/facilitator | | **M3** | **M2** | | | | | | | | | | | 5 | |
| | | | Orientation of the MNCHN coordinators/DOH Reps on the use of monitoring tool | Resource person, monitoring tool | | | | | | | | | | | | | | | |
| | | Progress reports | Monitor and document the results of the two interventions: FP integration in EPI and maximizing MNCHN services and facilities by on-site visits | Coaching/mentoring | | | | | **M3** | **M3** | **M4** | | | | | | | 10 | |
| 3. Capacity building on FP, MNCHN | 1.3.A.a | Database on service providers' capability profile established | Coordination with PHO to update/establish human resource database | | | **P1** | | | | | | | | | | | 1 | | |
| 4. ICV compliance monitoring | 1.3D.b | Provincial ICV compliance monitoring plan developed* | Meeting with PHO/PHTO for the discussion on the principles and concepts of ICV and the formulation of ICV compliance monitoring plan | Resource person, facilitator | | **P1** | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.3D.d | ICV compliance monitoring and reporting locally mandated* | Consultation meeting for the crafting of a provincial policy on ICV compliance monitoring (to be incorporated during the meeting on MNCHN grants policy)<br><br>Follow up approval of the provincial policy on ICV compliance monitoring | Resource person, materials<br><br>Coordination | | | | P1 | | | | | | | | | 1 | | |
| | 1.3D.c | ICV compliance of FP/RH service delivery sites monitored and reported* | Conduct of ICV monitoring using the developed tools thru KII to service providers and FP clients | Mentoring/coaching, forms | | | M2 | M4 | M4 | M6 | M6 | M4 | | | | | | 26 | 1 |
| | | | Quarterly consolidation and submission of reports | Coaching | | | | | | | | | | | | | 1 | | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local implementation of NHIP based on BDR approach | 1.2B.a | TOT in local NHIP implementation conducted | Orientation meeting with PHIC, PHO and MHOs in:<br><br>• Estimating investment requirements in NHIP<br>• Processes and documentary requirements of PHIC accreditation and renewal<br>• Management of PHIC capitation/reimbursement funds | Resource person/facilitator, tools, design | | P1 M26 C1 | | | | | | | | | | | 1 | 26 | 1 |
| | 1.2C.a | Application for facility accreditation by PhilHealth filed | Follow-through activities for the compliance of PHIC requirements | Mentoring, coaching | | M3 | M3 | M2 | M2 | | | | | | | | | 10 | |
| | 1.2C.b | Facilities accredited by PhilHealth* | Coordinate with PHIC to fast track approval of application for accreditation | Coordination | | | | | | M5 | M5 | | | | | | | 10 | |
| 2. Accessing and managing DOH MNCHN grant facility | | | Consultative meeting with the PHO/PHTO for the conduct of fund utilization review of the 2009 MNCHN | Resource person, activity design, tool, funding support | | P1 | | | | | | | | | | | 1 | | |
| | | | Fund utilization review with PHO staff; PHTL and DOH Reps; and MHOs on the utilization and liquidation of downloaded MNCHN grants | Facilitator, activity design | | P1 M26 C1 | | | | | | | | | | | 1 | 26 | 1 |
| | | | Workshop for the development of LGU policies/plan in accessing 2010 MNCHN grants facility | Resource person/facilitator, provincial allocation tool | | | P1 | | | | | | | | | | 1 | | |
| | 1.2A.b | MNCHN grant accessed | Mentoring provincial LGU thru guidance in ensuring that 2010 MNCHN grant criteria are met until submission of requirements to CHD | Mentoring, coaching | | | | P1 | | | | | | | | | 1 | | |
| | | | Monitoring the utilization of the 2010 MNCHN grant facility | Coaching | | | | | | | | P1 | | | | | 1 | | |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide AOP preparation, implementation, and M&E | 1.1A.h | AOP (IPH) prepared and integrated into the CDP-ELA* | Workshop with the LGU planning officers and members of the Local Finance Committee (LFC) | Resource person, facilitator, activity design, tools and templates<br><br>LTAP | P1 | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | | | Meetings by the local health board to discuss the importance of the PPAs/interventions for endorsement of the LHB to the LFC | Facilitator, mentoring<br><br>LTAP | | **P1 M26 C1** | | | | | | | | | | | 1 | 26 | 1 |
| | | | Meeting of Provincial/Municipal Development Council and LFC to integrate PPAs into the CDP-ELA | Resource person, facilitator, coaching<br><br>LTAP | | **P1 M26 C1** | | | | | | | | | | | 1 | 26 | 1 |
| | | | Monitor the integration of PIPH/MIPH into the CDP-ELA of the province/muncipalitites and city | Mentoring/coaching<br><br>LTAP | | | **P1 M26 C1** | | | | | | | | | | 1 | 26 | 1 |
| | 1.1A.g | PME for AOP adopted* | Meeting with PHO program coordinators and DOH Reps on the PME guide/toolkit | Resource person/facilitator, funding support - LTAP | | | **P1** | | | | | | | | | | 1 | | |
| | | | Province-wide orientation/training cum planning on the use of PME tool/guide for AOP activity monitoring in support of LGU score card | Resource person/facilitator, coaching | | | **P1 M26 C1** | | | | | | | | | | 1 | 26 | 1 |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Training of PHO logistics management team in FP commodity monitoring system (FPCMS) | Resource person/facilitator, mentoring | | **P1** | | | | | | | | | | | 1 | | |
| | | | Re-echo training for MHOs/CHO/PHNs in FPCMS | Resource speaker/facilitator, mentoring | | | | **P1 M26 C1** | | | | | | | | | 1 | 26 | 1 |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitoring the TA implementation - FP commodity monitoring and inventory by PHO team and DOH Reps | Coaching | | | | | | | | **P1 M26 C1** | | | | | | 26 | 1 |
| | | | Consultative meeting with the PHO/PHTO to assess gaps/issues/concerns and generate recommendations for improvement of the system | Facilitator | | | | | | | | | **P1** | | | | 1 | | |
| **D. Advocacy to newly elected officials** | 1.4B.c | LGU action plans to improve FP/MNCHN presented during the province-wide alliance workshop | Presentation of draft health agenda based on the consolidated LGU actions to improve FP/MNCHN during the province-wide alliance workshop | Resource person- STTA from Year 4, facilitator | **P1** | | | | | | | | | | | | 1 | | |

## Zamboanga Sibugay

Created in 2001, Zamboanga Sibugay, with a population of 546,186 in 2007, is a young and developing province in the Zamboanga peninsula. Classified as 3rd class, the provincial government is working closely with the local officials of its 16 municipalities to improve the quality of life of its constituents through the provision of socio-economic programs and projects and extensive delivery of basic social services.

**The Health Situation: Trends in SO3 Indicators**

All the maternal care indicators in the province (CPR, 4 ANC, SBA, and FBD) are the lowest among the provinces in the peninsula. The CPR, although increasing, is still far below the national performance standards. This is due to the shortage of contraceptives in some municipalities and the lack of demand generation activities to increase contraceptive use among married women of reproductive age (MWRA). Notably, CSR is not well accepted and implemented in the municipalities which could be due to lack of information among some LCEs on the importance of reproductive health and its relationship to human and economic development.

There has been no significant improvement in the deliveries attended by skilled birth attendants. Mothers still prefer the services of *hilots* over SBAs. Economic reasons and poor geographic access are some of the cited reasons for this low accomplishment aside from lack of well-equipped health facilities, bad road conditions, and personal and cultural preferences.

Prenatal care coverage has improved from 2006 to 2008 but dramatically dropped in 2009. It was noted that the PHO has initiated an Obstetric Management Information System (OBMIS) to ensure that mothers have adequate prenatal care. This seemed effective in 2008 as the province posted a 53% accomplishment in ANC, however, this dropped to 42% in 2009. The FBD has consistently been very low, ranging from 6% to 8% for the last four (4) years. The province is the lowest in the region despite the presence of four (4) MCP-accredited facilities. Most of the LGUs are IRA-dependent, thus, budget allocation for health services remains limited which hinders the delivery of quality health services even for the upgrading/repair of health facilities to comply with the requirements for PhilHealth accreditation.

While child health indicators have increased --- immunization, vitamin A coverage, and child with diarrhea given ORT --- these are still below the national standards. Only the performance for children with pneumonia is above the national standard. On the other hand, the province was able to improve its TB indicators. It has met the national standards for CNR, CDR, and CR.

A review and analysis of the province's health accomplishments pointed to the MaTaOl ILHD (GIDA Inter-Local Health District) and most of the LGUs in the Ipil ILHD as having low performance coverage for major health indicators. Thus, in Year 4, assistance in SDIR focused on the districts of MaTaOl and Ipil.

The MaTaOl ILHD is composed of three municipalities that are considered as geographically isolated and depressed areas (GIDA) in view of their being island municipalities. The district is also affected by problems of poverty, poor access to health facilities in interior areas due to poor road network, low income, as well as the LCEs' lack of political will and direction with regard to health. The peace and order situation is also unstable due to the presence of kidnappers and insurgents.

**Table 1: Selected health indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 20 | 21 | 25 | 27 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 43 | 41 | 53 | 42 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 49 | 50 | 49 | 60 | 80 |
| 4 | Percent of facility-based deliveries | 6 | 6 | 7 | 8 | 60 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 77 | 73 | 82 | 87 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 84 | 84 | 89 | 91 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 92 | 93 | 79 | 93 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 34 | 44 | 36 | 53 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 99 | 100 | 98 | 98 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 39 | 70 | 75 | 78 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 69 | 93 | 103 | 102 | 99 |
| 12 | TB cure rate (%) | 68 | 78 | 60 | 71 | 85 |

## The Response: TA interventions and Results

HealthGov's technical assistance to the province from Years 1-4 focused on capacitating the CHD and LGUs in adopting a comprehensive and participatory planning process in the development of its PIPH. HealthGov also supported the PHO in assisting LGUs in CSR+ forecasting and planning. During the 2008 and 2009 AOP formulation, the project assisted the province and ensured that the SO3 concerns were reflected in the AOP. The project also supported the province in strengthening AI preparedness and response, including the installation of a Community-Based Early Warning System (CBEWS) in selected municipalities. HealthGov also assisted the Alicia ILHZ in the documentation of its good practices in line with the Good Governance for Medicine award. However, majority of the HealthGov-planned technical assistance interventions were not implemented in Year 3 because of the PHO's requirement to have a signed Memorandum of Understanding (MOU) between the PLGU and HealthGov prior to implementing any technical assistance.

In the 3rd quarter of Year 3, CHD 9 requested HealthGov to assist the provinces in synchronizing and harmonizing the province-wide AOPs with the local health plans of the LGUs. Given the enormity of the TA requirements, especially on the part of the technical assistance providers, the agreement was to train the PHO staff, the DOH Reps, and local TAPs in the entire process of local planning and budgeting to be able to provide technical assistance to city and municipal LGUs. CHD views this exercise as part of the RCBI. After various futile attempts at reconciling schedules with the province, the activity pushed through with only the DOH Reps as trained TA providers.

In the 1st quarter of Year 4, HealthGov along with CHD 9, assisted the province in the improvement of its 2010 AOP. The PHO refused to join the CHD-funded AOP workshop but

when the call for JAC review was announced, the PHO technical staff joined the 2010 AOP enhancement workshop for the three (3) Zamboanga provinces. HealthGov assisted in the technical review of the plan and conducted follow-through on-site coaching. The resulting 2010 AOP was rated "A" by the DOH-JAC.

As planned, HealthGov's technical assistance to the province in Year 4 was geared towards the provincial handle of "*Improving health outcomes in GIDA and LPAs through CHD leadership, LGU and community partnership".* Priority was also given to the highly-populated Ipil District. Along this line, an LTAP has been engaged to conduct SDIR activities in GIDA and Ipil ILHD covering nine (9) municipalities. The new OIC PHO is very appreciative of this TA package and has requested assistance for its roll out in the remaining seven (7) municipalities of the province. To catch up with this activity, the PLGU sponsored the conduct of an SDIR for the remaining seven (7) municipalities of Alicia ILHD. The project, together with the PHO and PHTO, is currently conducting the SDIR process in the nine (9) LGUs to assess the status of program implementation vis-a-vis established standards and have an objective basis for setting future directions towards improving public health outcomes. With the CHD, through its DOH Representatives, the PLGU is in the process of doing a series of municipal pre-SDIR workshops to have a participative in-depth situational analysis during the review of program implementation. A corollary intervention is the conduct of data quality check for FHSIS indicators on FP/MNCHN to have a sound basis for their health planning. By the end of Year 4, the LGUs' acceleration plans will be formulated to serve as inputs to the 2011 Annual Operational Plan/ Annual Investment Plans of the MLGUs. The project and the PHTO will also assist in the implementation of the AOP/AIP to improve outcomes in FP, MNCHN, and TB.

The conduct of data quality check for FP current users data was also undertaken as a prerequisite activity for CSR+ plan updating. While the project started to assist the province in CSR planning in 2009, plan implementation and policy formulation have not yet been initiated. Data cleaning is currently being undertaken and funded by the province using its MNCHN grant. The PHO staff and health personnel were also oriented on the relevant ICV policies and the importance of monitoring compliance with these policies. As a result, the DOH Reps committed to conduct regular monitoring of the FP-RH service delivery sites.

It is equally important for the SDIR results to be disseminated to the LCEs and other political leaders to solicit support for their acceleration plans. In this regard, before the end of Year 4, TA was provided in the preparation of presentation materials for the newly-elected officials (NEO) for use in the NEO utilization conferences and NEO sessions at the local level. These activities are under Component II (Track 1B: Knowing my LGU) which is being conducted by DILG as an important component of the NEO Program. Briefers on MNCHN, Family Planning, and TB with appropriate key messages have been prepared. The health officers are being assisted by the project to enable them to obtain their respective LCEs' commitment to support the implementation of their municipal health plans towards improving health outcomes and contributing to total human development.

**Remaining Gaps and Challenges**

In view of the foregoing conditions in Zamboanga Sibugay, TA interventions which were stalled in the previous years need to be intensified. Assistance in improving its indicators such as CPR, FBD, and SBA also needs to be provided utilizing the MNCHN framework for service delivery provision. Equally important is the support for planning, logistics management, and financing that also have to be pursued to move forward the planned interventions and improve program performance.

To improve service delivery in family health, there is a need to enhance and update the CSR+ plans using "cleaned" FP data. It is also critical to ensure that the supply side meets the increased demand for FP commodities resulting from intensified health promotion activities. External funding for health also needs to be tapped to increase the resources for health, particularly for MNCHN. The low performance in CPR, SBA, and FBD also suggests the need to adopt more effective service delivery strategies to expand program reach and improve quality of care. This calls for the installation of relevant systems to ensure the availability of commodities at service delivery points, as well as a system for tracking the status of AOP implementation.

**Year 5 Priority Interventions and Expected Results**

Given the limited resources and time constraints, HealthGov's TA interventions for Year 5 will focus on:

A. Support to improving service delivery in family health:

- LGU CSR+ plan updating and re-forecasting, utilizing cleaned FP current users data, including MNCHN and TB;
- Capacitating PHO and DOH Reps on policy development and CSR+ advocacy and policy tracking
- Scaling up the interventions of FP integration into EPI and maximizing MNCHN services and facilities;
- Establishing service provider's capability profile database
- Institutionalizing ICV compliance monitoring;
- Facilitating access to and utilization of the 2010 MNCHN grant;

B. Strengthening family health program support through financing and governance:

- Continuing TA in data quality check for other FHSIS indicators, including analysis and utilization;
- Installing the FP Commodity Monitoring System; and
- Continuing TA support for advocacy to NEOs.

Expected to be achieved by the end of Year 5 are the following outputs/results:

- 16 LGU/province-wide CSR+ plans updated (CSR+ forecasts updated based on cleaned FP current users data);
- 5 Policies crafted with broad stakeholders participation;
- Health personnel in 9 RHUs with high FIC performance trained in two interventions, i.e., FP integration into EPI and maximizing MNCHN services and facilities;
- Action plans to accelerate performance and address SO3 concerns as a result of FP integration activities and maximizing utilization of MNCHN services;
- 16 service delivery sites monitored and reported for ICV compliance;
- 2009 and 2010 MNCHN grant facility utilized to finance MNCHN health programs;
- FP commodity monitoring system tool adopted by the province;
- Quality of FHSIS data ensured for accuracy, computation, reporting, and utilization for planning and decision-making; and

Given the delayed implementation of the TA interventions due to the former PHO leadership and in light of the remaining life span of the project, there is limited time to move the planned TA for

this depressed province in the peninsula. Despite these, the project expects to see by the end of Year 5, a provincial leadership that will utilize the developed HealthGov tools and products to improve its health outcomes. The full implementation of the CSR+ strategy and the sustained adoption of the FP-EPI integration strategy are foreseen to increase the very low CPR. By project end, the province would have also adopted, on a sustainable basis, the SDIR process and tools for improved planning, thus, ensuring the preparation of more responsive health plans.

**Priority TA Interventions and Activities**
**ZAMBOANGA SIBUGAY**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **1. Support to FP/MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.b | Quality of provincial aggregate of cleaned FP CU validated for accuracy vis-à-vis the submitted reports to PHO | Meeting with FHSIS coordinator/DOH Reps to discuss results of all LGUs FP data clean-up<br><br>Review and consolidate corrected data for provincial level | Coach PHO/PHTO | **P1** | | | | | | | | | | | | 1 | | |
| | 1.1B.b | LGU and province-wide CSR+ plans updated (CSR+ forecasting updated based on clean FP CU data)* | Consultative meeting for CSR+ plans updating utilizing FP CU cleaned data (to include micronutrients and TB) | Activity design, resource person/facilitator, forecasting tools, funding support | **P1 M16** | | | | | | | | | | | | 1 | 16 | |
| | 1.1C.a | Clean FP CU data used for CSR+ updating | | | **P1 M16** | | | | | | | | | | | | 1 | 16 | |
| | 1.1B.c | CSR+ policies crafted | CSR+ policy writeshop for MHOs and SB Chair of Committee on Health (to be dovetailed to the above activity) | Resource person/facilitator, supplies and materials, template, funding support | **P1 M16** | | | | | | | | | | | | 1 | 16 | |
| | 1.1Fa<br><br>1.4B.b | Policies crafted with broad stakeholders participation<br><br>LHB/LDC meetings held wherein health issues are discussed and deliberated with inputs from accredited NGOs/CSOs representative<br><br>NGOs/CSOs participated in crafting CSR policy | Dialogue/follow-up meetings including on-site visits to PHO and DOH Reps for participation of LHB members, NGOs/CSOs, community leaders and key officials to provide inputs in the finalization of the ordinances | Coaching/mentoring, resource person | | | **P1 M4** | | | | | | | | | | 1 | 4 | |
| | 1.1Bd (1.1F.b) | Approved CSR+ policies (based on CSR+ updated plans)* | Lobbying of the PHO/MHOs with SB Chair on Health for the passage of CSR/MNCHN ordinance | Mentoring, coaching | | **P1** | **M2** | **M2** | | | | | | | | | 1 | 4 | |
| | 1.1Be | CSR+ plan and policy implementation tracked | Meeting with PHO/DOH Reps for orientation on CSR+ the tracking tool | Resource person, tracking tool | | | | | **P1** | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | | | Coaching PHO staff/DOH Reps on policy tracking during on-site visits (will be conducted with other activity - ICV compliance monitoring and monitoring visits for progress on FP integration to EPI) | Coaching | | | | | | M2 | M2 | P1 | | | | | 1 | 4 | |
| | | | Meetings with PHO/PHTO for recommendations to improve CSR+ implementation | Facilitator | | | | | | | | | P1 | | | | 1 | | |
| 2. FP integration in EPI and maximizing utilization of MNCHN services | 1.3Ad | Service providers trained in integration of FP/EPI and maximizing utilization of MNCHN services | Orientation training cum planning of RHU personnel on the two interventions on FP integration in EPI and maximizing utilization of MNCHN services | Resource person, facilitator, tools | P1 M5 | M4 | | | | | | | | | | | 1 | 9 | |
| | | | Orientation of the MNCHN coordinators/DOH Reps on the use of the monitoring tool | Activity design, monitoring tool, resource person | | | P1 | | | | | | | | | | 1 | | |
| | | Progress reports - baseline data and progress of FP/MNCHN indicators | Monitoring the results of the interventions on integration of FP into EPI and maximizing MNCHN thru on-site visits, records review and KII | Coaching/mentoring | | | | M3 | M3 | M2 | M2 | | | | | | | 9 | |
| | | Documentation report | Documentation of the results and discussion with key staff on progress of performance | Data analysis and processing, resource person | | | | | | | | M5 | M4 | | | | | 9 | |
| 3. Capacity building on FP, MNCHN | 1.3.A.a | Database on service providers' capability profile established | Coordination with PHO to update/establish human resource database | | | P1 | | | | | | | | | | | 1 | | |
| 4. ICV compliance monitoring institutionalization | 1.3D.c | ICV compliance of FP/RH service delivery sites monitored and reported* | Quarterly meetings with PHTO/DOH Reps to monitor and gather report/findings of the ICV compliance monitoriing | Coaching/mentoring | | M5 | | | M6 | | | M5 | | | | | 1 | 16 | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Accessing and managing DOH MNCHN grant facility | | | Consultative meeting for the fund utilization review of 2009/2010 MNCHN grant | Resource person | | | P1 | | | | | | | | | | 1 | | |
| | | Proposal completed and submitted | Submission of the requirements in compliance to the release of 2010 MNCHN grant | Mentoring, coaching | | | | | | | | | | | | | | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.2A.b | MNCHN grant accessed | Monitoring of the 2009/2010 MNCHN grant facility utilization; Fund Utilization Report submission to CHD | Tracking tool, coaching | | | | | | | | P1 | | | | | 1 | | |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Data quality check on FHSIS indicators | | Schedule of LGU data cleaning with assigned provincial team members | Consultative meeting for re-orientation of PHO staff/DOH Reps/MHOs/PHNs for data cleaning, data analysis and utilization | Resource person, facilitator, tools | | P1 | | | | | | | | | | | 1 | | |
| | 1.1C.c | Quality of other family health performance indicators derived from FHSIS (i.e., SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | On-site FHSIS family health performance indicators check for accuracy by the DOH Reps and PHO coordinators | Mentoring, coaching | | M4 | M4 | M4 | M4 | | | | | | | | | 16 | |
| 2. FP commodity monitoring system (FPCMS) | 1.1E.a | TOT in FP commodity monitoring and inventory management conducted | Training of PHO logistics management team and MHOs/PHNs in FPCMS | Resource speaker, supplies and materials, training modules | | P1 | | | | | | | | | | | 1 | | |
| | 1.1E | FP commodity monitoring tool adopted | FP commodity availability monitoring by the FP Coordinator/DOH Reps quarterly for timely response to gaps identified | Mentoring, coaching | | | P1 | | | P1 | | | P1 | | | | 1 | | |
| | | Progress reports | Monitoring of TA implementation | Coaching | | | | | M3 | M3 | M3 | M3 | M4 | | | | | 16 | |
| **C. Advocacy to newly-elected officials (NEOs)** | 1.4B.c | LGU action plans to improve FP/MNCHN presented to NEOs in LGU conferences | Consultative meeting with LCEs and SB members for presentation of draft health agenda based on consolidated LGU actions | Resource person, STTA, advocacy materials, funding support | P1 | | | | | | | | | | | | 1 | | |

# Southern Mindanao

## Southern Mindanao

Southern Mindanao covers three regions, namely, Davao, SOCSKSARGEN, and CARAGA; five provinces - Agusan del Norte, Compostela Valley, Davao del Sur, Sarangani, and South Cotabato; and two cities - Davao City and General Santos City.

HealthGov's TA efforts in these areas have been directed toward a) providing technical support to the five provinces and two cities in implementing their JAC-concurred PIPH/AOP, particularly strengthening LGU financing, policy, and governance support to service delivery, and in improving MNCHN, FP, TB, and HIV/AIDS program coverage and performance; b) strengthening collaboration with the CHD and other regional partners to enable the CHD to take the lead in TA provision to LGU in line with the RCBI; and c) sustaining inter-CA collaboration.

Starting Year 4, all the USAID CAs, i.e., HealthPRO, TB LINC, A2Z, and PRISM2 had presence in all five provinces. HPDP is providing TA to Compostela Valley in implementing the Family Health Book. In Davao City and General Santos City HealthGov and HealthPRO are providing TA in specific interventions to strengthen local response to HIV/AIDS.

### Progress to date

The USAID technical assistance projects, specifically HealthGov's presence in the South Mindanao Region may be characterized by the extent, level, and nature of TA provision in the provinces. The first year was the "engagement and establishing partnerships" period, where the primary task was to introduce the USAID TA program to key regional and local partners and stakeholders. It was also a time for forging partnerships with CHD, PhilHealth, and Commission on Population (POPCOM) and in the provinces, with the Governor, PHO, Provincial Health Team Leader (PHTL), and other key local government officials.

The second year was the "planning year", the time when USAID TA became more visible and was demonstrated both at the regional and provincial levels. HealthGov, together with CHD Davao, CARAGA, and SOCCSKSARGEN provided TA to provinces (Sarangani, Compostela Valley) in formulating their respective PIPH. TA interventions focused on assisting the province prepare an in-depth situation analysis through the SDIR. The provincial planning teams were oriented on the DOH PIPH guidelines and tools. Moreover, HealthGov assisted General Santos City, Sarangani, Davao del Sur, and Agusan del Norte formulate a local AI Preparedness Plan, and strengthen local capacities in AI preparedness and response by training LGUs and communities in CBEWS. HealthGov started providing TA to South Cotabato in updating and enhancing its CSR plan. Inter-CA collaboration was further strengthened. The CAs collaborated in organizing the Inter-CA PIR to jointly analyze the health situation and agree on the overall direction of Inter-CA TA provision to the provinces. The CA agreed to adopt the "provincial handle" approach to provide the pathway to achieving a common set of goals that are responsive to SO3 concerns and the needs of the provinces.

In Year 3, HealthGov's TA aimed to "support provinces implement the PIPH, particularly interventions that would lead to improving FP, MNCHN, TB, and HIV/AIDS performance and health outcomes." At the same time, HealthGov collaborated with the CHD in providing technical support to South Cotabato, Sarangani, and Compostela Valley in preparing their Annual Operation Plan, and to Agusan del Norte, Davao del Sur, and General Santos City in the formulation of PIPH/CIPH. TA was provided by the different CAs to LGUs within the context of the provincial handle and support interventions related to SO3 concerns in the PIPH and AOP. It was during this time that the CAs became more conscious of the need for an inter-CA

approach to TA provision. The inter-CA group worked in close collaboration with the CHD-PHTO, particularly in the conduct of technical reviews and completion of PIPH and AOP; provision of follow-on TA in SDIR; facilitating access to the 2008 FP/MNCHN grants; installation of CBEWS in the high-risk municipalities of General Santos City, Sarangani, Davao del Sur, and Agusan del Norte; and health promotion interventions, e.g. Strategic Communication Package (SCP), health events, and social mobilization planning during GP. Towards the end of Year 3, the project started the capacity building for and engagement of local TA providers to assist the provinces in organizing and conducting SDIR and formulating the MIPH in Sarangani.

***RCBI.*** As the provinces and highly urbanized cities (General Santos City and Davao City) geared up for the implementation of their P/CIPH and AOP, the CHD had to be ready to respond to the TA needs of the LGUs. In response, the DOH launched the RCBI. The initiative is supported by USAID, the European Commission (EC), and other Sector-wide Development Approach for Health (SDAH) partners. As a starting point, the CHD was tasked to develop province-level F1 Implementation Support Plans and the USAID CAs was tasked to support this effort.

In June 2009, HealthGov participated in the regional orientation-cum-workshop on RCBI for CHD and TA providers from the Visayas and Mindanao to identify priority TA areas of the LGUs and CHD, assess the capabilities of LTAPs, and identify potential contractual mechanisms. This activity provided opportunities to identify and asses the capacities of CHD, development partners, and LTAPs (individuals, government and private institutions, academe) to respond to the challenges of health sector reform.

Some concerns were raised, e.g. the ability of CHD to spend large amounts of available resources within a limited timeframe. Standard government procurement rules will apply to the contracting of LTAPs by the CHD and these procedures are known to be circuitous. The RCBI TWG agreed to explore mechanisms to manage the circumstances surrounding Government accounting and auditing rules on contracting professional services. It was anticipated that any large-scale outsourcing of TA activities by the CHD to LTAPs will require considerable time and effort starting from writing the terms of reference to procurement process, and contracting will not be in place until early 2010. Given this consideration, TA provision to LGUs would initially be dependent on the CHDs and the development partners' capacities.

There are two main approaches in supporting RCBI in Years 4 and 5. First, HealthGov will continue to support the CHD in RCBI implementation (CHD taking the lead). The project will help the CHD respond to the TA needs of LGUs that are consistent with the SO3 priorities and the PIPH and AOP, and are within the context of HealthGov's provincial TA plan. HealthGov will mobilize in-house staff and engage LTAPs in the delivery of TA interventions until the CHD are ready to implement the outsourcing of services. In Regions 11, 12, and CARAGA, HealthGov will coordinate its assistance with the assigned primary TA provider – EC MHSPSP in 11 and 12, and Spanish Grant holder in CARAGA.

In pursuit of RCBI, HealthGov addressed the concern raised by the CHD Davao Director regarding the legitimacy of HealthGov's TA packages on SDIR and SDExH. The following events were organized jointly by HealthGov and CHD Davao to address the issue.

1. *CHD-Davao Orientation Workshop on SDIR and SDExH***.** HealthGov conducted an Orientation Workshop on SDIR and SDExH in response to the request of the CHD Davao Director to orient the CHD program coordinators and DOH Representatives on HealthGov's TA packages and to harmonize these with the existing DOH tools on program

implementation review and continuing quality improvement (CQI). The orientation also aimed to strengthen the capacities of program coordinators and DOH Representatives to provide technical assistance to LGUs in SDIR and SDExH. A total of 25 CHD Davao personnel composed of Program Coordinators, F1 Team, and the Provincial Health Team Leaders of Compostela Valley, Davao Sur, Davao Norte, Davao Oriental, and Davao City participated in the orientation workshop. There were nine facilitators, six from HealthGov and three from PRISM2.

Major points reached during this activity include: 1) the regional harmonized PIR and SDIR processes, tools, and indicators will be named Integrated PIR (IPIR), which will include all programs and will be conducted annually. However, the DOH Central Office- initiated individual program PIRs may still be conducted as directed; 2) organize a technical committee composed of the CHD cluster heads, CHD Planning Unit, CHD HIMU, and a HealthGov representative to review and finalize the harmonized indicators to include definitions and formulae for computations; A meeting will be conducted after the indicators have been finalized to discuss the adoption of the pre-assessment process of SDIR (with PHTL); 3) there is a need to maximize the results of the PIR (e.g. as advocacy tool to get support); 4) there is a need to align the PIR/SDIR with other LGU processes, i.e., synchronize the conduct of PIR with LGU planning and budget cycle and the DOH's call for submission of AOP. On SDExH, the agreements include: 1) the CHD-Davao (CQI) SSC technical assistance team to be included in the Phase 3 SDExH training for Compostela Valley Provincial Hospital; 2) DOH senior officials to be invited to the ceremony on Recognizing Achievements in SDExH at the Compostela Valley Provincial Hospital; and 3) the CHD-Davao (CQI) SSC TA team to be included in the SDExH training for COMMMONN ILHZ.

To date, the IPIR technical committee has come up with the list of service delivery indicators, including the definition and formulae for computation based on FHSIS version 2008. The CHD LHSD Chief, together with the Planning and RHSIS unit heads, reviewed and approved the IPIR indicators and agreed to adopt the SDIR process, i.e., pre-workshop activities and the provincial workshop. The IPIR guidelines will be written by the Planning and RHSIS unit heads, and upon approval by the Director, will be implemented in all provinces and cities in Region 11.

2. *Regional Implementing and Coordinating Team (RICT) CARAGA Region***.** HealthGov participated in the RICT-CARAGA meeting in April 2010 to present and advocate for the approval of the conduct of SDExH in one ILHZ in Agusan del Norte. The meeting was highlighted by the attendance of officials from the DOH and the provinces and cities in the region who were oriented on the concept and principles of SDExH and the results of its application in Misamis Occidental.

   Finally, the following were agreed upon with regard to the implementation of SDExH: 1) SDExH as a CQI tool will be offered to LGUs in response to their identified needs and demand/request; 2) SDExH will be harmonized with the existing DOH guidelines and tools; and 3) CHD CARAGA will capacitate its CQI team on SDExH in the context of CARAGA as pilot region for the PhilHealth Benchbook for Outpatient Services. Given this context, the PHO of Agusan del Norte requested CHD CARAGA to allow them to proceed with the implementation of SDExH in BueNasCar ILHZ.

3. *RICT meetings of CHD Davao and CARAGA and CHD-SDAH partners meeting of CHD SOCSKSARGEN*. These meetings provided an opportunity for the CHD to update the

development partners, P/C LGU Health Officers, Chiefs of DOH-managed hospitals, and heads of DOH attached agencies on its 2010 directions and priorities in terms of policies and projects. Development partners, on the other hand, oriented the CHD and LGU health officers on their TA products to increase their awareness and appreciation of the relevance and usefulness of the TA.

4. *Orientation on TA Products and Joint CHD-Development Partners TA Implementation Planning.* HealthGov, together with the other CAs, collaborated with the CHD F1 team in organizing and conducting the orientation. The objectives of this activity were to a) discuss the health situation and challenges of the region; b) identify the TA needs of the provinces based on the 2010 AOP and the results of the F1 regionalization workshop in October 2009; c) discuss the basic concepts, principles, and policy guidelines governing TA provision to help LGUs achieve their health goals; d) discuss the basic concepts of the TA products, and the status of product development and/or implementation in the provinces in response to USAID's and other development partners' commitment to help in the implementation of the 2010 AOP; and e) formulate joint CHD-Development Partners TA implementation Plan for LGUs.

   The CHD technical staff appreciated the discussion on the TA products. Many of them realized that the CHD staff, both the program coordinators and DOH Representatives also to need learn and be capacitated on these TA products/packages to enable them to provide TA to LGUs. While the PHTLs have high appreciation of the LGU needs and local health situation and are aware of the general concepts underlying the critical interventions to address local health challenges to improve health performance and outcomes, most of them do not have complete information on the status of TA and fund support to PIPH/AOP implementation. This is an area which the CHD Executive Committee and/or the HSR team can address so that the PHTL would be equipped to inform, negotiate, and advocate with LCEs. The development partners should also be able to design and implement capacity building programs for PHTLs to further enhance their competencies as frontline TA providers and health advisors to LGUs.

   In term of outputs, CHD Davao was able to identify the TA needs of the CHD and LGUs and, correspondingly, the development partners matched these needs with their TA support based on the TA products that are now ready to be provided to LGUs through the CHD. For CHD SOCCSKSARGEN, the TA needs were not identified because the LGU AOPs do not have clearly-articulated TA needs. Thus, the agreement was for the PHTL to identify and validate the TA needs together with the PHO and once these are identified, the CHD and development partners will sit down to identify the mechanisms to jointly implement the TA interventions. The CHD Director pointed out that his team has already identified their TA needs and they are just waiting for the development partners' proposal on how these TA needs will be appropriately responded to. On the other hand, CHD Caraga has given HealthGov and the other CAs the go signal to provide TA to Agusan Norte based on their AOP. The RD shared the CHD's work plan for 2010 and articulated that any other activity outside their work plan cannot be assured of their participation.

   ***Collaboration with the CHD and other regional partners***. HealthGov, along with the other USAID CAs, worked toward strengthening collaboration with the CHD and other regional partners through the following mechanisms: a) holding regular meetings and consultations with the CHD Directors, Assistant Regional Directors, concurrent F1 point persons, and the other members of the F1 core team; b) participation in CHD-initiated activities like the RICT meetings; and c) organizing coordination meetings with other SDAH partners to make

functional the coordinative mechanism to support PIPH/AOP implementation at the local level.

***Sustaining inter-CA collaboration***. The USAID CAs continued to interface and get their acts together, particularly in dealing with LGUs, CHD, and other TA partners. Inter-CA collaboration was best demonstrated during the start-up activities of TB LINC in South Cotabato, Agusan del Norte, and Davao del Sur; the *Garantisadong Pambata* April campaign, and the CHD orientation on the TA products and joint TA implementation planning. While the CAs committed to work as one, there has been a tendency for CAs to focus on their individual TA activities to be able to achieve their expected deliverables, thus, failing to synchronize their respective TA interventions to achieve optimum benefits in terms of capacitating CHD and LGU counterparts.

**Year 5 Priority Interventions and Expected Results**

At the regional level, TA in Year 5 will focus on the following:

- Strengthening the existing links and mechanisms in mobilizing the CHD and PHTO in TA provision to LGUs, i.e., training of trainers in the tools developed by HealthGov, assisting (coaching) the CHD and DOH Representatives in actual TA provision to LGUs;
- Creating opportunities for the LTAP and the CHD to collaborate and discuss future engagements in TA provision to LGUs and institutionalizing the TA products;
- Joint monitoring and coaching in completing the TA activities in the provinces; and
- Engaging the CHD and DOH Representatives in documenting the progress and results of TA activities in provinces, including success stories; and
- Developing with the CHD and PHO, a sustainability plan to ensure that the interventions that worked will be scaled up and sustained, and that lessons learned in the implementation of the TA interventions are summed-up and documented.

At the provincial level, HealthGov will focus on TA provision to ensure the LGUs' achievement of health sector outcomes. The following TA interventions will be implemented to improve key management systems to sustain service delivery, improve financing of key health programs, enhance the performance of service providers, strengthen advocacy for financing and delivery of health services at the local level.

- Data quality and utilization
  - FP current users DQC in 2 provinces, 2 cities and 24 MLGUs
  - Other family health (SO3) indicators DQC in 2 P/18 M/C LGUs
  - CHLSS in South Cotabato and General Santos City
- FP/CSR/MNCHN plan implementation
  - Acceleration plans on Integration of FP in EPI/post-partum services and maximizing utilization of MNCHN services in 5 P/33 M/C LGUs
  - 5-year CSR+ forecasting using FP validated data in 2 P/26 M/C LGUs
  - CSR+ planning with NGO/CSO participation and inputs in 2P/26 MC LGUs
  - CSR+ policy developed with NGO/CSO participation and inputs in 1 P/11 M/C LGUs
  - Annual training plan prepared as integral part of the AOP in 2 provinces
  - ICV monitoring system installed at the PHO in 5 provinces and 55 M/C LGUs, i.e., ICV monitoring plan, monitoring conducted by PHO and DOH Reps and results submitted to CHD

- SDExH (CQI program) with community participation mechanism completed in BueNasCar ILHZ (Agusan del Norte) and COMMMONN ILHZ (Compostela Valley)
- Accessing MNCHN grants: All 5 provinces have accessed the 2009 and 2010 MNCHN grant and utilized this fund for MNCHN activities and procurement of FP commodities
- Local NHIP implementation
  - Orientation Training in NHIP using the BDR approach in 3 P/29 M/C LGUs
  - PhilHealth accreditation focused on renewal of accreditation of existing accredited facilities in Agusan del Norte (11 OPB, 2 MCP); Compostela Valley (11 OPB, 11 DOTS, 1 MCP); Sarangani (7 OPB, 1 MCP); and South Cotabato (11 OPB), and support to assessment and application for new accreditation
  - Filing/claiming of benefit reimbursements and formulation of a management plan for the PhilHealth capitation and reimbursement funds in four provinces (except Davao del Sur)
- Integration of health plan in LGU development plan (PDPFP, CDP-ELA) in 3 P/29 M/C LGUs; integration of AOP into LGU annual investment plan in 3 P/29 M/C LGUs; and installation of PME at the provincial level in 5 provinces
- Logistics Management
  - FPCMS in 5 P/55 M/C LGUs through the CHD and DOH Representatives and PHO
  - Stock Inventory Monitoring System initiated in 2 P/18 M/C LGUs as pilot.

At the end of Year 5, HealthGov would have been able to hand over to the CHD and the PHO the following:

- TA products that were developed and implemented (modeled) in LGUs;
- Documentation of the results of implementation of the TA products in the form of Technical Notes;
- Profiles of LTAPs that were engaged to provide TA to LGUs; and
- Documentation of LGU success stories.

## Agusan del Norte

Agusan del Norte is one of the F44 (Others) provinces. It is composed of 10 municipalities and one city and has a population of 314,027 based on 2007 NSO Census of Population with 58,180 households. The province has an annual population growth rate of 1.32% and a poverty incidence rate of 56.35% in 2009.

**The Health Situation: Trends in SO3 Indicators**

The overall performance of the province in 2006 across all SO3 indicators fell below the national performance standards except for SBA, Vitamin A coverage and TB. The province consistently had a very good performance in TB prevention and control for the past four years (2006-2009) where significant strides have been made in CDR, CR and CNR. Low performance, however, is notably alarming in child nutrition indicators particularly the child diarrhea treated with ORT and cases of child pneumonia treated with antibiotic where the ratings of 16% in 2006 for both indicators significantly dropped to single digit in 2009. The national standard for the two indicators is set at 100%. For child nutrition indicators such as Vitamin A coverage and DPT3, the province is gaining and sustaining the improvement but the FIC dipped below the standard to 93% in 2009. Infant deaths are still high at 20 in 2009 though decreasing from 2007; however, a 44% increase in infant deaths was recorded between 2006 and 2007.

Most maternal health indicators have not achieved national standards such as antenatal care services, facility-based deliveries and contraceptive prevalence, however, a big improvement is seen in terms of facility-based delivery performance from a low rate of 17% in 2006 to 58% in 2009. CPR and SBA indicators are gradually increasing but a different trend is observed in terms of percentage of pregnant women getting adequate antenatal care services. For 2009, only 67% of pregnant women had at least four antenatal care visits. This rate is the same as in 2007 but lower than 2008's 80 percent.

The results of the enhanced 2009 Service Delivery Implementation Review (SDIR) indicated varying factors of performance and non-performance of the province based on selected health performance indicators. Despite a generally improving performance on maternal health, antenatal services and obstetrical care of pregnant women are not adequate and facility-based delivery at the community level is low. This resulted to more deliveries, including high risk pregnancies, delivered at homes which are handled by traditional birth attendants. The inadequate capability of rural health centers and hospitals to handle deliveries is also among the factors that led to five (5) maternal deaths in 2007, six (6) in 2008 and eight (8) in 2009. Immediate causes of deaths include post-partum hemorrhage, post-partum eclampsia and pregnancy induced hypertension, which are all preventable in nature. The results of a review conducted shows that delays in different levels contributed in the increasing number of maternal deaths—delay in seeking maternal care, delay in seeking appropriate care and delay in receiving care.

The SDIR results also showed the municipalities that are consistently performing low in MNCHN services are those belonging to the GIDAs particularly, Las Nieves and RTR, where the services of the doctors, PHN and RHMs are limited because of staffing concerns.

Affecting the low utilization of FP and MNCHN services as evidenced by slow performance in CPR, 4ANC, FBD, CD ORT and CC Pneumonia treated with antibiotic is insufficient quantity of Vitamin A and Iron supplements for pregnant and lactating women because the LGUs do not allocate enough budget for these commodities. In the previous years, the PHO procured and

distributed logistics to RHUs on the assumption that the MLGUs will procure the commodities using PhilHealth capitation fund. Furthermore, pregnant women from far-flung and hard to reach *barangays* cite distance and cost of transportation as problems. While referral of high risk pregnancies to higher level of care is being done, there are instances where referral is not followed by the pregnant women because it requires additional money and time. In short, poor access to financial support and the geographic location are factors that impede effective delivery of MNCHN services. In terms of behavior, women only seek consultation at the health center if they already experience quickening.

On child health and nutrition, the province did not achieve the national standard for FIC but achieved 95% in Vitamin A coverage. Agusan del Norte is the regional awardee on GP Champ. The reasons cited for the dip in FIC are low motivation of the staff to travel to far-flung *barangays* due to peace and order situation and bad road network. Also, the MHO and PHNs require a more proactive supervision.

The consistently good performance of the province on TB prevention and control program from 2006 to 2009 is attributed to the following initiatives: (a) the PHO established an External Quality Assurance (EQA) system for the TB program, and (b) in March 2007, the Provincial Hospital put up a public-private mix DOTS unit in partnership with the Agusan del Norte Medical Society and other private medical practitioners. No additional PPMD unit was organized in 2008. Table 1 shows the status of performance in selected health indicators in the Province of Agusan del Norte as reported in 2009 FHSIS.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 36 | 29 | 34 | 44 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 71 | 67 | 80 | 67 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 65 | 67 | 67 | 72 | 80 |
| 4 | Percent of facility-based deliveries | 17 | 17 | 32 | 58 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 76 | 78 | 80 | 81 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 88 | 99 | 95 | 93 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 94 | 91 | 96 | 95 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 16 | 12 | 6 | 5 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 16 | 16 | 15 | 7 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 75 | 88 | 73 | 94 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 96 | 95 | 91 | 91 | 99 |
| 12 | TB cure rate (%) | 115 | 108 | 129 | 131 | 85 |

Source: PHO FHSIS 2006-2009

**The Response: TA Interventions and Results**

To address the pressing health challenges, the province through the provincial and municipal LGU health offices formulated its Provincial Investment Plan for Health (PIPH 2009-2013) with technical support from CHD Caraga and HealthGov. The approval of the PIPH and the AOP jumpstarted the implementation of the LGU-led health reforms in the province. The PIPH contains critical health goals, strategies and interventions as well as the investments required to achieve the desired health outcomes in the medium term. The DOH mobilized technical assistance and development partners to assist the province in the PIPH implementation, namely, USAID – HealthGov, PRISM2, A2Z, TBLINC and HealthPRO, Spanish Grant i.e. *Fundacion Humanismo y Democracia* and AECID, Global Fund Malaria.

HealthGov's technical assistance and interventions were focused on assisting the province achieve increased skilled birth attendants and facility-based deliveries by improving LGU capacities in managing the PIPH/AOP implementation to: (a) better coordinate and harness resources for health that are generated from DOH, donor agencies and PhilHealth financing; and (b) to strengthen partnerships with private sector and communities for health service delivery. The specific TA interventions and the corresponding results are indicated below.

- PHO technical staff and DOH Reps were trained in the strategy of integrating FP into EPI/post partum services and maximizing utilization of MNCHN services. The provincial team took the lead in rolling out the implementation to five municipalities by capacitating the five RHU staff to formulate action plan to accelerate coverage and service delivery performance in FP and MNCHN services.
- HealthGov assisted the PHO in preparing the annual training plan based on the health human resource capacity profile generated during the EPIR internal assessment. Twenty RHMs were trained in FPCBT 1 and 20 RHMs and PHNs were trained in CMMNC. The PHO in partnership with HealthGov sent nine (9) RHMs to Northern Mindanao Medical Center in Cagayan de Oro City for Life Saving Skills Training. Nasipit RHU, the station of one of the trained RHMs, has been refurbished to comply with the MCP accreditation requirements with support from *Fundacion Humanismo y Democracia* (Spanish Grant).
- Leveraging the PIPH and 2010 AOP, AICED another Spanish donor agency committed PhP18 million to Agusan del Norte to refurbish RHUs and BHS in GIDA areas. To complement the facility improvement, the PHO will send 18 more RHMs to LSS Training in two batches, i.e. nine RHMs in September and another nine (9) in November 2010. HealthGov facilitated the acceptance of the RHMs in the LSS training program of NMMC.
- The PHO FP, MNCHN program coordinators, DOH reps, MHOs and PHNs of 11 RHUs/CHO were oriented on the principles and concept of Informed Choice and Voluntarism, and the ICV compliance monitoring. This resulted to commitments among MHOs and PHNs to adhere to ICV principles and concepts in the provision of FP services in their health facilities.
- BueNasCar ILHZ composed of three (3) RHUs and two (2) hospitals, the Agusan del Norte Provincial Hospital and Nasipit District Hospital, embarked on its CQI program, which is anchored on the provincial thrust to strengthen the referral system between the BHS-RHU and hospitals to provide quality preventive and curative health services. Central to the CQI program is to improve quality of MNCHN-FP services in the RHU and hospitals. HealthGov was given a mandate by CHD Caraga to provide TA to the PHO and BueNasCar health personnel in implementing its CQI through SDExH. The PHO technical staff and DOH Reps were trained as facilitators for SDExH. The health personnel in these facilities have completed the SDExH Phase 1 and 2 modules. With the completion of the two (2) phases of

SDExH, the service vision, service values, and local service standards were formulated. These health facilities have conducted an assessment on current level of achieving the local service standards and prepared a standard improvement plan.

- HealthGov with CHD and PhilHealth Caraga assisted the PLGU through the Health Sector Reform Action Group (HSRAG) in assessing the status of PhilHealth Sponsored Program Multi-payer scheme to determine its performance and results, issues and problems encountered, and identify recommended actions for the Governor's decision. To date, the HSRAG has identified recommendations to address issues to improve (i) enrollment, (ii) identifying the indigent families using CBMS and DSWD proxy means test, (iii) collection of premium payment from *barangays* and families, and MLGU, (iv) facility accreditation specifically DOTS and MCP, (v) reporting and claims, and (vi) benefit utilization.
- In support to localizing NHIP implementation, the province allocated PhP4.7M, the MLGU contributed PhP2.6M and the *barangays* and families put in another PhP1.3M for premium payment of NHIP Sponsored Program. The PhilHealth capitation fund was fully allocated and transferred to M/CLGU by the Governor so that it can be used to fund FP, MNCHN, TB, STI, and other health services.
- The Governor supported the health program as shown by the increase in the PLGU's budget by 31% from PhP119M in 2007 to PhP157M in 2010. The bulk of the budget allocation went to facilities improvements and operations of six hospitals. All 11 RHUs have acquired OPB accreditation from PhilHealth, three are MCP-accredited (Jabonga, Magallanes, and Nasipit) and four are TB DOTS-accredited (Kitcharao, Las Nieves, Magallanes, and Nasipit).
- HealthGov assisted the PHO prepare the documentation requirements to access the 2008, 2009, and 2010 DOH MNCHN grant. This resulted in CHD Caraga's transfer of PhP624,297 from the 2008 MNCHN grant to the provincial government, which was distributed to the 11 LGUs. In July 2010, CHD awarded another PhP285,000.00 from the 2009 MNCHN grant based on the province's domain 1 performance of which PhP115,000.00 was released and transferred to the PLGU. The MNCHN grants are additional funding sources for FP and MNCHN activities to capacitate service providers, procurement of FP commodities, and drugs and supplies for maternal and child, nutrition services, and monitoring and supervision activities.
- HealthGov assisted the PHO in planning and conducting the annual enhanced PIR using the SDIR tools/guide. The results of EPIR were utilized in the preparation for the PIPH and the AOP/AIP. CSO/NGO representatives of the PDC and the Local Health Board participated and provided inputs in the EPIR and health planning processes. The LGU also formulated local policies in support of priority health programs. For maternal health, the SP enacted an ordinance prohibiting *hilots* to attend to child deliveries and newborn care in support to the national policy on MNCHN.
- In the 3rd quarter of Year 4, the PPDC requested TA in integrating PIPH into the LGU development plans, i.e. PDPFP, LDIP, and AIP to ensure increased local funding and better complementation of resources. In response, HealthGov fielded a STTA and the Regional Governance Coordinator to assist the PPDC and PHO in undertaking the integration of PIPH to the PDPFP. To date, the PHO, PPDO, PBO, and SP on Health participated in a facilitated workshop to start the integration process, which resulted in a revised PDPFP document that has a PIPH dimension and the PIPH that is consistent with and supportive of the development objectives of the PDPFP and vice versa. The intended results aside from integration of PIPH in the PDPFP are inclusion of health in the LDIP and the AIP and the set of health legislative agenda to support the PPAs' implementation. The PPDC and PHO are the prime movers in the integration of health in the CDP-ELA of the 11 LGUs.
- HealthGov through OIDCI and JSI Deliver consultant assessed the logistics management system, which made the province qualify as pilot area for the implementation of the FP Commodity Monitoring System and Stock Inventory Management System. In September, the

PHO, MHOs, and PHNs will be trained in the logistics management tools through HealthGov's TA.

**Remaining Gaps and Challenges**

The major challenge encountered is the inadequate capacity of the Provincial Health Office to manage, coordinate and implement the various activities of the approved PIPH/AOP. This could be due to the limited number of personnel or no motivation for the existing health personnel because of inadequate capacity building activities that will help them better perform their duties. This situation in one way or the other hampered the full implementation of the TA interventions that were committed by HealthGov and the other CAs. Other HealthGov TA interventions were held in abeyance so that the PHO and RHU staff can focus on implementing other activities that were funded by 2009 DOH-CHD. The national election period also slowed down the implementation of the activities on the ground for almost four months.

**Year 5 Priority Interventions and Expected Results**

In year 5, HealthGov's technical assistance and interventions will be focused on further improving CPR and FIC, and sustaining increases in maternal health i.e. 4ANC, SBA, FBD, and child health and nutrition. This would entail consolidating and completing the TA interventions to support improving service delivery and health systems, specifically the following:

A. Support to improving service delivery in health:

- Assist the PHO and DOH representatives in completing the FP current users' data quality check in all 11 RHUs/CHO.
- Support PLGU in formulating the CSR+ plan
- Assist PLGU/ 5 CLGUs in FP/CSR and MNCHN plan implementation specifically integration of FP into EPI and maximizing utilization of MNCHN services in at least 5 CLGUs in order to accelerate service delivery performance in FP, maternal and child, and sustain good performance and coverage in Vitamin A.
- Capacity building of FP/MNCHN service providers by assisting the PHO update the data base on service providers' capacity profile
- Support the PLGU through the PHO access and manage the 2009 and 2010 DOH MNCHN grant to fund FP-MNCHN activities and procure FP commodities for the component LGUs.
- Assist PLGU and 3 MLGUs improve service delivery and quality of care thru SDExH with community participation in 2 hospital and 3 RHUs.
- Assist the PHO in institutionalizing ICV compliance monitoring system.

B. Strengthening family health program support: financing, policy and governance

- Assist the P/11 M/C LGUs in improving local NHIP implementation specifically to train the LCEs on PhilHealth using BDR approach and in formulating a NHIP plan
- Support the integration of health plan (PIPH-AOP) in LGU planning and budget
- Assist the PPDO and PHO complete the mainstreaming of the PIPH into the PDPFP and CDP-ELA, LDIP and 2011 AIP.
- With CHD, assist PHO and RHUs in improving data quality through (i) training of MHOs, PHNs and RHMs on the tools on FP current users' data quality check and validation, (ii) with the PHO technical staff and DOH representatives assist the PHNs and RHMs in doing the FP current users and other SO3 indicators data quality check.

- Assist the PHO and RHUs in improving its logistics management for essential drugs and commodities specifically capacity building of key personnel on FP commodity monitoring system and Stock and Inventory Management System at the RHUs/CHO.
- Support the P/M/C health officers in increasing its advocacy for health by integrating health in the NEO program and maximize on-going activities to inform and mobilize LHB, LFC and LCEs on progress of PIPH-AOP implementation to generate support for health.
- Assist PHO and at least 5 RHUs in mobilizing NGOs, communities and private FP-MNCHN providers in implementing FP and MNCHN strategy

By the end of Year 5, HealthGov's TA in Agusan del Norte will result in:

- 11 RHUs/CHO have validated FP current users data (1P/11MLGUs)
- PIPH integrated in LGU comprehensive development plan and LDIP
- PDPFP document that has a PIPH dimension and the PIPH that is consistent with and supportive of the development objectives of the PDPFP, LDIP, and 2011 AIP committed LGU budget for priority health programs, projects and activities.
- Enhanced PIR conducted, the results of which are input to development of 2011 AOP/AIP (1P/11MLGU)
- Results of enhanced AOP presented to joint LHB-LFC and LCEs to generate support to health (1P/11MLGUs)
- PHO-PPDC together are mobilizing LHB and LFC to support health development agenda
- P/11 LGUs formulated CSR+ plan based on a 5-year commodity forecast
- P/11 MLGUs providing funds and procuring FP commodities, and providing full range of FP services based on the CSR+ plan
- PHO and11 RHUs with improved logistics management for essential drugs and commodities (1PLGU/11MLGUs)
- LGUs collaboration improved in implementing referral system and continuing service quality improvement in BueNasCar ILHZ
- PLGU through the PHO accessed and utilized 2009 and 2010 DOH MNCHN grant for MNCHN, FP activities and services
- Improved implementation of local NHIP using BDR approach (1P/11MLGUs)
- PHIC enrollment plan enhanced
- RHUs trained to effectively file and collect claims on DOTS and MCP from PhilHealth
- Improved management plan of PhilHealth capitation and reimbursements
- Province-wide annual training plan prepared as sub-plan of 2011 AOP
- LGU with continuing service delivery quality improvement system (1P/3MLGUs)
- SDExH Phase 1, 2, 3 training completed in BueNasCar ILHZ and ANPH, Service Improvement Plan implemented and LGU implementing SDExH received recognition and award
- ICV compliance monitoring system functional at the PHO
- LHB meetings held where health issues were discussed with inputs of civil society representatives (1P/5MLGUs)
- Community concerns and feedback on FP, MNCHN, TB presented and discussed by NGOs/CSOs to LHB/LDC (1/5MLGUs)
- NGOs/CSOs participated in CSR, SDIR, SDExH and other events (1P/5MLGUs)

**Priority TA Interventions and Activities**
**AGUSAN DEL NORTE**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP, MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.b | Quality of FP current users data checked and validated for accuracy in collection, computation and reporting | DQC for FP current users | Technical guide, resource persons and facilitators<br><br>In-house staff<br><br>Supplies/materials | **1P 10M 1C** | | | | | | | | | | | | 1 | 10 | 1 |
| | 1.1C.a<br><br><br><br>1.1B.b | 5-year commodity forecast and budget requirement determined using clean FP CU data<br><br>11M/C enhanced CSR+ plan drafted | CSR+ forecasting workshop and enhancing CSR+ planning workshop include inputs on CSR policy formulation | Technical guides, handouts, supplies<br><br>In-house staff as resource persons/facilitators<br><br>Provincial TA team as facilitators | | | **1P 10M 1C** | | | | | | | | | | 1 | 10 | 1 |
| | 1.1.B.c | CSR policy crafted | CSR policy formulation | | | | | **1P 10M 1C** | **1P 10M 1C** | **1P 10M 1C** | | | | | | | 1 | 10 | 1 |
| 2. Integration of FP into EPI and maximizing utilization of MNCHN services | | Progress report on LGU implementation with baseline data of indicators and its progress | Monitor LGU implementation of key action plan in integrating FP into EPI and maximizing MNCHN services | Coaching/mentoring to 5 RHUs<br><br>Resource person/facilitator<br><br>FOG | | | | | | | | | | | | | | | |
| | 1.1.G.b<br><br><br><br><br>1.4.C.b | LGUs collaborated in implementing referral mechanism to maximize FP/MNCHN services and facilities<br><br>LGU-NGO/CSO partnerships established for networking and referral mechanism for MNCHN and FP services | Partnership meetings of public-private FP-MNCHN providers in 5 municipalities | Resource person/facilitator<br><br>Provincial TA team as resource person/facilitator<br><br>Meeting cost - 5 MLGUs | | **1P 5M** | | | | | | | | | | | 1 | 5 | |
| 3. Capacity building of FP/MNCHN providers | 1.3A.b<br><br><br>1.3A.b | Province-wide training plan prepared as part of 2011 AOP<br><br>Database on service providers' capacity profile established | Meeting to consolidate capacity profile of service providers, install the database at the PHO and develop a training plan for service providers | In-house staff in the installation of capacity profile database, coach PHO Chief of Technical Division | **1P** | | | | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 4. ICV Compliance monitoring and reporting system | 1.3D.b | Provincial ICV monitoring plan developed (ICV compliance monitoring integrated in MNCHN-FP program monitoring) | Consultative meetings to discuss ICV compliance monitoring and consolidation of reports | In-house resource person<br><br>Pro-forma of ICV compliance monitoring forms and guide to ICV compliance reporting | **1P** | | | | | | | | | | | | 1 | | |
| | 1.3D.c | ICV compliance of FP-RH service delivery sites monitored and reported | | | **2M 1C** | **2M** | | **2M** | **2M** | **2M** | | | | | | | | 10 | 1 |
| **B. Continuing quality improvement (CQI) in family health service delivery** | | | | | | | | | | | | | | | | | | | |
| 1. SDExH with community participation | 1.3B.a<br><br>1.3B.d | SDExH Phase 1, 2, 3 trainings completed<br><br>LGUs implementing SDExH recognized | Training of RHU and hospital personnel in SDExH Phase 3 | With CHD and PHO technical staff as resource persons and facilitators<br><br>Training supplies and materials, training design and modules | | | | **1P 3M** | | | | | | | | | 1 | 3 | |
| | | Progress reports | Monitor the implementation of service improvement plan and achieving standards | In house staff - monitoring and coaching<br><br>PHO SDExH facilitators | **1P 3M** | **1P 3M** | **1P 3M** | | | | | | | | | | 1 | 3 | |
| | 1.3B.c | Service Improvement Plan implemented | Coach QHITs and QAPC in formulating and implementing action plan to implement community feedback mechanism | Resource persons | **1P 3M** | **1P 3M** | **1P 3M** | **1P 3M** | **1P 3M** | **1P 3M** | | | | | | | 1 | 3 | |
| **II. Strengthening family health program support - financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local NHIP Implementation based on benefit delivery approach | 1.2B.b | Local NHIP implementation plan prepared/updated | Consultative meeting to review and validate recommended actions on issues on PhilHealth enrollment and capitation fund management | Technical guides, resource persons<br><br>Meeting cum action planning design, facilitators<br><br>Coach PHO-HSRAG<br><br>Cost of meeting | **1P** | | | | | | | | | | | | 1 | | |
| | 1.2B.a | LGU officials trained in PhilHealth BDR | Orientation and training of key P/M/C LGU officials in PhilHealth BDR and rapid assessment on policy and operation issues of local NHIP implementation | Technical guides, NHIP toolkit, resource persons<br><br>Design, training materials and modules<br><br>In-house staff as resource persons/facilitators | **1P 10M 1C** | | | | | | | | | | | | 1 | 10 | 1 |
| | 1.2A.c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed | Meetings with HSRAG and Provincial Health Board to discuss policy support to implementation of NHIP activities | Technical guides, resource persons | | | | **1P 10M 1C** | **1P 10M 1C** | **1P 10M 1C** | **1P 10M 1C** | | | | | | 1 | 10 | 1 |
| | 1.2B.a | Application for accreditation filed | Orientation and consultative meeting with MHOs/PHNs to complete documentation requirements of PhilHealth accreditation for MCP and renewal of OPB and DOTS | PhilHealth-CHD as resource persons and facilitators<br><br>PhilHealth accreditation guidelines<br><br>In-house staff as facilitators | **10M 1C** | **10M 1C** | | | | | | | | | | | | 10 | 1 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.2B.b | Facilities accredited by PhilHealth (10 RHUs/1 CHO with OPB and DOTS accreditation; at least 6 RHUs with MCP accreditation) | Monitor progress of RHU accreditation | Coach PHO-DOH Reps/HSRAG in monitoring progress in RHU accreditation | | | **10M 1C** | **10M 1C** | | | | | | | | | | 10 | 1 |
| | | | Orientation meeting with LGUs to discuss the process and structure in availing claims from PhilHealth | In-house staff as resource persons | | | | **1P 10M 1C** | | | | | | | | | 1 | 10 | 1 |
| 2. Accessing and managing DOH MNCHN performance grant (2009 and 2010) | 1.2A.b | MNCHN grant accessed | Meeting cum action planning of PHO-MHOs on allocation of 2009 and 2010 MNCHN grant based on DOH MNCHN performance grant guideline | CHD as resource person/facilitator<br><br>Copy of 2009 and 2010 MNCHN guideline | **1P** | | | **1P** | | | | | | | | | 1 | | |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide AOP formulation | 1.1A.h | AOP (PIPH) prepared and integrated into CDP-ELA* | Workshop with the LGU planning officers and members of the Local Finance Committee (LFC) | Resource person, facilitator, activity design, tools and templates | | **1P 10M 1C** | **1P 10M 1C** | **1P 10M 1C** | | | | | | | | | 1 | 10 | 1 |
| | 1.4B.b | LHB-LFC meeting held to discuss 2011 health plan as integrated in the AIP | Joint LHB-LFC meeting to present 2011 AOP/AIP | Technical guide<br><br>STTA | **1P 10M 1C** | | | | | | | | | | | | 1 | 10 | 1 |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Data management improvement | 1.1C.d | Personnel trained in DQC for FP current users | Training of PHNs in DQC for FP current users together with CHD Caraga | Technical guides, handouts, supplies<br><br>In-house staff as resource persons/facilitators<br><br>Provinical TA team as facilitators | **6M** | **4M 1C** | | | | | | | | | | | 1 | 10 | 1 |
| 2. Logistics management system improvement | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Training in FPCMS and SIMS for PHO program coordinators and MHOs/PHNs | Technical guide/tools, resource persons and facilitators<br><br>Training design, modules, supplies and materials | **1P 10M 1C** | | | | | | | | | | | | 1 | 10 | 1 |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitor the implementation of FPCMS/SIMS in the province | | **1P 10M 1C** | | | | | | | | | | | | 1 | 10 | 1 |
| | 1.1E.c | Inventory management tool for essential drugs and commodities adopted | Monitor the implementation of SIMS in the province | Technical guide/tools, resource persons and facilitators<br><br>Coaching | | **1P 10M 1C** | | **1P 10M 1C** | | **1P 10M 1C** | | **1P 10M 1C** | | | | | 1 | 10 | 1 |
| | 1.1E.d | TOT in stocks and inventory management system (SIMS) conducted | Training in SIMS for PHO program coordinators and MHOs/PHNs | | | | | | | | | **1P** | | | | | 1 | | |
| **D. Advocacy to newly elected officials (NEOs)** | 1.4B.c | Community concerns and feedback on FP, MNCHN, and TB presented and discussed to NEOs | Utilization conference for NEOs to ensure that health concerns are included in LCEs priority agenda | Technical guide, resource persons<br><br>Supplies and materials | **1P** | | | | | | | | | | | | 1 | | |

## Compostela Valley

Compostela Valley was created in 1998 carved out from its mother province – Davao del Norte. It is composed of 11 municipalities with a population of 637,366 based on 2007 NSO Population Census. The province formulated its Province-wide Investment Plan for Health (PIPH) for 2006-2012 with technical support of CHD Davao and HealthGov and other CAs and was concurred by Joint DOH and Donors Appraisal Committee. The formulation of the said investment plan is critical in ensuring the support to the different health programs and forging partnerships to achieve better health outcomes.

### The Health Situation: Trends in SO3 Indicators

The provincial government is consistent in its effort to address local health challenges. The stable political climate in Compostela Valley, with a Governor who enjoys the support of all mayors and the two congressmen, which has not been the case the previous years, has facilitated the implementation of local health reforms in the health care delivery system. This resulted in increasing trend in service delivery performance; however, critical indicators of MCH program are still below the national standard.

The Provincial Health Office reported that from 2006 to 2009, maternal health showed an increasing trend in key indicators, particularly on 4 ANC visits (50%), facility-based deliveries (47%), and deliveries by skilled birth attendants (62%). However, the performance of the province on said indicators are still below the national benchmarks. On the other hand, the province reported CPR of 65% in 2009, maintaining its performance in 2008. Furthermore, 10 of the 11 municipalities reported CPR of 50% and above in 2009. The 2008 and 2009 figures are slightly higher that the 2006 and 2007 figures (62%) The FP data, although validated based on the reconciled report of the RHU and PHO would need further data quality check to ensure its completeness and correctness.

On child health, the PHO reported that FIC increased to 91% from 88 % in 2008. Both figures showed a marked improvement compared to the 2006 performance of 78%. Vitamin A coverage also increased to 101% from 87% in 2008, which is also an improvement from the performance in 2006 of 88%. Child diarrhea treated with ORT is reported at 95% and child pneumonia treated with antibiotic is 99.6%. The province's effort to improve performance in child health program showed promising results, particularly in managing child diarrhea, which significantly improved in the last four years (from 9% in 2006 to 95% in 2009). However, their performance on the Expanded Program on Immunization is still below the national benchmark (91% compared to the 95% benchmark).

In relation to TB prevention and control, the provincial average for TB case detection, TB cure rate and case notification rate exceeded the national targets from 2006 to 2009. In the TB Program Implementation Review, it was observed that while performance on the whole in TB is consistent with targets, area-wide variations in CNR and CR can be observed with half of the areas performing below par in one or both parameters. Mabini having low CNR and low CR is the poorest performing area indicating program weakness in being able to detect and cure TB. Areas with high CNR but with low CR such as Monkayo and Mawab, ranked next in the order of priority. These are followed by low-CNR and high-CR such as Maragusan and Pantukan, which need to improve case detection and sustain its ability to adequately cure TB. It was concluded that given their state of performance in CNR and CR, distinct set of interventions need to be applied in order to bring the province-wide performance closer to the national standards.

The PHO validated the 2009 FHSIS data with the RHUs, however, the focus of the data validation was only to reconcile the RHU and the PHO FHSIS monthly and quarterly report. Data quality checking was also done as part of the technical assistance to enhance the CSR plans of the province and the municipalities. Based on the findings of the data reconciliation and the data quality check under the CSR Technical Assistance, the PHO technical office and MHOs agreed to conduct data quality check in order to update the RHMs on FHSIS recording and reporting. This is to ensure correctness and completeness of health records.

The high CPR is attributable to the following factors – all RHUs provide FP counseling and services, the providers of NSV continue to make this service available at the RHU. Moreover, DRH, CVPH and Pantukan District Hospital are performing BTL services regularly in addition to service providers i.e. ten MHOs and 14 PHNs that were trained in FP CBT I and II. The challenge is to ensure that FP commodities are constantly available to meet the needs of the MWRA in the province. Based on the CSR Plus plan and policy assessment conducted by HealthGov, all of the municipalities are allocating for procurement of FP commodities, although service providers admit that these are not sufficient to ensure that the needs of their MWRA in their municipality are met. Utilization of the budget remains a problem due to some concerns with LGU processes e.g. prolonged procurement process, Six municipalities are implementing cost-recovery schemes or user's fee for non-poor clients so they can recoup the cost of purchasing the commodities and use the income to purchase constant supply of commodities but they do not have clear policies or systems in identifying the poor and non poor MWRAs.

Although the service delivery performance is generally improving, utilization of FP, MNCHN and TB services are affected by physical and financial access. Out of the 237 barangays in the province, 45 are far flung and hard to reach, and these are found in the municipalities of Compostela, Laak, Maragusan, Monkayo, Montevista, New Bataan, Maco, Mabini, and Pantukan. These barangays are characterized by high terrain, inadequacy of all weather road networks and could be reached only on foot such that people living in these areas are deprived of social services, such as health, education, and other social welfare services afforded by the government.

Poverty also plays a significant part in the ability of families to access health services. The relatively high incidence of poverty in the province means that a number of households or families in the municipalities are socially deprived. Low family income finds it difficult to access basic goods like food, shelter, clothing, and services like education, health, and nutrition. These families are also dependent on services that the government provides for free. In terms of health, this means a significant number of people still cannot afford health services without the assistance of the government and are competing for the government's scarce resources.

The P/M LGU have made substantial investments in PhilHealth enrollment over the years. In fact in 2009, the provincial and municipal governments invested a total of PhP15M to enroll about 30, 456 households. The province, however is still working for universal coverage for the PHIC sponsored program. Another concern in health financing is how to maximize the benefits from capitation and reimbursement given few accredited public facilities. To date, Compostela Valley has 11 OPB and DOTS accredited RHUs. Only 1 RHU (Maco) is MCP accredited.

The Governor has also allocated funds to upgrade hospital facilities and improve service delivery, which are among the priorities identified in the PIPH. The health budget appropriated by the PLGU to its four hospitals and the provincial health office is higher than the desired 15%. The total budget was further increased to P85M in 2009. The Compostela Valley Provincial

Hospital and Pantukan District Hospital received the biggest bulk of the budget for its infrastructure and service improvements. Other hospitals also received support by increasing its total budget and by hiring additional medical officers. The Provincial Health Office's budget was also increased and additional programs were implemented. The Outreach services especially for the hard to reach far-flung barangays and MNCHN and FP programs were given priority.

The critical interventions to improve MNCHN services that were identified in the JAC concurred 2009 and 2010 AOP were not implemented because the DOH and EC funding support have not been released. Upgrading of the RHU and BHS, and hospitals that were identified as BEmONC facilities has not started because of funding limitation. Procurement of equipment and supplies to furbish the birthing facilities is also affected by the unreleased of DOH and EC funds. Training of health personnel for BEmONC, CMMNC and CEmONC is dependent on the training schedules of CHD and the accredited training institution.

On a more positive note, Compostela Valley was awarded by CHD Davao the amount of PhP1,582,782 and another PhP1.6M from the 2008 and 2009 MNCHN grant. For the 2008 MNCHN grant, the PLGU utilized PhP1,405,504 for purchase of commodities, training of service providers, monitoring and supervision activities. The PHO has utilized the 2009 MNCHN grant for training and procurement of FP commodities and micronutrients for mothers and children. The high PLGU commitment to health remains unmatched by most of the municipalities. More than half of the 11 municipalities have difficulty in achieving the ideal 15% budget for health. The average health budget allocated for health is only about 8.33%. This is due to many reasons but in general, budget allocation depended mostly on the initiative of the health officer as well on the priorities of the LCEs. The percentage of MOOE per municipality is noted to be generally acceptable except for the municipality of Mawab causing the total average MOOE to be only 28%, against the desired 45% by 2010. Again, it is believed that decisions on budget allocations rely greatly on careful planning and the power to advocate to the LCEs by the RHU and PHO's management team.

With the fresh mandate of newly elected officials, the Governor decided to convene a Provincial Health Summit in order for the PLGU and MLGU to appreciate their current performance in implementing local health reforms and reaffirm its province-wide health goals and objectives. The Governor wanted this event to result in increased support of the 11 MLGUs to make the local health systems responsive and equitable. The two Representatives gave their all out support to the health and development agenda of the Province.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 62 | 62 | 65 | 65* | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 43 | 45 | 46 | 50* | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 41 | 33 | 54 | 62* | 80 |
| 4 | Percent of facility-based deliveries | 22 | 22 | 31 | 47* | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 78 | 76 | 77 | 91* | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 78 | 74 | 88 | 91* | 95 |
| 7 | Percent of children under 5 years of age who received | 88 | 88 | 87 | 101* | 95 |

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| | Vitamin A from a USG-supported program | | | | | |
| 8 | Percent of child diarrhea cases treated with ORT | 9 | 2 | 6 | 95* | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 99 | 100 | 99 | 99.6* | 100 |
| 10 | TB case detection rate (per 100,000 population) | 84 | 82 | 94 | 101* | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 89 | 87 | 83 | 88* | 99 |
| 12 | TB cure rate (%) | 125 | 116 | 123 | 133* | 85 |

*[1] 2006 FPS; 2 NOH; [3] 2008 NDHS; OP targets DOH pop'n projection*
*Sources: RHIS 2008, 2009*
*Note: * validated data recording based on data reconciliation between RHU and PHO, 2009 RHIS data*

### The Response: TA Interventions and Results

Given all these factors combined: the high support for health by LCEs, and additional funds for health generated from increased budget allocation by the PLGU and PhilHealth capitation and reimbursement, coupled with the committed DOH and EC funds to support PIPH/AOP implementation, TA interventions of HealthGov and other USAID CAs were focused on assisting the province achieve desired improvement in family health particularly a) MNCHN and FP practice by improving P/MLGU capacities in managing and coordinating implementation of PIPH/AOP, b) managing resources for health generated from DOH, development partners and PhilHealth and, c) strengthening partnerships with private sector and communities for health. The progress to date is the following:

- The PHO technical staff and DOH representatives were trained on the strategy of integrating FP into EPI/post partum services and maximizing utilization of MNCHN services. The staff of 8 RHUs were trained and assisted in the formulation of action plan to accelerate coverage and service delivery performance in FP and MNCHN services. Progress and results in implementing the strategies by the RHMs and BHWs will be reported in the coming months.
- HealthGov also assisted the PHO in preparing the annual training plan based on the health human resource capacity profile generated during the EPIR internal assessment. The database on the training courses attended by the service provider was updated as part of the formulation of the 2010 Annual Operations Plan of the province. Furthermore, Municipal Health Offices also conducted an inventory of capability-building needs for PHNs and RHMs in terms of FP, MNCHN and TB as part of the CSR plus planning. Based on the training plan, the PHO was able to prioritize training activities. CHD Davao trained 10 MHOs and 14 PHNs in FP CBT 1, and 10 MHOs and 8 PHNs in FP CBT II.
- In addition, the PHO FP, MNCHN program coordinators, DOH representatives, MHOs and PHNs of 11 RHUs/CHO were oriented on the principles and concept of Informed Choice and Voluntarism. This resulted to commitment among MHOs and PHNs to adhere to ICV principles and concepts in the provision of FP services in their health facilities. Moreover, the DOH representatives and the PHO FP Coordinator have conducted ICV compliance monitoring, and no vulnerabilities were noted in the 11 RHUs.
- The third and final phase of the Service Delivery Excellence in Health (SDExH) in the Compostela Valley Provincial Hospital was finally conducted, completing the whole SDExH cycle in the said hospital. As a result of the TA on SDExH, CVPH was able to develop their service delivery excellence vision, service values, clinical and facility cycle and standards. They were also able to assess gaps in implementing the service and clinical standards and

develop a Service Improvement Plan (SIP) to address the gaps. The skills and knowledge that the staff acquired from the two phases of SDExH helped them to develop policies and protocols that were required by the PhilHealth to uphold their accreditation as a level 2 health facility. In fact, the hospital was able to get 44 points out of the 50 points required by PhilHealth under the Benchbook standards. With phase 3 already completed, they are finalizing their rewards and recognition system for achievements in service excellence among their staff. Six RHUs of COMMMONN ILHZ have completed two didactic sessions under the SDExH TA. HealthGov will continue to coach and mentor the RHU staff in implementing respective SIP in order to achieve the local service standards that were identified.

- HealthGov continued its partnership with the Gerry Roxas Foundation (GRF) in providing TA to CVPH in establishing the Quality Assurance Partnership Committee to generate community participation and establish community feedback mechanism on service delivery and quality. The pilot project was completed in June of this year with very encouraging results. Through the project, CVPH and five municipalities were able to develop a system of gathering feedback from the community on the services of CVPH, relaying the feedback to service providers and translating them into concrete actions, policy development and/ or changes in operational standards.
- The implementation of Family Health Book (FHB) in 4 municipalities also contributed to the increase in FP MNCHN program performance and coverage. The 441 navigators were able to assist at least 4,757 families to improve their health seeking behaviors and increase the utilization of MNCHN and FP services. Similarly, the PHO, with assistance from HealthPRO is utilizing other sectors such as public utility vehicle drivers to educate families on FP. The increase in FBD is attributed to the increasing number of pregnant women delivering in CVPH and the 11 RHUs. The Governor increased budget for hospital improvement and operation so that all the hospitals would be able to provide maternal, newborn and child services. However, only one RHU is MCP accredited (Maco) and nine of 11 RHUs (except Maragusan and Laak) are birthing facilities.
- CHD Davao together HealthGov and the other CAs provided technical support to the PHO in the formulation of the PIPH and 2008-2009-2010 AOP. As a result, PIPH and 2008-2009, 2010 AOPs formulated and concurred by DOH and JAC. The approval of the health investment plan provided opportunities to access external funds to support implementation of critical interventions to address challenges on maternal, child health and nutrition, FP, TB and other infectious diseases. The province was able to access technical and funding assistance from DOH, donor agencies and development partners like USAID, EC, and Global Fund. HealthGov assisted the PHO in planning and conduct of annual enhanced PIR using the SDIR tools/guide. The results of EPIR were utilized in preparing the PIPH and AOP/AIP.
- The enhanced province-wide and municipal (11 municipalities) CSR plus plans have been completed through major TA activities which included: 1) three-day province-wide CSR plus planning; 2) two-day municipal plan enhancement writeshop, which were conducted on-site; and 3) one-day technical review of the provincial and municipal plans. These activities were implemented by the CSR Technical Assistance (TA) team, composed of program coordinators from the Provincial Health Office, DOH representatives and the Institute of Primary Health Care of the Davao Medical School Foundation, the Local Technical Assistance Provider (LTAP) for CSR.
- HealthGov assisted the PHO prepare the documentation requirements to access 2008, 2009 and 2010 DOH MNCHN grant. This resulted to CHD Davao's transfer of PhP1.582,782 and PhP1.6M 2008 and 2009 MNCHN grants to the provincial government. The MNCHN grant are additional funding resource for FP, MNCHN activities like training of service providers,

procurement of FP commodities and drugs and supplies for maternal and child, nutrition services, monitoring and supervision activities.

**Remaining Gaps and Challenges**

In view of the foregoing conditions in Compostela Valley, it is expected that the TA interventions which were started in the previous years will be completed, and the PHO will be assisted in sustaining the initiatives that were started and found effective. Assistance in improving its low indicators on 4ANC and FBD, and FIC will be undertaken utilizing the MNCHN framework for service delivery provision. Equally important is the support for FP/CSR/MNCHN plan implementation with particular focus on (i) assisting LGU procure FP commodities using LGU budget and MNCHN grant and distributing these commodities to RHU and BHS, (ii) Policy advocacy will be pursued to ensure that CSR plan and policy are implemented i.e. LGU will provide budget allocation and procure commodities and continue providing broad range of MNCHN and FP services in all health facilities, (iii) complete the third phase of SDExH implementation in COMMMONN ILHZ including the community participation and feedback mechanism, and (iv) monitor and coach the 8 RHUs in implementing the strategies of integrating FP to EPI and post partum services, and maximizing utilization of MNCHN services in accelerate improvement of FP-MNCHN performance. Moreover, external funding for health will still be available so the TA in MNCHN grant accessing and utilization is also a priority. To ensure quality of care in FP, ICV compliance monitoring will be installed at the PHO and the FP and MNCHN Coordinator together with the DOH representatives will conduct ICV monitoring in health facilities to obtain information from the clients and service providers.

In terms of strengthening family health program support, the TA on financing, policy and governance will be provided to ensure that at the end of year 5, the P/M LGU have improved capacities in planning, financing, implementation and monitoring programs, projects and activities in health at all levels. The PHO and RHU will be assisted in completing the data quality check of FP and other family health indicators and use the validated data for planning and decision making. The PHO and PPDO will be trained on monitoring of their AOP implementation using the PME tool to track if the province and its component municipalities are towards achieving their planned objectives. The PHO and RHU personnel will trained on logistics management, particularly in setting up the FP Commodity Monitoring System (FPCMS) Finally, the PHO and MHOs will be assisted in the presentation of the local health situation and challenges to the newly-elected Governor and Mayors and advocate for increased support for financing and service delivery.

**Year 5 Priority Interventions and Expected Results**

In Year 5, HealthGov's technical assistance and interventions are focused on further improving MNCHN i.e. ANC, FBD, FIC and sustaining increases CPR, SBA, Vitamin A. This would entail consolidating and completing the TA interventions to support improving service delivery, health systems and health care financing, specifically the following - .

A. Support to improving service delivery in health

- Assist the province in CSR+ plan formulation
- Assist P/8 MLGUs in integration of FP into EPI and maximizing utilization of MNCHN services to accelerate service delivery performance in FP, maternal and child, and sustain good performance and coverage in Vitamin A.

- Support the PLGU through the PHO access and manage the 2009 and 2010 DOH MNCHN grant to fund FP-MNCHN activities and procure FP commodities for the 11 component LGU.
- Assist PLGU and 6 MLGUs improve service delivery and quality of care thru SDExH with community participation in CVPH and 6 RHUs of COMMMONN ILHZ.
- Assist the PHO in institutionalizing ICV compliance monitoring system.

B. Strengthening family health program support: financing, policy and governance

- Assist the P/11 M-C LGUs in improving local NHIP implementation specifically to train the LCEs on PhilHealth using BDR approach and in formulating a NHIP plan.
- Assist in monitoring the progress of accreditation for 11 RHUs.
- With CHD, assist PHO and RHUs in improving data quality through (i) training of MHOs, PHNs and RHMs on the tools on FP current users' data quality check and validation, (ii) with the PHO technical staff and DOH representatives assist the PHNs and RHMs in doing the FP current users and other SO3 indicators data quality check.
- With CHD, assist the PHO and RHUs in improving its FP commodity monitoring system PHO and RHUs.
- Support the P/M/C health officers in increasing its advocacy for health by integrating health in the NEO program and maximize on-going activities to inform and mobilize LHB, LFC and LCEs on progress of PIPH-AOP implementation to generate support for health.
- Assist PHO and 8 RHUs in mobilizing NGOs, communities and private FP-MNCHN providers in implementing FP and MNCHN strategy

By the end of Year 5, HealthGov's TA in Compostela Valley will result in:

- 11 RHUs have validated FP current users data (1P/11MLGUs) and other family health (SO3) data
- CSR Plan and Policy for the Province
- P/11 MLGUs providing funds and procuring FP commodities, providing full range of FP services based on the enhanced CSR plan and policy, and improved FP commodity monitoring system
- LGUs collaboration improved in implementing referral system and continuing service quality improvement in COMMMONN ILHZ
- PLGU through the PHO accessed and utilized 2009 and 2010 DOH MNCHN grant for MNCHN, FP activities and services
- Improved implementation of local NHIP using the BDR approach (1P/11MLGUs)PHIC enrollment plan enhanced
- RHUs trained to effectively file and collect claims on DOTS and MCP from PhilHealth
- Improved management plan of PhilHealth capitation and reimbursements
- LGU with continuing service delivery quality improvement system (1P/6MLGUs)
- SDExH Phase 3 training completed in COMMMON ILHZ and LGU implementing SDExH received recognition and award
- ICV compliance monitoring system functional at the PHO
- Community concerns and feedback on FP, MNCHN, TB presented and discussed by NGOs/CSOs to NEOs/LHB/LDC
- NGOs/CSOs participated in CSR, SDIR, SDExH and other events (1P/11MLGUs)

**Priority TA Interventions and Activities**
**COMPOSTELA VALLEY**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP, MNCNH strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation | 1.1B.a | CSR+ plan formulated | CSR+ planning workshop with participation of NGOs/CSOs | In-house staff coaching/mentoring<br><br>Resource person/facilitator | | **1P** | | | | | | | | | | | 1 | | |
| | 1.1B.c<br>1.1B.d | CSR+ policy crafted and approved | CSR policy formulation | | | **1P** | | | | | | | | | | | 1 | | |
| 2. Integration of FP into EPI and maximizing utilization of MNCHN services | | Progress report of the implementation of the key action points and the status of the indicators including baseline data | Monitoring implementation of key action points of integrating FP into EPI and maximizing MNCHN services | In-house staff coaching/mentoring PHO/DOH Reps/6 RHUs<br><br>Resource person/facilitator | | | | | | | | | | | | | | | |
| | 1.4C.b<br><br>1.1G.b | LGU-NGO/CSO partnerships (e.g. public-private referral mechanism) established maximize use of FP/MNCHN service providers/facilities<br><br>LGUs collaborated in implementing a referral mecahnism for FP/MNCHN service providers/facilities | Consultative meetings with public-private FP-MNCHN providers in 6 municipalities | In-house staff to coach provincial TA team/DOH Reps<br><br>Provincial TA team as resource person/facilitator | | **1P**<br>**3M** | | **5M** | | | | | | | | | 1 | 8 | |
| 3. ICV Compliance monitoring and reporting system | 1.3D.b | Provincial ICV compliance monitoring plan developed and integrated into the MNCHN/FP program monitoring | Meeting with FP coordinator and DOH Reps to discuss reports on ICV compliance monitoring and consolidate reports | In-house staff resource person<br><br>Pro-forma of ICV compliance monitoring forms and guide to ICV compliance reporting | **1P** | | | | | | | | | | | | 1 | | |
| | 1.3D.c | ICV compliance of FP/RH service delivery sites monitored and reported to CHD | Coordination with ICV-trained FP coordinator and DOH Reps in monitoring ICV compliance of FP/RH sites | | **3M** | **3M** | | **2M** | **2M** | **1M** | | | | | | | | 11 | |
| E. SDExH with community participation | 1.3B.b | 3 phases of SDExH training completed | Training of RHU personnel (COMMMONN ILHZ) in SDExH Phase 3 | With CHD and PHO technical staff as resource persons and facilitators<br><br>Training supplies and materials, training design and modules<br><br>In-house staff as resource persons and facilitators | **1P**<br>**6M** | **1P**<br>**6M** | | | | | | | | | | | 1 | 6 | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.3B.c | Service Improvement Plan implemented | Monitoring implementation of SIP of LGUs and achieving standards | In-house staff as resource person/facilitator<br><br>Coach PHO-DOH Reps in monitoring RHUs and hospital personnel | 1P<br>2M | 2M | 2M | | | | | | | | | | 1 | 6 | |
| | 1.4.C.c | Mechanism for community consultations (QAPC and community feedback mechanism) established with NGO/CSO inputs | Coach QHITs and QAPC in formulating action plan to implement community feedback mechanism | In-house staff - Resource persons<br><br>FOG | 1M | 1M | 1M | 1M | 1M | 1M | 1M | | | | | | | 6 | |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local NHIP Implementation | 1.2A.b (1.1F.a) | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed | Orientation and training of key P/M/C LGU officials in PhilHealth BDR and rapid assessment on policy and operational issues of local NHIP implementation | Technical guides, NHIP toolkit, resource persons<br><br>Design, training materials and modules<br><br>In-house staff as resource persons/facilitators | 1P<br>11M | | | | | | | | | | | | 1 | 11 | |
| | 1.2C.a | Application for accreditation filed in PhilHealth | Orientation and consultative meeting with MHOs/PHNs to complete documentation requirements of PhilHealth accreditation for MCP and renewal of OPB and DOTS | PhilHealth-CHD as resource persons and facilitators<br><br>PhilHealth accreditation guidelines<br><br>In-house staff - facilitator | 6M | 5M | | | | | | | | | | | | 11 | |
| | 1.2C.b | Facilities accredited by PhilHealth | Monitor progress of accreditation | Coach PHO-DOH Reps/HSRAG in monitoring progress in RHU accreditation | | | 6M | 5M | | | | | | | | | | 11 | |
| 2. Accessing and managing DOH MNCHN performance grant (2009 and 2010) | 1.4B.c | Province and component LGUs agreement on allocation of MNCHN grant (2009 and 2010) presented to Provincial Health Board | Meeting cum action planning of PHO-MHOs on allocation of 2009 and 2010 MNCHN grant based on DOH MNCHN performance grant guideline | CHD as resource persons<br><br>Copy of 2009 and 2010 MNCHN guideline<br><br>In-house staff facilitator/resource person | 1P | | | 1P | | | | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.2A.b | MNCHN grant accessed | Monitor utilization of 2009 and 2010 MNCHN grant | CHD as resource persons<br><br>In-house staff - Coach PHO/DOH Reps<br><br>MNCHN monitoring tool and report guide | **1P** | **1P** | **1P** | | **1P** | **1P** | | **1P** | **1P** | | | | 1 | | |
| **B. Systems Strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. Logistics Management for Essential Drugs and Commodities | 1.1E.a | TOT in FP commodity monitoring and inventory management conducted | Assist the CHD in the conduct of the training in FPCMS for PHO program coordinators and MHOs | Technical guide/tools, resource persons and facilitators<br><br>Training design, modules, supplies and materials | | **1P 6M** | | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitor implemention of FPCMS and SIMS | Technical guide/tools, resource persons and facilitators<br><br>Coaching | | | | | | | | | | | | | 1 | 11 | |
| **C. Advocacy to newly elected officials (NEOs)** | 1.4B.c | Utilization conference for NEOs to ensure that health concerns are included in LCEs priority agenda | Utilization conference for NEOs to ensure that health concerns are included in LCEs priority agenda | Technical guide, resource persons<br><br>Supplies and materials | **1P** | | | | | | | | | | | | 1 | | |

## Davao del Sur

Davao del Sur is composed of 14 municipalities and 1 city and has a population of 822,406 based on 2007 NSO Population Census. In recent years, the progress of the local health sector reform has been slow in the province of Davao del Sur. Many factors have contributed to this - one of the more significant causes is the on-going political discord among its local officials. Health is one of the priorities of the Governor; however, the political disagreement has resulted in divided direction and low health service delivery performance. The current governor enjoys support only from five of the 15 city/municipal mayors, one Congressional Representative and limited number of the members of the provincial, city and municipal legislators.

**The Health Situation: Trends in SO3 Indicators**

In general, Davao del Sur has low public health program performance, particularly on MNCHN programs. Public health program performance is low in municipalities with physical and economic access constraints i.e. mountainous and hard to reach *barangays*, and high concentration of indigenous peoples. These are the municipalities of Sarangani, Jose Abad Santos, Don Marcelino, Malita, Kiblawan, Malalag and Magsaysay. Governance has affected the implementation of health programs, as local officials have low appreciation on its importance, and the local health system did not have any strategic directions, thus many of the interventions are not responsive to the needs of the people.

In 2009, the PHO reported 18 maternal deaths and a corresponding maternal mortality ratio of 55/100,000 LB. Since 2006 (with 9 deaths), there has been a rise in maternal deaths in the province. Under-reporting cannot be discounted considering that hospital deaths are not included in the facility-based Field Health Service Information System (FHSIS). The major causes of maternal death are post-partum hemorrhage and retained placenta which are both preventable. These can be attributed to the fact that majority of the deliveries are attended by unskilled or traditional birth attendants and that the deliveries are done at home.

As of 2009, maternal deaths may be closely related to the significantly low deliveries attended by skilled birth attendants (41%) as well as low facility-based deliveries (29%). These figures are slightly higher compared to 2008, where deliveries by skilled birth attendants was 35% and deliveries in health care facilities was 22%. However, the number of women who go to government health facilities for prenatal check-ups according to the prescribed schedule has significantly declined – from 38% in 2008 to 25% in 2009.

The Integrated Program Implementation Review revealed that the main reason for poor maternal care outcomes from the demand side is the fact that majority of families cannot afford the high cost of transportation, services and medications if they decide to go to health facilities. There is also lack of information on the services provided by health facilities resulting in the lack of knowledge on available maternal health services in BHS and RHUs. On the supply side, BHS and RHUs are not able to provide quality maternal care services due to lack of dental, laboratory, medical supplies and equipment. Additionally, there are inadequate iron tablets for pregnant women, insufficient training in maternal and newborn care especially those RHMs who were hired as contractual and casual.

The provincial CPR in 2006 as recorded in the RHIS was 49%. This data is high compared to the 2006 FHS where Davao del Sur is reported at 39.9%. Therefore, there is a need to do data quality check for accuracy in the recording and reporting. The performance in Family Planning program is influenced by the following reasons: a) weak logistic management system resulting

in delayed procurement and distribution of FP commodities by the province and poor inventory and stock management; b) inadequate FP commodities due to the inability of five LGUs to respond to the FP commodity phase-out; c) more than 50% of RHMs who are casuals or on job orders are untrained in Basic FP (FP CBT 1); d) limited access to voluntary surgical services (BTL and NSV); and e) cultural beliefs, fear of side effects, and prevailing misconceptions on contraceptive use among women of reproductive age.

Infant mortality rate for 2009 was reported at 5.4/1000 live births or 101 infant deaths. The leading causes are pneumonia, CVD and congenital anomaly and disorders related to short gestation and low birth weights. Other leading causes of infant deaths are *sepsis*, SIDS, diarrhea, *asphyxia*, COPD, and *tetanus neonatorum*. Moreover, factors such as poor maternal and inadequate newborn and child health services for pneumonia and diarrhea health care contributed to infant deaths.

Based on the 2009 FHSIS report of the PHO, only 76% of the pneumonia cases were treated with antibiotics and only 14% of children with diarrhea were treated with ORT. There is an increase in DPT3 coverage rate from 73% in 2008 to 76% in 2009, however, FIC declined by 3 percentage points – 77% to 74% in the same period. It is also noted that there are discrepancy between DPT3 and FIC where the former should be higher than the latter. Vitamin A supplementation slightly increased in 2009 (85%) compared to 83% in 2008.

Infant deaths have been consistently high for the past five years and this can be attributed mainly to the poor program implementation of child care services. The reasons for low performance in child health programs remained the same. There is limited LGU support for procurement of ORS, antibiotics, Vitamin A and supplies like syringes and needles. There is also limited mobility of RHMs to do target client listing master listing of newborns, majority of RHMs are also untrained in IMCI. Moreover, RHMs and BHWs conduct limited follow-up of missed children and REB initiative is not fully implemented.

TB control program. The TB case detection and cure rates showed an increasing trend from 2006 to 2009. The Provincial TB outcomes are already above national standards due to the existence of case finding and treatment system in most of the LGUs, increased budget for TB drugs in the province, utilization of CBMIS, thus, facilitating the tracking of TB symptomatic, and presence of private-public referral network for DOTS.

Some municipalities identified the following as the causes of low CDR and CR: a) lack of TB drugs; b) failure of patients to submit to sputum examination for follow up; c) some clients do not comply with the treatment protocols as there are few treatment partners like BHWs to monitor them; d) there is still stigma attached to the disease, especially in remote areas; and e) absence of medical technologist/ microscopists in Sarangani and Don Marcelino.

Perhaps aggravating the situation is the limited LGU budget in support of FP, MNCHN, and TB programs, i.e., LGU budget for health ranged from 0.2 to 15 percent of the total LGU IRA. Given the high support of the Governor for health, the PLGU allocated PhP20M for PhilHealth premium subsidy for indigent families, PhP5M to support public health programs, i.e., medicines and supplies, and PhP3M for outreach services to far-flung barangays. However, hospitals upgrading and operations got the bulk of the provincial government's investments for health.

While PhilHealth enrollment is high because the PLGU invested P20M to achieve universal coverage, accreditation of health facilities – both the number of RHUs and hospitals remain insignificant. This results in poor utilization of health facilities especially among the poor. There is

lack of a reliable means of identifying the poor eligible for enrollment in the PhilHealth Sponsored Program. In addition, majority of the health facilities are not yet PhilHealth-accredited. As of June 2010, there are 7 OPB-, 1 DOTS- and 2 MCP accredited RHUs. Thus, the capacity of RHUs to recoup PhilHealth capitation fund and reimbursement from providing out-patient services are not optimally maximized.

The PHO with support from CHD Davao was able to organize and make functional the ILHZ and the province was awarded the Most Outstanding Provincial Health Board. Given this situation, there are opportunities that could be maximized to make things work and happen to improve service delivery performance and outcome. As F44 province, there are available DOH-CHD funds that can be used to support implementation of JAC-concurred PIPH/AOP. However, the continued political polarity resulting from the recent election has affected the technical relationship between the PHO and RHUs/CHO, making it difficult for support to cascade to the component localities.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 49 | 50 | 51 | 51 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 43 | 40 | 38 | 25 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 35 | 40 | 35 | 41 | 80 |
| 4 | Percent of facility-based deliveries | 23 | 24 | 22 | 29 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 84 | 76 | 73 | 78 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 73 | 86 | 77 | 74 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 90 | 86 | 83 | 86 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 8 | 7 | 5 | 14 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 53 | 100 | 51 | 76 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 78 | 79 | 87 | 95 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 82 | 82 | 86 | 85 | 99 |
| 12 | TB cure rate (%) | 102 | 106 | 111 | | 85 |

*Sources: RHIS 2008, 2009*

## The Response: TA Interventions and Results

Resulting from completion and JAC concurrence of the PIPH, the strategic directions of the LGU-led health reform inspired the provincial leadership to provide increased budget for health services amounting to PhP80M to support hospital operations, PhP5M to support public health services and the PHO technical office operations, and PhP3M for outreach services to far-flung rural *barangays.* In addition, the Governor appropriated PhP20M to increase enrollment of indigent families in the PhilHealth Sponsored Program. To match the PLGU investments in health, DOH through CHD Davao Region approved PhP120M for health facilities development program. This funding support will enable the province to renovate hospitals and RHUs.

Given the initiative of the PLGU in improving the hospital services, the SP on Health and PHO, together with the Governor planned to present the JAC approved PIPH and AOP to the Mayors, SB on Health, MHOs/CHO and other local stakeholders to inform and generate commitment for its implementation. However, this advocacy initiative was shelved because as early as January 2010, the local officials have started their political alignment and affiliation to political parties resulting in discord amongst them.

Together with the PHTO, HealthGov through a local TA provider (IPHC-DMSF) assisted the PHO organize and conduct its 2008-2009 enhanced PIR, the first comprehensive and integrated hospital and public health service delivery implementation review conducted province-wide in the last five years. The enhanced PIR provided opportunity for data validation and reconciliation between the RHU/CHO and PHO FHSIS, and the internal assessment capacitated the health providers and managers to analyze factors hindering and facilitating achievement of performance standards.

The results of the internal assessment were presented in the Provincial PIR workshop. Data showed that across the 15 localities, MNCHN indicators are far below the national benchmarks. Performance in TB prevention and control program sustained achieving national standards in CR, CDR and CNR for two years. By showing and talking about their service delivery performance, the health officers were able to raise awareness and impressed on the other local executives the significance of the public health programs and services in achieving the national objectives for health and MDG. As a result, the local executives committed to increase local investment (budget) for the implementation of priority health interventions that would lead to improvement in maternal, newborn, child health and nutrition, address the increasing trend of vector borne infectious diseases, and sustain the good performance in TB.

Moreover, the Provincial PIR provided avenue for sharing of good practices in service delivery. Digos City shared its strategies and innovations in TB program highlighting the public-private collaboration in DOTS, Malalag shared its successful strategies in family planning program, and Sulop talked about its innovations on maternal health program specifically the strategies to increase facility based deliveries. Furthermore, the DOH MNCHN strategy and Informed Choice and Voluntarism were discussed as part of the technical updates.

In addition, the PHO with HealthGov's technical support prepared a data base on service providers' capacity profile. The data were gathered from the result of the health providers training profile generated in the internal assessment. The PHO will prepare its 2011 training plan based using the information in the data base. In the same manner, the outputs of the enhanced PIR were used for preparing the RHU/CHO and hospital acceleration plan (AOP) and will be integrated in the 2011 LGU AIP. Moreover, the PHO and MHO/CHO together with the DOH representatives will disseminate the health situation analysis and AOP to the newly elected officials and multi-sector stakeholders in the 15 localities to advocate for increased investment for health.

In terms of the FP-EPI integration, HealthGov with CHD Davao trained the PHO program coordinators and DOH representatives and the result was the formulation of action plans to roll out the implementation of the strategies in Digos City, Bansalan, Sta Cruz and Malalag. All MHO, PHN and all RHM in these localities were oriented on the principles and concept of integration and bundling of MNCHN-FP services to address missed opportunities. The PHO and MHO shared that the integration and maximizing are practical and easy to do, and these are not really new, however, they miss to implement it as part of their routine activities in the health

centers. To date, the RHMs and BHWs are implementing the strategies and activities in their respective BHS. The progress and results will be reported in the coming months.

Similarly, HealthPRO is currently assisting the PHO in implementing IPCC/ BCC strategies for MNCHN and FP. Service providers were trained in conducting information and education activities that would improve the health seeking behaviors of families.

TBLINC and HealthGov together with CHD Davao provided TA to the PHO and DOH representatives and the RHU TB core team in conducting TB assessment in all 15 RHU/CHO and based on the result of the TB program PIR, the core teams were guided in formulating action plan to accelerate performance in TB prevention and control. In April this year, TBLINC has expanded its operations to Davao del Sur. Furthermore, TBLINC will take the lead in providing TA to the PHO and component municipalities and city in strengthening implementation of TB program.

With regard to PhilHealth accreditation of facilities, the PHTO and HealthGov oriented the M/CHOs and PHNs on PhilHealth accreditation guideline and requirements for OPB, DOTS and MCP, and will subsequently monitor and coach them in the assessment to determine their readiness for PhilHealth accreditation for the OPB, MCP or TB DOTS packages.

**Remaining Gaps and Challenges**

Based on the results of the IPIR, the province needs to improve its service delivery particularly along MNCHN and FP, because of their poor performance in the indicators of these major health programs. There is also a need to strengthen the support of LCEs and other LGU officials to health programs by ensuring that the health priorities of the province and the municipalities are incorporated into the CDP-ELA. Lastly, to ensure the sustainability of initiatives that have been implemented and that are implemented, there is a need to improve the health system of the province in terms of financing, governance and regulation.

HealthGov technical assistance would be directed towards: 1) improving capability of service providers to implement strategies that would accelerate their performance in these priority programs, 2) ensuring access to sources of financing (MNCHN grants, PhilHealth capitation, etc) and proper utilization of funds from these sources, 3) ensuring support of LCEs and other stakeholders to the health plans by incorporating these plans into the CDP-ELA, 4) ensure constant supply of MNCHN and FP commodities by assisting the province in developing their Commodity Self-Reliance Plans and policies, and 5) improve NHIP program in terms of enrolment, use of capitation funds and reimbursements and facility accreditation particularly on MCP, and 6) improve critical health systems such as data management and logistics management.

**Year 5 Priority Interventions and Expected Results**

In year 5, HealthGov's technical assistance and interventions are focused on further improving FP-MNCHN program performance in selected cluster of localities. This would entail consolidating and completing the TA interventions to support improving service delivery and health systems, specifically the following;

A. Support to improving service delivery in health:

- Assist the PHO and DOH Reps in FP current users data quality check in all 15 RHUs/CHO.

- Support P/15M/C LGUs in preparing the 5-year CSR plus commodity forecast and the enhanced CSR plus plan using the 5-year commodity forecast that was prepared with validated FP current users' data.
- Integration of FP into EPI and maximizing utilization of MNCHN services in at least 4 localities to accelerate service delivery performance in FP, maternal and child, and sustain good performance and coverage in Vit A.
- Support the PLGU through the PHO access and manage the 2009 and 2010 DOH MNCHN grant to fund FP-MNCHN activities and procure FP commodities for the 15 component LGU.
- Assist the PHO in institutionalizing ICV compliance monitoring system.

B. Strengthening family health program support: financing, policy and governance:

- With CHD Davao, assist PHO and RHUs in improving data quality through (i) training of MHOs, PHNs and RHMs on the tools on FP current users data quality check and validation and monitoring-coaching PHNs and RHMs in doing the FP current users data quality check
- With CHD Davao, assist the PHO and RHUs in improving its logistics management specifically capacity building of key personnel on FP commodity monitoring system at the RHU and CHO
- Support the P/M/C health officers in increasing its advocacy for health by integrating health in the NEO program and maximize on-going activities to inform and mobilize LHB, LFC and LCEs on progress of PIPH-AOP implementation to generate support for health.

By the end of Year 5, HealthGov's TA in Davao del Sur will result in:

- All 15 RHUs/CHOs have validated FP current users data
- All 15 RHUs/CHOs have validated other family health (SO3) data
- P/15 LGUs formulated CSR+ plan based on 5-year commodity forecast
- P/15 M/CLGUs providing funds and procuring FP commodities, and providing full range of FP services based on the enhanced CSR plan and policy
- PHO and 15 RHUs/CHO with FP commodity monitoring system
- PLGU through the PHO accessed and utilized 2009 and 2010 DOH MNCHN grant for MNCHN, FP activities and services
- ICV compliance monitoring system functional at the PHO
- Community concerns and feedback on FP, MNCHN, TB presented and discussed by NGOs/CSOs to LHB/LDC (1P)
- NGOs/CSOs participated in CSR, SDIR, SDExH and other events (1P)

**Priority TA Interventions and Activities**
**DAVAO DEL SUR**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP, MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1C.b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | Monitor progress and result of DQC for FP current users in 11 RHUs/CHOs | In-house staff with the PHO and PHTL | **14M 1C** | **14M 1C** | | | | | | | | | | | | 14 | 1 |
| | 1.1C.a<br><br>1.1B.b | Clean FP CU data used to determine 5-year commodity forecast and budget requirement<br><br>CSR+ plan updated | CSR+ forecasting workshop and enhancing CSR+ planning workshop include inputs on CSR policy formulation | Technical guides, handouts, supplies<br><br>In-house staff as resource persons/facilitators<br><br>Provinical TA team as facilitators | | | **1P 14M 1C** | | | | | | | | | | 1 | 14 | 1 |
| 2. Integration of FP into EPI and maximizing utilization of MNCHN services | | Progress report on LGU implementation with baseline data of indicators and its progress | Monitor LGU implementation of key action plan in integrating FP into EPI and maximizing MNCHN services | Coaching/mentoring to 4 RHUs<br><br>Resource person/facilitator<br><br>FOG | | | | | | | | | | | | | | | |
| | 1.1G.b | LGUs collaborated in implementing a referral mechanism for FP/MNCHN services | Partnership meetings of public-private FP/MNCHN providers in 4 municipalities | Resource person/facilitor<br><br>Provincial TA team as resource person/facilitator | | **4M** | **4M** | | | | | | | | | | | 4 | |
| | 1.4C.b | Public-private health managers in 4 municipalities adopting referral mechanism for FP/MNCHN services | | Meeting cost - 4 MLGUs | | **4M** | **4M** | | | | | | | | | | | 4 | |
| 3. ICV compliance monitoring and reporting system | 1.3D.b | Provincial ICV monitoring plan developed (ICV compliance monitoring integrated in MNCHN/FP program monitoring) | Consultative meetings to discuss ICV compliance monitoring and consolidation of reports | In-house resource person<br><br>Pro-forma of ICV compliance monitoring forms and guide to ICV compliance reporting | **1P** | | | | | | | | | | | | 1 | | |
| | 1.3.D.c | ICV compliance of FP/RH service delivery sites monitored and reported | | | **3M 1C** | **3M 1C** | | **8M** | **8M** | **8M** | **3M** | **3M** | | | | | | 14 | 1 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **II. Strengthening family health program support: financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Accessing and managing DOH MNCHN performance grant (2009 and 2010) | 1.4.B.c | Province and component LGUs agreement on allocation of MNCHN grant (2009 and 2010) presented to Provincial Health Board | Meeting cum action planning of PHO-MHOs on allocation of 2009 and 2010 MNCHN grant based on DOH MNCHN performance grant guideline | CHD as resource person/facilitator<br><br>Copy of 2009 and 2010 MNCHN guideline | **1P** | | | **1P** | | | | | | | | | 1 | | |
| | 1.2A.a | MNCHN grant accessed | Monitor utilization of 2009 and 2010 MNCHN grant | CHD as resource persons<br><br>Coach PHO/DOH Reps<br><br>MNCHN monitoring tool and report guide | **1P** | **1P** | **1P** | | | | | | | | | | 1 | | |
| **B. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. LGU data management system improvement | 1.1C.c | Personnel trained in improving quality of FP current users | Training of PHNs and action planning in DQC for FP current users together with CHD Davao | Technical guides, handouts, supplies<br><br>In-house staff as resource persons/facilitators<br><br>Provincial TA team as facilitators | **1P**<br>**14M**<br>**1C** | | | | | | | | | | | | 1 | 14 | 1 |
| 2. Logistics management | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | With CHD Davao, monitor the implementation of FPCMS in the province | Technical guide/tools, resource persons and facilitators | | **1P** | | | | | | | | | | | 1 | | |
| | 1.1E.b | FP commodity monitoring tool adopted | | Coaching | | **1P**<br>**1M**<br>**1C** | | **5M** | | **4M** | | **4M** | | | | | 1 | 14 | 1 |
| **C. Advocacy to newly-elected local officials (NEOs)** | 1.4B.c | Community concerns and feedback on FP, MNCHN, and TB presented and discussed to NEOs | Utilization conference for NEOs to ensure that health concerns are included in LCEs priority agenda conducted | Technical guide, resource persons<br><br>Supplies and materials | **1P**<br>**1C** | | | | | | | | | | | | 1 | | |

## Sarangani

Sarangani Province, formerly the 3rd congressional district of South Cotabato, was created into a province on March 16, 1992 by virtue of Republic Act 7228 signed by Pres. Corazon Aquino. It is composed of seven municipalities with Alabel as the capital town. Sarangani has a population of 475,514 based on 2007 NSO Population Census with an annual growth rate of 3.78% that is higher than the national average of 2.34%. Forty-five percent of its population possessed diversified culture and beliefs where all seven municipalities are home to considerable number of Indigenous Peoples (IP); a relatively young population with a median age of 19 years old; and a rather high estimated poverty incidence of 63.28%.

**The Provincial Health Situation - Trends in SO3 Indicators**

A review of the health service delivery performance of Sarangani showed that over the last four years (2006-2009), there were significant improvement in maternal, child and TB program indicators. On maternal health, pregnant women with at least 4 ante-natal care visits (from 44% in 2006 to 55% in 2009); delivery by skilled birth attendants (from 44% in 2006 to 54% in 2009); and facility based delivery (from 18% in 2006 to 23% in 2009) recorded an increasing trend but the performance remain below national standards. The CPR reflected a downward trend from 61% in 2006 to 42% in 2008 as a result of the data clean-up for FP current users. The PHO reported that the validated CPR (42% and 41%) is a more realistic FP performance of the province in 2008 and 2009, respectively. All child health indicators are in an upward trend except Vitamin A coverage which dipped below the standard from a high performance of 99% in 2008. Generally, all indicators are increasing on a yearly basis but the province needs a lot of catching up to do to establish a better service delivery performance. For instance, treatment of child diarrhea using ORT and treatment of child pneumonia using antibiotics have increased although a bit too slow to cause an arrest in the occurrence of infant deaths which is still high at 35 in 2009.

Sarangani has been confronted with problems on maternal and child survival. While there is a fluctuating trend in cases of maternal deaths, 2009 registered an alarming 17 maternal deaths. The municipalities of Alabel and Glan have the highest reported maternal deaths, followed by Maitum and Malungon, and Kiamba and Malapatan. It is possible that high maternal deaths are reported in Glan, Maitum and Malungon because these localities have hospitals and Alabel has private facilities. The recording and reporting of maternal deaths is location-specific or where it occurred.

The results of the maternal mortality review conducted in 2009 reported 12 maternal deaths in 2007, four (4) in 2008 and 17 in 2009. It also revealed that the causes of maternal death were hemorrhage due to uterine inversion and retained placenta. Other factors that contributed to maternal deaths were closely related to spaced births, frequent pregnancies, and increase in unwanted pregnancies as evidenced by a declining CPR of 61% in 2006 to 41% in 2009. The number of pregnant women with at least 4 antenatal care visits with skilled providers increased from 47% in 2006 to 55% in 2009 but cases of poor detection and management of high-risk pregnancies is still high.

Delivery by skilled birth attendants is low at 54% and FBDs is very low at 23% in 2009. The RHUs and hospitals lack the basic equipment and instruments necessary for emergency obstetric care. Home deliveries are still predominantly preferred by 77% of pregnant women in 2009. The lack of information on the importance of facility-based deliveries and lack of accessible birthing facility where clients can avail of the services are the two major reasons why

pregnant women still prefer to deliver at home and be attended by *hilots*. There is also inadequate MCH logistics (e.g. micronutrients, medical supplies, vaccines and basic life support equipment). Postpartum services have questionable quality and high-risk pregnancies are lost to follow up. There is delayed / poor referral system, no birth plan, and poor FP services.

Some health facilities in the barangays and sitios are difficult to access due to lack of available transportation and communication support systems specifically in dealing with high risk pregnancies. The high cost of transporting these patients to the nearest birthing facility in all seven municipalities further aggravates this problem.

On child health and nutrition performance, infant deaths remain consistently high for the period 2006 (40 deaths) to 2009 (35 deaths). Though the maternal mortality ratio and the infant mortality rate are much lower than the national standards, there is still doubt on the accuracy of these data coming from the communities since IP and other minority groups that comprise 36%-58% of their population usually do not register any events like births and deaths. Moreover, maternal and infant deaths occurring in health facilities particularly those admitted to hospitals in General Santos City are not included in the FHSIS recording and reporting system. This contributes to the under-reporting of maternal and infant deaths in the province.

Infant deaths contributed more than 60% of the total under-five deaths recorded in 2008 and 2009. Among the total infant deaths, 40% were neonatal deaths. Pneumonia was the leading cause of infant deaths, followed by congenital malformation, sepsis and diarrhea diseases. Also, infant deaths can be attributed to the low turn-out of quality prenatal care among pregnant women; low tetanus toxoid immunization and iron supplementation coverage among pregnant women; low number of mothers who practiced exclusive breastfeeding during the first 6 months; and very low number of newborn undergoing newborn screening were significant contributory factors to infant deaths. In the municipalities of Kiamba, Maasim, Maitum, Malapatan, Malungon, there is no LGU budget for the initial procurement of laboratory supply for the newborn screening kit, vitamin K for eye prophylaxis, micronutrient, vitamin A, albendazole.

Tuberculosis continues to be a major public health concern for Sarangani. In 2008, it is still in the top 10 leading causes of death being the fifth cause of mortality with 48 deaths registered due to TB. Based on the results of the FGD conducted by TBLINC, poor adherence to TB-DOTS is one of the reasons for the low cure rate. Of the patients initiated treatment, 67% were cured and 25% completed treatment. The cure rate should have been registered at 92% if the 25% of those with initiated treatment have completed the sputum follow up. There is also limited number of trained TB-DOTS treatment partners which resulted to low treatment compliance and still some health workers are not updated on TB treatment protocol. Lastly, RHU laboratories need to be upgraded to comply with the minimum requirements for TB-DOTS accreditation. Of the seven RHUs, only three are TB-DOTS accredited (Kiamba, Maitum, Malungon).The table below further shows the province's SO3 indicator performance for the period 2006 to 2009.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 61 | 58 | 42 | 41 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 47 | 46 | 53 | 55 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 44 | 44 | 50 | 54 | 80 |

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 4 | Percent of facility-based deliveries | 18 | 16 | 17 | 23 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 73 | 73 | 77 | 92 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 71 | 75 | 89 | 90 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 106 | 80 | 99 | 93 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 22 | 38 | 41 | 83 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 93 | 91 | 100 | ND | 100 |
| 10 | TB case detection rate (per 100,000 population) | 54 | 67 | 72 | 71 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases disaggregated by sex (male/female) | 72 | 71 | 67 | 81 | 99 |
| 12 | TB cure rate (%) | 77 | 89 | 94 | 95 | 85 |

Source: PHO FHSIS 2006-2009; ND-No data

### The Response: TA Interventions and Results

Given the local health situation and the high support for health development of the LCEs and the progress in mobilizing CSOs and private sector to support the socio-economic development agenda of the Province, HealthGov and the other USAID CA together with CHD SOCCSKSARGEN provided TA to P/M-LGUs in improving health performance particularly in system strengthening related to improve the health information system of the LGU, strengthening the local health planning and budgeting process, health policy development and improving service delivery in family.

HealthGov with CHD assisted LGUs in formulating their Provincial and Municipal CSR plan and policy. To date, all seven LGUs and the PLGU have completed their CSR plan which contains the 5-year FP requirement forecast based on clean and validated FP current users' data. The province passed a provincial ordinance and the LGUs adopted 5 municipal ordinances and one EO on CSR implementation. With the approval of the CSR plans and policies, the Provincial Health Board with the participation of two local NGOs (CAFI and RD Foundation), both NGO representatives in the Provincial Development Council were engaged to communicate the CSR plan and policy to local multi-stakeholders in seven municipalities, and to oversee CSR plan and policy tracking. The results of tracking were discussed among the MHOs, SB on Health, PHO and SP on Health to generate appropriate actions on the identified issues and gaps in CSR implementation. The PHO-MHO, SP-SB on Health and NGOs committed to sustain the CSR plan and policy tracking to ensure that RHUs are providing a broad range of FP services and FP commodities are made available in health facilities.

Through PHO and CHD, data quality checks of FP current users' data in the seven LGUs were conducted to arrive at an accurate forecasting of FP commodities as input to planning activities. In 2009 also, HealthGov together with PHO and DOH representatives assisted the MHO and PHN of the seven municipalities prepare their MNCHN plan based on the DOH MNCHN strategy. The plan identified critical interventions to address the high maternal mortality, maximize utilization of MNCHN services at BHS, RHU and hospitals and private providers, and strengthen referral system to CEmONC facilities. Demand generation activities were also

identified (i.e. master listing of pregnant women, pregnancy tracking and birth planning by RHM and BHW), and mobilizing Community Health Teams for community - advocacy and actions to support MNCHN activities at the peripheral level.

With the DOH representative and PHO program coordinators, HealthGov oriented the RHU staff of Maitum and Malungon on principles and concept of integration of FP into EPI and post partum services, and maximizing utilization of MNCHN services. The RHU staff of Maitum through the MHO organized the Community Health Teams in seven *barangays* namely Maguling, Ticulab, Malalag, Mabay, Upo, Zion and New La Union. These barangays were prioritized by the MHO because it has considerable number of IP and Muslim communities and these barangays have organized Community Care Groups (with assistance from AID International). The CHT is composed of the RHM, BHWs, TBAs, Barangay Captain or the Kagawad on Health and Community Care Group leaders. The same initiative was conducted in Malungon involving 31 RHMs with strong support from the Mayor and the Association of Barangay Captains (ABC). The ABC passed a resolution mandating the Punong Barangays to support the implementation of integration of FP and maximizing utilization of MNCHN services in all the barangays in Malungon.

HealthGov responded to the request of SP Committee Chair on Health to convene a local policy development workshop on MNCHN. In January 2010, Together with the CHD, a Policy Development Workshop on MNCHN was convened. Based on the PIPH MNCHN interventions and the municipal MNCHN plans, the local legislators and health officers crafted their local MNCHN policies which were filed in the Provincial and respective Municipal Sanggunian. The approval of the MNCHN policy was stalled due to the local election. As a result of these initiatives, the PHO earmarked P300, 000 out of the PIPH implementation start-up funds to roll out the implementation of integration FP and maximizing utilization of MNCHN services to five other municipalities.

CHD SOCCSKSARGEN also awarded the province P1, 300,000 from 2008 FP/MNCHN grant. The PLGU through the PHO utilized 100% of the funds for purchase of FP commodities which were given to all seven RHUs. In July 2010, CHD awarded Sarangani the 2009 MNCHN grant amounting to P1, 383,297. The PHO plans to use the money to purchase FP commodities and support the training and other MNCHN and FP activities of the municipalities.

In the same manner, CHD together with HealthGov and the other CAs provided technical support to the PHO in the formulation of the PIPH and 2008-2009-2010 AOP. As a result, PIPH and 2008-2009, 2010 AOPs were completed and concurred by DOH and JAC. The approval of the health investment plan provided opportunities to access external funds to support implementation of critical interventions to address challenges on maternal, child health and nutrition, FP, TB and other infectious diseases. The province was able to access technical and funding assistance from DOH and development partners like USAID, UNICEF, EC, and Global Fund Malaria.

The CHD and HealthGov also assisted the Province in strengthening its local preparedness and response to Avian Influenza. In 2008, with DOH-DA and HealthGov TA, the PHO-MHO together with the Provincial Veterinarian and the Municipal Agriculture Officers (MAO) in 6 municipalities (except Glan) formulated its AI preparedness and response plan. The Governor convened a Local Leaders Forum on AI Preparedness to ensure commitment and support of LCEs to AI preparedness. The Provincial Governor allocated additional budget to support the Provincial Veterinary Office to fund key interventions of the AI preparedness plan. Moreover, the PHO-PVO and the MHO-MAO were trained in installing CBEWS in high risk coastal barangays. CBEWS

was installed in *Barangay* Bula, General Santos City, Brgy Kawas, Alabel, Brgy Sapu Masla and Sapu Padidu in Malapatan, and *Barangay* Kabatiol in Maasim. The AI preparedness initiatives are sustained by the PVO with the support of the Department of Agriculture, Region XII and the DA Quarantine Office stationed in General Santos City.

HealthGov assisted the PHO in planning and conduct of annual enhanced PIR using the SDIR tools/guide. The results of EPIR were utilized in preparing the PIPH and 2008-2009-2010 AOP, and the seven MIPH. The PHO and PPDO requested TA from HealthGov in the formulation of MIPH in all seven municipalities. They advocated the MIPH formulation to the Mayors, MPDC and MHO because they believe that the objectives and goals of the local health reform (PIPH) would be achieved if municipalities will align and link the MLGU health programs, projects and activities to the PIPH.

HealthGov also oriented the P/M LGU health officers, planning and development officer, SP-SB on Health and other members of the MIPH planning team on PhilHealth BDR approach to increase awareness and appreciation on a framework to improve local NHIP implementation. With the PLGU's investment in premium payment to enroll the poor based on CBMS, and with very few accredited facilities (1 OPB, 3 DOTS, and 1 MCP), CHD and PhilHealth Regional Office need to assist the province improve and strengthen its local NHIP implementation.

With regard to health care financing, 8.5% of the indigent families were enrolled in the PhilHealth Sponsored Program in 2007. However, it significantly increased to 63 percent in 2008 due to the availability of CBMS data that helped identify qualified indigent families. With available CBMS data, the indigent families in all the seven municipalities were already identified and profiled in a master list. In response, Governor Rene Miguel Dominguez appropriated PhP10M of P-LGU budget to enroll indigent families to PhilHealth Sponsored Program, thus achieving universal coverage. In terms of PhilHealth accreditation, only one RHU (Maitum) is OPB and MCP accredited and three RHUs (Kiamba, Maitum, Malungon) are DOTS accredited. Meanwhile, the rational use and management of PhilHealth benefits reimbursement and capitation fund is becoming a concern of the provincial government.

**Remaining Gaps and Challenges**

In view of the foregoing conditions in Sarangani, HealthGov with CHD will focus its TA interventions with the LGUs in sustaining the initiatives that were started and found effective. Assistance to improve further performance in maternal and child health (i.e., 4ANC, FBD, SBA, diarrhea given ORT, FIC, Vitamin A supplementation) will continue using the MNCHN framework for service delivery provision. Equally important is the support for FP/CSR/MNCHN plan implementation with particular focus on a) assisting LGU procure FP commodities using LGU budget and MNCHN grant and distributing these commodities to RHU and BHS; b) mapping public and private FP-MNCHN service providers and forging agreement on referral and networking; and, c) monitor and coach the 7 RHUs in implementing the strategies of integrating FP to EPI and post partum services, and maximizing utilization of MNCHN services in accelerate improvement of FP-MNCHN performance. Moreover, external funding for health needs to be available which makes TA in MNCHN grant accessing and utilization also a priority. To ensure quality of care in FP, ICV compliance monitoring will be installed at the PHO and the FP and MNCHN Coordinator together with the DOH representatives will conduct ICV monitoring in health facilities to ensure that RHUs are providing quality FP services.

In terms of strengthening family health program support, the TA on financing, policy and governance will also be provided to ensure that at the end of year 5, the P/M LGU have

improved capacities in planning, financing, implementation and monitoring programs, projects and activities in health at all levels. The PHO and PPDO will be assisted to complete the MIPH and its integration in the CDP-ELA, and integration of health plan in the 2011 AIP. HealthGov with CHD and PHO will assist the 7 RHUs in completing the data quality check of other family health indicators and use the validated data for planning and decision making. The PHO and PPDO will be trained on monitoring of their AOP implementation using the PME tool in order to track if the province and its component municipalities are towards achieving their planned objectives. The PHO and RHU personnel will trained on logistics management, particularly in setting up the FP Commodity Monitoring System (FPCMS) and Stock Inventory Management System to ensure that FP-MNCHN and TB commodities are available at BHS, RHU and PHO technical office and program managers and better equipped in logistics management.

**Year 5 Priority Interventions and Expected Results**

HealthGov's TAs and intervention in Sarangani will focus assisting the PHO and all seven RHUs in implementing programs and activities that would accelerate improvement of province-wide performance on MNCHN/FP in the seven municipalities.

A. Support to improving service delivery in health

- Assist P/M LGUs in implementing integration of FP into EPI and post partum services, and maximizing utilization of MNCHN services to accelerate performance in FP, maternal and child health and Vitamin A coverage
- Assist the PHO update the data base on service providers' capacity profile and prepare a province-wide training plan as part of 2011 AOP
- Support the P-LGU through the PHO access and manage the 2009 and 2010 DOH MNCHN performance grant to fund FP-MNCHN activities and procure FP commodities.
- Assist the PHO in institutionalizing ICV compliance monitoring system and for PHO FP and MCH program coordinators and DOH Representatives to conduct ICV compliance monitoring in all seven RHUs and monitoring reports are submitted to CHD.

B. Strengthening family health program support: financing, policy and governance

- Assist the PHO-PPDO in completing the MIPH formulation and integration in the CDP-ELA
- Assist the PPDO and PHO in implementing the M&E of AOP
- Assist the P/MLGUs in improving local NHIP implementation specifically on (i) RHU accreditation in OPB, DOTS and MCP, (ii) capacitate Maitum RHU to effectively file and claim PhilHealth reimbursements, and capacitate the PLGU through the PHO-PPDO in fund management of PhilHealth capitation and reimbursement.
- Assist the PHO and RHUs in improving its logistics management for essential drugs and commodities specifically capacity building of key personnel on FP commodity monitoring system and Stock and Inventory Management System
- Support the P/M/C health officers in increasing its advocacy for health especially among the municipal LCEs, and maximize on-going health activities to inform and mobilize LHB, LFC and LCEs on progress of PIPH/MIPH-AOP implementation to generate support for health.
- Assist PHO and at least 7 RHUs in mobilizing NGOs, communities and private FP-MNCHN providers in implementing FP/CSR and MNCHN strategy
- Assist in ensuring health concerns are in LCEs priority programs through the NEO program

By the end of Year 5, technical assistance to the province would have resulted in the following:

- Health plan are integrated in PDPFP and CDP-ELA (1P/7MLGUs)
- Enhanced PIR conducted, the results of which are input to development of 2012 AOP/AIP (1P/7MLGUs)
- MHO/PHO together with MPDC/PPDC conducted M&E of AOP to track progress of programs, projects, activities implementation including fund utilization (1P)
- Results of enhanced PIR presented to joint LHB-LFC and LCEs to generate support to health (1P/7MLGUs)
- All 7 RHU/CHO have validated other family health (SO3) data
- PHO and seven RHUs with improved logistics management for essential drugs and commodities (1P-LGU/7MLGUs)
- LGUs collaboration improved in implementing action plan on integration of FP and maximizing MNCHN services (1P/7MLGUs)
- PHO accesses and utilized 2009 and 2010 DOH MNCHN grant to improve MNCHN, FP program coverage and performance (1P-LGU)
- Improved implementation of local NHIP using BDR approach
- Improved management of PhilHealth capitation and reimbursements (PLGU, 1MLGU – Maitum)
- Accreditation of RHUs in OPB (6 RHUs applied for OPB accreditation, 1 RHU renewed OPB accreditation) and MCP (1 RHU renewed MCP accreditation, 6 RHUs applied for MCP accreditation)
- LGU implemented province-wide training program for service providers
- Province-wide annual training plan prepared as sub-plan of 2011 and 2012 AOP
- ICV compliance monitoring system managed and functional (1P-LGU)
- LHB meetings held where health issues were discussed with inputs of civil society representatives (1P/7MLGUs)
- Community concerns and feedback on FP, MNCHN, TB presented and discussed by NGO/CSO to LHB/LDC (1/7MLGUs)
- NGOs/CSOs participated in CSR, SDIR, SDExH and other events (1P/7MLGUs)

**Priority TA Interventions and Activities**
**SARANGANI**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to Improving service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to FP/MNCHN Strategy** | | | | | | | | | | | | | | | | | | | |
| 1. Integration of FP into EPI, Postpartum FP and maximizing utilization of MNCHN services | | Status report of the implementation of the action plan to improve SO3 indicators | Consultative meetings with 7 RHU staff to discuss progress of the implementation of the MNCHN strategy | Coaching/mentoring 7 RHUs<br><br>In-house staff as resource person/facilitator | **7M** | | | **7M** | | | **7M** | | | | | | | 7 | |
| | | FP/MNCHN service provider network mapped and established<br><br>Volume providers for IUD, VSS identified | Orientation cum workshop on mapping of public-private FP/MNCHN providers in 7 MLGUs | Provincial TA team as resource persons/facilitators<br><br>In-house staff as resource persons | **7M** | | | | | | | | | | | | | 7 | |
| | 1.1G.b | LGUs collaborated in implementing a referral mechanism for FP/MNCHN services | Provincial consultative meeting and planning workshop for public-private FP/MNCHN providers to agree on referral mechanism | Provincial TA team as resource persons/facilitators<br><br>In-house staff as Resource persons | | **1P**<br>**7M** | | | | | | | | | | | 1 | 7 | |
| | 1.4C.b | Public-private partnerships established to improve referral mechanism for FP/MNCHN services | | | | **7M** | | | | | | | | | | | | 7 | |
| 2. Capacity building of FP/MNCHN providers | 1.1A.b<br><br>1.1A.a | Province-wide training plan prepared as part of 2011 AOP<br><br>Database on service providers' capacity profile established | Review/update capacity profile of service providers and install the database at the PHO and develop training plan for 2011 | In-house staff as resource person/coach in installation of capacity profile database | **1P** | | | | | | | | | | | | 1 | | |
| 3. ICV compliance monitoring and reporting | 1.3D.b | Provincial ICV monitoring plan developed (ICV compliance monitoring integrated in MNCHN/FP program monitoring) | Conduct ICV compliance monitoring | Mentor and coach<br><br>Pro-forma of ICV compliance monitoring forms and guide to ICV compliance reporting | | | **1P** | | | | | | | | | | 1 | | |
| | 1.3.D.c | ICV compliance of FP-RH service delivery sites monitored and reported | | | | | **4 M** | | | **3 M** | | | | | | | | 7 | |
| **II. Strengthening family health program support: financing, policy, and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local Implementation of NHIP based on benefit delivery approach | 1.2B.b | Local NHIP implementation plan formulated | Orientation of PHO/PPDO/PHTL/DOH Reps on PhilHealth BDR cum action planning on local NHIP implementation | Technical guides, resource persons<br><br>Coach/mentor CHD 12<br><br>In-house staff as resource persons and facilitators | **1P**<br>**7M** | | | | | | | | | | | | 1 | 7 | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.2B.a | Key personnel trained in local NHIP implementation | Orientation and Training of key P/M/C LGU officials in PhilHealth BDR and rapid assessment on policy and operational issues of local NHIP implementation including policy recommendations on -<br><br>- Enrolling the poor and LGU subsidy for premium payment | Technical guides, NHIP toolkit, resource persons<br><br>Design, training materials and modules<br><br>In-house staff as resource persons and facilitator | **1P 7M** | | | | | | | | | | | | 1 | 7 | |
| | 1.4B.b | LHB/LDC meetings held where status of local NHIP implementation were discussed with inputs from civil society representatives | Organize LFC and Provincial Health Board meetings for updates on status of implementation of NHIP activities/NHIP plan | Technical guides<br><br>Coach CHD/PHO<br><br>In house staff as resource person and facilitator | | | | **1P** | **1P** | **1P** | **1P** | | | | | | 1 | | |
| | 1.2C.a | 7 RHUs filed for MCP accreditation in PhilHealth | Orientation and consultative meeting with MHOs/PHNs to complete documentation requirements of PhilHealth accreditation for MCP and renewal of OPB and DOTS | PhilHealth-CHD as resource persons and facilitators<br><br>PhilHealth accreditation guidelines<br><br>In house staff as resource person and facilitator | **7M** | **7M** | | | | | | | | | | | | 7 | |
| | 1.2C.b | 7RHUs with OPB and DOTS accreditation; at least 6 RHUs with MCP accreditation | Monitor RHU progress in accreditation | In house staff - monitoring and coaching | | | **7M** | **7M** | | | | | | | | | | 7 | |
| 2. Accessing and managing DOH MNCHN grants (2009 and 2010) | | MNCHN allocation proposal by LGUs for 2009 and 2010 | Meeting cum action planning of PHO-MHOs on allocation of 2009 and 2010 MNCHN grant based on DOH MNCHN performance grant guideline | CHD as resource person<br><br>Copy of 2009 and 2010 MNCHN guideline | **1P** | | | | | | | | | | | | | | |
| | 1.4B.b | LHB meetings held to discuss status and issues of MNCHN utilization | Monitor utilization of 2009 and 2010 MNCHN grant<br><br>Meeting of provincial LHB to discuss status of 2009 and 2010 MNCHN grant utilization | CHD as resource persons<br><br>Coach PHO and PHTL<br><br>MNCHN monitoring tool and report guide | | **1P** | **1P** | | **1P** | **1P** | | | | | | | 1 | | |
| | 1.2A.b | MNCHN grant accessed | Coach PHO in preparing utilization report of 2009 and 2010 MNCHN grant | Fund Utilization Report template | | | | **1P** | **1P** | | **1P** | | | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide PIPH/AOP preparation, implementation and M&E | | 7 MIPH presented to LHB-LFC for endorsement and integration in CDP | Coach PPDC-PHO in organizing and conducting joint LHB-LFC meeting to present MIPH | LTAP<br><br>Resource persons/facilitators | **7M** | | | | | | | | | | | | | | |
| | 1.1A.h | AOPs (PIPH) prepared and integrated into CDP-ELA and AIP | LHB-LFC meeting to discuss 2011 health plan as integrated in the AIP | Technical guide<br><br>Coach CHD / PHO<br><br>STTA | **7M** | | | | | | | | | | | | | 7 | |
| | 1.1A.g | PME for AOP adopted | Orientation of PHO/MHOs, PPDC/MPDC on M&E of AOP | Technical guide<br><br>In-house staff as resource person and facilitators<br><br>Supplies/materials | | **1P 7M** | | | | | | | | | | | 1 | 7 | |
| | 1.4.B.b | LHB/LDC meetings held to discuss status of AOP implementation with inputs from accredited NGO/CSO representative | Joint LHB-LFC meeting to present result of monitoring of AOP implementation | Technical guides<br><br>Coach PHO/PPDC<br><br>Resource persons | | | | | | **1P** | | **1P** | | | | | 1 | | |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. LGU data management system improvement | | Action plan for AOP - AIP planning | Orientation training in DQC for FP current users and planning for conduct of EPIR/AOP - AIP formulation | Coach PHO/PPDC/MHOs | | | | | **1P 7M** | | | | | | | | 1 | 7 | |
| | | Province-wide consolidated and validated FP current users data | Technical meeting cum workshop among PHO, DOH Reps, MHOs and PHNs to review 2009 FP current users data to check if RHUs have sustained the validation/cleaning of FP data | Provincial TA team as resource persons/facilitators<br><br>In-house staff as resource persons<br><br>Technical guide to FP current users validation | **1P 7M** | | | | | | | | | | | | 1 | 7 | |
| | 1.1C.d | DOH Reps, MHOs and PHNs trained in data quality and validation tools and guide | Orientation training of DOH Reps, MHOs and PHNs in data quality tools/guide on selected MNCHN and TB indicators | Training design, modules, resource persons/facilitators<br><br>Supplies and materials | | | | **1P 7M** | | | | | | | | | 1 | 7 | |
| | 1.1C.c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | Assist PHO and PHTL in implementing action plan on data quality and validation at field level i.e. coaching RHU staff in data quality check of selected MNCHN indicators plus EPIR internal assessment | Provincial TA team as resource persons and facilitator<br><br>In-house staff as resource person and facilitators | | | | | **4M** | **3M** | | | | | | | | 7 | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| 2. Logistics management system improvement | 1.1E.a | TOT in FP commodity monitoring system (FPCMS) conducted | Assist the CHD in the conduct of the training in FPCMS for PHO program coordinators and MHOs/PHNs | Technical guide/tools, resource persons and facilitators<br><br>Training design, modules, supplies and materials | | | | **1P 7M** | | | | | | | | | 1 | 7 | |
| | 1.1E.b | FP commodity monitoring tool adopted | Monitor implemention of FPCMS | Technical guide/tools, resource persons and facilitators<br><br>Coaching | | | | | **4M** | **3M** | **4M** | **3M** | | | | | 1 | 7 | |
| | 1.1E.c | TOT in Stocks and Inventory Management System (SIMS) conducted | Assist the CHD in the conduct of the training in SIMS for PHO program coordinators and MHOs/PHNs | | | | | | | | | | | | | | | | |
| | 1.1E.d | Inventory management tool for essential drugs and commodities adopted | Monitor implemention of FPCMS and SIMS | | | | | | | | | | | | | | | | |
| **D. Advocacy to newly-elected local officials (NEOS)** | 1.4B.c | Community concerns and feedback on FP, MNCHN, and TB presented and discussed to NEOs | Utilization conference for NEOs to ensure that health concerns are included in LCEs priority agenda | Technical guide<br><br>In house staff as resource persons and facilitators<br><br>Advocacy materials | **1P** | | | | | | | | | | | | 1 | | |

## South Cotabato

South Cotabato is one of the progressive provinces of Central Mindanao. It is one of the first 16 F1 convergence sites. Being an F1 province, it has the funding support of the DOH and EC for the implementation of the province's PIPH and AOPs. It has a population of 790,761 (2009) with an annual growth rate of 1.46%. It is composed of 10 municipalities, 1 city and 199 barangays. It is home to indigenous peoples that comprised to more than 20% of the province's total population. They are mostly found in the municipalities of Lake Sebu and T'boli. Moreover, the province has 21 identified Geographically-Isolated and Disadvantaged Areas (GIDAs). These are located mostly in the municipalities of Lake Sebu, T'boli, Tampakan and Tupi with poor roads and rough terrain thus making provision of basic preventive health services in these areas very demanding for the local health authorities.

### The Health Situation: Trends in SO3 Indicators

A review of the provincial health situation in 2006 showed low performance and large variations in achieving results across municipalities in maternal and child health indicators. The 12 maternal deaths reported for this year were closely associated to low deliveries attended by skilled birth attendants (46%) as well as low facility-based deliveries (27%), while CPR, was also low at 41%. The low four ante-natal care visits (4ANC) at 20% was attributed to the inability of the pregnant women to visit the health facility for check up during the first trimester due to financial problems and lack of proper information on the benefits of prenatal visits. Infant death was alarming at 129 deaths the cause of which was related to poor maternal health care and deliveries at home by unskilled personnel. FIC coverage (84%) and children given with DPT3 (48%) were also below the national standards.

The province, however, recorded a good performance in TB Control except for the municipalities of Tboli, Lake Sebu and Tupi. The provincial TB Case Detection Rate was high at 103% with a Cure Rate of 86%. The Provincial TB Coordinator recognized that the presence of high IP population in these areas whose health-seeking behavior is generally poor and the difficult access in the far flung barangays of Lake Sebu were the factors that contributed to low TB performance in these municipalities.

In 2007, the province slowly gained momentum posting modest increases in almost all indicators for both maternal and child health while it sustained good performance in the TB Control Program. Maternal health performance indicators have improved though these are still below national standards. There was a significant increase of 130% in the percentage of pregnant women who completed the required four prenatal visits during their entire pregnancy from 20 in 2006 to 46 in 2007. The increase in the maternal health performance was attributed to the following: (a) increase in awareness of the clients on the maternal health services provided in the BHS and RHUs, (b) organizing and strengthening of the Women's Health Teams to help track pregnant women and do the master listing, and (c); training of health personnel on Basic Emergency Management on Obstetric Care (BEmONC) and Comprehensive Emergency Management of Obstetric Care (CEmONC)

The increase in CPR to 54% was attributed to the effort of the municipalities to ensure a stable supply of FP commodities in the RHUs for the clients after the gradual phase-out of these commodities. Municipal CSR Plans were formulated that resulted in the passage and approval of the Provincial and Municipal CSR Ordinances. On the health provider side, 69 service providers

were trained on FPCBT (Level I and II) including FP counseling to improve their capacity to provide quality family planning services in the community for wider service coverage.

Using the 2008 Provincial SDIR Data, health indicators showed continued increase. Maternal health indicators that showed positive increases include 4ANC (47%), SBA (62%), FBD (43%) and CPR (63%). The increase in FBD performance was the result of the province's initiatives to upgrade public health facilities and train health service providers in FPCBT and LSS. Also during this year, the province was able to access MNCHN (FP) grant from DOH amounting to Php1, 622,014. The PHO used the grant to procure and ensure steady supply of FP commodities, which was subsequently distributed to all 11 municipalities/city. Child health indicators, on the other hand, were above national standards indicating a more efficient delivery of health services for children under five years old. These indicators include DPT3 (99%), FIC (101%), children with pneumonia given antibiotics (100%), children with diarrhea given ORS (99%) and Vitamin A coverage (100%).

For 2009, the health situation of the province continued to show improving trends. Maternal health performance indicators have slightly improved (4ANC at 63%, SBA at 63%, FBD at 62% and CPR 65%) though still below the national standards and maternal deaths is still high at nine (9). The CPR, however, now has a more realistic data after the province, the 10 municipalities and one city conducted data cleaning for FP current users with HealthGov TA. Based on the consolidated data, the CPR stands at 42% (excluding T'boli and Lake Sebu data) using the updated FP current users data.

The performance indicators in child health and nutrition all showed more improved and encouraging trends particularly in DPT3 (99%), FIC (99%), children with pneumonia treated with antibiotics (98%) and Vitamin A coverage while the number of infant deaths dramatically dropped from 99 in 2008 to 34 in 2009. The province was awarded the Regional GP Champ for 2009 after consistently reaching the national VAC standards for the past three years.

**Table 1. Selected Health Indicators (2006-2009)**

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| 1 | Contraceptive prevalence rate (CPR) | 41 | 54 | 63 | 65 | 60 |
| 2 | Percent of pregnant women with at least 4 antenatal care visits with skilled providers | 20 | 46 | 47 | 63 | 80 |
| 3 | Percent of births attended by a doctor, nurse or trained midwife | 46 | 60 | 62 | 63 | 80 |
| 4 | Percent of facility-based deliveries | 27 | 32 | 43 | 62 | 70 |
| 5 | Percent of children less than 12 months of age who received DPT3 from USG-assisted programs | 48 | 51 | 99 | 99 | 95 |
| 6 | Percent of fully-immunized children (all vaccines, including Hepa B and measles) from USG-assisted programs | 84 | 94 | 99 | 99 | 95 |
| 7 | Percent of children under 5 years of age who received Vitamin A from a USG-supported program | 90 | 97 | 98 | 141 | 95 |
| 8 | Percent of child diarrhea cases treated with ORT | 92 | 93 | 94 | 91 | 100 |
| 9 | Percent of cases of child pneumonia treated with antibiotics | 91 | 94 | 98 | 98 | 100 |
| 10 | TB case detection rate (per 100,000 population) | 103 | 88 | 98 | 116 | 76 |
| 11 | TB Case Notification Rate (per 100,000 population) in new sputum smear positive pulmonary TB cases | 86 | 85 | 85 | 88 | 99 |

| Selected SOAg (OP) Indicators | | ACTUAL | | | | MDG / National Standards |
|---|---|---|---|---|---|---|
| | | 2006 | 2007 | 2008 | 2009 | |
| | disaggregated by sex (male/female) | | | | | |
| 12 | TB cure rate (%) | 83 | 114 | 115 | 158 | 85 |

*Sources: PHO FHSIS 2006 to, 2009 Note CPR* before the FP current users data quality check*

Despite an increasing trend in the province's health performance indicators, there were municipalities that continued to lag behind. The municipalities of Lake Sebu, T'boli, Tupi and Tampakan still have low performance in some health indicators. Factors contributing to low utilization of health services in low performing municipalities are cultural in nature, access-related (i.e. financial and geographic constraints), facility or information-related, and low quality care of health providers.

**The Response: TA Interventions and Results**

Various technical assistance were provided to the province during Year 1 and 2 that included a) technical guidance in the revision of the PIPH; and b) finalization of the AOP 2008. Most of these TAs led to full institutionalization of CSR at the LGU level. Moreover, technical assistance from Y3 to Y4 were focused on systems strengthening in the areas of service delivery, financing and resource mobilization, improving health information systems through data quality check, and capacity building of health providers on FP-MNCHN.

As part of the commitment of the province to the PIPH implementation, they adopted the province-wide Community Health and Living Standards Survey (CHLSS) in 2008. CHLSS is a PhilHealth-approved mechanism for means testing. Survey results helped the province develop a means test for client segmentation as well as identify clients with unmet needs for basic health services. A major milestone achieved in the third quarter of Y4 was the completion of the CHLSS for the 10 municipalities of the province. The results was presented to former Governor Daisy Fuentes, who appropriated P6 million to enroll poor families based on the CHLSS results to achieve universal coverage. The Provincial Development Council, on the other hand, passed a resolution adopting CHLSS as the local tool for means test in identifying social health insurance and program beneficiaries. Meanwhile, Koronadal City has completed the household survey and is undergoing data encoding and cleaning.

Using the results, the LGUs will now have a more reliable and solid basis on proper identification and enrollment of the poor families as well as expanding coverage to include informal sector. The CHLSS results will also help local health managers and planners to identify and purposively reach clients with unmet health needs and as a reliable benchmark data to monitor progress of achieving the MDGs at the local level.

A strategic governance approach to sustaining improved health delivery system in relation to local planning is the enhancement of health information management systems through data quality check. This also includes the integration of the health sector development plans using the approved DOH guidelines and tools in the LGU planning and budgeting processes, and purposive advocacy to newly elected local officials on health priority agenda in light of the recently concluded elections.

In the third and fourth quarters of Y4, TA activities were conducted to ensure that local investments for health will be integrated in the LGU planning and budgeting process. Together with CHD SOCCSKSARGEN technical support were provided to the P/M health and planning development officers in the formulation of the 2011-2015 MIPH and updating of the PIPH. The

innovation introduced was complementary to the DOH PIPH Guideline of a) formulation of MIPH as vital component of the PIPH, and b) mainstreaming of the health investment planning to the LGUs planning and budget.

The MIPH-PIPH planning process was also mainstreamed in the PLGU's PDPFP and M/C LGUs CDP-ELA. By ensuring that the health plan is integrated in the P/M LGU planning process, health development interventions are incorporated in the LGUs' priorities. The CHLSS results and the NHIP implementation plan are relevant inputs to the municipal and provincial comprehensive development plans and in the term-based executive and legislative agenda of the LGUs. The support of HealthGov in the NEO program of DILG-LGA is anchored in gaining the commitment of newly elected LGU officials to provide sufficient funding and relevant policy support to the health sector. Such commitment is expressed through the integration of the health development and investment plans in the LGU planning and budgeting process.

To achieve a reliable CPR performance and a responsive local CSR+ response, the province validated and cleaned up their 2009 FP current users' data including the 2010 Q2 data. The comparative results of the CHLSS and the 2009 FHSIS data showed indicative discrepancies which prompted the MHOs and the PHO to push for data cleaning to validate CPR performance and other health program indicators. As a result, the benefits from having appreciation of the FHSIS elevates, to some extent, the local health staffs' motivation to accurately record and report client transactions toward an increased LGU performance on CPR. It also ensures that a systematic data clean up and validation is executed properly towards a reliable health management information system and purposively linked to existing LGU database for health planning and policy development.

For the CSR+ Plan Implementation Assessment TA activities, the MHOs reviewed the existing CSR+ Plan and Policy and updated their FP current users' data for a more accurate and reliable commodity forecasting. The data validation activity was linked to P/MLGUs accessing 2009 and 2010 DOH MNCHN grant facility. Furthermore, the PHO and RHU staffs were assisted in coming up with an updated commodity forecast and budget requirements for 2011-2015 based on the validated FP current users' data. The commodity forecast requirements provided evidence for LCEs to make decision on policy i.e. protecting the poor beyond safety nets and funding allocation for FP, TB and micronutrient commodities. The PHO and M/C LGUs crafted their updated CSR plus plan taking into consideration the link of family planning program to MNCHN strategy and continuum of services to ensure that women are protected from unwanted and unplanned pregnancies.

Meanwhile, CHD together with HealthGov oriented the PHO and MNCHN, FP coordinators on the 2009 and 2010 DOH MNCHN grant guidelines and assisted them in complying with the documentation requirements to access the grant facility. To date, CHD SOCCSKSARGEN allocated the amount of P1, 452,693.78 from the 2009 MNCHN performance grant representing P692, 940 for Domain 1 and P759, 753 for Domain 2. The fund will be transferred to the PLGU as soon as cash allocation is released by DBM Region 12. The PHO will utilize the MNCHN performance grant to support FP and MNCHN activities and procurement of commodities for distribution province-wide.

On implementing advocacy and community actions to MNCHN, there are two site models currently undertaken in the municipalities of Polomolok and Lake Sebu. The Polomolok experience is mobilizing the local leaders and the *Barangay* Health Teams in implementing these actions that included the passage of the *Barangay* Resolutions adopting the DOH MNCHN Strategy; the initiative started in March 2009. Similarly, in February 2010, Lake Sebu started

engaging the local NGO network operating in the municipality to address MNCHN concerns of the 19 *barangays* especially the GIDA-*barangays*. HealthGov assisted the PHO and DOH representatives (Provincial TA team) in scaling up the implementation of integration of FP and maximizing MNCHN services in all component LGUs. To date, all the RHU/CHO staff in seven municipalities and Koronadal City was oriented on the strategies and action plan formulated. With the Provincial TA team, HealthGov will assist the MHO and PHN in documenting their experiences and results.

A more focused intervention to IPs of Lake Sebu, T'boli, and Tupi was implemented through the special study on the health seeking behavior of IPs. This was conducted alongside the internal assessment using the SDIR tool in 2009. Based on the results of the study, there were two major reasons that influenced the decision of IPs to avail or not to avail of the health services at the RHUs. These were a) financial constraints and b) poor health-seeking behavior due to the perceived idea that BHS and RHU offer poor quality health services to its clients because of inadequate supply of medicines, absence of medical equipment and uncooperative, uncaring behavior of health workers.

Though it was more of a descriptive type of research, it was able to present a fresh look at the concerns of the IP communities. It presented a more updated account of their health concerns and how they tried to cope with the changing cultural environment. There is a need to focus on interventions that will reduce inequities brought about by socio-cultural dimensions. The mode of addressing the health needs of IP communities should anchor on a culturally safe health service delivery that encourage people from within the IP community into the health discipline to provide and nurture safe, culture-sensitive health practices. The people most able or equipped to provide culturally safe health services are people from the same culture, thus the local health managers and providers should innovate and customize or tailor-fit its ways of providing health services to the needs and realities of IP families and communities.

Lastly, Y4 workplan has identified key TA interventions to improve implementation of TB program in at least two low performing localities, i.e., Lake Sebu and T'boli. HealthGov collaborated with TBLINC in organizing a consultative meeting with CHD SOCCSKSARGEN, the PHO and TB Program Coordinator to identify areas of technical assistance. The agreements on this meeting were a) PHO TB Coordinator and DOH representatives to coach the RHU TB core team in doing their facility capacity assessment using the TB assessment form developed by TBLINC; and b) TBLINC to train the DOH Representatives, PHO and RHU/CHO TB core team in data analysis to further increase capacity of health staff in analyzing status of TB prevention and control program. These TA interventions were accomplished during the quarter.

**Remaining Gaps and Challenges**

On health care financing, the province has low level of enrollment of the indigent population, enrolling only 3% of the estimated indigent households in 2006. PhilHealth Sponsored Program enrollment for 2009 is at 64 percent. To date, South Cotabato has 11 OPB accredited RHU/CHO, 11 DOTS accredited RHU/CHO. But the province remained zero in MCP. The RHU staffs are not motivated to pursue MCP accreditation because over the past three years, they have encountered difficulties and problems in fully availing the reimbursement on DOTS services. Thus, PhilHealth capitation fund is not plowed back to health.

Localizing the NHIP implementation through the lens of the benefit delivery rate (BDR) approach presents a challenge to all implementers in terms of operationalizing the concept at the local level. This involves, among others, securing local leadership/ a champion to push for the entire

BDR continuum, a proactive implementing structure and more importantly an enabling policy adopting the BDR approach at the local levels. Through CHD and PHO, the HealthGov could help setup a mechanism at the local level such as a PhilHealth Desk or incorporate assistance on PhilHealth related issues in a “one-stop-shop facility”, if there is any, of the LGU in order for the PHIC members to fully complete and optimize PhilHealth benefits that are due them. This mechanism will facilitate to create more demand to complete the benefit delivery package, thus increasing local funds intended for other health services.

On health management information system, optimize the use of CHLSS data for NHIP implementation plan; regularize data clean up activity by every quarter and to link health information to the larger information system of the LGU for planning and decision-making purposes through SDIR processes and tools.

On maternal care, there is a need to accelerate service delivery performance in FP and MNCHN in terms of tracking CSR+ plan and policy implementation, facilitate access to and manage the DOH MNCHN grants considering its low utilization and institutionalize ICV compliance monitoring system at all levels.

On LGU partnership with CSO/NGO in the delivery of health services especially to GIDAs, the partnership is relatively at its infancy stage where it needs sustaining support by continually engaging them in local health governance.

**Year 5 Priority Interventions and Expected Results**

In Year 5, HealthGov’s technical assistance for the province is focused on completing the implementation of TA interventions that were started in Y4.

A. Support to improving service delivery in health

- Support in enhancing/updating the CSR plus plan
- Assist in FP/CSR and MNCHN plan implementation specifically tracking of integration of FP into EPI and maximizing utilization of MNCHN services in at least 9 MLGUs in order to accelerate service delivery performance in FP, maternal and child health.
- Support the PLGU through the PHO access and manage the 2009 and 2010 DOH MNCHN performance grant to fund FP and MNCHN activities and procure FP commodities for the 11 component LGUs.
- Public-Private partnerships established to improve referral mechanism for FP-MNCHN services and facilities
- Assist the PHO in institutionalizing ICV compliance monitoring system

B. Strengthening family health program support: financing, policy and governance

- Assist in improving local NHIP implementation specifically to address the issues and difficulties encountered in sustaining enrollment of poor families using the CHLSS data, RHU accreditation in MCP and renewal in OPB and DOTS, capacitate RHU/CHO to effectively file and claim PhilHealth reimbursements, and improve fund management.
- Support the integration of health plan (PIPH-AOP) in LGU planning and budget
- Assist the PHO and RHUs in improving its logistics management for essential drugs and commodities specifically capacity building of key personnel on FP commodity monitoring system and Stock and Inventory Management System at the RHUs/CHO

- Support the P/M/C health officers in increasing its advocacy for health especially among the municipal LCEs, and maximize on-going activities to inform and mobilize LHB, LFC and LCEs on progress of PIPH-AOP implementation to generate support for health.
- Assist PHO and at least 9 RHUs in mobilizing NGOs, communities and private FP-MNCHN providers in implementing FP and MNCHN strategy
- Assist the province in the conduct of utilization conferences for NEOs on the health agenda

By the end of Year 5, HealthGov's TA in South Cotabato will result in:

- Improved health planning and budgeting system
- CSR plans and policy approved, and enhanced CSR plans and policy implemented
- Improved data quality, validated/cleaned data used for planning and decision making
- PHO with improved logistics management for essential drugs and commodities
- Access and utilization of the 2009 and 2010 DOH MNCHN grant to improve MNCHN, FP program coverage and performance
- Improved implementation of local NHIP using BDR approach
- LGU implementing province-wide training program for service providers
- ICV compliance monitoring system managed and functional (1PLGU)
- LHB meetings held where health issues were discussed with inputs of civil society representatives
- Community concerns and feedback on FP, MNCHN, TB presented and discussed by NGOs/CSOs to NEOs/LHB/LDC
- NGOs/CSOs participated in CSR, SDIR, and other events

**Priority TA Interventions and Activities**
**SOUTH COTABATO**
**October 1, 2010 to September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **I. Support to improve service delivery in family health** | | | | | | | | | | | | | | | | | | | |
| **A. Support to MNCHN strategy** | | | | | | | | | | | | | | | | | | | |
| 1. CSR+ (commodity security, FP service delivery, financing, policy, and monitoring and evaluation) | 1.1B.b | CSR+ plans updated | CSR+ forecasting workshop with inputs on enhancing P/M-C LGU CSR+ plan and identifying CSR policy options | Technical guides, handouts, supplies<br><br>Support to CHD/PHO in the facilitation of the workshop<br><br>Provincial TA team as facilitators | | | | | | | | | | | | | 1 | 10 | 1 |
| 2. Integration of FP into EPI and maximizing utilization of MNCHN services | | Documentation report on pilot/model of integrating FP into EPI and maximizing utilization of MNCHN services | Documentation of the pilot implementation in Polomolok, and Mayor to invite CHD and PHO in the presentation of the initiative | Documentation guide<br><br>In-house staff | **1M** | | | | | | | | | | | | | | |
| | 1.4A.b | Public forum with NGO/CSO participation conducted to report on experiences and results of community advocacy and actions on maximizing MNCHN services in Polomolok | Summing up of experiences of community advocacy and actions on maximizing utilization of MNCHN services in 10 barangays in Polomolok | FOG<br><br>In-house resource persons and facilitators | **1M** | | | | | | | | | | | | | 1 | |
| | 1.3A.d | PHO and DOH Reps trained in integration of FP/EPI and maximizing utilization of MNHCN services | Training of PHO technical staff , DOH Reps and MHOs in integration of FP into EPI and maximizing MNCHN services cum planning for roll-out implementation in 9 RHUs/CHO | Technical guide/handouts<br><br>In-house staff as resource person/facilitator | **8M/ C** | | | | | | | | | | | | | 8 | 1 |
| | | Progress reports on the implementation of the key action points and the status of the FP/MNCHN indicators | Monitor RHUs/CHO in implementing action plan on scaling up implementation of integrating FP into EPI and maximizing MNCHN services in 9 other RHUs/CHO | Coaching/mentoring to 9 RHUs/CHO<br><br>Resource person/facilitator | | | | | | | | | | | | | | | |
| | 1.1G.b | LGUs collaborated in implementing a referral mechanism for FP/MNCHN services | Conduct of public-private consultative meeting of FP-MNCHN providers in 9 municipalities | Resource person/facilitator<br><br>Provincial TA team as resource person/facilitator<br><br>Consultative meeting cost - 8 MLGUs | | **8M 1C** | | | | | | | | | | | | 8 | 1 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.4C.b | Public-private partnership established to improve referral mechanism for FP/MNCHN services and facilities | | | | | | | | | | | | | | | | 8 | 1 |
| | | Documentation report on integration of FP and maximizing utilization of MNCHN services in 8 municipalities including Lake Sebu's RHU-NGOs partnership in implementing maximizing MNCHN services | Documentation of results | Documentation guide<br><br>In-house staff | | | | | | | | | | | | | | | |
| 3. ICV compliance monitoring and reporting system | 1.3D.b | Provincial ICV monitoring plan developed (ICV compliance monitoring integrated in MNCHN-FP program monitoring) | Meeting with FP coordinator and DOH Reps to discuss reports on ICV compliance monitoring and consolidate reports and integration of MNCHN-FP monitoring | Resource person<br><br>Pro-forma of ICV compliance monitoring forms and guide to ICV compliance reporting | **1P** | | | | | | | | | | | | 1 | | |
| | 1.3.D.c | ICV compliance of FP-RH service delivery sites monitored and reported | | | **3M** | | **3M** | | **3M** | | **2M** | | | | | | 1 | 10 | 1 |
| **II. Strengthening family health program support - financing, policy and governance** | | | | | | | | | | | | | | | | | | | |
| **A. Financing** | | | | | | | | | | | | | | | | | | | |
| 1. Local NHIP Implementation | | Action plan on local NHIP implementation finalized | Consultative meeting to review and validate recommended actions on issues on PhilHealth enrollment and capitation fund management | Technical guides, resource persons<br><br>Meeting cum action planning design, facilitators<br><br>Coach PHO-PPDO-PSWDO<br><br>Cost of meeting | | | | | | | | | | | | | | | |
| | 1.2B.a | LGU officials oriented on PhilHealth BDR | Orientation and training of key P/M/C LGU officials in PhilHealth BDR and rapid assessment on policy and operational issues of local NHIP implementation including identification of policy recommendations for:<br><br>Enrolment of the poor based on CHLSS and LGU | Technical guides, NHIP toolkit, resource persons<br><br>Design, training materials and modules<br><br>In-house staff as resource persons/facilitators | **1P 10M 1C** | | | | | | | | | | | | 1 | 10 | 1 |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| | 1.2B.b | Local NHIP implementation plan prepared/updated | | | | | | | | | | | | | | | | | |
| | 1.4B.b | LHB/LDC meetings held where status of local NHIP implementation were discussed with inputs from civil society representatives | Meetings with expanded Provincial Health Board to discuss updates on status of local NHIP activities | Technical guides, in-house resource persons<br><br>Cost of meeting | | | | **1P** | **1P** | **1P** | **1P** | | | | | | 1 | | |
| | 1.2C.a | 10 RHUs/1 CHO filed for MCP accreditation in PhilHealth | | | **1P**<br>**10M**<br>**1C** | | | | | | | | | | | | | 10 | 1 |
| | 1.2C.b | 10 RHUs/1 CHO with OPB and DOTS accreditation; at least 6 RHUs with MCP accreditation | Monitor progress of RHU/CHO accreditation | In-house staff - monitoring and coaching PHO technical staff and DOH Reps | | | | | | | | | | | | | | 10 | 1 |
| 2. Accessing and managing DOH MNCHN performance grant (2009 and 2010) | | Province and component LGUs agreement on allocation of MNCHN grant (2009 and 2010) presented to Provincial Health Board | Meeting cum action planning of PHO-MHOs on allocation of 2009 and 2010 MNCHN grant based on DOH MNCHN performance grant guideline | CHD as resource persons<br><br>Copy of 2009 and 2010 MNCHN guideline | **1P** | | | **1P** | **1P** | | | | | | | | | | |
| | 1.2A.b | MNCHN grant accessed | Monitor accessing and utilization of 2009 and 2010 MNCHN grant | CHD as resource persons<br><br>Coach PHO-DOH Reps<br><br>MNCHN monitoring tool and report guide | **1P** | | **1P** | | **1P** | **1P** | | **1P** | | | | | 1 | | |
| **B. Governance** | | | | | | | | | | | | | | | | | | | |
| 1. Province-wide PIPH preparation/integration in LGU planning process/PME | 1.1A.h | MIPH and PIPH presented to LHB-LFC for endorsement<br><br>MIPH and PIPH integrated in Provincial Development and Physical Framework Plan/CDP<br><br>AOPs (PIPH) prepared and integrated into CDP-ELA and AIP | Conduct of joint LHB-LFC meeting to present the MIPH-PIPH with inputs from CSO | CHD-PHO-PPDO as resource persons<br><br>Technical guide and TA activity designs<br><br>Resource persons and facilitators | **1P**<br>**10M**<br>**1C** | | | | | | | | | | | | 1 | 10 | 1 |
| | 1.1A.e | AOP for PIPH formulated and approved | Orientation of PHO/MHOs, PPDC/MPDC on M&E of AOP | Technical guide<br><br>In-house staff as resource persons and facilitators | | **1P**<br>**10M**<br>**1C** | | | | | | | | | | | 1 | 10 | 1 |
| | 1.4.B.b | LHB/LDC meetings held to discuss status of AOP implementation with inputs from accredited NGO/CSO representative | Conduct joint LHB-LFC meeting to present result of monitoring of AOP implementation | Technical guides<br><br>In-house staff as resource persons and facilitators | | | | | | **1P** | | **1P** | **1P** | | | | 1 | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | | Target Areas province (P) municipalities (M) cities (C ) (5) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | P | M | C |
| **C. Systems strengthening** | | | | | | | | | | | | | | | | | | | |
| 1. LGU data management system improvement | 1.1C.d | MHOs and PHNs trained in other MNCHN DQC tools, action plan for EPIR and 2012 AOP-AIP | Orientation training cum action planning on data quality check; AOP and planning for conduct of EPIR/AOP/AIP formulation | Technical guide, resource persons and facilitators<br><br>In-house staff<br><br>Supplies/materials | | | | | **1P 10M 1C** | | | | | | | | 1 | 10 | 1 |
| | 1.1C.c | Quality of other family heath indicators derived from FHSIS checked and validated for accuracy in collection, computation and reporting | DQI of MNCHN indicators (SBA, FBD, FIC, among others) | Monitor and coach<br><br>Provincial TA team as resource persons and facilitators | | | | | | **6M** | **5M** | | | | | | 1 | 10 | 1 |
| 2. Logistic management for essential drugs and commodities | 1.1E.a | PHO program coordinators and MHOs trained in guide and tools in FPCMS | Training in FPCMS PHO program coordinators and MHOs/PHNs | Technical guide/tools, resource persons and facilitators<br><br>Training design, modules, supplies and materials | | | | **1P 10M 1C** | | | | | | | | | 1 | 10 | 1 |
| | 1.1E.b | FPCMS tool adopted | Monitor the implementation of FPCMS in the province | Technical guide/tools, resource persons and facilitators<br><br>Coaching | | | | | **6M/ C** | **5M** | **6M/ C** | **5M** | | | | | 1 | 10 | 1 |
| **D. Advocacy to newly elected officials** | 1.4B.c | Community concerns and feedback on FP, MNCHN, and TB presented and discussed to NEOs | Utilization conference for NEOs to ensure that health concerns are included in LCEs priority agenda | Technical guide, resource persons<br><br>Supplies and materials | | | | | | | | | | | | | 1 | | |

# HIV/AIDS

# HIV/AIDS

USAID's technical assistance to the Philippine Government with regard to HIV/AIDS is to help maintain low HIV prevalence status – that is, less than 3 percent among the most at-risk populations (MARPs) and less than 1 percent among the general population. This will be realized in close collaboration with the Department of Health (DOH) at the central and regional levels, through focused TA delivery by the USAID cooperating agencies (CAs) in 11 HIV/AIDS high-risk cities, namely, Angeles, Pasay, Quezon, Bacolod, Iloilo, Cebu, Lapu-Lapu, Mandaue, Davao, General Santos, and Zamboanga.

**The HIV/AIDS Situation**

For almost two decades since USAID helped establish the Philippines HIV surveillance system, the HIV prevalence goal has not been breached. Current epidemiologic data reveal that the general population and the MARPs sub-populations of the Philippines still have low prevalence for HIV infection.[1] However, the 2009 Integrated Behavioral and Serologic Surveillance (IHBSS) showed that the 3 percent threshold for certain MARPs in some cities had already been breached and a concentrated HIV epidemic may in fact be occurring.

The National HIV/AIDS Registry maintained by the National Epidemiology Center (NEC) of the DOH showed that from 1996, it took 10 years for the number of HIV cases to double, while from 2007, the doubling time was only two years. The registry maintained that sexual contact is still the predominant mode of transmission but considerably more homosexual/ bisexual males (around 70 percent) got infected in 2009.[2] The increase in HIV prevalence among males having sex with males (MSMs) is evident, not only based on the National HIV/AIDS Registry, but also on the IHBSS results from select USAID-supported HIV/AIDS sites.

The main drivers of HIV spread in the Philippines are unprotected anal/vaginal sex with multiple partners and needle sharing during injecting drug use as evidenced by a two percent syphilis rate among all MARPs in the sentinel sites and a 95 percent Hepatitis C prevalence among injecting drug users (IDUs) in Cebu City.[3] These are socially unacceptable and criminal behaviors and, therefore, a number of MARPs remain "hidden" and service providers find it difficult to extend services. To date, the only organized routine preventive program operational in cities covers establishment-based or registered female sex workers (RFSWs), who are regularly reached by LGU health workers with HIV interventions in the social hygiene clinics (SHCs). The other MARPs, which include groups with the highest spikes in recent prevalence increases, such as freelance female (FLSWs) and male sex workers (MSWs), IDUs and MSMs, rarely access the SHCs for sexual health check and only one of five are reached by sporadic outreach interventions. The prevalence rates for consistent and correct condom use during high-risk sexual encounters should be increased, while needle sharing during injecting drug use should be avoided, especially in Metro Manila, Metro Cebu, and Davao City where the HIV and syphilis burdens are highest.[4]

[1] 2009 IHBSS National Dissemination Forum presentation. Manila. December 11, 2009. Unpublished.
[2] 2009 National HIV/AIDS Registry Report. NEC-DOH
[3] 2009 IHBSS National Dissemination Forum presentation. Manila. December 11, 2009. Unpublished.
[4] 2009 IHBSS National Dissemination Forum presentation. Manila. December 11, 2009. Unpublished.

**The Response: TA Interventions**

HealthGov, together with the concerned DOH-Centers for Health Development (CHD) and USAID Cooperating Agencies (HealthPRO, PRISM2, and HPDP), assisted key stakeholders in the pilot cities of Quezon, Davao, General Santos, and Metro Cebu (Cities of Cebu, Lapu-Lapu, and Mandaue), to identify actionable HIV/AIDS prevention and control interventions. This local response planning approach aimed to engage LGUs to implement local responses with much more sustained intensity, wider coverage, and more strategic approaches than were usually implemented. Following are the major activities conducted:

- Through a workshop and on-site meetings, assisted health officers at DOH-CHD and City Health Offices (CHOs) of the pilot cities to update their information on emerging trends in HIV/AIDS and their understanding of the local drivers of the HIV/AIDS epidemic. Likewise, they were assisted in identifying effective HIV/AIDS prevention and control strategies.
- Through interviews with informants who could "influence" the local chief executives (LCEs), determined the "local action space" in relation to implementation of recommended technical interventions to respond to the HIV/AIDS epidemic in the pilot cities. The specific interventions and operational steps for implementation were likewise validated with the LCEs.
- Through a stakeholders' meeting, specified the operational steps to implement specific intervention modes that are within the "local action space", identified advocacy, financing, and other support from the LCEs, DOH-CHDs, and other partners for the implementation of approved interventions and developed a system for monitoring the implementation of the approved interventions.

Technical assistance was also provided to the National AIDS/STI Prevention and Control Program (NASPCP) and the DOH-NEC, as well as to other HIV/AIDS sites. The site-specific accomplishments are included in the discussion of the site-specific technical assistance operational plans. Following are the specific TA areas where assistance was provided:

1. Behavior change communication

   HealthGov assisted the DOH, CHD, and LGUs in training health workers and peer educators in IPC/C. The accomplishments were less than expected for the following reasons:
   - Lack of augmentation funds due to the sudden cessation of Global Fund Round 5 operations in September 2009 and delayed start of Phase 2 of the Global Fund Round 6; and
   - Competing LGU priorities, especially those related to the 2009 IHBSS and the 2010 national elections.

2. Conduct of HIV/AIDS-related events

   For the 2008 World AIDS Day commemoration, HealthGov, with HealthPRO and the CHDs assisted the cities of Angeles, Pasay, Quezon, Bacolod, Cebu, Mandaue, Lapu-Lapu, General Santos, Davao, and Zamboanga in planning, crafting messages, generating resources, and conducting the event.

   To prepare for the 26th International AIDS Candlelight Memorial commemoration in May 2009, HealthGov provided each of the 11 HIV/AIDS sites with a copy of the *Guide on the*

*Conduct of the International AIDS Candlelight Memorial Commemoration* produced by the Global Health Council.

3. Finalization of the Manual of Procedures for Social Hygiene Clinics

   HealthGov assisted in finalizing the Manual of Procedures for Social Hygiene Clinics (MOP for SHCs). The MOP is currently being circulated in DOH for review and, eventually, for adoption and use in SHCs all over the Philippines.

4. Implementation of advocacy activities to augment funding for VCT-related activities

   HealthGov provided technical inputs in drafting the DOH administrative order (AO) entitled "Guidelines in the Conduct of HIV Counseling and Testing at All Levels of Health Care". The AO is being routed in the DOH for eventual signing by the Secretary of Health. To operationalize the AO, HealthGov worked with the UNICEF-funded Pacific Rim Innovation and Management Exponents (PRIMEX), Incorporated in developing an implementers' manual entitled "How to Establish and Operate an HIV Counseling and Testing Facility". HealthGov reviewed the manual's technical soundness, form, and consistency with the DOH AO. Once completed and finalized, HealthGov would have fulfilled its commitment to assist DOH in developing guidelines for VCT operationalization at the LGU level.

5. IHBSS and the Rapid Assessment of Vulnerabilities to HIV/AIDS

   With HPDP, HealthGov assisted in analyzing the 2009 IHBSS results and mentored CHD 7, 11, 12, and NCR and the Cities of Quezon, Davao, General Santos, and Metro Cebu in data use for effective planning. Likewise, HealthGov provided technical inputs in planning, implementing, and analyzing the results of the NEC-led Rapid Assessment of HIV Vulnerabilities in 16 regions.

**Year 5 Priority Interventions and Expected Outputs/Results**

- Monitoring the implementation of the STI/HIV/AIDS local response plan (LRP) of the Cities of Quezon, Davao, General Santos, and Metro Cebu (Cebu, Mandaue, Lapu-Lapu) which entails the following activities:
  - Facilitating meetings with DOH-CHD and LAC to design and organize quarterly program implementation reviews (PIRs);
  - Coaching DOH-CHD in developing and preparing PIR materials and in documenting the PIR proceedings;
  - Facilitating and providing technical inputs in the conduct of quarterly PIR, specifically reviewing accomplishments vis-à-vis set targets; and
  - Facilitating and providing technical inputs to DOH-CHD and LAC in updating the LRPs and/or developing catch-up plan when needed.

  Likewise, documenting the local response planning approach to serve as input in the development of a process guide to be used by DOH in replicating the approach in other LGUs will be supported and this would entail:
  - Facilitating and co-funding meetings with NEC, NASPCP, PNAC, DILG, Global Fund, HPDP and HealthPRO to review the process leading to the development of the site-specific LRPs;
  - Drafting and finalizing an LRP process guidebook; and
  - Mentoring and coaching DOH in replicating the LRP process in other LGUs.

- Improving service delivery by supporting private sector partnership with the Davao City Chamber of Commerce and Industry to plan, implement, monitor, and evaluate STI/HIV/AIDS prevention and control activities in the workplace, specifically the call centers. An output of this technical assistance is the development of an implementation guide and manual for setting up a workplace STI/HIV/AIDS prevention and control program that will be used in General Santos City in training workplace health staff of SOCOPA-member companies and which may be adopted by other LGUs for local use; and
- Gathering of complete data on USAID project indicators. Since there is no comprehensive reporting system for key HIV/AIDS indicators in the LGUs, the data will aid the LGUs in assessing their performance which is useful for program planning. Likewise, the census will generate the data being required by USAID for reporting purposes.

***LGU-Specific Technical Assistance***

HealthGov will focus on completing unfinished technical assistance, particularly those aimed at fostering public-private partnerships, mobilizing additional LGU financing for HIV/AIDS, promoting zonal collaboration, and intensifying outreach prevention education, particularly among MSMs and IDUs. Priority will also be given to documention of implementation experiences to highlight innovative approaches and good LGU practices.

HealthGov will continue to coordinate and partner with other resource agencies to synergize efforts and to avoid duplication of assistance. HealthGov will continue to involve Pasay City in its TA activities, depending on its response and interest. Otherwise, TA will remain on-hold but, the project indicator targets for the city will still be retained. For the Cities of Iloilo and Zamboanga, technical assistance is limited to support during outreach prevention education and community mobilization trainings. This is due to the lukewarm response of Iloilo City, particularly the CHO, in pursuing STI/HIV/AIDS prevention. On the other hand, Zamboanga City demonstrated active involvement and support to STI/HIV/AIDS prevention activities, thus, requiring very minimal technical assistance support from HealthGov.

**Priority TA Interventions and Activities**
**HIV/AIDS**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Monitoring implementation of STI/HIV/AIDS local response plan (LRP) in the cities of Quezon, Davao and General Santos and in the tri-cities | | Planning meeting with DOH-CHD and LAC to design and organize quarterly program implementation review | Facilitator | | | | | | | | | | | | |
| | | Assist DOH-CHD in developing and preparing PIR materials and in documenting the PIR proceedings | Coach | | | | | | | | | | | | |
| | Quarterly PIR conducted | Conduct of quarterly PIR, specifically reviewing accomplishments vis-à-vis set targets | PIR design, facilitator, resource person | | | | | | | | | | | | |
| | LRPs updated and catch-up plans formulated | Meeting with DOH-CHD and LAC to update LRPs and/or develop a catch-up plan when needed | Facilitator, resource person | | | | | | | | | | | | |
| | | Meeting with NEC, NASPCP, PNAC, DILG, Global Fund, HPDP and HealthPRO to review the process leading to the development of the site-specific LRPs | Meeting design, facilitator, fund suppor; HPDP to input in data analysis and data use; HealthPRO to input in the development of the strategic communication component of the LRP | | | | | | | | | | | | |
| | | Edit/comment on process documentation | Technical writing | | | | | | | | | | | | |
| | | Submit draft process documentation to HealthGov CKMM for comments/edits | Technical review and finalization of process guide | | | | | | | | | | | | |
| | | With the CKM group and STTSA, draft a LRP guidebook | Technical writing | | | | | | | | | | | | |
| | | Circulate guidebook to USAID and DOH for comments | Coordinator | | | | | | | | | | | | |
| | Process Guide for LRP developed | Input comments to STTA to complete the process document to guide the CHDs to facilitate LRP development in other LGUs, specifically, the cities of Angeles, Bacolod, Iloilo and Zamboanga | Resource person, fund support | | | | | | | | | | | | |
| | DOH personnel trained to facilitate LRP for replication in other LGUs | Mentor and coach DOH in replicating the LRP process | Mentoring and coaching; technical backstop support | | | | | | | | | | | | |

| TA Intervention (1) | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Increasing service delivery by supporting private sector partnership with the Davao City Chamber of Commerce and Industry to plan, implement, monitor and evaluate STI/HIV/AIDS prevention and control activities in the workplace, specifically the call cent | | Consultation meeting with DOH-CHD 11, DCAC, PRISM2 and HealthPRO to design and organize the STI/HIV/AIDS prevention and control training for human resource managers and clinic staff in call centers | Facilitator; resouce person; PRISM2 and HealthPRO to provide technical inputs in manual development | | | | | | | | | | | | |
| | | Assist DOH-CHD 11 in developing and preparing writeshop materials and in documenting the writeshop proceedings | Coach | | | | | | | | | | | | |
| | Implementation guide and manual for workplace STI/HIV/AIDS prevention and control program developed | Conduct a 3-days writeshop to develop the implementation guide and manual for workplace STI/HIV/AIDS prevention and control program | Writeshop design, facilitator, resource person, fund support | | | | | | | | | | | | |
| | | Develop training design and materials for the workplace STI/HIV/AIDS prevention education program | Training design, materials development | | | | | | | | | | | | |
| | | Assist DOH-CHD 11 in developing and preparing writeshop materials and in documenting the training proceedings | Coach | | | | | | | | | | | | |
| | HR Managers and clinic/workplace health staff trained in basic STI/HIV/AIDS prevention and control | Conduct the 2-days training of workplace health staff on STI/HIV/AIDS prevention and control including the referral and reporting systems | Training design, facilitator, resource person | | | | | | | | | | | | |
| | | Mentor the DCRHWC staff in monitoring the implementation of the HIV/AIDS prevention and control activities in the workplace | Coach | | | | | | | | | | | | |
| | Workplace health staff providing STI/HIV/AIDS education activities to employees and referring cases for diagnosis, treatment, care and support | With DOH-CHD 11 and the DCAC, review reports and other documents submitted by workplaces | Review design, technical reviewer | | | | | | | | | | | | |
| | | Meetings with DOH-CHD 11 and DCAC secretariat to mentor in the documentation process | Mentor | | | | | | | | | | | | |
| | | Submit draft documentation report to HealthGov CKMM for comments/edits | Coordinator | | | | | | | | | | | | |
| | Documentation report completed and disseminated | Meeting with DOH-CHD 11 and DCAC to finalize report for dissemination | Technical writing, fund support | | | | | | | | | | | | |

| TA Intervention (1) | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Gathering complete data on USAID project indicators | | National specialist to develop SOW for 2011 census for PMG review and HIV/AIDS Inter-CA TWG approval | SOW development | | | | | | | | | | | | |
| | | Issue Task Order to OIDCI to commence census implementation | Task order finalization | | | | | | | | | | | | |
| | | Train census enumerators on census implementation | Resource person, training design | | | | | | | | | | | | |
| | 2011 census for OP, internal and CA-specific indicators implemented | Site visits to monitor census implementation | Resource person | | | | | | | | | | | | |
| | | Review data generated for submission to USAID | Technical review and finalization of figures | | | | | | | | | | | | |
| | Data for indicators determined and submitted to USAID | Submit data for OP, internal and select CA-specific indicators | | | | | | | | | | | | | |

## Angeles City

HealthGov's technical assistance to Angeles City is geared towards ***increasing budget allocation to sustain and implement planned HIV/AIDS prevention activities***. The release of an additional PhP5.0M for the STI/HIV/AIDS prevention and control program over and above the PhP6.5M allocated from the Gender and Development (GAD) Fund did not materialize in Year 4 because this was overtaken by the 2009 national elections and a change in the LCE and leadership of the CHO, the SHC, and the Angeles City AIDS Council (ACAC). There is a need to pursue this technical assistance to fund Angeles City's five-year integrated strategic and financial plan for STI/HIV/AIDS.

Accomplishments for Years 1 to 4 include the following:

- Advocated for the increase in number of medical technologists to process cervical/urethral smear gram stained slides and for the non-inclusion of syphilis testing in the required routine tests for securing the health card. Both were addressed by the CHO;
- Provided inputs in developing a proposal for an outreach prevention program for MSMs through an LGU Performance-Based Grant (PBG) to NGOs;
- Coached/mentored HealthGov-trained health educators who served as resource persons during Angeles City's Street Jam and Party 2009 that reached some 2,000 residents with HIV/AIDS prevention activities; and
- With HealthPRO, developed and pre-tested IEC materials for MARPs.

In Year 5, HealthGov, together with the central and regional DOH offices, other USAID CAs, and resource agencies, will work on the following:

- Increasing STI/HIV/AIDS financing through implementation of the amendments to Rule 8, Section 27 of Ordinance No. 106, series of 2000 and documenting the process from inception to end, specifically identifying essential action steps undertaken; and
- Supporting the training of outreach health educators and implementing an outreach prevention education program.

The activities and corresponding milestones, and expected results are detailed in the following operational plan matrix.

**Priority TA Interventions and Activities**
**ANGELES CITY**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Increasing STI/HIV/AIDS financing through implementation of the amendments to Rule 8, Section 27 of Ordinance No. 106, series of 2000 | | Special fund for STI/HIV/AIDS prevention and control approved by the Angeles City AIDS Council and funds allocated | Meeting with new ACAC members and secretariat to present and review ammendments to Rule 8, Section 27 of Ordinance No. 106, series of 2000 that was approved by previous LCE | Coach; facilitator; fund support | | | | | | | | | | | | |
| | | | Meeting with DOH-CHD 3 and ACAC secretariat to revise/enhance/update the amendment for ACAC chair (LCE) approval | Coach, facilitator | | | | | | | | | | | | |
| | | | Meeting with LFC to develop a checklist from ammendment approval to budget allocation for monitoring creation of special funds and budget allocation | Resource person, facilitator | | | | | | | | | | | | |
| | | | Regular follow-up with ACAC secretariat | Coordinator | | | | | | | | | | | | |
| | | | Meetings with DOH-CHD 3 and ACAC secretariat to mentor in the documentation process | Mentor | | | | | | | | | | | | |
| | | | Submit draft documentation report to HealthGov CKMM for comments/edits | Coordinator | | | | | | | | | | | | |
| | | Documentation report completed and disseminated | Meeting with DOH-CHD 3 and ACAC to finalize report for dissemination | Technical writing; fund support | | | | | | | | | | | | |
| Supporting the training of outreach health educators and implementing of outreach prevention education program | 1.3A.d | 52 outreach workers trained in BCC outreach prevention education | Conduct the IPC/C workshop for outreach health educators | Facilitator; HealthPRO to design workshop | | | | | | | | | | | | |
| | | 2820 MARPs reached through community outreach prevention education | Field visits to monitor activities implementation by trained outreach workers | Mentor; coach | | | | | | | | | | | | |
| | 1.3A.c | 3 LGU representatives participated in the TOT in community mobilization | With HealthPRO as lead, assist DOH-CHD 3 and ACAC to design and implement the community mobilization training of trainers that will augment BCC outreach activities | Resource mobilization, facilitator; HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |
| | | 12 LGU representatives trained on-site in community mobilization | Meeting with DOH-CHD 3 and ACAC to design, mobilize resources and implement the roll-out community mobilization training to other LGU stakeholders | Resource mobilization, facilitator; HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |

## Bacolod City

HealthGov's TA to Bacolod City is directed at ***obtaining information for focused action.*** In this regard, CHD 6 and HealthGov assisted in developing the design of the training in basic epidemiology, HIV surveillance, and Rapid Assessment of Vulnerabilities (RAV) to HIV/AIDS that resulted in a cadre of trained LGU and NGO representatives (15) who implemented the 2009 RAV. The Bacolod City RAV was completed in Year 4 and was presented to stakeholders, notably, the Bacolod City Local AIDS Council (BCLAC). The RAV results were used in evaluating the performance of the BCLAC members on STI/HIV prevention, in updating the Bacolod City five-year ISFP, and in advocating with the NEC for the inclusion of Bacolod City in the 2011 IHBSS.

Another notable initiative of Bacolod City is the implementation of the roving HIV/AIDS panel displays in public and private high schools. Unfortunately, this has been put on hold because of the dilapidated state of the IEC panels and the inability of the LGU to coordinate with the new school superintendent. HealthGov will document the initiative for endorsement to CHD 6 to advocate for its sustained implementation.

TA interventions for Years 1 to 4 include the following:

- Assistance in drafting and finalizing a presentation material on the RAV and an advocacy briefer to gain BCLAC's support for the adoption and funding of the city's ISFP;
- Coaching of the CHO on how to activate and engage the Bacolod City Club Owners of Video Bars and Entertainment Association (BACCOVBEA) in the mapping of fun establishments, promoting SHC regular visits of FSWs to increase SHC coverage, and supporting prevention education and condom promotion; and
- Assessment of the feasibility of including attendance in STI/HIV/AIDS Awareness Seminar as one of the requirements for securing health/medical certificate. This is viewed as a strategy to reach the general population on education about HIV/AIDS, eliminate the stigma attached to the MARPs and those afflicted with the disease, as well as educate MSMs who have not been reached by health educators in known cruising sites.

In Year 5, priority areas for assistance include:

- Documentation of the initiative on roving HIV/AIDS panel displays in public and private high schools;
- Documentation of the rapid assessment of vulnerabilities in Bacolod City; and
- Training of outreach health educators and implementation of an outreach prevention education program.

The activities and corresponding milestones, and expected results are detailed in the following operational plan matrix.

**Priority TA Interventions and Activities**
**BACOLOD CITY**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Support to the documentation of the roving HIV/AIDS panel displays in public and private high schools | | | Meetings with DOH-CHD 6 and BCLAC secretariat to mentor in the documentation process from inception to end, specifically identifying essential action steps | Mentor | | | | | | | | | | | | |
| | | | Submit draft documentation report to HealthGov CKMM for comments/edits | Coordinator | | | | | | | | | | | | |
| | | Documentation report completed and disseminated | Meeting with DOH-CHD 6 and BCLAC to finalize report for dissemination | Technical writing; fund support | | | | | | | | | | | | |
| Support to the documentation of the rapid assessment of vulnerabilities in Bacolod City | | | Meetings with DOH-CHD 6 and BCLAC secretariat to mentor in the documentation process from inception to end, specifically identifying essential action steps | Mentor | | | | | | | | | | | | |
| | | | Submit draft documentation report to HealthGov CKMM for comments/edits | Coordinator | | | | | | | | | | | | |
| | | Documentation report completed and disseminated | Meeting with DOH-CHD 6 and BCLAC to finalize report for dissemination | Technical writing; fund support | | | | | | | | | | | | |
| Support to the training of outreach health educators and implementing of outreach prevention education program | | 44 outreach workers trained in BCC outreach prevention education | Conduct the IPC/C workshop for outreach health educators | Facilitator, HealthPRO to design workshop | | | | | | | | | | | | |
| | | 870 MARPs reached through community outreach prevention education | Field visits to monitor activities implementation by trained outreach workers | Mentoring and coaching | | | | | | | | | | | | |
| | 1.3A.c | 3 LGU representatives participated in the TOT in community mobilization | With HealthPRO as lead, assist DOH-CHD 6 and BCLAC to design and implement the community mobilization training of trainers that will augment BCC outreach activities | Resource mobilization, facilitator; HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |
| | 1.3A.d | 12 LGU representatives trained on-site in community mobilization | Meeting with DOH-CHD 6 and BCLAC to design, mobilize resources and implement the roll-out community mobilization training to other LGU stakeholders | Resource mobilization, facilitator; HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |

## Davao City

HealthGov, together with CHD 11, has been advocating with the LGU for the implementation of a comprehensive MSM prevention education program. This is in light of the DOH conclusion that there is an ongoing HIV/AIDS epidemic among MSMs in the Philippines coupled with a preponderance of MSMs among the HIV positive cases recorded in the Davao Medical Center. After a series of coordination and advocacy meetings with the CHO and members of the Davao City local finance committee, a concept proposal for an MSM outreach prevention education program through an LGU performance-based grant (PBG) to NGOs was finalized, approved, and funded. Due to a shift in CHO priorities, however, the program has not been implemented yet.

Since the 2009 IHBSS showed that the HIV prevalence among MSMs in Davao City is 3.7%, *improving financing to increase the coverage of quality STI/HIV/AIDS services for MSMs* is critical. An MSM prevention education program could go a long way in increasing condom use to halt the spread of STI/HIV/AIDS.

TA interventions for Years 1 to 4 include the following:

- Assistance to the LAC in advocating with the Information Communication Technology-Davao (ICT-Davao, Inc.) to implement a workplace-based STI/HIV/AIDS program in call centers, in response to the Davao City AIDS Ordinance 041-02. HealthGov also assisted in drafting the Memorandum of Understanding between the City and ICT-Davao, Inc.
- Review and updating of the Davao City ISFP.
- Assistance to DOH-CHD in building its capacity to support the city in developing a local response plan on HIV/AIDS based on current data.

In Year 5, HealthGov, along with the central and regional DOH offices, other USAID CAs, and resource agencies, will give priority to the following:

- Implementing an outreach prevention education program for MSMs through TA in LGU PBG to NGOs and documentating the process from inception to end for replication in other LGUs; and
- Supporting the training of outreach health educators and implementation of an outreach prevention education program.

The activities and corresponding milestones, and expected results are detailed in the following operational plan matrix.

**Priority TA Interventions and Activities**
**DAVAO CITY**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Implementing outreach prevention education program for MSMs through TA in LGU PBG to NGOs | | | Meeting to develop implementing mechanism for LGU PBG to NGO including criteria for selection and accreditation of grantee and guidelines in assessing proposals submitted by NGOs | Meeting design, resource person, facilitator | | | | | | | | | | | | |
| | | | Meetings to mentor the DCAC in assessing proposals submitted by NGOs based on the PBG guidelines and award the grant agreement with particular focus on ensuring the documentation requirements of the PBG e.g. approved proposal, implementation plan with spe | Mentoring and coaching | | | | | | | | | | | | |
| | **1.4C.b** | Prevention education program for MSMs through LGU PBG to NGOs implemented | Field visits and records review to mentor and coach the DCAC in monitoring progress of implementation and assessing of results | Mentoring and coaching | | | | | | | | | | | | |
| | | | Review status report of implementation and provide feedback | Resource person | | | | | | | | | | | | |
| | | | Meetings with DOH-CHD 11 and DCAC secretariat to mentor in the documentation process from inception to end, specifically identifying essential action steps | Mentor | | | | | | | | | | | | |
| | | | Submit draft documentation report to HealthGov CKMM for comments/edits | Coordinator | | | | | | | | | | | | |
| | | Documentation report completed and disseminated | Meeting with DOH-CHD 11 and DCAC to finalize report for dissemination | Technical writing, fund support | | | | | | | | | | | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Support to the training of outreach health educators and implementing of outreach prevention education program | | 60 outreach workers trained in BCC outreach prevention education | Conduct the IPC/C workshop for outreach health educators | Facilitator; HealthPRO to design workshop | | | | | | | | | | | | |
| | | 2385 MARPs reached through community outreach prevention education | Field visits to monitor activities implementation by trained outreach workers | Mentoring and coaching | | | | | | | | | | | | |
| | 1.3A.c | 3 LGU representatives participated in the TOT in community mobilization | With HealthPRO as lead, assist DOH-CHD 11 and ACAC to design and implement the community mobilization training of trainers that will augment BCC outreach activities | Resource mobilization; facilitator; HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |
| | 1.3A.d | 12 LGU representatives trained on-site in community mobilization | Meeting with DOH-CHD 11 and DCAC to design, mobilize resources and implement the roll-out community mobilization training to other LGU stakeholders | Resource mobilization, facilitator; HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |

## Iloilo City

With technical assistance from HealthGov, Iloilo City has completed its HIV/AIDS ISFP, which was mainly an output of the City Health Office (CHO) and the City Planning and Development Office (CPDO). In the absence of an approved multi-sectoral ISFP, the LGU HIV/AIDS activities were mainly confined to the routinely planned SHC operations and some uncoordinated, donor-driven prevention activities. There is very limited partnership between DOH-CHD 6 and the CHO due to the City Health Officer's refusal to provide needed counterpart resources.

To spur renewed interest in STI/HIV/AIDS prevention and control, HealthGov worked for the finalization and legitimization of an ISFP with the participation of the multi-sectoral ISAC. With CHD 6, DOH-GFR6, and PROCESS-Panay Foundation, HealthGov assisted in organizing an ISAC meeting to finalize the five-year HIV/AIDS ISFP. The ISFP was eventually presented to the ISAC, completed, and endorsed to the CPDO for review and endorsement to the City Mayor.

To date, the Iloilo STD/AIDS Council (ISAC) has not been reactivated and the Iloilo ISFP has not yet been finalized. Considering that there is a new Mayor-elect, there is a need for the City Health Officer to present the STI/HIV/AIDS situation and plans to the new mayor. It was decided with CHD 6 that the Regional AIDS Assistance Team (RAAT) will schedule and conduct the briefing for the new mayor. CHD 6 will spearhead the preparation for this briefing. It is hoped that this briefing will spur the mayor to call for a meeting of the ISAC to review and finalize the ISFP in light of current STI/HIV/AIDS realities. If this materializes, HealthGov will assist CHD 6 in drafting the presentation and briefers. For now, HealthGov technical assistance is limited to ***improving outreach interventions among MARPs*** and this entails supporting the training of outreach health educators and implementation of an outreach prevention education program.

The activities and corresponding milestones, and expected results are detailed in the following operational plan matrix.

**Priority TA Interventions and Activities**
**ILOILO CITY**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Support to the training of outreach health educators and implementing of outreach prevention education program | 1.3A.d | 57 outreach workers trained in BCC outreach prevention education | Conduct the IPC/C workshop for outreach health educators | Facilitator; HealthPRO to design workshop | | | | | | | | | | | | |
| | | 1237 MARPs reached through community outreach prevention education | Field visits to monitor activities implementation by trained outreach workers | Mentoring and coaching | | | | | | | | | | | | |
| | 1.3A.c | 3 LGU representatives participated in the TOT in community mobilization | With HealthPRO as lead, assist DOH-CHD 6 and ISAC to design and implement the community mobilization training of trainers that will augment BCC outreach activities | Resource mobilization, facilitator; HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |
| | 1.3A.d | 12 LGU representatives trained on-site in community mobilization | Meeting with DOH-CHD 6 and ISAC to design, mobilize resources and implement the roll-out community mobilization training to other LGU stakeholders | Resource mobilization, facilitator; HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |

## General Santos City

The 2009 IHBSS highlighted the importance of educating and changing behaviors on consistent and correct condom use among clients of FSWs for STI/HIV/AIDS prevention and control. Studies revealed that the frequent clients of FSWs in General Santos City are deep-sea fishermen (DSF). General Santos City is home to about 17,000 DSF and the Fish Port is the convergence point for the 35,000 DSF of SOCKSARGEN. Thus, HealthGov's TA to General Santos City is geared towards *improving access to STI/HIV/AIDS services through LGU-private sector partnership.*

HealthGov, together with PRISM and the LGU, enjoined the South Cotabato Purse Seiners' Association (SOCOPA) to integrate STI/HIV/AIDS prevention and control activities into the workplace family health program that was initiated by PRISM targeting the workers of the fishing industry. Continuing technical assistance in basic STI/HIV/AIDS prevention and control, training for human resource managers and clinic staff/workplace family health program staff, and operationalization of a referral system for STI/HIV/AIDS services, including recording and reporting, should be provided.

In Year 3, with technical assistance from CHD 12 and HealthGov, General Santos City, through the CHO, embarked on the formulation of its City Investment Plan for Health (CIPH), incorporating the STI/HIV/AIDS prevention and control program as one of the priority critical interventions. The CIPH was approved by the DOH and Donors Joint Appraisal Committee in 2009.

Through HealthGov's advocacy activities, the LAC and the City Mayor committed an additional PhP1 million budget for SHC activities over and above the approved budget of PhP1.7 million intended for laboratory reagents and salaries of the contractual medical technologist and midwife. HealthGov also advocated for the reactivation of the City STI/HIV/AIDS Committee by enjoining member entities, especially the CPDO, to plan and implement STI/HIV/AIDS interventions.

HealthGov likewise assisted the city in completing its Annual Operational Plans, while the DOH-CHD 12 was assisted in building its capacity to provide technical support to the city in developing an actionable local response plan on HIV/AIDS based on most recent information.

In Year 5, HealthGov will undertake the following, together with the central and regional DOH offices, other USAID CAs, and resource agencies:

- Improve service delivery by supporting the establishment of private sector partnership with the General Santos City Chamber of Commerce and Industry, specifically SOCOPA, in planning, implementing, monitoring and evaluating the STI/HIV/AIDS prevention and control activities of the workplace family health program initiative, and documenting the process from inception to end, specifically identifying essential action steps undertaken; and
- Support the training of outreach health educators and implementation of an outreach prevention education program.

The activities and corresponding milestones, and expected results are detailed in the following operational plan matrix.

**Priority TA Interventions and Activities**
**GENERAL SANTOS CITY**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Increasing service delivery by supporting private sector partnership with the General Santos City Chamber of Commerce and Industry, specifically SOCOPA, to plan, implement, monitor and evaluate STI/HIV/AIDS prevention and control activities of the workpla | | | Meeting with DOH-CHD 12, GCAC, PRISM2 and HealthPRO to design and organize the STI/HIV/AIDS prevention and control training for human resource managers and clinic staff in fishing companies under SOCOPA | Facilitator; resouce person, fund support; PRISM2 and HealthPRO to provide technical inputs in manual development | | | | | | | | | | | | |
| | | | Facilitate a 2-days writeshop to adapt the implementation guide and manual for workplace STI/HIV/AIDS prevention and control program | Writeshop design, facilitator, resource person; HealthPRO to provide technical inputs in adapting the manual | | | | | | | | | | | | |
| | 1.3A.d | HR Managers and clinic/workplace health staff trained in basic STI/HIV/AIDS prevention and control | Act as resource person during the 2-days training of workplace health staff on STI/HIV/AIDS prevention and control including the referral and reporting systems | Resource person, training design, facilitator, HealthPRO and PRISM2 as resource persons | | | | | | | | | | | | |
| | 1.4C.b | Workplace health staff providing STI/HIV/AIDS education activities to employees and referring cases for diagnosis, treatment, care and support | Mentor the SHC staff in monitoring the implementation of the HIV/AIDS prevention and control activities in the workplace | Mentoring and coaching | | | | | | | | | | | | |
| | | | With DOH-CHD 12 and the GCAC, review reports and other documents submitted by workplaces | Coach, fund support | | | | | | | | | | | | |
| | | | Meetings with DOH-CHD 12 and GCAC secretariat to mentor in the documentation process from inception to end, specifically identifying essential action steps | Mentor | | | | | | | | | | | | |
| | | | Submit draft documentation report to HealthGov CKMM for comments/edits | Coordinator | | | | | | | | | | | | |
| | | Documentation report completed and disseminated | Meeting with DOH-CHD 12 and GCAC to finalize report for dissemination | Technical writing, fund support | | | | | | | | | | | | |

## Metro Cebu (Cities of Cebu, Lapu-Lapu, and Mandaue)

The STI/HIV/AIDS ISFP for the Cities of Cebu, Lapu-Lapu, and Mandaue, espouses the concept of LGU collaboration in implementing STI/HIV/AIDS projects and activities as an acceptable and feasible strategy. Thus, the centerpiece of HealthGov's TA to the three cities *is implementing STI/HIV/AIDS prevention and control through zonal collaboration*. HIV does not recognize political boundaries and the MARPs move from city to city. It is in the three cities' best interest to unify plans and policies; pool logistics for priority programs, projects, and activities; and share human resource expertise, especially now that a raging HIV epidemic among IDUs is happening (40-60% HIV and 95% hepatitis C prevalence). Continuing TA in crafting a unified strategic plan and the tri-city collaboration operational guidelines should be provided. Likewise, the collaboration which was formalized at the city health office/CHD level needs to be legitimized up to the level of the LCEs.

TA interventions for Years 1 to 4 consisted of the following:

- Assistance to Mandaue City in preparing a presentation material on its STI/HIV/AIDS prevention and control program for the Mandaue City Local Finance Committee, including a presentation material on the zonal collaboration concept, which was presented to other LGUs in Metro Cebu;
- Assistance to Lapu-Lapu City in drafting its ISFP and advocating for its adoption;
- Orientation of the CHD 6 staff on the STI/HIV/AIDS thrusts of the three cities and providing them with a map of NGOs conducting HIV/AIDS work in the area; and
- Building the capacity of DOH-CHD 7 in developing a local response plan on HIV/AIDS based on most recent data to enable them to assist Metro Cebu.

HealthGov, together with the central and regional DOH offices, other USAID CAs, and resource agencies, will undertake the following:

- Institutionalize tri-city collaboration in STI/HIV/AIDS surveillance, treatment, care, and support activities and document the process from inception to end, specifically identifying essential action steps undertaken; and
- Support the training of outreach health educators and implementation of an outreach prevention education program.

The activities and corresponding milestones, and expected results are detailed in the operational plan matrix.

**Priority TA Interventions and Activities**
**TRI-CITIES (CEBU, LAPU-LAPU, MANDAUE)**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Institutionalizing the TCC in STI/HIV/AIDS surveillance, treatment, care, and support activities | | | With DOH-CHD 7, assist the tri-cities in designing and conducting small group meetings to develop and finalize the TCC operational guidelines | Resource person; technical writing | | | | | | | | | | | | |
| | | | Meetings to assist DOH-CHD 7 and the tri-cities to organize advocacy activities directed to the LCEs for approval of the TCC | Coach, fund support | | | | | | | | | | | | |
| | | | Meeting with DOH-CHD 7 and tri-cities to design the field test of the TCC operational guide | Coach, resource person; fund support | | | | | | | | | | | | |
| | | | Site visits to monitor and coach DOH-CHD 7 and the tri-cities during field test | Mentor; draft TCC operational guide; field test design | | | | | | | | | | | | |
| | | TCC operational guidelines formulated | Meeting with DOH-CHD 7 and tri-cities to finalize TCC operational guide including SOPs on referral, unified health card and test packages and capacity building of CHOs | Resource person; facilitator; fund support | | | | | | | | | | | | |
| | 1.1G.c | TCC legitimized through a MOA signed by the LCEs | Memorandum of Understanding among tri-cities signed | Coach | | | | | | | | | | | | |
| | | | Meetings with DOH-CHD 7 and the tri-cities to mentor in the documentation process from inception to end, specifically identifying essential action steps | Mentor | | | | | | | | | | | | |
| | | | Submit draft documentation report to HealthGov CKMM for comments/edits | Coordinator | | | | | | | | | | | | |
| | | Documentation report completed and disseminated | Meeting with DOH-CHD 7 and the tri-cities to finalize report for dissemination | Technical writing; fund support | | | | | | | | | | | | |

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Supporting the training of outreach health educators and implementing of outreach prevention education program | | 44, 39 and 35 outreach workers trained in BCC outreach prevention education in Cebu, Lapu-Lapu, and Mandaue cities, respectively | Conduct the IPC/C workshop for outreach health educators | Facilitator, HealthPRO to design workshop | | | | | | | | | | | | |
| | | 2627, 703, and 738 MARPs reached through community outreach prevention education in Cebu, Lapu-Lapu, and Mandaue cities, respectively | Field visits to monitor activities implementation by trained outreach workers | Mentor, coach | | | | | | | | | | | | |
| | 1.3A.c | 3 LGU representatives participated in the TOT in community mobilization per city | With HealthPRO as lead, assist DOH-CHD 7 and the tri-cities to design and implement the community mobilization training of trainers that will augment BCC outreach activities | Resource mobilization, facilitator, HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |
| | 1.3A.d | 10 (in Cebu City) and 8 (each in Lapu-Lapu and Mandaue Cities) LGU representatives trained on-site in community mobilization | Meeting with DOH-CHD 7 and the tri-cities to design, mobilize resources and implement the roll-out community mobilization training to other LGU stakeholders | Resource mobilization, facilitator, HealthPRO for activity design and over-all conduct | | | | | | | | | | | | |

## Quezon City

HealthGov's TA to Quezon City is geared towards ***improving quality and coverage of STI/HIV diagnosis and prevention education.*** This was the intent when HealthGov, with the Philippine National AIDS Council (PNAC) and the Quezon City Health Department (QCHD) organized the owners and managers of entertainment establishments in the city. The initiative resulted in the creation of the Quezon City Health and Lifestyle Spa, Massage Clinics, Clubs, and KTV Association (QCHL SaMaCKA). The association assisted in mapping out activities that generated an accurate count of potential SHC clients for target setting. It also policed its own ranks leading to most members requiring their workers to submit to weekly check-ups, and assisted in implementing prevention education through peer education. All these are expected to lead to a decrease in STI/HIV cases. To strengthen the association, HealthGov linked it up with its counterpart in Angeles City for the latter to mentor and share good practices for possible adoption (i.e., strategies for continuing prevention education among MARPs, enforcement of regular weekly SHC check-up and 100% condom use during high-risk sexual encounters, resource generation for identified priority activities, and PhilHealth accreditation of male and female sex workers). TA was also directed at increasing the city's capacity to monitor and assess STI/HIV/AIDS prevention education coverage.

In Year 3, HealthGov provided technical assistance in refining the ISFP for inclusion in the 2010 AIP. TA was also provided in establishing a "one-stop-shop" to facilitate compliance with the SHC weekly examination requirement.

HealthGov also provided assistance in the development of a proposal for an MSM peer education program to be implemented by an NGO through a performance-based grant (PBG). The CHO, however, decided that QCHD handle this program with the hiring of 10 Community Health Outreach Workers (CHOWs). Parallel to this is another initiative of the Quezon City Vice Mayor's Office focusing on peer education at the *barangay* level. HealthGov assisted the QCHD in drafting a revised concept proposal for the operationalization of this scheme.

To improve the quality of SHC services, particularly STI diagnosis and prevention education, HealthGov will assist the CHD of NCR in implementing SDExH among the SHC staff in the three QCHD SHCs.

TA was also provided in the following areas:

- Mentoring of SHC physicians in calculating resource requirements for essential medicines, reagents, and supplies using the forecasting tool developed by HealthGov and the NASPCP-DOH;
- Review and updating of the map of registered entertainment establishments and public places where cruising for sex happens;
- Advocating for the hiring of a pathologist to head the city laboratory to ensure quality control;
- With HealthPRO, development and pre-testing of IEC materials intended for MARPs; and
- Capability building for CHD-NCR in developing a local response plan on HIV/AIDS to enable it to provide TA to the city.

In Year 5, HealthGov, along with the central and regional DOH offices, other USAID CAs, and resource agencies will prioritize the following:

- Assessing STI/HIV/AIDS prevention education coverage through TA to the LGU-QCHL SaMaCKA in routine monitoring of accomplishments and documenting the LGU-QCHL SaMaCKA partnership and inter-LGU technical assistance (with LACEM);
- Improving STI/HIV/AIDS service delivery in SHCs through SDExH; and
- Supporting the training of outreach health educators and implementation of an outreach prevention education program.

The activities and corresponding milestones, and expected results are detailed in the following operational plan matrix.

**Priority TA Interventions and Activities**
**QUEZON CITY**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Improving STI/HIV/AIDS prevention education coverage through TA to the LGU-QCHL SaMaCKA partnership in identifying and implementing PPAs in line with the ISFP | | | Meeting with QCSAC, QCHL SaMaCKA and LACEM of Angeles City to design a tool to monitor QCHL SaMaCKA operations | Facilitator | | | | | | | | | | | | |
| | | Comparative monthly 2010-2011 SHC number of attendees reported | Mentor and coach the QCCAC in monitoring progress of implementation and assessing of results | Monitoring tool, coach | | | | | | | | | | | | |
| | | | Review status report of implementation and provide feedback | Mentor | | | | | | | | | | | | |
| | | | Meetings with DOH-CHD NCR and QCSAC secretariat to mentor in the documentation process from inception to end of the LGU partnership with QCHL SaMaCKA and Inter-LGU technical assistance (with LACEM), specifically identifying essential action steps | Mentor | | | | | | | | | | | | |
| | | | Submit draft documentation report to HealthGov CKMU for review | Coordinator | | | | | | | | | | | | |
| | | Documentation report completed and disseminated | Meeting with DOH-CHD NCR and QCSAC to finalize report for dissemination | Technical writing, fund support | | | | | | | | | | | | |
| Supporting the training of outreach health educators and implementing of outreach prevention education program | | 59 outreach workers trained in BCC outreach prevention education | Conduct the IPC/C workshop for outreach health educators | Facilitator | | | | | | | | | | | | |
| | | 4526 MARPs reached through community outreach prevention education | Field visits to monitor activities implementation by trained outreach workers | Mentoring and coaching | | | | | | | | | | | | |
| | | 3 LGU representatives participated in the TOT in community mobilization | Assist DOH-CHD NCR and QCSAC to design and implement the community mobilization training of trainers that will augment BCC outreach activities | Resource mobilization, facilitator | | | | | | | | | | | | |
| | | 12 LGU representatives trained in community mobilization | Meeting with DOH-CHD NCR and QCSAC to design, mobilize resources and implement the roll-out community mobilization training to other LGU stakeholders | Resource mobilization, facilitator | | | | | | | | | | | | |

## Zamboanga City

The Zamboanga City STI/HIV/AIDS prevention and control program is backed by an active Zamboanga City Multi-Sectoral AIDS Council (ZCMSAC), a supportive city mayor, and local NGOs/CSOs/POs. It is one of the better funded and dynamic LGU HIV/AIDS programs in the country. In fact, the city has been a recipient of several awards and recognition for HIV/AIDS prevention and control.

Lately, however, there has been an influx of IDU deportees from Malaysia who share needles with the locals. To monitor and prevent HIV transmission across borders, specifically that with Malaysia, HealthGov supported the development of a proposal for the conduct of an assessment that will help the city establish VCT and prevention education. The assessment will be funded through the Citywide Investment Plan for Health (CIPH), which HealthGov and DOH-CHD 9 helped develop.

Another challenge that the city faces is the rising number of MSMs detected through VCT, the high syphilis prevalence among MSMs, narrow reach/low coverage of prevention education, and high-risk sexual encounters of many MSMs with girlfriend, wife, and FSWs. HealthGov advocated with DOH-CHD 9 to pursue interventions targeting the MSMs, specifically, community-based prevention education program for MSMs incorporating site-specific strategies in three priority *barangays* (Recodo, Campo Islam, and Upper Calarian).

In Year 5, HealthGov's TA to the city is limited to ***improving outreach interventions among MARPs*** since the LGU is already actively supporting STI/HIV/AIDS prevention activities. HealthGov will support the training of outreach health educators and facilitate the implementation of an outreach prevention education program.

The activities and corresponding milestones, and expected results are detailed in the following operational plan matrix.

**Priority TA Interventions and Activities**
**ZAMBOANGA CITY**
**October 1, 2010- September 30, 2011**

| TA Intervention (1) | IR CODE | Expected Output/Result or Milestone* (2) | Activities (3) | Nature of TA Support from HealthGov and other CAs (4) | TIMELINE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | | | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept |
| Training of outreach health educators and implementation of outreach prevention education program | | 44 outreach workers trained in BCC outreach prevention education | Conduct the IPC/C workshop for outreach health educators | Facilitator | | | | | | | | | | | | |
| | | 1825 MARPs reached through community outreach prevention education | Field visits to monitor activities implementation by trained outreach workers | Mentoring and coaching | | | | | | | | | | | | |
| | 1.3A.c | 3 LGU representatives participated in the TOT in community mobilization | Assist DOH-CHD 9 and ZCMSAC to design and implement the community mobilization training of trainers that will augment BCC outreach activities | Resource mobilization, facilitator | | | | | | | | | | | | |
| | 1.3A.d | 12 LGU representatives trained in on-site community mobilization | Meeting with DOH-CHD 9 and ZCMSAC to design, mobilize resources, and implement the roll-out community mobilization training to other LGU stakeholders | Resource mobilization, facilitator | | | | | | | | | | | | |

# Annex C
# HealthGov Performance Milestones

## ANNEX C1 - LUZON FY5 Quarterly Milestones Against Performance Indicators

| IR Indicators/ Milestones | | ALBAY | | | | | | | | | | | | | | | BULACAN | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | 1 | 3 | 15 | 1 | 3 | 15 | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| c | CSR (CSR+) policy crafted | | | 9 | | | 9 | | | | | | | | | | | | | | | | | | | | | | | | |
| d | CSR (CSR+) Policy approved | | | 9 | | | 4 | | | 5 | | | | | | | | | | | | | | | | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | 1 | 3 | 15 | 1 | 3 | 15 | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | 1 | 3 | 15 | 1 | 3 | 15 | | | | | | | | | | 1 | 3 | 21 | | 3 | 14 | 1 | | 7 | | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | CAGAYAN | | | | | | | | | | | | | | | ISABELA | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | 1 | | | 1 | | | | | | | | | | | | 1 | | | | | | | | 35 | | | | | | |
| c | CSR (CSR+) policy crafted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | CSR (CSR+) Policy approved | 1 | 1 | 9 | 1 | | | | 1 | 9 | | | | | | | | | | | | | | | | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | | | | | | | | | | | | | | | | 1 | | | | | | 1 | | | | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | 1 | 1 | 28 | 1 | 1 | 28 | | | | | | | | | | 1 | 2 | 35 | | 2 | 15 | 1 | | 10 | | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | NUEVA ECIJA | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | | | | | | | | | | | | | | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | | | | | | | | | | | | | | | | | | |
| c | CSR (CSR+) policy crafted | | | | | | | | | | | | | | | | | | |
| d | CSR (CSR+) Policy approved | | | | | | | | | | | | | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | | | | | | | | | | | | | | | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | 1 | 1 | 8 | 1 | 1 | 8 | | | | | | | | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | 1 | | 14 | 1 | | 14 | | | | | | | | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | | | |

| | IR Indicators/ Milestones | ALBAY | | | | | | | | | | | | | | | BULACAN | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | 1 | 3 | 15 | 1 | 3 | 15 | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 3 | 15 | | 1 | 5 | | 2 | 10 | | | | | | | | 3 | 21 | | 3 | 10 | | | 11 | | | | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | 9 | | | 9 | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Policies approved | | | 9 | | | 4 | | | 5 | | | | | | | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | IR Indicators/ Milestones | CAGAYAN | | | | | | | | | | | | | | | ISABELA | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | | | | | | | | | | | | | | | | 1 | 2 | 35 | 1 | 2 | 35 | | | | | | | | | |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 1 | 28 | | 1 | 8 | | | 20 | | | | | | | 1 | 2 | 35 | | | 20 | | 2 | 15 | | | | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | 1 | | | | | | 1 | | | | | | | | | | | | | | | | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | 1 | 28 | | | | | 1 | 18 | | | 10 | | | | | | | | | | | | | | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Policies approved | 1 | 1 | 9 | 1 | | | | 1 | 9 | | | | | | | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | IR Indicators/ Milestones | NUEVA ECIJA | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | 1 | | | 1 | | 14 | | | | | | | | | |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 5 | 27 | | 5 | 27 | | | | | | | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | |
| b | Policies approved | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | | | | | | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | ALBAY | | | | | | | | | | | | | | | BULACAN | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | 3 | 15 | 1 | 3 | 15 | | | | | | | | | | 1 | 3 | 21 | 1 | 3 | 10 | | | 11 | | | | | | |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Local NHIP implementation plan prepared/ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Local NHIP implementation plan approved and/or implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | 3 | 6 | | 3 | 6 | | | | | | | | | | | | 3 | | | 3 | | | | | | | | | |
| b | Facilities accredited by PhilHealth | | 3 | 6 | | | | | 3 | 6 | | | | | | | | | 3 | | | | | | 3 | | | | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| b | Province-wide annual training plan prepared | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated training design/ modules | | 2 | 7 | | 2 | 7 | | | | | | | | | | 1 | | 10 | 1 | 10 | | | | | | | | | | |

| IR Indicators/ Milestones | | CAGAYAN | | | | | | | | | | | | | | | ISABELA | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | 1 | 28 | 1 | 1 | 28 | | | | | | | | | | 1 | 2 | 35 | 1 | | 20 | | 2 | 15 | | | | | | |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | 1 | | | | | | 1 | | | | | | | | | | | | | | | | | | | | | | | |
| b | Local NHIP implementation plan prepared/ | 1 | 1 | 28 | | | | 1 | | 18 | | 1 | 10 | | | | | | | | | | | | | | | | | | |
| c | Local NHIP implementation plan approved and/or implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | | 5 | | | 5 | | | | | | | | | | | | 7 | | | 7 | | | | | | | | | |
| b | Facilities accredited by PhilHealth | | | 5 | | | 5 | | | | | | | | | | | | 7 | | | | | | 7 | | | | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| b | Province-wide annual training plan prepared | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated training design/ modules | 1 | | 5 | 1 | | 5 | | | | | | | | | | 1 | | 6 | 1 | | 6 | | | | | | | | | |

| IR Indicators/ Milestones | | NUEVA ECIJA | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | 5 | 27 | 1 | 5 | 27 | | | | | | | | | | |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | | | | | | | | | | | | | | | |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | | | | | | | | | | | | | | | | |
| b | Local NHIP implementation plan prepared/ | | | | | | | | | | | | | | | | |
| c | Local NHIP implementation plan approved and/or implemented | | | | | | | | | | | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | | 10 | | | 10 | | | | | | | | | | |
| b | Facilities accredited by PhilHealth | | | 10 | | | | | | 10 | | | | | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | 1 | | | 1 | | | | | | | | | | | | |
| b | Province-wide annual training plan prepared | | | | | | | | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated training design/ modules | 1 | 1 | 8 | 1 | 1 | 8 | | | | | | | | | | |

| | IR Indicators/ Milestones | ALBAY | | | | | | | | | | | | | | | BULACAN | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | 1 | 1 | 3 | 1 | 1 | 3 | | | | | | | | | |
| b | 3 phases of SDExH training completed | 1 | | 3 | 1 | | 3 | | | | | | | | | | | 1 | 3 | | | | | | | | 1 | 3 | | | |
| c | Service Improvement Plan implemented | | | 3 | | | | | | 3 | | | 3 | | | | | 1 | 3 | | | | | 1 | 3 | | 1 | 3 | | | |
| d | LGUs implementing SDExH received recognition and awards | | | 3 | | | | | | 3 | | | 3 | | | | | 1 | 3 | | | | | | | | 1 | 3 | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | | 3 | 15 | | 2 | 4 | | 1 | 5 | | | 6 | | | | | | | | | | | | | | | | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | | | | | | | | | | | | | | | | | 3 | 21 | | 1 | 7 | | 1 | 7 | | 1 | 7 | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | IR Indicators/ Milestones | CAGAYAN | | | | | | | | | | | | | | | ISABELA | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | | 1 | 28 | | 1 | 19 | | | 9 | | | | | | | | 2 | 35 | | | 12 | | 2 | 11 | | | 12 | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | IR Indicators/ Milestones | NUEVA ECIJA | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | | | | | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | 1 | 5 | 27 | 1 | | 10 | | 2 | 10 | | 3 | 7 | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | | | | | | | | | | | | | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | ALBAY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | 2 | 7 | | 2 | 7 | | | | | | | | | |

| IR Indicators/ Milestones | | BULACAN | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | CAGAYAN | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | | 5 | | | 5 | | | | | | | | | |

| IR Indicators/ Milestones | | ISABELA | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | NUEVA ECIJA | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | 1 | 8 | | 1 | 8 | | | | | | | | | |

## ANNEX C1 - LUZON FY5 Quarterly Milestones Against Performance Indicators

| IR Indicators/ Milestones | | PANGASINAN | | | | | | | | | | | | | | | TARLAC | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | LUZON TOTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | AC | PC | QC | AC | PC | QC | AC | PC | QC | AC | PC | QC | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | 3 | 15 | 3 | 3 | 15 | | | 35 | | | | | |
| c | CSR (CSR+) policy crafted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 9 | | | 9 | | | | | | | |
| d | CSR (CSR+) Policy approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 18 | 1 | | 4 | | 1 | 14 | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | | 3 | 44 | | 3 | 20 | | | 24 | | | | | | | | | 4 | | | 4 | | | | | | | | | | | | | | | | | | | | | | 3 | 7 | 71 | 2 | 7 | 47 | 1 | | 24 | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | | 3 | 44 | | 3 | 20 | | | 24 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5 | 12 | 157 | 3 | 12 | 106 | 2 | | 41 | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | | 3 | 44 | | 3 | 20 | | | 24 | | | | | | | | 1 | 17 | | 1 | 17 | | | | | | | | | | | | | | | | | | | | | | | 4 | 61 | | 4 | 37 | | | 24 | | | | | |

| | IR Indicators/ Milestones | PANGASINAN | | | | | | | | | | | | | | | TARLAC | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | LUZON TOTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | AC | PC | QC | AC | PC | QC | AC | PC | QC | AC | PC | QC | P | C | M | P | C | M | P | C | M | P | C | M |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5 | 5 | 50 | 5 | 5 | 64 | | | | | | |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | 7 | | | 7 | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 3 | 43 | | 3 | 20 | | | 24 | | | | | | | | 1 | 17 | | 1 | 5 | | | 12 | | | | | | | | | | | | | | | | | | 1 | 18 | 186 | | 14 | 95 | | 4 | 92 | | | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | 2 | | | 1 | | | 1 | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | | | 1 | 4 | | | | 1 | | 4 | | | | | | | | | | | | | | | | | | | 2 | 32 | | | | 1 | 1 | 22 | | | 10 | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 9 | | | 9 | | | | | | | | |
| b | Policies approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 18 | 1 | | 4 | | 1 | 14 | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | PANGASINAN | | | | | | | | | | | | | | | TARLAC | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | LUZON TOTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | AC | PC | QC | AC | PC | QC | AC | PC | QC | AC | PC | QC | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | 3 | 44 | 1 | 3 | 14 | | | 15 | | | 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 6 | 17 | 170 | 6 | 15 | 114 | | 2 | 41 | | | 15 | | | |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | 1 | 10 | | | | | 1 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 10 | | | | | 1 | 10 | | | | |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | | 1 | | | 1 | | | | | | |
| b | Local NHIP implementation plan prepared/ | 1 | 3 | 44 | 1 | 3 | 20 | | | 24 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 4 | 72 | 1 | 3 | 20 | 1 | | 42 | | 1 | 10 | | | |
| c | Local NHIP implementation plan approved and/or implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | | | | | | | | | | | | | | | | | 5 | | | 5 | | | | | | | | | | | | | | | | | | | | | | | 3 | 36 | | 3 | 36 | | | | | | | |
| b | Facilities accredited by PhilHealth | | | | | | | | | | | | | | | | | | 5 | | | | | | 5 | | | | | | | | | | | | | | | | | | | | 3 | 36 | | | 5 | | 3 | 31 | | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | | | | | | | | | | | | | | | | 1 | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | 5 | | | 5 | | | 1 | | | | | | |
| b | Province-wide annual training plan prepared | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated training design/ modules | 1 | 1 | 4 | 1 | 1 | 4 | | | | | | | | | | 1 | | 5 | 1 | | 5 | | | | | | | | | | 1 | 1 | | | | | | | | | | | 6 | 5 | 45 | 6 | 15 | 35 | | | | | | | |

| IR Indicators/ Milestones | | PANGASINAN | | | | | | | | | | | | | | | TARLAC | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | LUZON TOTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | AC | PC | QC | AC | PC | QC | AC | PC | QC | AC | PC | QC | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 3 | 1 | 1 | 3 | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 6 | 1 | | 3 | | | | | 1 | 3 |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 6 | | | | | 1 | 6 | | 1 | 6 |
| d | LGUs implementing SDExH received recognition and awards | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 6 | 1 | | | | | 3 | | 1 | 6 | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | | 2 | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | 1 | 3 | 44 | 1 | 3 | 10 | | | 19 | | | 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 14 | 149 | 2 | 6 | 55 | | 5 | 54 | | 3 | 40 | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | 1 | | | 1 | | | | | | | | | | | | | 1 | 17 | | 1 | 6 | | | 6 | | | 5 | | | | | | | | | | | | | | | | 1 | 4 | 38 | 1 | 2 | 13 | | 1 | 13 | | 1 | 12 | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | IR Indicators/ Milestones | PANGASINAN | | | | | | | | | | | | | | | TARLAC | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | | | TOTAL | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | AC | PC | QC | AC | PC | QC | AC | PC | QC | AC | PC | QC | P | C | M |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | 7 | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 3 | 20 |

## ANNEX C2 - VISAYAS FY5 Quarterly Milestones Against Performance Indicators

| IR Indicators/ Milestones | | AKLAN | | | | | | | | | | | | | | | BOHOL | | | | | | | | | | | | | | CAPIZ | | | | | | | | | | | | | | NEGROS OCCIDENTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | 1 | | | | | | | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | 1 | | | 1 | | | | | | | | | | | | 1 | | | | | | | | | 1 | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | 1 | | 17 | 1 | | 17 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | CSR (CSR+) policy crafted | 1 | | 9 | 1 | | 9 | | | | | | | | | | | 1 | 25 | | 1 | 25 | | | | | | | | | | 1 | 8 | | 1 | 8 | | | | | | | | | | 8 | 12 | | 8 | 12 | | | | | | | |
| d | CSR (CSR+) Policy approved | 1 | | 9 | 1 | | 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 7 | | | | | | | | | | | | | | | | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | | 2 | | | | | | 2 | | | | | | | | 1 | 10 | 1 | | 5 | | | 5 | | | | | | | 1 | | 8 | 1 | | | | | 8 | | | | | | | | 2 | | | 2 | | | | | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | 1 | | 17 | 1 | | 17 | | | | | | | | | | | 1 | 25 | | 1 | 25 | | | | | | | | | | 1 | 16 | | 1 | 16 | | | | | | | | | | 8 | 12 | | 8 | 12 | | | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | 1 | | 17 | 1 | | 17 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | 1 | | 17 | | | | 1 | | 10 | | | 7 | | | | | | | | | | | | | | | | | | | 1 | 16 | | 1 | 16 | | | | | | | | | | | | | | | | | | | | | |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | 1 | | 17 | | | | 1 | | 17 | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | AKLAN | | | | | | | | | | | | | | | BOHOL | | | | | | | | | | | | | | | CAPIZ | | | | | | | | | | | | | | | NEGROS OCCIDENTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | 1 | | 17 | 1 | | 7 | | | 10 | | | | | | | | 1 | 47 | | 1 | 7 | | | 30 | | | 10 | | | | | 1 | 16 | | | | | 1 | 16 | | | | | | | | 12 | 19 | | 10 | 9 | | 2 | 10 | | | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | | | | 1 | | | | | | | | | | | | | | | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 16 | | | | | 1 | 10 | | | 6 | | | | | | | | | | | | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | 1 | | 9 | 1 | | 9 | | | | | | | | | | | 1 | 25 | | 1 | 25 | | | | | | | | | | 1 | 8 | | 1 | 8 | | | | | | | | | | | 8 | 12 | | 8 | 12 | | | | | | | | |
| b | Policies approved | 1 | | 9 | 1 | | 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | 7 | | | 7 | | | | | | | | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | | 1 | | 13 | 1 | | 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | | 5 | | | | | | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 4 | 7 | 1 | 4 | 7 | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 16 | | 1 | 16 | | | | | | | | | | | | | | | | | | | | | | |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of the approved total annual LGU budget | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | | 17 | 1 | | 17 | | | | | | | | | | 1 | 1 | 47 | | | | 1 | 1 | 47 | | | | | | | 1 | 1 | 16 | | | | 1 | 1 | 16 | | | | | | | 1 | 12 | 19 | 1 | 12 | 19 | | | | | | |

| IR Indicators/ Milestones | | AKLAN | | | | | | | | | | | | | | | BOHOL | | | | | | | | | | | | | | CAPIZ | | | | | | | | | | | | NEGROS OCCIDENTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | | 5 | | | 5 | | | | | | | | | | | | 13 | | | | | | 8 | | | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | | | 5 | | | 5 | | | | | | | | | | 1 | | 13 | 1 | | 13 | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Local NHIP implementation plan prepared/ updated | 1 | | | 1 | | | | | | | | | | | | 1 | | 13 | 1 | | 13 | | | | | | | | | 1 | 1 | 16 | 1 | 1 | 16 | | | | | | | | | | | | | | | | | | | | | |
| c | Local NHIP implementation plan approved and/or implemented | | | | | | | | | | | | | | | | 1 | | 13 | | | | 1 | | 13 | | | | | | | | | | | | | | | | | | | | 4 | 7 | | | | | 4 | 7 | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | | 5 | | | 5 | | | | | | | | | | | | 13 | | | 5 | | | 5 | | | 3 | | | | | | | | | | | | | | | | 4 | 7 | | 2 | 3 | | 1 | 2 | | 1 | 2 | | | |
| b | Facilities accredited by PhilHealth | | | 5 | | | | | | 5 | | | | | | | | | 13 | | | 5 | | | 5 | | | 3 | | | | | | | | | | | | | | | | 4 | 7 | | 2 | 3 | | 1 | 2 | | 1 | 2 | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | |
| b | Province-wide annual training plan prepared | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated | | | 10 | | | 10 | | | | | | | | | | 1 | | 25 | 1 | | 25 | | | | | | | | | | | 7 | | | | | | 7 | | | | | 1 | 11 | 14 | 1 | 11 | 14 | | | | | | |

| IR Indicators/ Milestones | | AKLAN | | | | | | | | | | | | | | | BOHOL | | | | | | | | | | | | | | | CAPIZ | | | | | | | | | | | | | NEGROS OCCIDENTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | 1 | | 17 | | | 5 | 1 | | 5 | | | 7 | | | | | 1 | 47 | | | 15 | | 1 | 15 | | | 17 | | | | 1 | 1 | 16 | | 1 | 6 | | | 5 | | | 5 | | | | 1 | 12 | 19 | | 4 | 7 | | 4 | 6 | | 4 | 6 | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | | | | 1 | | | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | 1 | | | | | | | 1 | | | | | | 1 | | | | | | | | | 1 | | | | | | 1 | | 1 | | | 1 | | | | 1 | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | AKLAN | | | | | | | | | | | | | | | BOHOL | | | | | | | | | | | | | | | CAPIZ | | | | | | | | | | | | | | | NEGROS OCCIDENTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | 1 | | | | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | 9 | | | 9 | | | | | | | | | | | 1 | 25 | | 1 | 25 | | | | | | | | | | 1 | 8 | | 1 | 8 | | | | | | | | | | | 8 | 12 | | 8 | 12 | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | | 10 | | | | | | 10 | | | | | | | | | 3 | | | | | | 3 | | | | | | | | | 7 | | | | | | 7 | | | | | | | | 11 | 14 | | 11 | 14 | | | | | | | |

## ANNEX C2 - VISAYAS FY5 Quarterly Milestones Against Performance Indicators

| IR Indicators/ Milestones | | NEGROS ORIENTAL | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | | | | | | | | | | | VISAYAS TOTAL | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | | | | | Q2 | | | | | Q3 | | | | | | Q4 | | | | | | | | | | | | | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | | | | | | | 1 | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | | | 3 | | | | | | 1 | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 17 | 1 | | 17 | | | | | | | | | |
| c | CSR (CSR+) policy crafted | | 4 | 11 | | 4 | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 14 | 65 | 1 | 14 | 65 | | | | | | | | | |
| d | CSR (CSR+) Policy approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 9 | 1 | | 16 | | | | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 22 | 2 | | 7 | | | 15 | | | | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 10 | 70 | 1 | 10 | 70 | | | | | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | 1 | 6 | 19 | 1 | 6 | 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 6 | 36 | 2 | 6 | 36 | | | | | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 33 | | 1 | 16 | 1 | | 10 | | | 7 | | | |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | 17 | 1 | | | 1 | | 17 | | | | | | |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | 1 | | 6 | 1 | | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 6 | 1 | | 6 | | | | | | | | | |

| IR Indicators/ Milestones | | NEGROS ORIENTAL | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | | | | | | | | | | | VISAYAS TOTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | | | | Q2 | | | | | Q3 | | | | | Q4 | | | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5 | | | 5 | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 6 | 19 | | 6 | 5 | | | 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 20 | 118 | 1 | 17 | 28 | | 3 | 80 | | | 10 | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | | | | 1 | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 16 | | | | | 1 | 10 | | | 6 | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | 4 | 11 | | 4 | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 14 | 65 | 1 | 14 | 65 | | | | | | | | | |
| b | Policies approved | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | 16 | 2 | | 16 | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 13 | 1 | | 13 | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 4 | 12 | 1 | 4 | 7 | | | 5 | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | | 3 | | | | | | | | 1 | 1 | 1 | | | | | | | | | | | | 3 | | | | | 3 | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 16 | | 1 | 16 | | | | | | | | | |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of the approved total annual LGU budget | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | 6 | 19 | 1 | 6 | 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5 | 20 | 118 | 3 | 18 | 55 | 2 | 2 | 63 | | | | | | |

| IR Indicators/ Milestones | | NEGROS ORIENTAL | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | | | | | | | | | | | VISAYAS TOTAL | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | | | | | Q2 | | | | | Q3 | | | | | | Q4 | | | | | | | | | | | | | | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 4 | 25 | 1 | 4 | 12 | | | 8 | | | 5 | | | |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | 18 | 2 | | 18 | | | | | | | | | |
| b | Local NHIP implementation plan prepared/ updated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 3 | 1 | 29 | 3 | 1 | 29 | | | | | | | | | |
| c | Local NHIP implementation plan approved and/or implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 4 | 20 | | | | 1 | 4 | 20 | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | 1 | 6 | | 1 | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5 | 31 | | 3 | 19 | | 1 | 7 | | 1 | 5 | | | |
| b | Facilities accredited by PhilHealth | | 1 | 6 | | | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5 | 31 | | 2 | 11 | | 1 | 12 | | 1 | 5 | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | |
| b | Province-wide annual training plan prepared | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 1 | 1 | | 1 | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated | 1 | 2 | 12 | 1 | 2 | 12 | | | | | | | | | | 2 | 1 | 1 | | | | | | | | | | | | | | | | | | 3 | 15 | 68 | 3 | 15 | 61 | | | 7 | | | | | | |

| IR Indicators/ Milestones | | NEGROS ORIENTAL | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | | | | | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | | 6 | 19 | | 2 | 7 | | 2 | 6 | | 2 | 6 | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | 1 | | | 1 | | | | | | | | | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | 1 | | | | | | | | | 1 | | | | | |

| IR Indicators/ Milestones | | HIV CITIES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Q1 | | | | | | Q2 | | | | | | Q3 | | | | | | Q4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | C | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | | | | | | | | | | | | | | | | | | | | | | | | | | | 3 | 20 | 118 | | 7 | 40 | 1 | 7 | 37 | | 6 | 41 | | | | | | | | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | 3 | | | 2 | | | 1 | | | | | | | | | | | | | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | | | | | | | | | | | | | 3 | | 2 | | | 1 | | | | 4 | | | | | | | | | | | |

| IR Indicators/ Milestones | | VISAYAS TOTAL | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | | | | | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | 3 | 20 | 118 | | 7 | 40 | 1 | 7 | 37 | | 6 | 41 | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | 3 | | | 2 | | | 1 | | | | | | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | 3 | | 2 | | | 1 | | | | 4 | | | | | |

| IR Indicators/ Milestones | | NEGROS ORIENTAL | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | | | | | | | | | | | | | | | VISAYAS TOTAL | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | | | | | Q2 | | | | | Q3 | | | | | | Q4 | | | | | | | | | | | | | | | | | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | BC | IC | CC | LC | MC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | | 1 | | | 1 | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | 4 | 11 | | 4 | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 14 | 65 | | 14 | 65 | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | 2 | 12 | | 1 | 6 | | 1 | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 13 | 46 | | 12 | 20 | | 1 | 26 | | | | | | |

## ANNEX C3 - NW MINDANAO FY5 Quarterly Milestones Against Performance Indicators

| IR Indicators/ Milestones | | BUKIDNON | | | | | | | | | | | | | | | MISAMIS OCCIDENTAL | | | | | | | | | | | | | | | MISAMIS ORIENTAL | | | | | | | | | | | | | | | ZAMBOANGA DEL NORTE | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | 1 | | | | | | | | | | | | | | | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | | | | | | | | | | | | | | | | 1 | 3 | 14 | 1 | 3 | 14 | | | | | | | | | | 1 | 2 | 23 | 1 | 2 | 23 | | | | 1 | 2 | 23 | | | | 1 | | | 1 | | | | | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | CSR (CSR+) policy crafted | | 2 | 8 | | 2 | 8 | | | | | | | | | | 1 | 1 | 6 | 1 | 1 | 6 | | | | | | | | | | 1 | 1 | 11 | 1 | 1 | 11 | | | | | | | | | | | | | | | | | | | | | | |
| d | CSR (CSR+) Policy approved | 1 | 2 | 8 | 1 | 2 | | | | 8 | | | | | | | 1 | 1 | 6 | | | | 1 | 1 | 6 | | | | | | | 1 | 1 | 11 | | | | 1 | 1 | 11 | | | | | | | | | | | | | | | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | 2 | 8 | | | | | 2 | 4 | | | 4 | | | | | 1 | 6 | | 1 | 2 | | | 2 | | | 2 | | | | 1 | 10 | | | | | 1 | 5 | | | 5 | | | | | | 19 | | | 7 | | | 7 | | | 5 | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | 1 | 2 | 20 | 1 | 2 | 20 | | | | | | | | | | 1 | 1 | 14 | 1 | 1 | 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 2 | 25 | 1 | 2 | | | | 15 | | | 10 | | |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | | 1 | 1 | 7 | 1 | 1 | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | BUKIDNON | | | | | | | | | | | | | | | MISAMIS OCCIDENTAL | | | | | | | | | | | | | | | MISAMIS ORIENTAL | | | | | | | | | | | | | ZAMBOANGA DEL NORTE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 2 | 20 | | 2 | 8 | | | 12 | | | | | | | | 3 | 14 | | 2 | 5 | | 1 | 5 | | | 4 | | | | | 2 | 23 | | 2 | 10 | | | 13 | | | | | | | 2 | 25 | | 2 | 9 | | | 9 | | | 7 | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 5 | | 1 | 2 | | | 3 | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | 2 | 8 | | 2 | 8 | | | | | | | | | | 1 | 1 | 6 | 1 | 1 | 6 | | | | | | | | | | 1 | 1 | 11 | 1 | 1 | 11 | | | | | | | | | | | | 6 | | | 4 | | | 2 | | | | | |
| b | Policies approved | 1 | 2 | 8 | 1 | 2 | | | | 8 | | | | | | | 1 | 1 | 6 | | | | 1 | 1 | 6 | | | | | | | 1 | 1 | 11 | | | | 1 | 1 | 11 | | | | | | | | | 6 | | | 2 | | | 4 | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of the approved total annual LGU budget | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | 2 | 20 | 1 | 2 | 8 | | | 12 | | | | | | | 1 | 3 | 14 | 1 | 2 | 5 | | 1 | 5 | | | 4 | | | | 1 | 2 | 23 | 1 | 2 | 7 | | | 9 | | | 7 | | | | 1 | 2 | 25 | 1 | | 10 | | 2 | 15 | | | | | |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | | | | | | | | | | | | | | | 1 | 1 | 7 | | | | 1 | 1 | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | BUKIDNON | | | | | | | | | | | | | | | MISAMIS OCCIDENTAL | | | | | | | | | | | | | | | MISAMIS ORIENTAL | | | | | | | | | | | | | | | ZAMBOANGA DEL NORTE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | 2 | 25 | 1 | 2 | 25 | | | | | | | | |
| b | Local NHIP implementation plan prepared/ updated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Local NHIP implementation plan approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | | | | | | | | | | | | | | | | 1 | 7 | | 1 | 7 | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Facilities accredited by PhilHealth | | | | | | | | | | | | | | | | | 1 | 7 | | | | | 1 | 7 | | | | | | | | 4 | | | 2 | | | 2 | | | | | | | | | | | | | | | | | | | | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Province-wide annual training plan prepared | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated | | | 10 | | | 10 | | | | | | | | | | 1 | | 9 | 1 | | 9 | | | | | | | | | | 1 | | 14 | 1 | | 4 | | | 10 | | | | | | | 1 | | 12 | 1 | | 12 | | | | | | | | |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | BUKIDNON | | | | | | | | | | | | | | | MISAMIS OCCIDENTAL | | | | | | | | | | | | | | | MISAMIS ORIENTAL | | | | | | | | | | | | | | | ZAMBOANGA DEL NORTE | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | 1 | | 1 | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | | 2 | 20 | | 2 | 6 | | | 8 | | | 6 | | | | | 3 | 14 | | 3 | 2 | | | 6 | | | 6 | | | | 2 | 23 | | 2 | 7 | | | 9 | | | 7 | | | | 2 | 25 | | 2 | 10 | | | 9 | | | 6 | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | 1 | 2 | 8 | 1 | 2 | 8 | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | | | | | | 1 | | | | | | | | | | | | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |

| IR Indicators/ Milestones | | BUKIDNON | | | | | | | | | | | | | | | MISAMIS OCCIDENTAL | | | | | | | | | | | | | | | MISAMIS ORIENTAL | | | | | | | | | | | | | | | ZAMBOANGA DEL NORTE | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | | | 1 | 6 | | 1 | 6 | | | | | | | | | | 1 | 1 | 11 | 1 | 1 | 11 | | | | | | | | | | | | | | | 6 | | | 6 | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | | | | | 6 | | | 6 | | | | | | | | |

## ANNEX C3 - NW MINDANAO FY5 Quarterly Milestones Against Performance Indicators

| IR Indicators/ Milestones | | ZAMBOANGA DEL SUR | | | | | | | | | | | | | | | ZAMBOANGA SIBUGAY | | | | | | | | | | | | | | HIV CITIES | | | | | NW MINDANAO TOTAL | | | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Q1 | Q2 | Q3 | Q4 | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | ZC | ZC | ZC | ZC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | 1 | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 3 | | | 3 | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | 1 | 1 | 26 | 1 | 1 | 26 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | 6 | 63 | 4 | 6 | 63 | | | | 1 | 2 | 23 | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | | | | | | | | | | | | | | | | 1 | | 16 | 1 | | 16 | | | | | | | | | | | | | | | 1 | | 16 | 1 | | 16 | | | | | | | | | |
| c | CSR (CSR+) policy crafted | | | | | | | | | | | | | | | | 1 | | 16 | 1 | | 16 | | | | | | | | | | | | | | | 3 | 4 | 41 | 3 | 4 | 41 | | | | | | | | | |
| d | CSR (CSR+) Policy approved | | | | | | | | | | | | | | | | 1 | | 4 | | | | | | 4 | | | | | | | | | | | | 4 | 4 | 29 | 1 | 2 | | 2 | 2 | 29 | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | 1 | | 25 | | | 11 | | | 7 | | | 7 | | | | | | | | | | | | | | | | | | | | | | | | 1 | 4 | 68 | | 1 | 20 | | 3 | 25 | | | 23 | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | 1 | 1 | 26 | 1 | 1 | 26 | | | | | | | | | | 1 | | 16 | 1 | | 16 | | | | | | | | | | | | | | | 2 | 1 | 42 | 2 | 1 | 42 | | | | | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | | | 16 | | | 16 | | | | | | | | | | | | | | | 1 | 2 | 41 | 1 | 2 | 16 | | | 15 | | | 10 | | | |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 3 | 34 | 2 | 3 | 34 | | | | | | | | | |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 7 | 1 | 1 | 7 | | | | | | | | | |

| IR Indicators/ Milestones | | ZAMBOANGA DEL SUR | | | | | | | | | | | | | | | ZAMBOANGA SIBUGAY | | | | | | | | | | | | | | | HIV CITIES | | | | | NW MINDANAO TOTAL | | | | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | Q2 | Q3 | Q4 | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | ZC | ZC | ZC | ZC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | 6 | | | 6 | | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 1 | 26 | | 1 | 10 | | | 8 | | | 8 | | | | | | 16 | | | 10 | | | 6 | | | | | | | | | | | | 10 | 124 | | 9 | 52 | | 1 | 53 | | | 19 | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 5 | | 1 | 2 | | | 3 | | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | | | | 2 | 4 | 35 | 2 | 4 | 33 | | | 2 | | | | | | |
| b | Policies approved | | | | | | | | | | | | | | | | | | 4 | | | | | | 4 | | | | | | | | | | | | 3 | 4 | 35 | 1 | 2 | 2 | 2 | 2 | 33 | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of the approved total annual LGU budget | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | 1 | 26 | 1 | | 6 | | | 10 | | | 10 | | | | | | | | | | | | | | | | | | | | | | | | 5 | 10 | 108 | 5 | 6 | 36 | | 3 | 51 | | | 21 | | | |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 7 | | | | 1 | 1 | 7 | | | | | | |

| IR Indicators/ Milestones | | ZAMBOANGA DEL SUR | | | | | | | | | | | | | | | ZAMBOANGA SIBUGAY | | | | | | | | | | | | | | | HIV CITIES | | | | | NW MINDANAO TOTAL | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | Q2 | Q3 | Q4 | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | ZC | ZC | ZC | ZC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 3 | 2 | 25 | 3 | 2 | 25 | | | | | | | | | | |
| b | Local NHIP implementation plan prepared/ updated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Local NHIP implementation plan approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | | 10 | | | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 21 | | 1 | 21 | | | | | | | | | | |
| b | Facilities accredited by PhilHealth | | | 10 | | | 5 | | | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 21 | | | 7 | | 1 | 14 | | | | | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | 2 | | | 2 | | | | | | | | | | | |
| b | Province-wide annual training plan prepared | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | | | | | 1 | | | 1 | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated | | | 10 | | | | | | 10 | | | | | | | 1 | | 9 | 1 | | 9 | | | | | | | | | | 1 | 1 | | | | 4 | 1 | 64 | 4 | 1 | 44 | | | 20 | | | | | | | |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | ZAMBOANGA DEL SUR | | | | | | | | | | | | | | | ZAMBOANGA SIBUGAY | | | | | | | | | | | | | | | HIV CITIES | | | | | NW MINDANAO TOTAL | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | Q2 | Q3 | Q4 | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | ZC | ZC | ZC | ZC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5 | | 1 | 5 | | | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | | 1 | 26 | | 1 | 9 | | | 8 | | | 8 | | | | | | | | | | | | | | | | | | | | | | | | | 10 | 108 | | 10 | 34 | | | 40 | | | 33 | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | 1 | | | 1 | | | | | | | | | | | | | | 16 | | | 10 | | | 6 | | | | | | | | | | | | 5 | | 16 | 5 | | 10 | | | 6 | | | | | | |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | | | | | 2 | 2 | 12 | 1 | 2 | 12 | | | | 1 | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 19 | | | 7 | | | 7 | | | 5 | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | 6 | | | 6 | | | | | | | | | | | | |

| IR Indicators/ Milestones | | ZAMBOANGA DEL SUR | | | | | | | | | | | | | | | ZAMBOANGA SIBUGAY | | | | | | | | | | | | HIV CITIES | | | | | NW MINDANAO TOTAL | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | Q1 | Q2 | Q3 | Q4 | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | ZC | ZC | ZC | ZC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | | | | 4 | | | 4 | | | | | | | | | | | | | | 1 | 2 | 27 | 1 | 2 | 27 | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 10 | | | 10 | | | | | | | | | |

## ANNEX C4 - S MINDANAO FY5 Quarterly Milestones Against Performance Indicators

| IR Indicators/ Milestones | | AGUSAN DEL NORTE | | | | | | | | | | | | | | | COMPOSTELA VALLEY | | | | | | | | | | | | | | | DAVAO DEL SUR | | | | | | | | | | | | | | | SARANGANI | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 7 | 1 | | 7 | | | | | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | 1 | 14 | | | | 1 | 1 | 14 | | | | | | | | | | | | | | | | | | | | |
| c | CSR (CSR+) policy crafted | 1 | 1 | 10 | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | CSR (CSR+) Policy approved | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 14 | | | | 1 | 1 | 14 | | | | | | | | | | | | | 1 | | 7 | | | | 1 | | 7 | | | | | | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 14 | 1 | 1 | 14 | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 1 | 14 | 1 | 1 | 14 | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | AGUSAN DEL NORTE | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 1 | 10 | | 1 | 10 | | | | | | | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | 1 | | | 1 | | | | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | 1 | 10 | | 1 | 4 | | | 6 | | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | |
| b | Policies approved | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | 1 | | 5 | 1 | | 5 | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | COMPOSTELA VALLEY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | | | 11 | | | 4 | | | 4 | | | 3 | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | |
| b | Policies approved | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | 1 | | 8 | 1 | | 3 | | | 5 | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | DAVAO DEL SUR | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | 1 | | | | | | | | | | | |
| b | FP commodity monitoring tool adopted | 1 | 1 | 14 | 1 | 1 | 6 | | | 6 | | | 2 | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | |
| b | Policies approved | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | 1 | | 4 | 1 | | 4 | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | SARANGANI | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | | | | 1 | | | | | | | | |
| b | FP commodity monitoring tool adopted | | | 7 | | | | | | 7 | | | | | | |
| c | TOT on stocks inventory management system (SIMS) conducted | 1 | | | | | | 1 | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | 7 | | | | | | 4 | | | 3 | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | |
| b | Policies approved | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | 1 | | 7 | 1 | | 7 | | | | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | AGUSAN DEL NORTE | | | | | | | | | | | | | | | COMPOSTELA VALLEY | | | | | | | | | | | | | | | DAVAO DEL SUR | | | | | | | | | | | | | | | SARANGANI | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of the approved total annual LGU budget | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | 1 | | | | | | 1 | | | 1 | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | 1 | 1 | 10 | | | | 1 | 1 | 4 | | | 6 | | | | 1 | | 11 | 1 | | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 7 | 1 | | 7 | | | | | | | | |
| b | Local NHIP implementation plan prepared/ updated | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 7 | 1 | | 7 | | | | | | | | |
| c | Local NHIP implementation plan approved and/or | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | 1 | 10 | | 1 | 10 | | | | | | | | | | | | 11 | | | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 7 | | | 7 | | | | | | | | |
| b | Facilities accredited by PhilHealth | | 1 | 10 | | | | | 1 | 10 | | | | | | | | | 11 | | | 6 | | | 5 | | | | | | | | | | | | | | | | | | | | | | | | 7 | | | 3 | | | 5 | | | | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | |
| b | Province-wide annual training plan prepared | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated training design/ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | AGUSAN DEL NORTE | | | | | | | | | | | | | | | COMPOSTELA VALLEY | | | | | | | | | | | | | | | DAVAO DEL SUR | | | | | | | | | | | | | | | SARANGANI | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | 1 | | 3 | | | | 1 | | 3 | | | | | | | | | 6 | | | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Service Improvement Plan implemented | 1 | | 3 | 1 | | 3 | 1 | | 3 | 1 | | 3 | | | | | | 6 | | | 6 | | | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | | 1 | 10 | | 1 | 4 | | | 6 | | | | | | | | | 11 | | | 6 | | | 5 | | | | | | | 1 | 14 | | 1 | 6 | | | 4 | | | 4 | | | | | | 7 | | | 4 | | | 3 | | | | | |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | AGUSAN DEL NORTE | | | | | | | | | | | | | | | COMPOSTELA VALLEY | | | | | | | | | | | | | | | DAVAO DEL SUR | | | | | | | | | | | | | | | SARANGANI | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | 1 | | | 1 | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | | | | 6 | | | | | | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | | 5 | | | 5 | | | | | | | | | | | | 8 | | | 3 | | | 5 | | | | | | | | 4 | | | 4 | | | | | | | | | | | | | 7 | | | 7 | | | | | | | | | |

## ANNEX C4 - S MINDANAO FY5 Quarterly Milestones Against Performance Indicators

| IR Indicators/ Milestones | | SOUTH COTABATO | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | S MINDANAO TOTAL | | | | | | | | | | | | | |
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| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | Q2 | | Q3 | | Q4 | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | DC | GSC | DC | GSC | DC | GSC | DC | GSC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.1 Key management systems to sustain delivery improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1A | No. of provinces with PIPH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Mandate to conduct PIPH secured | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | PIPH/ CIPH/ MIPH formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | PIPH technical review completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Plan (PIPH/MIPH/CIPH) completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | AOP for PIPH formulated and approved | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | |
| f | AOP for Municipalities/Cities formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g | PME for AOP adopted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h | AOPs (PIPH) prepared and integrated into CDP/ELA and AIP | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | 3 | 2 | 27 | 3 | 2 | 27 | | | | | | | | |
| 1.1B | No of LGUs with CSR implementation plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CSR (CSR+) plan formulated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | CSR (CSR+) plan updated | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | 4 | 3 | 34 | 3 | 2 | 20 | 1 | 1 | 14 | | | | | 1 | |
| c | CSR (CSR+) policy crafted | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 1 | 10 | 1 | | | | | | | | | | |
| d | CSR (CSR+) Policy approved | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | |
| e | CSR (CSR+) Plan and Policy implementation tracked | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1C | No. of LGUs with improved data management | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Health performance (SO3) FHSIS data used for planning and decision making | | | | | | | | | | | | | | | | | | | | | | | | | 3 | 2 | 31 | 1 | 1 | 10 | 2 | 1 | 21 | | | | | 1 | |
| b | Quality of family planning current users data derived from FHSIS checked and validated for accuracy in collection, computation and reporting | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 2 | 24 | 2 | 2 | 24 | | | | | | | | 1 | |
| c | Quality of other family health performance indicators derived from FHSIS (i.e, SBA, FBD, ANC4, VAC, DPT3 and FIC) checked and validated for accuracy in collection, computation and reporting | 1 | 1 | 10 | | | | 1 | 1 | 5 | | | 5 | | | | | | | | | | | | | 1 | 1 | 17 | | | | 1 | 1 | 12 | | | 5 | | | |
| d | Personnel trained in data custody of health-related data (FHSIS DQC, CHLSS, 3PME and LHA) used for planning and decision-making data | 1 | 1 | 10 | | | | 1 | 1 | 10 | | | | | | | | | | | | | | | | 3 | 3 | 34 | 2 | 2 | 24 | 1 | 1 | 10 | | | | | 1 | |

| IR Indicators/ Milestones | | SOUTH COTABATO | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | S MINDANAO TOTAL | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | Q2 | | Q3 | | Q4 | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | DC | GSC | DC | GSC | DC | GSC | DC | GSC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.1 D | No. of LGUs implementing a client classification system for identifying the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | CHLSS adopted as means test tool to identify the poor. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 E | No. of LGUs with improved logistics management for essential drugs and commodities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on FP commodity monitoring system (FPCMS) conducted | 1 | | | | | | 1 | | | | | | | | | | | | | | | | | | 5 | | | 3 | | | 2 | | | | | | | | |
| b | FP commodity monitoring tool adopted | | 1 | 10 | | | | | 1 | 4 | | | 6 | | | | | | | | | | | | | 1 | 3 | 52 | 1 | 2 | 20 | | 1 | 21 | | | 11 | | 1 | |
| c | TOT on stocks inventory management system (SIMS) conducted | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | | 1 | | | 1 | | | | | | | | |
| d | Inventory management tool for essential drugs and commodities adopted | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | 17 | | 1 | 4 | | | 10 | | | 3 | | | |
| 1.1F | No of LGUs with health related policies passed as of the current year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Policies crafted with broad stakeholder participation and support. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Policies approved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1G | No. of LGUs collaborating with each other in systems development and implementation (e.g., ILHZ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LGUs collaborated in planning (ILHZ planning for IPH, CSR, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LGUs collaborated in implementing plans (financing, M&E, SDExH, referral, logistics management, etc) | | 1 | 8 | | | | | 1 | 8 | | | | | | | | | | | | | | | | 4 | 1 | 32 | 4 | | 19 | | 1 | 13 | | | | | | |
| c | LGUs signed MoU detailing areas of collaboration such as referral system, financing, personnel/other resources, planning, surveillance, health promotion, M&E, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 H | Number of municipalities/cities providing inputs to the health sector program or deliberations at the provincial level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Inter-LGU planning events (e.g. SDIR, AOP, etc) conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| IR Indicators/ Milestones | | SOUTH COTABATO | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | S MINDANAO TOTAL | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | Q2 | | Q3 | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | DC | GSC | DC | GSC | DC | GSC | DC | GSC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.2 LGU financing for key health programs improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2A | No. of LGUs that increased and sustained public sector investments in health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Increased health budget as percentage of the approved total annual LGU budget | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | MNCHN grant accessed | 1 | | | 1 | | | 1 | | | 1 | | | | | | | | | | | | | | | 5 | | | 5 | | | 1 | | | 2 | | | | | |
| c | Local policy for management of PhilHealth reimbursements and capitation fund for re-investments in health developed and implemented | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 1 | 21 | 1 | | 11 | 1 | 1 | 4 | | | 6 | | | |
| 1.2B | No. of LGUs with increased PHIC coverage of the poor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | TOT on local NHIP implementation conducted | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | 3 | 2 | 27 | 3 | 2 | 27 | | | | | | | | |
| b | Local NHIP implementation plan prepared/ updated | 1 | 1 | 10 | 1 | 1 | 10 | | | | | | | | | | | | | | | | | | | 3 | 1 | 17 | 2 | 1 | 17 | | | | | | | | |
| c | Local NHIP implementation plan approved and/or | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2C | No. of LGUs with increased number of accredited health facilities for OPB,MCP,TB-DOTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Application for accreditation filed | | 1 | 10 | | 1 | 10 | | | | | | | | | | | | | | | | | | | | 2 | 38 | | 2 | 38 | | | | | | | | |
| b | Facilities accredited by PhilHealth | | 1 | 10 | | 1 | 2 | | | 4 | | | 4 | | | | | | | | | | | | | | 2 | 38 | | 1 | 11 | | 1 | 24 | | | 4 | | |
| IR1.3 Performance among service providers improved | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3A | No. of provinces implementing a province wide training program for service providers in any or all of the ff: FP,TB, MCH,STI/HIV/AIDS,AI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Data base on service providers' capability profile established | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | | 2 | | | | | | | | | | |
| b | Province-wide annual training plan prepared | | | | | | | | | | | | | | | | | | | | | | | | | 2 | | | 2 | | | | | | | | | | |
| c | TOTs on FPCBT, PHN supervision and ICV compliance monitoring conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d | Providers trained in FP, FP-EPI integration and maximizing utilization, TB, HIVAIDS, MNCHN and/or AI control using updated training design/ | 1 | 1 | 8 | 1 | 1 | 8 | | | | | | | | | | 2 | 1 | 1 | | | | | | | 1 | 3 | 8 | 1 | 3 | 8 | | | | | | | | |

| IR Indicators/ Milestones | | SOUTH COTABATO | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | S MINDANAO TOTAL | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | Q2 | | Q3 | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | DC | GSC | DC | GSC | DC | GSC | DC | GSC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| 1.3B | No. of LGUs with a continuing service delivery quality improvement system. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | SDExH has been mandated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | 3 phases of SDExH training completed | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 9 | | | 6 | 1 | | 3 | | | | | |
| c | Service Improvement Plan implemented | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | 9 | 1 | | 9 | 1 | | 9 | 1 | | 3 | | |
| d | LGUs implementing SDExH received recognition and awards | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3C | Number of LGUs conducting an annual enanced Program Implementation Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Pre SDIR workshop has been conducted for cities and municipalities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial-level SDIR workshop has been conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c | Annual acceleration plan formulated by LGU | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3D | Number of provinces with a monitoring system for ICV compliance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Personnel trained in ICV compliance monitoring | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Provincial ICV Compliance Monitoring Plan developed | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | 5 | | | 5 | | | | | | | | | | |
| c | ICV compliance of FP-RH service delivery sites monitored and reported | | | | | | | | | | | | | | | | | | | | | | | | | | 2 | 42 | | 2 | 20 | | | 18 | | | 4 | | 1 |
| d | ICV compliance monitoring and reporting locally mandated/CSR Ordinance Policy Updated to include a section on ICV compliance monitoring | | 1 | 10 | | 1 | 3 | | | 4 | | 3 | | | | | | | | | | | | | | | 1 | 10 | | 1 | 3 | | | 4 | | 3 | | | |

| IR Indicators/ Milestones | | SOUTH COTABATO | | | | | | | | | | | | | | | HIV CITIES | | | | | | | | | S MINDANAO TOTAL | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | | TOTAL | Quarterly indicative milestones | | | | | | | | TOTAL | | | Quarterly indicative milestones | | | | | | | | | | | |
| | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | Q1 | | Q2 | | Q3 | | Q4 | | | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| | | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M | C | DC | GSC | DC | GSC | DC | GSC | DC | GSC | P | C | M | P | C | M | P | C | M | P | C | M | P | C | M |
| IR1.4 Advocacy for the financing and delivery of health services at the local level increased | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4A | No. of LGUs where public hearings on any health sector issues have been conducted by the Sanggunian and/or other LGU officials during the year. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | Public hearings with NGO/CSO participation conducted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Public forums conducted with NGO/CSO participation to inform public of health sector program, plans and policies | | | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | |
| 1.4B | Number of LGUs where civil society is actively participating on LHB/LDCs in the following program areas: FB, TB, MCNH, AI, HIV/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | LHB and/or LDC (e.g. Local AIDS Council) inventory of accredited NGO/CSO representation completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | LHB/ LDC meetings held where health issues were discussed and deliberated with inputs from accredited NGO/CSO representative | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | 4 | 1 | 10 | 4 | 1 | 10 | 1 | | | 1 | | | | | |
| c | Community concerns and feedback on FP, MNCHN, TB, HIV/AIDS/STI and AI presented and discussed by NGOs/CSOs to LHB/LDC | 1 | | | 1 | | | | | | | | | | | | | | | | | | | | | 5 | | | 5 | | | | | | | | | | | |
| 1.4C | No of LGUs with civil society providing inputs to the health sector program or budget deliberations at the municipal level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a | NGO/CSO participated in PIPH, CSR, SDIR, SDExH and other participatory events. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b | Mechanism for community consultations such as FGDs, community meetings, barangay leadership forum established with NGO/CSO inputs | | | | | | | | | | | | | | | | 2 | 1 | 1 | 1 | 1 | 1 | 1 | | | | 2 | 6 | | 2 | | | 2 | 6 | | 2 | | | | |
| c | LGU-NGO/CSO partnerships established for planning, budgeting, implementation, monitoring, policy development (e.g. social mobilization for increased access or maximization of health services, Integration of FP in EPI, Social mobilization for Vit A and E | | 1 | 8 | | 1 | 8 | | | | | | | | | | | | | | | | | | | | 1 | 32 | | 1 | 27 | | | 5 | | | | | | |