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Program Management Technical Advisors  
Team-Management Sciences for Health  
(PMTAT-MSH)

PROJECT COMPLETION REPORT

MARCH 2004

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**PROJECT:** Integrated Family Planning and Maternal Health Program

**CONTRACT NO:** 492-0480-C-00-5093-00

**PERIOD OF CONTRACT:** September 1, 1995 - March 31, 2004

**CONTRACTOR:** Management Sciences for Health

**SUBMITTED BY:** Management Sciences for Health --Program Management Technical Advisors Team

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## TABLE OF CONTENTS

List of Tables.....	1
List of Acronyms.....	2
I. Introduction.....	4
II. The Integrated Family Planning and Maternal Health Program.....	5
A. Major Components of the IFPMHP.....	5
B. The LGU Performance Program.....	6
C. The Matching Grant Program.....	8
III. The Program Management Technical Advisors Team.....	11
A. Specific Objectives/Scope of Work.....	11
B. Organization and Staffing.....	12
C. Work Methods.....	14
IV. Activities Undertaken to Achieve Contract Objectives.....	18
V. Key Results.....	21
A. Achievement of Deliverables.....	21
B. Other Accomplishments.....	45
VI. Financial Report.....	52
VII. Lessons Learned.....	54

## LIST OF TABLES

<b>Table No.</b>	<b>Title</b>	<b>Page No.</b>
1	Courses Conducted Under the EDF Sub-Contract, 1995-1998	22
2	Matching Grant Program Enrollees (as of September 30, 2003)	28
3	Status of No-Scalpel Vasectomy Services in MGP Areas (as of September 30, 2003)	47
4	Urban Poor Family Planning Initiative Results (as of September 30, 2003)	50
5	NSV Accomplishments in Priority IP-Populated Areas (as of September 30, 2003)	52
6	Financial Report as of December 31, 2003	53

## LIST OF ACRONYMS

ADB	Asian Development Bank
ARI	Acute Respiratory Infections
ARMM	Autonomous Region of Muslim Mindanao
BHS	Barangay Health Station
BHW	Barangay Health Worker
BLHD	Bureau of Local Health Development
CAR	Cordillera Administrative Region
CARI	Control of Acute Respiratory Infections
CAs	Cooperating Agencies
CBMIS	Community-Based Monitoring and Information System
CBT	Competency-Based Training
CDD	Control of Diarrheal Diseases
CHD	Center for Health Development
CHOs	City Health Offices
CPR	Contraceptive Prevalence Rate
CQI	Continuous Quality Improvement
CRP	Certification/Recognition Program
DOH	Department of Health
DOTS	Directly Observed Treatment Short Course
EDF	Economic Development Foundation
EPI	Expanded Programme on Immunization
FCs	Field Coordinators
FCF	Facility Certification Form
FIC	Fully Immunized Child
FP	Family Planning
FPS	Family Planning Service
FSAC	Facility Self-Assessment Checklist
GOP	Government of the Philippines
HES	Human Ecology Security
ICS	Interpersonal Communication Skills
IDA	Iron Deficiency Anemia
IDD	Iodine Deficiency Disorders
IEC	Information, Education, and Communication
IECM	Information, Education, Communication, and Motivation
IFPMHP	Integrated Family Planning and Maternal Health Program
IUD	Intra-Uterine Device
LGU	Local Government Unit
LPP	LGU Performance Program
MCH	Maternal and Child Health
MGP	Matching Grant Program
MGP-TAP	Matching Grant Program Technical Assistance Package
MHC	Main Health Center
MICS	Multi-Indicator Cluster Survey

MIS	Management Information System
MOA	Memorandum of Agreement
MSH	Management Sciences for Health
NCR	National Capital Region
NGO	Non-Government Organization
NHIP	National Health Insurance Program
NIH	National Institutes of Health
NSV	No-Scalpel Vasectomy
NTAT	National Technical Assistance Team
OR	Operations Research
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PHIC or PhilHealth	Philippine Health Insurance Corporation
PHO	Provincial Health Office
PIR	Program Implementation Review
PMO	Project Management Office
PMTAT	Program Management Technical Advisors Team
QA	Quality Assurance
QAP	Quality Assurance Program
QIH	Quality in Health
RH	Reproductive Health
RHO	Regional Health Office
RHU	Rural Health Unit
RTAs	Regional Technical Advisors
RTAT	Regional Technical Assistance Team
SIM	Self-Instructional Method
SO	Strategic Objective
SSM	Sentrong Sigla Movement
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TOT	Training of Trainers
TPP	Top Performers Program
TT2+	Tetanus Toxoid Immunization Plus
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	Vitamin A Capsule
VHWs	Volunteer Health Workers
VSC	Voluntary Surgical Contraception
VSS	Voluntary Sterilization Services

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### I. Introduction

In 1995, USAID awarded Management Sciences for Health (MSH) with an institutional contract to provide support to the Department of Health (DOH) in the implementation of the Integrated Family Planning and Maternal Health Program (IFPMHP). The Program, which was formulated in 1994 with USAID assistance, was designed to assist the country attain its development objective of reduced population growth rate and improved maternal and child health by: 1) increasing public sector provision of family planning/maternal-child health (FP/MCH) services; 2) strengthening national systems to promote and support the FP/MCH program; and 3) increasing private sector provision of contraceptives and FP/MCH services. These were to be accomplished by increasing contraceptive prevalence, expanding family planning utilization among the poor and high-risk women, immunizing children and women to protect children against neonatal tetanus, supplementing children's diets with vitamin A capsules, and by developing an effective and sustainable fee-for-service family planning program.

MSH, through the Program Management Technical Advisors Team (PMTAT), provided technical assistance to the DOH and selected local government units (LGUs) in developing, managing, and sustaining their FP/MCH programs. PMTAT was responsible for technical support in a number of specialized areas, including data collection, service delivery, and dissemination activities.

The MSH contract was originally intended to end by 2000, however, to sustain the momentum created by the project, this was extended for four more years. This project completion report summarizes the activities that were undertaken by PMTAT to achieve contract objectives and realize the desired results. It is in compliance with one of the terms of the contract, which stipulates that "within 45 days after the contract completion date, the Contractor will submit a final completion report that describes, in summary form, the following: 1) specific objectives of the contract, 2) activities undertaken to achieve contract objectives, and 3) the results achieved."

## **II. The Integrated Family Planning and Maternal Health Program**

The IFPMHP formulated in 1994 with USAID assistance, was a six-year program, national in scope, with the development objective of reduced growth rate and improved maternal and child health. These objectives were met by (1) expanding the availability of reproductive health services in the public and private sectors and increasing use of those services by women in high-risk groups; and (2) fostering continued provision of other selected child health interventions at the local government level.

To accelerate the expansion and improvement of FP/MCH services, IFPMHP began with an urban strategy, which emphasized program development, in rapidly expanding urban areas. Although a national program, the potential for achieving a significant impact on population growth by accelerating the provision of FP/MCH services in urban areas was considerable because more than 50% of women of childbearing age reside in urban areas and was predicted to continue to do so in the foreseeable future.

IFPMHP also followed a strategy of integrating FP services with support for four key MCH interventions – Acute Respiratory Infections (ARI), Expanded Programme on Immunization (EPI), Oral Rehydration Therapy (ORT), and micronutrients (including Vitamin A). These services were integrated at the LGU level where responsibility for service delivery was lodged after the devolution of health services in 1991.

Another strategic objective of the IFPMHP was to work towards institutional and financial sustainability in all activities supported by the program. Financial sustainability and the expansion of commercial and private sector provision of FP/MCH services and commodities was seen to eventually shift individuals who can pay for all or a part of service costs from free or highly-subsidized government services to these non-government channels. Consequently, limited government resources can be better targeted towards individuals who are truly unable to pay for FP/MCH services. Though this process will occur slowly, IFPMHP's assistance was expected to contribute to greater efficiency in government expenditures for FP/MCH services.

### **A. Major Components of IFPMHP**

IFPMHP had three components. Component 1 or National Services expanded support for the development of a National Family Planning Program that included contraceptives procurement; national contraceptives logistics; information, education, communication, and motivation (IECM); training; operations research (OR); voluntary surgical contraception (VSC) services; advocacy and policy development; and national program monitoring.

Component 2 or private sector expanded assistance for strengthening NGO capability for FP/MCH service delivery, intensifying in-plant, industry-based FP/MCH programs and developing private sector channels for provision of FP/MCH services and commodities through social marketing.

Component 3 or public sector advanced policy and institutional reforms needed to establish and strengthen post-devolution relationship between the DOH and LGUs in support of expanding and improving FP/MCH services. This was through performance-based disbursements linked to the achievement of significant progress, i.e., benchmarks, toward the institutionalization of reforms needed in the light of the devolution of service delivery responsibilities to the LGUs. This led to the conceptualization of the LGU Performance Program.

#### **B. The LGU Performance Program**

As the component charged with the responsibility for increasing public sector provision of FP/MCH services, the LGU Performance Program (LPP) was designed to help LGUs build their capacity to plan, manage, and evaluate their FP/MCH program. As such, LPP focused on:

- Improving the institutional capability of provinces and highly-urbanized cities to support service delivery in sub-units;
- Supply-side interventions such as training, logistics, procurement, monitoring, distribution, equipment, support, etc;
- Implementing national programs and achieving minimum national population coverage targets; and
- Capitalization, infrastructure, and systems.

The LPP covered the following programs: EPI, ARI, Iodine Deficiency Disorders (IDD), Iron Deficiency Anemia (IDA), Control of Diarrheal Diseases (CDD), Vitamin A supplementation, and FP.

The LPP provided both technical and financial assistance to the LGUs. Technical assistance to the LGUs began with orientation visits and planning workshops to introduce the LPP's objectives, standards, and benchmarks. As early as the orientation visit and during the planning workshop, LGU staff began to plan for the following years. The DOH and the Regional Health and Population Offices through the national and regional technical assistance teams (NTAT and RTAT) provided follow-up assistance to LGUs in data-based planning and management, quality improvement, monitoring and evaluation, training, IEC, logistics, sustainability, and urban health.

Financial assistance was in the form of a performance-based grant mechanism, featuring performance benchmarks as the basis for releasing the grants. The achievement of these benchmarks or innovative activities entitled the LGU (province/independent city) to receive regular base grant, the premium grant or both, as the case may be. To operationalize the performance-based grant mechanism, performance benchmarks consisting of tasks and targets were developed. These benchmarks were selected and agreed upon by the DOH and the LGUs to ensure the attainment of targets for vital program elements (FP, MCH, and nutrition).

Upon joining the program, LGUs had to satisfy three start-up capacity-building benchmarks to receive their first year grant, namely, 1) development of a comprehensive plan, 2) establishment of a contraceptive distribution system, and 3) program endorsement from the local chief executive. On their second year, LGUs were required, in addition to the first three benchmarks, to accomplish capacity benchmarks that included training of service providers and availability of necessary equipment and supplies. They were also required to accomplish program coverage benchmarks (% of children who received vitamin A the past six months, % of fully immunized children (FIC) at 1 year old, % of children protected at birth against neonatal tetanus, and % of married women using a contraceptive method).

The amount released to LGUs was determined by the DOH-Central Office, which set the amount available for grants each year based on estimated amount of funds coming from USAID plus any unused funds from the previous year. The allocation per LGU was computed based on equal weights assigned to population size, per capita income, and year of enrolment. This resulted in progressively declining enrolment for each subsequent year because of the expected declines in unmet needs. Three types of grants were subsequently made available to the LGUs starting in 1999, namely:

**Base Grant Program:** Based on the findings of the LPP mid-term assessment (1997), the grant mechanism was redesigned to move beyond the initial capacity-building focus and emphasized the need for attaining service coverage benchmarks for Vitamin A capsule (VAC) supplementation, FIC, tetanus toxoid plus (TT2+) immunization, and contraceptive prevalence rate (CPR). The redesign made the program more performance-based and shifted the focus from inputs to impact. As redesigned, LPP became the Base Grant Program. Grant funds continued to be calculated using population, income, and entrance year criteria. The performance goal was to meet the minimum population coverage targets for national programs. Once LGUs have reached or exceeded their benchmarks as determined by a household-based survey, they graduated to the Top Performers Program.

**Top Performers Program:** This was implemented to provide performance premiums for LGUs that have met or exceeded the minimum coverage standards for key IFPMHP programs. Once an LGU reached this status, there were no more input or activity benchmarks; all benchmarks were strictly measurements of progress toward achievement of LGU performance indicators. This program gave premiums for performance, rewarded success, and created a cadre of higher performers within the LPP. The technical focus switched from institution building to program impact, from provincial/city level to municipal/health facility level and prioritized demand-side rather than supply-side interventions. Under this program, LGUs received a 50% increase in their base grant for meeting minimum FIC, TT2+, and VAC targets and another 25% increase in their base grant for meeting the CPR performance standard.

**Matching Grant Program:** This program was made available to selected component cities/municipalities so as to further the program impact. As counterpart, LGU enrollees were expected to increase their annual appropriation for population, FP, MCH, and

nutrition programs. This increasing allocation for the programs indicates the LGU commitment to assure the long-term sustainability of the programs.

### **C. The Matching Grant Program**

The main weakness of the LPP as a means for expanding coverage of essential public health services was that financial and technical assistance was extended to the Provincial Government whose implementing responsibilities were limited to the operation and management of devolved hospitals. Implementation of essential public health programs, including FP, MCH, and nutrition services were the basic responsibilities of municipal and city governments. The expected filtering down of LGU capacities, results, and outcomes of technical assistance from the province to its component municipalities and cities were not always realized. Hence, some provinces felt it necessary to offer sub-grants to selected municipalities and cities whose poor performance pulled down the provincial benchmarks. The project corrected this oversight by implementing the Matching Grant Program (MGP) in 1999. Through the MGP, technical assistance and financial grants were made available directly to the LGUs responsible for implementing public health programs, i.e. the municipal and city governments, which had not yet participated in the LPP.

**Service delivery expansion through grants to municipalities and cities.** The DOH-Centers for Health Development (CHDs) invited eligible municipalities and cities to enroll in the MGP. Priority was given to municipalities and cities that fell short of the national targets for FIC, vitamin A supplementation coverage, TT2+ coverage, and modern contraception prevalence rate. The LGUs that can match the grant and develop a feasible work plan relevant to the improvement of FP and child survival services in their distressed communities can avail of the full grant amount. The required 25% local counterpart may be used to meet national quality standards for health facilities and/or enroll indigent families in the national health insurance program.

#### ***The MGP Enrollment/Application Process***

The application process for the MGP begins when the LGU submits a letter of interest to the CHD. The CHD then orients the LGU on the MGP and signs a Memorandum of Agreement (MOA) with the LGU. The CHD then releases 40% of the grant. At this point, the LGU avails of the first of two phases of the MGP Technical Assistance Package (MGP-TAP) offered through the CHD technical assistance team (formerly Regional Technical Assistance Team or RTAT). The MGP-TAP includes training of health teams to set up a Community-Based Monitoring and Information System (CBMIS) and conduct health facility self-assessments. The CBMIS is a tool used to identify the FP and child survival needs of women and children in different barangays. A health facility self-assessment entails the use of a checklist similar to the quality standards list for health facilities of the DOH-Central Office used by health personnel to identify areas for improvement.

Phase II of the MGP-TAP occurs 8 weeks after Phase I where the LGU proceeds to develop a work plan for service delivery. The Phase II workshop is designed to help the LGU process and analyze the data gathered, identify and prioritize the communities' health problems, prepare a spot map, develop a work plan for service delivery, and finalize the budget for its implementation. The unmet needs identified by the CBMIS provide the basis for specifying FP and child survival program activities and interventions. Actions toward health facility improvement, including upgrade of equipment, medicines, and medical supplies (i.e., vaccines, contraceptives, etc.), especially those relevant to FP and child survival services, are also incorporated in the work plan. The work plan is submitted to the CHD for review and approval of the RTAT. Through this plan, the CHD, including provincial staff and DOH representatives, are able to monitor the LGU's MGP interventions as well as the allocation and use of funds.

Upon approval of the work plan submitted by the LGU, the CHD releases the second tranche, which is 60% of the total grant amount. The LGU then implements the work plan. The CHD and concerned province monitor MGP implementation in the locality and provide technical assistance as needed.

The LGU reapplies for the MGP grant after successfully implementing their work plan by the end of one year, subject to availability of MGP funds (as well as of LGU counterpart) and the LGU's need for further improvement in its health care service delivery.

**Improvement of quality of health services through *Sentrong Sigla*.** Service delivery expansion was pursued alongside efforts to improve the quality of health services through the *Sentrong Sigla*. MGP-participating LGUs were required to use their counterpart to upgrade their health facilities to meet the prescribed standards. The *Sentrong Sigla* is an initiative that institutionalizes quality assurance by fostering a more effective collaboration between the DOH and the LGUs in providing the public with quality health services via *barangay* health stations (BHSs), rural health units (RHUs)/city health offices (CHOs), and public hospitals. It works by using recognition as prime motivation for LGUs to comply with and even exceed the quality standards. *Sentrong Sigla* has four pillars, namely, quality assurance, grants and technical assistance, awards, and health promotion.

As defined by the DOH, quality assurance is a "set of activities that are carried out to set standards and to monitor and improve performance so that care provided is as effective and as safe as possible. It includes activities that periodically or continuously review the conditions under which care is provided, that monitor the care itself, that track the outcomes of care using quality assurance." When deficiencies have been identified and corrected, resulting improvements in health and well-being arise.

Phase I: *Sentrong Sigla* started in 1998 as the Quality Assurance Program (QAP), which aimed to institutionalize a system for regularly updating, disseminating, and promoting program standards, set up a nationwide system for certification/recognition of health facilities, compliance by 80% of RHUs and health centers with the minimum standards for readiness to provide services, and implementation of programs to train and support

municipal/city health facilities in 80% of LGUs. QAP was anchored on two strategies: Certification/Recognition Program (CRP) and Continuous Quality Improvement (CQI)/Total Quality Management. CRP is a scheme that focuses on health facilities' compliance with standards. Health facilities are assessed based on established standards or criteria before they can be considered providers of quality health service. CQI featured a process-oriented management system that emphasized the capabilities of facilities on building basic quality concepts, principles, methodologies, and tools to address service delivery challenges.

In 1999, QAP grew into the *Sentrong Sigla* Movement (SSM). It was managed by the Steering Committee at the national level and subcommittees for Standards and Procedures; Technical Assistance and Monitoring; and Advocacy Awards. At the CHDs, SSM was overseen by assessment teams or technical assistance teams. SSM maintained the CRP and CQI strategies in addition to strengthening DOH-LGU partnership, with the DOH as provider of technical and financial assistance and the LGUs as direct program implementers and primary developers of the health system.

Phase II: In 2002, the CQI strategy was further enhanced through the Quality in Health (QIH) program. This led to the involvement of the entire health sector and the use of existing instruments such as mandatory licensing and accreditation and reimbursement schemes of the Philippine Health Insurance Corporation (PHIC), to improve quality. *Sentrong Sigla* certification became an important part of the QIH Program strategy.

*Sentrong Sigla* Certification is based on the following principles: 1) focus on public health programs proven to be most cost-beneficial to the people; 2) roles and responsibilities, including contributions, must promote appropriate counterpart and reciprocity; 3) provision of technical assistance is purposive; and 4) recognition for achieving quality is the main incentive in *Sentrong Sigla* certification, not cash awards. The lead providers of technical assistance for self-assessment are the DOH representatives. Technical assessment, however, is separate from the formal assessment and certification to ensure that the certification process remains objective.

*Sentrong Sigla* certification involves three levels. Level 1 or Basic *Sentrong Sigla* Certification Category involves input, process, and output standards for integrated public health services for four core programs (child health, maternal health and family planning, prevention and control of infectious diseases, especially tuberculosis, and promotion of healthy lifestyle), facility systems, regulatory functions, and basic curative services. Recognition takes the form of a *Sentrong Sigla* seal, individual recognition, and matching grants.

Level 2 or Specialty Award Category is quality standards for selected public health programs in addition to Level 1 core programs and facility systems. Examples of this include the Directly Observed Treatment Short Course (DOTS) center award and Social Hygiene clinic award. Such awards are acknowledged with a specialty banner, individual recognition, and matching grants.

Level 3 is the Award for Excellence and represents the highest level of quality standards for maintaining Level 2 standards for the four core public health programs and Level 2 facility system for at least three consecutive years. A trophy, individual recognition, matching grant, and other incentives are given as recognition.

In support of the *Sentrong Sigla* Certification Program, PMTAT was actively involved in the development, pilot testing, and adoption of quality standards and tools for the Program, development of training modules, and actual training of technical assistance/assessment teams in all DOH regional offices nationwide.

### **III. The Program Management Technical Advisors Team**

#### **A. Specific Objectives and Scope of Work**

PMTAT was created with two main thrusts, 1) at the national level, to assist the DOH to implement core activities inherent to the IFPMHP, and 2) at the local level, to provide technical and financial assistance to the LGUs in the management and implementation of FP/MCH programs in accordance with DOH standards. The twin thrusts were meant essentially to enable both the DOH and the LGUs to mobilize available resources and maximize the authorities vested in them by the Local Government Code of 1991. These thrusts were carried out through the National Services Component, the LPP, and the MGP.

The members of PMTAT were thus selected to constitute a goal-driven technical team with the capability to assist the DOH and the LGUs in the delivery of specific program outputs. With regard to the DOH, the envisioned outputs were the following:

1. A system to define and operationalize an efficiently-managed FP/MCH program at the national level;
2. A system to develop and implement special program strategies for FP/MCH in urban centers;
3. A system to manage the LPP that provides technical and financial assistance to LGUs in the management of the FP/MCH programs at their level;
4. A system to strengthen the provision of FP/MCH training to service providers;
5. A system for providing information to program managers to promote the efficiency of FP/MCH service delivery; and
6. A system for monitoring and documenting program benchmark achievement under the SO3 for the purpose of performance-based tranche disbursements.

As far as the LGUs were concerned, PMTAT was to oversee the delivery of the following outputs:

1. A system for developing, implementing, and managing FP/MCH programs in conformance with DOH standards, and

2. A system to ensure the continued implementation of appropriate FP/MCH programs, enabling the creation of sustainable and replicable local financial management and revenue mobilization systems.

True to the spirit and intent of the program assistance, the members of the technical team were primed and oriented not merely to render technical assistance. They were required to have the practical and advisory capabilities to assist the DOH and LGUs gain financial and human resource management expertise, utilizing maximum participatory approach from peers, participants, and key players at the national and local levels. Thus, through the efforts of the team, MSH created a wide circle of program participants, which included the LGUs, local funding donors, USAID cooperating agencies (CAs) engaged in parallel FP/MCH programs, and other institutions to achieve mutual objectives.

### **B. Organization and Staffing**

To carry out these functions and facilitate the accomplishment of program goals and the establishment of desired systems and procedures, a dynamic organizational structure and workflow were designed and implemented. Through the years, these were modified systematically to respond to the needs and concerns that were raised in the course of program implementation.

PMTAT's final reorganization came in response to the expansion of the coverage of the MGP to include areas with low contraceptive prevalence rate; develop the capacity of the central and regional authorities to source out additional funds for LGUs and increase the size of the grants; to further expand the capacities of the CHDs to manage the *Sentrong Sigla*-certified health centers and RHUs; and enable the grant to serve as a temporary bridging mechanism until the new assistance program is fully in place (Figure 1).

In the performance of its obligations under the contract, MSH carried out its staffing functions across the specific work landscape, to cover the following:

#### **1. Creation of a shortlist of short- and long-term technical advisors**

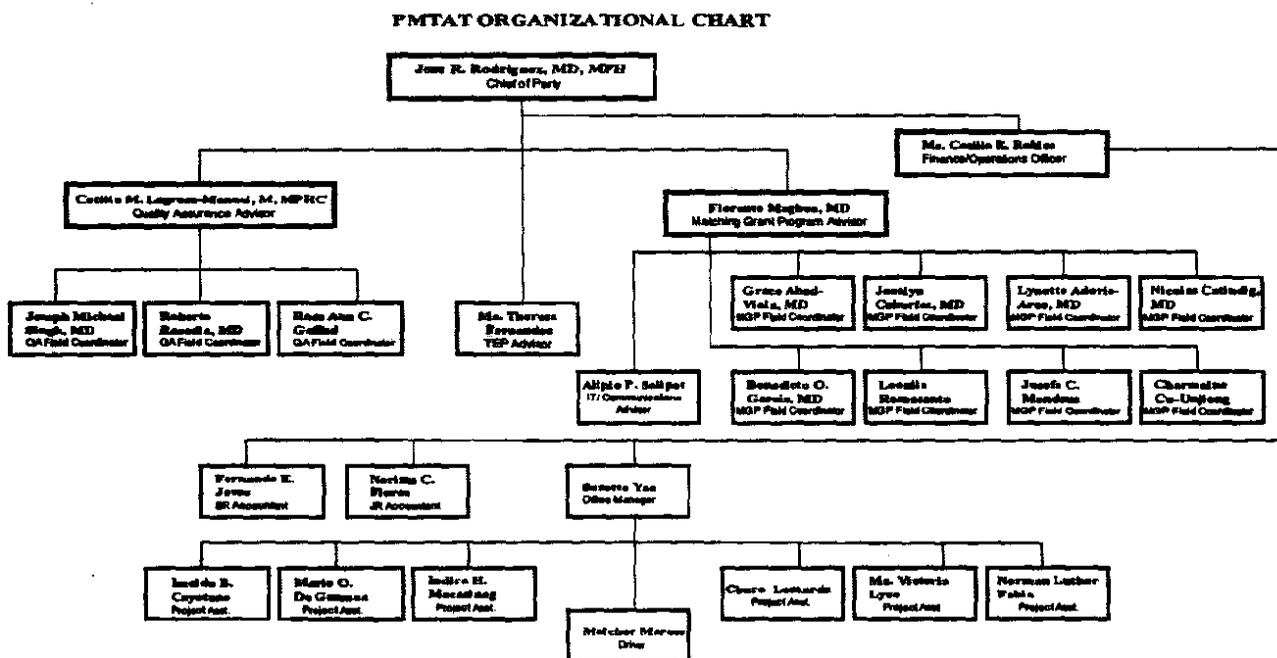
MSH identified needed MSH identified needed positions for staffing to implement the technical component of the project. Positions were opened for Regional Technical Advisors (RTA), who were given geographical areas of assignment allocated into the 16 regions, and for the National Services Component, staff were hired to fill up positions for the Urban Advisor, Monitoring, Sustainability, and LGU Advisors. An expatriate Deputy Chief of Party was later hired to oversee the quality of technical activities.

#### **2. Establishment of personnel, administrative, and financial management procedures and systems**

The plantilla position for Finance/Operations Officer was created and filled up in July 1997, following the transfer of the Administrative Advisor to the Technical Unit to Head the National Services Component. Comprising the Administrative Staff, with the

Finance/Operations Officer at the helm, are an Accountant, two (2) Project Assistants, 2 drivers, and a utility person. Collectively, the administrative team provided logistical, secretarial, and administrative support to the technical activities of the project.

Figure 1



**3. Provision of core and consulting staff in the conduct of workshops, conferences, and other meetings in support of DOH and LGU activities**

The project had a core team composed of an RTA, the counterpart technical staff from the DOH's Project Management Office (PMO), a representative from the relevant technical office at the Central DOH office, relevant staff from the regional DOH offices, and a PMTAT project assistant. The core groups coordinated and conducted workshops, conferences, and other meetings in their respective areas of coverage.

**4. Fielding of coordinators to work with other USAID contractors and grantees as well as with GO/NGOs and LGUs in the fulfillment of SO3 activities**

In late 1999, at the start of the MGP, three (3) field-based coordinators were hired to provide more focused technical assistance to the LGUs.

5. Procurement of vehicles, equipment, and other commodities needed in contract management

MSH, through Development Associates, one of its subcontractors, procured office equipment for staff use and two vehicles to make the team more mobile and facilitate their travel to the LGU sites.

6. Subcontracting with individuals and institutions to develop and implement training needs assessment, training designs and strategies, training plans for FP/MCH and for the conduct of actual public sector FP/MCH training for DOH and the LGUs

MSH had a major subcontractor, the Development Associates, who fielded a Training Advisor in Manila that handled the Training Component of the project. A local subcontractor, Economic Development Foundation (EDF), handled the logistical requirements of the training component. The two major subcontractors conducted the Basic FP course using the classroom model. The Self-Instructional Method (SIM) later replaced this model. The SIM trainings were later handled in-house when the two subcontracts were terminated due to poor performance.

### C. Work Methods

**Creation of Teams.** To provide the widest reach for the limited number of PMTAT technical staff, technical teams were created within PMTAT, complemented by a counterpart staff from the DOH's PMO, Family Planning Service, and regional DOH offices, such that each team had a specific area(s) to manage.

**Annual/Quarterly Meetings and Progress Reporting.** To monitor the status of implementation of the technical activities, quarterly and annual meetings were held and these were participated in by PMTAT, DOH, CHDs, and USAID. These meetings served as vehicles to evaluate performance, and measure the achievement of project benchmarks, which was the basis for the release of fund tranches.

**Weekly meetings.** Within PMTAT, weekly staff meetings, chaired by the Chief of Party, were held to update the team of the previous week's activities, resolve issues, and plan for the following week.

**Sub-contracting.** Two major subcontractors, the Development Associates and the Economic Development Foundation provided assistance in the conduct of the basic course in FP. Together, the two subcontractors managed and ensured the quality of the FP trainings attended by the Municipal Health Officers (MHOs), physicians, nurses, and midwives from participating LGUs. Another subcontractor, Pathfinder, assisted by local consultants, was engaged by the project to develop and initially implement the SIM, a sustainable FP training model found to be cost-effective and replicable in other LGUs.

Other subcontracts were issued to conduct specific studies on FP. The National Institutes of Health (NIH) of the University of the Philippines-Manila was subcontracted in early 2003 to conduct a study on the ability of barangay health workers to dispense contraceptive pills initially. Save the Children, meanwhile, was engaged in May 2003 to test the feasibility of conducting FP counseling among peer groups.

**Short-Term Technical Assistance (STTA).** In addition to the technical expertise provided by the technical staff of the MSH home office in Boston, the project made use of the expertise of local consultants. Local consultants were engaged to assist the project in three major areas, namely, health sector reform, LPP/MGP, and *Sentrong Sigla*. Below is a list of local consultants grouped by category.

- **Health Sector reform:**

**Eduardo Banzon:** together with Orville Solon, assisted PMTAT in analyzing and making recommendations on health policy issues related to the health sector reform agenda of the DOH.

**Roberto Bartolome:** conducted a financial assessment of hospitals in preparation for their corporatization.

**Maricar Bautista:** together with Dr. Benito Reverente, provided general advice on health insurance expansion, management, and reform to DOH and PHIC officials as requested; assisted PMTAT in defining its technical assistance (TA) agenda and strengthening its capabilities in the areas of health insurance; and assisted PMTAT in planning and conducting its TA work in the four target provinces, starting with Capiz, particularly in expanding FP services through health insurance schemes.

**Rosendo Capul:** assisted the office of Dr. Mario Villaverde and other concerned offices of the DOH to come up with detailed work plans to carry out the health sector reform agenda, and assisted the DOH in organizing workshops and other venues to present and discuss health sector reform plans and activities.

**John Merenna:** conducted an assessment of the information technology requirements as well as an assessment of the organizational structure of the PHIC.

**Benito Reverente:** provided general advice on health insurance expansion, management, and reform to DOH and PHIC officials as requested; assisted PMTAT in defining its TA agenda and strengthening its capabilities in the areas of health insurance; and assisted PMTAT in planning and conducting its TA work in the four target provinces,

starting with Capiz, particularly, in expanding FP services through health insurance schemes.

**Mario Taguiwalo:** reviewed, updated, and prepared a draft of the USAID/Philippines' SO3 Strategic Framework for 2002-2004.

**Melchor Lucas:** conducted an assessment, and recommended actions for improving the operation of provincial and selected district hospitals in the three pilot sites namely, Pangasinan, Bukidnon, and Capiz.

**Juan Nafagas:** conducted an assessment of the hospital services in the province of Pangasinan and presented options to introduce hospital reforms.

**George Purvis:** conducted a review of the hospital reform strategies in Pangasinan, Capiz, Ilocos Norte, and Bukidnon.

**Orville Solon:** assisted PMTAT in analyzing and making recommendations on health policy issues related to the health sector reform agenda of the DOH.

**Elmer Soriano:** assisted the LPP Health Reform team in coordinating the progress of the expansion of the Indigent Program of the National Health Insurance Program in the provinces of Capiz and Pangasinan.

• ***Sentrong Sigla:***

**Jessica de Leon:** assisted the Undersecretary in mobilizing and coordinating with private and government offices/agencies and the business sector for the *Sustansya Para sa Masa*, specifically for policy and legislation, social mobilization activities, and mobilization of *sustansya* funds for relevant activities.

**Linda Buhat:** assisted PMTAT in developing and conducting a training curriculum on CQI in Capiz, Pangasinan, and Bukidnon.

**Elvira Dayrit:** assisted PMTAT in strengthening the *Sentrong Sigla* Program, particularly in field testing the *Sentrong Sigla* standards in the DOH regional offices, and in facilitating the training of the CHD *Sentrong Sigla* assessment teams.

**Eireen Villa:** assisted PMTAT in designing and implementing a series of *Sentrong Sigla* Training on Certification, Orientation Program for the technical teams, and Assessors' Training Program for the assessment teams in 16 regions.

Divina Capuchino, handled the facilitation of the five (5) *Sentrong Sigla* Technical Assistance teams' workshops, and six (6) Assessors' workshops.  
Priscilla Cuevas,  
Melanie Santillan,  
Francisca Cuevas:

- **LPP and MGP**

Ismael Naypa: assisted PMTAT in training local health physicians to perform no-scalpel vasectomies in MGP areas not covered by EngenderHealth.

Gerardito Cruz, assisted PMTAT in revising the training materials for *Barangay Health Volunteers for Home Delivery of Family Planning*, including Noel Raymundo, pre-testing and training of selected regional, provincial, and LGU Alejandro San Pedro: trainers.

**Hiring of Regional Field Coordinators.** To respond to the needs of the MGP, i.e., provision of technical assistance to the municipalities, Field Coordinators (FCs) were hired. Initially, four FCs were hired, but was augmented later by seven more. Four (4) of the FCs were required to be based in the low CPR regions namely, Regions V, VIII, ARMM, and CAR.

Similarly, three FCs were hired, and one RTA was re-assigned as an FC to implement the *Sentrong Sigla* activities in the MGP areas. The *Sentrong Sigla* activities were initially focused on the development of standards for assessing and accrediting health facilities in the MGP LGUs. The *Sentrong Sigla* FCs performed the dual functions of providing technical assistance to the DOH in standards development, and in testing and rolling out the standards in the LGUs.

**Collaboration with other CAs/Donors.** The project worked with other USAID Cooperating Agencies and linked with other projects assisted by UNICEF, ADB, GTZ, and the World Bank.

PMTAT specifically shared responsibilities with UNFPA and Johns Hopkins University in the launching and development of training materials for the *Sentrong Sigla* activities. Two separate video presentations were developed launching and advocating for the *Sentrong Sigla*.

Training materials on the competency-based FP training developed by the GTZ was used by PMTAT in conducting its own CBT in the MGP LGUs.

PMTAT coordinated with other USAID CAs in the conduct of the first Governors' Workshop in February 1999 and the second convention attended by Local Chief Executives and health officers of LGUs in 2001. PMTAT organized and conducted project implementation reviews with the CAs, who participated with presentations of their own project activities. The reviews served as vehicles for technical discussions and sharing of best practices among their project sites.

#### **IV. Activities Undertaken to Achieve Contract Objectives**

PMTAT implemented several types of technical assistance activities towards achievement of contract objectives. These included:

##### **A. Orientation**

Project staff embarked on a series of orientation activities for DOH counterparts at the national and regional levels, other partners/funding and CAs, and target LGUs: provinces, municipalities, and cities. Some orientation activities were unstructured; whereas others were more formal and structured, especially those conducted for local chief executives and LGU health managers. Materials were developed depending on the target audience and the level of detail that needed to be imparted by the project staff during the orientation.

##### **B. Creation of Advisory, Management, and Technical Committees and Organization of Technical Assistance Teams**

Advisory, management, and technical committees were created through DOH issuances like Department Orders, Administrative Orders, and Regional Orders. These groups or teams either performed oversight functions, technical functions, particularly, developmental work, or managed the project. From the time of the LPP up to the implementation of the MGP, there were advisory/steering committees, with DOH, USAID, other CAs, and PMTAT as members. National and regional technical assistance teams were organized to provide assistance directly to LGUs. PMTAT provided support to these teams.

Technical committees, with regional and LGU representatives abound, particularly under the quality assurance project component (*Sentrong Sigla*) since a lot of developmental work had to be done to meet contract objectives. These committees met regularly under the sponsorship of PMTAT.

##### **C. Workshops**

The holding of workshops was adopted as a major project strategy. This was one of the most important and effective means of gathering ideas and getting feedback essential for developing tools, instruments, and documents, doing action or work planning, and reviewing past performance. Since the project started in 1995, a lot of workshops were held for different purposes. This was the key method in developmental work for the QA component and in doing annual planning and program reviews.

Consultative workshops proved effective in gathering comments and recommendations from representatives at different levels of project implementation, e.g. LGU, regional, and national levels. The consultative workshops at times served as substitute for field-testing of tools through regional and LGU visits.

## **D. Training**

PMTAT was instrumental in the development of project training designs, modules, and manuals and in the implementation/adoption of the same. The most noteworthy technical training programs developed under the project include the Competency-Based Training on Family Planning, Training on CBMIS for health staff and volunteer health workers, Training for *Sentrong Sigla* Technical Assistance Teams and Assessors Teams, and the No-Scalpel Vasectomy Training (in collaboration with EngenderHealth). During the early years, project funds (coursed through the DOH) supported technical program trainings for LGU health workers in the areas of FP, immunization, CARI, and CDD.

### **Training Courses with Modules**

#### **LPP/MGP**

1. Data Utilization Training Course for LGUs
2. Competency-Based Family Planning Training (Levels 1 and 2)
3. Community-Based Disease Surveillance Training
4. MGP Technical Assistance Package (MGP-TAP) Training (Phases 1 and 2)
5. CBMIS Training (for non-MGP sites)
6. Standard Days Method (SDM) Training
7. BHW Refresher Training on Family Planning
8. No-Scalpel Vasectomy Training in A Rural Health Setting (in collaboration with DOH and EngenderHealth)

#### ***Quality Assurance (Sentrong Sigla)***

1. Technical Assistance Team Training (with TOT course)
2. Assessment Team Training
3. Understanding Quality Assurance Concepts

## **E. Development of Program Strategies and Framework, Tools, Manuals, and Other Instruments**

The most crucial part of the technical assistance to DOH and LGUs was in the area of program strategies/framework and tools development. PMTAT assisted the DOH in coming up with an FP, MCH, and Nutrition MIS Strategy (including the LGU Multi-Indicator Cluster Survey Model), an FP Training Strategy, and an Urban Strategy during the early years of the project. The Reproductive Health/Family Planning Clinical Standards Manual was updated for the DOH. Under the QA component, a *Sentrong Sigla* Strategic Framework and 4-Year Plan was likewise developed. Project tools such as standards lists and manuals, technical notes and briefs, planning guides, and templates, e.g. MOA for LGUs, were also developed.

Through the creation of technical working groups, field testing, holding of focus group discussions, and conduct of consultative meetings, workshops, and write shops, the project was able to develop a number of tools and instruments.

### **Technical References and Strategy Papers (stand alone documents)**

#### ***LPP/MGP***

1. FP/MCH/Nutrition MIS Strategy
2. Urban Strategy
3. FP Training Strategy
4. FP Clinical Standards Manual
5. Guide to Planning Government Health Services: *The Matching Grant Program in the Philippines*
6. NSV: An Illustrated Guide for Surgeons
7. NSV Curriculum: A Training Course for Vasectomy Providers and Assistants Participant's Handbook
8. Updates from the Field: Best Practices Series
9. Updates from the Field: Technical Notes Series

#### ***Quality Assurance (Sentrong Sigla)***

##### **Phase 1 Implementation of QA Program (1997 – 2000)**

1. 1997 Quality Improvement Strategic Plan
2. 2000 *Sentrong Sigla* Strategic Framework and Plan for 2000-2004
3. Level 1 Quality Standards List for *Barangay* Health Stations
4. Level 1 Quality Standards List for Rural Health Units
5. Level 1 Quality Standards List for Hospitals
6. Level 1 Health Facility Assessment Module for *Barangay* Health Stations
7. Level 1 Health Facility Assessment Module for Rural Health Units
8. Level 1 Health Facility Assessment Module for Hospitals
9. Level 1 Facility Self-Assessment Checklist for Rural Health Units
10. Level 1 Facility Self-Assessment Checklist for *Barangay* Health Stations
11. MTP Series: Understanding Quality Assurance Concepts (2) for Health Facilities
  - Defining Quality, Quality Assurance, and Quality Improvement; Understanding QA Techniques; Organizing Quality Circles
  - Understanding the 5 "S" Concepts; Applying "5" S in the Workplace
12. MTP Module for Hospitals:
  - Module 1: How to Improve the Management of Drugs and Medical Supplies in Hospitals
  - Module 2: How to Improve Housekeeping and Image of the Hospital
  - Module 3: How to Improve the Quality of Hospital Services
  - Module 4: How Much Drugs and Medical Supplies the Hospital Needs
  - Module 5: Where is the Hospital Going

### Phase 2 Implementation (2001-2003)

1. Level 1 Quality Standards List for Rural Health Units (includes Level 1 Supervisory Package for Rural Health Units)
2. Level 1 Technical Package for Rural Health Units
3. Level 1 *Sentrong Sigla* Facility Certification Form (FCF) for Rural Health Units
4. Level 1 Facility (RHU) Self-Assessment Checklist (FSAC)
5. Level 2 Draft Standards for Rural Health Units (Version 2)
6. Framework for Developing Standards for *Sentrong Sigla* (working document for standards development)

#### **F. Study Tours**

Study tours, both local and international, were made available to or arranged for LGUs and DOH staff for them to learn from other LGUs (as part of the LGU to LGU technical exchange), institutions, and other governments. One international study tour to Malaysia and Egypt was arranged for a team composed of DOH national and regional representatives. This was instrumental in the development of the DOH's *Sentrong Sigla* Certification Program.

#### **G. Conferences**

PMTAT funded the LGUs' and DOH's attendance in technical conferences both here and abroad. Apart from learning from these technical conferences, selected DOH and LGU representatives were able to share their project experiences in international fora like the Global Health Council and American Public Health Association Conferences held annually.

As part of the project's technical exchange component, a series of conferences, e.g. the LPP Summit, MGP Technical Conference, and MGP regional conferences, were held to provide technical updates to LGUs and allow them to share their best practices with their counterparts. PMAT also co-sponsored several national and regional conferences organized by the DOH.

#### **V. Key Results**

This section is divided into two parts. The first part gives a rundown of PMTAT's major deliverables under the project, which are further broken down into two phases, namely, 1995-2000 (original project duration) and 2000-2003 (extension period). The second part enumerates PMTAT's other outputs beyond the stated deliverables.

##### **A. Achievement of Deliverables**

#### Phase I (1995-2000)

1. System for strengthening the provision of FP/MCH training to service providers

A new competency-based Reproductive Health/Family Planning (RH/FP) training program was developed, pilot tested, and adopted. In 1999, a total of 394 trainers and preceptors from 72 LGUs and 16 DOH regional offices were trained on the new training curriculum. The concerned LGUs and regions were also provided with basic training equipment such as pelvic and breast models and intrauterine device (IUD) kits. To date, all provinces and major cities already possess the capabilities to train their own service providers and are conducting their own training courses.

This was an important milestone for the project and the DOH since this was the first training program to be decentralized to the LGUs. More importantly, the new training curriculum integrated the otherwise fragmented FP courses and adopted a competency-based approach that focused on developing essential clinical skills among health care providers.

Under the EDF subcontract, a total of 352 courses (57.8% higher than benchmark) were conducted with 6,767 service providers trained. The courses conducted covered such areas as DMPA, Basic Comprehensive, Basic FP, Interpersonal Communication Skills (ICS), Preceptors Course, Natural FP, FP Clinic Supervision, SIMS/CBT Level 1, and Training of Trainers for the New Training Strategy.

**Table 1**  
**COURSES CONDUCTED UNDER THE EDF SUB-CONTRACT**  
**October 1, 1995 – December 31, 1998**

COURSE	1995		1996		1997		1998		TOTAL	
	No.	Pax	No.	Pax	No.	Pax	No.	Pax	No.	Pax
DMPA	25	412	24	516	8	143	9	173	66	1,244
Basic Comprehensive	-	-	42	854	36	714	-	-	78	1,568
Basic FP	-	-	22	446	57	1,132	18	357	97	1,935
ICS	5	101	37	672	49	909	-	-	91	1,682
Preceptors Course	1	24	6	103	3	47	-	-	10	174
FP Clinic Supervision	2	39	1	18	-	-	-	-	3	57
SIMS/CBT Level 1	-	-	-	-	-	-	4	57	4	57
Trainers Orientation Seminar	-	-	-	-	2	36	1	14	3	50
<b>TOTAL</b>	<b>33</b>	<b>576</b>	<b>132</b>	<b>2,609</b>	<b>155</b>	<b>2,981</b>	<b>32</b>	<b>601</b>	<b>352</b>	<b>6,767</b>

2. System for monitoring and provision of information to program managers that will facilitate improving the efficiency and effectiveness of FP/MCH programs

PMTAT developed an MIS strategy that includes the following:

- Use of the Multi-Indicator Cluster Survey (MICS) to meet the information needs of provinces and highly-urbanized cities. The data generated helped the LGUs in prioritizing activities, especially those critical in meeting program targets and objectives.

- Introduction of a community-based monitoring and information system, which involves the masterlisting of all married women of reproductive ages and children below five years in the barangay. This tool was effectively used in MGP areas to identify priority clients for follow-up and service delivery.
  - Conduct of national surveys to provide data and information on program coverage. PMTAT worked with the DOH and the National Statistics Office in the development of the questionnaire for the annual MCH rider survey.
  - PMTAT also produced annual FP/MCH/Nutrition Status Reports for the period 1995-1997. A significant feature of the production of the 1997 report was the active involvement of the DOH in the collection of data and writing of the reports under the guidance of the MIS Technical Working Group, which was a step towards institutionalizing the initiative.
  - In close coordination with the Health Intelligence Service of the DOH, PMTAT developed and pilot tested the training manuals for the Data Utilization Training Course, which was designed to enhance the capability of health managers in using health data and information for decision-making at the local level.
3. System for developing and implementing special program strategies for FP/MCH in urban areas

PMTAT undertook the development of an urban strategy to improve access to FP/MCH services. Entitled *An Urban Strategy for the Philippines: Achieving Equitable, High-Quality, and Sustainable Family Planning, MCH, and Nutrition Services for the Entire Urban Population*, the document a) establishes the need for a special Philippine urban strategy, b) spells out the roles of the DOH, the urban LGUs, and the urban private sector in improving the health status of urban dwellers, and c) identifies the main strategies and suggests ways to implement these to achieve cost-effective and sustainable services for all. Following are the major elements of the urban strategy:

- Focus public sector provision of services on the urban poor;
  - Facilitate the expansion of private sector services, both for profit and not-for-profit, for those who can afford to pay;
  - Develop and implement an effective and sustainable program for meeting the reproductive health needs of urban adolescents and young adults; and
  - Strengthen the capability of urban LGUs to develop and manage sustainable, high-quality FP, MCH, and nutrition programs while enhancing the role of the DOH in supporting urban LGUs.
4. System for updating and disseminating service standards and mechanisms for their compliance at the health facility level to ensure high quality services

PMTAT provided technical assistance in updating the FP clinical standards. An important feature of the updated version is the inclusion of new sections on reproductive health standards and procedures. About 2,000 copies of the new Clinical Standards Manual for Family Planning and Reproductive Health were produced and distributed nationwide to all RHUs and government hospitals.

PMTAT also assisted the DOH in the development and implementation of a quality improvement program, more popularly known as *Sentrong Sigla*. In this regard, a Quality Assurance Program Plan was formulated to guide program implementation. The program has the following elements:

- Certification of health facilities that meet national standards enabling them to receive financial and technical assistance from the DOH.
- Conduct of a focused communication campaign aimed at promoting the significance of the *Sentrong Sigla* seal of excellence and generating greater demand for family planning/maternal and child health services.

Technical assistance was also provided to the DOH in drawing up the quality standards for RHUs and BHSs for each level of certification. It likewise took the lead in the development of tools, systems, procedures, and materials, e.g. assessment tools for public health facilities and hospitals, system/process for assessing and certifying health facilities, and guidelines for awarding performance grants. It also funded the development and production of promotional materials, *Sentrong Sigla* seal, plaques, and pins.

##### 5. System for ensuring the continued implementation of appropriate FP/MCH programs

Steps were undertaken to identify various options for ensuring the sustainability of FP/MCH programs. Field visits and interviews with relevant LGU officials were conducted to determine how LGUs allocate resources for health and explore other possible sources of funds for health. A survey was conducted to determine how LGUs utilized their Human Ecology Security (HES) funds, a potential source of funds for health. As an offshoot of this initiative, a joint resolution/Memorandum of Understanding was signed by DOH and the LGU Leagues clarifying their roles and responsibilities in the provision of FP/MCH services to the populace. Inter-LGU cooperation was also promoted as a means of mobilizing additional resources for health.

Together with the DOH regional counterparts, an advocacy program was initiated to convince LGUs to increase their budgetary support for public health programs, resulting in 22 provinces allocating increased resources for health.

At the national level, PMTAT worked for the institutionalization of the LPP granting mechanism within the DOH via the *Sentrong Sigla* Program. PMTAT assisted the program's Grants and Technical Assistance component in designing the *Sentrong Sigla*

Performance Grants Program, which aims to provide financial assistance to provinces, cities, and municipalities using GOP funds. The team's inputs were particularly useful in the design of the grants application and approval process, formulation of the guidelines on the utilization of grants, and development of the grants allocation model.

#### 6. System for managing the LPP

PMTAT played a major role in crafting the management procedures to ensure the efficient and effective implementation of the LPP. Its technical assistance to the DOH in this particular area included the following:

- Establishment of criteria and standards for selection of LGUs.
- Development of start-up and annual LPP and LGU benchmarks.
- Development of tools and procedures for orientation, planning, and monitoring, taking into consideration the need for broader participation of stakeholders at the LGU level. Participatory techniques were introduced to promote local ownership of national programs.
- Establishment of systems for deselecting LGUs, tracking procurement, monitoring disbursements, managing training, and allocating equipment/supplies.
- Formulation of financial guidelines to assist the LGUs in decision-making and addressing local issues within the overall context of the project. The guidelines were simplified to minimize auditing and accounting procedures.
- Organization of Regional Technical Assistance Teams to mobilize DOH technical resources to support the LGUs in LPP implementation.
- Organization and facilitation of orientation/planning workshops for LGUs.

Finally, based on the recommendations of PMTAT, the LPP organized the Top Performers Program (TPP) and the Matching Grant Program (MGP). A program for high-performing LGUs, the TPP was intended to motivate LGUs to accelerate implementation of program activities as those LGUs that meet their end-of-Project benchmarks ahead of schedule will be entitled to a performance grant equivalent to 75% of their base grants. A total of 45 LGUs (out of 99 LPP LGUs) were recognized as top performers and qualified for performance grants. The MGP, on the other hand, was launched to assist municipalities and cities expand service delivery coverage and improve the quality of primary health care given to women and children within a decentralized setting. As of September 2000, there were 50 LGUs enrolled in the MGP.

#### 7. System for monitoring and documenting the progress of benchmark achievement under S.O. 3 for purposes of the performance-based tranche disbursements

PMTAT assisted the DOH in establishing and refining the mechanisms for reviewing and assessing the progress towards meeting the LPP and LGU benchmarks. PMTAT was instrumental in decentralizing to the regions the functions for monitoring, validating, and certifying benchmark achievement by the LGUs. At the national level, a tracking form was designed to determine the LGUs' performance per benchmark. Mid-year Regional Update/Consultative Meetings were conducted to determine the LGUs' progress towards benchmark achievement as well as to discuss implementation problems and issues. These meetings were conducted prior to the holding of the mid-year review with USAID.

***Phase II (2000-2003)***

1. **At least 80 LGUs in low CPR regions participating in the MGP, bringing a total of not less than 300 LGUs participating in the MGP**

The MGP, as a granting mechanism and service delivery strategy, was effective in assisting LGUs to improve health services by making more resources available locally. To a large extent, it corrected inequities in the delivery of health services by prioritizing areas and population groups with high unmet needs, and facilitated the flow of funds to the point of service. By the end of September 2002, there were already 338 LGUs participating in the MGP. The target for MGP enrolment was exceeded despite a substantial reduction in the MGP budget of the DOH. This was made possible by mobilizing funds from the CHDs and provinces that had LPP savings of at least PhP1 million.

During the final extension period (October 2002-September 2003), priority was given to the enrolment of LGUs from five (5) regions, namely, the Cordillera Administrative Region (Cordillera Administrative Region, Bicol Region, Eastern Visayas Region, Autonomous Region of Muslim Mindanao (ARMM), and National Capital Region (NCR). The first four regions have contraceptive prevalence rates falling below the national figure (46.5%), as revealed by the 1998 National Demographic and Health Survey. Meanwhile, the NCR, while possessing a relatively higher CPR, still has a number of women of reproductive age, who do not use family planning services, particularly those in depressed areas (urban poor communities). These areas were prioritized to increase their utilization of family planning, particularly modern contraceptive methods.

To ensure the availability of funds for MGP expansion in these areas, PMTAT helped mobilize additional resources from the Center for Family Health and the Center for Health Development-Southern Tagalog, which made available PhP5 M and PhP3 M, respectively. The additional amount was proportionately shared by the five regions.

As a result of these efforts, an additional 132 LGUs were enrolled in the MGP, bringing the final total to 470 nationwide (Table 2). Out of the 470 LGUs, 128 are from the five priority regions: CAR with 17 LGUs, NCR with 8, Bicol with 40, Eastern Visayas with 38, and ARMM with 25.

Based on the CBMIS reports submitted by 81% of the total participating LGUs, 97% reached the target for Vitamin A supplementation among children aged 12-59 months, 80% for TT2+ for pregnant women, 63% for fully-immunized children aged 12-23 months, and 48% for modern CPR. These summary indicators were a result of the interplay of various factors obtaining at the LGU level, i.e., availability of supplies and how LGUs respond to lack of it, LGU support in terms of counterpart funds, ease/complexity of MGP-related financial transactions, ease/difficulty of LGUs in adopting new strategies, etc.

A major output of the PMTAT during this phase was the development and adoption of an MGP-Technical Assistance Package (MGP-TAP) that utilizes a learning-by-doing approach in conducting training and planning activities for the LGUs. The technical package includes training of health providers in implementing a CBMIS and conducting health facility self-assessments. The MGP-TAP training courses were organized and conducted by the CHDs, with the PMTAT Field Coordinators serving as technical backstops.

2. At least 80 % of all LGUs participating in the MGP have at least one RHU or main health center (MHC) certified as *Sentrong Sigla*

Under the contract, there should be at least 300 LGUs participating in the MGP by the end of 2003. Based on this minimum figure, the proportion of MGP-participating LGUs that have at least one *Sentrong-Sigla* certified health facility was computed at 104% (See Table 2).

3. At least half of MGP LGUs with *Sentrong Sigla*-certified RHU or MHC have at least one barangay health station certified as *Sentrong Sigla*

Only 57 or 18.2% of 313 LGUs with *Sentrong Sigla*-certified RHU/MHC achieved certification for at least one of their BHSs. It should be noted that assessment activities had been carried out on a very limited scale during the last two years pending the finalization of the modifications on the *Sentrong Sigla* framework and certification standards.

**Table 2. Matching Grant Program Enrollees as of September 30, 2003**

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
1	Ilocos Norte	Laoag City	/	/	908
		Bangui	/	/	1,314
		Burgos	/	/	1,673
		Marcos	/	/	1,265
		Curimaao	/	/	708
		Banna	/	/	1,329
		Piddig	/	/	2,089
		Paoyay	/	/	2,048
		Badoc	/	/	909
		Sarrat	/	/	1,356
	Pangasinan	Asingan	/	/	750
		Mangaldan	/	/	1,000
		Laoac	/	/	440
		Urdaneta	/	/	500
		Binalonan	/		
	La Union	San Fernando	/	/	2,213
		Tubeo	/	/	1,269
Ilocos Sur	Narvacan	/			
	Sta. Maria	/	/	1,049	
2	Isabela	Ilagan	/	/	1,208
		Cauayan	/	/	285
		Cabagan			
	Quirino	Nagtipunan	/	/	514
	Cagayan	Tuguegarao	/	/	1,975
		Baggao	/		
		Aparri	/		
Tuao		/	/	3210	
CAR	Mountain Province	Sabangan	/	/	822
		Tadian	/	/	1,550
		Bauko	/	/	2,921
		Sagada	/	/	1,062
		Besao		/	772
		Paracelis	/	/	1,464
		Bontoc		/	1,725
	Benguet	Baguio City	/	/	1,751

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
		Kibungan	/	/	240
		Kapangan	/	/	219
		Sablan	/	/	101
		Bokod	/	/	97
		Kabayan	/	/	163
		Bakun	/	/	172
		Mankayan	/		
	Abra	San Quintin		/	439
		Pidigan	/	/	527
	Aurora	Casiguran	/	/	271
		Dilasag		/	141
		Dinalungan	/	/	74
		Dipaculao	/	/	649
	Bataan	Hermosa		/	38
		Orani	/	/	96
		Samal	/	/	59
	Bulacan	San Miguel	/	/	478
		Angat	/	/	1,007
		Baliuag	/	/	448
		Bustos	/	/	2,880
		Dona Remedios Trinidad	/	/	418
		San Rafael	/	/	352
		Bocaue	/	/	313
		Pandi	/	/	1,614
		Marilao	/	/	297
		Meycauayan	/	/	701
		Norzagaray	/	/	221
		Sta. Maria	/	/	801
	Pampanga	Bacolor		/	466
		Minalin		/	1,389
		San Fernando		/	1,754
		Sto.Tomas		/	1,142
	Tarlac	Camiling	/	/	100
		Mayantoc	/	/	887
		San Clemente		/	230
		Sta. Ignacia	/	/	1,963
Zambales		Masinloc	/	/	1,662

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
		Candelaria	/	/	693
		Sta. Cruz		/	1,045
	Nueva Ecija	Cabanatuan	/	/	499
		General Tiño			
		Penaranda	/	/	867
		San Leonardo		/	2,923
		Gapan	/	/	701
		Cuyapo	/		
		Guimba	/		
		Nampicuan	/	/	710
		Talugtog	/	/	405
		4	Cavite	Dasmarinas	/
Imus	/			/	2,470
Tanza	/			/	2,103
Magallanes	/			/	2,425
Naic	/			/	1,818
Maragondon	/			/	1,322
Ternate	/			/	1,942
Taytay	/			/	1,805
Rizal	Cainta		/	/	1,553
	Antipolo		/	/	1,588
	Binangonan		/	/	49
	San Mateo		/		
	Tanay		/	/	708
	Batangas		Batangas City	/	/
Alitagtag			/	/	2,941
Cuenca			/	/	1,301
Sta. Teresita			/	/	1,354
Lipa City			/	/	3,118
Tanauan			/	/	5,221
Taal			/	/	1,785
Quezon	Sariaya	/	/	473	
	Candelaria	/	/	12	
Laguna	San Pablo City	/	/	1,438	
	Binan	/	/	598	
	Sta. Rosa	/	/	5,764	
	Pila	/	/	608	
	Victoria		/	1,143	

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
	Oriental Mindoro	Sta Cruz		/	466
		Calapan City	/	/	13,051
		Socorro	/	/	347
		Pinamalayan	/	/	370
	Occidental Mindoro	San Jose	/		
	Marinduque	Sta. Cruz	/	/	329
		Torrijos	/	/	935
	Rombion	Calatrava	/	/	235
		Odiongan	/	/	892
		San Agustin	/	/	500
		San Andres	/	/	196
	Palawan	Narra	/	/	848
		Aborlan	/	/	232
		Coron	/	/	353
		Linapacan	/	/	10
		Culion		/	428
	NCR		Navotas	/	
		Taguig	/		
		Pateros	/		
		Malabon	/		
		Marikina	/		
		Muntinlupa	/		
		Pasig	/		
		Valenzuela	/		
	Albay	Daraga	/	/	2,060
		Tabaco	/	/	5,610
		Tiwi		/	672
		Malinao	/	/	1,719
		Malilipot	/	/	2,365
		Bacacay	/	/	430
		Sto. Domingo	/		
		Jovellar		/	1,050
		Polangui	/	/	335
		Oas	/	/	1,869
		Libon		/	84
		Ligao	/	/	4,333
	Guinobatan		/		

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
	Camarines Sur	Naga City	/	/	
		Buhi	/		
		Libmanan	/		
		Iriga City	/		
	Catanduanes	Bagamanoc	/	/	483
		Baras	/	/	1,154
		Bato	/	/	837
		Caramoran		/	2,336
		Gigmoto	/	/	413
		Pandan		/	888
		Panganiban	/	/	519
		San Andres	/	/	801
		San Miguel	/	/	305
		Viga		/	1,008
		Virac	/	/	1,745
	Sorsogon	Donsol	/	/	1,817
		Pilar	/	/	100
		Casiguran	/	/	493
		Juban	/		
		Magallanes	/	/	1,367
Camarines Norte	Capalonga	/	/	729	
	Sta. Elena	/	/	259	
	Panganiban		/	358	
	Paracale	/	/	625	
	Labo	/	/	559	
6	Negros Occidental	Bago City		/	2,535
		Silay City	/	/	1,682
		Kabankalan	/	/	6,333
		Sagay City	/	/	6,372
		San Carlos	/	/	1,229
		Calatrava	/	/	608
		Escalante		/	
		Cadiz	/	/	1,349
		Talsay	/	/	5,697
		Valladolid		/	483
		Isabela		/	432
		La Carlota	/	/	
Moises Padilla		/	489		

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
		Ilog	/	/	4,148
		Candoni	/	/	1,621
		Hinobaan	/	/	737
		EB Magallona		/	
		Murcia	/	/	360
		San Enrique		/	900
		Roxas City	/	/	1,538
	Iloilo	Jamindan		/	651
		Cuartero		/	527
		Dumarao		/	707
		Anilao	/	/	371
		Barotac Viejo		/	638
		Iloilo City	/	/	5,468
		Leganes		/	1,125
		San Enrique	/	/	677
		San Rafael		/	
		San Joaquin		/	1,576
		Zarraga		/	1,831
		Pavia	/	/	2,029
	Aklan	Buruanga	/	/	353
	Antique	Culasi	/	/	944
		Valderamma		/	999
	7	Cebu	Belison		/
Minglanilla			/		
Bogo			/		
Oslob			/	/	1,010
Ronda					
Medellin			/		
Pilar					
Sibonga			/		
Pinamungahan			/	/	1,000
Tabuelan			/		
Tuburan			/		
Argao			/		
Dalaguete				/	1339
Alcoy			/	/	937
Sogod	/	/	254		

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
		Tabogon	/		
		Borbon	/		
		Catmon	/		
		Barili		/	498
		Aloguinsan			
		Dumanjug		/	2087
		Danao	/	/	1056
		Carmen		/	249
		Compostela	/	/	319
		Liloan	/	/	200
	Negros Oriental	Bayawan	/		
		Basay	/		
		Sta. Catalina	/		
		Siaton			
		Zamboanguita		/	1,516
		Mabinay			
		Manjuyod			
		Bais		/	737
		Tanjay	/		
		Pampuna			
		Valencia			
		Dauin		/	989
		Amlan	/	/	1,975
		San Jose			
		Dumaguete City		/	116
		Bacong			
		Sibulan		/	612
		Bindoy		/	3,672
		Ayungon	/	/	1,753
		Tayasan	/		
	Siquijor	Lazi		/	920
		Maria		/	608
		San Juan			
		En Villarueva		/	244
		Larena	/	/	539
	Siquijor		/	920	
	Bohol	Mariboloc		/	297

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)			
				w/ MOA	# of Enrolled Households		
		Antiquera	/	/	245		
		Cortes		/	230		
		Sikatuna		/	765		
		San Isidro		/	90		
		Catigbian		/	291		
		Balilihan		/	1,219		
		Corella	/	/	112		
		Candijay	/	/	483		
		Calape		/	848		
		Dagohoy	/	/	383		
		Getafe		/	161		
		Bilar	/	/	977		
		Garcia Hernandez		/			
		Inabangan					
		Sevilla		/	379		
		8	Leyte	Ormoc City	/	/	2,000
				Albuera	/		
				Baybay	/	/	1
				Tanauan		/	710
				Matag-ob		/	100
San Isidro				/	350		
Alang-alang				/	531		
Sta. Fe				/	200		
Pastrana							
Dagami				/	739		
Dulag			/	508			
East Samar	Balangiga		/	/	600		
	Giporlos		/	/	254		
	Lawaan		/	/	455		
	Hernani			/	363		
	Quinapondan		/	/	248		
	Mercedes			/	317		
North Samar	Catarman		/	/	1,373		
	San Jose		/				
	Mondragon			/	827		
	Allen	/	/	133			
	San Isidro	/	/	500			

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
		San Antonio	/	/	151
		Bobon	/		
		Maasin	/	/	1,223
	South Leyte	Padre Burgos	/	/	291
		Pintuyan	/	/	166
		San Francisco	/	/	86
		San Ricardo	/	/	170
		Malitbog	/	/	452
		Macrohon	/	/	953
		Motiong	/	/	437
	Western Samar	Marabut		/	100
		Basey		/	1,000
		Gandara			
		Pinabacdao			
		Biliran	Naval	/	/
Culaba				/	638
9	Zambo del Norte	Dipolog City		/	940
		Sindangan	/	/	660
		Siayan	/	/	243
		Polarco	/	/	389
		Leon Postigo	/	/	120
	Independent City	Zamboanga City	/	/	2,706
	Zambo del Sur	Pagadian City	/	/	479
		Aurora	/	/	
		Vincenzo Sagun	/	/	524
		Dumingag	/	/	2,481
		Dumalinao	/	/	555
		Ramon Magsaysay	/	/	1,563
	Zambo Sibugay	Dinas		/	1,537
		Ipil	/	/	327
		Malangas	/	/	1,084
Basilan	RT Lim	/	/	496	
	Isabela City	/	/	7,565	
10	Bukidnon	Valencia City	/	/	26,302
		Malaybalay	/	/	26,250
		Manolo Fortich	/	/	9,880

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
	Misamis Occ.	Ozamis City		/	1,641
		Oroquieta City	/	/	1,000
	Misamis Oriental	Gingog City	/	/	989
	Lanao del Norte	Magsaysay		/	
		Baroy	/	/	1,000
		Lala	/	/	
		Linamon	/	/	1,389
	Independent City	Iligan City	/	/	9,944
CARAGA	Surigao del Norte	Surigao City	/	/	2,064
		Claver	/	/	730
	Surigao del Sur	Bislig	/	/	3,645
		Cantilan	/	/	1,198
		Hinatuan	/	/	184
	Agusan del Norte	Butuan City	/	/	5,100
		Buenavista	/	/	623
		Magallanes	/	/	375
	Agusan del Sur	San Francisco	/	/	937
		Prosperidad	/	/	1,050
		Bayugan	/	/	1,050
11	Davao Sur	Digos	/	/	634
		Malita	/	/	94
		Hagonoy			
		Padapa		/	44
		Sulop	/	/	2,612
		Sta. Cruz	/	/	1,366
		Matanao		/	3,976
		Sta. Maria		/	291
		Magsaysay		/	794
		Malalag	/	/	466
		Bansalan	/		
		Davao Norte	Tagum	/	/
	Island Garden of Samal			/	6,524
	Talaingod			/	2,562
	New Corella		/	/	1,963
	Panabo		/	/	4,807
	Asuncion		/	/	4,607
	B.E. Dujali			/	4,054

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)	
				w/ MOA	# of Enrolled Households
		Sto. Tomas	/	/	2,657
		Carmen	/	/	2,935
		Kapalong	/	/	4,261
	Sarangani	Alabel		/	473
		Maitum	/	/	50
		Malapatan		/	50
		Glan			
		Kiamba	/	/	50
		Maasim	/	/	50
		Malungon		/	473
		Compostela Valley	Laak	/	
	Mabini		/	/	2,557
	Maco		/		
	Maragusan		/	/	227
	Mawab		/	/	4,075
	Monkayo		/	/	1,692
	Montevista		/	/	1,435
	Nabunturan		/	/	1,161
	New Bataan		/	/	332
	Pantukan		/		
	Compostela		/	/	280
	South Cotabato	Koronadal	/	/	811
		Tampakan	/	/	1,744
		Norala	/	/	3,901
		Lake Sebu		/	787
		Tupi	/	/	892
		Polomolok	/	/	168
		Banga	/	/	1,223
		Sto. Nino	/	/	2,438
		Surallah	/	/	442
		Tantangan	/	/	864
T-boi		/	/	840	
Davao Oriental	Mati	/	/	14	
	Lupon		/	115	
	Banaybanay	/	/	411	
	Gov. Generoso		/	107	
	San Isidro	/	/	123	
	Baganga	/	/	13	

Region	Province	LGU	SS Certified Facilities	Enrollment in the Indigent Program of PhilHealth (as of Sept 30, 2003)		
				w/ MOA	# of Enrolled Households	
		Manay		/	53	
		Boston	/	/	52	
		Caraga	/	/	22	
		Cateel	/	/	41	
		Tarragona		/	41	
		Independent City	Davao City	/	/	634
	Independent City	Gen. Santos City	/	/	5,532	
	12	Lanao del Norte	Magsaysay			
			Baroy	/	/	1,000
			Lala	/		
			Linamon	/	/	1,389
Independent City		Iligan City		/	9,944	
North Cotabato		Kidapawan	/	/	1,800	
		Mlang	/	/	1,010	
		Midsayap		/		
		Kabacan		/	1,178	
		Makilala	/	/	3,632	
		Aleoson		/	493	
		Alamada		/		
		Carmen				
		President Roxas	/	/	729	
		Pigcawayan		/		
		Mapalam		/	158	
		Magpet		/	701	
		Antipas		/	368	
		Libungan		/	675	
Tulunang			/			
Sultan Kudarat		Lebak		/	500	
		Esperanza	/	/	652	
		Isulan	/	/	1,010	
	Lambayong		/	2,024		
	Tacurong City		/	4,200		
	Lutayan		/	1,500		
	Bagumbayan		/	101		
	Sen. Ninoy Aquino		/	673		
Palimbang						



4. Promote sustainability by at least 80 MGP LGUs enrolling in the Indigent Program of the Philippine Health Insurance Corporation (PhilHealth)

As of September 2003, there were already 394 MGP-participating LGUs that have enrolled their indigents in PhilHealth's Indigent Program (See Table 2). Of these, 379 were in the "servicing stage", i.e. had remitted the required premium payments and the IDs already issued to the enrollees. In terms of population coverage, this translates to about 514,646 indigent families covered by PhilHealth's social health insurance program.

5. System for LGU technical exchange established

PMTAT developed the framework for the implementation of the Technical Exchange Program as a major strategy for disseminating lessons learned and rolling out best practices. The program was designed to accelerate the cross-fertilization of ideas among LGUs, promote the replication of best practices, and encourage the sharing of lessons learned. The program utilized several venues for technical exchange, which included national and sub-national technical conferences, local study tours, technical briefs/updates, and web-based information sharing. To help LGU staff to identify, document, and present best practices, success stories, and lessons learned, PMTAT organized two workshops (1998 and 2000) for representatives from regional offices and selected provinces, cities, and municipalities.

PMTAT documented the MGP-participating LGUs' innovative interventions and had these printed for both local and international circulation. A total of 22 issues of *Updates from the Field: Best Practices* were published while 9 *Technical Notes*, which outlined the different systems, mechanisms, and processes adopted by LGUs to improve program implementation and management, were printed and disseminated.

PMTAT organized a National LPP Summit and two Top Performers Fora in 1999, an MGP National Conference in 2000, a National Consultative Workshop (in coordination with other cooperating agencies) in 2001, and three Program Implementation Reviews/MGP technical conferences – one for each of the major island groups – in 2002. The conferences were aimed at providing the LGUs with program and policy updates as well as at disseminating the best practices of and the attendant valuable lessons learned by LGUs in the course of program implementation.

PMTAT collaborated with the League of Municipalities for the inclusion of the MGP and the *Senrong Sigla* in the agenda of the League's 2000 conferences for Luzon, Visayas, and Mindanao where relevant best practices were presented to the municipal/city mayors.

PMTAT maintained the project website to make project information readily available to interested parties and to the general public. In addition, it coordinated the preparation and printing of the document *Guide to Planning Local Government Health Services: The Matching Grant Program in the Philippines*, which is intended for both local and international dissemination.

To facilitate technical exchange among the regions, PMTAT provided all CHDs with a computer and provided technical assistance in setting up their internet connections. PMTAT also initiated an electronic discussion group, which may be participated in by the CHDs and LGUs.

6. System for sub-granting of provincial funds to component cities and municipalities developed

PMTAT developed a plan for a provincial sub-granting program utilizing primarily the province's unexpended balance from the LPP grant. The plan was developed based on the results of a series of focus group discussions conducted with members of the LPP teams of the Provinces of Pangasinan and Negros Occidental, two LPP-participating provinces that have pioneered the sub-granting mechanism in their respective areas.

Together with the PMO, PMTAT oriented and encouraged LPP provinces with substantial savings from their base grant to sub-grant these funds to expand the implementation of the MGP in their respective municipalities and cities.

7. Pilot test on expanded role of volunteer health workers (VHWs) in family planning service delivery conducted and results disseminated to DOH

PMTAT contracted the services of the NIH of the University of the Philippines to conduct the study on the efficacy and safety of utilizing VHWs to dispense oral contraceptives. The study aimed to determine the effectiveness of a community-based pill dispensing package vis-à-vis clinic-based service delivery in terms of accessibility, acceptance, safety, quality of care, and continuation of pill use. The cities of Marikina and Lucena were selected as intervention areas while Pasig City and Sariaya served as control areas.

A baseline community survey was conducted as part of the study to gather information on current pill dispensing approaches in the study sites, including community perceptions and experiences regarding pill use. In the intervention phase, trained VHWs were allowed initial pill dispensing and re-supply using a dispensing and monitoring checklist. This was followed by a quasi-experiment to test the sensitivity-specificity of the screening checklist and to test the significant differences between the intervention and control sites in terms of accessibility, acceptance, and safety. An end-line pill user survey accessed clients' cognitions and attitudes regarding pill use and pill dispensing methods.

Results showed that clients in the intervention sites (community-based approach) had easier access to pills compared to those in the control sites (clinic-based approach). In terms of safety, there was no significant difference in the experiences of side effects among clients in both groups. To continue the process of institutionalizing the population program at the local level, this study proposes to improve the use of community-based approach through a) the selection of experienced and adequately-trained VHWs as initial dispensers; b) continuous updating of knowledge and skills of pill dispensers in place to

improve grassroots competence and efficiency; and c) increase access to medical tools like sphygmomanometer to adequately screen and monitor clinical cases.

The results of the study will be presented to the DOH during the policy forum being organized by the Health Policy Unit of the DOH for the first quarter of 2004.

8. System for resource mobilization for MGP developed, in place and functional in the CHDs of the five low CPR regions

A system for resource mobilization has been developed in all CHDs. The CHDs now develop an annual MGP work and financial plan that estimates the funds needed based on the number of currently enrolled LGUs and number of potential enrollees. This work and financial plan is submitted to the DOH-Central Office for approval and allocation of funds. The MGP is now a line item under the Local Health Assistance Division budget of the CHDs. A total of Php 66,876,761 was allocated for MGP in 2003. Fifty-six percent (56%) of this amount has been released to the LGUs.

9. 16 CHDs have demonstrated capacity to conduct program implementation reviews and technical exchange activities at the local level

In line with strengthening the capacity of the Centers for Health Development to manage the MGP, PMTAT worked towards building their capability to organize and conduct regional program implementation reviews (PIRs). These program reviews are being conducted to supplement the regular monitoring visits. Careful design and management of these program reviews are crucial since these are the perfect venues for ventilating and discussing program implementation issues, providing technical assistance to LGUs, and identifying and sharing best practices and lessons learned.

All CHDs have conducted at least one regional-level PIR for the MGP during the period October 2002-September 2003. Aside from providing the venue to assess the status of MGP implementation in the project sites, the PIRs also allowed the participating LGUs to share their best practices in the areas of family planning, maternal/child health, and nutrition. These program reviews were organized, conducted, and funded by the CHDs utilizing their program management funds.

Originally designed as a three-day activity, most regions have made their PIRs into either a one or two-day activity due to budget constraints. As a result, the CHDs have increasingly encouraged the provinces to organize program reviews for their MGP LGUs at their level. Provinces such as North Cotabato, Sultan Kudarat, Davao Norte, Davao Oriental, Davao Sur, Compostela Valley, Negros Occidental, Negros Oriental, Catanduanes, and Pangasinan organized PIRs for their MGP-participating municipalities/cities, with technical assistance from their respective CHDs. Meanwhile, it is worth noting that in Region VIII, district-level PIRs were organized and sponsored by the concerned MGP-participating LGUs, with the CHD staff facilitating said PIRs. A total of 32 district-level program reviews were conducted during the period October 2002 -September 2003 in the region.

PMTAT likewise facilitated interregional technical exchange among the CHDs, particularly for CBMIS training. The CHDs, on the other hand, have been instrumental in facilitating technical exchange among their LGUs, particularly in promoting the LGU-LGU training approach where trainers from one or more LGUs are tapped to provide training on CBMIS and/or no-scalpel vasectomy (NSV) for another LGU. Moreover, the CHDs assisted their LGUs in documenting their best practices for presentation in the MGP technical conferences, using the guide for documenting best practices that was developed and disseminated by PMTAT to all CHDs and LGUs.

#### **10. *Senrong Sigla* standards/criteria finalized**

The improved *Senrong Sigla* framework identifies three certification levels, namely, a) Basic Certification, b) Specialty Certification, and c) Certification of Excellence. During the project's final year, PMTAT assisted the DOH finalize the new Level 1 standards for Phase II implementation. These standards are limited to RHUs, with the BHS standards to be incorporated under the facility systems category of the RHU's Levels 2 and 3.

PMTAT likewise assisted the DOH in developing a *Supervisory Form/Checklist* for use of RHU supervisors/staff, *Facility Certification Form* for assessors, and Level 1 *Technical Assistance Package* for the TA Teams of the CHDs.

Assistance was also provided to the DOH in finalizing the document describing the development principles and procedures for Level 2 standards.

#### **11. *Assessment teams* in 16 CHDs organized and trained on new *Senrong Sigla* standards and criteria**

There are two *Senrong Sigla* teams at the regional level, i.e., *technical assistance/monitoring team*, who provides technical assistance to LGU health facilities, and the *assessment team*, who formally certifies health facilities. The DOH national and regional offices have reorganized their respective assessment and technical assistance/monitoring teams with the assistance of PMTAT.

The training of trainers (TOT) course for TA teams was conducted ahead of the training for assessment teams since the TA teams needed to assist the LGUs prior to formal assessment. PMTAT assisted the DOH-Bureau of Local Health Development (BLHD) in conducting four training courses, with 30 participants per batch coming from the different CHDs. To date, all 16 CHDs have at least 5-6 trained trainers and at least eight have started their rollout training in their respective regions.

A fifth run of the TA training was conducted for the CHDs' assistant regional directors and regional *Senrong Sigla* point persons to update them on the improved tools and procedures and for these regional managers to plan for *Senrong Sigla*-related activities, which include training, advocacy, LGU technical assistance, facility assessment, and awarding. This made *Senrong Sigla* certification a priority activity for the CHDs.

In addition, PMTAT assisted the DOH in training four of seven batches of *Sentrong Sigla* assessors. Each region has at least four assessors to date. During the training for assessors, three national and one LGU technical staff were identified and trained as trainers for DOH-BLHD.

12. DOH order institutionalizing *Sentrong Sigla* management and implementation structures issued

The DOH issued Administrative Order 17-B s. 2003: *Philippine Quality in Health Program 2003-2007*, which broadened the effort to improve quality of health services in the country by mobilizing main instruments to influence specific priority groups of health providers. One of the main components/strategies in this quality improvement framework is *Sentrong Sigla* certification for primary care units. This Order set the stage for the issuance of Administrative Order 100, s. 2003, which outlines the guidelines to strengthen *Sentrong Sigla* certification.

**B. Other Accomplishments**

In addition to the achievement of the above deliverables, PMTAT undertook other relevant initiatives to facilitate the attainment of the project benchmarks. To wit:

1. Ensuring program sustainability

PMTAT initiated activities in support of the DOH's Health Sector Reform Agenda, which is a package of health sector reforms that will help ensure the sustainability of the programs supported by the LPP. Among these initiatives was the conduct of a national pharmaceutical management assessment in late 1998 and pilot testing of health sector reform activities in the Provinces of Capiz and Pangasinan in 1999. This resulted in the recommendation of a prime vendor model for procurement and distribution, development of a centralized bidding protocol for prices, with decentralized procurement, and establishment of a pooled resource scheme for provincial and district hospitals in Pangasinan, resulting in lower prices and timely delivery of essential drugs. Quality improvement initiatives at the provincial, district, and community hospitals were also undertaken in both provinces.

2. Developing, strengthening, and consolidating capacity of LGUs to deliver male sterilization services

- *Mobilizing and training BHWs to strengthen FP service delivery*

Based on the past successes of community-based programs where involvement of an organized network of volunteers is at its core, PMTAT invested in training BHWs on FP, initially in priority regions and later in non-priority regions. This was to enable the BHWs to give initial information on family planning, with subsequent referral to the rural health midwife for counseling of prospective clients. A total of 16,775 BHWs all over the

country have undergone the Competency-Based Training for Family Planning (CBT-FP). These BHWs are now actively recruiting potential FP clients and the effect is reflected in the increase in demand for and utilization of sterilization services in MGP-LGUs. Of the total MGP LGUs, 156 are now able to generate clients for NSV.

- *Developing local capacity for No-Scalpel Vasectomy : LGU-to-LGU approach*

PMTAT facilitated NSV “peer training” by bringing competent LGU NSV service providers to other MGP areas to train interested local physicians. Interested physicians are first made to read two manuals on NSV (NSV - An Illustrated Guide for Surgeons and NSV Curriculum - A Training Course for Vasectomy Providers and Assistants Participant’s Handbook). Training is then done on-site, where the peer trainer demonstrates the procedure first, with the trainee as assistant/observer. The trainee is then allowed to do the procedure with the peer trainer assisting him. This is repeated during subsequent NSV service delivery rounds until the local physician has gained confidence to do the procedure with his team. Although not a requirement for NSV service provision, PMTAT also encouraged LGU NSV providers to seek certification from EngenderHealth to assure provision of quality NSV service. A total of 107 local providers have been trained to provide NSV service as of September 30, 2003 (Table 3).

- *Consolidating NSV service provision : NSV regional trainers*

PMTAT, in coordination with EngenderHealth, developed the training curriculum and assessment tools for No-Scalpel Vasectomy Training in a Rural Health Setting. This module, together with two NSV manuals from EngenderHealth, were used during the series of NSV Training of Trainers courses held from July to September 2003 in South Cotabato (T’boli), Negros Occidental (Cadiz City), and Iloilo (San Joaquin). Certificates of course completion were given to participants. A total of 18 regional trainers were identified from regions 1, 4, 5, 6, 7, 8, 10, 11, 12 and CARAGA. These trainers were “introduced” to their respective CHD directors and family planning coordinators to make them aware that these trainers may be tapped by the CHD in training other LGUs interested in setting up NSV services in their areas. Meanwhile, NSV instruments are now available through an exclusive local distributor. At least 124 NSV instruments have been distributed to RHUs nationwide. Table 3 shows the total number of NSV procedures that have been done as of September 30, 2003.

**Table 3. Status of No-Scalpel Vasectomy Services In MGP Areas, as of September 30, 2003**

Region	No. of Provinces with LGUs currently providing NSV services	No. of LGUs INTERESTED to provide NSV services	No. of LGUs CURRENTLY generating NSV clients	Number of Doctors providing NSV services	Number of NSV sets available	Number of vasectomized clients										
						Year 2002	Year 2003									
							Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Total
I	2	14	9	6	0	26	14	11	0	14	2	0	0	0	1	68
II	2	3	3	7	0	0	21	1	0	0	0	0	0	0	0	22
III	3	16	6	0	2	0	0	0	0	4	5	20	0	0	0	29
IV	3	14	7	0	5	0	0	15	24	9	2	7	9	3	2	71
V	4	24	15	6	4	44	27	57	13	31	37	24	14	41	26	311
VI	1	14	10	9	26	191	37	50	80	75	111	11	141	140	35	871
VII	2	11	11	4	2	51	3	19	0	23	0	0	16	13	38	163
VIII	5	26	19	16	12	19	11	25	45	25	25	20	17	53	0	240
IX	1	4	1	1	0	0	0	8	0	2	0	0	0	0	0	10
X	1	4	3	2	3	34	29	11	22	21	1	11	48	12	9	198
XI	4	37	32	34	29	39	36	203	210	48	82	96	55	26	0	795
XII	5	27	23	8	13	14	24	2	299	41	105	35	168	0	0	688
ARMM	2	3	2	2	0	0	0	2	0	0	5	3	0	0	0	10
CAR	2	11	5	1	1	0	0	0	7	5	6	0	6	0	0	24
CARAGA	3	8	5	3	9	0	0	12	14	4	14	0	24	38	0	106
NCR		12	5	0	0	11	3	6	5	8	2	4	1	0	0	40
<b>TOTAL</b>	<b>40</b>	<b>228</b>	<b>156</b>	<b>99</b>	<b>106</b>	<b>429</b>	<b>205</b>	<b>422</b>	<b>719</b>	<b>310</b>	<b>397</b>	<b>231</b>	<b>499</b>	<b>326</b>	<b>111</b>	<b>3646</b>

### **3. Improving access to FP services in poor and disadvantaged communities in urban areas**

In eight selected urban poor areas under the Urban Poor Family Planning Initiative of the DOH and in seven MGP enrollees in Metro Manila, the project successfully trained 928 health volunteers to recruit and motivate FP clients. This technical assistance provided by MSH was designed to assist the LGUs and DOH in developing approaches to improve access to FP services, especially among the disadvantaged communities in Metro Manila. So far, this effort has generated 1,326 clients that have availed of both male (71) and female sterilization (1,255) services in these areas (Table 4).

### **4. Promoting public-private sector collaboration**

In mid-2002, PMTAT initiated the establishment of cross-referral arrangements between the MGP-participating LGUs and the FriendlyCare Clinics of Friendly Care Foundation, Inc. as well as with the Well-Family Midwife Clinics under John Snow International's TANGO II Project. This initiative was intended to decongest public health facilities, particularly Rural Health Units, of paying clients, thus, enabling them to concentrate on their poor and disadvantaged constituents and, in turn, help improve the partner clinics' income and ensure their long-term viability.

The Municipalities of Cainta and San Mateo and the Cities of Antipolo and Marikina already have signed MOAs with FriendlyCare Foundation and have started cross-referral of clients. It is also worth noting that as an offshoot of the initiative, other LGUs in Rizal, i.e. Tanay and Binangonan, have also started referring clients to FriendlyCare, even without any formal agreement. As of September 2003, total referrals from the six LGUs for no-scalpel vasectomy and bilateral tubal ligation reached 78 and 325, respectively.

Meanwhile, the Municipalities of Carmen and Kapalong in Davao Norte, Lupon in Davao Oriental, and M'lang in North Cotabato have formalized their partnership with the Well-Family Midwife Clinics in their respective areas. In the pipeline are Makilala and Kidapawan City in North Cotabato. Initial discussions have been held with the MHOs of Asuncion in Davao Norte, and Mati and Banaybanay in Davao Oriental.

It was noted that the referral system was quite successful in areas where the BHWs were given proper orientation, e.g. Carmen in Davao Norte and Cainta in Rizal. Any initiative of this nature should, therefore, ensure that all key stakeholders and actors are properly and adequately informed to ensure smooth and effective implementation.

### **5. Improving access of indigenous peoples (IPs) to family planning and other health services**

Tribal families tend to be large because indigenous people marry at a very young age. Being usually located in the hinterlands, these people have little or no access to basic services. Existing cultural beliefs and practices also adversely affect this group's access to and utilization of health and related services. Considering that indigenous people still comprise a major portion of the population in certain areas, PMTAT gave priority attention to this group in the implementation of MGP-related

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**Table 4. Urban Poor FP Initiative Results (Oplan Tall) as of September 30, 2003**

UPFPP LGUs	Catchment Urban Poor Area	Population	Number of BHWs trained on CBTFP	Voluntary Sterilization Site	DOH Hospital performing VS	Actual number of clients ligated	Actual number of clients vasectomized																																																																											
CALOOCAN CITY	Brgy. 177	42,957	74	Camarin Iyng-in clinic	East Avenue MC	122	8																																																																											
	Brgy. 178	59,455	100					MAKATI CITY	Cembo	27,231	46	Pasig City Gen. Hosp.	Rizal Medical Center	20	0	MANILA CITY	Baseco	20,214	34	WHCF clinic	JRRMC	2	1	Happy Land	12,295	21	Tondo Gen Hos	2	0	PASAY CITY	Brgy. 137	2,980	4	Pasay City General Hospital	JRRMMC	8	0	Brgy. 138	909	2	Brgy. 143	3,111	4	Brgy. 145	1,750	3	QUEZON CITY	Payatas A	58,429	56	Payatas B Health Center	QMMC	318	22	Payatas B	58,429	117	SAN JUAN	Batis	9,518	10	San Juan Population Office FP clinic	Rizal Medical Center	22	0	San Perfecto	3,760	13	TAGUIG	Western Bicutan	88,403	147	Taguig-Pateros District Hospital	Jose Fabella MH	297	17	Malabon	Damata, Brgy Tonsuya	10,163	15	Pagamutang Bayan ng Malabon	-
MAKATI CITY	Cembo	27,231	46	Pasig City Gen. Hosp.	Rizal Medical Center	20	0																																																																											
MANILA CITY	Baseco	20,214	34	WHCF clinic	JRRMC	2	1																																																																											
	Happy Land	12,295	21		Tondo Gen Hos	2	0																																																																											
PASAY CITY	Brgy. 137	2,980	4	Pasay City General Hospital	JRRMMC	8	0																																																																											
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TAGUIG	Western Bicutan	88,403	147	Taguig-Pateros District Hospital	Jose Fabella MH	297	17																																																																											
Malabon	Damata, Brgy Tonsuya	10,163	15	Pagamutang Bayan ng Malabon	-	25	7																																																																											
	East Riverside, Brgy Potrero	6,243	14																																																																															

UPFPP LGUs	Catchment Urban Poor Area	Population	Number of BHWs trained on CBTFP	Voluntary Sterilization Site	DOH Hospital performing VS	Actual number of clients ligated	Actual number of clients vasectomized
	Sitio 6, Brgy Catmon	9,559	16	Sto. Niño HC	ARMC	174	8
	Marikina	8,000	15				
	Bonanza Ph I-IV	6,000	10				
	Tumana (HC side) Concepcion I	10,000	15				
Muntinlupa	Joaquin Cmpd/Kelly Cmpd/Prk 4/Prk 4 Ext/Bautista Cmpd/ Purok 6B/ Runggut/ Purok 7A, 7B,7C/Batibot/ Morning Breeze/Davao Cmpd/San Roque. BRGY ALABANG	30,000	50	Muntinlupa lying-in		0	3
Navotas			40	Pagamutang Bayan ng Malabon	-		
Pasig	Guhit Acacia, Brgy Pinagbuhatan	12,850	26	Pasig City General Hospital	RMC	100	3
	B Santos, Brgy Pinagbuhatan	8,581	18				
	Ilugin Matanza, Brgy Pinagbuhatan	3,000	8				
	Nagpuyong, Brgy Pinagbuhatan	15,500	30				
Pateros			0	Taguig-Pateros District Hospital	Jose Fabella MH	49	1
Valenzuela			40	Valenzuela District Hospital		115	1
<b>TOTAL</b>		<b>509,317</b>	<b>928</b>			<b>1,255</b>	<b>71</b>

interventions. Starting out in two municipalities (Alabel and Malapatan) in Sarangani, PMTAT expanded to three more provinces, namely, Sultan Kudarat, South Cotabato, and North Cotabato.

Activities in these areas consisted mainly of: a) establishing partnerships with relevant donors and organizations for the integrated delivery of appropriate services; b) coordinating with tribal leaders to facilitate MGP implementation in these areas; c) identifying and selecting priority barangays; d) training of volunteers on FP; e) training of local doctors on NSV; and f) actual service delivery.

**Table 5**  
**NSV ACCOMPLISHMENTS IN PRIORITY IP-POPULATED AREAS**  
**(as of September 30, 2003)**

<b>LGU</b>	<b>No. of Trained Volunteers</b>	<b>No. of NSV-Trained Doctors</b>	<b>No. of NSV Acceptors</b>
Sarangani	389	1	117
South Cotabato	258	3	511
Sultan Kudarat	80	2	14
North Cotabato	133	1	46

In April 2003, the Municipality of Malapatan in Sarangani initiated its integrated delivery of health services. The activity focused on Vitamin A supplementation and family planning. During the event, nine (9) men obtained vasectomies, and 32 children were given Vitamin A supplementation. Meanwhile, Alabel's integrated service delivery held in May 2003 recorded the following accomplishments: immunization of 82 children, Vitamin A supplementation for 70 children, provision of pre-natal services to 39 pregnant women, and vasectomy of 13 males.

## **VI. Financial Report**

The project was initially given a funding of \$9.2M over a 4-year implementation period. It was incrementally funded as the contract was modified and extended for a total of eight and a half (8 ½) years, the total funding reaching \$17.1M. The project was issued a final no-cost extension of three (3) months to allow for closedown activities through March 31, 2004.

As of March 31, 2004, the contract has an accumulated expenditure of \$16.7M, with the balance of contract funds projected to cover accrued expenditures and expenses for closedown activities both from the field and home offices (Table 6). A final report of expenditures will be submitted by the MSH home office after all expenses have been claimed and paid by the project.

**Table 6: Financial Report as of March 31, 2004**

<b>LINE ITEM</b>	<b>CONTRACT BUDGET</b>	<b>EXPENDITURE THRU LAST QUARTER ENDING 12/31/03</b>	<b>EXPENDITURE DURING THE QUARTER ENDING 03/31/04</b>	<b>CUMULATIVE EXPENDITURE TO DATE</b>	<b>BALANCE IN CONTRACT BUDGET</b>
I. SALARIES AND WAGES	4,212,237	3,982,252	58,607	4,040,859	171,378
II. OVERHEAD	2,400,467	2,254,173	15,761	2,269,934	130,533
III. POST DIFFERENTIAL	78,367	78,367	0	78,367	0
IV. CONSULTANTS	514,879	513,806	0	513,806	1,073
V. ALLOWANCES	250,263	250,263	0	250,263	0
VI. TRAVEL AND TRANSPORTATION	1,298,399	1,297,582	2,033	1,299,615	(1,216)
VII. SUBCONTRACTS (1)	3,754,135	3,585,702	127,000	3,712,702	41,433
VIII. OTHER DIRECT COSTS	1,446,400	1,382,736	29,087	1,411,823	34,577
IX. TRAINING (2)	2,562,039	2,570,778	20,746	2,591,524	(29,485)
X. PUBLICATIONS	104,436	27,781	45,168	72,949	31,487
XI. FIXED FEE	482,682	410,280	72,402	482,682	0
<b>TOTAL</b>	<b>17,104,304</b>	<b>16,353,720</b>	<b>370,804</b>	<b>16,724,524</b>	<b>379,780</b>

(1) Includes USD 127,000 payment to EDF

(2) Request for re-alignment is underway

## VII. Lessons Learned

The 8 and 1/2-year implementation period of the IFPMHP in the Philippines gave valuable insights on project management and implementation under a decentralized setting. Among the more important lessons learned that could guide future implementation of similar programs are:

**LGUs have varying degrees of interest, capacities, and needs.** LGUs were at different stages of development when they started out in the project. They varied in demographic, economic, and geographic characteristics. They had different concerns and priorities. Given these realities, it was, therefore, not effective and efficient to prescribe a single solution or strategy for adoption by all participating LGUs. While the project had a clearly defined focus and a set of standardized tools and techniques, it was necessary to adjust the type and extent of technical assistance provided in recognition of the wide diversity of interest, capacities, and health needs of LGUs. Strategies needed to be customized and tailored to respond to specific LGU problems. Cognizant that each LGU is unique, efforts were made to formulate LGU- or problem-specific solutions and strategies.

For instance, Bago City's CBMIS showed that many couples in Bago City who do not want any more children are either not practicing family planning or are using temporary family planning methods. Aggravating the problem is the fact that long-term family planning options such as tubal ligation and vasectomy are not available in the city. Women wanting to avail of tubal ligation have to be referred to a neighboring district hospital.

Given this scenario, the project initiated its male sterilization efforts in Bago City to help address its family planning concerns and make vasectomy services available in the locality. The decision was based on the following considerations: 1) the training requirements for NSV, unlike female sterilization are simple; 2) the procedure can easily be performed in a health center; and 3) there is minimal chance of complication or infection, which is not true of bilateral tubal ligation. With its success in Bago City, the strategy was eventually replicated in other LGUs under similar circumstances.

**Putting back together the devolved health structures is a difficult and time-consuming task.** Decentralization fractured the ties between the province and municipalities. With the municipalities now having complete responsibility for public health service provision, it was difficult implementing a project that required close coordination between the province and its erstwhile constituent municipalities.

In the case of the LPP, grants were given to the provinces although the municipalities were the ones directly involved in health service delivery. It was, therefore, difficult ensuring program impact when the grantee was not the direct implementer. Since the municipalities were neither accountable to the project nor to the province, they were less committed towards achieving the project benchmarks.

This was eventually addressed with the implementation of the MGP, which provided grants directly to the municipalities. However, it was still necessary to work with the provinces for the required technical supervision/assistance and augmentation of limited municipal resources. The project tried to address this problem by encouraging the organization of health districts. This entailed convincing a group of municipal and city political leaders to unite and enter into an agreement with the province and the DOH for mutual support and cooperation. The result was a new health structure that concretizes the collaboration among the city/municipal, provincial, and national governments.

The establishment of district health systems proved to be difficult under a decentralized system. With the cities/municipalities now administratively independent from the province, it was more difficult convincing all parties to pool their resources to meet common goals. Moving forward this initiative required more time and effort since individual negotiations with all key players had to be made. There was a need to meet and advocate with the LCEs and representatives of other government agencies and NGOs to generate support and enhance recognition, legality, and credibility of the initiative. Each of the LGUs concerned had to pass a *Sanggunian* Resolution authorizing its mayor to join the collaboration and enter into a MOA for purposes of establishing the district health system. Other steps involved included gathering of baseline data; identifying, motivating, organizing, and mobilizing the target beneficiaries; and setting up a common fund.

Once established, however, project coordination was made easier since the project just had to deal with the health district rather than with the individual LGUs. Program coverage likewise improved with the pooling and sharing of resources.

**National support systems are still needed in a decentralized health system.** While the responsibility for delivering public health services has been devolved to the LGUs, there are still activities or programs that require or are dependent on national-level intervention, particularly in the area of procurement of commodities, e.g. vaccines. In the case of the EPI, it was clear that the program suffered when national supply of vaccines dwindled. Given that it is more cost-effective for the DOH to procure and distribute the vaccines, LGUs still rely on the DOH for their vaccine supplies. The system of procurement and distribution of these critical commodities, however, has to be modified given the structural changes brought about by devolution. Failure of the DOH to adapt to these changes had resulted in critical supply shortages in the field, thus, adversely affecting local program performance.

**There are many local health champions and they need not necessarily come from the health sector.** While the support of the LCEs is important, it is not a prerequisite to ensure project success. What is crucial is to have local champion(s) who could help move the project forward. These health advocates could very well be from sectors other than health. It may be noted that project implementation was quite successful in the Provinces of Pangasinan and Bukidnon in spite of their project coordinators being the Provincial Population Officer and the Provincial Planning and Development Officer, respectively. What was important was the champions' level of involvement, managerial skills, and

close relationship (personal and professional) with the local chief executives. It also helped that the champions had real or perceived stature in the locality. Moreover, these people's understanding and appreciation of the complexities of the health problems, as well as their commitment to improve the quality and coverage of health services, enabled them to become effective health advocates.

There is little doubt that the presence of these local champions greatly contributed to the success of the project. Unfortunately, it is hard to institutionalize this kind of personal advocacy and there were several instances where an LGU had to be dropped from the project due to unsatisfactory performance after its local champion got reassigned or moved elsewhere. Notwithstanding this limitation, it is certain that without a local champion, no project is going to be successful.

**Decentralization enhanced the LGUs' creativity in finding solutions to local problems.** Prior to devolution, the LGUs relied on the DOH in the design and implementation of local health programs. They adopted and implemented whatever health strategies and initiatives handed down by the DOH. They never realized that they could introduce innovations in the way they implement these programs.

One of the advantages of devolution is producing the environment for LGUs to try new ways of doing things. Decentralization gave the LGUs the opportunity to design and implement innovative programs suited to their local needs. The project was able to demonstrate that the LGUs, if given encouragement, support, and resources, can come up with locally initiated interventions and implement them with resulting success.

Documenting these innovations/best practices and disseminating these help promote replication and encourage the generation of more creative ideas. Within a few years of implementation, the project was able to document many best practices from the field, which were later compiled in a *Compendium of Best Practices*. The project newsletter *Updates from the Field* featured 22 best practices and 9 technical notes on the different innovations and systems adopted by the LGUs in the area of health. These best practices covered a wide range of topics, to wit:

- Establishing collaboration/partnerships with the private sector, NGOs, foreign donors, and other government agencies to fill in service gaps and augment resources
- Personalized client follow-ups through issuance of call slips (reminders)
- Reaching out to indigenous communities
- Pooling of procurement to reduce drug prices
- Developing community-based health care financing schemes
- Setting up disease surveillance systems and district health systems
- Improving access to sterilization and IUD services
- Sharing of technical resources.

**DOH needed guidance in adjusting to their new roles under a devolved set-up.** After devolution, the DOH found it difficult to adjust to their new role as mere provider of technical assistance to the LGUs. A number of DOH officials behaved as if they still had

operational control over devolved health staff. Long after the decentralization process was completed, the DOH still issued administrative guidelines ordering devolved health staff to perform certain activities and tasks. The DOH personnel were still in the “implementing mode” and continued to regard the LGU health staff as their subordinates. This only served to widen the gap between the DOH and local governments and affected program implementation.

The project, therefore, organized and held a series of role clarification workshops to define the roles and responsibilities of the central, regional, provincial, and municipal/city levels, particularly in the implementation of the project. Being new to its post-devolution role, the DOH also needed assistance in building its own capacity to provide needed support for LGUs. In this regard, project resources were mobilized to help DOH develop rational and efficient systems and procedures, hone technical skills of staff, and pilot-test alternative mechanisms for responding to LGU technical assistance needs.

**Financial grants and recognition are effective mechanisms to influence local behavior.** The MGP grew from 12 enrollees in 1999 to 470 as of project completion. More would have been enrolled if more grant resources were available. While the technical assistance package has attracted a number of adherents, there is little doubt that it was the financial assistance that made the program attractive to local officials. However, local support was not primarily determined by the amount of the grant. Minimal as the grant may seem, many local officials viewed it as a manifestation of the national government’s sincerity to help local governments. Whatever may be the reason, it was obvious that financial assistance and any cost-sharing scheme is a very powerful mechanism to get LGUs to support national programs and directives.

The *Sentrong Sigla* certification program proved to be another effective strategy for influencing local behavior under devolution. During the certification program’s first year of implementation, roughly two-thirds of cities and municipalities participated. The prospects of national recognition and financial reward served as incentives to LGUs to improve the quality of services at their health centers.

Citing or recognizing LGUs for outstanding performance and creativity in implementing innovative interventions will also go a long way in further improving or sustaining program performance. This practice will not only boost the morale of the LGU leadership and its health manpower, but will also serve as an inspiration or motivation for other LGUs to do better. The project recognized 45 top-performing LGUs under the LPP while several LGUs were handed out plaques of recognition for their best practices. Technical conferences were also organized to allow the LGUs to share their best practices with their counterparts. These initiatives were greatly appreciated by the LGUs and inspired them to perform better, consequently, enabling the project to realize its major objectives.

**Decentralization encouraged LGUs to look for technical resources outside the DOH.** Prior to decentralization, the LGUs were totally dependent on the DOH for their technical and logistical needs as far as health is concerned. Everything was handed down to them and all they needed to do was implement. But with devolution giving the LGUs the sole

responsibility of looking after the health needs of their respective constituents, the LGUs had no recourse but to be resourceful and creative in dealing with their health concerns. They have come to realize that collaboration is not limited to the DOH and it does not have the monopoly of technical health resources.

Based on project experience, many LGUs expanded their service provision and program coverage by establishing linkages with NGOs and private clinics for specific services. Referrals were increasingly adopted to ensure that people are able to avail of the necessary services regardless of source and also to enable the public health centers to focus on the truly disadvantaged. The Cities of Ormoc and Naga improved their family planning performance by working with the Population Services Pilipinas, Inc., which operates 12 reproductive health clinics nationwide, for the provision of bilateral tubal ligation services to interested and qualified women. Tie-up with the Well-Family Midwife Clinics also proved beneficial to the Municipalities of Carmen and Lupon in increasing its MCH program coverage. Collaborating with the FriendlyCare Clinics, meanwhile, enabled Antipolo City and Cainta to serve more sterilization clients.

**Horizontal learning is a better way of scaling up the introduction of new interventions.** The project was able to demonstrate the benefits of encouraging direct technical exchange among LGUs, particularly in the area of training. It may be noted that a major factor contributing to the success in the re-introduction of NSV is the approach of utilizing LGU trainers.

In order to meet the huge demand for training from a great number of interested LGUs, the team opted to adopt the LGU-to-LGU training approach as opposed to tapping the services of trainers from the medical centers of the DOH. For instance, practitioners and trainers from Bago City, North Cotabato, and the different Davao provinces were mobilized to assist in training the LGU providers in South Cotabato, Sarangani, and Sultan Kudarat, among others, thus, making NSV services readily available in these areas sooner than expected.

This approach was adopted since the LGU medical personnel proved to be more readily available in terms of providing technical assistance as compared to their busy counterparts from the national and regional levels. Through this approach, actual service provision was facilitated and anticipated delays were minimized, if not, eliminated.

As the MGP experience has shown, this horizontal transfer of skills is effective given the fact that the best teachers are those who have done it or undergone the process themselves because they can transfer not only theoretical but more importantly, practical knowledge and skills.

**Grants to higher levels in the health care system will not work unless there is a mechanism to transfer funds to the ultimate beneficiaries.** Although provincial governments were useful partners for technical supervision and channels of national support to municipal governments, it was necessary to provide more direct support to municipal governments and component cities in the form of sub-grants to achieve

immediate impact on service coverage. Grants to provinces could still work if funds could be sub-granted to the municipalities for the implementation of specific project activities.

This involves a MOA between the provincial government and its satellite city or municipality where the provincial government offers a sub-grant to the municipal or city government for the implementation of a set of defined activities that would facilitate the achievement of project benchmarks. The Provinces of Pangasinan and Negros Occidental adopted this sub-granting mechanism during the initial stages of project implementation. The sub-grants were taken from the financial assistance that the provinces received from DOH for an agreed level of service coverage targets. The provinces offered the sub-grant to selected cities and municipalities based on assessed needs and/or potentials for achieving service targets. In some cases, the sub-grant was used as an incentive to raise service coverage of LGUs whose performance lag behind those of other LGUs in the province. Due to its success in the two provinces, other provinces, particularly those with sizeable LPP savings, eventually replicated the mechanism.

**Provision of grants to LGUs should be done on a selective basis.** Selection of LGUs for financial assistance should consider not only health indicators but also financial indicators. Some LGUs may exhibit poor health performance but the problem may not be due to lack of resources. It may be due to misallocation of funds due to wrong prioritization, misuse of available funds, or simply, poor absorptive capacity by the LGU. LGUs should, therefore, be evaluated taking into account their annual budget for health, presence of other foreign donors and NGOs in the area, and their track record in mobilizing and moving funds based on actual plans. Under the LPP, a number of provinces were found to have a significant amount of savings from their grant at the close of each calendar year. Some of these were able to accomplish their planned activities, suggesting either prudent spending or availability of funds from other sources, while others were unable to fulfill their commitments due to inability to move the funds either because of too much red tape or sheer poor and slow implementation process. Still others had high utilization rates but had nothing to show in terms of program performance, indicating that the funds have been used other than for its intended purposes.

**Collaboration should be in response to a specific problem.** LGUs need to be increasingly encouraged to collaborate with the private sector and other stakeholders in their major undertakings. But the areas for collaboration and the desired outcomes should be clearly spelled out prior to establishing such linkages. An LGU should enter into an agreement with other stakeholders with a specific action or purpose in mind. It should not be a “blanket” agreement where both parties make no specific commitments. For instance, the pilot municipalities’ decision to work with the Well-Family Midwife Clinics was borne out of their desire to decongest their public health centers of paying clients and, thus, enable them to concentrate their resources on the poor and disadvantaged. This will not only improve the quality of their health services but also improve program coverage. For the clinics, this meant additional income from these referrals.

Meanwhile, collaboration was established between some LGUs and the FriendlyCare Clinics in response to the need to make sterilization services available to the LGUs' constituents as a family planning option. This was particularly true for those LGUs with high unmet family planning needs but are still unable to provide sterilization services on their own. By entering into a MOA with FriendlyCare Foundation, Inc., such LGUs as Cainta, San Mateo, and Antipolo City were able to provide the service to more clients. As in the case of the midwife clinics, the FriendlyCare clinics were also able to realize increased income.

**When working with disadvantaged groups, e.g. indigenous peoples, it is best to involve them in the process.** Indigenous peoples comprise about 60-70% of the total population in certain areas and it is of great concern that this group continues to be unserved/underserved due to geographical, cultural, and religious barriers. Unlike the Muslim people, ethnic tribes are less aggressive in bringing their cause to the attention of the proper authorities, thus, resulting in the apparent neglect of this group by the government. It was noted that the level of unmet needs among this group, particularly for basic health and FP services, remains high. In view of this, PMTAT made it among MGP's priorities to improve this group's access to health services, especially those in the Mindanao regions.

Based on the project's experience in dealing with indigenous tribes, it is advisable to work through their leaders to facilitate understanding and acceptance of project initiatives by the tribal people. The tribal leaders wield so much influence on their respective constituents such that no program or project would readily and willingly be accepted by the indigenous tribes unless either sanctioned or supported by their leaders. In promoting the MGP in provinces with a large number of indigenous populations, the project conducted briefings for and initiated consultations with the tribal leaders to enlist their support and ensure their cooperation in implementing the project activities in their respective areas. This was done for the Provinces of Sarangani, South Cotabato, Sultan Kudarat, and North Cotabato. This could largely account for the significant client turnout for vasectomy and other FP services in these provinces where the tribal leaders actively participated in the identification and recruitment of clients.

It is also best to recruit BHWs from among these groups, including tribal leaders, and invest in training them on proper information dissemination and client motivation. Being members of the community, these people are known to practically everyone in the community and could, thus, easily gain the trust of community leaders and members and have direct and easier access to the households. For instance, the Municipality of Sen. Ninoy Aquino in Sultan Kudarat organized a Highlanders IEC Team, specifically to address the IEC requirements of the Manobos, an ethnic majority in the province. On the other hand, the Municipalities of Alabel and Malapatan in Sarangani included members of the indigenous tribes in the BHW training to facilitate IEC and service delivery among the tribal communities.

**Volunteer health workers are the life of health programs.** In most areas, health workers are still unable to visit and provide basic health services to their communities.

They seldom conduct outreach activities and are satisfied to simply stay in the health center and wait for people to come and seek health services. Considering that a large proportion of these people are also unable to go to the health center for a variety of reasons, the health workers are left with no concrete idea of what specific services are required, who require these services, and where they are located. Volunteer health workers have thus been continuously recruited and increasingly relied upon to serve as a link between the health workers and the communities.

For instance, volunteer workers at the barangay level played a critical role in the implementation of the MGP. They were instrumental in facilitating the identification of individuals and families with unmet needs for FP, child survival, and other services, being in direct contact with the clients. Equipped with a tool such as the CBMIS, they were most successful in keeping track of the health needs of community residents. Their services were also invaluable in disease surveillance, advocacy and counseling, and even in re-supply of contraceptives and distribution of ORS. Empowering the health volunteers through training, tools, and incentives would greatly help to improve the health-seeking behavior of community residents, generate more demand, and increase program coverage.

**Project tools should attempt at field-level integration of programs.** The lack of field personnel has often been cited as the reason for poor performance. The numerous vertical programs that require attention have led to the perception that field personnel are overworked. Field personnel had to keep different master lists for reproductive-aged women, for under-five children, for newborns, for pregnant women, etc. Efforts to integrate the programs would, therefore, greatly reduce the demands on their time and effort. For example, the CBMIS, which covers several programs related to family health, was deeply appreciated by the health personnel since it somehow served as an integrating mechanism in tracking the unmet needs of their constituents for specific services/programs. In fact, a number of LGUs have adopted CBMIS even for their non-MGP barangays because they saw its usefulness. The adoption of the CBMIS demonstrated how client-focused tools and interventions might be adapted for multi-program use.