



MGP TECHNICAL CONFERENCE FOR MINDANAO

Theme: Improving Access to Family Planning Services

HIGHLIGHTS OF PROCEEDINGS

October 29 – 30, 2002
Grand Regal Hotel
Davao City

Management Sciences for Health
Philippines Program Management Technical Assistance Team Services (PMTAT)
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Plenary : October 29, 2002

Opening Ceremonies

Welcome Remarks

Hon. Milagros Fernandez

Undersecretary of Health and Head,
Mindanao Health Development Office

Undersecretary Fernandez welcomed participants to the conference that included local chief executives, provincial and municipal health officers, health practitioners, partners, and stakeholders in Mindanao. She looked forward eagerly to hear and learn from their best practices, innovative approaches and experiences for the delivery of better quality health services. The MGP strategy under the Integrated Family Planning and Maternal Health Program is a scheme that assists local government units. The scheme is supported by foreign funding institutions in health and credit should go to the United States Agency for International Development (USAID) for its assistance. The MGP is implemented under a Memorandum of Agreement (MOA) with the Department of Health, with benefits accruing to the LGUs, enabling them to identify community needs, develop their plans, and acquire grants-in-aid. She hoped that the project would continue to improve services in the rural health units (RHUs), barangay health stations (BHS), devolved hospitals, and other community-based clinics. On behalf of the DOH Secretary, Dr. Manuel Dayrit, she wished the participants a fruitful conference.

Message

Hon. Joseph Mussomeli

Deputy Chief of Mission, United States Embassy

Mr. Mussomeli arrived in the Philippines in 1984 and has since wanted to visit Mindanao, in the light of the priority given by the United States to programs that would ensure the health of the Filipino people and help them escape the cycle of poverty. The focus given to the development of Mindanao, particularly the Autonomous Region of Muslim Mindanao (ARMM) is a top priority of the US government. The region has lagged behind other areas and the analysis is that development was very uneven. Regions X and XI are comparable to the best but ARMM rates lowest from all health indications, hence, the need to widen opportunities for livelihood and maintain peace and order.

The devolution of responsibility to the local governments translates into the need to strengthen capabilities for local management. Since the '90s, the USAID has tried to assist local health initiatives and the Family Planning programs through Management Sciences for Health (MSH). These programs helped support health service delivery and train local volunteers and partners in health; these are exemplified by the *Sentrong Sigla* (SS) initiative adopted at the LGU level that helps to set standards for local health facilities. None of those around may individually provide the answers to all the issues and challenges, but the conference could collectively help in finding the appropriate solutions.

The US' position on the contraceptive procurement assistance to the Philippines is an issue of serious implication to the LGUs. USAID support goes back a long way but the time has come for the USAID to shift from its position as provider of contraceptives to that of other systems, in anticipation of the trend toward self reliance.

It is projected that US\$3 million so far extended is enough to meet and sustain local demand for contraceptives through 2004. As the US reduces contraceptive support, it will facilitate the active participation of the private sector. It is estimated that about one million users who get free contraceptives supplies can afford to pay for them. The private sector can help them and this will free government facilities that should be left to address the needs of the poor. The USAID realizes that the lion's share of the credit goes to the DOH and its providers to support the program. The ultimate credit or failure goes to them and to the people of the Philippines.

- Cultural Presentation -

Presentations :

- 1. Maliit na Pamilya: Masaya, Maginhawa**
Dr. Loreto B. Roquero, Jr.
Director, Center for Family Health, DOH

Responding to the unmet needs of the population for FP is urgent and our collective responsibility is to work toward the realization of these needs. There are 80 million Filipinos at present representing the 14th largest population in the world with a growth rate of 2.36 percent that is expected to double in 29 years. Forty percent of this population lives in poverty. There is a gap between desired and actual fertility: 1.1 million women wanted to stop giving birth in 1998 - pointing to a backlog in the provision of surgical methods. One in six pregnancies end up in abortion, reflecting the failure of efforts in FP. The tough truth to face is that 30 percent of all pregnancies are teenage pregnancies and 21 percent of illegitimate births are between 15 to 19 years.

There are four basic strategies to consider in crafting FP policy: FP itinerant teams, FP for the urban poor, mainstreaming Natural Family Planning (NFP), and strengthening FP in the regions. There is, therefore, a need to expand Community-Based Monitoring Information Systems (CBMIS) to non-MGP areas in order to promote identification of clients, master-listing acceptors, and provide for market segmentation. This can be done by front lining hospitals, setting up Voluntary Surgical Sterilization (VSS) itinerant teams, medical surgical missions with FP services, GO-NGO subsidy for indigents, and expanding PhilHealth services. Moving the program forward will require the utilization of alternative approaches that may be done by expanding the roles of voluntary health workers (VHWs) who render home services, help identify and motivate clients, disseminate information, organize acceptors, and provide referrals. It is equally vital to expand urban poor outreach in the metros of Manila, Cebu, and Davao.

Over the years, 18 percent of FP users used traditional methods. This is a market that can be moved to modern FP. There is a need to strengthen FP in CAR, Regions V, VIII, and ARMM. There should be no missed opportunities. Unmet needs should be explored during the first point of contact, in the hospital or the community through active case finding. There should be prompt delivery of services, zeroing in on FP drop outs and bridging them to other methods. A zero backlog can be attained by meeting unmet needs for permanent surgical and spacing methods. Friendly care should be able to remove barriers in service delivery such as the biases of health providers. Hence, the need to simplify procedures, rationalize requirements, and ensure privacy and confidentiality. Hospital capabilities should be strengthened in the management of abortion complications and post-abortion cases, strengthening FP counseling, and

integration into maternal care services. Men's and adolescents' reproductive health can be promoted by building the capacities of hospitals, community clinics, alternative service channels, and health workers tasked to promote fertility awareness, sexual responsibility, and responsible parenthood.

The crisis to face in FP commodities is that demand outstrips supply. The deficits encountered prompted the formation of FP Lifelines via the Contraceptive Interdependence Initiative Action Agenda. The approach is toward market segmentation through expanded PhilHealth coverage, LGU financing and cost sharing, private sector participation, and national subsidy for the poor. The action agenda involves coalition building among DOH and its partners, capacity enhancement, strong service networks, and priority budgeting by LGUs. Meanwhile, opposition to FP can be managed by intensifying private sector involvement, contingency measures and lobbies, and the development of allies as champions and prime movers.

Issues and Concerns

Training of VSC itinerant teams. The DOH is presently doing its best to respond to training needs but this will have to be funded by a new project. Team formation has been started at the DOH Central Office and the provincial hospitals. Undersecretary Fernandez added that the training can take place at the Davao Provincial Hospital. The DOH should be provided with the names of prospective trainees. The agency should first look into the capabilities of the MHOs/ CHOs.

Updates on Marie Stopes. The Bureau of Licensing and Regulation has issued a Cease and Desist Order. The basis for the issuance of the Order was the question on the quality of their work. They have not complied with DOH standards. This should present a challenge to the DOH to respond to the demand for permanent methods by strengthening the hospitals and provincial itinerant teams.

2. *Sentrong Sigla* Certification Program Updates ***Hon. Milagros Fernandez*** Undersecretary of Health & Head, MHDO

The *Sentrong Sigla* quality assurance program of the DOH was developed in partnership with LGUs and implemented over a period of four years. A review revealed certain strengths and weaknesses. One finding was that cash awards have sometimes proven to be disincentives; it took some time before they could be granted due to the unavailability of funds. The *Sentrong Sigla* is a good program that ensures quality health services at the LGU level, but the DOH

Secretary felt that there was a need to review the program. He created a Subcommittee on Standards and Procedures that reviews the standards and procedures; a Subcommittee on Technical Assistance and Monitoring that assists LGUs in achieving levels of quality; and a Subcommittee on Health Promotion and Rewards.

The standards were re-engineered into three pillars. The framework that was conceptualized as an offshoot of the study consisted of: 1) improved standards and measurement indicators; 2) improved processes and outcome indicators; and 3) shift to a sustainable but appealing rewards system that enhances internalization of the desire for quality service delivery and not for cash.

The new rewards system has three levels: Level 1, awarding basic certification and cash reward of up to Php250T; Level 2, awarding the Specialty Awards to facilities that run specialty programs ranging from Php500T to Php1M; and Level 3, conferring the Award for Excellence to consistent awardees for three or more consecutive years with bigger matching grants, huge trophies, and possibly, national/international study grants for health professionals concerned. The new system will grant not merely cash, but also individual rewards as incentives for the health providers. These new standards were developed with multi-sectoral involvement – LCEs, CHD staff, the PHIC, and NGOs who were organized into a Task Force. The standards were designed to be comprehensive and stable with input and output processes. The *Sentrong Sigla* is limited to public health facilities, covering Rural Health Units (RHUs) and Barangay Health Stations (BHSs). Hospitals, which are covered by PHIC standards, are excluded.

The new processes and procedures are open and involve the wide participation of stakeholders at the local level. They include purposive technical assistance for identified priority areas, institutionalized supervision at the facility level, and monitoring to motivate further improvement. All these will be undertaken in partnership with LGUs, the sub-committees, and DOH Representatives.

Sentrong Sigla procedures for Level 1 Basic Certification include orientation and invitation, self-assessment of service quality, extension of technical assistance and matching grant for effort, and provision of technical assistance services by the respective sub-committees concerned. Level II Specialty Awards have been proposed for core preventive public health services like maternal/child health, safe motherhood and family planning, TB-DOTS and promotion of health lifestyles. Matching grants will be awarded based on the needs at the RHU and barangay levels, i.e., building construction and renovation, equipment, etc. Matching grants for effort made by the LGUs will also be granted to facilities that were not completed due to funding constraints at the local level, etc. The *Sentrong Sigla* Certification Procedures for Level II awards will be ready by June 2003. Level III Service Awards for Excellence will only be given if all preceding

qualities and indicators were achieved and Level II compliance has been maintained for three successive years or more.

The Subcommittee on Standards is now finalizing the DOH protocols and measurement indicators that will be pre-tested further and are targeted for completion by December 2002. Pre-test results are still to be discussed. The goal desired is a body of ready-to-use, synthesized and simplified, practical and integrated DOH protocols for infectious diseases. Program coordinators will soon meet to discuss these matters. Also to be undertaken are the field testing of standards and tools of assessment, orientation of regional technical assistance teams, training of regional assessors, and re-launching of the Sentrong Sigla by November 2002.

The action points foreseen are: 1) the use of new standards by the first quarter of 2003; 2) application of new standards for Level 1 Basic Certification for June 2003 awarding; 3) use of old standards for applicants this year and award by region in December 2002; (Note: There will be no national awarding for 2002. Whatever facility will be certified this year will receive the regional award.) 4) for old SS-certified facilities, regions will assist them meet the new requirements for Level I and II. Regional offices will be asked to render assistance to those already certified.

There being no further questions, Day 1 plenary was duly closed.

Concurrent Sessions : October 29, 2002

CONCURRENT SESSION I
STRENGTHENING FAMILY PLANNING SERVICES

Highlights of Presentations

1. Increasing Male Involvement in Family Planning

Dr. Rhodora Antenor

Esperanza, Sultan Kudarat

Dr. Roy Dan Firma

M'lang, North Cotabato

Dr. Joseph Nilo Parreñas

Asuncion, Davao Norte

Dr. Amymone Rayray

Midsayap, North Cotabato

Four municipalities in Mindanao that enrolled under the MGP sought to involve a wider section of the local male population in Family Planning (FP). Their experiences revolved around the promotion of No-Scalpel Vasectomy (NSV) as a fresh, convenient, and affordable approach to FP. Thanks to their innovative approaches, the program quickly gained adherents among heads of local families.

- ***Esperanza, Sultan Kudarat***

Dr. Antenor, MHO of Esperanza and concurrent epidemiologist of the Province of Sultan Kudarat, informed that Sultan Kudarat was enrolled as an MGP site in 2001, with nine barangays (out of a total of 19) as target areas. It has a population of 49,500. Based on CBMIS data, 983 MWRAs or married women of reproductive age either wanted to space their children or no longer wanted to have a child. However, the survey revealed that they were not practitioners of FP for one reason or another. Another fact that surfaced was that around 177 MWRAs did not actually use traditional FP method. There was a gap that had to be filled.

An orientation program was organized to inform and educate couples on the municipal FP program, with particular focus on No-Scalpel Vasectomy. In this technique, no scalpel is used for the operation. NSV is done with the use of only two basic instruments. Perforation is done on the skin but it is very small. The

healing period is very fast and there is practically no blood loss. Only local anesthesia is applied.

After the orientation, the LGU gained an initial headstart of seven male volunteers for NSV. The MGP covered nine barangays. One barangay was home to a number of Indigenous Peoples (IPs) while in another, there were Muslims. Still another has a predominantly Muslim population. Those who signified acceptance came from different religious persuasions. Non-acceptors were either limited or restricted by their cultural beliefs.

Complementary activities were carried out including plans for the continuous identification and recruitment of potential NSV clients especially for couples that have reached their desired family size. NSV activities took place at the RHU in collaboration with MSH and EngenderHealth. Efforts were equally made to strengthen collaboration for continued technical assistance.

The municipality moved to replicate NSV in adjoining areas. Among the significant activities undertaken in the course of the program were the training of BHWs in FP counseling, identification of clients for NSV with the aid of the CBMIS data, and the involvement of satisfied users in advocacy campaigns and FP promotion. The advocates effectively provided personal testimonials, thus encouraging others in the locality to become users and actively support the program.

- *M'lang, North Cotabato*

M'lang is a first class municipality in North Cotabato with a population of 78,190. It became an MGP site in 2001 when it enrolled in the grant program covering 19 of its 37 barangays.

Based on CBMIS data, the locality was able to identify the following unmet needs: 729 not wanting to have a child or who wanted to space their children but have not been practicing FP for various reasons; 56 persons who were not satisfied with their current methods; and another 119 using traditional FP methods. To address these needs, an orientation program was held in October 2002, participated in by 100 persons. This groundbreaking FP activity became an instant success that was partly attributed to the close coordination and teamwork among various LGUs.

Local chief executives, including provincial and municipal health officers closed ranks to conceptualize, support, and undertake campaigns intended to expand FP acceptance among the local population. The mayor, vice-mayor, and councilors were instrumental in encouraging male government employees and military

reservists to attend the NSV orientation in October 2002. Couples who attended became deeply interested in NSV as a quick, more effective, and least costly method to adopt in planning their families. The testimonial of an NSV acceptor was included to prove that couples can continue to enjoy an active sex life even after undergoing the procedure.

Dr. Firma noted the invaluable assistance of the PHO, Center for Health Development, local government units, and MSH in providing technical, financial, and administrative support. These efforts were crucial particularly in organizing and mobilizing health workers. The LGU plans to conduct more massive information campaigns, train more BHWs in CBT-FP, recruit more clients, organize itinerant teams for VSS, and work for accreditation with PhilHealth. Significantly, M'lang has allocated PhP300,000 for the enrollment of indigent constituents. This will hopefully unburden the LGU from shouldering the full cost of the NSV procedure.

Issues and Concerns

FP acceptors among Muslims/ Christians/ IPs. The MGP covered nine barangays, in one of which there are indigenous peoples and in another, Muslims. A third has a predominantly Muslim population. Those who signified acceptance came from different religious persuasions. Non-acceptors were either limited or restricted by cultural beliefs. No patient has yet undergone NSV as of this report because the program will be implemented in November 2002. However, during the orientation, seven have signified intents to join the program. A Manobo tribal leader present at the orientation promised to advocate for the program.

NSV vs SV procedures. As the name implies, the operation is not done with a scalpel but with only two basic instruments that make tiny perforations on the skin. Healing is fast and there is no blood loss. Only local anesthesia is applied. Dr. Joe Rodriguez added that NSV means less morbidity, less cost, and better tolerance on the part of the patient. NSV costs can be reimbursed by PhilHealth however, the procedure must be done in hospitals. If RHUs can be made part of the district health system, wherein the RHU is part of the health facility network under the district hospital, the RHUs can be reimbursed. PhilHealth presently pays P950 for every procedure.

Health provider certification/ for NSV. PhilHealth requires an accredited facility. The hospital, therefore, should be accredited. For training on NSV, 10 clients is enough for a physician to get certified.

Reimbursements for NSV done in PhilHealth-accredited RHUs. There is a need to distinguish between accreditation as a provider of outpatient services which is

essentially paid for using the capitation scheme, and reimbursement that can be availed of for NSV procedures done in the RHU. The OP package is only for laboratory services and consultations. In order to obtain PhilHealth reimbursement for NSV, an agreement must be made between the hospital and the RHU to make the RHU an extension or outpatient department of the hospital. NSV can be performed as an outpatient service.

- ***Asuncion, Davao Norte***

Asuncion is a municipality located 60 kilometers from Davao City, with a population of 61,985. Out of 26 barangays, 12 were considered priority areas when the MGP started in 2000. During the same year, the provincial government passed an ordinance mandating the organization of Male Reproductive Health (RH) clinics. The main function of the clinics was to promote NSV as an FP method. A point to remember is that the Province of Davao del Norte can be credited for the initiative to set up male RH clinics when it issued Provincial Ordinance 2000-2003 that mandated all health facilities to set up male RH clinics.

The strategy was to build on the capacities of RH coordinators to manage advocacy campaigns. They attended orientations and consultative meetings with stakeholders and conducted monitoring and evaluation activities. Massive house-to-house campaigns were initially done in barangays Buclad and Bantayan. Simultaneous activities included the training of BHWs, target setting, information dissemination during community assemblies and house-to-house visits, counseling, and testimonials from satisfied NSV patients.

As a result of the campaign, 20 male participants immediately signed up for NSV in November 2002. Support activities included house-to-house follow-ups and one-on-one counseling. After the program was launched, providers kept close track of its progress.

Among the lessons learned in the course of implementing the program were the fact that Filipino male mentality cannot change overnight and that a massive tri-media campaign involving local officials was necessary. This is a key factor to ensure the success of the program.

- ***Midsayap, North Cotabato***

Midsayap is a first-class municipality with 57 barangays, out of which 18, covering 27 percent of the total population were prioritized for MGP assistance. According to the 1995 census, it has a population growth rate of 2.65%.

Midsayap was enrolled as an MGP site in 2001. No health facility in Midsayap has yet been certified a *Sentrong Sigla*.

Using the CBMIS, the local health office was able to identify unmet FP needs of the community. These are as follows: 633 respondents reported their desire not to have a child or to "space" their children but have not been practicing FP; another 122 respondents, on the other hand, were using traditional methods of FP. Unfortunately, poor access to FP services and the unavailability of permanent FP methods, compounded by a weak IEC and advocacy campaign, were seen as severely limiting factors.

To address the situation, an orientation on NSV was held in October 21, 2002. Among the invitees to the orientation were members of the Armed Forces and the PNP. The municipality also organized and mobilized BHWs and male motivators to assist in recruiting clients for NSV. To spice up the affair, testimonials from NSV acceptors were presented. The actual performance of the NSV procedure has been tabled for November 2002.

The Municipal Health Office plans to orient more barangays on NSV and involve AFP reservists and military personnel – the so-called male-dominated groups-as potential sources of volunteers. Other plans include the training of more BHWs on CBT-FP and recruitment of clients. FP itinerant teams will also be organized at the local level. The LGU will also work towards *Sentrong Sigla* and PhilHealth accreditation of its health centers.

Issues and Concerns

Facilities for male clinics and means of promotion. Clinic activities were temporarily held at the sanitary inspector's office and the Municipal Health Office. "*Massive promotion*" basically refers to house-to-house campaigns.

Effect of clinics on increase in male clients. More male patients came in. The male RH clinics facilitated the treatment and monitoring of cancer cases. Dr. Hornido added that the provincial initiative on male reproductive health started with the issuance of Provincial Ordinance 2000-003 that tasked all health facilities to set up male RH clinics with services for the screening of probable prostate cancer patients.

Profile of acceptors. Though there was no discrimination among age groups, those who joined the NSV program were actually 40 years old and above.

Problems of male patients consulting female doctors. Confidentiality is a basic problem in Davao del Norte. To address this, male counselors and advocates are being trained in FP.

Gender issues. FP practices depend on the choice of the couple, but there were problems in getting males to participate in FP program. There is really no problem in getting women involved but there is also a need to get the active participation of the male population. Mr. Despabiladeras added that FP programs are predominantly directed towards women. Greater consultation with and active involvement of the male population will hopefully increase the use of FP methods.

2. Increasing Access to IUD Services in a Mountainous Barangay

Dr. Nelson Morales

Pantukan, Compostela Valley

Pantukan, Compostela Valley is a municipality located in the hinterlands. In order for health services to be delivered at the site, the strategy adopted that led to the wide acceptance of IUD as a preferred method in FP was the formation and deployment of mobile clinics. IUD is regarded as a safe and relatively permanent method, and the supply is constant.

Pantukan is located 92 kilometers from Davao City. It is divided into 13 barangays. In 2002, the population stood at 63,539. It has one main health center, 10 barangay health stations, and one district hospital. It has been an MGP recipient since 2000.

Through CBMIS, the MHO was able to identify a number of unmet needs in the public health areas of EPI, Vitamin A supplementation, tetanus toxoid immunization, and FP. A major strategy employed was the formation of mobile IUD clinics. The purpose of organizing the mobile clinics was to bring IUD services to remote barangays such as Barangay Tagugpo that lies 145 kilometers from the town proper. Aside from being far from the health center, there are no trained midwives who can perform IUD insertions. Although there are trained BHWs, there was a low acceptance of IUD as an FP method.

On 24 October 2002, the MHO organized an orientation program on IUD. Sixty-one mothers came in for counseling. By the end of the orientation, 23 out of the 61 attendees have accepted IUD as their FP method of choice. Buoyed up by the warm response of the community, the Municipal Health Office has lined up a number of follow-up activities such as the launching of mobile clinics; celebration of an IUD fiesta on the first Wednesday of every month; and creation of a Copper T club.

Aside from these activities, the MHO is also intent on advocating and lobbying with the barangay government for the passage of legislations favorable to FP. BHWs will continually be monitored and assessed to reinforce capabilities on counseling. On-the-job-trainings on IUD insertion are also in store for untrained midwives. And in order to identify potential acceptors, the MHO plans to award certificates to all IUD acceptors and increase efforts to attract spousal involvement in FP.

3. Beading to Better Days: The Standard Days Method

Dr. Nemesia Andoy

Banaybanay, Davao Oriental

The Standard Days Method (SDM), a modern method of family planning using a bead necklace representing the female reproductive cycle, was successfully pioneered and promoted in Banaybanay, Davao Oriental. It was advocated as a means to a "better" and more progressive lifestyle. It has proven to be highly effective in women with regular menstrual cycles.

Banay-banay is a municipality that lies 43 kilometers from Mati, Davao Oriental and 120 kilometers from Davao City. It has 14 barangays, with a total population of 33,988. It has one main health center, 13 barangay health stations, and a district hospital.

Upon its enrollment as an MGP site in September 2001, the municipality conducted training for BHWs on FP. Eight BHWs from Barangay Mogbongcogon attended the training. A massive IEC campaign followed. The SDM was promoted by means of a house-to-house campaign that resulted in the identification of 41 SDM acceptors. Three of the 41 acceptors were Muslims. Part of the initial success of the SDM in the area may be attributed to the strong support extended by local officials including the mayor, SB members, barangay officials, and *purok* leaders.

In the future, the Municipal Health Office plans to continue promoting SDM in Barangay Mobongcogon, follow-up current SDM users, and train the BHWs in other barangays so they can eventually expand the coverage of the program.

Issues and Concerns

Back-up FP method for Standard Days Method. A major consideration of the program is sensitivity to local religious beliefs. The local health office intentionally did not provide a back-up method as it may contradict this.

However, if couples decide to use a supplemental method, he or she is not recorded as a user of SDM.

Dr. Malintad, PHO of Davao Oriental added that the local health office consistently advises couples to recognize on-and-off periods in SDM. In NSV, the husband is the primary decision-maker. In SDM, the couple shares responsibility for success.

FP methods popular among Muslims. Dr. Tato Usman of ARMM informed that the condom and withdrawal methods are two of the most highly accepted methods among Muslim communities. The withdrawal method was practiced as far back as the time of the prophet Mohammad. Thus, these methods may serve as alternatives for Muslim couples.

Target groups for SDM/ sources of the beads. SDM is applicable only to women with regular menstrual cycles of 26 to 32 menstrual day cycles. The first batch of beads was borrowed from the PHO. Some were brought from the Institute for Reproductive Health at a cost of PhP50 each.

Advantages of the IUD for IPs. The device is safe, relatively permanent, and the supply is constant. In highly inaccessible and mountainous areas, it is the next best thing to permanent FP methods like BTL and NSV.

Capability of midwives to perform IUD insertions. There is a midwife in mountainous areas capable of determining if discomforts/ complications are related to the IUD. The midwife can also refer patients to the appropriate health provider, if necessary. The untrained midwife does not do IUD insertions. A trained midwife in adjacent barangays can perform the insertion. Dr. Calingin of Senator Aquino, Sultan Kudarat, however, said that the best strategy is for LGUs to educate untrained midwives in the barangay rather than depend on those from adjacent barangays. Dr. Prieto said that caution must be exercised before authorizing midwives to perform IUD insertions. There should be preliminary tests that must be conducted and the midwife should obtain clearance from the MHO.

CONCURRENT SESSION II
STRENGTHENING COLLABORATION AND NETWORKING

Highlights of Presentations

1. Private Hospital - LGU Collaboration in Making Bilateral Tubal Ligation Accessible to Low-Income Clients

Dr. Rosendo Diagan
General Santos City

Presented was the experience of the Rosendo O. Diagan Memorial Hospital, a cooperative hospital based in General Santos City. The hospital is currently working on collaborative programs with LGUs and the private medical sector in the delivery of health services.

The hospital has a rich background in service delivery, counting an IMCH partnership from 1990-96, a community development partnership with John Snow International and EngenderHealth, the FP-RH project, from 2000 to 2002, and the establishment of an FP-RH clinic. The FP-RH project had for its objective the strengthening of the hospital's quality assurance and referral systems, and included the conduct of outreach activities utilizing the CBMIS. The activities formalized BHW training and coordination and led to accomplishments in the acceptance rates for Bilateral Tubal Ligation (BTL) and other FP methods.

The program explored and established partnerships with LGUs notably with the Province of Sarangani, and the Southern Mindanao Reliance & Medical Foundation. Presented were working arrangements between the province and hospital, outreach sites, and accomplishments. The hospital hopes to further strengthen LGU collaboration and expand partnerships with other provinces.

Issues and Concerns

Collaborative assistance from the religious sector/ other LGUs/ CHD. A congregation of religious sisters extend help to the hospital. Dr. Diagan provides them with living amenities like food and clothes, and the mutual assistance has done wonders for the hospital. The sisters extend services during hospital procedures, including the performance of VSS. The Province of Sarangani and the Regional Health Office were drawn into the hospital's collaborative undertaking in the area of medical supplies.

Dr. Awiten advised that collaboration and networking demonstrated by this partnership should be reinforced. The support of potential team leaders deserves to be recognized.

Dr. Diagan commended NGOs with the heart for health programs that could capably fill in the gaps experienced in public service. Partnerships were likewise forged with the Muslim groups but accomplishments in FP are not enough. The hospital must derive some income somewhere, hence, the networking idea came about.

FP acceptance among religious sects/ indigenous communities. One of the sisters had some apprehensions but she was realistic. She thought that if the communities truly understood the situation, they would accept FP as a good practice in aid of economic development. She focused her attention primarily on serving the needs of big families.

Breaking traditional negative beliefs. As far as the Muslim groups are concerned, the members of the Christian congregations have broken ground in Maitum and mobilized the communities there, without higher-level supervision and on their own initiative.

The PHO of Sarangani informed that one of the sisters working in the parish of Maitum immerses herself in the community and is aware of the realities. Patients, particularly T'boli women, always seek her out. She counsels the tribal families on the benefits of family planning, and refers patients to the health facilities when necessary.

Dr. Loreto Roquero said that the presentation demonstrated clearly that it was possible for a private hospital to deliver FP services in depressed areas and that together with the LGUs, religious sectors, and the CHD, it can provide basic health services.

2. POPCOM-DOH Institutional Collaboration for Effective MGP and RH/FP Program Implementation
Director Rene Bautista
RPO IX

The "POPCOM-CHD Institutional Collaboration for Effective MGP-CBMIS and other FP-RH Programs" implemented in the Zamboanga Peninsula is a regional initiative that aims to define the involvement and support of POPCOM in the implementation of the MGP. Dr. Bautista rendered a brief background of POPCOM's participation in past health programs that led to the formalization of the terms of reference for the collaborative exercise.

The aims of the collaborative undertaking were to conceive, develop and implement RH services for adolescents, reduce unmet needs for FP and expand access to these services, and enhance quality RH care and services. Today, POPCOM enjoys a strong working relationship with DOH-CHD, there is an active support for MGP and FP-RH activities, and active resource complementation from partners.

So far, the collaboration enabled the organization of FP-RH teams, formulation of the regional plan for 2002, organization of a Core of Trainors, and the continued improvement of the regional management plan. Dr. Bautista recommended the exploration of other areas for collaboration, conduct of joint learning exercises, and holding of a semestral review of activities.

Issues and Concerns

Parallel institutional collaborative efforts. Observations from the regions were welcomed, such as the creation of the National Program Management Committee and the intensification of advocacy through the creation of Advocacy Teams that helped in generating funding support from local governments.

Dr. Bautista noted that the findings on unmet needs and STPR 1 were similar to advocacy activities for the expansion of MGP. With support from the CHD, reach-out activities were made possible in provinces and municipalities in the program areas as well as in LGUs that chose to adopt and institutionalize CBMIS. They were successful in collaborating with partners who backstopped the implementation of the program in the last quarter of 2002. Different activities were lined up utilizing funds from the CHD through the end of the year. If more support could be generated, stronger collaborative efforts with POPCOM and CHD is possible.

3. Mobilizing Resources for Family Planning ***Dr. Timoteo Molleno*** Sultan Kudarat

Presented were strategies adopted by partners in the collaborative endeavor to source, mobilize, and maximize local resources for FP. The objective of the project is to expand acceptance and adoption of FP methods, including DMPA and the pill, among married couples and raise CPR.

An initial survey was conducted among the target municipalities to identify needs, determine gaps and lapses in service, develop strategies for appropriate interventions, and formulate plans to address those needs.

Issues and Concerns

Helping people internalize problem solving. Adverse field conditions are often perceived by the people as the concern of health providers and not their own. Health practitioners should be assisted in institutionalizing the gains. It should be a common concern for government to address in mutual partnership.

Non-acceptors of FP: of 344 women, only 19 women had accepted FP – better collaboration should draw in the balance of 325. Data shows that only 20 out of 245 women are on DMPA and the pill. In collaboration with the LGU, POPCOM, DOH and MSH, CBMIS will be utilized to identify families and persons to address.

Value of documentation in defying strategies to remove barriers. Intervention plans are based on program thrusts. Municipalities were tasked to consolidate reports, identify unmet needs, and make plans for correct interventions. There are plans to involve the private sector.

4. LGUs & WFMCs: A Critical Collaboration for Expanded, Enhanced FP/MCH Service Delivery

Dr. Warlito Vicente

Davao Medical School Foundation-Center for
Education, Research & Development for Health

The presentation culled lessons from innovative exercises in FP-Maternal and Child Health service delivery, made possible through the collaboration between local midwifery associations and LGUs.

Program activities included the establishment of clinics for basic health services with focus on FP-MCH, the conduct of training programs, and the adoption of standards for clinical services. There is a stepladder program for midwives who want to proceed to the nursing profession and later on to medicine. The program has a long-term benefit to the community and collaborative undertakings are being mulled for the expansion of the program to other provinces in CARAGA.

Issues and Concerns

Accreditation and licensing standards. Dr. Vicente explained that the clinics were established on the basis of quality standards. The slides showed a specific signage, a specific training program and a specific size for the facility. The CHD has endorsed the project. On a trip to Mati, efforts were seen and appreciated, as the key facilities are usually crowded and practitioners do not wish to treat patients who could afford fees for services. Alternatives were provided while seeing to it that standards were met, aided by national-level consultations with DOH. This is social accountability, not purely business because midwives are running the clinics on their own. They are not paid. The project provided them with training, equipment, and support in terms of marketing.

Dr. Roquero added that the DOH is working with the Bureau of Health Facilities and looking at existing standards for FP services and the licensing and accreditation of stationary and mobile clinics and the concept of itinerant teams. DOH licensing is basic, regardless of whether a clinic is managed by government, an NGO or the private sector. Accreditation guidelines are being finalized together with the amendment to the administrative order on the licensing of mobile clinics.

Dr. Awiten formally raised a recommendation to fully endorse the fast-tracking of the amendment to the licensing standards for mobile clinics.

Activities of traditional midwives. In General Santos, traditional midwives are allowed to attend to deliveries in convert clinics. It should be noted that many home-based deliveries are highly risky and that the convert clinics are better choices. The traditional midwives are being encouraged to bring their clients to these clinics.

5. LGU-NGO Collaboration for Bilateral Tubal Ligation

Dr. Roy Dan Firma

M'lang, North Cotabato

The gains posted by the Municipality of M'lang, North Cotabato in propagating the wider use of BTL as a means of FP were presented.

One of the unique initiatives was the establishment of rapport and working relations with members of a Catholic religious order for sisters. With encouragement and support from the LGU, the Municipal Health Office was able to launch a successful FP program in the community, with participation from local religious leaders, Christians and potentially, Muslims and midwives.

Future thrusts include the formation and launching of VSS itinerant teams, the involvement of more NGOs and other sectors, in particular, Muslim religious leaders, and intensified male involvement in FP-RH.

Issues and Concerns

Self-reliance strategies. There are plans to launch an itinerant team for Cotabato province as a way of maximizing available resources.

Muslim advocates. In Davao, there are Muslim advocates, but they usually maintain a low profile. In FP practice, only husbands are consulted, not the women. Perhaps a joint advocacy can be done to effect certain cultural changes. Health providers should pay closer attention to their culture.

Income opportunities for midwives/ health personnel and the need for collaboration. Dr. Awiten called on the POPCOM Directors of CARAGA and Zamboanga for closer collaboration. A significant development in these regions is that midwives earn from P20,000 to P200,000 a month in the business of private deliveries. This should serve as an inspiration to put things in proper perspective that the lowliest paramedical profession is worthwhile. Collaboration between LGUs and NGOs is crucial to the success of the health sector.

CONCURRENT SESSION III
IMPROVING SYSTEMS AND PROCESSES

Highlights of Presentations

- 1. Enhancing Community-Based Health Delivery Systems Through CBMIS**
Dr. Elsie Caballero
Butuan City
- 2. LGU Empowerment for CBMIS**
Dr. Aristides Tan
CHD-Zamboanga Peninsula
- 3. Reducing Unmet Needs for Family Planning: CBMIS At Work**
Dr. Renelito Bautista
Malaybalay City, Bukidnon
- 4. A Parkinsonian Journey Towards Quality Health Services**
Dr. Rhodora Antenor
Esperanza, Sultan Kudarat

The four presentations in this session underscored the value of the CBMIS (Community-Based Monitoring Information System) in the generation of data in aid of the management of local health service delivery systems. It proved valuable as well in the development and fine-tuning of processes suited to these services, in the context of realities in local resources that were ably augmented by MGP funds.

The core of the community-based health delivery systems were the barangays. These political units were piloted on the basis of the demonstrated support of leaders and the unwavering commitment of health personnel and BHWs. In Butuan City, the barangays provided the basic information, provided logistics, and served as venues for trainings and consultations. They likewise accurately pinpointed unmet needs in the locality, and were instrumental in the follow up of clients with those needs. The CBMIS data boards are prominently displayed in the barangays. The positive outcomes of the CBMIS were strengthened partnerships among providers and LGUs, increased demand for health services, and counterparting initiatives. Clear innovations were the involvement of barangay leaders, the installation of feedback mechanisms, and the design of call cards for improved utilization of services.

LGU empowerment for CBMIS began with advocacy among LCEs, commitment from LCEs, capability building and training of LGU personnel, LGU counterpart

funding, and implementation. The outcomes are promising. The core group training for Mindanao LGUs resulted in the active implementation of the CBMIS by four municipalities in Zamboanga del Sur, Zamboanga City and other LGUs in the regions.

In Malaybalay City, Bukidnon that is on its third year as an MGP enrollee, the CBMIS charter unmet needs that were responded to. Validation visits to cross-check initial data gathered turned out vital information on FP method used. The ensuing campaign to meet the popular need for VSS was backstopped by the establishment of VSS facilities at the Bukidnon Provincial Hospital and the main health center, introduction of VSS in far-flung barangays, and provision of services for clients who prefer NFP.

Issues and Concerns

CBMIS contribution to the achievement of program objectives. The CBMIS is capable of yielding all unmet needs that leads to the identification of the interventions needed. This will lead as well to an increase in the number of immunized children and the strengthening of FP services.

CHD role in the program. At the moment, the regional office, together with POPCOM, only provide technical assistance. But the funds provided by the DOH may be used for possible re-enrollment of LGUs under the MGP.

Progress of surveys in seven pilot barangays. The program was implemented municipal-wide, followed by a monthly validation of the process and program evaluation in December 2001. The latter was done in collaboration with members of the *Sangguniang Bayan* and other barangay officials to address the basic needs of the people and implement the interventions in accordance with the law.

Interventions in ARMM that need funding and logistical support from LCEs. There is a need to befriend the local officials concerned because once they appreciate the benefit of CBMIS as a whole, they would find ways to extend financial assistance. One apprehension is, even if LCEs are supportive now, by 2004 there may be a change in administration and in priorities. There should, therefore, be another round of advocacy to generate support and understanding.

Ways of dealing with unfriendly LGUs. Self-reliance is the best approach. In cases where politicians unwillingly support health programs, health providers have to cope with what they have. The needs of the community can be suitably addressed through massive social mobilization for certain projects. Advocacy will depend on the attitudes and skills of health workers in the community. It would be very difficult to ask support from local officials if their priorities differ.

At this point, Dr. Sukarno Asri said that the Province of Tawi-Tawi is compelled to coordinate with the mayors, especially in cases wherein services have not been fully devolved to the local government. Population figures are inaccurate, prompting the need for the CBMIS data that assists health workers in solving problems. This should be carefully coordinated with the mayors, especially in areas where the voting population is higher than the actual population.

Dr. Carmelina Pelobello of Compostela Valley said that the province has relied on the CBMIS for the past three years. It was beneficial because it reflected the overall health status of the community - immunized children, unmet needs in FP, etc. No problems were encountered because of the dedication of the BHWs.

Strategies used in CBMIS to involve male members in FP. In a Visayan LGU, men's awareness of their responsibility in FP is starting to increase. After two vasectomy cases in Negros Oriental, health providers had the chance to interview the clients. Men were found to be taking a more active role. For instance, they wanted to make sure that their families are adequately provided for and at the same time, not compromising the health of their wives. There is a need to advocate for a change in male attitude towards FP.

Dr. Abdulwahid of Tawi-Tawi said that the situation in ARMM is unique due to the undeveloped LGUs. Although LGUs were involved in Phase I of the MGP, a Memorandum of Agreement must be forged with the mayors. The MOA had undergone several revisions, making it different from the standard version. For one, the 25% counterpart to the MGP was deleted from the MOA. However, there is a provision mandating support for the MGP program. With regard to the flow of funds from the RHO, the first transfer is 50% while the second is at the IPHO level; in effect, funding transactions that should benefit RHUs are taking place at the IPHO, not the LGU level.

CBMIS effect on systems and processes. Dr. Renelito Bautista of Malaybalay said that the CBMIS was found highly useful in responding to unmet needs for FP even after contraceptives were made widely available. The city is now concentrating on VSS and SDM that are now being promoted as better alternatives to traditional methods. In the case of VSS, food assistance is provided to the clients. This includes seven kilos of rice, ten cans of sardines, and ten packs of noodles. The assistance enables a client to stay home and recuperate from the procedure. In the management of BTL, MGP shoulders the PhP150.00 hospital fee while the CHO provides the drugs. The city has procured 2000 cycle beads for the community to use for free on the condition that they would have to return them when no longer used. They are bound by a letter of agreement that considers the beads as properties of the CHO. A problem foreseen was the limited space at the tertiary hospital in Malaybalay. They were only given two days in a month to tend to their patients. That is why the city mayor renovated the city main health center and equipped it with a mini O.R.

At this point, facilitator Dr. Uysingco counseled the participants to put a premium on client relations. It should be ascertained that surveys are non-coercive because this is the first point of contact with the clients. Good rapport should be established in order to develop a personal relationship with them.

Dr. Rhodora Antenor of Esperanza, Sultan Kudarat said that in many hard-to-reach areas, funding from the MGP and LGUs are not enough to address the needs of poor communities. They have sought the assistance of private civil society to generate additional funds. The CBMIS can identify prospective clients by names and addresses in lieu of codes, making possible the "*personal touch*."

Advocating for CBMIS. Advocacy for CBMIS is not a one-time deal but a continuous process to enlist the support of different stakeholders. Advocacy is a challenging aspect in public health that could either make or break the program.

Summary of Issues. CBMIS is a tool for packaging and strengthening programs and putting systems and processes in place. In advocacy, hard facts are needed to sensitize people. CBMIS has presented these facts to the community and made people aware of their condition. It is a powerful non-threatening strategy that involves the people themselves in data gathering. CBMIS also presents data in a simplified manner for all levels, the community and its leaders. It can be used in program intervention and advocacy for greater support. It is also worth noting that through CBMIS, a strong bond with clients was developed by rendering the "*personal touch*."

CONCURRENT SESSION IV
LOCAL CHIEF EXECUTIVES FORUM

Highlights of Presentations

1. Making CBMIS Work through Barangay Health Workers
Mayor Florencio Flores, Jr., MD
Malaybalay City, Bukidnon

Malaybalay City's Community-Based Monitoring and Information System (CBMIS) shows how an LGU can empower its Barangay Health Workers (BHWs) to be at the forefront of the local health service delivery system and work more efficiently for the benefit of constituents. Malaybalay has 46 barangays with 487 active BHWs, with a ratio of one BHW for every 57 households. If midwives function as the hub of the CBMIS wheel, the BHWs can be considered to be the spokes.

The city has invested substantially in training, education and career enrichment programs for old and new BHWs. These untiring health workers work purely in the spirit of volunteerism and are not provided with honoraria but only an allowance of Php200 per month. However, in recognition of their efforts, they are granted official accreditation by the City Health Department. After a period of service, the city government recommends the BHWs to the Civil Service Commission for the grant of 2nd grade civil service eligibility after five years of continuous service. After this, they are considered for possible integration into the official plantilla of the city government.

The BHWs are also enrolled in the PhilHealth program. To this day, Malaybalay continues to sink investments in BHW development, and even holds a Congress for their annual gathering. Among the allowances and incentives granted to them are facilities for program review, uniforms, allowances and a fund for retiring BHWs. Funds for these incentives are locally legislated. The budget proposal originates from the City Health Office and the matter is acted upon by the Sangguniang Panglungsod. The barangay governments further support the BHWs with supplemental funds. The city's yearly budget for health services depends on the Internal Revenue Allotment (IRA)

The MGP in Malaybalay has posted many gains. Aside from attracting counterpart investments from other LGUs, it has addressed unmet needs for childhood vaccination from May 2000 to September 2002, unmet needs for tetanus toxoid vaccination among pregnant women, unmet needs for Vitamin A

supplementation, and unmet needs for family planning that brought the number of unserved constituents from 4,427 to about half or 1,628.

The city intends to improve upon its record and even intensify its thrusts in BHW career training and development. There are plans to continually recruit and train more BHWs particularly in FP service delivery. It also intends to promote the awareness of newly-elected barangay officials of the program through orientation meetings or conferences. A bigger facility will be provided for Voluntary Surgical Sterilization (VSS) at the City Health Office building.

Mayor Flores pointed out a number of lessons learned in the BHW program. Political interference on the matter of BHW appointments can be avoided by making LGUs perform only recommendatory functions. They do not have the prerogative to hire or fire BHWs who, like ordinary citizens, can campaign and vote for any candidate during elections. There is no law barring BHWs from political exercise but they should be prepared for any eventuality in case of a victorious opposition. BHWs should be oriented toward the concept of true service.

Issues and Concerns

Incentives to BHWs. Honoraria are not provided to BHWs, they only receive Php200 a month added on to whatever is provided by barangay governments. Honoraria is reserved only for specific assignments given to them. Their work is done in the spirit of volunteerism. The BHW-to-population ration is more balanced in the rural areas. The LGU is appropriating an amount that will increase this incentive to Php500 worker per month.

Civil Service Eligibility for BHWs. This was worked out in coordination with Civil Service Commission, Province of Bukidnon. The agreement was to grant 2nd grade CSE after 5 years of continuous service, after which they are considered for integration into the official plantilla of the local governments.

Illegal termination of BHWs. Barangay officials can only recommend applicants to the CHO. This will avoid risks muddling the electoral process. It is not the barangay's prerogative to hire or fire BHWs who, like any other citizen, can campaign for and vote anyone they want. There is no law that prohibits their political involvement, but they have to understand that those actions can be taken against them in case the opposition candidate wins. They should be oriented toward the concept of true service.

Funding sources for uniforms, allowances/ other BHW incentives. Budget proposals, that represent a technical aspect of city administration, come from the

CHO and are approved by the Sanggunian. The Mayor includes this in the city budget legislated by the Sanggunian. Governor Fuentes added that it is a matter of allocating a specific budget to the CHO, with counterpart from the municipality or the barangay. The barangay supports BHWs with supplemental funds from the city, municipality, or province.

Retirement fund for BHWs. The Sanggunian members has a special projects fund. The Vice Mayor gets PhP1 Million and councilors PhP800 Thousand each, per year, that they can appropriate for various programs of the local government. As for the mandatory age for BHW retirement, Malaybalay has a big number of BHWs who are over 60 years old but are still active. It even has one who is over 65 but who continues to serve. Retirement is based on the number of years of service rendered. A certain type of compensation is awarded to them.

Yearly budget for health. This depends on the Internal Revenue Allotment (IRA). Health services received minimal amounts only since emphasis is on social services as a whole. The percentage of the IRA for health falls below 10 percent of its annual budget. This is quite low and the LGU is trying to increase it little by little. It is not easy working with the Sanggunian where everybody seems to be against you, particularly during times of appropriation.

2. Establishing Inter-Local Health Systems

Governor Daisy Fuentes
South Cotabato

South Cotabato is a land-locked province in southern Mindanao, with an estimated population of 700,000. The Provincial Health Office set out to increase the value of human capital by improving access of the poor to quality basic health services. The province employed the dual approach of strong community involvement and effective LGU service delivery wherein the provincial government itself sought to increase its capacity to implement health services, including those that required referral to higher levels. Prior to the establishment of the inter-local health systems, the province suffered from severed linkages between public health and hospital services, poorly-defined roles, duplications and gaps, lack of community and medical sector involvement, inactive health boards, political interference, insufficient financing, and inefficient use of resources.

The province responded to these challenges by adopting the Inter-Local Health Zone Framework endorsed by the DOH under the decentralized set-up. The provincial government launched the Local Area Health Development Zone (LAHDZ) on August 19, 1999. EO 205, series of 2000, provided the policy and conceptual frameworks to guide systems development and other activities that led

to the efficient functioning of the LAHDZ. It also provided optimal strategic directions where all health component activities can be coordinated, integrated and addressed with the participation of stakeholders and the communities for bottom-up planning.

The definition of roles facilitated the LAHDZ setting. Resources were accessed to address financial gaps, and personnel development was pursued through training. An integrated supervision, monitoring and evaluation approach called the Structured Component System was adopted as a strategy. It involved the strengthening and development of the overall health management system and its sub-systems in MIS, health care financing, health care planning, human resource development, and the LGU management system involving coordination, referral and delivery, facilities construction, and medical procurement.

What proved to be most challenging was the mobilization of NGOs, POs and communities. This was carried out by establishing the Community Resource Center where trainings in community health management were conducted involving the participation of multi-sectors. After the Health Summit of April 1999, the provincial government, after consultative conferences and workshops with medical stakeholders, implemented the three-phased plan for the establishment of the functional integrated health system.

The preparatory phase resulted in the development of five area health zones, LAHDZ I to V. LAHDZ II became the convergence point where developed systems were piloted. Service packages were identified and made available at each level of health care. At the barangay level, health services focused on health promotion and prevention. Services at the municipal level consisted of environmental sanitation, laboratory and curative services, including minor surgeries and dental care. Core hospital services complemented activities at the primary level. They focused on a higher degree of curative services that could be provided on an emergency basis. The province established health referral protocols by organizing the Clinical Protocol Advisory Committee that oversees and reviews existing and emerging concerns as a result of therapeutic review committee findings, quality assurance committee findings, investigation reports, and mortality review programs. The protocols were designed on the basis of the World Health Organization, DOH, and PhilHealth clinical protocols.

The provincial Sanggunian was involved in all decision-making processes, providing the legal basis for executive action. During the pre-implementation phase, LHB Resolution No. 1, series of 1999 endorsed the adoption of the Integrated Health System (H IS); the Governor then issued EO 99-080 formally establishing the H IS and creating the LAHDZ. A MOA was signed between the Governor and mayors adopting the conceptual framework of the H IS. Strategies adopted were the forging of stakeholder support, continuous social marketing

strategies through regular radio broadcasts, printed materials, and lobbying with national, executive, and legislative officials of all government units.

During the implementation phase, good practices in the pilot areas were replicated. Other LAHDZs explored avenues unique to the pilot LAHDZ and duplicated them whenever applicable. The province benefited from the technical expertise of advisory groups and the support of the LAHDZ Boards.

The achievements of the province included the use of the Hospital MIS that generates live information, use of the Rural Health Information System and the simplified Rural Health Unit Management System that facilitated LCE management and decision making, and the application of other systems that assess felt and unmet needs for national health programs. Another information system currently pilot-tested is the Community-Based Disease Surveillance System.

There evolved an ownership of plans by those directly involved in the activities. Component municipalities with a number of facilities in a certain area planned together and developed goals consistent with their situations. Common niches, resources, and expertise were shared to fill the gaps of the others. In monitoring and evaluation, the systems include a registry of programs, projects, and activities that needed review. Implementors were reminded of the degree of development, improvement or lapses in any activity. The province also conducted formal participatory reviews for institutionalization purposes. Community participation and awareness were solicited to gauge compliance with governmental policies. Catchment surveys were done to assess the capability of the facilities and obtain information on rising health demands.

The development of human resources was done through organizational diagnosis. Previously, problems that prevailed were inequitable distribution of resources, loose top management, web-like organizational structure, and limited HR development. In response, the unit-based management system was adopted that utilized disciplinary approaches and established the unit-based Cost Center. The Cost Center increased administrative autonomy since stocks were maintained and partnerships were sought with other facilities. This led to the achievement of goals that focused on sound expenditure and cost containment.

In the Health Care Financing System, the unique achievement was the integration of laboratories in LAHDZ I and II that resulted in PhilHealth's accreditation of RHU facilities. Equally successful were the implementation of the community-based insurance program, income retention of by devolved hospitals, and adoption of the graduated users fee after the conduct of public hearings. The province embarked on parallel drug importation for the hospitals that were also allowed to run income generation and retention programs through fee-for-service in which they have posted earnings of up to PhP7 million.

Governor Daisy Fuentes indicated that this is in keeping with the provincial directive not to dispense services completely for free, since this would undercut hospital management costs. Indigent costs are shouldered by DSWD for specific amounts while patients who could afford are encouraged to pay. Congressional initiatives and locally legislated funds are pooled into an indigency fund that enables the provincial government to pay the hospital for the cost of indigent care in addition to PhilHealth. The province is presently constructing a Pay Ward building for this purpose so user fees can be made to subsidize indigent costs..

As a result of the LAHDZ, many benefits and gains were posted: 91 percent of rural health facilities became SS-certified, seven were accredited by PhilHealth, and four received capitation funds. Improvements were seen in health facilities and referral systems. Priority programs were upscaled: 73.32 percent had sanitary toilets, 92.9 percent had potable water supply, TB cure rate increased from 38 percent in 1998 to 85 percent in 2001, and diarrhea cases fell from 24.20 per 100T population to 18.33 within the same period.

Governor Fuentes informed that the LAHDZ was an effort toward sustainability. The mayors became very active in hospital management systems and were in fact politically benefited. They were encouraged by the positive outcome of the referral through which their constituents can be endorsed. However, the LAHDZ can function even without LGU intervention.

Issues and Concerns

Constraints and issues that faced the LAHDZ. The process of making LAHDZ work was an effort toward sustainability. Mayors were apolitical and became active in hospital management systems. The LGU will be able to sustain these initiatives because of the Mayors' interest and commitment. They are encouraged by the fact that there is a referral system at work through which their constituents are served. This system ensured the cooperation of all sectors. There are incentives to BHWs given by the province, municipalities, and barangays. Mayors took the lead but the LAHDZ moved even without LGU intervention. A doctor, mayor, *Sanggunian* member, NGO, and hospital owner sat on the board. The *Sanggunian* members attended all LHADZ meetings that enabled them to stake an ownership in the program.

Ways of ensuring drug availability. South Cotabato joined the parallel drug importation, authorizing hospitals to retain income through fee for service that enabled them to post earnings of up to PhP7 million. Indigent costs are shouldered by DSWD. Should legislators keep referring patients to hospitals then question the drain in supplies, the issue can be thrown back to them. Patients who

could afford are encouraged to pay. Congressional initiatives and locally legislated funds are pooled into an indigency fund. The province pays the hospital for indigents in addition to PhilHealth. The LGU is in the process of building a Pay Ward Building. Facilities cannot be improved on a free mode. User fees in effect subsidize the indigent costs. Drugs are always available at the hospital pharmacy.

Management of medico-legal cases in doctorless RHUs. In the absence of a medico-legal officer, a call could be made to other facilities, or the PHO can act as such. It is only in extreme cases that hospital chiefs can function as medico-legal officers. Dr. Salting added that all MHOs are trained to act as medico-legal officers, so if there are three MHOs in a LAHDZ, one of them can carry out the function in the requesting municipality. Policies were made by the LAHDZ boards to this effect, and all the needy municipality has to do is to pay for the medico-legal kit of PhP500.

Political issues surrounding universal insurance. PhilHealth identifies the beneficiary. No one in South Cotabato questions this as it has set uniform standards and criteria. In universal coverage, clear criteria should be set and no violations/exceptions should be made. Politicians don't commit to a certain act because they are afraid of losing. They fight for meritocracy in public service.

Politics as reason for negative outcomes. The prime consideration is one's very reason for entering public service. If this same objective is continually fought for and one emerges uncorrupt, there is nothing to be sorry for. Systems enable political leaders deliver efficient services. Whether the system will work or not depends on who is running the system. The LAHDZ in place will not depend only on the mayor, PHO or MHO. What is unique about LAHDZ is the multi-sectoral involvement of persons who must carry out important decisions. It is a good practice model of community members coming together. South Cotabato is continuing the struggle to perfect a system that is continually evolving. The work that takes place after every session should matter. If it lapses into routine, then it defeats its purpose.

How to address a situation wherein the plan to establish universal insurance and the money are available but the system of prioritization in higher LGUs negates it. One has to rise above it. Even as an LCE, Gov. Fuentes bends to enlist the cooperation of the mayors and barangay leaders, because she respects mandate. One has to find ways and means, and in the matter of giving drugs to the district hospital, there is nothing wrong with that except for the fear on the part of politicians that it could surface their own inadequacies. The key factors are communication and physical presence – an LCE should go to the site and convey the message. When one believes in a program such as health, she should be ready to make compromises. One should appreciate the situation of the doctor in a political world. He should not mind if the governor or barangay captain

disagrees with his plans – he can do the best he could to find a way of doing the things he believes are good even without help. The assistance of the congressional representatives can also be sought in this instance.

Concept of the revolving drug fund. While most LGU revolving funds come solely from the governor's office, the region's revolving drug fund, the social health insurance fund that can come from PhilHealth, is the source of PhP100T granted to every core hospital. The prerequisite is a counterpart fund from the province, city or municipality that could take the form of a fund, space or supply. The PhilHealth funds could not be used for political purposes. All the provinces of the region took the challenge and provided their respective counterparts, with the exception of one, which was unfortunate for their constituents. The mayors agreed to provide counterpart funds particularly when hospitals were located in their vicinities. Gov. Fuentes would have wanted the governor in question to dedicate at least a space for the showcase or storage of the drugs. PhilHealth funds could have done so much for the indigents. The condition for the grant of the fund, however, is the presence of 500 indigents. Additionally, the LGU in the process of designing a protocol specific to the region but applicable to all provinces.

Bases for the clinical protocols. The clinical protocols of the World Health Organization, DOH, PhilHealth and others were compiled, consolidated, and studied by a team of consultants who developed the standard protocol. As it happens, the protocols usually encountered are piecemeal and the DOH protocols often do not reach the private medical sector. The models have been available for quite some time. The bases are not complete but were compiled one after the other over time.

Method of operationalizing income retention for hospitals. This program has been designed for implementation in 2003 although it turned out to be quite a struggle in the budget, accounting, treasury and general services departments. The LGU has pursued it as a form of commitment to its hospitals. The usual MOOE for drugs for the first three quarters was provided to the hospitals and leave them to operate on their own on the fourth quarter, using their retained income. It will take another year to see if it will work.

Note: it was clarified that the PCSO has approved PhP67.6 million in local government subsidy for allocation to 4th to 6th class LGUs ranging from 75 to 90 percent. When granted to these LGUs, only PhP11.00 in monthly premium would be effectively paid by the families. This could provide the region with the required subsidy.

Summary of Issues. Dr. Dorotan of Sorsogon said that the issues of health and politics are related because an investment in health is a political act. Techno-political people in the DOH, PHOs, MHOs, and nursing profession are being

developed as experts with the political knowhow. In the case of political disagreements, marketing strategies can be made to operate. In Bukidnon, Governor Zubiri enrolled 155,000 households, or 90 percent of the population. If health can be sold as a political issue, as long as public and private hospitals are in place, universal coverage can be attained with no necessary out-of-pocket spending.

The beauty is that the LAHDZ system originated in South Cotabato and could soon be national in scope. Negros went further in cost sharing in their Inter-Local Health Zones. Three or four municipalities shared costs of up to PhP106,000 per year. This was strengthened by a provincial counterpart of PhP500,000 and an MGP grant of PhP5 million. With the LAHDZ system, the financial base can be increased, indigents can be enrolled, and drug prices can be decreased through bulk procurement. The health zones effectively increase total financing packages from the congressmen, governors and mayors. Negros' "*Pesos for Health*" goes to the extent of involving the indigents who give a peso each for their health in return for which they get PhP200 worth of medicines. Some of the ILHZ have turned into corporations registered with the Securities and Exchange Commission (SEC). Contributions were placed in a trust fund managed by a board composed of LCEs, NGOs, and POs. These become the convergence point of stakeholders, reforms and services. In the end, it redounds to the satisfaction of the patients, political mileage on the part of LCEs. LHADZ is a good strategy for health.

Plenary: October 30, 2002

1. Highlights of the 2000 Family Planning Maternal / Child Health Surveys

Ms. Heidy Palencia

National Statistics Office XI

The 2000 Family Planning Survey of the National Statistics Office presented data on contraceptive use in the Philippines. The sample took into account the background characteristics of Filipino women and the incurrent CPR. The pill turned out to be the most popular contraceptive method within the period covered across age groups, among poor and non-poor women alike. The public sector was the main provider of modern contraceptive supplies to about three out of four women.

The 2001 Maternal-Child Health Survey is the fourth survey to be conducted by NSO. Presented were data on pre-natal care, provider composition, status of immunization, and vitamin A supplementation. Prenatal care providers in the rural areas were mostly midwives whereas in urban settings, women went to doctors. There was an increase in the percentage of iron and iodine supplementation and tetanus toxoid vaccination, prompted by the fact that neonatal tetanus is the most common cause of infant mortality. Data on immunized children revealed that the number of fully immunized children stands at 61.3%, the current national figure.

Women after childbirth consult service providers mainly for the check-up of their babies and baby care advise. About 89.9 percent of Filipino women breastfeed their babies, and one out of ten women do not breastfeed, primarily due to insufficient milk and work habits.

Issues and Concerns

Epidemiologic survey results. The highest figures for child immunization were attained in the areas of BCG, DPT and oral polio. One of the reasons cited for the low figures was that mothers failed to make return visits to the centers with their children for the 2nd and 3rd doses. As far as supplies and products are concerned, the statistical community had no control over this. Only the survey results are presented.

Meaning of FP "advise" as differentiated from "counseling." For statisticians, the two definitions mean one and the same thing. The question asked was general

in nature, namely, "*Which of the FP services were offered during your post-natal visit?*" The so-called advise was partly counseling. Technically, it could be taken to mean counseling and not merely advise.

Dr. Roquero reiterated that there should be "*no missed opportunities for FP*" but in reality, only 45 percent were served. We have not really made sure that we were able to cover all in terms of FP counseling – they are there but we have not maximized the opportunity of FP counseling for mothers.

Survey results in the ARMM showing discrepancies between actual and reported population. The figure refers to the total population according to the survey results. The ARMM census on population included transient populace that are not in place but are working elsewhere. They are still counted in the barangays. Otherwise, a big segment of the population will be left out during the actual conduct of survey, which has a cut-off period. Specific examples are Tawi-Tawi residents working in Sabah.

2. The National Family Planning Campaign
Mr. Jose Miguel de la Rosa
Johns Hopkins University

The national campaign on FP should be complemented by local strategies. Attention should be paid to messages, characters, etc. Presented in the next half hour were TV plugs entitled *Buhay ay Masaya Kung Maliit ang Pamilya*, *Sentrong Sigla, Health ang Una, Pumili Kayo ng Paraan ng Hiyang sa Inyo*, and *Responsableng Pagplano ng Pamilya*.

These messages have been operative for about nine years and were meant for the consumption of the public and in support of strides in FP undertaken by NGOs and the health sector. The messages incorporated a call to action at the end - *kumunsulta sa health center*. They were also unique in the sense that real persons, doctors and authorities were used as characters to endorse the concept and the program. The image consistently projected was "*Kung sila'y mahal nyo, magplano*" and gave the program its branding.

The component activities of the 2002 National FP Communication Campaign are as follows: national and local campaign strategy; two (2) spots on national TV; positioning FP as a desirable part of normative lifestyle; six-month airing coinciding with national and local events; partners and stakeholders are encouraged to conduct local activities; FP signage component; and urban poor component. Other components are national media television spots and local community programs, with the participation of key stakeholders whose names and

logos will be included in the ads, etc. Synergy points include promos and fairs, public drives and caravans, public sector initiatives, and stakeholder activities. It should be noted that knowledge about FP is high but usage is low to about 50 percent. It is expedient upon partners in local government and health workers to support the national campaign that has been ongoing for 30 years. It has come to the point wherein influentials will be tasked to put NFP on the national agenda. What can we do to support the campaign? There will be more focus on multi-sectoral involvement. The message strategy is to increase use and social acceptance of FP, targeting married couples of reproductive age with unmet needs.

The observation over the years was that the national campaigns were not exclusive to DOH but involved NGOs, the private sector and government. Messages and objectives, however, are influenced by the political environment – there is no consistent build-up of an FP brand by government or the private sector.

Issues and Concerns

How to fight influentials advocating against the FP program. We have agreed with the Catholic Church that these moves should simply be ignored, the more you debate, the worse it will become. Until now, some messages that contraceptives are abortifacients are no longer given much importance. A Pulse Asia Survey ad says that the public no longer listens to the church or to politicians. Why engage them in debate?

How to communicate NFP messages. JHU can produce a campaign, but the point is to bring couples to health workers who can help them make the informed choice, who can expose them to information. Exposure and access are the means.

How to come up with low-cost advertisements utilizing traditional media channels. JHU has a local component with radio versions. Copies are given to regional offices of the DOH and POPCOM. But it cannot finance all activities at the local level. However, materials are available.

Concurrent Sessions : October 30, 2002

CONCURRENT SESSION I
EXPANDING HEALTH SERVICE DELIVERY (1)

Highlights of Presentations

- 1. Bringing Sterilization Services to the Main Health Center**
Dr. Marlyn Agbayani
Valencia City, Bukidnon
- 2. Clustering: A Strategy to Improve Health Service Delivery**
Dr. Eva Rabaya
Matalam, North Cotabato
- 3. Organizing A Regional Itinerant Team for Voluntary Sterilization Services**
Ms. Nelia Gumela
CHD- Southern Mindanao

Presented were the experiences of local health providers and their collaborative partners in three inter-related undertakings, namely, 1) the establishment of VSS services at the main health center of Valencia, Bukidnon; 2) formulation of barangay clustering strategies to improve the delivery of basic health services in Matalam, North Cotabato, and 3) the creation of a regional itinerant team for VSS in the Southern Mindanao Region.

The MGP-assisted programs relied heavily upon baseline data taken from the CBMIS that indicated the number of persons in need of infant vaccination, tetanus toxoid vaccination, and FP services. The use of the CBMIS data was facilitated by the holding of community-based activities such as barangay assemblies and client testimonials. These events made possible the recruitment of clients for the main health center, barangay health stations, and itinerant team outreach clinics. It likewise provided information that led to the identification of partners from the local NGO circle.

With the CBMIS as springboard and with the support of the MGP and LGU counterpart funds for supplies, mini-operating room set-up, and barangay-based activities, the MGP program posted gains in the areas of maternal and infant immunization and FP services, notably BTL and vasectomy.

Issues and Concerns

Generation of clients. Prior to the creation of VSS itinerant teams, conferences were held at the PHO and CHD offices where the plans were presented to the staff, who eventually became the client generators. Clients are referred by the LGUs to the teams and the procedures would follow at the local hospitals. The first step in the generation of clients is to identify targets from the CBMIS data. When the clients report, information leading to other target clients can be sourced through them.

Fees for VSS procedures. Part of VSS costs for vasectomy and BTL are taken from the MGP fund. The transport allowances of the team and supplies are shouldered by the CHD. Supply budgets are augmented by LGUs whenever procedures are done in their areas. Only per diem and transport allowances are given to the team as they are regular employees of the CHD.

Procedures followed in the clustering of barangays/ role of Barangay Captains/ cluster immunizations. Barangay clusters differ from BHS catchment areas in the sense that the permanent midwife assigned to the BHS confines her recording only to the BHS. In barangay clustering, the midwife records the activities of the whole cluster or group. Barangay captains are consulted only in areas with security problems. However, no MOA was drafted. Cluster immunizations consist of measles check and BCG that are done monthly.

Trained personnel who leave the service. The itinerant team was basically organized to augment the need for trained surgeons. Sustainability is a real problem to face. It is common for medical practitioners nowadays to leave for greener pastures after completion of training. Dr. Roberto Alcantara, CHO of Davao City, informed at this point that at the Davao Medical Center, consultants with permanent appointments in the hospital are the ones sent for training, not the residents. Hence, they are committed not only to the VSS program but also to the hospital. Therefore, the VSS trainees should have permanent appointments. Tasks in the VSS program are shared among members of the medical team, no personnel were added.

Summary of Issues. Presenters encouraged service providers to go out in search of clients, so that they do not wait in the facilities for clients to come. It is important to note that partnership is critical among NGOs, health centers, and LGUs. The program should be properly coordinated, with the full cooperation of those involved. Mobilization of resources is the key to the success of innovation. An environment should be set up that would encourage committed service providers.

CONCURRENT SESSION II
EXPANDING HEALTH SERVICE DELIVERY (2)

Highlights of Presentations

- 1. Bringing Health Services to Far Flung Barangays via the Tawi-Tawi Floating Clinic**
Dr. Sukarno Asri
DOH – ARMM

Presented was the highly innovative health program of Tawi-Tawi, the formation and deployment of Floating Clinics for the purpose of delivering health services to island barangays. The objective of the program, assisted by the MGP grant, was to improve people's access to basic services, bring down morbidity and mortality rates, promote maternal-child health, and raise health indicators.

The principal objective of the program, however, was to increase life expectancy in the islands, many of which are too remote for patients to be brought to the centers, and for doctors to reach on calls.

The 1998 National Demographic Health Survey and the NSO Survey both assessed life expectancy in the province to be low in comparison to more prosperous areas in Mindanao. The island configuration serves as a barrier to the delivery of health services. With the introduction of the floating or mobile clinics on boats that are able to penetrate inter-island municipalities, a better array of services were delivered on doorsteps. Utilization of the CBMIS and the support of the CHD and LGUs facilitated the successful launching of the program. If sustained, the services could impact on the total health profile and public health programs.

Dr. Asri recommended the strengthening of the capabilities of the floating clinics, further training for doctors, nurses and midwives, sustained LGU support and counterparting, and increased logistics in terms of vessels, pharmaceuticals, and supplies.

Issues and Concerns

Major causes of life expectancy rate in Tawi Tawi. The life expectancy was based on the 1998 National Demographic Health Survey. Even in the survey of

the National Statistics Office (NSO) in Tawi-Tawi, the FIC is very alarming. There is a discrepancy of about 20 percent between the census made by the agency and reports from field services.

Program constraints in island province affecting morbidity/ mortality. The problem lies in the peculiarity of the islands that are hard to reach and facilities that are inaccessible to most people. A midwife has to commute by bamboo banca or motorized boat. The leading causes of mortality are infectious diseases followed by malaria, which is endemic. The floating clinic addresses the problem of inaccessibility and is used in places like Turtle Islands that takes 14 hours to reach. Only one midwife is assigned there, hence, the need for assistance.

Undersecretary Milagros Fernandez remarked that provinces like Tawi-Tawi should be prioritized in terms of assistance. Life expectancy in the province is short because people have difficulty accessing medical attention. Many succumb to diseases without ever seeing a doctor hence, the high maternal mortality.

2. Inter-District IUD Itinerant Team

Dr. Wilson Solis

Makilala, North Cotabato

Dr. Solis presented the experience of the municipality of Makilala in Cotabato Province, one of the first recipients of the MGP grant in 2001. The program sought to increase CPR, organize IUD itinerant teams, create three referral centers, and strengthen IEC. The itinerant teams conducted outreach activities in distant barangays.

The CBMIS proved highly instrumental in identifying clients within the community. Some of the valuable lessons learned in the MGP-assisted program were the following: widening of service access to the client population from the skilled providers, increased usage of the IUD method, appreciation from clients and supporters in various sectors, and support from the LGU that provided funds in the amount of Php62.5T.

Dr. Solis recommended the provision of additional IUD kits and other logistics, and continued training in FP for the staff.

Issues and Concerns

Foreseen donor/LGU pull-outs. The good performance indicators in IUD usage could nose-dive in the event of the pull-out of donors and support of LGUs that have previously supported supplies and distribution.

Capability of itinerant teams to dispense IUDs/ insertion services. The team is composed of a medical doctor assisted by nurses and midwives trained in FP. There are back-up services like dental and sanitation. The barangays are supportive. Visits on immunization days and other events are scheduled with their cooperation. These rounds are supplemented by lectures on other health programs. FP acceptors are referred to the nearest health center. The skills of health workers are being maximized.

Sufficiency of IUD stocks. All possible external sources are being considered for the assurance of supplies. One is the UNFPA that will extend US\$3 million worth of contraceptives. On the part of LGUs, however, political will and moral support is low, hence, the need for self-reliance. Funds will be utilized for training and mainstreaming natural family planning methods.

3. Davao Norte's Male Reproductive Health Clinics ***Dr. Agapito Hornido*** Davao Norte

Presented were program objectives, targets and strides gained by Davao del Norte's local health facilities in male reproductive health.

The establishment of RH clinics in hospitals enabled the LGU to address related infections, counseling, and detection of prostate cancer in the male patients. The contribution influenced the Contraceptive Prevalence Rate (CPR) minimally, owing to the low patient turnout. This situation was addressed by the fielding of male health providers.

Issues and Concerns

Contribution of male involvement to total CPR/ baseline of target to increase involvement by 80 percent. Baselines were adopted in one municipality that organized male FP advocates. This was supported by the mayor and participated in by church groups and NGOs. The CBMIS tested in Davao del Norte was used as a tool to respond to unmet needs. It served as the baseline. Other baselines

were records of male patients who availed of services in RTI clinics. There are factors behind the low number of male patients. One is the bias of health providers towards females. In response to this gender bias, the LGU selected male dentists, nurses, RHIs, and male BHWs for training as male coordinators.

Types of male cases in RTI clinics. STD is often associated with women which is a misconception especially on the part of the males. There is a discrepancy in numbers because one, there is no space provided for clinics for males; second, there is no counselor with whom males can relate; and third, rural men try to hide their problems for as long as they can. Once, a relative came to consult for the treatment of scrotal swelling only after two weeks of intense pain, and after consulting quacks who advised him to take Caltex water and detergent. The idea was to take some kind of radiator wash. After two weeks, he was hospitalized.

Cancer screening in males. A regular outreach on prostate cancer has been instituted. The best so far is the preventive aspect of early determination of prostatic growth.

Male clinic location. Male RH outlets are located in existing hospitals where spaces have been allocated for the clinics.

Issue of confidentiality in STD treatment. This is something that cannot be fully guaranteed, hence, the need to improve the quality of the doctor-client relationship.

Staff support provisions for male RH. Undersecretary Fernandez pointed out that male reproductive health involves personnel. There should be an ordinance that should provide for a staff/ male coordinator to give emphasis on male RH.

CONCURRENT SESSION III
INCREASING DEMAND FOR FAMILY PLANNING AMONG
INDIGENOUS PEOPLES

Highlights of Presentations

1. Promoting Family Planning in a Tribal Community

Dr. Alfredo Calingin

Sen. Ninoy Aquino, Sultan Kudarat

The municipality of Senator Ninoy Aquino has a very high concentration of the Manobo, an indigenous group based in Mindanao. Approximately 20% of its population is Manobo. Manobo women marry as early as age 12. The practice exposes them to pregnancy risks and increases their chances of having more children. Thus, the Manobos were considered ideal targets of the FP campaign of the local health office.

Before embarking on the FP advocacy campaign, the Municipal Health Office worked on the formation of a "Highlanders' IEC Team." IEC materials on FP, originally published in the English language, were translated in the local dialect. Illustrations and text were also reviewed to ensure conformity with the gender and cultural norms of the Manobo.

Translating FP materials into local dialect perhaps triggered transformation in the attitude of the indigenous people (IPs). They were able to understand the message much easier. When they began to understand, responses were generated, allowing the health advocates to further explain the program and address specific concerns of couples.

An orientation seminar was also organized to train the team on the proper use of IEC materials. Team members were taught the basics on the conduct of IEC campaigns, proper timing of the campaigns (e.g. cultural, religious, and political gatherings), and strategies to motivate people (including the employment of testimonials). An actual orientation on FP, using the revised materials, was held recently. It was warmly received by the Manobo community. After the orientation, most of the attendees expressed preference for DMPA as an FP method.

The municipal health office plans to integrate other health issues into the program materials and replicate the strategy in other IP communities.

2. Innovative Strategies in Delivering Family Planning Services to Indigenous Peoples

Dr. Fidel Peñamante

General Santos City

General Santos City is one of the fastest growing towns in Mindanao and in the whole country. The acceleration is ascribed not only to its economic development but to its population growth rate as well, the latter increasing by at least five percent annually.

Dr. Peñamante shared the local health office's innovative strategy of employing theater to put the FP message across to the IPs. A play was patterned after the B'laan culture and participated in by members of the B'laan community themselves. The play included explanations of the different FP methods. Towards the close, it challenged viewers to visit their community health centers.

Dr. Peñamante underscored the importance of penetrating the local culture. There were existing biases to face, as highlanders consider themselves second-class citizens primarily due to poverty and differences in their culture. A situation must be created where they could relate freely. Humor was built into the script to catch the attention of the community. The local health office did not merely view the event as a plain medical mission but as a form of an infotainment (informative, educational, and entertaining).

This strategy was not only a hit in that it entertained the community; it was also an effective method of putting the FP message across to the indigenous people, setting aside the boundaries of language and open communication.

Some of the lessons learned were that B'laans usually are not comfortable talking about their private concerns. It can be quite difficult at the start to establish rapport but this is important to gain the confidence of the IPs. And when a commitment is made, it should be fulfilled. Rapport and confidence building must also be made with the leaders first, since indigenous communities look up to their leaders. Using members of the community to carry out immunization activities may also help in securing and increasing community support. The leaders must be persuaded to see that the program will benefit the community. If the leaders understand, they will be the ones who will help advocate. Government must work within the system in the locality.

Dr. Peñamante added that the health office should guarantee that expenses related to medical treatment and other support mechanisms are made available to members of the community. The IP groups need assurance that the government is sincere in providing them with assistance. With respect to the theatrical plays, the local health office recognized the fact that IP communities do not have regular

entertainment. The play is a good medium to get the message across. Health providers also have to prove their worth and deliver results so the community will trust them.

Another finding is the patriarchal nature of IP and Muslim societies, where women are less involved in community affairs. Admittedly, it is difficult to promote FP services in IP and Muslim communities. However, the strategy is to try convince the women to see the need for counseling which should involve their male partners. The persuasion is usually done when they submit themselves for medical check-ups or before and after deliveries.

Another challenge is the continuity and availability of services in IP areas. FP services are not provided often due to the absence of support from LGUs, plus social and religious pressure. DR. Peñamante closed by saying that there is an inter-faith group composed of Muslims, Catholics, and Protestants in General Santos City that could be tapped. There is common ground they share that FP is good and must be observed. Religious leaders are influential people within the local communities. Health practitioners or FP advocates should actively solicit the assistance of these leaders who can be partners in FP whether they advocate a particular method or another. The final decision as to what FP method to use rests upon the couple. The important thing is for health/FP providers to be prepared to offer a range of services in support of the IEC campaigns.

Issues and Concerns

Key to attitudinal change of IPs. Translating FP materials into the local dialect perhaps triggered the transformation in the attitude of the IPs.. They were able to understand the message much easier. When they began to understand, their responses were generated, allowing health advocates to further explain the program and address specific concerns of couples.

Functions of the BHSs / BHWs in IP programs. There is a BHS in the barangay but it takes four hours to get to the site. There is one BHW but she lives in another sitio that is also far, so another BHW residing in the *sitio* itself being trained. The local government has also been asked to declare the area a calamity area. This will hopefully sink in more resources to improve roads and health facilities.

IP attitude toward FP. The Koronadal City Health Office has targets within the B'laan areas. In these communities, the assigned midwife is B'laan and thus belongs to the tribal community. She is a big help to the conduct of IEC. She is usually taken along on visits to other communities where there are B'laans to address cultural and language barriers. Using members of the community to

carry out immunization activities helps in securing and increasing community support. Tribal leaders should be persuaded into thinking that the program will benefit the community. If the leaders understand, they will be the advocates. The principle is to work within the system in the locality.

Profile of IP acceptors. There are male and female acceptors among the IPs, including VSS and condom users. It is not difficult to convince the male members in the community. Manobos do not declare faith in any religion. A big barrier standing in the way of health practices like FP, for instance, is the thinking that having more children guarantees more manpower for livelihood (e.g., agricultural) activities.

CONCURRENT SESSION IV
ENHANCING SOCIAL MOBILIZATION

Highlights of Presentations

1. *Sentrong Sigla at the Household Level*
Dr. Charito A. Awiten
CARAGA Region

Sentrong Sigla at the Household Level (SSH) is the first program of its kind in CARAGA. Since the *Sentrong Sigla* concept has caught fire among public health workers in the region, they thought of bringing it down to the level of the households, where families would be empowered to take control of their health. The concept involves families, service providers, and stakeholders, utilizing the framework of the District Health System.

The SSH movement starts within the barangay. The prime motivators are the Family Health Workers who are supervised by the BHWs. Five to ten households are organized into a cluster. To qualify as a cluster, certifications must be obtained from the barangay government. Barangay Puting Bato is one of the lead clusters. It has 297 farming households divided into 319 families.

One only needs to visit the area to see that mothers are truly concerned about their health and the health of the entire neighborhood. Mothers are closely organized. They are abreast with health news and updates in the community, since the family heads are involved in all of the barangay's health events. They have a working knowledge of health care for emergencies, and maintain healthy lifestyles. They help in the construction of sanitary facilities, garden fences, and herbal gardens. They are equipped with medical kits. Households can give services to other households – *bayanihan* style.

In the process of organizing the SSH and qualifying them for the award of the seal, household clusters are presented to the RHU for assessment according to policy guidelines of the SSH Assessors Board. A total of 98 SSHs were awarded the SS seal. Support structures were established, including a referral system, a health savings system, and a cooperative that sells gasoline.

All these activities resulted in positive outcomes in terms of lowering the morbidity and mortality rate. The SSH clusters have achieved independence and are on the road to institutionalization. The SSH clusters reflect the same stability of the families under them, with a value system based on learnings and exposures.

There are future plans to replicate the SSH in other barangays as a concrete way of putting health in the hands of the women.

The key factors behind the success of the SS at the household level are the women. The team organized women as catalysts who were assisted by the community organizers. The women were chosen for their leadership skills and their capacity to overcome problems. Moreover, the people actively participated from planning to implementation. The DOH, partner NGOs and local politicians helped to sustain these efforts in CARAGA.

Issues and Concerns

Key factors of empowerment. Credit should go to the women's health partnership. The team organized women as catalysts. The households should be made the centers of Sentrong Sigla, not just the health centers. This was the springboard. It was more of a movement within a barangay. This was facilitated by the presence of community organizers who worked on women's health. Component activities were assisted by the European Union and partner NGOs.

The plus points in the empowerment approach were as follows:

- We trusted the women and their capacity to overcome problems.
- The people themselves participated from planning to implementation.
- Support was extended by DOH, and partner BGO.
- Involvement of local political leaders.

2. Institutionalizing the Child Friendly Movement

Dr. Antonio Yasaña
Sarangani Province

Sarangani Province's Child Friendly Movement was aimed at putting the child in the center of the local development agenda, using the principles of the Convention on the Rights of the Child as the inspirational springboard. In deference to Executive Order 31 and DILG Memo Circular 2002-121, the province issued and promulgated the Provincial Child Welfare Code. The provincial and municipal governments allot a portion of their local budgets to children's programs on the strength of this code. The code, which was adopted in 2000, is now strictly enforced and monitored.

This program's rights-based life cycle approach involves child health, maternal health, child protection, community participation, and family health practices. To

jumpstart the movement, a number of enabling structures were set up. Strategy 1 involved organizing Councils for the Welfare and Protection of Children at the provincial, municipal, and barangay levels. Strategy 2 involved the mainstreaming of the Child Friendly Movement and the CRC objectives through the formulation of the Provincial and Municipal Development Plans and the promulgation of the Provincial Welfare Code for Children. It also required the establishment of a Functional Knowledge Center, the issuance of an Annual State of the Children Report, and an Annual Investment Plan for Children.

Strategy 3 spelled out ways of expanding sustainable models and best practices like the institutionalization of public health facilities, child-friendly day care centers, schools, and homes. Strategy 4 called for the extension of basic services to respond to the needs and rights of children. A specific output was the establishment of the child-friendly schools and the *Katarungang Pambarangay* for the benefit of errant minors. Strategy 5 called for the integration and convergence services at the community and barangay levels like early childhood care and development, health, and nutrition. Health centers were compelled to provide regular services to 0-2-year old kids as well as opportunities for early psychosocial stimulation. Health and nutrition posts were tasked to put up maps showing the development indicators.

In Sarangani, the child-friendly barangays work hard at building an environment where children can grow up to full potentials. Parents are encouraged to partner with local barangay governments to look after the children's total well-being. These barangays have a functional Barangay Council for the Protection of Children, a functional children's organization, justice system, health and nutrition system, and early child care and development center.

Issues and Concerns

How the movement broke ground and the mechanisms instituted to sustain it. Dr. Yasaña related that The Children's Movement was a success in Sarangani primarily because of the structures that were not merely set up – various sectors were enjoined to participate in giving life to the movement. Another crucial factor was the monitoring system, which was established with the aid of the United Nations Children's Fund (UNICEF). The Barangay Council for the Protection of Children has various working committees with close partners from the different sectors. Schools were enjoined to raise child concerns at their level to the Councils. In case of child abuse, the council acts on the case, with respect to matters of confidentiality. Additionally, the barangay maintains a data base on the unmet needs of children and their families. Health indicators could be generated from the system. The key to its success lies in the orientation of all sectors on the urgency and importance of attending to children's health.

Standards checklist for SSP/ SSH. SSH has included for its concerns budgetary allocations for children and the paradigm shift from cigarette smoking to children's programs. Children's programs are built into local programs, e.g. supply of drugs and medicines, information systems, and public health programs like salt iodization in which mothers are the frontliners.

A partnership in Agusan Sur has spearheaded a similar Child Friendly Movement wherein adults provide the enabling structures for children. It focuses as well on children's participation; hence, there is a child-to-child movement where children do things at their level. A six-module program has also been launched to combat parasitism in children.

Local development plans presuppose the participation of the child. Children have been tapped and trained as advocates, mainstreamed in local activities and events, and are also trained as trainers.

3. Developing Community-Based Nutrition Services: The Kiamba Experience

Dr. Elmer de Peralta

Kiamba, Sarangani

Kiamba is a third-class municipality with 19 barangays, 25 percent of which is composed of indigenous peoples (IPs) and 20 percent, Muslims. Some of the pressing local issues are the high incidence of malnutrition, limited access to health services, limited family welfare capability, lack of awareness on family planning, and a high illiteracy rate.

To address these problems, the municipality embarked on a program to establish and operate Barangay Health and Nutrition Posts. The community was mobilized, starting with the formation of a Technical Working Group at the municipal level that took care of orienting municipal and barangay officials about the program. The TWG members also worked on cluster mapping and the nomination of cluster heads. The community members were inspired and motivated by the prospect that the post would be eventually owned and managed by the community itself.

A community survey was done to obtain individual health and nutrition profiles, identify cluster problems in health and nutrition, and seek out the commitment of community members. People were encouraged to participate in the planning process. Barangay leaders assisted in the conduct of assessments and the actual establishment of the Health and Nutrition Posts in remote and far-flung areas. More importantly, they extended the needed financial and logistical support.

One thing going for Kiamba was the close coordination of the key players in the program. The activities that followed the establishment of the posts were the holding of caregiver classes, home counseling, monthly weighing for children 0-59 months, home food production, and provision of health services. The IPs were given supplies for personal hygiene while the posts were supplied with horticulture materials for the construction of herbal gardens. Trainings were likewise conducted for family health workers. Nowadays, the posts not only provide health and nutrition services; they also serve as venues for the conduct of child health programs and services for the mountain communities.

Many learnings surfaced from the Kiamba experience. One is that people from various cultures can be organized to influence behavior towards the adoption of good health and nutrition practices. Notable achievements were posted in nutrition – malnourished children received Vitamin A and food supplements; 100 percent of the households were made to patronize iodized salt; 100 percent of the families were able to bring infants for monthly weighing; and 100 percent of the children were fully immunized. Many mothers practically breastfeed. There was also a marked reduction in the number of maternal deaths and heightened knowledge and acceptance of family planning methods.

**4. Improving Vitamin A Capsule Coverage through Social Mobilization:
Garantisadong Pambata: The Tawi-Tawi Experience
Dr. Shan Abdulwahid
Tawi-Tawi**

Tawi-Tawi was formerly a part of the Sultanate of Sulu that became a province of the Autonomous Region of Muslim Mindanao. A 6th class province, it is a top producer of seaweeds and pearls because of its extensive reefs. There are 307 islands with 207 barangays. There are five hospitals, 12 RHUs, and 37 BHSs. It has an indigenous population, and the poverty rate is quite high.

To reduce the vulnerability of its population to disease wrought by the poverty situation, the *Garantisadong Pambata* program was launched as a social strategy to promote good child-rearing practices and provision of health services right within the community. It is an LGU-NGO and IPHO partnership. The province, in coordination with the NGO network and service providers, went on a massive advocacy campaign, organizing a GP provincial task force with committees that were composed of socially-committed community leaders and NGOs.

Social mobilization activities were undertaken in remote municipalities like Mapun and Turtle Islands. The GP monitoring team went to work in earnest, and were provided with vaccines, micronutrients, and information materials. They conducted orientation workshops that were attended by members from various

sectors. Caregivers were trained and mothers were encouraged to attend healthy lifestyle classes. Even the broadcast media cooperated by providing air time for plugging health-related information.

A very unique feature of the program is the *Tawi-Tawi Floating Clinics*. It is a clinic aboard a seacraft that delivers the GP health services directly to the underserved communities. The floating clinics were widely welcomed and received as they have done much to improve the health of people, particularly the indigenous tribal communities in the far-flung islands. Other outstanding features of the GP program are the *Floating Patak Centers* where health workers dispense Vitamin A supplements and oral anti-polio vaccines. The sea-roving clinics were cited for being in harmony with the sea-based culture of the coastline people.

Program implementers also utilized alternative channels like provincial high school students. They went on campus tours to tap students who would bring GP messages across their neighborhoods. Some 27 high schools were covered.

The program benefited a lot from the involvement of Muslim religious leaders (*ulamas*) who helped disseminate information on nutrition, health, and family planning among their followers, thus, serving as effective partners in the program. They advocated for family planning, informing the people that FP practices do not run in conflict with the teachings of Islam. Local IEC materials were translated in the vernacular, making house-to-house campaigns even much easier. A related program in dental health helped to promote dental health among pre-schoolers.

Garantisadong Pambata resulted in substantial Vitamin A Coverage. Latest coverage figures ran up to 99.60 percent from 82 percent, posting 2nd place at the national level. The province likewise achieved a 91 percent coverage in the immunization of children and 80 percent in Tetanus Toxoid vaccinations. The GP was cited as a point-specific strategy to provide people in remote island barangays with access to needed health services. It helped build alliances through partnership and networking. It was successfully able to utilize indigenous venues for advocacy, enlist the participation of influentials, create working task forces at all levels, all of which combined to bring about a well-coordinated program.

The province plans to sustain GO initiatives that it started to keep the momentum of social mobilization, particularly in the area of coverage expansion, legislation, and monitoring.

5. Healthy Babies Make Bislig City Healthy

Dr. Brenda Estrella

Bislig City, Surigao del Sur

The Healthy Baby Program is one of Bislig City's best practices. It sought inspiration from the national concept of Health in the Hands of the People by 2020. This was a valid call, considering the prevalence of infectious diseases in the city. The program targeted infants one year and below as program beneficiaries. The intent was to achieve 100% vaccination by the end of the project.

The Healthy Baby Program drew heavily from the strength of its human resources. CHD personnel were mobilized as community organizers. They made use of the CBMIS and local family profiles to determine population magnitude and check on families' unmet needs city-wide. A survey questionnaire was distributed to the mothers and the data culled was analyzed for the purpose of determining infant/child morbidity and mortality in the areas covered. The community organizers set up linkages with various sectors, including funding agencies. A total of 25 unit clusters were organized and provided with facilities for focus group discussions and information systems.

Program activities began with the identification of needs, particularly financial needs that were sought through LGU subsidies. It was also necessary to orient LCEs and build the competence of families to focus on health through IEC campaigns. Household cards were distributed to nine percent of the population, from which family heads/members were gathered to form focus discussion groups. Some of the inhibiting factors that were encountered were the lack of vaccines and the absence of a Parent's or Mothers' Club, but these were suitably addressed.

Innovative marketing approaches were adopted in the course of the immunization campaign. The practice of cost sharing was introduced, which started with the availment of a credit line from the local pharmacy. The marketing function was delegated to the parent-members of the EPI Club. The parents took up the advocacy trail and prevailed upon LCEs, barangay authorities, and funding agencies to expand the needed budget for EPI. Meanwhile, the health providers made regular inventories of vaccines. Expenses for the vaccines were made chargeable to the EPI Club and Health Center.

The real achievement of the program was drug security. Through the efforts of the program organizers, LGUs, NGOs, and more importantly, the family members and mothers themselves, the constant availability of vaccines, supplies, and immunization paraphernalia was made possible. The ultimate lesson that was learned was that community resources could be generated for the benefit of

beneficiaries, in this case the “healthy babies of Bislig City.” According to the organizers, they were able to make the program work through the mechanics of “*secular humanism*.”

Issues and Concerns

Discrepancy between national and local mortality rate in Tawi-Tawi. The figures do not match those reflected in the National Demographic Survey.

Key to success in Tawi-Tawi. The surveys presented opportunities and attracted donors to assist program implementation. One of the implications that surfaced was the scarcity and lack of vaccines; this should be put on record since it affects coverage.

Summary of Issues. There are similarities that were shared in the working elements: community organization, multi level sectoral organizations and structural organization. There was marked barangay involvement in terms of family clusters, and peoples’ participation in decision-making. Thought should be given on how to share and internalize the experiences.

Closing Ceremonies

Closing Remarks

Dr. Dolores Castillo

Center for Health Development – Southern Mindanao

We wish to recognize and thank the LCEs who stayed throughout the conference. We are equally thankful that the four rights discussed at the start of the conference were put into practice. There are mixed feelings and apprehensions among participants, for which I wish to share the story of a mother who set on the stove three different pots containing a potato, eggs, and coffee beans. In life, there are various responses to situations. The workshop surely brought out persons who are either softened like the potato, who crack up like the egg, and who color and flavor their world like the coffee bean. We hope that the conference provided valuable insights into good practices, enabling replication back home, creating situations that may be happily endorsed to the next generation that will receive it.

- Community Singing -