

LGU Performance Program (LPP) Summit

Documentation of Proceedings

January 25-26, 1999
Westin Philippine Plaza
CCP Complex, Roxas Blvd.
Pasay City

**LGU Performance Program (LPP)
Documentation of Proceedings of
LPP Summit**

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The LGU Performance Program (LPP) Summit could not have been organized and successfully convened without the support of the Department of Health (DOH), the USAID and the Management Sciences for Health (MSH); the determination of the various local government units under the aegis of the LPP to sustain and institutionalize shared practices; and the technical backstop of the officers and staff of the DOH and the MSH. The Summit revolved around the presentations and discussions of "good practices" and the preparation on how best to sustain these worthwhile practices given all the rich ingredients for success found in most of them. For these insightful sharing, we wish to give thanks to all the LGU presentors who made the discussions productive; and provided the participants and concerned government officials a better understanding and appreciation on how best to initiate and deliver health service(s) using available community resources. Our appreciation also goes to the workshop facilitators who guided participants to focus on the more important issues and aspects of the discussions and to the team of documentors who prepared this report.

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PROGRAMME OF ACTIVITIES

January 25 – Morning Session

8:00 – 9:00	Registration of Participants
9:00 - 9:30	Opening Ceremonies Invocation Dr. Brenda D. Lopez Program Manager Reproductive Health – DOH Pambansang Awit Welcome Remarks Dr. Susan Pineda-Mercado Undersecretary – Office for Public Health Services – DOH Acknowledgement of Participants Dr. Juan A. Perez Director – Local Government Assistance And Monitoring Services – DOH
9:30 – 9:45	Coffee Break
9:45 – 10:05	Highlights of the National Demographic and Health Survey Dr. Elizabeth M. Go Director, Household Statistics Department National Statistics Office
10:05 – 10:25	Emerging Trends in LPP-Participating LGUs Summary Results of the Multi-Indicator Cluster Surveys Dr. Loreto Roquero, Jr. Director, Family Planning Service – DOH
10:25 – 10:40	Open Forum
10:40 – 11:00	Sustansya Para Sa Masa Ms. Adelisa C. Ramos Director, Nutrition Service – DOH
11:00 – 11:20	Sentrong Sigla Dr. Zenaida O. Ludovice Asst. Secretary, Office of Standards and Regulation – DOH
11:20 – 11:40	LPP Updates Dr. Brenda D. Lopez Program Manager, Reproductive Health – DOH
11:40 – 12:00	Open Forum
12:00 – 12:30	Message Ms. Patricia Buckles USAID Mission Director Message Hon. Alberto G. Romualdez, Jr. Secretary of Health

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Afternoon Session

- 1:30 – 1:50 Project Cocoon
Dr. Milagros L. Fernandez
Undersecretary, Office of Standards and Regulation – DOH
- 1:50 – 2:00 Open Forum
- 2:00 – 4:30 Concurrent Sessions: Sharing of "Good Practices" Among LGUs
- Group I: Service Delivery
 Group II: IEC/Advocacy/Social Mobilization
 Group III: Resource Generation and Mobilization/Research/MIS
 Group IV: Initiatives of Cooperating Agencies
 Group V: Special Session
- 4:30 – 5:30 Opening/Viewing of Regional Exhibits
Dr. Susan Pineda-Mercado
Undersecretary – DOH
- 5:30 – 7:30 Cocktails
Songs and Ballroom Dancing

January 26 – Morning Session

- 8:00 – 10:00 Next Steps: Making Things Happen (Workshop)
- 10:00 – 11:00 Presentation of Group Outputs/Synthesis (Plenary)
- 11:00 – 12:00 Recognition of Innovative LGUs and LPP Top Performers
Sec. Alberto G. Romualdez, Jr. and P.E. Balakrishnan, Chief, OFHN-USAID

LUNCH/DEPARTURE

Masters of Ceremonies: Ms. Dyesebel Dado and Dr. Jose Rodriguez

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LGU Performance Program (LPP) Summit

January 25-26, 1999

Westin Philippine Plaza

CCP Complex, Roxas Blvd., Pasay City

EXECUTIVE SUMMARY

The two-day LPP Summit was the culmination of a three-level process of documentation and information sharing of innovative models of health service delivery schemes, particularly in the areas of family planning and selected child survival programs. These *good practices* were identified and selected, first at the provincial level, the "best" of which were presented and shared at the regional level, and eventually at the national level LPP Summit. The innovators and change agents who conceived of these models and taken action to make them work, include the following:

- ❖ Local chief executives who provide the necessary institutional support to allow the devolution of health services to gain headway;
- ❖ Program managers who are willing to try out other ways to improve health services in their areas;
- ❖ Committed service providers, researchers, and field workers who form the backbone of these innovations; and
- ❖ DOH representatives and cooperating partner agencies who provide the technical inputs, and when necessary, the financial assistance to spur these innovations.

Some 450 participating delegates, including local chief executives led by governors, city and municipal mayors, board members and councilors, health and population officers, other designates and participants from the DOH, POPCOM national and regional offices, representatives from USAID and other cooperating agencies shared actual experiences in program management and implementation. Each is considered a technical resource to peers, and represented different key players in the health care delivery system.

The Summit showcased more than 70 models of *good practices* from all over the country, 31 of which were presented in five concurrent sessions. The proposed House Bill No. 5125, otherwise referred to as *Health Care Modernization Act*, sponsored by Congressman Emilio Macias II of Negros Oriental, was presented and its merits discussed in the Special Session.

The Summit was divided into four parts: the technical/program updates, the sharing of good practices, the workshop session on next steps, and the awarding ceremonies for LGUs with *good practices* and the LPP Top Performers.

The concurrent sessions were divided into five categories. These were *Service Delivery; IEC/Advocacy/Social Mobilization; Resource Generation and Mobilization/ Research/MIS/Monitoring; Initiatives of Other Cooperating Agencies; and Special Session.*

The LPP Summit was designed as a "sharing" forum, as well as the venue for recognizing the LGUs' initiatives and creativity to improve their operations under a devolved set-up. The five concurrent sessions held on the first day of the Summit served as the "sharing" forum where the good practices were presented by their proponents, and the merits, problems and results were discussed with the participants. A workshop, "Next Steps: Making Things Happen," held the following day in five concurrent sessions, served as venues where participants were given the opportunity to examine and evaluate the possibilities of shared practices, and to find the most appropriate model or models that may be replicated in their areas. The primary objective of this sharing is to allow participating LGUs to learn from each others' experiences, and if feasible, to replicate or adapt *good practices* of other LGUs.

These workshops yielded several recommendations and insights calculated to improve health policies both at the national and local levels. These innovations may also provide new standards for health care delivery once these practices are proven to be effective and more efficient in addressing local health concerns/problems given available resources at the local level. The recommendations were the results of the discussions that revolved around three key questions asked of the panelists, such as:

- What advice would you give those who would like to be change agents in their LGUs and adopt your good practice?

- What assistance can you offer to those LGUs that would like to adopt your *good practice*?
- What would you suggest as ways of sustaining the sharing of *good practices* among LGUs over time?

The questions were meant to identify the responsibilities of *change agents*¹ in the LGU setting; to determine the factors that facilitate or hinder the introduction of new ideas and approaches; and to propose ways in which participants in these workshops can assist their counterparts in other LGUs to introduce and adapt good practices.

Based on the five workshop outputs which were presented during the main plenary session, the advise most appropriate for other LGUs to profit from, would be to maintain strong relations with their clients and stakeholders, to be persistent and demonstrative of their commitments, and to give due recognition to all involved in the development and implementation of innovations. The most practical forms of assistance mentioned by the participants include the need for technology transfer or sharing through documentation, the extension of on-site technical assistance, motivational talks, and site visits like Lakbay-Aral.

Suggestions that were offered for the greater sustainability of the program are the adoption of internet technology for easy access to LGUs' good practices and innovations, LGU-level summits, establishment of a "Good Practices University" and continuing education programs, and the integration of innovations into existing livelihood programs. For the goal to be achieved, funds, time, and effort should also be invested, and the LCEs' need to exercise political will and resolve to make things happen. It should also be noted, that for the practices to be truly effective, these should be culturally sensitive as well.

These elements may provide the proper mix for a good practice "recipe" or "menu."

An equally important component of the Summit was an exhibit that showcased the different good practices through photographs, display of information materials, and products from the LGUs. The exhibit is a most innovative strategy for the promotion and marketing of the different models of good practices brought together for the

¹ A change agent is someone who takes the lead in initiating a new idea, approach, or activity; gathers support for this innovation among influential people; works with supporters to develop a plan for change; and oversees the implementation of the change.

Summit. It provided the most creative, graphic and persuasive presentations of the replicable features of the good practices. There were photographs to show the strides and breakthroughs, products to validate claims of success, and information materials in print and videos that chronicle the achievements resulting from these practices.

Sixty-three innovative LGUs and 15 LPP Top Performers were recognized during a fitting ceremony that served as the highlight of the Summit. Health Secretary, Dr. Alberto G. Romualdez, Jr., was assisted by USAID-OPHN Chief Mr. P.E. Balakrishnan in presenting the awards. The list of awardees may be found in another section of this documentation.

Day 1 : January 25

- ∅ Opening Program**
- ∅ Program Updates**
- ∅ Concurrent Sessions**

LGU Performance Program (LPP) Summit
Opening Program
Westin Philippine Plaza
CCP Complex, Roxas Boulevard, Pasay City
Day 1 - January 25

The LGU Performance Program Summit was formally opened with an invocation led by Dr. Brenda Lopez, Program Manager - Reproductive Health, Department of Health (DOH), and the singing of the Philippine National Anthem.

I. Welcome Remarks
Dr. Susan Pineda-Mercado
Undersecretary, Office for Public Health Services, DOH

The LPP Summit, according to Undersecretary Mercado, represented the culmination of a series of activities undergone by the project, and was held purposefully to chart directions for the future. She enjoined the participants that, given the limited resources of the project and its LGU counterparts, the issues the Summit should look into are sustainability, the need to involve the private sector at the local level, and how to lower costs on the part of government.

The LPP, as expected, should expand toward emerging public health problems such as infectious disease control, tuberculosis, dengue fever, and malaria since current situations call for health care delivery innovations in these areas.

Other concerns would be getting non-government organizations (NGOs) and other sectors involved in health, to work in league with the LPP and its implementors. This also means re-energizing the Barangay Health Workers (BHWs), civic and people's organizations, as partners of the LGUs in their effort to improve health service delivery at the local level.

Undersecretary Mercado likewise informed the participants, that by mid-99, the DOH would launch "Project Cocoon," a re-engineering process designed to reconfigure health programs, strategies and processes, to be more responsive to LGUs. The intent is to put more money into the LPP, increase the base of national government and foreign resources, and prod partner agencies to come up with bigger budgets for health services.

Finally, she thanked the United States Agency for International Development (USAID) for its valuable assistance to the LPP.

II. Acknowledgment of Participants

Dr. Juan A. Perez, III

Director, Local Government Assistance and Monitoring Service, DOH

Dr. Juan A. Perez III acknowledged the delegates which included local chief executives led by governors, city and municipal mayors, board members and councilors; local health and population officers; other designates, and representatives from the DOH, the Commission on Population (POPCOM), the USAID and other cooperating agencies.

III. Message

Ms. Patricia Buckles

USAID Mission Director

Ms. Buckles expressed warm thanks for the experiences gained through LPP. An instance of strengthening partnerships among and between LGUs. Ms. Buckles noted that the Summit draws spirit from the 1998 National Health Assembly which sought to make health programs work effectively for people's health needs.

She also thanked governors and mayors for their time. The USAID 1998 Mid-Term Assessment showed that the LPP was the right program to fund at the right time. Clearly, it gave birth to innovations on the part of LCEs.

In her message, she noted that there are programs that are successful to a greater or lesser degree. She hoped that stronger LGUs would help out weaker ones as partners or twins. Partnership is necessary for development to improve the living conditions of the poor. In this sense, she said that the program is definitely in line with the pro-poor stand of the Estrada administration. She concluded that it rests on those involved to make decentralization work for the poor communities of the country.

IV. Message

Hon. Alberto Romualdez, Jr.

Secretary of Health

Secretary Romualdez reckoned that a lot of work was accomplished between 1992 to 1994 by the combined USAID, LPP and LGU team. But problems remain which could be remedied by talking to one another, capitalizing on the advice of those with

experience, and the support of national and international experts in the identification of sources of funds. By and large, accomplishments were made and activities are encouraged so that LGUs will have the opportunity to develop fully

Major challenges, according to Secretary Romualdez, continue to be faced. Devolution re-instituted the separation of hospital and public health services. Integration as a joint effort between levels of government indicates that LGUs should cooperate to facilitate the process.

Another problem he mentioned, is the imbalance between devolved functions and resources. A debate is ongoing between the Finance department and LCEs. It is hoped that issues will be resolved to identify direct sources of finance. There is a need to explore other financing options, he noted. He also hopes that the health insurance system and the fast tracking of its enactment into law would prove of assistance since it is complementary to the intents of the Local Government Code. Another form of address is the involvement of the private sector in health.

When he first stepped into office, the central issue was drug procurement. The DOH was neither supplying the kind or amount of medicines needed by the poor. To be credible, the DOH, according to Secretary Romualdez, should check the difficulties of accessing resources and ensuring availability. Hence, the priority given to these issues. LCEs are best urged to look at procurement and supply guidelines. He announced that the DOH would seek to purchase 30 percent more than the previous volume to enable LGUs to have steady supply and to conserve their pesos.

Tuberculosis control, meanwhile, is a good indicator of progress. It is not a problem with most developed countries. It is chronic and takes a longer time to treat but it remains solvable. It is now a departmental priority due to its association with poverty and in accordance with presidential directives. Having been a former LCE himself, President Estrada vowed to help the LGUs in their fight against the disease.

The Secretary announced that during his visit to La Union to mark the groundbreaking of the GAO Hospital, he was amazed at the overwhelming support shown by the community, which donated a four-hectare property for the facility in tandem with the European Union. It was a testimonial to the involvement of various levels of government and the people for common welfare. What is currently needed is enlightened local leadership and health workers. Local executives should make sure

that they take full advantage of technology and resources. He continues to be confident of strong international support.

He is aware of the problems still besetting certain LGU health personnel who have not received their benefits to this time as he continues to set up dialogues with local leaderships. Some difficulty may be encountered among lower class LGUs, and admittedly, no quick solutions are ready. However, the exercise of autonomy has shown that devolution works for both LGUs and the people.

He closed by congratulating all the participants to the Summit and saying that a blueprint should materialize for further development.

LGU Performance Program (LPP) Summit
Program Updates
Westin Philippine Plaza
CCP Complex, Roxas Boulevard, Pasay City
Day 1 – January 25

SUMMARY OF PRESENTATIONS

1. **Highlights of the National Demographic and Health Survey**
Dr. Elizabeth M. Go
Director, Household Statistics Department, National Statistics Office

The National Demographic and Health Survey (NDHS) serves as a basis for policy development and decision-making in population and health. Essentially, it provides baseline information on population trends and patterns. It assists the health department and implementors of population and health programs to determine levels of public awareness and availment of family planning (FP) and maternal and child health (MCH) services in order to evaluate the effectiveness of on-stream strategies for the improvement of these services. Funded by USAID and DOH, the NDHS, which started in 1968, is conducted every five years.

For the 1998 NDHS, 75 sample areas were covered including 13,708 households. Preliminary results showed that the country's Total Fertility Rate (TFR) from 1995 to 1997 is 3.7 children or four live births per woman of reproductive age. Childbirth peaks with women between 25 to 29 years of age, with most having up to two children by age 29, and up to five children by age 40.

The knowledge of FP in the Philippines is considered universal. Ninety-eight percent of the population knows of at least one contraceptive method. Seven out of 10 married women of reproductive age (MWRAs) have used available methods, to which the pill and bilateral tubal ligation (BTL) or female sterilization emerged as the most popular. The survey reports that 47 percent of MWRAs use a contraceptive method.

Historical developments showed that the Contraceptive Prevalence Rate (CPR) in the country increased three times since the late sixties to the current 47 percent in 1998, with usage highest among women in their thirties. The users acquired most of their FP supplies from government service outlets. Geographically, usage appears to be highest among populations in southern Mindanao provinces, and lowest in the Cordillera Administrative Region (CAR).

Non-users cited as reasons for their non-acceptance of FP their desire to have more children, fear of side effects from the use of the pill and other methods, and other health concerns.

**II. Emerging Trends in LPP Participating LGUs:
Summary Results of the Multi-Indicator Cluster Surveys**
Dr. Loreto B. Roquero, Jr.
Director, Family Planning Service - DOH

Dr. Loreto B. Roquero recalled that the enactment of the Local Government Code of 1991 signalled the devolution of health service delivery to local governments. With this development, the LPP was conceived to assist LGUs administer and manage devolved health facilities, personnel and functions. The Multi-Indicator Cluster Survey (MICS) conducted by the LPP was designed to provide population-based data, evaluate mechanisms for action, and assist local chief executives and their staff develop the necessary skills in research and monitoring activities.

The latest cluster survey covered a total of 46 LGUs and four focus areas, namely, Contraceptive Prevalence Rate (CPR), fully immunized children (FIC), tetanus toxoid immunization coverage (TT2+), and Vitamin A supplementation coverage. Three-part questionnaires were farmed out to gather information on family planning and child survival programs with the assistance of 29 local-based academic institutions. Each LGU allocated approximately P100,000 to P200,000 of its LPP grant for the conduct of the survey.

Among the LPP top performers, CPR ranged from a high of 75.5% in Iloilo City to a low of 47.5% in Surigao del Norte. The lowest CPR (11.8%) was recorded in ARMM. In terms of method mix, the pill enjoyed the highest popularity, particularly in Capiz. In the Cordilleras, female sterilization was the most preferred. In Bukidnon and Cagayan the Oro City, intra-uterine devices or IUDs were most widely used. About

82% of the users obtained their FP supplies from rural health units (RHUs) and health centers, whereas only 15.4% got these from private sources.

Davao City (93.6%) and Davao del Norte (93.3%) posted high records in the Expanded Program for Immunization (EPI). Majority of provinces in Regions 10 and 11 registered FIC coverage rates of over 80%. According to the survey, mothers were not able to have their children immunized because there were no other persons the mothers could rely upon to bring their kids to the centers, if they are unable to do so.

The province with the best TT2+ immunization coverage was Davao del Norte. The 15 LPP top performers showed good results of over 80% coverage. Some of the difficulties that were encountered pertained to fear of vaccine side effects, inadequate drug supply, and incomplete dosages for those who did not come to the service facilities regularly. Meanwhile, the top placer in Vitamin A supplementation was Davao City, which had a 97% coverage.

The MICS indicated that while the LPP had contributed significantly to the rise in CPR, some LGUs still lagged behind with ratings of below 50%. This shows that there is a need to focus assistance on these areas, e.g., in the conduct of technical reviews and useful exchanges.

Since the public sector appears to be the strongest supplier of drugs and supplies that ensure maternal health and child survival, it remains for government to attract more private sector institutions to participate in the program. On the part of public health facilities, the implementation of user-fees for greater sustainability should be considered. The reasons cited for non-contraception, particularly misconceptions regarding FP and fear of side effects, should not be laid aside. Proper counseling of health workers is still necessary. All these should serve as springboards from which to jumpstart assistance to low-performing LGUs and enable them to improve the quality of health services.

LGU implementors will have to ensure availability of supplies at the key service delivery points, improve staff communication skills in dealing with clients, and implement a supply inventory system.

To improve the overall nutrition scenario, consultations should be conducted regularly to be able to successfully implement needed interventions. National campaigns are needed in areas with lower coverage of Vitamin A. Moreover, efforts in food

fortification and dietary counseling should be intensified. Message-specific IEC materials should be developed to enjoin mothers to bring their children to health centers to avail of services.

❖ **Open Forum**

Moderator: Ms. Dyezebel Dado, DOH

An open forum was held after the first two presentations and discussed issues concerning the CPR, i.e., the reasons for the high CPR of most of the provinces compared to the national average, and the lower regional average in 1998 compared to that posted by the LPP-participating LGUs. On the issue of sustainability, an inquiry was made on whether the LPP funds can be used to assist the LGUs with small internal revenue allotments (IRA). The following is a summary of Dr. Roquero's response:

- The 46 LGUs enrolled in the LPP excelled due to the intensity of program focus and the availability of technical and financial resources
- The MICS results should not be viewed as competing nor conflicting data, but rather as a complementing tool in the assessment of LGU performance
- The LPP funds are not intended to replace the existing regular funds of LGUs. The LPP grant requires local counterpart funding. It is the responsibility of LGUs as implementors to source supplemental funds as part of their joint commitment with the DOH.

III. **Sustansya Para Sa Masa**

Adelisa C. Ramos
Director, Nutrition Service - DOH

The nutrition problem in the Philippines is nationwide, according to Director Ramos. It presents serious public health concerns: about one million schoolchildren still suffer from protein-energy malnutrition, while another two million are afflicted with iron-deficiency anemia. Twenty-one million Filipinos, counting adults, are affected by iron-deficiency anemia, which is also responsible for learning disabilities among some 60% of the child population. On the other hand, more than three million Filipino women are iodine-deficient.

The results of the National Nutrition Survey showed that in some areas, provincial and municipal strategies to combat nutritional deficiencies in women and children

need strengthening. While figures have been staggering, there is still hope that the problem could be prevented from worsening.

Interventions identified by the DOH include improvement of diet, food fortification, introduction of supplements, and public health measures such as birth spacing and parasite control. According to NSO statistics, nutritional interventions have reached only 70% coverage, and calls have been made for greater focus and consistency in approaches. To boost national efforts at their level, LGUs should adopt measures necessary to lower the morbidity and mortality rates among children.

Sustansya Para sa Masa (SPM), which was launched in July 1998, is the mechanism conceived to fight malnutrition. The greater heinous crime, according to proponents, is to neglect the interests of helpless infants and children. The program intends to make the Filipino child "*Malusog, Masaya at Matalino*." It aims to ensure nourishment of children during the first two years of their lives by zeroing in on women at high risk - those giving birth at very early and late ages, those with childbirth too closely spaced, those prone to prematurity, and those suffering from one or more nutritional deficiencies. The program hopes to enlist the participation of NGOs and other sectors.

SPM has seven action points, namely, 1) organization of a program task force; 2) organization of nutrition orientation workshops led by DOH resource speakers; 3) "Adopt a Community" program which can also take the form of a family; 4) identification of community human resources such as local nutritionists, dietitians and nutrition scholars, civic groups, and establishments, e.g., bakeries and food manufacturing companies; and 5) development of a one-year plan which includes Baby Watch activities, cooking classes for mothers patterned after the *DOH Mothercraft*, backyard gardening, iron deficiency control through the "cleaning by doing principle", feeding programs and Vitamin A supplementation to improve child IQ; 6) drafting of project proposals for funding; and 7) documentation of activities, conduct of sharing conferences, and compilation of success stories such as those done by Nueva Vizcaya and Agusan del Sur.

Director Ramos wrapped up with a quote from Undersecretary Susan Pineda-Mercado who said: "Good nutrition is the cheapest, easiest and most effective prevention for all types of diseases."

IV. Sentrong Sigla

Dr. Zenaida O. Ludovice

Assistant Secretary, Office for Standards and Regulation - DOH

An AV presentation on *Sentrong Sigla* was shown to the participants. Basically, *Sentrong Sigla* is a component of the DOH's overall Quality Assurance Program which aims to ensure the quality of public health services. It seeks to improve the capability of health centers (HCs) and Rural Health Units (RHUs) and to accredit and certify them as *Sentrong Sigla*, provided they meet basic standards in infrastructure, equipment, health personnel training, and drug supply.

HCs and RHUs in the localities can qualify to be a *Sentrong Sigla* with assistance from their local governments. LGUs should invest more funds to enable their units to meet the set criteria, conduct training activities to improve provider competence, and advocate with their community leaders for support.

Sentrong Sigla promises to benefit local chief executives in that they will be credited with giving preventive medical services to their constituents. This lessens the need for hospitalization, which can be very expensive. Deserving RHUs and HCs will receive the Seal of Excellence for posting at entry doors, the staff of the facility will wear the *Sentrong Sigla* pin, while the plaque goes to the LCE.

II. LPP Updates

Dr. Brenda D. Lopez

Program Manager for Reproductive Health, DOH

According to Dr. Lopez, there are reasons to believe that the LPP will go on if properly coordinated, just as strongly as it has gone on for the past five years. Over this time, mileage has been gained in efforts to increase the capability of LGU officials to manage and implement FP, child survival, and population development programs. To date, a total of 85 provinces and cities are enrolled and the number is expected to rise.

Future thrust is directed toward increasing program assistance to LGUs through several grant mechanisms. One mechanism is through the Base Grant that will be expanded nationwide. Presently, there are 13 new LGU entrants whose activities will be sustained through year 2000. The Top Performers Grant mechanism will continue to give recognition to outstanding LGUs. The Matching Grant, on the other hand,

aims to assist municipalities and component cities achieve maximum coverage and impact in various program areas.

Other activities in store are the promotion of *good practices* to include sharing and demonstrations/study tours, planning workshops, drug procurement, training and technical updates. Greater attention will be paid to establishing closer coordination and rapport among program implementors at the local level, and to the introduction of new technologies and innovations.

❖ **Open Forum**

Moderator: Ms. Dyezebel Dado, DOH

This open forum covers clarification of issues related to the preceding presentations. Similar questions were grouped together in the summary given below, for clarity and brevity. However, care was given that such summary is made in the context of the program(s) presented and discussed.

In relation to the Nutrition Program, the issue of funding was raised, or whether nutrition projects at the barangay level can tap LPP. The corresponding responses are summarized below.

- According to Dr. Rodriguez of MSH, inter-agency coordination and resource pooling are two strategies that may be explored. He also said that the Nutrition Program is one area that the Matching Grant Program could support in response to the query on how LPP funds may be tapped
- Director Ramos informed the assembly that there are ongoing activities to mobilize resources for nutripak-making. She also enjoined LGUs to avail of the matching grant to sustain efforts under the ongoing feeding program. With regard to the participation of other sectors, the DOH is in partnership with local manufacturers of nutripak.

Another important issue raised was how to access funds under the LPP. The following are the responses from the panel:

- The grants are meant to facilitate the transfer of responsibility to the LGUs
- The Matching Grant, according to Dr. Rodriguez, will be given based on the assumption that the base grant has already been awarded. The role of the province would be to support its municipalities. LGUs are encouraged to fully

implement the LPP programs and make an impact on the community. This allows them the opportunity to increase coverage instantly. The provinces, on the other hand, should freely allocate resources and provide technical support.

On the issue of sustainability, one point raised was that there is no specific recommendation on how to attract more NGOs and LGUs to the LPP or how to increase the current number of participants.

- What and who among the NGOs (to attract to the program) is still under study, according to Dr. Lopez. She continued that the DOH is shifting resources away from central office to the regions and districts. In the budget hearings, Congressman Macias presented a plan of support that shifts the budget from the DOH central to the regional offices. This is facilitative of the devolutionary process. Dr. Lopez clarified that NGOs are not yet the focus at this point.
- According to Dr. Roquero, LGUs should be able to sustain their projects in the long term, but that at this time, no direct answers can be provided yet.
- Dr. Juan Perez added that the wider participation of the private sector in LGU activities should be able to hasten full decentralization.

The issue on the how the provincial and municipal health offices could be made to work in harmonious tandem still remains, according to some of the participants.

- Dr. Cabugas related that in the case of Bukidnon, municipal health executives failed to function autonomously after the devolution. This problem was addressed when the Governor set the standards for the municipalities and gave them full autonomy to run their affairs, with the province providing only technical supervision. The Governor, however, ensured the implementation of all local projects. This set-up made it easy to pinpoint deficiencies in the municipal health system and avoided the fragmentation of services.
- Another observation made by Dr. Cabugas is that the provincial government should be able to make factual observation of activities at the field level such as that done by Governor Arnaiz of Negros Oriental.
- A participant from Pangasinan observed that devolution has moved from subordination to partnership in terms of provincial-municipal relations, particularly in Pangasinan. This development takes time to develop and

requires some effort from both partners. With regard to responsibilities, it was recommended that health managers should see to it that local policies are implemented at the municipal level.

Governor Amatoñg observed that one basic problem of the devolution of functions is the imbalance between devolved functions and available resources.

- Dr. Lopez suggested that in lieu of re-nationalization of health personnel, remedies to reinforce local autonomy should be sought. Accordingly, the DOH is undertaking a regional tour to obtain insights into the revival of the district health system, which will integrate hospitals with public health services. The referral system will be maintained to limit the use of hospitals and reserve income for maintenance and repairs.
- Dr. Lopez also revealed that starting 1999, the DOH would implement budgetary reforms. Up to 80% of the Maintenance and Other Operating Expenses (MOOE) will be transferred to the regional health offices for the implementation of programs that are responsive to local needs. Retained hospitals will receive only 20 - 30% of the budget for administrative purposes.
- Furthermore, by the year 2000, the DOH budget will be more responsive to and supportive of LGU programs and projects. It is hoped that everyone will bear with the problems of transition. The DOH Secretary has called for a reorganization of the DOH structure inclined toward the strengthening of regional health offices. This will involve the transfer of centrally-based personnel to the regions and districts, along with their plantilla positions.

It was also noted that out of 85 enrolled LGUs, only a handful of local executives are present at the Summit. Unless this mindset is changed, the LPP will not progress. The exercise of autonomy would be useless unless a mechanism to ensure attendance to such important conferences is made.

In summary, participants' consensus calls for a re-unification of efforts and the strengthening of partnerships between provincial and municipal governments. It is the initiative of the DOH at this time to implement devolution and effect the transfer of funds for devolved health services to LGUs.

LGU Performance Program (LPP) Summit
Concurrent Sessions
Sharing of Good Practices
Group 1: Service Delivery
Romblon/Mindoro Room
Day 1 - January 25

SUMMARY OF PRESENTATIONS

Six *good practices* under the Service Delivery category were presented to an audience composed of 50 MHOs and PHOs. These six initiatives share common characteristics such as creativity, innovation, and wise use of available local resources. They also underscore that improved health care can be delivered through low-cost projects for as long as they have the strong support of the community.

The *Mail Order Immunization in La Trinidad, Benguet*, aims at promoting EPI by sending letters to target households, not necessarily through the postal system, but through couriers and other community-based channels of communication. Dr. Dons Jovellanos presented a skit, and showed slides on how the practice has increased the level of awareness and established good rapport between BHWs and target parents on the importance of immunization. During the open forum, questions raised centered on the following: the percentage of actual responses, how couriers are tapped, the language used to write letters, and the possible effects of religious beliefs on the project.

The second practice, *Calamay Hati Nutripak-Making* presented by Dr. Ray Catague, aims at reducing the level of malnutrition in M'lang, Cotabato by using the appeal and taste of a local delicacy in the preparation of a nutrition-packed food supplement. A complete recipe was distributed, and actual taste test conducted, to support the benefits and merits discussed by Dr. Catague. Questions on the kind of ingredients, preparation, and storage procedures were raised during the Open Forum.

The third practice, the *Pirma Muna - Masterlisting of Newborns*, was presented by Dr. Mercy Chua, who cited the advantages of effecting not only an updated list of births, but also an increase in output of other health programs because of the practice. One question raised was on the percentage of accomplishment.

Dr. Bebina Casiño presented the fourth practice on the *Mobilization of BHWs as Program Coordinators*. She reported on the expanded functions of the BHWs and the positive results gained in tapping their capabilities. Issues raised in the forum include the absence of a regular salary for these BHWs, their allowances, and the rate of turnover of BHWs.

Ms. Luz Muego discussed the fifth practice, *Accessing VSS in a District Hospital*. She related how the program was able to increase referred VSS clients, offer quality services, and effect better coordination among key players. Questions raised centered on how the program was able to overcome Catholic resistance and how the cost-sharing scheme works.

Kalusugan Ko, Kalusugan ng Bayan was presented by Dr. Hamilcar Saniel of Bohol. He presented the San Miguel Infirmary and its unique services, and how its health assistance program has benefited the entire locality and its LGU. Questions raised were on the manpower staff and costs required building a local infirmary, the cost-sharing scheme and the occupancy rate of the infirmary.

I. MAIL-ORDER IMMUNIZATION : SENDING LETTERS TO PROMOTE EPI

Dr. Doris Jovellanos, MHO
La Trinidad, Benguet

❖ Highlights of the Presentation

Faced with the challenge brought about by low performance in the fight against preventable diseases such as measles, diphtheria, pertussis, tetanus, TB, hepatitis B and polio due to the resistance of the community, and inadequate health manpower who could barely provide services to their targets - frontline health care providers such as Public Health Nurses (PHNs) and the midwives intensified home visits and the conduct of information, education and communication campaigns to popularize EPI. From among the activities initiated by the nurses and midwives, such as public announcements and the posting of immunization schedules in community centers, the practice of sending personalized letters evolved as an even more effective method.

Initially, only a few midwives practiced sending personalized letters, as they found it difficult to look for "couriers". Further, most target areas are rural and difficult to reach because of bad roads. As an aftermath of the July 16, 1990 earthquake, a new awareness on the importance of health and well-being developed among the people. Amidst the growing concern for personal health, nurses, midwives, and other health personnel took advantage of this opportunity to promote and strengthen EPI and other health programs.

Taking the cue from their colleagues, almost all midwives eventually adopted the practice of sending letters to their clientele. Their accomplishment level increased, as they now have a wider and better coverage, and majority of the clients responded well.

Giving letters of invitation is a practice that produced good results, such as: 1) awareness on the importance of child immunization; 2) establishment of rapport between parents and health workers; 3) community awareness and participation in the promotion of child welfare; 4) accurate information on the date, time, and place for immunization were given directly to clients; 5) shared responsibility is fostered in both father and mother who are recipients of the letter, and 6) community mobilization is established and people empowerment is fostered with the participation of community resources such as jeepney drivers and neighbors.

Before success was finally achieved, several improvements had to be made, such as: 1) mass production of invitation letter forms; 2) update and review of the TCL and birth registries; 3) better gender-sensitivity; and 4) institutionalized process of sending letters.

Through the practice, the Fully Immunized Child (FIC) accomplishment index improved from a low of 64% in 1987, to a high of 106.3% in 1997. The increase in FIC coverage was achieved because even dropouts and defaulters rejoined and were influenced through letters. Majority of those who responded arrived during the scheduled date, and almost all members of the community participated in the effort.

❖ **Open Forum**

Moderator: Dr. Gerardito Cruz

Inquiries were made and discussed regarding such matters as 1) number of letters sent and lost, number of clients who didn't respond to one letter, the percentage of those who came for immunization as a result of the letter, and the use of the postal system in the project; 2) use of the strategy to follow-up other programs; 3) other means used to contact clients and how BHWs are utilized in the program; and 4) the language of communication.

- To the first set of questions, the presenter replied that the program has not made any actual count of letters delivered, not delivered, or lost along the way. The effectiveness of the strategy is measured based on the increase in number of participating clients and the increase in the number of fully-immunized children. The response to the letters has been generally good and when there is no response, the midwife makes personal visit to the client. The postal system is rarely used in the project since it relies mostly on volunteer couriers such as BHWs, the midwives themselves, drivers, neighbors, sari-sari stores, and others.
- The use of follow-up letters is gradually being expanded to include other programs.
- The BHW remains as the number one courier of the letters. BHWs are very effective since they are familiar with the program.
- The language used in the letter is English, which is an accepted language in the Trinidad Valley where people are familiar and conversant in the language, having been educated mostly by English-speaking foreign missionaries.

- Religious beliefs have always been known to influence acceptance of certain health programs, including immunization. Whether the letters have any influence on their acceptance or resistance of the program has not yet been determined. Those who do not respond at all are visited personally by the midwife.

II. CALAMAY HATI NUTRIPAK-MAKING

Dr. Ray Catague, Acting PHO
North Cotabato

❖ **Highlights of the Presentation**

Dr. Ray Catague recalled that malnutrition was a problem in M'lang, Cotabato in 1994. Although the food supplement nutripak was available, it was unacceptable to clients. To address this problem, the nutripak was made more palatable and acceptable by using a modified recipe of Calamay Hati¹, a popular delicacy in Iloilo and Negros, to appeal to the taste of clients.

The idea was presented to the mayor, who approved of it and immediately gave P200 support for every cooking demonstration in every purok and barangay all over M'lang, Cotabato. Cooking demonstrations and taste tests showed that target clients and mothers prefer the Calamay Hati to *lugaw* because of its taste. It is also easier to prepare and the ingredients are available in local stores.

A significant decrease in the rate of 2nd and 3rd degree malnutrition in pre-school children (from 11.3% to 7.6%) was noted. Calamay Hati continues to gain popularity not only in M'lang but in four other municipalities that adopted the project under the Provincial Nutrition Committee.

To sustain the project, the following activities are done regularly: 1) quarterly growth monitoring and submission of reports; 2) seeking continued LGU support for augmentation of efforts; and 3) encouraging all mothers to use and promote Calamay Hati style of cooking nutripak.

❖ **Open Forum**

Moderator: Dr. Gerardito Cruz

The participants to the workshop gave the product (Calamay Hati) a good rating, noting its sweet taste that appeals to children especially. One participant mentioned

¹ The recipe for Calamay Hati was made available at the exhibit booth during the Summit. Samples of the product were also made available and visitors to the exhibit were encouraged to taste the product.

that she would recommend the project for immediate replication in Region 5. Among other things discussed were the shelf life of the product and its appearance, recipe, and where and who prepares it. The following is a summary of the discussion:

- The Calamay Hati looks exactly like a regular Calamay Hati. The difference is that in the Visayas, it is stickier because it uses sticky rice or malagkit. The recipe remained loyal to the nutripak, maintaining the rice, dilis and sesame seeds for flavoring, with addition of the monggo and brown sugar. The Calamay Hati has the same consistency, color and taste as the regular Visayan delicacy. When refrigerated, it can stay fresh for two to three weeks, otherwise, it can only last for two days. Ground dilis and rice should be stored in bottles and placed in a cool, dry place. Mothers are advised to cook only what can be immediately consumed since Calamay Hati is basically for supplemental feeding, as it provides only 1/4 of the recommended dietary allowance (RDA) for calories of children.
- Initially, the Municipal Nutrition Committee prepared the Calamay Hati for the mothers as part of their household classes, after which samples of ingredients are given them to be cooked at home. When the samples were consumed, the mothers started buying the ingredients themselves. Each child under the program is monitored every three months to determine the effectiveness of the nutripak in terms of weight increase of the child.
- One grinder is available at each municipality for the use of mothers in preparing the ingredients.

III. PIRMA MUNA: MASTERLISTING OF NEWBORNS

Dr. Mercy Chua, MHO
Daraga, Albay

❖ Highlights of the Presentation

Pirma Muna - Masterlisting of Newborns was conceptualized to improve the efficiency of the procedure of birth registration and the masterlisting of newborns. Before *Pirma Muna*, the health center suffered from inadequate masterlisting, reporting, and recording of newborns, thus, adversely affecting the Maternal Health Care program.

An intervention mechanism was identified and presented to the Local Civil Registrar to make it official and binding. The LCR issued a memorandum obliging all hillots or traditional birth attendants to inform their midwife of the birth and to get her signature before registering the birth. This practice allows the midwife to enter such birth in the masterlist and birth registry.

The innovative practice resulted in better and updated masterlisting of newborns, and adequate reporting and recording of births, as evidenced by an increased coverage for EPI which is currently greater than the targets that have been maintained throughout the years. Subsequently, there has been a significant increase in the output of other health programs, especially MCH.

❖ **Open Forum**

Moderator: Dr. Gerardito Cruz

One question was raised concerning the more than 100% (110% and 103%) increase in EPI accomplishment.

- The steady over-the-target accomplishment was achieved through the *Pirma Muna* innovation that allowed for the 100% masterlisting and registration of all newborns.

IV. MOBILIZATION OF BHWs AS PROGRAM COORDINATORS

Dr. Bebina Casiño, PHO
Misamis Oriental

❖ **Highlights of the Presentation**

In 1990, the Provincial Health Office of Misamis Oriental mobilized its Barangay Health Workers (BHWs) as Program Coordinators. The strategy employed to reduce the mortality rates due to the three leading causes of death (tuberculosis, pneumonia and diarrheal diseases) in the province was to utilize the active BHWs as coordinators of NTP, CDD and CARI. This was also intended to lighten the workload of rural health midwives, who are responsible for the delivery of all health programs at the grassroots level. In Misamis Oriental, one midwife covers one or two barangays as catchment area.

In order to achieve this, the BHWs were given proper training in their chosen programs. They became not only generalists, but also specialists in their particular program, and are referred to as the "little midwives" in their respective barangays.

The BHWs were assigned general and specific functions and responsibilities, the latter pertaining mainly to their functions as program coordinators, e.g., NTP, CARI, CDD, and others.

With the mobilization of BHWs as program coordinators, the rural health midwife has been charged with the monitoring, supervision and evaluation of the BHW Program Coordinators as to their effectiveness in the implementation of the program.

This special project was pilot-tested initially in four municipalities, namely, Claveria, Balingasag, Hasaang and Talisayan, which had high mortality rates. In 1993, the coverage area was expanded to include five more municipalities in the western part of Misamis Oriental. In early 1996, all 24 municipalities of Misamis Oriental including the city of Gingoog were covered by the project. Other programs were also included in the project, resulting in more comprehensive coverage.

After two years of implementation, an evaluation of the BHW program coordinators' accomplishments in NTP showed that there was an increase in the number of symptomatic patients identified. Also, there was a significant increase in sputum collection. In CDD, the number of clients motivated to construct toilets increased. So did the number of clients given ORESOL. For CARI, there was an increase in the number of referrals of pneumonia cases to hospitals and RHUs. For the health education function, more clients were motivated to attend the Purok Household Classes.

Other significant results of the project include the following:

- There was no increase in the mortality rate due to tuberculosis for the period 1993 - 1997 despite the inadequate supply of anti-TB drugs. In fact, it started to decline between 1996 to 1997.
- Infant mortality rate due to pneumonia also started to decline during the period 1996-1997.
- Infant mortality rate due to diarrhea also significantly declined in 1996-1997.

The results of the study showed that the mobilization of BHWs as program coordinators for the CDD, NTP and CARI programs greatly contributed to the reduction in mortality rates. Because of the proven effectiveness of the BHWs in assisting rural health midwives, the Provincial Health Office decided to add five more programs with BHWs as coordinators. These are Nutrition, Maternal and Child Care, Family Planning, Expanded Program on Immunization and Environmental Sanitation.

❖ **Open Forum**

Moderator: Dr. Gerardito Cruz

The points raised during the discussion include the following: 1) remuneration of the BHWs and how their level of motivation is sustained; 2) who plans the project; 3) attrition rate over time; and 4) the ratio of midwife to population. The following is a summary of the presenter's response:

- BHWs, being volunteer health workers, are not given monthly honorarium. The province only gives P400/BHW once a year before Christmas. Last year, they received P600 from the DOH. The high level of motivation of BHWs is sustained through non-monetary incentives, such as regular refresher courses to upgrade their skills after which they are given Certificates of Training, community recognition, free uniforms like T-shirts and, sometimes, umbrellas.
- The PHO does the planning for the project. The BHWs are called to meetings during implementation, with the midwives doing the follow-up.
- There are only four BHWs for every 1,000 population. Some municipalities have fewer BHWs, in which case, one BHW may handle two to three programs.
- When the project started, there were only 250 volunteers; at present, there are 2,537. A small percentage is no longer with the project due to death, transfer of residence, or old age. When some volunteers leave the unit, either their children or relatives replace them. The program has no record of the percentage of BHWs who have left for one reason or another, something that the program may have to look into.
- Before devolution, the ratio of 1 midwife to 5,000 population was common in most units, a ratio that was questioned by Misamis Oriental. With devolution, some midwives have only 700+ population due to employment of more casuals by the LGU who are eventually assigned in barangays. There are now municipalities where all barangays have a midwife, thus, making the issue of understaffing no longer a problem in most municipalities. Understaffed municipalities, on the other hand, are covered by BHWs.

V. ACCESSING VSS SERVICES IN A DISTRICT HOSPITAL SETTING: THE URDANETA DISTRICT HOSPITAL EXPERIENCE

Ms. Luz Muego, PPO
Pangasinan

❖ Highlights of the Presentation

Ms. Luz Muego discussed the fifth practice, *Accessing VSS in a District Hospital*, and related how the program was able to increase referred VSS clients; offer quality services; and effect better coordination among key players.

The Urdaneta District Hospital (UDH) or Don Amadeo Perez, Sr. Memorial Hospital in Urdaneta City became a forerunner of the population/family planning program by providing health and family planning services. The services include a broad range of modern family planning methods such as voluntary surgical sterilization or VSS. Bilateral tubal ligation was also made available five days a week prior to devolution.

Following devolution, the supportive outreach network ceased to function in 1987 till 1992. Consequently, the FP program in the province weakened and client referrals for VSS to hospitals declined. Program subsidies for VSS stopped and the limited hospital budgets were earmarked for priority services that excluded FP. To regain lost ground in FP in 1992, the provincial government reactivated the Provincial Population Office through an administrative order that paved the way for a pilot project that expanded access to VSS in the devolved district hospital. The project gained support from the DOH and the AVSC International.

With the full support of the provincial government, DOH, and AVSC International, the project was able to accomplish the following: 1) improved the hospital operating room facilities for VSS; 2) improved the capability of hospital staff for VSS; 3) provided community organizing and mobilization support; and 4) program management support. All of these interventions were calculated to increase the number of VSS clients; improve the standards of services; and expand area coverage, among others. Within three years, the project was able to achieve these objectives.

❖ Open Forum

Moderator: Dr. Gerardo Cruz

Questions were raised on how the program was able to overcome Catholic resistance to sterilization, and how the cost-sharing scheme works. The presenter made the following responses:

- The initial reaction of the church was one of dissociation, and not of association. Recently, the FP program was presented to church representatives during a Kapihan sa Kumbento, as a program working towards improving the quality of the family, which is also their concern. The dialogue and advocacy continues.
- Initially, donations were accepted but these couldn't be accounted for. To ensure that funds go to the hospital, payments have since been covered with receipts. The collected amount goes to a trust fund for family planning.
- The client shoulders part of the service according to one's capacity to pay. If the total procedure is P1,500, the client only shells out P300. Indigent patients need not pay for services. Under such arrangement, the hospital, which is supported by the PHO, actually shoulders P1,200. That is how the cost-sharing scheme works.

VI. KALUSUGAN KO, KALUSUGAN NG BAYAN: THE SAN MIGUEL INFIRMARY AND HEALTH ASSISTANCE

Dr. Hamilcar Saniel, MHO
San Miguel, Bohol

❖ Highlights of the Presentation

"Kalusugan Ko, Kalusugan ng Bayan" is a model on how an isolated fifth class municipality was able to establish a hospital and install mechanism to sustain its operations.

The health program has three components: 1) the San Miguel Municipal Infirmary sub-program, which delivers primary hospital services, 2) Health Assistance sub-program, and 3) information dissemination sub-program.

The infirmary was established through a resolution passed by the Sangguniang Bayan in 1994. Its main objective is to provide affordable and accessible hospital services in the municipality. A vacant government building was transformed into an infirmary through combined fund-raising activities of the LGU officials and the Municipal Health Office. Donations from residents as well as financial help from the District Representative also helped purchase basic and necessary supplies and equipment.

The San Miguel Infirmary provides hospital services to children, uncomplicated adult patients, pregnant women as well as newborn babies. Surgical and more complicated cases are referred to more advanced hospitals.

To cut the operating expenses of the infirmary, innovative measures were introduced, such as the following:

1. Meals are not provided since families of patients can cook their own meals in the infirmary kitchen;
2. Instead of paid janitors, Barangay Health Workers (BHWs) do housekeeping chores;
3. Patients bring their own linens.

The municipality maintains the hospital through fees generated from the medical services of the Rural Health Clinic and the infirmary. During the first quarter of 1998, the DOH granted the infirmary its license to operate as a Primary-Level General Hospital.

To help local residents avail of hospital services, the second component of the program; the Health Assistance sub-program was also implemented in all barangays to provide loans to patients. Seed money, held in trust by the Barangay Treasurer, is generated from contributions of Fifty Pesos per household. Payment of contribution entitles its members to borrow money from the program when hospitalized in accordance with a loan policy adopted by all barangays in San Miguel.

An intensive information dissemination program is the third program component. The program informs people of hospital services and other health programs. Information is disseminated through government action caravans, barangay assemblies, as well as seminars in all barangays of the municipality. These activities are very important to ensure acceptance of the payment scheme for medical services. It is also a tool to monitor feedback on services rendered.

From 1994 to the present, the program has accomplished the following:

- Local residents, as well as patients from neighboring municipalities, have availed of the services of the hospital.

- The infirmary manages simple and uncomplicated cases only. Patients are screened before they are referred to higher-level hospitals. Only those who really need to be referred are sent to secondary and tertiary hospitals.
- Costly out-of-town hospitalization is avoided when patients from the municipality are admitted to the infirmary for treatment. Surveys have shown significant savings on the part of patients' families.

The program has also benefited the regular health programs in terms of better implementation, good monitoring, and increased awareness of health programs at the community level.

The Municipal Health Office and the local government are confident that the program will be sustained because of the following reasons:

- Health is a basic service that transcends political affiliations. Ironically, people who have campaigned against this program during the last two elections had themselves been admitted to the infirmary after the elections.
- The infirmary has its own staff distinct from the staff of the Municipal Health Office.
- All fees have undergone public hearing and have been approved by the Sangguniang Bayan.
- The modern medical equipment constitutes expensive investments that need to be maintained by the municipality. Fees from the laboratory procedures generate income for the municipality.
- People have already benefited from the program. Discontinuing such services will leave a negative mark on the performance record of the incumbent administration.
- Sickness in a small rural community does not affect the individual patient or his family alone. The entire community is affected, especially if help is sought from elected officials or from the line agencies.
- The San Miguel Infirmary and Health Assistance Program underscores the fact that health should be the concern of all and not only of the health providers.

❖ **Open Forum**

Moderator: Dr. Gerardito Cruz

The following features of the program were discussed: 1) clarification on the availment of loan from the Health Assistance sub-program and the percentage that an individual pays for services, 2) medical staff complement of the infirmary, 3) annual income, and 4) occupancy rate.

- Under the program, the municipality does not provide capital for the loan; rather, it is generated through contributions from the community. Under the scheme, a household is encouraged to contribute P50.00 as membership fee. This money is placed in trust with the Barangay Treasurer. If a person from a member family is hospitalized, a note is requested from either the nurse or midwife certifying that this patient is in this hospital. This note is sent to the Treasurer, and anywhere from P500 - P1,000 is made available to the patient, which can be paid over a period of two months without interest. From the third month onwards, a corresponding interest is already charged. A co-maker is required for every loan. This arrangement was resorted to in order to avoid the experience under the Botika sa Barangay project where medicines procured through loans were not repaid on the members' belief that the money that put up the Botika came from the government.
- At present, the infirmary has five nursing staff, one medical technologist, one hospital ambulance driver, and one security aide. Visiting physicians are on rotation 16 days a month. The MHO serves in the remaining 14 days. This arrangement does not ensure 24-hour service since the budget of P16,000 covers only the 16-day service of visiting physicians. Since all the tariffs are paid to the Municipal Treasurer's Office, the infirmary has no clerks or cashiers. Aside from the MHO who serves as volunteer, the residents of government hospitals also render service at the infirmary, to the point that the hospital chief faced charges from the Ombudsman on the grounds that two or three residents were doing service at the hospital. This incident has already been settled, since the provincial governor himself authorized these doctors to render service in the infirmary. Among the three visiting physicians, two are residents of the district hospital, while one is a private practitioner. Since San Miguel is an isolated area surrounded by mountains, it takes about an hour to wait for a public utility vehicle and another hour to transport the victim to the nearest district hospital. With the success of the infirmary, a physician with excellent diagnostic facilities at Tagbilaran City has put up her x-ray facilities in

San Miguel under an arrangement wherein the municipality provides a room for the machine, while the owner of the x-ray machine pays for the technician, and the electricity consumed. Ten percent of the revenue goes to the municipality.

- The operating expenses of the hospital per month total about P40,000 of which P16,000 goes to the doctors. The nurses are casual employees. In one year, the operating expenses reach anywhere from P500,000 - P600,000. The various fees generated by the MHO help defray some of the expenses. Since no patient is treated for free, the funds generated by the infirmary is now held by the municipality as a trust fund to cover its expenses. The municipality puts in P60,000 - P80,000 per annum, which is far outweighed by the benefits and advantages of having a hospital within the municipality.
- Occupancy rate is from 3-5 patients per day. The operating expenses per month approximate about P40,000. An average occupancy of 3-5 patients per day, paying P400-P500 per confinement, assures a break-even operation, since there are no meals, no medicines, no janitors, no linens, and no clerical staff to spend for.

LGU Performance Program (LPP) Summit
Concurrent Sessions
Sharing of Good Practices
Group II: IEC/Advocacy/Social Mobilization
Mindanao Room
Day 1 – January 25

SUMMARY OF PRESENTATIONS

A session on *Information Education Communication/ Advocacy/Social Mobilization* was held at the Mindanao Room and was participated in by more than 50 MHOs and PHOs. The idea behind the workshop is to encourage an exchange of innovative practices among the participants for possible adoption or replication on their own IEC/Advocacy/Social Mobilization programs. Eight selected LGU representatives presented and discussed key features of their *good practices*. Most presentations were done through audio-visual (AV) and video formats, colorful and imaginative slides, which everyone knows, are the stock-in-trade of IEC practitioners to make communicating, both an educational and entertaining experience. Recommendations, comments, questions, and other issues were raised during the open forum after each presentation.

Mobilization of Satisfied Users as FP Motivators was presented using slides that illustrate the involvement of the satisfied users of FP in client motivation. The satisfied users were organized and trained not only as good motivators, but as FP counselors as well.

Dr. Tahir Sulaik discussed *Peddlers of Influence: The Health Advocating Ulamas* in Maguindanao, a culturally sensitive strategy on how male Muslim religious leaders or *ulamas* are utilized as FP program advocates in a predominantly Muslim province. Questions on the aspects of cultural differences, religious beliefs and values, and gender sensitivity were raised during the open forum.

The third practice presented was the *100% Achievers Club* of Bataan which was conceptualized for the KOP (Knockout Polio) activities of the DOH. The program includes interaction between the devolved health personnel and technical staff, provision of technical support to low-performing municipalities, "adopt-a-municipality"

approach, and other strategies to boost the morale and spirit of the devolved health unit personnel. During the open forum, questions on the program's impact on the community, effect of salary standardization, coordination with the LCEs, motivation of staff, sustainability of the club, and financial support were raised.

Health Scouts: Child to Child Approach of Bontoc, Mt. Province is a program on empowering children and youth to be active partners in health promotion through the conduct of health care courses in schools. The idea is for the older children to learn basic health care skills that they may in turn teach younger children. Clarifications on issues related to the formation of values and the skills of the children, use of measurable indicators, adoption of the program by DECS or the health sector, and ownership of the program were raised during the open forum. A suggestion to incorporate the lessons in the DECS curriculum through a MOA was also made.

The fifth practice was the *Pahayagang Bato*, a structure made of stone erected in strategic locations along the entrance to the Marikina River Park (MRP) and resettlement sites where health messages may be posted on both sides, including announcement of health activities in the MRP. A slide presentation and a skit emphasizing the effectiveness, durability, and low maintenance cost of the *Pahayagan* were shown. A question on why *Pahayagang Bato* was chosen instead of *pahayagang puno* or plywood was raised during the discussion of the project.

A video presentation of an actual stage performance of *Ang Pamilyang Nagpasagad*, a short play that depicts the travails of a poor, ignorant, and irresponsible couple was shown. The short play provides information, and creates awareness on, and appreciation for the various health programs, particularly immunization, FP, and MCH. The performance is always scheduled during special occasions and festivities to take advantage of huge audience turnout.

Organization and Mobilization of FP-IEC Core Team is part of a strengthening strategy of the PFPP-IEC component in Davao City. Each team of health volunteers from selected barangays was trained on interpersonal communication skills to become effective at providing information on FP and other health programs. The positive outcome of the project is the significant increase in CPR. The team is strengthened by the partnership between health workers and local government officials.

The eighth practice, the *Bukidnon BSPO Federation, Inc.: The Vital Link* illustrates how a group of volunteers banded together to form a federation to ensure the

sustainability of the project. The presentation also highlighted the efforts of the BSPOs to support their activities for the population management program and other health-related activities, through various income-generating projects.

This particular session stands out for the wide variety of innovative and creative information dissemination and communication strategies utilized by the proponents. Such models presented went beyond the use of traditional medium such as print materials, e.g., brochures, leaflets, and other similar reading materials. Instead, the participants were provided with an array of innovative approaches and successful IEC models such as community theater, mobilization of stakeholders and influentials, and outdoor community billboards.

I. MOBILIZATION OF SATISFIED USERS AS FP MOTIVATORS

Dr. Melba Billones, MHO
Anini-y, Antique

❖ Highlights of the Presentation

Tutok FP was conceived to address the low CPR (11.9% in 1991, 28.9% in 1994) of the municipality. When the town became the preceptor area for a practicum on Basic Comprehensive Training for Antique, fully equipped facilities and supplies were provided by the LGU, and health providers were trained. The RHU staff continuously reviewed possible FP clients on the masterlist, and high-risk ones were identified and tagged. They render intensive personalized information dissemination and FP services even at the onset of the first pre-natal check-up to postpartum visits. FP services, like IUD insertion, are provided either at the clinic or at home after making sure that the equipment is sterile.

Clients who were given personalized quality service and priority consideration during check-ups and re-supply became continuing users, and eventually satisfied FP users. Holistic focus is given to the client and other members of the family. Health providers are available in the clinic to counteract and correct rumors and misconceptions. With these, satisfied users become motivators. In 1995, a steady stream of walk-in clients were referred, or accompanied and motivated, by the satisfied user. Testimonies were heard, minor complaints discussed, reinforced, and clarified by the RHU staff during barangay visits. Implementation of non-FP programs like breastfeeding, immunization, and nutrition became easy.

A satisfied user and FP motivator enjoys some benefits. When satisfied users become BHWs, they are given honorarium from the IRA of the barangay. Some become members of community-based livelihood projects assisted by the UNFPA and are acknowledged by the RHU staff during barangay visits. They are also included in the annual Christmas Party of the RHU.

As a result of the motivation of satisfied users in the barangay, and the quality service rendered by the RHU staff, a marked increase in CPR was noted in 1997 to around 47 per 1000 MCRA's and a decrease in fertility rate of around 30%, as shown by the decrease in the number of live births.

❖ **Open Forum**
Moderator: Dr. Josefina Cabigon

Two questions were raised: one, on whether the users are organized (as in a group), and two, why users are mostly women. A participant in the audience reminded the presenter that breastfeeding, MCH, and nutrition are DOH programs and should be referred to as such.

- The satisfied users are not organized, but some have become BHWs and are given honorarium from the barangay IRA.
- There are more women users and satisfied motivators since the 30% male acceptors are using condoms and seldom come to the RHU to ask for supplies. There is a plan to use them as motivators in the future.

II. THE PEDDLERS OF INFLUENCE: THE HEALTH-ADVOCATING ULAMAS
Dr. Tahir Sulaik, PHO
Maguindanao

❖ **Highlights of the Presentation**

Males are the decision-makers in the predominantly Muslim Maguindanao society, and most of them regard an abundance of children as a blessing. However, economic realities cannot sustain the well being of big families - resulting in mothers and children dying of conditions, which are preventable.

To improve reproductive health (RH) in the province, the strategy of using *ulamas* (male Muslim religious leaders) as health advocates is tailored to suit the patriarchal nature of Muslims while, at the same time, improving reproductive health in the province. It also reflects the cultural importance accorded to males in the society.

To involve the *ulamas* in the promotion of FP and reproductive health program, the PHO conducted several advocacy meetings with the provincial core group of *ulamas*; exposed them to similar projects in foreign Muslim countries; and facilitated attendance in seminars. The experiences of *ulamas* in other countries were also used as models; Islamic position papers on FP and RH were translated into local dialects; and copies provided to the local *ulamas*. The core group of *ulamas* continues to reach out to other local Islamic groups and NGOs, and has launched

sustained information dissemination campaigns in mosques during religious caravans, including radio programs.

The strategy resulted in the formation of a provincial core group of five senior *ulamas* who have re-echoed to 20 other local counterparts their own experiences and motivations. Five other Muslim religious organizations have shown interest in promoting the program and the ongoing information campaign is showing positive results.

This local initiative has contributed to the significant increase in the use of injectible contraceptives among FP clients. Local *ulamas* that had initially shown some reservations about FP in relation to Islam belief have changed their point of view.

❖ **Open Forum**

Moderator: Dr. Josefina Cabigon

A question related to gender sensitivity among Muslims was raised. The extent and acceptability among the Muslim population of contraceptives focusing on males, such as condom and vasectomy, were also discussed. An observation that those FP methods are more acceptable among females than males was also made.

- Dr. Sulaik responded that the trend in Maguindanao is to move away from temporary methods (condom) by encouraging users after thorough counseling - to accept the more permanent methods. In deference to certain cultural or religious idiosyncrasies, health personnel refrain from mentioning condom, although there are acceptors of condom. In the same manner, the use of condom is not actively encouraged.
- It has been observed recently, that women acceptors have increased in number and that FP practice is gaining acceptance among Muslims.

The UNFPA participant mentioned that they have a training module for *ulamas*, which has been endorsed by the ARMM Secretary of Health, and inquired whether the PHO is already using this, and if it has reached the other *ulamas*.

- According to Dr. Sulaik, nothing has been endorsed to their level yet, and no funding has reached them up to this time.

Dr. Sulaik was asked whether the program has encountered any obstacle, and if yes, how these were solved.

- Dr. Sulaik replied that they were also faced with problems similar to those encountered by other health providers. The only difference is that they have to confront as well, the tip of the arnalites whenever FP issues are discussed. In spite of the danger, Dr. Sulaik continued that they never gave up, but used the challenge to discover more innovative strategies that would help overcome uncertainties with regard to the program. The result is what has developed as the wise partnership with *ulamas* that have become major stakeholders in the implementation of the program. Nowadays, advocacy is no longer the sole duty of the health personnel of Maguindanao, but is equally the concern of the health-advocating *ulamas*. The *ulamas* conduct religious and information caravans on health programs from one municipality to the other.
- So far, there are no insurmountable obstacles despite the non-receipt of funds intended for IEC. The *ulamas* are still continuing their activities and have even spent their own money for the weekly radio program and related caravans.

An observation was made that the PHO is lucky to have the *ulamas* as advocates, considering certain religious beliefs against contraception. In which case, the presenter was asked how he was able to transcend such obstacle, so that others may use it to duplicate the advocacy model, given a similar situation.

- Dr. Sulaik shared that they discussed the risks through statistics showing newborn babies who will never reach their 1st birthday. Other equally disturbing statistics of mothers' death due to hemorrhage and the risks of closely spaced pregnancies were also used to illustrate the need for family planning. In Maguindanao, the Y group (male BHWs) assists the *ulamas*.
- On whether Christian leaders are also encouraged to join in the advocacy for FP, Dr. Sulaik replied that religion and religious affiliations are never discussed with the *ulamas*, rather, disturbing statistics (local statistics) remain the focus.

III. 100% ACHIEVERS CLUB

Dr. Jocelyn Cabarles, Chief of Technical Division - PHO
Bataan

❖ Highlights of the Presentation

The *100% Achievers Club* of Bataan began with the KOP (Knockout Polio) activities of the DOH. It was organized to boost the morale of devolved health workers and to

challenge them to achieve higher program accomplishments despite delays in the payment of salaries and lack of logistical support. Members include physicians, nurses, midwives in the RHU or at the barangay health station (BHS) who have achieved 100% coverage in two rounds of KOP. This is one of the innovative strategies that also include the following:

- Socialization activities among health personnel
- Provision of technical support to low-performing municipalities to enable them to achieve higher level of accomplishment
- "Adopt a Municipality" program
- Regular consultative meetings.

The benefits derived from these strategies translate to increased level of performance of health personnel. Other results include strong motivation to achieve targets, better health service to target clients and stronger bond among health personnel which results in better performance. These results also help cushion the effects of devolution, such as delayed salary, less benefits, and the demoralization among the ranks.

On the other hand, the members of the 100% Achievers Club received the following morale-boosting benefits:

- Tangible awards;
- Certificate of Commendation for good performance;
- A sense of belonging;
- The chance to go up the ladder of achievement;
- Enhanced skills that can be used in planning and exploring resources;
- Better relationship with devolved health unit;
- The chance to network with NGOs;
- Permanent recognition through the Wall of Fame where names of those who have achieved 5 years of excellent performance are inscribed; and
- Members are given priority for in-country observation tours and exchange grants to other countries.

❖ **Open Forum**
Moderator: Dr. Josefina Cabigon

Commendations and observations were made regarding the program. These include the use of win-win strategy by its proponents, which the participant from Sorsogon

hopes to replicate in the province. Another participant observed that the strategy is not new since it has been used in his area, but only for a year, and suggested that the strategy may be duplicated for FP program participant. Most of the questions raised were on the mechanics of the program, such as:

1. length of implementation of the program;
2. health programs covered by the club;
3. monitoring scheme to validate claimed achievements; and
4. manner of coordination and feedback mechanism between the LGUs and LCEs and between the PHO and MHOs.

Below is a summary of the response given by the presenter.

1. The program is the result of a brainstorming session among the technical staff on how to boost the morale of the devolved health personnel. After the program was conceptualized, its proponents lobbied for financial support. Through a Provincial Board Resolution, funds were allocated initially from the HES fund, thus, making available an additional source of funds aside from the regular budget.
2. The pilot or initial activity was focused not only on special immunization, Knockout Polio (KOP), but also included the routine immunization activity of the Expanded Program on Immunization. Since the concept is quite successful, there are already plans of including the nutrition program.
3. Reports were validated by evaluating the masterlist of children covered by immunization as a way of counterchecking what have been received by the PHO.
4. Since devolution, communications are channeled through the LCEs, such as the Mayor, including coordination for training, socialization activities, and consultative meetings. The socialization activities, which involve both the health workers and LCEs, provide opportunities for discussing the different health programs and generating feedback. Such activities also serve as venues where feedback is solicited from health workers and LCEs.

Regarding the impact of the program on the community, Dr. Cabarles informed the group that no measurable indicators have yet been developed that would determine the decrease in measles outbreak in the area.

Dr. Cabarles offered the following information on how the club is sustained; how the health workers are motivated to qualify as members of the club; and other strategies to make the club successful.

1. Health workers are motivated to become club members because of the challenge posed to them.
2. The feeling brought about by solid accomplishments is a strong morale-booster.
3. Being in the company of equally accomplished colleagues elevates ones self-esteem.
4. Tangible awards await successful achievers.
5. The prospect of having one's name inscribed in the "Wall of Fame" makes all participants strive to do their best.

IV. HEALTH SCOUTS: CHILD TO CHILD APPROACH

Dr. Penelope Domogo, MHO
Bontoc, Mt. Province

❖ Highlights of the Presentation

In traditional Igorot society, older children take the role of caregivers to their younger brothers and sisters because parents leave early for work in the farm and come home late at night. With primary health care, parents receive training from the MHO and BHWs. However, they do not always have the time to apply what they had been taught, especially in the care of their children. The Health Scouts (HS) Program was born in 1991 in response to this situation. The program empowers children and the youth to become partners in health. Under this program, older children should, in turn, teach other children.

The objectives of the program are for children to:

- Develop proper attitudes and practices, not only for health, but for life in general;
- Develop health skills appropriate to their age and culture to help care for the family, classmates and others;
- Provide opportunity for children and youth to articulate and gain deeper sense of self-worth and direction; and
- Develop a sense of group consciousness and commitment to community service.

To accomplish these objectives, several activities were completed that led to the implementation of the program in several schools. It started with meetings with school authorities for the acceptance of the program. A teacher-coordinator monitors the children's activities in school, including enrolment in the Health Scouts Program. Grade 4 pupils are encouraged to enroll voluntarily. The Program is open to both boys and girls, but parental consent is necessary.

Several strategies are used to implement the Program and make it successful. These include the following:

1. Basic health course of about 10-12 sessions is conducted for Grade 4 students for 40 minutes per session and contains basic messages essential to child survival. This course includes training to be healthy children (e.g., washing of hands), zero waste management, first aid, proper eating habits (e.g., avoiding junk food), and food preparation at home.
2. Advance health course (Phase I) for Grades 5 and 6 children teaches more complicated skills and introduces traditional medicine and practice of getting vital signs (BP).
3. Advance health courses (Phase II) for high school students promote adolescent health concerns, including sexuality and reproductive health.
4. Special training in the arts is made available to health scouts.
5. Health scouts are also given the chance to attend camps and interact with fellow health scouts in camp activities that enhance their skills.
6. Community exposure and outreach activities provide hands-on training to health scouts.
7. Educational trips provide opportunities for wider exposure that enriches learning experiences.
8. Teen's corner on local radio stations provides the medium for wider information dissemination and platform for health advocacy.

While the Program can already lay claim to significant success, it also had problems that include limited facilitating skills among MHO staff, the non-cooperation and lack of interest of school authorities, and dropouts from Health Scouts enrolment.

❖ **Open Forum**

Moderator: Dr. Josefina Cabigon

Foremost among the questions asked is how the children who are only in Grades 4 to 6 managed complicated fractures considering the level of their knowledge, attitudes, skills, experiences, and values.

- Dr. Domogo clarified that the Program starts with children whose values are still being formed, particularly the sense of responsibility and caring for their younger brothers and sisters when the adults are busy. The skills being taught are also appropriate for their age and capability. Dr. Domogo emphasized that children do not manage fractures, but are taught to do first aid, e.g., splinting which may have been misunderstood as managing complicated fractures.

The related questions on how the objectives were attained; the evaluation indicators used to measure success; and how these measurable indicators were used were also discussed. The following summarizes the response of Dr. Domogo:

- According to Dr. Domogo, there are no verifiable indicators yet to objectively measure the success of the Program. At the moment, anecdotal indicators are used which are not objectively measurable, nor easily verifiable. At present, there are plans to come up with measurable indicators.

The following information were given in response to the questions on the length of Health Scouts training, and on how many of those trained have remained functional:

- The basic course consists of 10 to a maximum of 12 sessions conducted on a staggered basis. The training starts in October and culminates in March, with fitting graduation ceremonies. Some Health Scouts previously trained are still with the program. Even after high school graduation, these Health Scouts maintain contact with the MHO.
- There is no MOA yet between the DECS and the MHO, but the governor has already suggested that if the Program were to expand province-wide, a MOA with the DECS Division Office needs to be signed.

One of the participants asked whether the teacher-coordinator takes part in the teaching.

- Dr. Domogo replied that the MHO does the teaching and some trained midwives handle simple classes so that they can do it in their barangay. According to Dr. Domogo, the MHO reinforces what the school system teaches in order to bridge the gap between what they know and what they practice.

Dr. Domogo was also asked whether the Health Scouts are also used for disease surveillance or whether they report illnesses that happen at home.

- Some Health Scouts report illness at home informally to their parents, to BHWs, or to the midwife. There are no formal report forms, but there is already a plan to develop simple health forms that may be used by the Health Scouts as report forms.

It was also recommended that the Program work things out with the Boy/Girl/Cub Scouts movement as a strategy for institutionalizing the practice within the educational system. In response to this suggestion, Dr. Domogo mentioned that in some schools, Health Scouts are also members of the scout movement.

V. PAHAYAGANG BATO

Dr. Roberto Antonio Rosadia, Assistant CHO
Marikina City

❖ Highlights of the Presentation

Pahayagang Bato is an original idea of Marikina Mayor Bayani Fernando and Mr. Jojo Pinga of the Parks Development Office. Originally, the concrete structure was only used to announce activities of the Marikina River Park (MRP). The first structures of *Pahayagang Bato* were placed in strategic locations along the entrance to MRP and resettlement sites. It measures 10 feet tall by 3 feet wide and 7 inches thick and constructed of durable materials. It costs about P20,000 to build one unit of the *Pahayagan*. It only requires soap and water for maintenance and an occasional fresh coat of paint.

The project is basically a community billboard. It was initially undertaken in response to the need to disseminate information on the different activities in the newly rehabilitated Marikina River Park (MRP). However, its potential as an effective medium to promote other government activities, as well, was realized by the City Health Office. Thus, *Pahayagang Bato* evolved as an effective vehicle for disseminating health information and schedules of health activities, such as immunization. This strategy has resulted in wider awareness of health programs in the community. It has also made health services more accessible to the community, through the regular information posted on the billboard. A slide presentation and a short skit showing the effectiveness, durability, and low maintenance cost of the *Pahayagan* were also shown.

❖ **Open Forum**
Moderator: Dr. Josefina Cabigon

The only question asked is why the billboard is made of concrete instead of wood or plywood.

- Dr. Rosadia's response was that wood or plywood also brings the same results, but concrete is more stable, would last longer, and is easily maintained.

VI. ANG PAMILYANG NAGPASAGAD
Ms. Genoveva Amantiad, PHN
Bacolod, Lanao del Norte

❖ **Highlights of the Presentation**

Ang Pamilyang Nagpasagad is an IEC strategy using theater, or the dramatization of the life of a family. A video presentation of selected episodes of actual stage performances was also shown for the benefit of the participants.

Theater as an information dissemination strategy, is not often used because of the long preparation involved in its production and the high degree of creative skills required from its proponent. Theater, however, is effective in putting across even several messages. Because of this quality, it is also an entertaining medium that elicits longer audience attention and better retention of information.

The play *Ang Pamilyang Nagpasagad* provides information about health programs and activities that promote healthy lifestyles by depicting the travails of a large poor family headed by irresponsible parents. This 20-minute play is staged during special occasions, like fiestas, assemblies, anniversaries, and launching of health activities.

The play is a self-help project. The community provides food during rehearsals and the LGU, through the municipal mayor, provides the transportation for the cast and crew of the play. Local talents from among the BHWs act the parts in the play. The creative production staff comes from the ranks of MHO employees, including the rural health physician. Through this drama presentation, a significant increase in the awareness and appreciation of health programs was noted. It also educates the community on the different health programs. The MHO conducts an open forum after the staging of the play. This is another innovation introduced by the proponent to get immediate feedback from the audience. Producing and staging the play also

promotes better and closer relationship or teamwork between the BHWs and health personnel in the health center.

❖ **Open Forum**
Moderator: Dr. Josefina Cabigon

There were no questions asked during the Open Forum.

VII. ORGANIZATION AND MOBILIZATION OF FP-IEC CORE TEAMS

Ms. Elma Albay, FP Coordinator - CHO
Davao City

❖ **Highlights of the Presentation**

One of the contributing factors to the success of the Davao City FP program is its strong communication component being implemented by the FP-IEC Core Teams. The core teams of health volunteers composed of BHWs, NGOs, and GO representatives were organized at the city and district levels as part of the strengthening of the PFPP-IEC component. Each team was trained on Interpersonal Communication Skills. One of the strongest features of the team is its strong community component. The project benefits as well from LGU support and JICA assistance. The teams are expected to provide coherent structure that will address the FP-IEC concerns of the LGU.

The project provides information regarding health risks of reproduction, available reproductive choices and the benefits of FP, providing the link between the community and service provider, and maintaining a strong referral system for services. Promotion of FP and other health programs is done through the conduct of household visits and health education classes.

Sixty barangay FP-IEC teams were organized for this project. The teams are composed of BHWs, NGOs and other GO representatives in the barangay. Other members include women's group representatives, SK members, barangay officials, and midwives.

Prior to the implementation of this practice, the proponent conducted meetings, orientation, and planning workshop attended by the members of the various teams. It was during the planning workshop that a plan of operation was developed including action plans for each barangay FP-IEC team. Selection of pilot barangays was based on the availability of at least five to ten active community volunteers.

The most significant result of this practice is the increase in CPR in the pilot areas.

- ❖ **Open Forum**
Moderator: Dr. Josefina Cabigon

There were no questions asked during the Open Forum.

VIII. BUKIDNON BSPO FEDERATION, INC.: THE VITAL LINK

Mr. Romeo Cardoza, PPO
Bukidnon

- ❖ **Highlights of the Presentation**

This project illustrates how a group of volunteers for the Population Management Program successfully organized themselves into a federation with the objective of providing the means for sustaining volunteer activities. This project started in 1990 through fund-raising activities. Over the years, the federation has raised over P1 million in cash and other assets.

Federation funds are used for their activities, such as putting up of data boards in the barangays, production of posters and other information materials, conduct of information dissemination campaigns, and management of the Couples Organization for Responsible Parenthood and the Concerned Youth for Population and Development. The federation members also perform other health-related activities such as MWRA masterlisting, referral of health cases, preparation of data boards, and other community service.

At present, confidence among members is high to the extent that they have become self-assured when assuming the basic functions of a population officer. The BSPO Federation has truly evolved as a vital link to the barangays in the implementation of PPMP in the province. At the same time, it sustains the basic needs of the program through membership fees, income-generating livelihood projects, raffles, hog dispersal and fattening, catering services, and cutflower project.

- ❖ **Open Forum**
Moderator: Dr. Josefina Cabigon

There were no questions asked during the Open Forum.

LGU Performance Program (LPP) Summit
Concurrent Sessions
Sharing of Good Practices
Group III: Resource Generation/Mobilization
Research/MIS/Monitoring
Sulu Room
Day 1 – January 25

SUMMARY OF PRESENTATIONS

Not having enough resources for devolved functions such as health service delivery is a common refrain among local government units. The imbalance between devolved functions and resources hounds the implementation of health programs to the detriment of service delivery particularly at the lower levels. Since the LGUs can not abdicate the responsibility, locally initiated strategies evolved and are resorted to, so as not to jeopardize health service delivery. Resources at the local level are generated and ingeniously utilized to augment meager budgets. Systems are configured to make services more effective and cost efficient. Data and information generated by research are utilized to improve health and family planning services. Skills and capabilities are enhanced or upgraded to meet the challenge of managing health care under a devolved set-up.

The six good practices presented and discussed in this workshop illustrate how the LGUs and their health units work out systems, interventions, and other ingenious and creative approaches to generate and mobilize resources at their level to maintain acceptable standards of health service delivery and sustain the implementation of priority health programs.

Fee for Health Services: An Alternative Scheme for Sustainability of Malaga, Davao del Sur was presented by Dr. Josie Lyn Java. It is a community-based health financing strategy. It follows a socialized scheme based on income level from the Social Reform Agenda Minimum Basic Needs (SRA -MBN) Family Profile Survey. There are four categories that range from families with higher than P50,000 annual income, who pay 100% of charges; to families having lower than P15,000 annual income who pay 25% of charges.

Parañaque developed a health information system that handles data from both public and private health facilities. The *Disease Surveillance System* as discussed by Dr. Dr. Nicolas Catindig, is essential in the early detection of disease outbreaks in this city south of Manila.

The devolution of health services brought about the establishment of the *Community-Based Family Planning Management Information System (CBFPMIS) of Pangasinan* which was initiated by the Provincial Population, and presented in the Summit by Mr. Edward Muego. Data gathered from this MIS program are utilized by the LGU in program planning and allocation of resources.

Parents as strong movers in society are organized to become both advocates and clients of the provincial population management program through the *Movement for Responsible Parenthood for Empowering Families*. Three hundred forty organized movements have already been established in 21 municipalities in Leyte where 3,400 couples have been reached. The project was presented by Ms. Betty Garrido.

Dr. Tahir Sulaik discussed the project *When the "Reds" Become the Priority*, a color-coding evaluation scheme initiated by the Provincial Health Office of Magu ndanao in early 1996. It categorizes provincial, municipal and barangay health programs according to color codes. Prioritizing areas and programs allows health managers to efficiently allocate scarce resources, with the coding serving as a basis for resource distribution.

The *Intervention Research: Providing Health Care for Quality Life* according to Dr. Agapito Homido, provided factual information to improve program implementation; trigger more effective intervention upgrade of FP service and facilities; and reduce the unmet reproductive needs of the client. In this way, research allows program managers to view individual clients not only as demographic targets, but also as effective partners in the implementation of FP programs. This innovation has found success in Davao del Norte.

The key points raised by the group is best shown in this recapitulation by its moderator, Dr. Aurora Perez:

- ❖ It takes a long time to veer away from the traditional concept of clients as targets, and move towards clients as partners in the FP service. The lesson learned is the improvement of services through factual information and

neither through the persuasion of the governor, nor the skills alone of the provider. Providers should facilitate the achievement of the desired family size.

- ❖ The goal is the reduction of unmet reproductive needs, a theme to pursue in all research endeavors. This refers to the sustainability aspect itself, or how to win LGU support. The first presentation showed how to set service fees that would redound to the improvement of those same services. They may have not been enough, but were used effectively to introduce improvements within the system. Other basic auxiliary support went into the improvement of health service.
- ❖ Another lesson is how to get families to contribute to program implementation. The movement in Leyte contributed to a longer sustained movement involving entire communities. Families themselves were utilized as the movers of preventive health.
- ❖ The effective use of colors was shown by Maguindanao, *"kailangang patingkarin ang blue at ang berde, at I-prioritize ang red."* The fact that this was a centralized move should not detract from the move toward devolution and to see the empowerment of the basic unit of the family. The core group should be the LCEs themselves, through effective delineation of functions.
- ❖ The bottom line is that change can be done as long as there is political will, prioritization of scant resources, and unification of efforts. No single agency or organization could do great things alone. The success stories show a snowballing effect among LGUs brought about by the LPP.

I. FEE FOR HEALTH SERVICES: AN ALTERNATIVE SCHEME FOR SUSTAINABILITY

Dr. Josie Lyn Java, MHO
Malalag, Davao del Sur

❖ Highlights of the Presentation

The *Fee for Health Service Program* of Malalag, Davao del Sur is a locally conceived socialized scheme designed to keep municipal health services that are self-sustaining, and not fully dependent on LGU fund allocations. Service charges are based on family income level. Before its implementation, a review of the families' paying capacity was done through barangay assemblies. The scheme was approved by the *Sangguniang Bayan* and made part of the Malalag Revenue Code.

Resistance to change by the public was the initial problem encountered by the program. Some clients went to neighboring municipalities to avail of free services. Increased awareness and acceptance of the program was achieved through continuous education and information campaign. The project proves that the community can easily accept a health care insurance system and learn to help themselves.

A public information campaign was conducted to ensure wide acceptance and support. The challenge was to influence people to change their concept of free health service, towards a modified health care insurance program which requires their active participation and contribution. This did not prove difficult with the help of a sustained information drive. Fees collected are pooled into the general municipal fund, and spent for health reinvestments like vehicle maintenance, purchase of drugs and supplies at minimum cost, among other things. There are plans to separate the health fund from the general fund and to constitute a revolving capital for health service reinvestments.

❖ Open Forum

Moderator: Dr. Aurora Perez

Questions on whether there is an ordinance allowing earnings to comprise the provincial general fund; the difficulties encountered in the disbursement of these funds; if the process does not run in conflict with the Local Government Code; collection and issuance of receipts; and whether supplies are charged against clients. The following is a summary of the response:

- A procurement process is being followed, but there are still difficulties in the utilization of the fund. An internal arrangement between collectors from the Municipal Treasurer's Office and rural health midwives exists. The collector assigns official receipts and collects them from the midwives. Clients are charged only for health services and not supplies. The legal basis of these processes is the Malalag Revenue Code which does not run counter to the provisions with the LGC.

If there are plans to increase costs to make the project viable since the fees being collected cover only a minimal percentage of the cost of operations, yet the LGU is reinvesting in the facility.

- There are no current plans to increase cost, but support is being solicited from the private sector such as business companies, banana plantation owners, and civic groups.

II. SETTING-UP A DISEASE SURVEILLANCE SYSTEM

Dr. Nicolas Catindig, Epidemiologist - CHO
Parañaque City

The disease surveillance system (DSS) of Parañaque was conceived to handle data coming from a number of city health facilities. The present setup serves as an early warning system for communicable disease outbreaks and enables local health practitioners to respond promptly without waiting for the DOH central office to send experts. The city enabled the Medical Health Officer to undertake a two-year intensive training course in epidemiology. A unit was added to the Medical Health Office in January 1997 for the purpose of instituting disease prevention measures. The surveillance system is a primary function of this unit and it also maintains a library of relevant information on endemic diseases and public health.

The Parañaque DSS currently monitors 14 diseases. It serves as an effective management information tool for city executives for the timely intervention and control of diseases ranging from amoebiasis to viral hepatitis. The data, presented by person, place and time, is collected from 17 health centers weekly and entered into the computer. The generated output includes analytical indicators of disease trends, descriptions of the demographic character of diseases, and others. Interpretation, however, is approached with caution to minimize margins of error. The current data excludes hospitalized cases.

From the 1997 data, the city was able to detect a cholera outbreak in a barangay and to implement corresponding preventive measures. In 1998, the city was able to gather information on the incidence of dengue fever and diarrheal diseases. It is still difficult to measure the impact of the system. However, the timely detection and clustering of cases has contributed greatly to the prevention and further spread of disease, and introduction of preventive and promotive health practices. The set-up has strengthened the city's overall health care delivery system. There are plans to expand toward hospital-based services.

❖ **Open Forum**
Moderator: Dr. Aurora Perez

An inquiry on whether the existing sentinel sites at San Lazaro and Jose Reyes Medical Center are being utilized, and what should be done to ensure compliance among respondents. The response include the following:

- The San Lazaro sentinel sites are being used. Surveillance may be classified into active and passive. Waiting for response is passive. The Parañaque system is active because the personnel themselves identify the cases and locate the patients. All cases are recorded in logbooks and visited in their respective homes to obtain more information including personal data, immunization status, and all laboratory results. Plans in 1999 include the creation of a complete epidemiology unit.

If the "Unknown" element in the casefile is significant or not.

- The immunization status of patients is a difficult area to capture and this is encountered by many systems in the country. The answer lies in the training of the epidemiology staff. The National Epidemiology Surveillance System does not have a permanent staff to gather and collate these data. Even in Parañaque, some patients do not have a record of their immunization status considering the temporary nature of their residence. If a certain "Unknown" case has had a history of vaccination, this is of significance, but if they do not have a history, then something substantial is missing. There are ways of dealing with these problems and the DOH is prepared to lend technical assistance inasmuch as it requires factual data for health intervention programs.

III. COMMUNITY-BASED FAMILY PLANNING MIS

Mr. Edward Muego, Demographer – PPO
Pangasinan

The devolution of health services brought about the establishment of the *Community-Based Family Planning Management Information System (CBFPMIS)* in Pangasinan. Data gathered from this MIS are utilized by the LGU in program planning and allocation of resources.

The program was launched in 1995 and now covers 46 municipalities in Pangasinan. The program is funded through a cost-sharing arrangement with municipalities, managed by the Population and District Population Offices, and assisted by Barangay Service Point Officers (BSPOs) in 1,033 barangays. The process commenced in phases starting with the creation of a structure on system workability, pretesting, operationalization, and trouble shooting. Some of the early constraints faced were wrong attitudes of program partners, lack of incentives for volunteers, duplication of roles, and the technical nature of the project. The system itself needed refinement and stronger emphasis on data utilization.

Consequently, the program raised the CPR and improved contraceptive usage. It also strengthened the volunteer network. Moreover, it served to complement Pangasinan's population and development program. The system is easy to operate and utilize, and in the future, provincial planners hope to expand the system to include high-risk and unmet need indicators.

❖ Open Forum

Moderator: Dr. Aurora Perez

A request for an elaboration of the reason for using the unmet needs approach and how data utilization can improve the effectiveness of service delivery.

- The unmet needs approach covers larger areas and intends to bring about quality services. The high-risk approach is focused more on the needs of women. The former approach is more responsive to the immediate need and would eventually cover the latter.

Clarification of the role of the volunteers in maintaining the MIS; what problems are encountered with data retrieval and utilization; and where data samples could be found.

- The BSPOs form part of the network. They receive their forms from, and file their reports to the district, provincial, or municipal population offices. BSPOs hold monthly meetings where reports may be secured. The data collected go immediately into the system. However, BSPOs have not been taught yet on how to utilize the data gathered.
- On the issue of utilization of information, the Pangasinan Population Office has undertaken an operations research which superimposes the Unmet Needs Approach Algorithm on the system. The outcome was a masterlist of Married Women of Reproductive Age (MWRA) and women at high risk. The data enables the province to prioritize those in most need of services – women who want to practice FP, those who do not want any more children but are not using FP, and those using contraceptives but want to change their methods, among others.

IV. MOVEMENT FOR RESPONSIBLE PARENTHOOD (RP): AN EMPOWERING APPROACH

Ms. Betty Garrido, Provincial Population Officer
Leyte

❖ Highlights of the Presentation

The project was initiated as a strategy of the provincial Population Management Program of Leyte to assist families in meeting their need to improve their health status as well as the relationship between and among family members, and the community. The province has organized the RP movement in 41 municipalities.

The basic component of the program is the conduct of classes in nine RP subject areas for community members. One of the greater challenges is the gathering of family members in the evening. Other program components include the following:

- Family and youth development
- Sessions on adolescent fertility
- The "Tree of Love Project" which grants marriage licenses only to couples who plant trees, and
- Livelihood projects such as duck raising.

The program has become a model for other LGUs, and the provincial government intends to institutionalize the program at the barangay level.

❖ **Open Forum**

Moderator: Dr. Aurora Perez

The presenter was asked whether the movement complements FP and the strategies adopted to implement FP.

- Operating guidelines were followed. The program started with couples per barangay, and parents with malnourished children. They have pledged to attend the classes before the movement is organized. The ones who identify priority couples are the BSPOs and barangay nutrition scholars. In barangays where the movement became a success, a high rate of contraceptive usage was registered.

One observation made is that other LGUs have implemented similar programs but experienced problems of "maintaining the club," or the movement. In relation to this, the questions on how the project is done to ensure continuity and where funds are sourced were asked.

- BSPOs were trained in community organizing. The Population Executive Committee chaired by the Mayor and the barangay captains was established at all LGU levels. Family livelihood and children's programs are widely assisted, and a yearly evaluation of the program is held for recognition and awards giving. Project monitoring is an integral part of the program, including home visit. The community is also involved in all development planning. Communication is maintained at all times. Budget allocation for the RP Program is reflected in the provincial annual investment plan, and is replicated at the municipal and barangay levels. The funds come from the 20% development fund. Its utilization is supported by an ordinance.

V. WHEN THE 'REDS' BECOME THE PRIORITY: COLOR-CODING OF AREAS AND PROGRAMS

Dr. Tahir Sulaik, Provincial Health Officer
Maguindanao

❖ **Highlights of the Presentation**

The province of Maguindanao is the largest province in ARMM and has more than 456 barangays. Since these have become the points of economic development priority, the province decided to adopt a color-coding scheme - a monitoring and

evaluation tool designed to categorize program areas. It was adopted in 1996 and serves as basis for focusing health interventions.

Color-coding is an evaluation scheme initiated by the Provincial Health Officer in early 1996. It categorizes provincial, municipal, and barangay health programs according to color codes. It was realized that there is a need to prioritize areas and programs because of scarce resources. The coding scheme serves as a basis for distribution. The green code means that 90-100% of annual targets has been accomplished; blue for 80-89% and red for less than 80%.

Of the 18 municipalities in Maguindanao, five are coded green, nine are blue, and four are red. Majority of these are upland areas which are now the focus of monitoring of outreach activities.

Implementation steps include the submission of the health personnel of its program accomplishments to superiors. The superiors review and analyze data and assign color codes to the barangay/municipality based on percent accomplishment of annual targets or for the health program based on program objectives and outputs. Color codes are relayed to subordinates during regular staff conferences for feedback and appropriate action. As a form of summary information, color-coded spot maps of barangays and municipalities as well as color-coded listing of health programs are prepared and displayed (wall posters) for ready reference. The scheme utilizes existing manpower. The FP program involves more male members (ulamas) than female since the male holds the locus of decision making in a Muslim community. Basically, the program involves the creation of visual aids that are forwarded to MHOs and PHOs for approval. There are geographic presentations and color-coded wall posters. Inputs to the scheme consist of accomplishment reports that are submitted by the program coordinators to the Provincial Health Office.

❖ **Open Forum**

Moderator: Dr. Aurora Perez

The first set of questions focused on the following: the indicators used to evaluate the program, specific parameters for a specific health program, quality control and assurance. The following is a summary of the respond given by Dr. Sulaik.

- The program is objective rather than indicator-based. The province implements the program through the area coordinator assigned at every LGU level who is assisted by the BHWs in the planning process. They are given

forms with which to monitor various programs and the reports are sent directly to the health office.

On the question on how volunteers are supported at the barangay level, the following was the response given.

- One of the province's good practices is reinventing the BHWs by involving them in provincial planning and in the quarterly provincial staff conferences. At year-end, they are given awards, and the province sources funding for their travels to Manila and abroad. They were all supposed to receive a regular allowance but not all mayors agreed to this. Only 13 out of 18 municipalities provide allowance. With or without allowance, the BHWs still carry on with their work.

VI. INTERVENTION RESEARCH: PROVIDING HEALTH CARE FOR QUALITY LIFE

Dr. Agapito Hornido, Provincial Health Officer
Davao del Norte

❖ Highlights of the Presentation

The main objective of the intervention research is to improve health services for the provincial population through information exchange, a key factor necessary for effective FP delivery. Prior to 1996 when the study began, there were misconceptions about FP, and facilities were inadequate. FP supplies and contraceptives were often not available. Health providers lacked knowledge and FP skills. A joint seminar workshop sponsored by the LGU Performance Program in 1997 resulted in the drafting of a proposal to improve FP services in the province. The design divided the problems in the experimental and control areas based on geographic considerations and socioeconomic profile.

Four key interventions were training and counseling, supervisory training of field supervisors, the rapid assessment team approach, and development and production of IEC materials. The Association for Voluntary Surgical Contraception (AVSC) assisted the conduct of training in female sterilization methods. Facilities began to be staffed by friendly personnel who helped explain FP processes to clients. Supervisory training included familiarization with the monitoring system. Reporting to chief executives became important as well as rapid assessment and feedback. Resources were given to health facilities involved in the study. The fourth intervention

was the production of IEC materials on DMPA, pills, condoms, and other contraceptive devices.

A community survey was done to validate the changes that were noted after two years of improved service implementation. The findings include a decrease in the dropout rate, an increase in contraceptive usage, improved health facilities, availability of equipment and supplies, and changed outlook among health care providers. The most telling aspect is that FP clients are effective movers of the program.

❖ **Open Forum**
Moderator: Dr. Aurora Perez

There were no questions asked.

LGU Performance Program (LPP) Summit
Concurrent Sessions
Sharing of Good Practices
Group IV: Initiatives of Other Cooperating Agencies
Samar Room
Day 1 – January 25

SUMMARY OF PRESENTATIONS

The Cooperating Agencies (CAs), both from the National Services and the Private Sectors/NGO play vital roles in the implementation of the FP Program. Although the ideal is for the LGUs to initiate their own projects in support of the program, sometimes it is inevitable that there are slight imperfections brought about by the limited resources and technical expertise of the LGUs. The CAs are not instructors with rulers to beat on the little hands of the LGUs, they are partners who just want to help a colleague.

The session on the "Initiatives of Cooperating Agencies" defined the roles of the CAs as change agents by providing technical and financial assistance to the LGUs and partner-NGOs. There were six topics presented.

Dr. Zeldá Zablan of the UP Population Institute gave the first presentation on the study: *Improving the Quality of Care in FP/RH Services of Selected Communities of Pangasinan: An Intervention Study (Population Council)*. Dr. Zablan stressed the importance of enhancing interpersonal communication skills as one step to improving the quality of FP service delivery. Moreover, the study showed that an LGU utilizing CBMIS could monitor the existing FP program of a community with the end-view of improving the quality of FP services by prioritizing and addressing the needs.

Ms. Ellen Villate of Helen Keller International, Inc. briefly discussed *Implementing the Child Survival Intervention in the Context of Weighing Posts*, which is HKI's approach of working within existing institutions to strengthen existing groups rather than building a new one. In tandem with Ms. Villate, Dr. Honorata Catibog, the PHO of Samar, presented the project *Re-engineering of the 10 Municipal Nutrition Councils*

of Samar, an intervention program that resulted in strengthened and effective nutrition program.

The third topic *Increasing Client Demand through a Signage Project (Kalusugan sa Pamilya Project)* was discussed by Mr. Jose Miguel dela Rosa of Johns Hopkins University, who emphasized that the FP program should develop a "corporate identity" through its logo "Kung Sila'y Mahal N'yo Magplano." This would allow the audience to immediately identify the logo and relate it with the program. He mentioned Jollibee's and McDonald's marketing approach (Happy Meal, Fallow Pals) of inviting clients through their promotional campaigns. He stressed that the FP program should reach that level of marketing, that is, innovative, modern, and effective.

The *TANGO Project* of the John Snow Research and Training Institute, Inc. is a technical assistance project for partner-midwives and NGOs. The assistance is intended to create demand for FP services rather than to address the need, and to put a price to it. Ms. Easter Dasmariñas of JSI-RTI discussed the project.

Ms. Socorro Reyes of the PCPD presented *RP/MCH Project in the Industrial Sector*. The objective of the project is to provide the workforce with RP/MCH services, which has often been overlooked in the industrial setting. In promoting FP among industrial workers, the emphasis is on how the practice contributes to the attainment of a healthy workforce and higher productivity. The provision of FP services in the workplace is also mandated in the Labor Code. Therefore, companies which have institutionalized FP services as part of the benefits of workers are complying as well with the mandate of the Code. To illustrate the benefits of such practice, a representative from the *American Standard, Inc.*, delivered a short account of the benefits the company and its manpower gained through the project.

Establishing a Model Voluntary Surgical Sterilization Site is a model of cooperation among the AVSC International, DOH, and the Hinatuan District Hospital. Dr. Danilo Viola shared the experience of Hinatuan District Hospital in establishing the VSS services in the hospital and in increasing client referrals. The unique intervention scheme of the Hinatuan District Hospital helps ensure the success of the project.

Due to time constraints, discussions of the different presentations were not done. The time that should have been allotted for discussions was instead utilized to

accommodate other speakers who came in tandem with some of the cooperating agencies, since their contributions are equally important to the presentations.

I. IMPROVING THE QUALITY OF CARE IN FP/RH SERVICES OF SELECTED COMMUNITIES OF PANGASINAN PROVINCE: AN INTERVENTION STUDY

Dr. Zelda Zablan, Associate Professor
UP Population Institute

❖ Highlights of the Presentation

The study presented three interventions. The first intervention is to enhance the information exchange skills of FP service providers and outreach workers, thus, improving the quality of FP services at the clinic level. The second intervention is the Supportive Supervision level, wherein certain issues on FP methods were stressed between the provider and the client. The third and last intervention, is the use of the Unmet Need Algorithm (UNA) as a means of identifying and prioritizing women with unmet needs.

The process by which the first intervention was achieved can be summarized as G-A-T-H-E-R. FP service providers (doctors, midwives and nurses) were given the full GATHER training. GATHER stands for: **G**-greet the patient, **A**-ask about the experiences encountered in her previous method used, **T**-tell her about the methods available, **H**-help her choose among the methods, **E**-explain to her the advantages and disadvantages of the method, and **R**-refer her or ask her to return for the next visit. On the other hand, the outreach workers were trained for GATR since they are not equipped with the full knowledge of the application and explanation of FP methods.

At the Supportive Supervision level, certain points on the FP methods were highlighted. Method options were presented without necessarily promoting a particular method. Moreover, the contraindications, warning signs, and side effects were stressed between clients and providers. Follow-up requirements and information about the duration of effectiveness was emphasized. The possibility of switching method and source of supply if the method is not suitable to the client was among the new concerns raised since the workers are not target-driven, instead they follow the choice of the women.

The Unmet Need Algorithm (UNA) could track down Contraceptive Prevalence and is a useful tool in managing the activities of the outreach workers or useful for Area-Based Planning. With the UNA, outreach workers were able to enhance the quality of FP services, thus, facilitating the achievement of an important benchmark - more satisfied clients, higher retention and continuity rate, and higher CPR.

Based on the study, several changes were observed after the intervention. The intervention provided data that are essential to area-based planning and program implementation. Observable result is on the maintenance of contraceptive prevalence which is mainly attributed to the continued contacts made by health volunteers with clients. It was noted that knowledge on the quality of care, monitoring, supervision, and FP had a significant increase among the experimental group over that of the control group. The clinics have a regular supply of IEC materials due to the awareness of the health workers of its importance.

II. IMPLEMENTING THE CHILD SURVIVAL INTERVENTION IN THE CONTEXT OF WEIGHING POSTS & THE RE-ENGINEERING OF THE NUTRITION PROGRAM IN SAMAR

Ms. Ellen Villate, Deputy Country Director
Helen Keller International, Inc.
Dr. Honorata Catibog, PHO
Samar

❖ Highlights of the Presentation

Helen Keller International, Inc. has long been a partner of the DOH in its Child Survival Program. HKI provides technical assistance in developing community-based nutrition intervention packages and IEC materials. In addition, HKI assists the DOH in reviewing government policy on the Vitamin A program.

For the Integrated Family Planning and Maternal Health Program (IFPMHP) of the DOH and USAID, HKI was tasked to provide technical assistance to LGUs in re-engineering their nutrition program. HKI implements a two-pronged approach. First, strengthening LGU capability through workshops and training aimed at reorganizing or restructuring existing groups involved in the nutrition program of the community, e.g., Provincial Nutrition Committee (PNC) and the Municipal Nutrition Committee (MNC). The second approach is strengthening Service Delivery to improve nutritional

status of children and women by considering the accessibility and coverage of key nutrition services.

One of the beneficiaries of the assistance is Samar Province. In 1996, the PNC recommended the re-engineering of the nutrition program of Samar based on the results of the evaluation of its Annual Municipal Action Plan (AMAP).

The intervention required a three-day live-in workshop with an estimated cost of P12,500 for food, supplies and materials. An average of three facilitators from the PNC Task Force handled the workshop.

The workshop topics included the following:

1. Re-engineering strategy, including consultative meetings, cross-visits among municipalities, and team building.
2. Advocacy skills training and advocacy forum with LCEs.
3. Development of proposals and health and nutrition situation report.
4. How to link/bridge with other funding sources.
5. Training of trainers.
6. How to review programs.
7. Development of Communication Plan and intervention planning.
8. Community-Based Monitoring.

As a result of the intervention, the ten pilot municipalities of Samar were able to organize Local Nutrition Committees (LNCs) with defined roles and capability to assess, plan, facilitate, conduct, generate resources, and advocate nutrition programs that are tailor-made to the needs and priorities of their municipalities. In addition, the intervention improved and standardized delivery of nutrition services at the municipal level.

In general, the re-engineering of the LNCs resulted in strengthened and effective nutrition programs with significant results as noted:

1. Reduced the prevalence of underweight among young children from 30% to 25.5%.
2. Increased proportion of women exclusively breastfeeding their infants from birth to 4 months of age from 58.9% to 63.9%.

3. Increased coverage of Vitamin A supplementation from 88.5% to 90.3% and the consumption of Vitamin A-rich foods.

The results are the product of partnership founded on mutual respect, technical know-how, and the desire to serve those who are in need. To achieve success, three elements are needed and these are political will, technical will, and popular will.

III. INCREASING CLIENT DEMAND THROUGH A SIGNAGE PROJECT: (KALUSUGAN SA PAMILYA PROJECT)

Mr. Jose Miguel dela Rosa, Resident IEC Advisor
Johns Hopkins University

❖ Highlights of the Presentation

In 1998, the *Kalusugan sa Pamilya* Project (KSP) was launched in four selected areas representing three regions of the country. These areas, Baguio City, Iloilo Province, Iloilo City, and South Cotabato, were chosen on the basis of the expressed support of the LCEs for the FP program and their active participation in the LPP.

The KSP Project aims to 1) promote FP and its linkages to child survival information services; 2) position FP as an integrated component of family health at the community level through the pro-family, pro-child program; 3) establish FP as a social norm; and 4) position FP as a suitable means for improving family health.

The overall strategy is the installation of FP logo (*Kung Sila'y Mahal N'yo, Magplano*) in residences of Barangay Service Point Officers (BSPOs). The signs designated the services provided by BSPOs, including information on FP, counseling, and re-supply of pills and condoms. Research showed that the signage project not only helped clients know where to get supplies, but it "established" a community-based service delivery point as well.

Aside from the signage project, the KSP supported several activities and training including:

1. Capability building, orientation and training of LGU officials, health service providers and the community.
2. Advocacy activities.
3. Mass media and community-based IEC activities.
4. Mobilization of the community.

5. Improving and strengthening referral system between and among health facilities in project sites.
6. Installation of tracking system.

IV. TANGO PROJECT

Ms. Easter Dasmariñas, Resident Advisor
John Snow Research & Training Institute, Inc.

TANGO stands for Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippines' Non-Governmental Organizations (NGOs). The project is funded by the USAID and implemented by JSI-RTI.

The objective of the project is to increase the availability of FP services in the private sector by significantly expanding the number of midwife-owned clinics that provide FP/MH services.

The project was implemented in selected urban areas in regions 1, 3, 4, 6, 7, 8, CAR, SOCSARGEN, and NCR. The key players are the partner-NGOs and midwives that were carefully selected in accordance with the criteria set by JSI.

A series of training workshops was conducted for the partner-midwives. Among them are Basic/Comprehensive FP services, interpersonal communication skills, counseling, ambulatory health facility management, and salesmanship.

The project staff was tasked to supervise the project and the NGOs provide services and manage the clinics. For the project, the partners were trained in supervision and monitoring, project management, costing and pricing, public relations and grassroots promotion, rapid market appraisal, and business planning and development.

The project implemented the Performance-Based Payment Mechanism (PBPM) which is the basis of the contractual agreement of JSI with the partner NGOs. The strategy was designed to encourage the partner-NGOs in carrying out the project efficiently - they were paid in accordance with their successes.

V. FP/MCH PROJECT IN THE INDUSTRIAL SECTOR

Ms. Ma. Socorro Reyes, President

Philippine Center for Population and Development

It is a fact that farmers and industrial workers do not put health, or the availment of health services in their list of priorities. The concept is even alien to them especially when they have to pay for such services and to acknowledge FP as a basic health need. The reason lies primarily on financial constraints, availability of time, and the lack of knowledge on the importance of FP.

The government is aware of such constraints. This is the reason why the provision of FP services in the industrial sector is mandated in the Labor Code. In addition, the DOH and its Cooperating Agencies institutionalized the provision of FP/MCH services in the industrial sector and agro-industrial companies to respond to the health and welfare needs of the workers. It is also one of the objectives of the FP program.

Presently, there are about 23 areas with a total of 150 companies, covered by the project implemented by PCPD. Among them are Bulacan, Cavite, Rizal, Batangas, South Cotabato, Misamis Oriental, Davao del Sur, Saranggani, Laguna, Cebu, Davao del Norte, Manila, Marikina, Valenzuela, Pasay, Las Piñas, Mandaluyong, Taguig, Parañaque, Muntinlupa, Quezon City, Pasig, and Makati.

The first task of PCPD is to persuade companies to adopt the project. To do this, they make the client or participant realize the benefits to be derived by the company by providing FP/MCH services.

In the case of *American Standard*, the company sought the help of union leaders in promoting and persuading the workers to avail of the FP/MCH services. The strategy is unique in that the union and management worked hand in hand for the project. The strategy is effective. Since it targeted an already organized group, the spread of information regarding FP/MCH services provided by the company was spontaneous. Thus, a huge number of workers avail of the services. The results are healthy workers, healthy working environment, and a productive company.

VI. SETTING-UP A VOLUNTARY SURGICAL STERILIZATION (VSS) SITE: THE HINATUAN DISTRICT HOSPITAL EXPERIENCE

Dr. Danilo Viola, Chief, Hinatuan District Hospital

Dr. Edward Tandingan, AVSC International

The Hinatuan District Hospital in Surigao del Sur is one of the service delivery sites of AVSC International. It is equipped to provide voluntary surgical sterilization (VSS) services to the community it serves. It is a 25-bed capacity hospital located in the town proper of Hinatuan, Surigao del Sur. It serves two municipalities, namely, Hinatuan and Tagbina with a combined population of 70,000.

The VSS service delivery of Hinatuan took shape with the training of two teams of VSS providers at the Davao Medical Center in 1991, thus, providing the hospital with capability to provide VSS on a regular basis. Consequently, there was a gradual but steady increase in VSS output from 1991 to 1996. In 1997, the same year AVSC International's support started, a sharp increase in VSS was observed. The year 1998 marked the highest VSS performance rate with the notable participation of Family Health Workers (FHWs) and BHWs in the advocacy and campaign for the acceptance of bilateral tubal ligation (BTL) as a permanent FP method.

In 1997, the VSS site of Hinatuan District Hospital was set up with the assistance of AVSC. The agency provided funds for its renovation, installed OR equipment and surgical instruments to make the room fully functional. In the same year, another team of VSS providers was sent to UP PGH for Mini Lap training. In addition, a nurse was trained in FP counseling and is presently functioning as the hospital's FP counselor. The Hinatuan experience presented very unique interventions to ensure regular VSS services to the communities it covers. Among the unique interventions are the following:

1. The arrangement among neighboring district hospitals on borrowing of VS medicines and supplies.
2. The commitment and active participation of the Chief of Hospital that serves as a motivating factor for others to follow through.
3. The escort service for the "would-be" BTL candidate to the site as a sign of concern and sincerity.
4. The free transport service for clients provided by the local health board.
5. Transfer of skills from a trained surgeon to resident physician.

LGU Performance Program (LPP) Summit
Concurrent Sessions
Sharing of Good Practices
Group V: Special Session
Leyte Room
Day 1 – January 25

SUMMARY OF PRESENTATIONS

The Special Session provided the venue for the presentation of HB No. 5125 "Health Care Delivery Modernization Act" sponsored by House Representative Emilio Macias II. Six other LGU *good practices* were presented. HB No. 5125 reflects some of the issues that cropped up when health services were devolved resulting in confusion and duplication of functions among public health providers and the LGUs. The *good practices* presented, on the other hand, illustrate the earnest efforts, resourcefulness, and imagination of local health units, local chief executives, and the community in plugging the gaps brought about by devolution, and in the process, come up with innovative and practical solutions that could serve as models for others in similar situations.

Health delivery programs, like any other development efforts, are subject to the changing political season and the personal bias of the incumbent local chief executive. A lot of effective programs were changed or discontinued with changes in government, or the election into office of new sets of government officials. To solve such problem, it is important that a comprehensive health service delivery program be developed and be made part of the long-term development plan of the local government. These elements were brought into focus in the day's presentation of *House Bill (HB) No. 5125* otherwise known as "*An Act Providing for the Modernization of the Health Care Delivery System, Appropriating Funds Therefore and for Other Purposes*" introduced by Honorable Emilio Macias II (2nd District, Negros Oriental) and the project *Strengthening Provincial-Municipal Partnership Through Sub-Granting*, both of which seek to institutionalize strong LGU support to sustain health service delivery.

House Bill No. 5125 provides for the establishment of district health boards in every district, in regional medical centers, and in specialty hospitals as a strategy to achieve genuine local autonomy. *Strengthening Provincial-Municipal Partnership Through Sub-Granting*, on the other hand, is designed to improve the existing management mechanism for the delivery of health services in Pangasinan, and to strengthen the capacity of local health and population personnel to plan and implement health and population programs within the context of devolution.

"Health empowerment in the hands of the people through an integrated quality health care delivery system amidst the devolution process" underscores the strength and success of the projects *Health in Every Home* of La Union and *The Local Health Board Plus* of Itogon, Benguet. They also help illustrate the strategic role of the local health board in the success of the implementation of health programs and the compelling reasons why health boards should be made functional.

Give Me Ten: Tapping Barangay IRA for Health and *Peso for Health* are two similar practices that show that existing local resources, including the community's capacity to spend for health, may be tapped and used by health program managers to augment limited budget for health. These *good practices* show the strong potentials of the LGU and the community to find the means to make good health services available and accessible to all, regardless of economic status.

The *good practices* showcased in the session underscore the importance of local institutional support to health service delivery that can be provided by such strategic partners as the LGU/LCEs, the community, POs/NGOs, and other stakeholders. These practices also share common features or elements from where they have successfully drawn their strength and sustainability. These are 1) strong institutional support from their LGUs through the LCEs, local health boards and barangay councils; 2) appropriate local legislations supportive of health programs; 3) strong community support and active participation; 4) recognition of the principle of shared responsibility; and 5) creative utilization of local resources. These practices in effect illustrate that devolution can work and should be allowed to seek its level over time, since change is a process that is not attained overnight. The elements that propelled these brave attempts to their initial success, when properly studied and evaluated, could be used to improve health policies both at the local and national levels, or set new standards and practices for health care service delivery.

I. HOUSE BILL NO. 5125: HEALTH CARE DELIVERY MODERNIZATION ACT
Representative Emilio Macias II, M.D.
2nd District, Negros Oriental

❖ **Highlights of the Presentation**

The Local Government Code of 1991 (Republic Act No. 7160) provides for the devolution of the function of managing public health and district hospitals to the local government units. This, however, resulted in confusion and duplication of functions among public health care providers which up to now remains unresolved. The problem lies in the fact that when the many functions of the DOH were passed on to the local government units, such did not come with funds to cover the cost of the devolved functions.

The proposed bill entitled "*An Act Providing for the Modernization of the Health Care Delivery System, Appropriating Funds Therefore and for Other Purposes*" (House Bill No. 5125) introduced by Honorable Emilio Macias II (2nd District, Negros Oriental) seeks to rationalize and to modernize the delivery of health care in the country. In order to remedy the problems brought about by devolution and to realize genuine local autonomy, it provides for the establishment of district health boards in every district, and health boards in regional medical centers and specialty hospitals. To be composed of multisectoral representatives, including members of Congress and the local chief executives, the said board is separate and distinct from the local health boards provided for in the Local Government Code.

It provides, among others, for the delineation of specialized functions to enable the DOH to institutionalize a dependable two-way referral system from the public health units to the specialty hospitals and vice-versa. It encourages partnership between and among local government units and the DOH in establishing modern health care facilities and introduces private sector participation in the management of its own health care program.

❖ **Open Forum**

Moderator: Ms. Lyn Almario

The discussion revolved primarily on whether there is a need for a health board at the provincial level, its composition or representation, and such other related issues that are proposed in the Macias bill. The following is a summary of the issues discussed in the open forum.

- It was pointed out that in the proposed health care delivery system, the governor will be advised by the DOH Specialists for Public Health and for Hospitals. The nutritionists and dietitians are not included in the team when they should also be working with the governors at the provincial level, and with the mayors at the municipal level.

The response of Congressman Macias is that such arrangement depends on the governor or the mayor, since there is cost involved.

- On why health boards should be established at the provincial level when this could be done at the municipal level, Congressman Macias noted that there is a need to involve influential people and those who are occupying strategic positions such as the politicians and local government officials because they also have a stake in the successful implementation of health programs. There will be more boards, with the congressman represented only in the district. The Sangguniang Panlalawigan member represents the district where the hospital is located, and the mayor, of the catchment area of the district.
- As to the reason for the proposed representation of the religious sector in the health board, Congressman Macias replied that the representative from the religious sector could act as a convenor.
- On the inquiry on whether the proposed changes in the Bill is in line with the plan of the DOH for a subnational delivery of health services, it was pointed out that if the Bill becomes a law, the DOH should align itself with the proposed changes. These changes call for the upgrading of general hospitals into regional hospitals, and district hospitals to provincial hospitals. In line with the new approach on hospital management as proposed in the Bill, non-doctors may be involved in the running of hospitals.
- On the issue of how the proposed changes would affect the integrated health system in Manila and cities that have not devolved their hospitals since they were established by the local government itself, it was clarified that the proposed Bill has no provision for such cases, and that this is one area that needs further study.

II. STRENGTHENING OF PROVINCIAL-MUNICIPAL PARTNERSHIP THROUGH SUB-GRANTING

Dr. Ophelia Rivera, MHO

Mangaldan, Pangasinan

❖ Highlights of the Presentation

The local government units realized their lack of capacity to plan and implement health and population programs with the devolution of health services, as provided by the Local Government Code. With the absence of technical support from the DOH and the Population Commission, and the discontinuance of funding and program management support mechanism, the municipal health officers performed dual roles, i.e. as managers and as service provider at the same time.

The quality of health services delivered suffered due to problems in logistics, ranging from lack of medicines and clinical equipment to lack of office supplies. This was exacerbated by lack of focused technical assistance by the Provincial Health Office and limited monitoring visits.

The provincial government of Pangasinan came up with a mechanism to address these problems by improving the existing management mechanism for the delivery of health services. A pilot project was conducted with the goal of improving the health of women, men, and children in the province, and reducing the unmet demand for family planning and child survival program services. Mangaldan, a second class municipality composed of 30 barangays with a population of 76,540 was selected as the pilot area. The selection was based on population size, presence of population and health offices, presence of community volunteer network, commitment of local chief executive and degree of support of the local government.

The DOH and the Management Sciences for Health-Program Management Technical Assistance Team (MSH-PMTAT) provided assistance in the project design and initial implementation. A grant of P150,000 was given by the LGU Performance Program, a counterpart of P171,240 was provided by the municipality, and P313,550 was provided by the barangays.

The program was faced with constraints such as confusion on the roles and functions of the population and health personnel, limited technical assistance and irregular

monitoring, and limited technical capabilities of program coordinators. Role clarification seminars and assistance to the health personnel were extended to address these problems. Closer coordination and collaboration between province and municipal government was initiated through regular meetings. Additional training activities for barangay service point officers (BSPOs) and barangay health workers (BHWs) were conducted; the technical assistance coming from the provincial staff was improved; the health facilities were upgraded; and the financial and procurement tracking system was installed.

Because of these efforts, a functional referral system was developed. The quality of human resources was also improved. BSPOs now provide family planning and reproductive health information and assistance to both men and women in the municipality and about 98% of the BHWs have trained on family planning and child survival programs and now assist the midwives. Logistic support was also improved through the acquisition of equipment such as BP apparatus and weighing scales and additional medicines and supplies.

The success of the program is attributed to the support extended by the local chief executives, the mayor of Mangaldan and the governor of Pangasinan and the committed and competent municipal and provincial population and health officers. To ensure the sustainability of the project, funds were allocated specifically for the purposes of the programs. The full support of the local chief executives to the programs was elicited and continuous skills development among the health workers was conducted. Participatory and consultative process was used to ensure the support of the local health workers and the community.

❖ **Open Forum**

Moderator: Ms. Lyn Almanio

Among the issues that cropped up during the discussion were those related to the nature of LPP assistance and the activities funded by the LPP grant, how the confusion and duplication of duties between the population officers and health officers were resolved, and who initiated the project.

- On whether the LPP assistance was for the whole province or to a specific municipality, it was pointed out that the assistance was for the province of Pangasinan but a portion of it was sub-granted to Mangaldan.

- The activities funded by the P150,000 sub-grant from the province included training of the BSPOs, purchase of equipment such as BP apparatus and weighing scales, reproduction of forms, and conduct of program and operations review.
- The Provincial Population Officer initiated the project that enjoys the support of the governor and the mayor.
- The problem of duplication of duties was resolved through the conduct of workshops where roles were delineated and responsibilities were clarified.
- The question on how the project managed to enter the municipal and provincial levels without upsetting their budget was not answered, while that of whether the development plan was considered as benchmark got a positive reply.

III. HEALTH IN EVERY HOME

Dr. Conrado Vito, Assistant PHO
La Union

❖ Highlights of the Presentation

Adopting "Health empowerment in the hands of the people through an integrated quality health care delivery system amidst the devolution process" as its vision *Health in Every Home* is a comprehensive program that enhances the primary preventive, curative, and rehabilitative aspects of health. It was adopted by the Provincial Board of La Union through Resolution No. 145 Series of 1992. It utilizes the resources available in the locality and involves the people in the delivery of health services.

The project has three components, namely, a) capability building, which includes community organizing activities and training of health workers in the province; b) setting up of support systems such as the organization of the Provincial Federation of Barangay Health Workers and the establishment of a data bank known as the La Union Health Registry; and c) provision of specific needs and services such as feeding program, provision of sanitary toilets and potable water services, development of walking blood donor network, improvement of hospital facilities and services and their economic and structural support system.

Because of this project, the malnutrition rate of the province decreased from 14.65% to 6.16% and Infant Mortality Rate went down from 22.94% to 13.01%. PTB cases drastically went down to 497 cases from 3,425 cases. About 80% of the households have herbal gardens and 6,500 have volunteered as blood donors. In terms of environmental sanitation, 89.71% of households have sanitary toilets while 86.92% enjoy potable water supply.

Hospital services have been improved with the acquisition of hospital equipment, improvement of the operating room, and the hiring of additional personnel. Community participation and cooperation in promoting self-reliance have also been strengthened. Due to the success of the project, several recognition and awards were given to the local health board and to the province.

❖ **Open Forum**

Moderator: Ms Lyn Almario

Questions raised include budget allocation and other sources of funding; how the P1,000 allocation/BHW is disbursed; whether a pharmacist is hired for the Botika sa Barangay and the kind of medicines it dispenses.

- P8 million was allocated by the LGU out of the P200 million initially requested. For the current year, the LGU allocated P5 million.
- The budget for the feeding program came from other sources which the project has initially identified and not from the LPP alone.
- The P1,000 assistance to BHWs represents the maximum amount of hospital services that they are entitled to per confinement.
- The Botika sa Barangay has no pharmacist and the medicines in the Botika are basic over-the-counter types that can be sold without prescription.

IV. GIVE ME TEN : TAPPING BARANGAY IRA FOR HEALTH

Dr. Raoul Zantua, Rural Health Physician
Daraga, Albay

❖ Highlights of the Presentation

There was a time when the Rural Health Unit of Daraga was unable to adequately provide for the needs of its clientele, particularly drugs and medicines for common illnesses. People tend to count on the local executives for support, but this is not available most of the time. A Barangay Kagawad suggested that 10% of the Barangay Development Fund be allocated for the purchase of drugs and medicines. The suggestion was accepted by the Sangguniang Bayan through a resolution that was eventually adopted by all the barangay councils of the municipality.

Consequently, the supply of drugs and medicines for the use of the people of Daraga was stabilized. A marked improvement in the health status of the community was noted, and the capacity of the rural health unit to provide immediate medical attention was improved.

❖ Open Forum

Moderator: Ms Lyn Almario

The discussions were mostly on the procurement system for drugs and medicines and the annual budget for the procurement of drugs and medicines, how these are procured, who procures at the barangay level and at the municipal level, and how the project deals with the Commission on Audit regarding its procurement. Other concerns include how the Botika sa Barangay fits into this scheme.

- The annual budget for drugs and medicines is P1.2 M, which is not sufficient to meet the needs of the entire municipality.
- A list of drugs and medicines that should be part of the supply of the municipality and the barangay is prepared and is used by the procurement officer of the municipality. The barangay procures its medicines based on the same list.
- The procurement is subject to the usual government accounting procedure.

- The Give Me Ten scheme is designed to augment the capacity of the Botika sa Barangay.

V. THE LOCAL HEALTH BOARD PLUS

Dr. Ignacia Ciriaco, MHO
Itogon, Benguet

❖ Highlights of the Presentation

The *Local Health Board Plus* has the following components, namely, a) the *WATSAN Para sa Kalusugan* which encapsulates the environmental health services, especially addressing problems with water, toilet and sanitation, b) the Blood Bank for Life which addresses the need for safe and available blood supply and motivates blood donors to donate blood, and c) the Cordillera Iodized Salt which addresses the high prevalence of iodine deficiency disorder and promotes the use of the Cordillera iodized salt. The program was implemented through the local health board in collaboration with non-government organizations, peoples' organization, and the local government unit.

Although the program was beset with problems regarding budget, geography, and weak intersectoral linkages, it nevertheless was able to provide for the construction of 500 sanitary toilets, completion of three waterworks project, establishment of blood bank for donors, and the acquisition of machine to iodize salt.

❖ Open Forum

Moderator: Ms. Lyn Almario

The questions raised focused on the blood bank - where it is located, how it came about; and how it was started - and on the provision of iodized salt in the community

- The blood bank is in the municipality. The problem of blood supply was discussed in a meeting of the health board, resulting in the governor's decision to develop a project to solve such problem. Blood typing and bloodletting activities were conducted. A masterlist was developed to identify the donors' blood types
- A provincial resolution was passed requiring that the salt to be sold in the market should be iodized. At present, there is no control yet on the sale of non-iodized salt.

VI. PESO FOR HEALTH

Dr. Fidencio Aurelia, Chief - Guihulngan District Hospital
Guihulngan, Negros Oriental

❖ Highlights of the Presentation

Peso for Health is a strategy to solve the problems of poverty, limited income opportunity, lack of access to health providers, high cost of health services and inadequate health resources in Guihulngan, Negros Oriental. It is a community-funded integrated hospital and public health program that has identified the community as its partner. A bottom-up approach fosters a sense of ownership of the program among its innovator and participants. The innovative approach encourages partnership among the local government unit, DOH, NGOs and the community through a cost-sharing scheme that allows for the sustainability of health services.

The program has two packages: the basic benefit package and the expanded benefit package, which is composed of emergency medical service, maternal and child health service, family planning service, growth monitoring and nutrition supplementation. Benefits may be availed of by enrolling in the program and paying household membership fee and monthly dues that may come in cash, in kind, or corresponding service.

Integration of the essential players in the health care delivery system is positioned in several levels. Trained family health workers play an important role in bringing health in the hands of the people at the household level. Barangay health workers supervise and monitor the activities of family health workers at the community level. At the municipal level, rural health unit personnel mobilize the community. At the district level, the district hospital provides general administrative and technical support services. The Provincial Health Office provides support to hospital and public health services at the provincial level.

The program resulted in improved accessibility of health services to the community, increased utilization of health facilities, reduced maternal mortality and morbidity, and increased public awareness on health. Keys to the success of the program are active community participation, strong intersectoral linkages, use of indigenous resources, and emphasis on culture and values system.

❖ **Open Forum**
Moderator: Ms. Lyn Almanio

The discussion centered on how the common fund is handled, the responsibility of the BHW over his collection; whether the government provides for the medicines, and the reason why the project does not cover the entire province. The response included the following:

- The fund collected is considered money that belongs to the community. A separate trust fund is not subject to COA rules. A body composed of people's organizations, NGOs, and barangay health workers is responsible for its accounting and has control over the fund.
- While the government provides for the medicines, the people have a corresponding responsibility or active role in the delivery of health care services. The program encourages the participation of the private sector and instills the idea that public health is not the sole responsibility of the government but of everybody, including the private sector.
- The project is being continuously modified. Right now, five municipalities are covered. There is an allocation from the internal revenue allotment intended as part of the seed money for the program. The fund collected from the community is placed in trust, as a separate fund. This is another way of financing health care. The project is also looking at utilizing alternative sources of funds other than the government.

Day 2 : January 26

∅ **Next Steps: Making Things Happen Workshop**

∅ **Plenary Session**

∅ **Presentation of Workshop Outputs**

∅ **Awarding Ceremonies**

**LGU Performance Program (LPP) Summit
Workshop on Next Steps: Making Things Happen**

Westin Philippine Plaza
CCP Complex, Roxas Boulevard, Pasay City
Day 2 – January 26

Purpose and Content

The purpose of the *Next Steps: Making Things Happen* workshop is for participating LGUs to prepare to replicate or adopt *good practices* from other LGUs. Participants were each assigned to a particular workshop group. Unlike the previous day's arrangement where participants were encouraged to join the session of their choice, participants to the *Next Steps* workshop were pre-selected. The idea behind this arrangement is to allow sharing of different experiences and wide dissemination of information. The rich and varied experiences of the participants would also enrich the discussion of issues.

In the workshop, the participants were asked to define the role of *change agent* and encouraged them to come up with answers to three questions enumerated below and previously prepared by workshop organizers.

- What advice would you give to those who would like to be *change agents* in their LGUs and adopt your *good practice*?
- What assistance can you offer to those LGUs that would like to adopt your *good practice*?
- What would you suggest as ways of sustaining the sharing of *good practices* among LGUs over time?

Workshop Objectives

- To identify the responsibilities of *change agents* in the LGU setting.
- To determine the factors that facilitate and hinder the introduction of new ideas and approaches.
- To propose ways in which participants in the workshop can assist their counterparts in other LGUs to introduce and adapt *good practices*.

- To develop specific strategies and identify concrete steps for sustaining LGU-LGU sharing of *good practices*.

Workshop Mechanics

The documentors of each of the five concurrent workshops were assigned as presentors in the plenary session. At the start of the session, the facilitator or moderator posted the definition of a *change agent* on a flip chart or slide projector. Two LGU representatives sat on the panel and were assisted by the moderator in the discussion of the questions. The participants were encouraged to make additional comments or suggestions based on their experiences. The comments were also recorded.

The group selected and agreed on no more than three key points or answers for each of the questions. These were recorded and presented at the plenary session. Below is a summary of the workshop proceedings.

- I. **Group I:**
Romblon/Mindoro Room
Moderator: Dr. Gerardito Cruz
Documentor: Ms. Anna Ventura

Participants of the Group I workshop on "*Making Things Happen*" were briefed on the context of the session which revolved around the definition of *change agent* and discussions of three key questions. The discussions that followed yielded the key issues that are summarized below and subsequently presented at the plenary session. Dr. Hamikar Saniel, MHO of San Miguel, Bohol, and Dr. Ignacia Ciriaco, MHO of Itogon, Benguet served as panelists for Group 1.

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

- ❖ For *change agents*, the advice given include the necessity for (1) organizational development and such activities as strategic planning, survey of needs, and capability building to start a project or *good practice* on the right footing; (2) advocacy activities for both local executives and beneficiaries that could result in strengthening the political will of the LCEs and in inculcating a sense of ownership of the practice in both the

beneficiaries and local leaders; and (3) the change agent should have commitment, credibility, and acceptability in the community.

Question 2: What assistance can you offer to those LGUs that would like to adopt your *good practice*?

- ❖ LGUs should be given assistance that could include (1) study tours such as the Lakbay-Aral; (2) exchange of regular correspondence, including the use of E-mail, documentation of *Good Practices*, and the preparation of a Directory of *Good Practices*; and (3) technical assistance.

Question 3: What would you suggest as ways of sustaining (the sharing of) *good practices* among LGUs over time?

- ❖ Several strategies were proposed to sustain the sharing of *good practices*, namely, (1) conduct of more summits in coordination with the leagues of local government units and the DILG, (2) use of communication technology such as the internet and DOH website; (3) recognition and ownership of *good practices* through more people involvement and empowerment, and technical and financial support from DOH; and (4) the utilization of built-in structures and local resources through integration of such in the Local Development Plan.

II. Group II:
Mindanao Room
Moderator: Dr. Josefina Cabigon
Documentor: Ms. Renee Talavera

After discussing the definition of *change agent* and the context around which the discussions would revolve, Group II shared, discussed, and agreed to present at the plenary session the following key points.

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

- ❖ The group recommended that the *change agent* must (1) exhibit commitment as a worker, (2) make health as a priority program synchronized with all other programs down to the lowest level; (3) seek the support (moral, financial, and others) from the LCEs; (4) maintain operational flexibility and the will to

manage according to set policies; and (5) observe transparency in all transactions.

Question 2: What assistance can you offer to those LGUs that would like to adopt your good practice?

- ❖ The assistance that one may offer LGUs include (1) project site visitation to allow cross-fertilization of ideas; (2) general administrative support (logistics and financial assistance for health insurance); and (3) general technical support such as process documentation, training, research, and conduct of seminars.

Question 3: What would you suggest as ways of sustaining (the sharing of) good practices among LGUs over time?

- ❖ Sustaining the sharing of *good practices* over time would involve the following activities:
 1. Promotion of inter-LGU cooperation Networking at all levels/sectors in
 - The promotion of environmental awareness and sanitary practices.
 - Development and pursuit of a legislative agenda favorable to health.
 - Formulation of an integrated health agenda.
 - Development of cost-sharing schemes.
 - Organizing a functional local health board.
 2. Inventory of health and health-related resources at all levels (foreign and local).
 3. Encourage community health care financing for universal coverage according to the provision of the National Health Insurance Act.

III. Group III:
Sulu Room
Moderator: Dr. Jose Rodriguez
Documentors: Ms. Mary Anne Barcelona
Mr. Renato Manaligod

While the previous day's concurrent workshops were devoted to the presentation and sharing of good practices at the field level, how to adopt or replicate the innovations that were shared by LGU representatives was at the core of the second day's discussions. The definition of a *change agent* was made clear to all participants in

order to set the tone for the discussions that followed. The exercise was designed to enable local executives present to assimilate the lessons of the previous day; take a cue from *good practices* shared and actions pledged on the second day; and for the next step, "take the lead" in applying them in their own settings.

Two presentations were shared by Cotabato and Antique. Dr. Ray Catague, PHO of North Cotabato and Dr. Melba Billones, MHO of Anini-y, Antique offered as the centerpiece of the discussion a successful supplemental feeding program and the marketing of FP through satisfied users.

The following summarize the key points or issues raised by Group III.

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

- ❖ *Change agents* should (1) maintain strong relationships with clients and stakeholders; (2) be persistent and demonstrate commitment at all times; and (3) give proper recognition to all involved.

Question 2: What assistance can you offer to those LGUs that would like to adopt your *good practice*?

- ❖ The assistance that may be offered to LGUs includes (1) technology sharing through documentation; (2) onsite technical assistance; and (3) motivational talks.

Question 3: What would you suggest as ways of sustaining (the sharing of) *good practices* among LGUs over time?

- ❖ To ensure sustainability, the following suggestions were made by the group:
 1. Introduce and provide internet technology to access *good practices/innovations*;
 2. Establish a "Good Practices University" and provide a continuing education program; and
 3. Introduce innovations into livelihood programs.

IV. Group IV:
Samar Room
Moderator: Ms. Pinky Ogena
Documentor: Ms. Gilda Patricia C. Maquilan

The workshop provided the LGUs the opportunity to share among themselves the secret of their successes and the problems encountered by their respective projects. As a result, the session did not only make suggestions in support of the local projects. It also gave the participants assurance and strength that there are compelling reasons to innovate and there are people with common goals that are willing to share, teach, and provide assistance. The suggestions from this session were not limited to the panel since the participants actively contributed to the discussions as well, resulting in a rich harvest of suggestions and insights from both sides. The panel is composed of Dr. Miguel Oppus III, CHO, Davao City, Ms. Elma Albay, FP Coordinator, Davao City and Dr. Roberto Rosadia, Asst. CHO of Marikina City.

It is the common opinion of this group that in order for the *change agent* to be effective, and the innovation to be successful and sustainable, the following steps should be part and parcel of the effort: 1) consultation with the LCEs and the community; 2) identification of the problems and priorities of the community should be given urgent attention; and 3) alliance building to include the wives and children of LCEs.

After such preliminary steps have been undertaken, the *change agent* should be able to identify the thrust of the LGU and to allow for the complementation of efforts. Lobbying for the inclusion of health budget in the annual LGU budget should be done in earnest. It may also be necessary for the proponent to provide LCEs with a one-page summary of the project highlighting its significance. The summary should be simple and direct to the point. Project proponents should not give up on their ideas and innovations and, if necessary, repackage ideas and projects.

Change agents should also explore technical assistance and grants for their projects through networking and regular communication and distribution of information materials. Once the project is already in the mainstream, it is necessary to have an effective monitoring and evaluation strategy and to recognize the contributions of top performers, project partners, the community and the LGU.

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

Change agents should continuously 1) strengthen alliances with local bodies and community organizations (local and international); 2) complement the program thrust of local governments; and 3) provide simple accurate information to allow LCEs to better understand the problems of the community and the benefits that can be derived from the project.

Question 2: What assistance can you offer to those LGUs that would like to adopt your *good practice*?

- ❖ Assistance can be in the form of (1) Lakbay-Aral or exposure trips to other projects; (2) monitoring and evaluation guide; and (3) technical assistance from cooperating agencies.

Question 3: What would you suggest as ways of sustaining (the sharing of) *good practices* among LGUs over time?

- ❖ To sustain the project, it is necessary (1) to lobby for a resolution from the Sanggunian to include the project in the annual budget; (2) give awards of recognition; and (3) hold regular mini summits at the national, provincial and district levels.

V. Group V:
Leyte Room
Moderator: Dr. Aurora Perez
Documentor: Mr. Romeo de la Cruz

The delivery of health services, being a complex thing, should be viewed in a holistic perspective. Different approaches should be employed in order to effect change and efficiency in the context of the cultural milieu of the community. Within this context, the workshop was used by its participants to focus on the role of the *change agent* in the development and implementation of innovative and creative health service delivery practices; the assistance that the *change agent* can offer the LGL; and the different ways by which the sharing of *good practices* may be sustained.

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

- ❖ Early in the discussion, the group agreed that as a *change agent*, one has to put heart into one's role. To realize this mindset, one has to participate in the process of changing the existing structure and social conditions and be ready to be part of the rethinking of the approaches in health delivery. The local government executive, as a *change agent* himself, should have the political will to change existing conditions. He should be creative in facing and solving political, social, and religious barriers. The support and attention of the local government executive is one of the major factors necessary for the smooth and effective implementation of the programs and projects. Hence, in order for the *change agent* to elicit the involvement and commitment of the LCE, he/she should also be creative, consistent and persistent in wooing the local government executive. Mutual sharing and regular meeting between the policymakers and the health workers should be conducted. For the goals to be achieved, money, time, and effort should also be invested.

Question 2: What assistance can you offer to those LGUs that would like to adopt your *good practice*?

- ❖ Health delivery programs, like any other development efforts, are subject to the changing political climate and the personal bias of the incumbent local chief executive. It is, therefore, important that LGUs be given assistance in such areas as:
 1. Development of a comprehensive health care delivery program that should be made part of the long-term development plan of the local government.
 2. Involvement of other community leaders, stakeholders and influential groups in the programs and projects, particularly in the project design and planning.
 3. A strong and intensive advocacy program to carry out the objectives and to elicit the support of the community and leaders. Health advocacy, however, should go hand in hand with the other concerns of the

community. It should not be separated from the other issues and problems being addressed by the community. Peace and social stability are factors in the attainment of efficient health delivery system. Hence, health advocacy campaign should also emphasize attainment of peace and social stability. It should be noted that for it to be effective, it should be culturally sensitive as well.

Question 3: What would you suggest as ways of sustaining (the sharing of) good practices among LGUs over time?

1. Technical assistance and sharing of resources may be extended by program participants to other local government units that intend to do the same kind of programs and projects.
2. Collaboration in looking for funds, program planning, and project design should be encouraged.
3. LPP participants and would-be participants should strengthen their linkages. Mechanisms for them to share their experiences and to learn from each other should be established. Multi-sectoral linkages should also be made in order to convince the community that improved and efficient delivery of health services may be realized only if everybody is involved.

LGU Performance Program (LPP) Summit
Next Steps: Making Things Happen
Plenary Presentation of Group Outputs/Synthesis
Westin Philippine Plaza
CCP Complex, Roxas Blvd., Pasay City
Day 2 – January 26

Mechanics

The plenary moderator opened the session with an explanation that the five breakout groups will each present their key points for each of the three questions previously discussed at the workshop. These questions were also flashed on the screen at the session hall. As earlier agreed upon, the five group documentors presented the results of the deliberation of their particular group.

Group I Presentation

Presenter: Ms. Anna Ventura

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

❖ **Top Three Answers Presented**

1. Organizational Development
 - Strategic Planning
 - Survey of Needs
 - Capability Building
2. Advocacy for both local executives and beneficiaries
 - Strong political will
 - Ownership of practice by both leaders and beneficiaries
3. Commitment, credibility and acceptability of the *change agent*

Question 2: What assistance can you offer to those LGUs that would like to adopt your *good practice*?

❖ **Top Three Answers Presented**

1. Study tours such as Lakbay-Aral.
2. Correspondence and documentation of *Good Practices*

- Directory of *Good Practices*
- Use of E-mail

3. Technical assistance.

Question 3: What would you suggest as ways of sustaining (the sharing of) good practices among LGUs over time?

❖ **Top Three Answers Presented**

1. Sharing of *good practices* through
 - conduct of more summits
 - tapping the leagues of local government units & the DILG
 - use of recent technology, i.e. Internet and DOH Website
2. Recognition and ownership of *good practices* through
 - People involvement and empowerment
 - Technical and financial support from DOH
3. Utilization of built-in structures and local resources
 - integration in the Local Development Plan

Group II Presentation

Presenter: Ms. Renee Talavera

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

❖ **Top Three Answers Presented**

1. To provide commitment as a leader, worker and partner to make health care a priority program that is synchronized with all other programs down to the lowest level.
2. To seek support (moral, financial, and others) from the LCEs
3. To maintain operational flexibility: the free will to manage according to set policy and transparency in all transactions

Question 2: What assistance can you offer to those LGUs that would like to adopt your *good practice*?

❖ **Top Three Answers Presented**

1. To undertake project site visitation
2. To provide general administrative support (logistics/financial assistance for health insurance).

3. To provide general technical support, e.g., process documentation, conduct of training.

Question 3: What would you suggest as ways of sustaining (the sharing of) good practices among LGUs over time?

❖ **Top Three Answers Presented**

1. Promote inter-LGU cooperation through networking at all levels/sectors in
 - The promotion of environmental awareness and sanitary practices
 - The development of a legislative agenda
 - The formulation of an integrated health agenda
 - The development of a cost-sharing scheme
 - The development of a functional local health board
2. Inventory of health and health-related resources at all levels (foreign and local).
3. Encourage community health care financing for universal coverage in accordance with the mandate of the National Health Insurance Act

Group III Presentation

Presenter: Mr. Renato Manaligod

Question 1: What advice would you give those who would like to be change agents in their LGUs and adopt your good practice?

❖ **Top Three Answers Presented**

1. To maintain strong relationship with clients and stakeholders
2. To be persistent and demonstrate commitment at all times
3. To give proper recognition to all involved.

Question 2: What assistance can you offer to those LGUs that would like to adopt your good practice?

❖ **Top Three Answers Presented**

1. To promote technology sharing through documentation
2. To provide onsite technical assistance.
3. To provide motivational talks.

Question 3: What would you suggest as ways of sustaining (the sharing of) good practices among LGUs over time?

❖ **Top Three Answers Presented**

1. Introduce and promote internet technology for easy access to information on *good practices/innovations*.
2. Establish a "Good Practices University" and a continuing education program
3. Introduce innovations into livelihood programs

Group IV Presentation

Presenter : Ms. Gilda Patricia C. Maquilan

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

❖ **Top Three Answers Presented**

1. Strengthen alliances with local bodies and community organizations (local and international).
2. To complement the program thrust of local governments.
3. To provide simple accurate information to allow LCEs to better understand the problems of the community and the benefits that can be derived from the project.

Question 2: What assistance can you offer to those LGUs that would like to adopt your *good practice*?

❖ **Top Three Answers Presented**

1. Conduct or facilitate Lakbay Aral-type of exposure trips to other projects
2. Provide monitoring and evaluation guide.
3. Technical assistance from cooperating agencies.

Question 3: What would you suggest as ways of sustaining (the sharing of) *good practices* among LGUs over time?

❖ **Top Three Answers Presented**

1. Enabling resolution from the Sanggunian to include the project in the annual budget.
2. Giving awards of recognition.
3. Holding regular mini summits at the national, provincial and municipal levels

Group V Presentation

Presenter: Mr. Romeo de la Cruz

Question 1: What advice would you give those who would like to be *change agents* in their LGUs and adopt your *good practice*?

❖ **Top Three Answers Presented**

1. To put heart into one's role.
2. Strong political will to change existing conditions
3. He/she must also be creative, consistent and persistent in wooing the local government executive.

Question 2: What assistance can you offer to those LGUs that would like to adopt your *good practice*?

❖ **Top Three Answers Presented**

1. Development of a comprehensive health service delivery program that should be made part of the long-term development plan of the local government.
2. Involvement of other community leaders, stakeholders and influential groups in the programs and projects, particularly in project design and planning
3. A strong and intensive advocacy program

Question 3: What would you suggest as ways of sustaining (the sharing of) *good practices* among LGUs over time?

❖ **Top Three Answers Presented**

1. Technical assistance and sharing of resource materials.
2. Collaboration in looking for funds, program planning, and project design should be encouraged.
3. Multi-sectoral linkages should also be made in order to convince the community that an improved and efficient delivery of health services may be realized only if everybody is involved.

Overall Moderator: Dr. Aurora Perez

**LGU Performance Program (LPP) Summit
Recognition of Innovative LGUs
& LPP Top Performers**

Westin Philippine Plaza
CCP Complex, Roxas Blvd., Pasay City
Day 2 – January 26

The highlight of the LPP summit was the awarding ceremony that formally recognized the strides (good practices) of the 60 innovative LGUs that contributed to the successful and efficient implementation of selected health programs in their areas. The 15 LPP Top Performers were also cited for their achievement of the end-of-Project benchmarks for fully immunized children (FIC), tetanus toxoid (TT2+) immunization, and vitamin A supplementation coverage. Ten Mindanao provinces and cities, and five provinces and cities in the Visayas were recognized as the LPP Top Performers. The Health Secretary, Dr. Alberto G. Romualdez Jr. was assisted by USAID-OPHN Chief Mr. P.E. Balakrishnan in presenting the awards. LGU awardees were represented by their local health officials in the awarding ceremony.

The following are the innovative LGUs awarded for their good practices.

- ❖ Region I
 - Municipality of Mangaldan, Pangasinan
 - Province of Pangasinan
 - Province of Ilocos Sur
 - Province of La Union

- ❖ Region II
 - Municipality of Dupax del Sur, Nueva Vizcaya
 - Municipality of Villaverde, Nueva Vizcaya
 - Province of Nueva Vizcaya
 - Municipality of Gattaran, Cagayan
 - Province of Isabela

- ❖ Region III
 - Municipality of Candaba, Pampanga
 - Municipality of San Fernando, Pampanga
 - Province of Bataan

- ❖ Region IV
 - Municipality of Cardona, Rizal

- Municipality of Imus, Cavite
 - Municipality of Lopez, Quezon
 - Municipality of Naujan, Oriental Mindoro
 - Province of Oriental Mindoro
 - Province of Palawan
- ❖ Region V
 - Municipality of Daraga, Albay
 - Municipality of Prieto Diaz, Sorsogon
 - Province of Camarines Norte
 - Province of Masbate
- ❖ Region VI
 - Municipality of Anini-y, Antique
 - Municipality of Hamtic, Antique
 - Municipality of Hinigaran, Negros Occidental
 - Municipality of Pulupandan, Negros Occidental
 - City of Bago, Negros Occidental
- ❖ Region VII
 - Municipality of Guihuingan, Negros Oriental
 - Municipality of San Miguel, Bohol
 - City of Cebu
- ❖ Region VIII
 - Province of Leyte
 - Province of Samar
 - Province of Northern Samar
 - Province of Eastern Samar
- ❖ Region IX
 - City of Zamboanga
 - Province of Zamboanga del Sur
 - Province of Zamboanga del Norte
- ❖ Region X
 - City of Cagayan de Oro
 - City of Gingoog, Misamis Oriental
 - Province of Misamis Oriental
 - Province of Bukidnon
- ❖ Region XI
 - Municipality of Matanao, Davao del Sur
 - Municipality of Malalag, Davao del Sur

	City of Davao Province of Davao del Norte
❖ Region XII	Municipality of Bacolod, Lanao del Norte Municipality of Tubod, Lanao del Norte Province of Lanao del Norte Municipality of M'lang, North Cotabato Province of North Cotabato Municipality of Ninoy Aquino, Sultan Kudarat
❖ CAR	Municipality of Itogon, Benguet Municipality of La Trinidad, Benguet Municipality of Bontoc, Mt. Province City of Baguio
❖ NCR	City of Valenzuela City of Marikina
❖ CARAGA	Municipality of Basilisa, Surigao del Norte Province of Surigao del Norte Municipality of Marikatag, Surigao del Sur Province of Surigao del Sur Province of Agusan del Sur
❖ ARMM	Province of Maguindanao

The following are the LPP Top Performers, ranked according to accomplishment of FIC, TT2+, and Vit. A Targets:

1. Davao del Norte
2. Davao City
3. Negros Occidental
4. South Cotabato
5. Surigao del Norte
6. Davao Oriental
7. Iloilo Province
8. Davao del Sur
9. Capiz

10. Cagayan de Oro City
11. Cebu City
12. Surigao del Sur
13. Iloilo City
14. Misamis Oriental
15. North Cotabato

LGU Performance Program (LPP) Summit

January 25-26, 1999

Westin Philippine Plaza

CCP Complex, Roxas Blvd., Pasay City

LIST OF GUESTS

I. DEPARTMENT OF HEALTH (DOH)

1. Hon. Secretary Alberto G. Romualdez
2. Undersecretary Milagros Fernandez
3. Undersecretary Susan Pineda-Mercado
4. Asst. Secretary Zenaida Ludovice
5. Director Brenda Demerre-Lopez
6. Director Adeiisa Ramos
7. Director Loreto B. Roquero, Jr
8. Director Juan A. Perez III

II. UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

1. Ms. Patricia Buckles
2. Mr. P. E. Balakrishnan

III. COMMISSION ON POPULATION (POPCOM)

1. Executive Director Tomas Osias
2. Deputy Exec. Dir. Mia Ventura

IV. OTHER AGENCIES

- | | | |
|----|-----------------------|---|
| 1. | Hon. Emilio Macias II | House of Representatives |
| 2. | Dr. Satish Mehra | United Nations Fund for Pop'n Assistance |
| 3. | Director Elizabeth Go | National Statistics Office |
| 4. | Director Sol Matugas | Dept. of Educ , Culture & Sports - CARAGA |
| 5. | Ms. Jennifer Bowman | De La Salle University |
| 6. | Mr. Quintin Orpiada | The Philippine Post |

LGU Performance Program (LPP) Summit

January 25-26, 1999

Westin Philippine Plaza

CCP Complex, Roxas Blvd., Pasay City

LIST OF PARTICIPANTS

I. LOCAL GOVERNMENT UNITS (LGUs)

Region 1 - Ilocos Region

Ilocos Sur

1. Mr. Santos Ancheta
2. Ms. Rosa Casia
3. Dr. Carmeliza Singson

La Union

1. Hon. Socorro Zarate-Escalante
2. Dr. Jose Ostrea
3. Dr. Conrado Vito

Pangasinan

1. Atty. Geraldine Baniqued
2. Ms. Victorina Bañez
3. Mr. Fyodor Edward Muego
4. Ms. Luzviminda Muego
5. Dr. Ayle Ochotorena
6. Dr. Ophelia Rivera
7. Ms. Victoria Sotto
8. Dr. Alfred Sy

Region 2 - Cagayan Valley

Cagayan

1. Dr. Edgardo Baguion
2. Ms. Albina Garen

3. Mr. Hilario Reyes
4. Dr. Nida Nolasco-Rosales

Isabela

1. Ms. Loreta Domingo
2. Ms. Rochelle Javier
3. Dr. Carmela Labog
4. Ms. Rosalinda Paggao

Nueva Vizcaya

1. Mayor Romeo Magaway
2. Mayor Rodrigo Tabita, Jr.
3. Hon. Marianne Zuraek
4. Ms. Vivian Dumangeng
5. Dr. Virginia Laccay
6. Ms. Lita Tabudlo
7. Dr. Ferdinand Tolentino

Region 3 - Central Luzon

Bataan

1. Dr. Rolando Banzon
2. Dr. Jocelyn Cabarles
3. Mr. Noel Orosco
4. Ms. Zenaida Ramos
5. Ms. Marcelina Rodriguez

Bulacan

1. Hon. Jose B. Lava
2. Ms. Nancy Mandap
3. Dr. Eduardo Valencia

Nueva Ecija

1. Dr. Felicisimo Embuscado
2. Ms. Ma. Aurora de Guzman
3. Dr. Felicitas de Leon

Olongapo City

1. Dr. Elizabeth Carrillo
2. Dr. Maria Socorro Francisco

Tarlac

1. Ms. Teresita Cacdac
2. Ms. Develyn Florendo
3. Dr. Ricardo Ramos

Zambales

1. Dr. Gregorio Cabacar
2. Dr. Imelda Maribeth Garcia
3. Ms. Leonila Padua

Region 4 - Southern Tagalog

Cavite

1. Dr. Antonio Ilano
2. Dr. Nereza Javier
3. Ms. Lenila de Vera

Lucena City

1. Mr. Carlos Daleon, Jr.
2. Dr. Ma. Caridad Diamante
3. Ms. Aurora Mancenido
4. Ms. Leonard Pensader

Marinduque

1. Ms. Ana Mane Hidalgo
2. Dr. Efren Labay
3. Dr. Honesto Marquez

Mindoro Occidental

1. Dr. Michael Enarbia
2. Dr. Antonio Ramos, Jr

Mindoro Oriental

1. Dr. Elsa Alberto
2. Dr. Aristeo Baldos
3. Ms. Norine Dacula
4. Dr. Rogelio Ilagan

Palawan

1. Ms. Chanto Asuncion
2. Ms. Monica Pagayona
3. Dr. Jose Antonio Socrates

Quezon

1. Ms. Caridad Alano
2. Ms. Yolanda Chionglo
3. Dr. Mario Cuento
4. Ms. Salome Paycao
5. Ms. Merlinda Valeña

Rizal

1. Dr. Racquel Aparejo
2. Dr. Angelito dela Cuesta
3. Dr. Eloisa Silao
4. Ms. Flora Simeon

Romblon

1. Ms. Marlie Albano
2. Ms. Brenda Ornum

Region 5 - Bicol Region

Albay

1. Dr. Mercy Chua
2. Dr. Raoul Zantua

Camarines Norte

1. Ms. Marilou dela Cruz
2. Ms. Loria Dipasupil

Catanduanes

1. Dr. Zenaida Rodolfo
2. Ms. Delia Soriao

Masbate

1. Dr. Florenda Almero

2. Ms. Marina Menoles

Sorsogon

1. Dr. Leonor Borja
2. Dr. Ingrid Magnata
3. Dr. Arturo Perdigon

Region 6 - Western Visayas

Aklan

1. Engr. Loma Cawaling
2. Ms. Amparo Sasis
3. Ms. Nuella P. Zaldivar

Antique

1. Gov. Exequiel Javier
2. Mayor Jose Javier
3. Mayor Reynaldo Policar
4. Dr. Nelly Abierra
5. Dr. Melba Billones
6. Dr. Mancar Esperida
7. Dr. Ma. Eva Pacificador
8. Ms. Mildred Quilino

Capiz

1. Gov. Vicente Bermejo
2. Dr. Margarita Albaña
3. Ms. Cristita Granflor
4. Ms. Deborah Juanico

Iloilo City

1. Mayor Mansueto Malabor
2. Ms. Ann Jean Armonio
3. Ms. Mary Edurese
4. Mr. Saturnino Gonzales
5. Ms. Fermina Hamsani

Iloilo Province

1. Gov. Arthur Defensor
2. Ms. Elizabeth Bañez
3. Mr. Godofredo Cubil

Negros Occidental

1. Mayor Carol Guanco
2. Mayor Antonio Suatengco
3. Hon. Mae Javellana
4. Ms. Nelly Arana
5. Dr. Francisco Aycayno, Jr.
6. Ms. Teresita Bayona
7. Dr. Luisa Efren
8. Ms. Maria Celia Fuentebaja
9. Dr. Hedy Gonzales
10. Dr. Pilar Mabasa
11. Ms. Mila Lourdes Tandoy

Region 7 - Central Visayas

Bohol

1. Mayor Silvino Evangelista
2. Hon. Lorenzo Bomcaces
3. Ms. Rosalinda Amodia
4. Ms. Nenita Fullido
5. Dr. Francisco Razalo
6. Dr. Hamilcar Sanie!

Cebu City

1. Hon. Fe Mantra-Ruiz
2. Dr. Erlinda Cabatingan
3. Dr. Felicitas Manaloto
4. Dr. Milagros Padron

Cebu Province

1. Dr. Coralou K. Aznar
2. Dr. Antonio Villamor

Negros Oriental

1. Gov. George Arnaiz
2. Dr. Fidencio Aurelia
3. Ms. Chita Labe
4. Ms. Marietta Mijares
5. Dr. Mary Angeles Piñero

Region 8 - Eastern Visayas

Leyte

1. Gov. Remedios Petilla
2. Ms. Betty Garrido
3. Ms. Aurora Laboy
4. Ms. Lourdes Sari

Eastern Samar

1. Gov. Ruperto Ambil, Jr.
2. Ms. Teresita Orisa
3. Ms. Genevieve Rivera
4. Dr. Renerio Zamora

Western Samar

1. Hon. Domingo Siopongco
2. Dr. Honorata Catibog
3. Ms. Cynthia McKinly
4. Mr. Emilio Rama III

Region 9 - Western Mindanao

Basilan

1. Dr. Abdel Hajir Amat
2. Rajah Mujamad Asad

Zamboanga City

1. Mr. Generoso Celerio
2. Ms. Natividad Ledesma
3. Ms. Leonides Macabinguil

Zamboanga del Norte

1. Gov. Isagani Amatong
2. Ms. Delia Regencia
3. Ms. Annabelle Tan

Zamboanga del Sur

1. Dr. Cathrina Campomanes
2. Ms. Imelda S. Luy

3. Mr. Eriberto Sumalinog

Region 10 - Northern Mindanao

Bukidnon

1. Ms. Violeta Almacen
2. Dr. Jose Cabugas
3. Mr. Romeo Cardoza

Cagayan de Oro City

1. Dr. Efren Celeste
2. Ms. Bernadette Sabio

Misamis Occidental

1. Gov. Ernie Clarete
2. Mayor Jun Azcuna

Misamis Oriental

1. Gov. Antonio Calingin
2. Hon. Salvador Mercado, Jr.
3. Dr. Ma. Bebina Casiño
4. Dr. Vincent Gonzaga
5. Ms. Marilyn Jacot
6. Ms. Vilma Mendez

Region XI - Southern Mindanao

Davao City

1. Ms. Elma Albay
2. Dr. Miguel Oppus III
3. Ms. Digna Salmasan

Davao del Norte

1. Gov. Rodolfo del Rosario
2. Mr. German Brion
3. Ms. Nelia Gumela
4. Mr. Camilo de Guzman
5. Dr. Agapito Hornido
6. Atty. Ruben Pasamonte

Davao del Sur

1. Mr. Floro Jaca, Jr.
2. Dr. Magdalena Josielyn Java
3. Dr. Maxima Martin
4. Dr. Patricia Ornales
Dr. Mahelinde Zambarrano

Davao Oriental

1. Gov. Rosalind Lopez
2. Ms. Josephine Caadiang
3. Dr. Resuldo Malintad
4. Ms. Daisy Mapayo

South Cotabato

1. Gov. Hilario de Pedro III
2. Mr. Samuel Babas
3. Ms. Lorna Lagos
4. Dr. Edgardo Sandig

Region 12 - Central Mindanao

Iligan City

1. Ms. Cleo-Jean Angara
2. Dr. Jessie Diamante
3. Mr. Oliver A. Yap

Lanao del Norte

1. Gov. Imelda Dimaporo
2. Ms. Genoveva Amantiad
3. Ms. Annie Ducay-Lim
4. Dr. Jaime Magat
5. Ms. Fe Soria

North Cotabato

1. Mayor Luigi Cuerpo
2. Dr. Ray Catague
3. Ms. Charita Doyongan
4. Ms. Eulalia Papna
5. Ms. Lutgarda Perocho

Sultan Kudarat

1. Hon. Editha Ancheta
2. Dr. Alfredo Calingin
3. Ms. Lily Derecho
4. Ms. Evangeline Golveque
5. Dr. Timoteo Molleno, Jr.

Cordillera Administrative Region (CAR)

Baguio City

1. Dr. Rowena Galpo
2. Dr. Ma. Felicidad Ganga

Benguet

1. Mayor Cresencio Pacalso
2. Dr. Ignacia Cinaco
3. Dr. Doris Jovellanos
4. Dr. Norma Pacalso
5. Ms. Juliet Sacley
6. Ms. Grace Soriano

Ifugao

1. Ms. Miriam Baguidudol
2. Engr. Carmel Buyuccan
3. Dr. Florence Lunag

Mountain Province

1. Hon. Marcelino Balaso, Jr
2. Dr. Benjamin Dominguez
3. Dr. Penelope Domogo
4. Ms. Catherine Melecio

National Capital Region (NCR)

Caloocan City

1. Dr. Alexander Cruz
2. Ms. Vilma dela Cruz
3. Ms. Loida Gaba
4. Ms. Consolacion Manansala
5. Ms. Leonisa Pantaleon

Las Piñas City

1. Ms. Francisca Catenza
2. Dr. Eliezer Natividad
3. Dr. Esther Oliveros
4. Mr. Angel Urbano

Malabon

1. Ms. Rhodora Alducerte
2. Ms. Victoria Ang
3. Dr. Billy Goco
4. Dr. Purita Javier
5. Dr. Cecilia Marquez
6. Dr. Iluminada Soriano
7. Dr. Florencio Tan

Mandaluyong City

1. Dr. Yolanda Almodiente
2. Dr. Aleli David
3. Ms. Ma. Fe Guilalas
4. Dr. Teresita Lim
5. Ms. Delia Mediana
6. Ms. Ma. Corazon Valencia

Marikina

1. Mr. Federico Adriano
2. Ms. Julie Borje
3. Ms. Blesilda Enriquez
4. Mr. Lorenzo Gatbonton
5. Dr. Alberto Herrera
6. Mr. Romeo Perez
7. Dr. Reynaldo Ponteres
8. Dr. Roberto Antonio Rosadia

Muntinlupa City

1. Ms. Liwayway Argana
2. Mr. Mamerto R. Espino
3. Ms. Ellen Garcia
4. Ms. Erlinda Servillon
5. Dr. Ma. Teresa Tuliao
6. Dr. Azucena Velasco

Parañaque City

1. Ms. Chin Chin Alib
2. Dr. Cecille Catindig
3. Dr. Nicolas Catindig
4. Mr. Philip Carl Jose
5. Dr. Oscar de Leon
6. Dr. Dionisio Sabio
7. Dr. Monchi Vargas
8. Ms. Adoracion Villanueva
9. Mr. Alvin Vizcarra

Pasay City

1. Ms. Teresita Hilario
2. Dr. Editha Estrada
3. Dr. Elvira Lagrosa
4. Ms. Corazon Rivera
5. Dr. Mercedes Salle

Pasig City

1. Dr. Sozonte Domingo
2. Ms. Thelma Mandilag
3. Ms. Teresita Puente
4. Ms. Trinidad Timbol

Quezon City

1. Ms. Lily Bautista
2. Dr. Perla Dosayla
3. Ms. Soledad Encinas
4. Dr. Teresita Novera
5. Mr. Reynaldo Quijano
6. Dr. Ma. Paz Ugalde

Valenzuela City

1. Dr. Irineo Candido
2. Dr. Romulus Peter Roberto Instrella
3. Dr. Antonio Olegario

Autonomous Region in Muslim Mindanao (ARMM)

Maguindanao

1. Ms. Maura Bueno
2. Ms. Agnes Sampulna

3. Dr. Tahir Sulaik

Tawi-Tawi

1. Dr. Mohammad Abdulwahid

CARAGA Region

Agusan del Norte

1. Ms. Grace Miriam Ruth Clemente
2. Ms. Gloria Pabillore

Agusan del Sur

1. Ms. Esterlita Arreza
2. Dr. Joel Esparagoza
3. Mr. Felipe Parilla

Butuan City

1. Dr. Elsie Caballero
2. Ms. Meriam Guanco
3. Ms. Erlinda Milloria

Surigao del Norte

1. Gov. Francisco Matugas
2. Vice Mayor Floro Baltar, Jr.
3. Ms. Rosemarie Catelo
4. Mr. Arturo Cruje
5. Dr. Leonita Gorgolon
6. Dr. Analiza Pingal

Surigao del Sur

1. Gov. Primo Munillo
2. Ms. Milagros Arreza
3. Ms. Lourdes Eliot
4. Dr. Cesar Pagaran
5. Dr. Danilo Viola

II. DEPARTMENT OF HEALTH (DOH)

Central Office

1. Ms. Azucena Banga
2. Ms. Dyesebel Dado
3. Dr. Jose Bernie Franada
4. Dr. Rowena Frogoso
5. Ms. Onofria de Guzman
6. Ms. Liberty Importa
7. Ms. Ma. Ofelia Infante
8. Dr. Ciriaco Manrique
9. Ms. Geraldine Monternayor
10. Ms. Ma. Luisa Orezca
11. Ms. Ofelia Oseo
12. Dr. Orlando Pagulayan
13. Ms. Ma. Cecilia Pangilinan
14. Mr. Angeiito Ramirez
15. Dr. Noel Rico
16. Dr. Wilma Sandoval
17. Mr. Giovanni dela Torre
18. Ms. Portia Vitug

Regional Offices

1. Dr. Edna Abcede
2. Dr. Mary Grace Alviar
3. Ms. Remedios Barretto
4. Dr. Jazmin Chipeco
5. Dr. Ma. Socorro de Gracia
6. Dr. Dibagulun Mamainte
7. Ms. Josefa Mendoza
8. Ms. Nenita Noche
9. Ms. Leticia Olivar
10. Mr. Claudio Pancho
11. Dr. Benita Pastor
12. Ms. Herodina Preston
13. Dr. Lydia Ramos
14. Dr. Emilie Reyes
15. Ms. Leonila Romasanta
16. Dr. Ruben Siapno
17. Ms. Luisa Sibug
18. Dr. Rose Sunio
19. Dr. Aristides Tan
20. Ms. Marilyn Tumiiba
21. Dr. Perla Yray

III. COMMISSION ON POPULATION (POPCOM)

Central Office

1. Ms. Rosela Prada

Regional Offices

1. Director Ignacio Arat
2. Director Rene Bautista
3. Director Pompeia Cortel
4. Director Maduh Damsani
5. Director Manuel Gutlay
6. Director Oscar Mabalot
7. Director Madelyne Mamuri
8. Director Rosalinda Marcelino
9. Director Vicente Molejona
10. Director Psyche Palar
11. Director Camilo Pangan
12. Director Ma. Aurora Quiray
13. Director Leo Rama
14. Director Marcial Terrado

IV. UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

1. Mr. Ephraim Despabiladeras
2. Mr. Charles Lerman
3. Ms. Cora Manaloto
4. Ms. Nilda Perez
5. Ms. Ma. Paz de Sagun
6. Mr. Nap de Sagun

V. UNITED NATIONS FUND FOR POPULATION ASSISTANCE/PROJECT MGT. TEAM (UNFPA/PMT)

1. Dr. Teresita Castillo
2. Mr. Eleazer Collado
3. Ms. Feliciana Erakdo
4. Dr. Rosalinda Majorais
5. Dr. Rita Papey

VI. COOPERATING AGENCIES

Access to Voluntary Surgical Contraception (AVSC)

1. Dr. Ma. Otelia Costales
2. Dr. Annabel Sumayo
3. Dr. Edward Tandingan

Helen Keller International (HKI)

1. Ms. Emerita Garma
2. Ms. Nancy Haselow
3. Ms. Catalina Sandrino
4. Ms. Ellen Villate

Integrated Maternal & Child Care Services & Dev't, Inc. (IMCCSDI)

1. Ms. Chita Quitevis

Johns Hopkins University/Pop'n Communication Services (JHU/PCS)

1. Mr. Jose Miguel dela Rosa
2. Ms. Rosario Nolasco
3. Ms. Lolita Tabale

John Snow, Inc./Family Planning Logistics Management (JSV/FPLM)

1. Mr. Clifford Olson

John Snow Research and Training Institute, Inc. (JSRTI)

1. Ms. Easter Dasmarinas
2. Ms. Lerna Melo

Management Sciences for Health (MSH)

1. Ms. Daisy Abdao
2. Mr. Ferdinand Alfaro
3. Ms. Ann Buxbaum
4. Mr. Arthur Encamacion
5. Ms. Rose Ann Gaffud
6. Ms. Ma. Theresa Fernandez
7. Dr. Cecilia Lagrosa
8. Ms. Leticia Licera
9. Dr. Florante Magboo
10. Ms. Emily Maramba
11. Ms. Ma. Celia Marin
12. Mr. Romeo Mascardo
13. Ms. Cecilia Robles
14. Dr. Jose Rodnguez
15. Ms. Judith Seltzer
16. Ms. Ma. Loida Sevilla

Philippine Center for Population Development (PCPD)

1. Atty. Robert Doller
2. Ms. Cynthia Herce
3. Ms. Ma. Socorro Reyes

Population Council (POPCOUNCIL)

1. Dr. Marilou Costello
2. Dr. Zelda Zablan

VII. OTHERS

1. Ms. Lyn Almario
2. Ms. Mary Anne Barcelona
3. Mr. Henry Briones
4. Dr. Josefina Cabigon
5. Dr. Gerardito Cruz
6. Mr. Romeo dela Cruz
7. Ms. Gilda Custodio
8. Dr. Angel Libre
9. Mr. Renato Manaligod
10. Ms. Gilda Patricia Maquilan
11. Ms. Pinky Ogena
12. Dr. Aurora Perez
13. Ms. Renee Talavera
14. Ms. Anna Ventura