Strengthening Local Governance for Health (HealthGov) Project

Second Annual Work Plan
October 1, 2007 to September 30, 2008

Cooperative Agreement No. 492-A-00-06-00037
(Revised) November 12, 2007

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This document was produced for review by the
United States Agency for International Development/Manila

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Annexes

List of Acronyms

ADB	Asian Development Bank
AI	avian influenza
AIP	annual investment plan
AO	administrative order
ARMM	Autonomous Region in Muslim Mindanao
BAI	Bureau of Animal Industry
BCC	behavior change community
BHW	*barangay* (village) health worker
BTL	bilateral tubal ligation
CA	cooperating agency
CDLMIS	Contraceptive Distribution and Logistics Management Information System
CEDPA	Centre for Development and Population Activities
CHD	Center for Health Development
CHLSS	Community Health and Living Standards Survey
COP	Chief of Party
CSO	civil society organization
CSR	Contraceptive Self-reliance
DBM	Department of Budget and Management
DCOP	Deputy Chief of Party
DILG	Department of the Interior and Local Government
DOF	Department of Finance
DOH	Department of Health
DOH Rep	Department of Health representative
EC	European Commission
F1	FOURmula ONE
FGD	focus group discussion
FHSIS	Field Health Services Information System
FP	family planning
FPS	Family Planning Survey
GAD	gender and development
GTZ	*Deutsche Gesellschaft für Technische Zusammenarbeit*
HealthGov	Strengthening Local Governance for Health Project
HIV/AIDS	human immunodeficiency virus/acquired immunedeficiency syndrome
HMIS	health management information system
HPDP	Health Policy Development Project
HRHMD	Human Resource for Health Management and Development
HSR	Health Sector Reform

ICV	informed choice and voluntarism
ILHZ	inter-local health zone
IP	indigent population
IR	intermediate result
IRA	internal revenue allotment
IT	information technology
IUD	intrauterine device
LAC	local AIDS council
LCE	local chief executive
LCP	League of Cities of the Philippines
LEAD	Local Enhancement and Development for Health Project
LGU	local government unit
LHB	Local Health Board
LMP	League of Municipalities of the Philippines
LPP	League of Provinces of the Philippines
LSI	Living Standards Index
M&E	monitoring and evaluation
MARP	most-at-risk population
MCH	maternal and child health
MHO	Municipal Health Office/Officer
MIPH	municipal investment plan for health
M/I/PIPH	municipal/inter-local health zone/province-wide investment plan for health
MIS	management information system
MLGU	Municipal local government unit
MOA	memorandum of agreement
NCDPC	National Center for Disease Prevention and Control
NCR	National Capital Region
NDHS	National Demographic and Health Survey
NEDA	National Economic and Development Authority
NGA	national government agency
NGO	non-governmental organization
NSV	no-scalpel vasectomy
OH	Office of Health
OIDCI	Orient Integrated Development Consultants, Inc.
OP	operational plan
PC	Provincial Coordinator
PHB	Provincial Health Board
PHIC	Philippine Health Insurance Corporation
PhilHealth	Philippine Health Insurance Corporation
PHN	Public Health Nurse

PHO	Provincial Health Office/Officer
PHTL	Provincial Health Team Leader
PIPH	Province-wide Investment Plan for Health
PLGU	provincial local government unit
PMG	Project Management Group
PMT	Provincial Management Team
PNGOC	Philippines NGO Council on Population, Health and Welfare, Inc.
POPCOM	Commission on Population
PPA	program, projects, activities
PPT	Province-wide Planning Team
PRISM	Private Sector Mobilization for Family Health Project
PSEP	Public Service Excellence Program
RC	Regional Coordinator
RCT	Regional Composite Team
RH	reproductive health
RHM	Rural Health Midwife
RICT	Regional Implementation and Coordination Team
RNA	rapid needs assessment
RTI	Research Triangle Institute
SA	situational analysis
SBMR	Standards-based Management with Recognition
SDIR	Service Delivery Implementation Review
SHIELD-ARMM	Sustainable Health Initiatives through Empowerment and Local Development Project – Autonomous Region in Muslim Mindanao
SO	strategic objective
SOAg	Strategic Objective Agreement
STI	sexually transmitted infection
STTA	short-term technical assistance
TA	technical assistance
TAP	technical assistance provider
TB	Tuberculosis
TB LINC	Linking Initiatives and Networking to Control Tuberculosis Project
TL	Team Leader
TOT	training of trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

1 Purpose and overview of the project

1.1 Goals and objectives

The *Strengthening Local Governance for Health* (HealthGov*)* Project is USAID's flagship project designed to strengthen local government units' (LGU) commitment to and support for public health services and their capacity to plan, provide, manage, and finance quality health services sustainably, particularly family planning (FP), maternal and child health (MCH), tuberculosis (TB), and HIV/AIDS services. The project puts premium on getting local leaders to invest in health. It focuses on empowering LGU staff and developing their capacity to meet the organizational, financial, and systems development challenges to address emerging health needs. It seeks to reinforce the capacity of NGOs and civil society to advocate successfully for improved health services. The HealthGov Project is implemented by RTI International, in partnership with JHPIEGO, the Centre for Development and Population Activities (CEDPA), the Philippines NGO Council on Population, Health and Welfare (PNGOC), and Orient Integrated Development Consultants, Inc. (OIDCI).

Focusing on sustainable solutions, HealthGov will develop LGU capacity for continuous participatory problem solving to improve health systems, build LGU support for investing in health, and strengthen the participation and advocacy skills of civil society. To accelerate these efforts, HealthGov will develop a network of technical assistance providers or TAPs (e.g., universities, NGOs, consultants, government agencies) that LGUs may engage to provide them with customized training and technical assistance (TA) services to solve key problems. In addition to improved health outcomes, sustainable "success" as a result of HealthGov assistance will be achieved when an LGU can properly identify its health sector problems and practical solutions in a participatory manner, and has access to sufficient resources (financial and technical, internal and external) to solve these problems.

HealthGov will help broker and develop long-term sustainable relationships between (1) LGUs and local technical assistance provider organizations that will help enhance LGU skills and knowledge, and (2) LGUs and their constituents to improve the quality and accessibility of health services. Toward this end, HealthGov will focus on four key activity areas, which correspond to the results framework of USAID's SO3: Improved Family Health Sustainably Achieved:

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

- ***Improving and expanding LGU financing for health (IR 1.2)*** – HealthGov will (1) support LGUs integrate priorities into multi-year investment plans and explore

national and local partnerships to sustain HIV/AIDS surveillance and prevention activities; (2) introduce performance-based decision making to LGUs; (3) assist LGUs to diversify their financial base; and (4) help them complete market segmentation.

- ***Improving service provider performance (IR 1.3)*** – HealthGov will help LGUs (1) improve human resource management, (2) enhance health service quality assurance systems, (3) strengthen health provider training systems, and (4) boost their response to infectious diseases including TB, HIV/AIDS and AI.

- ***Increasing advocacy for health (IR 1.4)*** – HealthGov will help (1) deepen LGU officials' and leaders' commitment to health by providing advocacy tools and training and introducing advocacy concepts during LGU orientation and participatory planning workshops; (2) reinforce the capacity of health providers and civil society champions to develop and deliver effective health advocacy messages to local government officials and decision-makers; (3) intensify civil society advocacy and participation with training and grants; and (4) strengthen partnerships between health providers and civil society to promote supportive policies and priority health programs, and expand opportunities where information is shared and consensus is built.

This work plan describes the proposed activities during the second year of the project. **Chapter 1** summarizes the overall goals and objectives of HealthGov and describes the project's organization and management structure. Progress during the first year of the project is highlighted in **Chapter 2:** the achievements to date influence the strategies and activities of HealthGov during subsequent years. **Chapter 3** describes the overall strategic approach for the second project year, including LGU engagement. **Chapter 4** provides an overview of the regional and provincial level technical assistance plans of the project for the second year of implementation. (Detailed provincial work plans are included in **Annex 2** to this report). **Chapter 5** describes the TA interventions developed and supported by HealthGov that respond to the needs and priorities of the LGUs identified in the regional and provincial TA plans. Finally, the project's monitoring and evaluation system is described in **Chapter 6**: this starts with a description of the links between the project's TA and the desired health outcomes, followed by progress on the baseline conditions and targets for USAID's OP indicators and HealthGov's project level indicators, as well as development of the project management information system (PMIS) and website.

1.2 Project organization and management

HealthGov views collaboration as a basic requisite for the effective implementation of the project's technical assistance interventions and its organizational structure was developed to avoid a "silo effect." The objective is to foster among the staff a culture of interdependency, instead of a collection of separate entities. HealthGov comprises three inter-related teams (see organizational chart below) that work across diverse disciplines in a spirit of cooperation.

Project Management Group

- Chief of Party
- Deputy Chief of Party
- LGU Governance Team Leader
- Health Programs Team Leader
- Field Operations Team Leader
- Finance and Administrative Manager

promptly and that staff and consultants are quickly mobilized to provide support to the field teams. The Field Operations Team Leader directly supervises the regional teams based in the three project field offices.

- ***Regional Teams.*** The three Regional Teams are each led by a Regional Coordinator and include technical staff and Provincial Coordinators. The Regional Teams are responsible for developing strategic partnerships with regional stakeholders, and for engaging LGUs, NGOs, and other local partners in achieving the project's goals. The teams identify local needs and priorities and ensure that TA provided by the project is appropriate and responsive to local conditions, needs and priorities.

2 Progress during the first year of the project

2.1 Project start-up

The HealthGov project mobilized in October 2006 with all five key staff members on board and other senior technical staff were engaged early on in the first year. Most of the vacant positions were filled during the course of the year, but the project has not yet been able to find qualified candidates for the positions of Grants and Contracts Manager and HIV/AIDS Specialist. In the interim the Finance and Administrative Manager handles grants and contracts and a consultant provides TA for HIV/AIDS.

All the project offices, including the national project office and regional offices for Luzon, the Visayas and Mindanao, were set up and are fully operational. During the first year of operation the office policies and procedures related to financial management, procurement, travel, expense reimbursements, and office communications were also established.

2.2 Project coordination

External and internal coordination is critical to effective project management and DOH, the national government counterpart of HealthGov, is closely involved in the planning, preparation, and implementation of project activities. Following an orientation meeting with the Secretary of Health at the start of the project, consultations are held on a regular basis with DOH and its regional offices, the Centers for Health Development (CHD) (see text box). The project also meets with other national, regional, and local counterparts, including LGUs, on a regular basis.

Key national-level counterparts

- **DOH family:**
  - **BIHC and FICO** (coordination of support for the implementation of Health Sector Reform and FOURmula ONE for Health)
  - **NCDPC** (piloting of new approaches to service standards and quality improvement, service delivery performance analysis)
  - **CHDs and DOH Reps** (local coordination, planning, capacity building, and training)
  - **PhilHealth** (social health insurance coverage, enrollment, accreditation)
  - **POPCOM** (informed choice and voluntarism)
- **DILG, DOF**
- **LGU leagues** (LPP, LMP, LCP)

USAID/OH organizes a monthly COP meeting in which HealthGov participates and project staff also frequently meet with the CTO and other OH staff. In addition, senior OH staff have traveled to the field to meet with HealthGov counterparts, in particular with governors and their provincial teams. To promote close collaboration and coordination among the various health projects, USAID/OH has initiated a number of inter-CA Technical Working Groups (TWGs) and HealthGov leads or actively participates in many of these groups. (See also section 2.7 on Inter-CA Collaboration).

HealthGov staff regularly discuss coordination with other donor-funded projects, especially at the field level. At the national level, coordination meetings have been held

with other donor-funded projects (EC, GTZ, ADB) and the COP has participated in a number of donor coordination meetings.

In addition to these external coordination efforts the project has involved its own staff members in planning, consultations, and capacity building activities. Regular management and staff meetings, planning sessions, and workshops are organized to strengthen the cohesion, understanding and capacity of the project team.

To build team cohesiveness and to establish a common understanding of project activities and team members' roles and responsibilities, staff members participated in a number of internal conferences during the first year. The purpose of these forums was to prepare the first year work plan and cross-train staff in project technical areas. Topics covered in the orientations include the local government code, health governance, health sector reform, Service Delivery Implementation Review (SDIR), Standard-based Management and Recognition (SBM-R) approach, Contraceptive Self-reliance (CSR), Tiahrt Amendment and the Mexico City Policy, LGU advocacy concepts and processes, civil society dynamics, administrative orders (AOs) issued by DOH that require participation of and implementation by LGUs, and coordination with USAID cooperating agencies (CAs). Orientation was also provided on the DOH FOURmula ONE (F1) for Health policy framework and the preparation and implementation of the Province-wide Investment Plan for Health (PIPH).

2.3 LGU engagement and orientation

HealthGov defines LGU engagement as a continuum of activities that starts with the first contact with the LGU – this may be a courtesy call with the local chief executive or a meeting with a health program manager – and progresses to the provision of technical assistance supported by monitoring and evaluation. The engagement process ends with the LGU's "graduation" from any need for HealthGov-provided TA.

HealthGov sees LGU engagement as building and nurturing a relationship with the participating LGU, with each party having its own roles and responsibilities. Depending on the LGU's needs TA may be provided at different points of the continuum. For example, TA to support the preparation of a health investment plan is extended early on in the engagement process to many of the participating LGUs and this activity will help identify other TA needs of the local government.

The LGU engagement plan takes into account three different categories of provinces with respect to health sector reform and other activities, and the HIV/AIDS high-risk zones (See text box). These LGU categories are (1) initial F1 convergence sites for health sector reform, (2) F1 roll-out sites for health sector reform, and (3) other HealthGov sites.

In the project's first year, HealthGov engaged and provided technical support to 23 provinces which were selected by DOH and USAID, with input from the project, based on a set of criteria. The selection criteria included population size; health conditions in the areas of FP, MCH, TB, HIV/AIDS, and child nutrition; poverty level; LCE commitment to pursue health reforms; and other donor activities in the province. A visit to each province to introduce the USAID assistance program, consult partners at the provincial level and identify initial TA needs denoted the formal start of the engagement process.

Following the election of new local chief executives (LCEs) in June 2007, HealthGov considered it critical to carry out a second round of LCE orientations. CHDs and PHOs, with TA from HealthGov, initiated these orientations on health sector reform and the local health sector agenda. In addition, HealthGov engaged local NGOs and CSOs to participate in health reform implementation, initially through orientation on HSR and FOURmula ONE, followed by participatory planning.

HealthGov-supported LGUs

1. Initial F1 convergence sites
- Pangasinan
- Capiz
- Negros Oriental
- Misamis Occidental
- South Cotabato

2. F1 Rollout convergence sites
- Isabela
- Albay
- Zamboanga del Norte
- Zamboanga del Sur
- Zamboanga Sibugay
- Compostela Valley
- Sarangani

3. Other HealthGov sites
- Cagayan
- Tarlac
- Nueva Ecija
- Bulacan
- Negros Occidental
- Aklan
- Bohol
- Agusan del Norte
- Bukidnon
- Davao del Sur
- Misamis Oriental

4. HIV/AIDS high-risk zones
- Clark Development Zone (Angeles City and San Fernando)
- Metro Manila (Pasay City and Quezon City)
- Iloilo City and Bacolod City
- Metro Cebu (Lapu-Lapu, Mandaue, and Cebu City)
- Zamboanga City
- Davao City and General Santos City

From Year 2 onwards the project will focus on extending TA to clusters of municipalities and cities even as it continues to support the 23 provinces to maintain the momentum of health reforms implementation. The total number of LGUs (provinces, municipalities, and cities) that may benefit directly from HealthGov support could reach 576. The involvement of LGUs will depend on local needs and priorities and the commitment of local decision makers to health sector reform.

2.4 Situation analysis

Between January and March 2007, HealthGov visited all the regions, the 23 provinces and 12 HIV/AIDS high-risk LGUs covered by the project. Called a “scoping mission”, this data gathering activity was one of the initial steps in the LGU engagement process. It included consultations with CHD directors and other regional partners like the Commission on Population (POPCOM), Philippine Health Insurance Corporation (PhilHealth) and the Department of the Interior and Local Government (DILG). At the provincial level scoping involved an orientation meeting with the governor and meetings with LGU officials, public health staff and civil society organizations (CSOs).

The objective of the scoping mission was to gather from each region and province information on the LCE's commitment to health, recent health sector developments, the dynamics of the local health system and areas where the provinces may need technical assistance. Scoping helped to surface the responsiveness of the provinces to and readiness for TA. It also determined how local champions and CSOs can be engaged and capacitated to support and advocate for sufficient funding and a favorable policy environment for health.

Collectively, this information gave HealthGov (and other USAID CAs) an indication of the TA requirements of the regional partners and provincial LGUs, as well as the form and focus of TA the project is expected to provide to counterparts to help them strengthen key LGU management systems, increase LGU financing for health, improve service provider performance, and broaden advocacy on service delivery and financing. The results of the scoping missions were summarized in provincial fact sheets. These fact sheets will be updated regularly as new information becomes available.

2.5 Initial technical assistance provision

During the first year, HealthGov provided TA based on the F1 site classification of the 23 provinces. For example, in the F1 convergence sites (Pangasinan, Capiz, Negros Oriental, Misamis Occidental and South Cotabato), HealthGov was requested by DOH to focus on the preparation and implementation of the contraceptive self-reliance (CSR) plan of the LGUs. In preparation for TA to the F1 roll-out sites (Isabela, Albay, Sarangani, Compostela Valley, Zamboanga del Norte, Zamboanga del Sur and Zamboanga Sibugay), HealthGov worked closely with the DOH central office and HPDP to review and revise the tools and guidelines for use in the PIPH preparation. HealthGov also assisted DOH in orienting the CHDs on HSR, F1 and the PIPH process. As mentioned above, following the local elections in May the project supported the CHDs and PHOs of the 23 provinces to design and implement LCE orientations. In the remaining provinces (Cagayan, Bulacan, Nueva Ecija, Tarlac, Bohol, Negros Occidental, Aklan, Agusan del Norte, Bukidnon, Davao del Sur and Misamis Oriental) the project, together with the CHDs and PHOs, identified current gaps and weaknesses in the local health systems that impede improvements in health outcomes, especially the high priority health indicators identified by USAID. The TA activities undertaken by HealthGov in the first year are summarized in the following sections

PIPH preparation
In collaboration with CHDs and regional partners, TA during the first year of the project focused on assisting LGUs prepare their Province-Wide Investment Plan for Health (PIPH) in six F1 roll-out provinces and 12 other provinces. HealthGov participated in an Inter-CA Task Force that assisted DOH-BLHD to formulate Guidelines for PIPH Development and the project introduced a number of innovations in operationalizing the Guidelines:

- Training of trainers and facilitators from a pool of CHD staff, DOH-Reps, and PHO staff;
- Ensure wider participation of LGUs through the preparation of municipal or component city investment plans for health as well as ILHZ investment plans;
- Introduction of SDIR as a key tool for situation analysis;

- Development of guidelines for internal review, consolidation and integration of municipal, inter-local, and provincial plans into a PIPH.

Contraceptive Self-reliance (CSR)

HealthGov supported CHD and POPCOM in Region 10 in enhancing the CSR monitoring tool. HealthGov identified information domains and indicators that correspond to the five attributes of a successful local CSR implementation (viz., political commitment to eliminate the unmet need for family planning (FP), an LGU-provided safety net for free contraceptives, improved access to all other FP methods, expansion of private sector sources, and integration of FP with other services for women) and incorporated them in the monitoring tool.

The improved tool takes stock of the enabling environment for CSR at the LGU level (e.g., CSR planning, executive and legislative issuances that support CSR); determines LGU commitment to the CSR strategy in terms of forecasting, financing, procurement, and targeting of free contraceptives for distribution to the poor; ascertains LGU provision for improved access to other family planning methods; and establishes information on the LGU's expansion of private sources of contraceptives as IUD, BTL, and NSV services.

Service Delivery Excellence in Health (SDExH)

HealthGov initiated the modeling of a continuing quality improvement approach called Service Delivery Excellence in Health. SDExH integrates the strengths of the Public Service Excellence Program (PSEP) and the Standards-based Management and Recognition (SBM-R) approach, and adopts *Sentrong Sigla* quality standards as reference standards. SDExH will sharpen the focus on clinical processes to produce measurable improvements in service provision. The NCDPC Director has adopted SDExH as one of DOH's continuing quality improvement approaches. The project conducted an SDExH orientation training for DOH-CHD representatives from the F1 provinces of Pangasinan, Negros Oriental, South Cotabato, and ARMM as well as program managers from the DOH central office. Following the design and orientation phase the first of four SDExH workshops was pilot-tested in Misamis Occidental. DOH, recognizing the value of SDExH, issued Department Personnel Order No. 2007-1394 creating a technical working group (TWG) on Service Delivery Excellence in Health. The TWG is tasked, among other things, to develop and SDExH operational framework and comprehensive plan, advocate for the adoption of the SDExH approach in other health programs and projects, provide TA as well as monitor and evaluate SDExH implementation.

Service Delivery Implementation Review (SDIR)

In collaboration with DOH-NCDPC and other USAID CAs, HealthGov developed a service delivery-centered assessment tool that provides a performance analysis framework for F1. Called SDIR, the tool is intended to provide program managers, service providers and policy makers with information on the service delivery status in their province, municipality or city. SDIR allows its users to determine gaps between desired and actual performance, identify underserved populations, assess the status of the support systems for the health programs (e.g., governance, financing, regulation, referral, logistics, procurement, supervision, monitoring), and evaluate the effectiveness of existing interventions. SDIR enables health officials to identify underlying causes of performance gaps and formulate strategic interventions that will enhance service delivery performance. SDIR outputs can also be used to advocate with LCEs for support to and inclusion of key interventions in the annual investment plan. During Year 1, the project

provided TA in the conduct of an SDIR workshop for one city and 16 municipalities in Capiz and an orientation on SDExH for the Municipal Health Officers and Public Health Nurses in Bulacan and Aklan. HealthGov also provided TA to CHD 9 in the use of SDIR as a situation analysis tool to generate data for PIPH preparation in the three provinces of the Zamboanga peninsula, and to CHD 10 in assessing program performance and identifying the most pertinent and necessary interventions.

Informed choice and voluntarism (ICV)
HealthGov crafted the project compliance monitoring plan that was implemented in the first project year.

NGO/CSO orientations
In collaboration with CHDs, HealthGov organized and facilitated NGO/CSO orientation workshops on health sector reform for six clusters of provinces (south, north, and west Mindanao; Visayas; and two clusters in Luzon). The orientations were designed to help broaden stakeholder involvement in health decision-making, build support and constituency for health, enhance partnerships for health between LGU health staff and NGO/CSO/community, and strengthen NGO/CSO community advocacy for health.

2.6 Monitoring and evaluation

The project has developed an M&E system that will track both USAID Operation Plan (OP) indicators and HealthGov's own project indicators. The project team has collected data from local counterparts and facilities through the scoping visits, interviews, and secondary data analysis to establish baseline conditions and identify TA needs and priorities. In addition, HealthGov carried out a population survey among 3,000 households in 29 provinces to collect baseline data for selected OP indicators.

oject deliverables

- First Annual Work Plan
- Branding and Marking Plan
- M&E Plan
- Quarterly Reports (Q1 to 3)
- Second Annual Work Plan

The draft M&E plan was submitted to USAID in December 2006 and June 2007 (revised) and describes the proposed M&E system. (Other key project reports are listed in the text box). The M&E plan identifies the performance indicators and explains data collection and reporting methods. The report also describes the Project Management Information System (PMIS) designed to capture and manage the flow of relevant data for the project, and the project website, which was created to provide access to information to all project staff and to other HealthGov stakeholders. Data on project-supported training activities is uploaded on USAID's TraiNet facility.

2.7 Inter-CA coordination

During the first year of the project HealthGov participated actively in several collaborative activities with other USAID CAs and DOH. Among these activities are the following:

- HealthGov maintained coordination with other USAID CAs to respond to common issues related to USAID concerns both at the central and regional project levels. This included inter-CA coordination related to monitoring and evaluation and baseline

data-gathering for the OP indicators led by HPDP; informed choice and voluntarism, CSR monitoring and family planning (FP) in the workplace led by PRISM; quality service delivery and provider performance (the technical working group of which is spearheaded by HealthGov); advocacy and behavior change, chaired by SHIELD- ARMM; and tuberculosis led by TB LINC. HealthGov also initiated the PhilHealth Technical Working Group (TWG) to address health care financing issues, particularly in relation to Philippine Health Insurance Corporation (PHIC) universal coverage and accreditation.

- HealthGov participated in meetings and provided technical inputs to the DOH TWG on CSR Plus. In addition, HealthGov (together with HPDP) assisted in the preparation of the new PIPH guidelines for the F1 rollout sites. HealthGov staff attended other meetings convened by DOH as well as other stakeholders such as the Commission on Population (POPCOM) and PHIC on issues related to *Sentrong Sigla* (center of excellence) certification and the utilization of the TB-DOTS reimbursement fund, among others.

- HealthGov conducted regional coordination meetings with other CAs to discuss interfacing of project activities in LGUs where other CAs are also active.

- During the initial scoping missions, HealthGov staff touched base not only with CHDs but also with the regional offices of POPCOM, PHIC, and the Department of the Interior and Local Government (DILG) to identify areas for potential collaboration.

3 Overall strategy for the second year of the project

3.1 Strategic directions

The overall direction of the project for the second year of implementation will build on the foundations laid in the first year. The various scoping visits and data collection activities, workshops and orientations of LCEs and local government counterparts, and capacity building of NGOs, CSOs and other stakeholders has provided the project with a strong local network of partners and in-depth knowledge of the situation on the ground. This has enabled the project to prepare initial provincial level work plans that respond to local conditions, needs and priorities. The design, piloting and evaluation of TA interventions in the first year – including improved PIPH guidelines, SDIR and SDExH approaches, and CSR planning and monitoring tools – provide a menu of strategies and tools that LGUs can select from when they address their health priorities. More TA interventions will be developed during the second year of the project.

As described in our technical proposal and the work plan for Year 1, HealthGov TA to LGUs is directed by a number of guiding principles: HealthGov assistance is demand- driven and strategic in nature; the project engages regional and local partners as technical assistance providers; project activities are closely coordinated with other CAs; and HealthGov TA is guided by the DOH's Health Sector Reform framework.

Demand driven. HealthGov TA is based on a thorough analysis of local conditions and participating LGUs are directly involved in the identification of their needs and priorities and in the selection of appropriate TA responses. To receive TA support, LGUs are expected to contribute some of their own resources to implement TA activities: their contributions are counted as cost share to the project. The partnership between the project and the LGU is based on a mutual commitment: to be eligible for further TA support the LGU is expected to implement the recommended actions resulting from earlier assistance.

Strategic TA provision. To maximize the use of limited (personnel and financial) resources, HealthGov needs to decide what TA is made available when and where. The project will not be able to respond to every TA demand from the LGUs but it will identify issues and priorities that fall within the scope of the project and are common to a number LGUs and that can be addressed by providing TA to a "cluster" of LGUs. TA will also be phased, depending on the situation: for instance, in providing TA for PIPH preparation priority will be given to the F1 roll-out sites that need to complete their plans by October
2007, while other HealthGov provinces can be assisted later.

Sustainable engagement of TAPs. HealthGov will not directly perform the tasks of its regional and local counterparts, but empower them to improve their performance by providing technical advice, building capacity, and providing training. This approach will ensure that local capacity is created to sustain the improvements brought about with USAID support beyond the life of the project. While in the first year the main focus has been to develop the capabilities of CHDs and PHOs (particularly in the preparation of LGU investment plans for health), in the second year the variety and number of TAPs working with the project will be significantly broadened and expanded. Potential new TAPs include a number of national partners (such as the leagues of provinces, municipalities and cities) and regional or local organizations (including universities and

NGOs). The use of a voucher system will be piloted to support the development of a sustainable way of providing TA to LGUs (see Section 3.2 below).

Collaboration with other CAs. HealthGov will continue to coordinate and cooperate intensively with other CAs to maximize the impact of USAID assistance. In addition to our leadership and participation in national-level TWGs (see Section 2.7 above) HealthGov staff will actively engage other CAs at the regional level in the coordination of plans, joint field visits and collaboration in the implementation of project activities, including data collection, workshops and training and other TA. (See also Section 3.3 on inter-CA collaboration).

Health Sector Reform framework. The HSR policy of DOH will continue to provide the overall strategic framework for the project, guiding the support to the participating LGUs. As described in more detail elsewhere in the report, our TA will be tailored to the individual conditions and needs in each province, municipality or city, but the provinces can be grouped into three broad categories: F1 convergence sites, F1 roll-out sites and other HealthGov supported sites. Support for the preparation, improvement and/or implementation of their investment plan for health will be a common theme in every LGU.

3.2 The use of a voucher system to fund technical assistance

The purpose of a voucher system is to manage the flow of resources to the participating LGU and help ensure that these resources are utilized for priority TA needs that the LGU has identified and the project has committed to provide. A voucher essentially represents a (financial) limit against which an LGU is authorized to draw from, to fund TA inputs needed to ensure the success of a priority program, project or activity eligible for such assistance. The limits may be set annually or for the entire duration of the project.

There are three key elements to the voucher system namely: the participating LGU or other project counterpart, the technical assistance needs and the level of resources.

Participating agency. Participating agencies are the organizations or institutions that the project is assisting. These agencies include the participating provincial, municipal and city governments and the DOH, including the CHDs. A formal Memorandum of Agreement (MOA) will broadly define the terms of participation and it provides the framework for the types of assistance that the project can provide.

Technical Assistance needs. TA needs refer to specific inputs to programs, projects and activities that the participating agency identifies as priority and are determined to be eligible for assistance under the project. Not all TA needs may be provided by HealthGov. Aside from eligibility of the program, project or activity, HealthGov will also determine that the TA is critical to the success of the project. As mentioned earlier, the MOA could provide the basis for the eligibility of a TA need.

Resources. Resources refer to the value of financial assistance that a participating agency may draw upon to fund its TA need. There are two modes for setting a limit to the value of TA available. One mode is to set an amount based on a criteria determined by the project. This mode would be applicable if the limit needs to be set before details (especially financial details) of TA are available. Another is to set a limit based on a batch of TA needs identified and costed by the participating agency. In the latter case, a batch

of TA needs is translated into a TA package in which, among others, inputs expressed in terms of specialist's man-days, workshop expenses, travel expenses and others are costed and cost sharing arrangements are defined. Based on these packages, a limit is set. The TA package also provide the basis for monitoring progress on the priority program or project as well as the TA itself. The disadvantage of this mode is that the TA packages have to be prepared beforehand. In this mode, the agency has a firm basis for the determination of its counterpart. In both modes, the participating agency is encouraged to prioritize its TA needs.

The TA packages are the bases for drawing against the voucher. HealthGov, through its own specialists, will assist the agency organize for the implementation of TA packages, especially in identifying and mobilizing appropriate advisers or specialists (including assistance to the agency in preparing Scopes of Work), designing and implementing training programs or consultative events and monitoring the effectiveness of consultants or advisers, called upon to assist the agency. An added responsibility of the project is to assist the agency evaluate the effectiveness of the support in the context of the performance of the agency's priority program, project or activity for which the TA was provided. The agency will be regularly apprised of the status of resources available to it.

HealthGov will establish a roster of consultants, specialists and advisers who possess expertise relevant to the needs of the participating agencies. This roster is expected to expand as the emerging TA needs of LGUs and other participating agencies are confirmed and more local expertise is identified.

3.3 Inter-CA collaboration

HealthGov will continue to lead in a number of inter-CA TWGs that have been formed during the first year. These TWGs will continue to serve as the venue where key technical areas that require inter-CA coordination are discussed and issues that affect implementation are resolved. These TWGs include Service Delivery, PhilHealth, Procurement and Logistics. And as new issues emerge that would necessitate inter-CA response new TWGs or Ad Hoc inter-CA groups will be created.

HealthGov will also continue to participate and provide technical inputs to the following TWGs spearheaded by other CAs (named in brackets): Monitoring and Evaluation (HPDP), IMNCH (HPDP), HIV/AIDS (USAID/OH), CSR (PRISM); TB (TB Linc), Advocacy (Shield-ARMM) and ICV (USAID/OH). With HealthPRO now on board, it is expected that a TWG related to materials development and BCC will be formed under its leadership.

The results of these various collaborations will be translated in the form of regional and provincial TA activities of HealthGov. For example, the Family Health Book that will be developed by the IMNCH TWG will be pilot tested in one of HealthGov's project sites, Compostela Valley and Davao City. The ICV compliance monitoring tool that was developed by the ICV TWG will be integrated in the CSR TA plan for the different provinces. HealthGov also assisted the DOH and POPCOM in integrating this into the roll out of the Responsible Parenthood Movement at the LGU level. The strategic directions for the HIV/AIDS sites that were agreed upon by the HIV/AIDS TWG will serve as one of the bases for the development of the TA plan for the 12 high risk sites for HIV/AIDS covered by the project.

In addition to the USAID inter-CA collaboration, HealthGov's technical inputs to the various DOH initiated TWGs like CSR Plus, ICV and TA to the CHDs are also deemed significant especially in the development of tools and guidelines as well as in their use and field implementation.

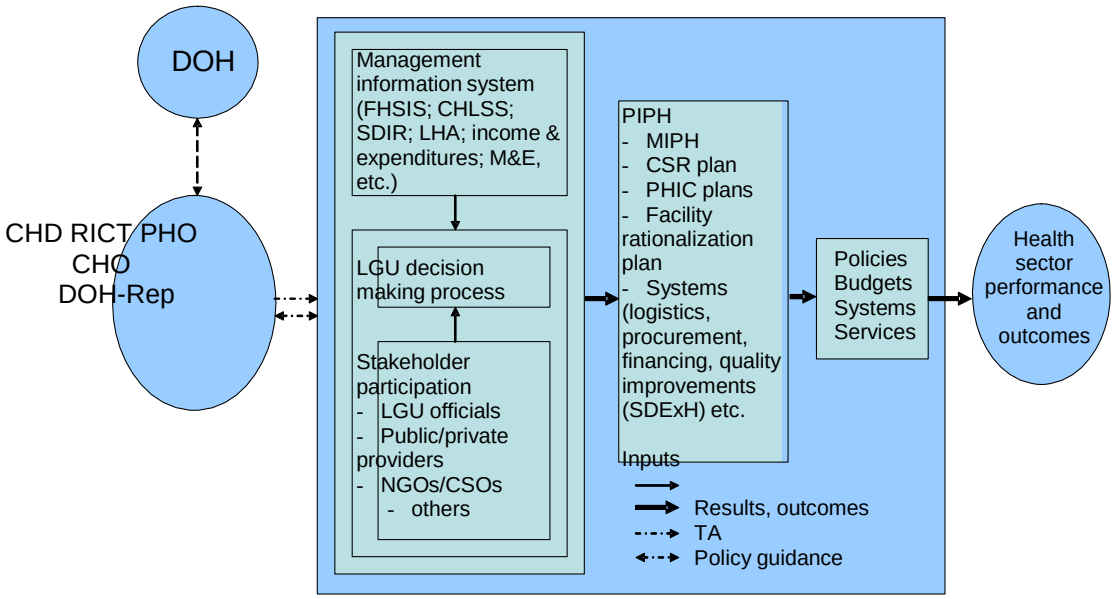
At the regional and provincial levels, HealthGov will collaborate very closely with primary and secondary stakeholders in the implementation of its TA activities. This will include activities related to identification and planning of TA to LGUs, quarterly review and scheduling of activities. Specific coordination and collaboration activities are articulated in the individual TA plans of the 23 provinces.

4 Technical Assistance Interventions

4.1 Strategy for TA production and delivery

The strategy for TA provision is anchored on the goal to provide policy and TA support to strengthen local governance for health through greater stakeholder participation and increasing use of locally generated information for decision making. This framework can be described with the aid of the following figure.

Strengthening policy and TA support to local governance for health through evidence-based participatory local decision making



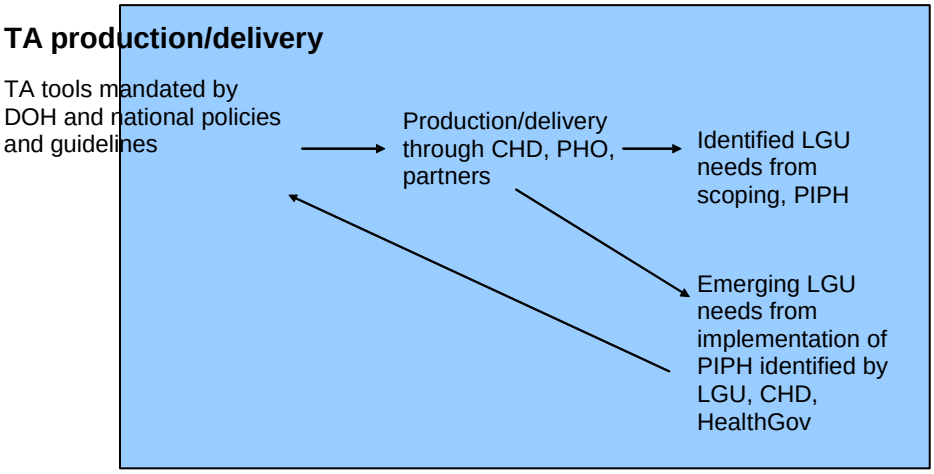
Local governance is about making decisions that are reflected in better policies, bigger budgets, more effective systems, and expanded high quality services. These in turn impact positively on health sector performance and health outcomes. But LGU decision making can be made more effective if it involves wider participation of various stakeholders, including NGOs/CSOs and the private sector. Moreover, LGU decision making can be more relevant if informed by national and locally generated information on the various aspects of the health sector, i.e., outcomes, sector performance, finance, and coverage of target populations. Once these two ingredients are built into the LGU decision-making process, a model emerges of what might be called "evidence-based, participatory local decision making" for health.

These decisions, arrived at in this manner, will be embodied in the Province-Wide Investment Plan for Health (PIPH), with its component sub-plans such as the Municipal City, and ILHZ investment plans for health (MIPH, CIPH and ILHZ-IPH), CSR plans, plan for achieving universal PhilHealth coverage as well as systems improvement sub-plans.

The implementation of these plans will then translate into policies, budgets, systems and expanded quality services.

To initiate and sustain this process, a number of tools are needed: health management information tools for locally generated data gathering and analysis for decision making, planning tools, tools for capacity building in policy development, and tools for expanding the participation of a larger number of stakeholders. HealthGov, in collaboration with other CAs, will provide TA to counterparts in the production of these tools and in rolling out these tools to LGUs. These counterparts and their roles include the DOH in the development of national policy or guidelines, the CHDs in the development of tools and capabilities to provide technical assistance to LGUs, and PHOs in the development of capabilities for effective implementation and timely monitoring.

The strategy for TA production and delivery based upon national policy and guidelines is depicted in the figure below. TA tool development responds to the needs identified by LGUs as revealed in HealthGov's initial scoping during the early LGU engagement process and in the PIPH. These TA tools will be developed for and with selected counterparts. They in turn will delivery the TA assistance to the LGUs with technical backstop support from HealthGov, TAPs and other CAs as needed.



In the implementation of the PIPH, new TA needs identified by the LGUs are likely to emerge. These will also be developed with target partners as co-producers and delivery by these partners to the LGUs with technical support from HealthGov, other CAs and TAPs as needed.

4.2 Overview of technical assistance

The anchor of HealthGov's TA plan for the second year is the comprehensive situation analysis derived from the results of provincial scoping, service delivery implementation reviews, annual reports, extent of LGU engagement in the first year and baseline data collected in each of the 23 provinces. The customized provincial-level TA plans (presented in **Chapter 5** and **Annex 2**) are based on a common set of underlying considerations:

- Alignment with overall USAID SO3 concerns, including achievement of USAID operational indicators and HealthGov indicators;
- Support to health sector reform with particular reference to F1 policy framework;
- Changes in the provincial and municipal political landscape brought about by local elections;
- LGU health priorities and demand for TA as reflected in their respective PIPH;
- Strengthening of mechanisms for broader stakeholder participation, including NGOs, CSOs and other community representatives, in the planning and implementation of PIPH;
- Building on the strategies and tools developed during Year 1 of the project (i.e., PIPH guidelines, SDIR, SDExH, CSR monitoring, MIPH/ILHZ planning) for replication and institutionalization;
- Implementation of innovative approaches for the provision of TA, dissemination and wider application of best practices, and proven and cost-effective methods of TA delivery;
- Local capacity of CHDs, PHOs and LGUs to absorb TA and to implement follow-up activities;
- Utilization of external TAPs to assist LGUs manage their respective TA needs, and;
- Harmonization with the HealthGov TA plans and that of other USAID CAs and donors.

The project's TA interventions will continue to be lodged within the four intermediate result areas of HealthGov, intertwined with the four pillars of F1, and implemented at the LGU level through the PIPH. Accordingly, the priority areas of TA during the second year of HealthGov will focus on strengthening systems and processes that will lead to improvements in health outcomes in the participating provinces, particularly in the program areas of FP/MCH, TB, Vitamin A and micronutrients, HIV/AIDS, AI and other infectious diseases. The priority TA interventions for the second year of the project are listed in **Table 1** below.

Table 1: Technical Assistance Areas

Technical areas/issues	Technical Assistance		
	National	**Regional**	**Local/provincial**
Service delivery			
Service Delivery Excellence in Health (SDExH)	Support to DOH in the: • Completion of SDExH models • SDExH implementation review • Enhancing the SDExH modules • Development of the guide in operationalizing SDExH • Formulation of plan of action for SDExH expansion	Build capabilities of CHDs on SDExH monitoring and provision of technical assistance	Build capabilities of LGUs in SDExH monitoring and provision of technical assistance and implementation
Service Delivery Implementation Review (SDIR) follow- up	Support DOH in enhancing the SDIR tools	Provide TA to CHD regional teams in managing and supporting SDIR outputs.	Build capacities in implementation of acceleration plans /monitoring and supervision
Improving the FP training system	• TA support in enhancing the training module for FP-CBT • Support to DOH-NCDPC in the conduct of TOT	Build capabilities of CHD regional teams for FB-CBT training	Support to training of service providers on FP-CBT
Informed choice and voluntarism (ICV) compliance monitoring	• Support to the training of program coordinators / technical staff on ICV and RPM. • Support to develop mechanism of reporting ICV compliance	Build capabilities in conducting training on ICV for service providers	• Build capabilities in conducting training on ICV for service providers • Support implementation of ICV and reporting mechanism for ICV compliance
Pilot testing of integrated maternal, newborn and child health services (Family Health Book)	Participates with HPDP in developing framework and tools for FHB	Support HPDP in mobilizing regional partners to support FHB	Build Capability for FHB implementation

Ensuring access to broad range of FP services including VSC	Coordinate with HPDP and other CAs to support DOH in development of CSR strategy / tools in expanding access to high quality VSC and maximizing high volume service providers	• Support in documentation of best practice • Support in establishing network of FP service providers and trainers	TA support for training of service providers on FP VSC or building confidence of service providers for IUD / VSC
Improving procurement and logistics system	• Support in consolidating and integrating forecasting tools for essential commodities for MCH / FP / TB / STI / HIV –AIDS • Support in the development / enhancement of guidelines / tools in the procurement options, inventory control and distribution and storage.	Build capacities in providing TAs in procurement and logistics system	Support in the implementation of improved procurement and logistics system
Improving supervision and monitoring	Support in enhancing PHN Manual on Supervision	Build capabilities in providing TA to LGUs in strengthening supervision and monitoring.	Support to capacity building in strengthening supervision and monitoring
Strengthening LGU HIV/AIDS program	With HPDP, support DOH in developing a guide in formulating strategic and investment planning for HIV / AIDS Prevention and Control Program	Build capacity in providing TA to LGUs in strategic and investment planning for HIV/AIDS	• Support capacity building in strategic / investment planning for HIV/AIDS. • Support LGUs in implement-ting their strategic plans specifically in governance, financing and prevention intervention strategies.
Improving local TB responses	Participate in the discussions of national issues / concerns through the TB TWG.	Support to CHD in providing TA to LGUs with low performance.	Build capacities in improving TB case detection, cure rate and EQA.
Developing a community-based early warning system (CBEWS) for avian influenza	• Support DOH / DA and National AI Task Force in the finalization of the training manual on Community- Based Early Warning System • Participate in the national activities of the task force	Build capacities in providing TA to LGUs for CBEWS.	Support in the establishment of CBEWS

Governance and Regulation			
Planning and implementation			
Investment planning for health – use of health sector/F1 framework for planning	Support to DOH for the completion of the PIPH planning manual through development in collaboration with HPDP and other CAs	Support to CHDs to build their capacity to lead the development of PIPH, monitor its implementation, and provide technical assistance to catchment LGUs, including development of guidelines for PIPH sub-plans to include MIPH, CIPD, ILHZ-IPH, in collaboration with other CAs	Support to PHOs to build their capacity to develop the PIPH, monitor its implementation, and provide technical assistance to component M/C-LGUs and ILHZs in collaboration with other CAs.
CSR –strengthen national policy on and local response to CSR	Support DOH in developing a national policy for strengthening local CSR response and identification of CSR TA toolkit for CHDs in collaboration with HPDP and PRISM	Support to CHDs to build their capacity to lead in the development and implementation of CSR TA toolkit consisting of planning and monitoring tools for assisting LGUs (in collaboration with PRISM)	Support PHOs and other local bodies to build their capacity to develop and implement CSR planning and monitoring tools in collaboration with PRISM
Performance-based grants/contracting in implementing PIPH	Support DOH in developing implementing guidelines for performance-based grants or contracting based on existing AO applied to public health, in collaboration with HPDP	Support CHD in developing implementing guidelines for performance-based grants or contracting based on existing AO, applied to public health and providing TA to LGUs	Support PHOs in designing and implementing performance-based grants or contracting based on existing AO applied to public health and providing TA to LGUs
Health Management Information System			
Local data generation for identifying unmet needs and for identification of the poor (Community Health and Living Standards Survey)	Assistance to DOH and PhilHealth in developing national policy on identifying indigent families to be enrolled in the Sponsored Program of the NHIP through the Inter-Agency Technical Working Group for the Implementation of PhilHealth Board Resolution No. 982, s. 2007, in collaboration with HPDP and EC	Support to CHDs to build their capacity to provide technical assistance to LGUs to develop, implement and use locally generated data for identifying unmet needs and for identifying the poor through a Community Health and Livings Standards	Support to PHO and other local bodies to build their capacity to develop, implement and use locally generated data for identifying unmet needs and for identifying the poor through a Community Health and Livings Standards Survey

	TA teams	Survey	
Local Health Accounts	Support DOH to develop CHD Technical Assistance Tool to monitor impact of health sector reform among LGUs in collaboration with HPDP and Shield	Support to CHDs to build their capacity to provide technical assistance to LGUs to develop, implement and use LHA for monitoring health financing reforms among LGUs	Support to PHOs to build their capacity to provide TA to develop, implement and use LHA for monitoring health financing reforms contained in PIPH
Local health policy development			
Capacity building for local policy development	Support DOH to develop capacity building program for LCEs, Sanggunian members, and NGO/CSOs for local policy development	Support CHDs to develop capacity to provide technical assistance to LGUs in local policy development involving LCEs, Sanggunian members, and NGO/CSOs	Support PHO, Sanggunian, and local NGO/CSO to develop capacity in local policy development involving LCEs, Sanggunian members, and NGO/CSOs
Financing			
Guidelines for planning for achieving PhilHealth universal coverage	Support to DOH for the completion of the PIPH planning manual (of which the planning guidelines for achieving PhilHealth universal coverage is a component part) in collaboration with HPDP	Support to CHDs to build their capacity to provide technical assistance to LGUs to develop and implement province-wide plan for PhilHealth universal coverage that includes identification of the poor, accreditation of facilities, and schemes for sharing of premium subsidies, among others	Support PHOs and other local bodies to build their capacity to develop and implement province-wide plan for PhilHealth universal coverage that includes identification of the poor, accreditation of facilities, and schemes for sharing of premium subsidies, among others
Guidelines for Public Finance Management (PFM) planning for health	Support to DOH for the completion of the PIPH planning manual (of which PFM planning guidelines is a component part) in collaboration with HPDP	Support to CHDs to build their capacity to provide technical assistance to LGUs to assess, develop and implement LGU PFM plans	Support PHOs and other local bodies to build their capacity to assess, develop and implement LGU PFM plans in support of PIPH implementation
Public expenditure management study	Assist DOH to develop a mechanism for spending the DOH budget for greater impact, specifically to develop a system for bulk contracting, manage expenditure flows through performance-based	Support to CHDs in implementing DOH expenditure management system from the results of the pilot study in CHD 11	Assist PHOs to develop capacity to identify and use DOH and CHD resources for local financing requirements for health.

	triggers, and design and implement a monthly monitoring scheme for funds flow, through a pilot study on the flow of funds from DBM to CHD 11 and to LGUs in the catchment area, in collaboration with HPDP and EC TA teams		
PhilHealth Benefit Review study	Support to DOH and PhilHealth to undertake a systematic and strategic review of PhilHealth's benefit packages based on PhilHealth Benefit Review Plan, with attention to the review of existing institutional arrangements related to effective implementation of benefit programs based on policy intentions, in collaboration with HPDP and other CAs	Support to CHDs to build capacity for monitoring of implementation of PhilHealth benefit packages with attention to coordination of PhilHealth and DOH at central and regional levels, PhilHealth relationships with LGUs and PhilHealth's relationships with providers, employers, beneficiaries and other stakeholder groups, in collaboration with HPDP and other CAs	Support to PHOs to build capacity for monitoring of implementation of PhilHealth benefit packages in component LGUs
Case studies of local financing schemes	Support to DOH to compile case studies of local financing schemes for advocacy, capacity building, and planning purposes at the LGU level in collaboration with CAs	Support to CHDs to identify, develop and use case studies of local financing schemes for advocacy, capacity building, and planning purposes at the LGU level in collaboration with CAs	Support to PHOs to identify, develop and use case studies of local financing schemes for advocacy, capacity building, and planning purposes at the LGU level in collaboration with CAs
Advocacy			
Guide to Building Partnerships for Health	Support to DOH in installing HSR consumer participation strategies, specifically developing a guide to building and sustaining partnerships for health including the setting up of appropriate coordination and partnership mechanisms	Support to CHDs in enhancing their capacity to engage various local stakeholders specifically NGOs/CSOs in HSR	Support to M/C/PHOs and other LGU health staff to link up, engage and collaborate with local NGOs/CSOs and other stakeholders on health
Training on Effective Championing for	Support to DOH in developing a pool of trainers and mentors on advocacy and	Support to CHDs in strengthening the capacity of	Support to M/C/PHOs, other LGU health staff ,

Health	effective championing for health	HEPOs and DOH Reps to directly advocate and/or provide TA to LGUs to develop and implement health advocacy activities	NGOs/CSOs, and LGU health champions in increasing advocacy for health
Training on Constituency Building for Health	Support to DOH in developing a pool of trainers and mentors on constituency building for health and in building a broad base of support for health/HSR	Support to CHDs in enhancing their capacity to provide TA to LGUs to build a solid constituency for health anchored on evidence-based and participatory health governance	Support to M/C/PHOs, local Sanggunian, LGU officials, NGOs in LGU special bodies in building a mass base or solid constituency for health
Tool for Community Health Monitoring	Support to DOH in establishing community feedback mechanisms and strengthening its monitoring of health policies, programs, plans , projects, activities, other services and budgets	Support to CHD in enhancing their capacity to provide TAs to LGUs to install community health monitoring and feedback mechanisms	Support to M/C/PHOs in fostering the involvement of people and the communities in monitoring health services, policies, PPAs and budgets including reporting of incidence of diseases in their localities, community-based surveillance or health watch, articulation of their satisfaction/ grievances, etc.
Guide to documenting LGU experiences in health advocacy and partnership building for health	Support to DOH in enriching its existing pool of knowledge and best practices on health governance	Support to CHDs in building their capacity to identify, document and disseminate promising approaches in health governance	Support to M/C/PHOs and partner NGOs/CSOs in harnessing locally- driven solutions and approaches in health governance

TA will be implemented through capacity building activities like training and workshops. These will be supported by the development of strategies and tools, guidelines and manuals, mentoring and access to external TA providers and consultants. Continuing TA will be based on LGU commitment and support from CHDs and PHOs to implement mutually agreed upon milestones to sustain TA interventions and to ensure that systems that have been put in place are functional, operational and lead to tangible results.

4.3 Strengthening LGU management systems and financing for health

In the second year of the project, TA will focus on assisting LGUs complete and implement their PIPH. The principal TAPs will again be the CHDs and other regional partners with support from HealthGov. HealthGov, in collaboration with other CAs, will use a monitoring tool to ensure that the Family Health component of the PIPH is implemented well in order to impact on OP indicators.

Specifically, TA will focus on the development with partners and roll-out to LGUs of tools and guidelines in the following broad areas: (See also **Appendix 2** for a matrix of TA products for development and roll-out):

HealthGov Year 2 TA interventions to improve LGU Management Systems and Financing (IR 1.1 and 1.2)

Planning and implementation

- Completion of PIPH
- Monitoring to track local progress in PIPH implementation
- CSR assessment and monitoring tool
- CSR planning in the context of the new AO
- Performance-based contracting in implementation of PIPH

Financing

- Planning for universal coverage of PhilHealth
- Identifying the poor (see also under Management Information System above)
- Local health accounts (see also under Management Information System above)
- Public finance management guidelines
- Case studies of complementary local health care financing

Management information system

- Local data generation for identifying unmet needs and for identification of the poor
- Local health accounts

Local policy development

- Capacity building for local policy development of LCEs, LHB, Sangguanian, NGOs/CSOs, and barangay officials
- Strengthening DOH-PHIC-CHD-LGU policy links

4.4 Planning and implementation

Completion of PIPH. Towards the end of Year 1 (September 2007) many of the provinces that have formulated their PIPH were still be conducting an internal technical review, consolidation and integration process and it is expected that this process will spill

over to the beginning of the second year. This will be followed by a mandate to implement by the LCEs (Governor and Mayors) through a Provincial Partnership Forum with the participation of NGOs, CSOs and other stakeholders. An operational plan for 2008 will be developed by each province and this will be implemented starting January 2008.

Monitoring to track local progress in PIPH implementation. TA will be provided to develop guidelines for setting up a monitoring system to track the local progress of PIPH implementation. The guidelines will be co-produced by an Inter-CA group led by HealthGov and its counterparts, namely DOH, CHD and PHO of a pilot province. The resulting guidelines will subsequently be delivered to other LGUs through the CHD (to provinces) and through the PHO (to the municipalities) in the form of orientations and training on the use of the guidelines.

CSR assessment and monitoring tool. A draft CSR assessment and monitoring tool was co-produced by CHD 10 and RICT partners and an Inter-CA group consisting of HealthGov and PRISM. This tool was originally designed for the region but was deemed useful for nationwide use and it is currently being reviewed by the DOH CSR TWG for possible adoption nationwide. In Year 2, work will involve finalization of the tool and development of guidelines for implementation and analysis. Once approved by the DOH CSR TWG, the tool will be rolled out by DOH to the CHDs, and in turn the CHDs will roll it out to the provinces for LGU adoption. TA to training of trainers in the use of the guidelines will be provided by HealthGov in collaboration with other CAs.

CSR planning in the context of the new AO. A forthcoming AO on CSR to strengthen local CSR response contains a number of new directions, including the promotion of all FP methods, integration of FP into MCH and safe motherhood services, protecting the poor, and expanding private sector participation through development of high volume providers for IUD and VSC. An Inter-CA group led by HealthGov will work with DOH, CHD and PHO as co-production partners in producing a set of planning guidelines to address the new directions of the new AO. South Cotabato will serve as the pilot province in developing a province-wide CSR plan adopting the PIPH approach. The resulting planning guidelines will then be applied by LGUs through the TA support of CHDs and regional partners, with backstop assistance from HealthGov and other CAs.

Performance-based contracting in implementation of PIPH. One of the features of the PIPH is the option to implement some key interventions through performance-based agreements with NGOs and the private sectors, both to achieve efficiencies in the use of resources and to widen stakeholder participation in health. Initial applications might be in the HIV/AIDS high risk areas, where certain critical interventions to assist difficult to reach clients might be implemented by NGOs and the private sector.

4.5 Management information system

Local data generation for identifying unmet needs and for identification of the poor. With HealthGov support, a new tool was drafted by CHD 10, the PHO of Misamis Occidental and the CHO of Oroquieta. The tool combines information generated by the old Community-Based Management Information System (CBMIS) that collected data on unmet needs for FP, Vitamin A supplementation, TB and maternal care, with the Living Standards Survey (LSS) that collected data for means test and classification of clients

according to the "poverty" status. The new tool is called Community Health and Living Standards Survey.

In Year 2, this tool will be finalized together with implementation guidelines and pilot tested in Misamis Occidental. The output of the test will be a final set of guidelines for application in other provinces. The tool will be rolled out to the other provinces by CHDs, PHOs and CHOs with technical support from HealthGov.

Local health accounts. The Local Health Accounts (LHA) is a province-wide estimate of health care expenditures by all financing agents, which include national and local governments, PhilHealth, households, and other private groups. Expenditure uses include personal care, mainly hospital care, and public health care, i.e., expenditures on RHUs and BHSs by municipalities and health centers by city governments. The LHA is a useful set of information to track progress of HSR/F1 implementation through changes in expenditure patterns.

To institutionalize the process of routinely estimating LHA, the guidelines for the preparation of LHA will be co-produced with the DOH, CHD, PHO, Local Finance Committee, and the National Statistical Coordination Board through its regional offices. HealthGov and other CAs will provide TA and the guidelines will be tested in a pilot CHD and one of its provinces, namely, CHD 7 and Negros Oriental. The output of this co- production will be a set of guidelines including implementation modes and coordination with DOH and NSCB. Other CHDs and PHOs will be oriented and trained in the use of the guidelines and they in turn will transfer the technology to other provinces.

4.6 Financing

Planning for universal coverage of PhilHealth. A major source of financing for health is PhilHealth. There is a need to plan for progressive achievement of universal coverage, first among the indigents to ensure financial protection of the poor, and then to the other programs. A planning guideline will be developed by HealthGov with partner CHDs and PHOs in three pilot regions and provinces (CHD 6 and Aklan; CHD 5 and Albay, and CHD 2 and Cagayan) to be used by LGUs in planning for universal PhilHealth coverage.

The guidelines will cover methodologies and data requirements for projection of households by PhilHealth program groups, estimation of premium subsidies, estimation of reimbursements and capitation payments, estimation of investment requirements of facility accreditation and expansion of IPP enrollment. The guidelines will also include options for ensuring the use of PhilHealth revenues for health at the hospital and RHU levels. The guidelines will then be roll-out by CHDs to F1 convergence and roll-out sites through orientation and training of trainers with HealthGov providing backup technical support.

Identifying the poor (see also under Management Information System above)

Local health accounts (see also under Management Information System above)

Public finance management guidelines. A major support system for the implementation of the PIPH is public finance management. The DOH and donors will specifically evaluate the adequacy of such a system in decisions regarding award of

grants to the F1 roll-out sites. Even for non-roll out sites it is important that these investments are managed well as the LGUs will be making large investments in health through the PIPH.

The guidelines will be co-produced with the CHD, PHO and MHO in a pilot province and municipality (tentatively CHD 2 and Isabela). It will cover the procurement and logistics system, planning and budgeting system, setting of financial outcomes (funds flow, trust funds, revolving funds, and special accounts) and resource mobilization. The section on resource mobilization will cover alternative options for financing, alternative modes of non-traditional financing schemes, revenue enhancement programs, and public-private partnership arrangements. The resulting guidelines on public finance management will include an orientation and training guide for training of trainers.

Case studies of complementary local health care financing. Several LGU experiences in health care financing need to be documented and analyzed as case studies to provide LGUs examples of what others have done. This is the best way to advocate certain types of financing modes. Guidelines for tapping existing sources such as loans already exist: what is needed is to show which LGUs have tapped such sources, why and with what results.

The case studies will include such innovations as corporatization of health facilities (e.g., La Union hospital), alternative models of imposing user fees, and PhilHealth premium subsidy sharing among LGUs and households (e.g., Agusan del Norte). These case studies will be used by other CHDs, PHOs and MHOs to advocate to LCEs new sources of financing for health.

4.7 Local policy development

Capacity building for local policy development of LCEs, LHB, Sangguanian, NGOs/CSOs, and barangay officials. A key to the strengthening of local governance for health through wider participation of stakeholders and increasing use of locally generated data for decision making is the capacity building of LCEs, LHBs, Sangguanian members, NGO/CSO, and barangay officials in what is popularly known in LGU circles as “evidence-based participatory local decision making”.

The capacity building design (or curriculum) will include case studies illustrating evidence-based legislation and decision making; the assessment and use of locally generated data to formulate a problem that can be addressed by legislation or focused intervention. The co-producers of HealthGov for the capacity building design will include the CHD, DILG, PHO, Governor, SP on health, and Liga ng Barangay in a pilot province. The roll-out to other LGUs through orientation and training of trainers will be carried out by the CHD, PHO and SP with technical backup support by HealthGov.

Strengthening DOH-PHIC-CHD-LGU policy links. There is a need to better link policy issues experienced by LGUs with policy making at central levels (DOH and PhilHealth) to inform national policy making. Likewise, there is a need to bring down national policy guidelines to the LGUs for guidance in implementing key health sector interventions. HealthGov will participate in the DOH TWG on CSR, the Inter-CA TWG on CHD Toolkit development, the Inter-CA TWG on PhilHealth, and the Inter-Agency TWG for the Implementation of the PhilHealth Board Resolution of Means Testing, and other such

DOH TWGs, Inter-CA groups, and Inter-Agency TWGs that provide venues for bringing local concerns to national attention.

4.8 Improving service provider performance

In Year 2, HealthGov will contribute to improving the performance of LGU service providers and ensuring quality of services through the provision of TA in the following key areas:

HealthGov Year 2 TA interventions to improve service provider performance (IR 1.3)	
Improving human resource management • Improving the service provider training system by updating the Family Planning Competency-based Training Manual and Supervisory Training Manual	**Ensuring high quality in health service delivery** • Establishment of SDExH models; enhancing SDExH; expanding SDExH implementation • Managing the results of SDIR and the implementation of acceleration plans in 23 provinces and HIV/AIDS high-risk zones • Informed choice and voluntarism compliance monitoring • Ensuring access to a broad range of FP services • Pilot-testing an integrated approach to maternal, newborn, and child health and nutrition services through the Family Health Book
Strengthening the health provider system • Implementation of an integrated procurement and logistic system • Improving the monitoring and supervision system	**Improving response to HIV/AIDS, TB, AI, and other emerging infections** • Strengthening HIV/AIDS programs, particularly in high-risk zones • Improving local TB response • Setting up an integrated community-based early warning system for AI

4.9 Service Delivery Excellence in Health (SDExH)

In Year 1, SDExH was implemented in two pilot provinces: Oroquieta Inter-local Health Zone in Misamis Occidental, and Metropolitan ILHZ in Negros Oriental. The final module of SDExH – Workshop IV on Recognizing Achievements – will be conducted in December 2007 and January 2008 in Misamis Occidental and Negros Oriental, respectively.

At the national level, the project will support DOH by providing an external consultant who will review the modeling of SDExH in the two provinces. Likewise, it will support a

consultative meeting of stakeholders to discuss the findings and recommendations of the review. In addition to the external consultant, JHPIEGO will provide short-term technical assistance (STTA) to improve SDExH. A major output of this exercise will be an implementation plan for SDExH including a DOH plan to expand this intervention in non- project areas. HealthGov will assist the TWG consisting of representatives of DOH and other CAs in improving the trainers' guide and participants' manual and an operational guide will also be developed.

Due to competing activities, the CHD 7 was not able to participate in the SDExH workshops in the pilot LGUs while CHD 10 partially attended some workshops. In addition, follow-up and mentoring were not intensively conducted to ensure implementation of agreed-upon next steps. Based on these observations, the project will identify outside TA providers, such as universities and NGOs, to support CHDs and PHOs in responding to LGU needs for SDExH training.

During the third quarter, DOH with assistance of the project will conduct a TOT for TAPs other than the CHDs to make SDExH accessible to other interested LGUs. This intervention aims to improve service providers' performance, ensure quality of services, and satisfy customers' expectations. The project will continue to provide technical support to LGUs in the training of service providers. Implementation of SDExH needs intensive social preparation of LGUs and CHDs to ensure its sustenance and expansion. Therefore, HealthGov staff will continue to mobilize LGUs to buy-in to the continuing quality improvement approach. Bulacan and Capiz are examples of provinces that have signified their interest in the SDExH training and these provinces will serve as expansion sites for SDExH implementation.

In addition to their participation in the training of trainers, regional level partners specifically, CHD technical staff will be actively involved in the monitoring and coaching in the SDExH process and LGU service improvement plan implementation.

At the LGU level, the trainers will roll out the training to ILHZs that need SDExH training. The project will provide TA and monitor the SDExH training to ensure quality and success. The project will also assist the provincial government in establishing and/or strengthening the recognition and award system to provide external motivation.

Documentation of good SDExH practices will be prepared and disseminated by HealthGov to other LGUs during SDIR or other related activities.

4.10 Service Delivery Implementation Review (SDIR) follow-up

During the first year, HealthGov provided TA and some counterpart funds for conducting SDIR. As a result, LGUs have prepared their acceleration plans for improving service providers' performance and ensuring quality of services. Some activities in the acceleration plan do not need any external resources. In a number of provinces in Mindanao and the Visayas the results of the SDIR and the acceleration plan were used as the basis for the PIPH and MIPH. This facilitated the inclusion of these activities into the LGU annual investment plan. The municipal and city acceleration plans were consolidated at the PHO level in Capiz and Bulacan and have served as the basis for TA planning for the PHO, CHD and other USAID-supported projects.

In Year 2, the Project will assist DOH Representatives and PHOs in monitoring and coaching health personnel in the implementation of the acceleration plans. The follow-on TA aims to:

- Ensure that interventions and activities especially those that do not need investment and those that are within the control of the service providers and RHU/CHO are being implemented;
- Assist in addressing difficulties in implementing interventions that need additional advocacy activities to LCEs and other stakeholders;
- Ensure that activities are integrated into their local development plans and budget preparation for the year 2009;
- Ensure that acceleration plans are inputted into the PIPH operational plans in the F1 provinces;
- Track the progress of program performance of OP indicators in MCH, FP, TB and HIV-AIDS during monitoring and quarterly or semi-annual review;
- Ensure improvement in data management.

At the regional and provincial level, HealthGov will continue to provide TA support to CHDs and provinces that will conduct an annual SDIR. During the first quarter, at the national level, DOH and the inter-CA will revised the SDIR tool based on the lessons learned from different provinces. The tool will include the next steps that the province will have to undertake to prioritize LGUs and programs for support. It will also define the steps in translating the acceleration plan into a local investment plan. Models of integration of FP and MCH will also be introduced in the SDIR process to stimulate field managers and service providers to start integrating services effectively.

At the municipal and city level, the project in collaboration with CHDs and PHOs will provide technical assistance to enhanced capabilities in validating data, assessment of status of service delivery indicators and its enabling environment and utilize this data in planning for acceleration. In addition, CHDs and PHOs will be supported in managing outputs of SDIR of the LGUs.

4.11 Improving the FP training system

The SDIR tools collect baseline data on health personnel capability in MCH, FP, TB and HIV AIDS. Based on this data, some LGUs need for FP competency based training. This also supports the DOH's need for updating the existing FP CBT training manual.

At the national level, the project will support DOH in updating the FP CBT manual to be consistent with the FP Clinical Standard Guidelines by hiring a consultant. In the second quarter, HealthGov will support the DOH in the training of trainers using the updated FP CBT manual. These trainers will mostly be regional / provincial FP coordinators and training staff of the CHDs. The project will mobilize DOH and LGUs to provide funds for the training of service providers on FP CBT.

At the LGU level, the project will prioritize areas for support in training of service providers. These are LGUs that have untrained personnel, where CPR is below national performance standard and with the greatest number of married women of reproductive

age group. HealthGov will work with the DOH in providing training to selected staff of the Social Hygiene Clinic identified in the rapid assessment and SDIR.

4.12 Informed Choice and Voluntarism (ICV) compliance monitoring

Informed Choice and Voluntarism (ICV) is when a client freely makes a contraceptive decision based on accurate and complete information on a broad range of available modern FP methods. ICV improves quality of service provision in family planning and ensures effective access to complete and accurate information and services on the range of family planning methods. ICV enables a couple to exercise Responsible Parenthood in accordance with their religious and ethical values and cultural background.

During the first year, HealthGov supported the participation of DOH/NCDPC and CHDs in the workshop on *"United States Government Family Planning Statutory and Policy Requirements"* conducted by PRISM. Subsequently, the DOH with the support of HealthGov, conducted a workshop to develop a plan of action to ensure ICV compliance. In August 2007, the project in coordination with PRISM and SHIELD, conducted a three- day training of trainers from DOH/NCDPC, CHDs and POPCOM on ICV compliance monitoring and the broad range of FP methods available to clients. The workshop also discussed the national government's Responsible Parenting Movement (RPM). These trainers in turn are responsible for the roll-out of 22 batches of training for regional, provincial and city health technical staff and the FP coordinators. The training will be conducted in September- November 2007. DOH will provide budgetary support for the training while HealthGov will monitor and provide TA to these training sessions for ICV.

Subsequently, CHDs, PHOs and CHOs will conduct the training of service providers in the third and fourth quarters of Year 2 to create awareness on informed choice and voluntarism. The project will also continue to integrate ICV compliance awareness in most of the project activities at the LGU level.

During the second year, the project in support to DOH will provide assistance in setting up a mechanism of reporting of ICV compliance from the LGU to national level. Monitoring ICV compliance will be conducted in two ways: (1) project field operations will conduct quarterly monitoring of LGUs; and (2) DOH through CHDs and DOH representatives will report their monitoring results every six months. HealthGov will report promptly to USAID any incidents of violation and vulnerability.

The project's reporting mechanism will be integrated into the quarterly M&E reporting. The field operation units will be responsible for the monitoring and reporting of the ICV compliance. On the other hand, the NCDPC will be responsible to consolidate reports from the CHDs,

4.13 Pilot testing of integrated maternal, newborn & child health services

HPDP initiated the development of the Family Health Book (FHB), an approach to provide an integrated package of selected maternal, newborn and child health services. The strategy will mobilize both the private and public sector to provide such services that are assured of financing from different sponsors, specifically local and national governments, social health insurance and other possible donors. Initially, the services will

prioritize interventions that are most cost-effective and have direct impact in reducing deaths among mothers, newborns and children under-five.

HPDP conducted a consultative workshop in August 2007 for selected LGUs of Compostela Valley and Davao City, all CAs, CHD XI, and WHO advisers to discuss the FHB. The representatives of the LGUs of Compostela Valley agreed to pilot test the FHB and HealthGov will support HPDP and the CHD in this exercise. At the LGU level, HealthGov regional teams will provide support to HPDP and the PHO in developing a roadmap or plan to implement the pilot testing of the FHB. Political and facility mapping of the proposed sites will be conducted, as well as a training needs assessment of public and private health providers. The project will support a series of advocacy activities to LCEs and provide an orientation to PHO technical staff, DOH representatives and service providers on FHB. In addition, HealthGov will support CHD and PHO in monitoring the implementation of the strategy.

The schedule of activities for the implementation of FHB is dependent on HPDP as the lead of this activity. At the national level, this includes the finalization of the Family Health Book, training manuals and referral system guide, among others. The intervention will ensure access to essential quality maternal, neonatal, and child health services including family planning.

4.14 Ensuring access to broad range of FP services including VSC

One of the core attributes of the proposed expanded DOH AO includes local CSR response by improving access to voluntary surgical contraceptives. LGUs need to ensure that a broad range of FP methods is accessible, available and affordable to respond to the unmet FP needs of clients. Illustrative evidence for this attribute include: competent public and private providers of FP methods within convenient reach of potential clients; a system of referring local clients to these providers; and a system of paying for services rendered to local clients by these providers.

At the national level, the project will support DOH in coordination with HPDP in developing a CSR strategy for expanding access to high quality VSC services and maximizing high volume IUD and VSC providers, both public and private through the services of a STTA. On the other hand, it will support CHDs and PHOs in developing a guide on maximizing high volume service providers. The project will also assist CHDs and PHOs in identifying and documenting models of functional networks of IUD and VSC service providers. This will be shared during workshops and training activities of the project.

During the second and third quarters, the HealthGov provincial coordinators and service delivery coordinators will assist ILHZs and PHOs with the DOH Representatives to develop a mechanism for improving access to IUD/VSC services. The Project will support CHDs, PHOs and CHOs in establishing or strengthening a referral system for VSC.

In F1 convergence sites and roll-out provinces, HealthGov will facilitate FP training activities by mobilizing competent trainers for different LGU needs. The SDIR results will be utilized to prioritize areas that fall below the LGU performance standards for CPR.

4.15 Improving the procurement and logistics system

Procurement and logistics falls under the Health Programs component of HealthGov, although operationally procurement and logistics will also directly impact on the LGU systems to sustain delivery of selected health services, which falls under the Governance component of the project.

The procurement and logistics plan for Year 1 anticipated developing an integrated procurement and logistics systems manual for LGUs. This was based on the assumption that these systems and manuals were not yet in place and/or available and that these were what the LGUs needed. However, the review and assessment of the logistics operation in six LGUs (Bulacan, Pangasinan, Bohol, Capiz, Sarangani and South Cotabato) during the first year showed that there were already some systems, manuals and guides in existence (forecasting and procurement for FP, TB and Vit. A commodities) and that the need was more for the enhancement or improvements of these materials to incorporate necessary modifications brought about by program or policy changes. Moreover, while logistics related TA needs identified by the LGUs varied, the common priority needs were related to forecasting, procurement and distribution, particularly for the FP commodities. In response to these findings, the activities planned for Year 2 in the area of procurement and logistics are more demand driven and designed to respond to the prevailing situation and needs of the LGUs.

For Year 2, the main TA interventions and strategies will be geared towards developing and enhancing the logistics systems of the LGUs, including the management and monitoring thereof, to ensure the adequate and continuous availability of essential health program commodities (FP, TB, Vitamin A, MCH, HIV/AIDS). At the national level, in consultation with DOH program managers and in collaboration with other CAs, tools with their corresponding guidelines will be developed or enhanced for the following logistics components.

- **Forecasting** – this will be a priority during the first quarter to coincide with the planning and budgeting cycle, especially for FP commodities which under CSR will be completely phased-out in 2008. The forecasting will also include other essential commodities for MCH, TB and STI / HIV/AIDS. Forecasting data and methods will include population, consumption and case incidence;
- **Procurement** – alternative methods or options for procuring health commodities that will be most cost effective and beneficial (value for money) to the LGUs. These options or methods include pooled procurement, government-to-government (G2G), DOH retained hospitals (DOH AO 2005-0010), social franchising (POPSHOPS of DKT and Health Plus of PNPF), and PITC (Botica Ng Bayan and Botica Sa Barangay) and will adhere to the requirements or provisions of GPRA (RA 9184) and the PNDF;
- **Inventory control** – Maximum-Minimum (Max-Min) inventory and ordering system model considering the limited resources, erratic ordering and procurements of the LGUs. This system will ensure adequate supplies both for operating as well as buffer or safety stocks;
- **Distribution and storage** – distribution system for DOH supplied or provincial procured public health drugs from the provincial to the municipalities and barangays using the modified CDLMIS model (FP commodities). This will also

include guidelines for proper storage and transport or handling of commodities to minimize unnecessary damage to the commodities.

Prior to finalization, these tools and guidelines will go through a consultation process with the Logistics Inter-CA TWG, DOH and LGUs, as well as pre-testing in selected LGUs for additional inputs and refinements. The pre-tested tools can be subsequently used in the PIPH/MIPH implementation, CSR planning, SDIR, SDExH and other workshops. A TOT for regional and provincial trainers will be provided for the F1 and roll-out sites.

4.16 Improving supervision and monitoring

The results of conducting SDIR and SDExH indicated the need for TA in strengthening supervision and monitoring systems at the LGU level. Discussions with health personnel during scoping visits also revealed the limited or non-existent supervision of midwives by public health nurses or municipal health officers.

One of the standards identified by provincial health officers and technical staff is the use of a monitoring/supervisory tool in their regular monitoring. At the LGU level, the project will assist PHOs in developing the tool based on the standards set by municipalities and cities. This TA will be part of the follow-up activities of SDExH.

DOH has an existing training manual on supervision that needs to be reviewed and updated. During the first quarter, the project will provide TA to assist at the national level, the DOH in updating the training manual on supervision for public health nurses. This manual will be pre-tested and finalized.

At the regional and provincial level, the DOH and the project will conduct training of trainers. While at the LGU level, HealthGov will also provide TA in training public health nurses on supervision as they are the supervisors of frontline service providers, specifically midwives.

The project will provide TA to LGUs in Bulacan and Capiz and others that highlight their intent to improve monitoring and supervision systems in their acceleration plans. In addition, LGUs in Misamis Occidental and Negros Oriental that have implemented SDExH will also be prioritized. Specifically, assistance will include support to the LGU in developing their own monitoring and supervisory checklists and mentoring and coaching on how to manage results of these activities. These interventions will lead to improved service provider performance and ensure quality health services to clients.

4.17 Strengthening LGU HIV/AIDS program

During the first year of the project, a rapid needs assessment was conducted in HIV/AIDS high-risk areas. It reviewed the results of the 2005 IHBSS in terms of the behavior of the most at risk population (MARPs), specifically female sex workers (FSW), males having sex with males (MSMs) and injecting drug users (IDUs). In general, the MARPs have low knowledge of ways to prevent HIV transmission and despite knowing that consistent condom use is protective, very few consistently use condoms during sex... The utilization of the social hygiene clinics by FSWs, particularly the establishment-

based, is high. Very few however, among the freelance FSWs were reached through community outreach. Less than 25% of FSWs and IDUs and less than 10% of MSMs submitted to Voluntary Counseling and Testing (VCT). Budgetary support for programs is typically limited and NGOs are dependent on international donors in the absence of LGU funding.

During the first quarter of Year 2, HealthGov will support at the regional level the CHDs in monitoring and coaching LGUs in improving and finalizing their acceleration plans for HIV/AIDS. The follow-up aims to: (1) support the inclusion of the investment requirement of the acceleration plan into the AIP of the LGU; (2) identify steps in resource mobilization to increase financing; (3) formulate an HIV/AIDS strategic plan; (4) plan for capability building on policy development and advocacy, monitoring and evaluation; and (5) ensure that activities that do not need investments and those that are within control of the LGUs are implemented in a timely manner.

At the national level, per concurrence with the HIV/AIDS Inter-CA TWG, the project conducted an assessment of the OP and HealthGov indicators. In addition, the project and HPDP will support DOH in developing a guide in formulating strategic and investment plan for HIV/AIDS Prevention and Control Program adopting the Fourmula I framework. A STTA will be hired who will develop the guide and training design for facilitators. DOH, HPDP, SHIELD and HealthGov will conduct training of facilitators on strategic and investment planning which will be participated by CHD program coordinators and selected CHO staff.

The project will also support DOH-NCDPC-NASPCP, SACCL and NEC in supporting social hygiene clinics by updating the manual of operations, training or re-training of key SHC staff and formulating a quality assurance monitoring and on-site coaching plan. The project will also assist HPDP in revamping IHBSS. It will also continue to support DOH in the conduct of SDIR for high risk cities.

During the second and third quarters, HealthGov will provide TA at the LGU level for all eleven high risk cities in nine planning workshops to formulate a 5-year strategic and investment plans with the participation of major stakeholders including the MARPs. This will serve as the framework for stakeholders, projects and programs in operationalizing the HIV/AIDS program at the local level. The project will support the modeling of ILHZ collaboration on HIV/AIDS in Metro Cebu cities and LGU performance grant to NGOs in Davao City. With CHDs, the project will provide TA support to LGUs in developing their monitoring and evaluation plan for HIV/AIDS. As part of the acceleration plan of some cities, TA support will be provided to SDIR at the LGU level.

The project will also support CHOs in advocating for increased and expanded resources and NGO and government participation, developing guidelines for performance grants, policy development and monitoring and evaluation of the responsibilities and performance of the LACs as stipulated in local legislation.

4.18 Improving local TB responses

In addition to collaborating with TB Linc in the 12 shared sites, HealthGov will provide support to improve the response of LGUs to tuberculosis in the other 11 non-TB LINC supported provinces. Based on SDIR results, TA in support to CHDs and PHOs will be

provided to LGUs that have TB case detection rate, TB cure rate and direct sputum smear microscopy quality rates that fall below performance standards.

Provinces supported by TB Linc will also benefit from HealthGov TA, through SDIR, SDExH and the integrated procurement and logistic system, and monitoring and mentoring of LGU implementation of their acceleration plans. The improvement of the TB data management is integrated as part of the over-all strategic management information system and SDIR.

4.19 Community-based early monitoring system for avian influenza

Avian influenza (AI) is a highly infectious disease of birds caused by the influenza virus H5NI. It causes sudden death in birds and spreads quickly. All birds (chickens, ducks, geese, quail, turkeys, wild birds, etc.) can be infected by the virus but not all get sick. Ducks can get infected by all strains, usually do not get sick but may be carriers. Humans can be infected by the type-A influenza H5NI strain from sick birds through: contact with infected poultry at home; handling or playing with dead birds; when slaughtering, processing or transporting sick poultry; exposure to poultry droppings from sick birds, and; eating soft boiled eggs or half-cooked poultry meat from sick chickens.

While the Philippines is one of three countries in Asia that is free of bird flu, it is threatened by outbreaks in the neighboring countries of Vietnam, Cambodia and Thailand. In July 2007, USAID-Phil/OH sent a team of Filipino health workers and veterinarians, both from government and USAID CA project staff to Indonesia to learn about workable strategies and lessons in implementing community early warning system (EWS) on AI that could be adapted in the Philippines.

The team developed a training module for barangay volunteers and a simple monitoring tool as an initial step to establish a community-based early reporting system for the purpose of early detection and rapid notification of AI in birds and humans. The system will also serve as a mechanism to provide education on prevention and personal protection of the public. These tools were pre-tested in the cities of Angeles and General Santos.

At national level, during the first quarter, HealthGov, in coordination with DOH and the Department of Agriculture - Bureau of Animal Industry (DA-BAI) and inter-CA, will review existing efforts in responding to bird flu. At the regional level, inter-CA lead by HealthGov and the DOH-NCDPC and DA-BAI will conduct consultative planning workshops for Luzon, Visayas and Mindanao to assess the local and regional status of AI preparedness, identify issues and concerns that need to be addressed, formulate key action points and develop TA plan to support AI interventions to be put in place at different level.

The inter CA will also support the DOH and DA in crafting and issuance of a national policy and guidelines on the establishment of an AI community-based early warning system (CBEWS). The CAs will also support the development / enhancement of tools to ensure functionality of these CBEWS. This includes finalization of the CBEWS reporting tool, and training modules for facilitators and participants.

At national level, the project will support DOH/ DA in reviewing the result of the KAP study conducted by DA, conduct an inventory of IEC materials, and develop a communication plan by identifying geographic areas and audience and kind of information that need to be communicated. The project will hire an STTA to provide TA on AI communication who will work closely with DOH National Center for Health Promotion and DA BAI on these efforts.

In addition, at all level, the Project will also support DOH and DA in strengthening capability of LGUs in high risk areas on AI preparedness especially its community surveillance system. In addition, it will also support the training of master trainers which include at regional, provincial, and municipal levels on the use of CBEWS. The training would include AI simulation exercises (table top and real time SLEs).

At the LGU level, capacity building of LGUs for AI preparedness to meet and satisfy the four elements of AI preparedness namely functional AI TF, ordinance, preparedness and response plan, compliance to AI checklist. Likewise, inter-CA will support the master trainers in the roll-out of training in identified barangays in high-risk areas. This would include AI simulation exercises. Health Gov will hire an STTA on AI simulation exercises. Support the implementation of CBEWS in identified barangays in high-risk areas, and support the monitoring and documentation of CBEWS implementation to ensure quality will be likewise provided.

The regional field offices of USAID CAs will be mobilized to support Provincial, Municipal or City AI Task Force in the implementation and monitoring of identified activities.

4.20 Increasing advocacy for health

In the second year HealthGov's advocacy activities (IR 1.4) will be geared towards enhancing partnerships between LGU health staff and civil society groups, and improving the capacity of LGU health staff, local health champions and civil society groups to advocate for sufficient funding and a favorable policy environment for public health. In particular, HealthGov will provide TA in the following key areas:

- Ensure NGO, CSO and community participation in PIPH formulation, implementation and monitoring (including review of service delivery and quality) and their representation and active participation in LGU special bodies, i.e. LHBs/LDCs;
- Improve advocacy skills of LGU health staff, civil society and local health champions as they present their health plans and budgets and advocate for sufficient funding and policies on health;
- Mobilize communities for health, especially those from LGUs marked as "red" in SDIR and similar assessments, where the performance of health service delivery needs improvement;
- Document and disseminate advocacy and partnership building processes, focusing on promising approaches and practices in local governance for health that HealthGov helped foster.

HealthGov's TAs and advocacy support activities will be customized to suit the needs of particular provinces, the nature of LGU-civil society partnerships in place, and the level of engagements of local NGOs/CSOs in HSR.

In areas classified as **"***other" HealthGov sites* the PIPH is in varying stages of development, the level of engagement of NGOs and CSOs varies, and the nature of LGU-civil society partnerships is in different stages of maturity. Based on their needs the following TA will be provided to PHOs and MHOs in these LGUs:

- Engage local NGOs/CSOs and community groups for health/HSR and ensure their active participation in the PIPH processes in particular and their representation in LGU special bodies such as LHBs and LDCs in the long term. Specific action items for civil society groups will include the conduct of community focus group discussions on service delivery and service quality as inputs to SDIR/SA, and support to constituency building of the NGO/PO/private sector representatives in the LHBs/LDCs;
- Incorporate sessions on advocacy in the existing PIPH workshops particularly on securing the mandate to implement PIPH and gain wide stakeholder support and involvement in operationalizing the PIPH. Mechanisms will include the conduct of Provincial Partnership Forums, public hearings and dialogues with LHBs, LDCs and Sanggunian Committee on Health, among others;
- Initiate and support Municipal Health Assemblies as springboards for mobilizing communities for health, involving municipal and barangay officials, and community and sectoral leaders from "red-marked" LGUs where the delivery of basic health services needs improvement. The assemblies will increase the commitment of stakeholders to the SDIR acceleration plans, define their roles in improving service delivery and mobilize additional resources from the municipalities and barangays to implement the plans. Following these meetings, barangay leaders may more readily commit funds to address their health challenges and may convene their respective barangay health assemblies, discuss their local health situation based on SDIR results and identify ways to address issues on service coverage and quality. To complement the initiatives of barangay officials, leaders of community-based organizations and sectoral groups may convene their constituencies (women, youth, etc.) and agree on concrete steps to help their barangays address the health challenges. This may include community events, community-based research on health, reporting incidences of diseases in the locality, monitoring of health programs and services in their barangays. At the municipal level, mayors of "red-marked" LGUs may commit funds and initiate appropriate policies to address their specific health challenges (i.e., the creation of local TB Councils that will include networks of cured TB patients for TB education and TB prevention programs; intensified immunization campaigns; LGU support for micronutrient interventions; FP campaigns; local CSR plans; insurance coverage of indigents, etc.);
- Mobilize local NGOs and CSOs to assist PHOs and MHOs in monitoring the implementation of health related policies and the PIPH, including the quality of public health. This may include the conduct of community FGDs on health service delivery and quality, NGO caucuses on health as forums for discussing the LGU's performance of health services delivery. Local NGOs and CSOs will also be tapped to provide information about health and service providers through the conduct of community health forums that will build support for local health policies and serve as forums to disseminate relevant national health policies, such as those related to birthing facilities, micronutrient supplementation, health insurance, TB prevention, ICV-FP, and AI preparedness.

In the *F1 roll-out provinces* supported by HealthGov preparatory activities to support municipal and province-wide investment planning for health have already commenced. The following TA will be provided to PHOs and MHOs on the basis of local demand:

- Design and implement local NGO/CSO forums on health/HSR;
- Promote the active participation of NGOs and CSOs in LGU special bodies and in the various processes involved in PIPH formulation, implementation and monitoring, particularly in the situational analysis as they conduct and present results of community FGDs on service delivery and quality as inputs to SDIR/SA and/or present the NGO/CSO agenda for health;
- Incorporate sessions on advocacy in the existing PIPH workshops, particularly on securing a mandate to implement PIPH, and identify appropriate mechanisms that will help secure the mandate to implement the consolidated health plans and gain broad stakeholder support to operationalize the PIPH.

In *F1 convergence sites* PIPH plans are to be operationalized and TA from HealthGov focuses on CSR implementation. The following advocacy TA will be provided to the PHOs and MHOs, as required:

- Engage local NGOs and CSOs in HSR, ensure their active participation in LGU special bodies, and equip them for CSR advocacy. This may include CSR orientations and support for their active participation in the review, monitoring and implementation of local CSR plans;
- Design and implement Provincial Partnership Forums or Workshops to build broad stakeholder support for PIPH/CSR investment plans and ensure broad stakeholder participation in the implementation and monitoring of PIPH/CSR plans in their localities.

In **high risk HIV/AIDS areas** HealthGov will provide the following TA to help strengthen local multi-sectoral responses to HIV/AIDS prevention:

- Provide support in the preparation of orientations and planning sessions for Local AIDS Councils (LACs) involving LAC members, Budget Officers, Treasurers, Planning Officers, SP Committees on Health, NGO representatives and members of LHBs. These sessions will focus on the local HIV/AIDS situation, including the results of a rapid assessment of high-risk LGUs, and identification of appropriate LGU responses and local actions. Local responses are expected to be included in the city investment plan or development plan;
- Engage focal NGOs or NGO members of LACs to monitor and ensure that LAC plans are implemented. The results of their monitoring efforts will be regularly reported to the LACs;
- Design and implement local policy review and formulation workshops (anchored on evidence-based participatory local decision making). Training workshops for LACs will be organized and include essentials of policy formulation and the local policy making process, and communicating HIV/AIDS concerns to LCEs. The workshops will also review existing HIV-related policies and local responses and identify issues that require policy action. The activity is expected to result in HIV-related ordinances, resolutions or executive orders and corresponding budget allocations for HIV/AIDS prevention activities;

- Formation and initial training of a core of trainers for peer education and community health outreach. These trainers will be tasked to form core groups of peer educators among sex workers and conduct learning group sessions within the establishments, utilizing existing training curriculum and implemented in collaboration with the LACs and focal NGOs or NGO members of LACs.

To operationalize the above TAs, HealthGov's advocacy component, together with partner CHDs, PHOs and selected NGOs, will develop the following tools in Year 2:

- Guide to building partnerships for health;
- Guidelines for setting up coordination mechanisms between LGU health office and civil society groups;
- Training curriculum on evidence-based participatory policy making for NGO and CSOs;
- Training curriculum on effective championing for health, anchored on specific health governance challenges such as CSR, HIV/AIDS and TB prevention;
- Guide to documenting LGU experiences in health advocacy and partnership building for health.

5 Regional implementation plans

5.1 Overview

In its first year of project implementation, HealthGov's regional activities laid the groundwork for project interventions in the second and succeeding years. The achievements in year 1 focused on strengthening the role of various stakeholders at the regional and provincial levels in health sector reform, mobilizing NGOs and CSOs for health sector reform advocacy, formation of technical teams and facilitators from the CHDs and PHO to provide appropriate TA to LGUs in health investment planning including development of appropriate tools and guidelines, advocating to new LCEs to prioritize health in their in their respective executive agenda, and establishing coordination mechanisms with other CAs to harmonize TA efforts to the provincial LGUs.

During this second year of project implementation, the regional implementation plans for Luzon, Visayas and Mindanao are geared towards further building the capacities of the CHDs, including the DOH Reps and provincial health staff as TA providers in key technical areas to enable them to be more responsive to the TA needs of the LGUs. A TA plan customized and responsive to the priority needs each of the 23 provinces has been developed. The coordination mechanism with various stakeholders and TA providers including the LGUs, NGAs, NGOs and the private sector and USAID collaborating agencies will also be strengthened consistent with the sector wide approach to the implementation of the PIPH of the 23 provinces.

5.2 Luzon Regional Implementation Plan

The Luzon region covers seven target provinces categorized as follows: F1

Original Site - Pangasinan (region I)
F1 Rollout Site - Isabela (region II), Albay (region V)
Others - Bulacan (region III), Cagayan (region II), Nueva Ecija (region III), Tarlac (region III)

Going into Year 2, all regional offices are generally supportive of the HealthGov project. Regions II, III and V exhibit a generally higher level of involvement with their respective provinces in terms of coordination and provision of technical assistance. The improved dynamics between Region I office and the province of Pangasinan still needs nurturing given that the follow-through activities for the PIPH were stalled in Year 1. There needs to be constant (monthly) consultations with these offices to determine their available calendar time and manpower for joint activities.

With the inroads achieved in Year 1, the plans per province articulate the technical assistance that is essential to respond to their health program and health systems situation.

Summary of Provincial TA Plans

Pangasinan

Pangasinan is the only existing F1 site in Luzon. In year 1, scoping missions, data gathering and orientation sessions were conducted among various LGU health and non- health officials and regional stakeholders prior to the May election period. HealthGov provided some TA for the preparation of the Implementation Plan, Roadmap and the Public Finance Management Plan required for PIPH operationalization. Orientations covered these topics: Health Gov, USAID TA Program, CSR Monitoring tools, SDIR tools, LCE orientation and training of convenor NGOs.

In Year 2, the HealthGov's TA will revolve around the theme *"The poor at the center of development"* in response to the governor's expressed directions for the health program that will address the needs of the poor. To help the province achieve this mission, the following activities have been identified as the focus areas for technical assistance: (1) Poverty mapping/ client classification (e.g. CHB/LSS) for expansion in new municipalities; (2) CSR Plan assessment and Planning (3) Informed Choice and Volunteerism continuing advocacy; (4) Capacity-building of NGOs/CSOs for effective participation in governance for the poor.

Isabela

Isabela is one of the two F1 Rollout Sites in Luzon. In year 1, scoping missions, data gathering and orientation sessions were conducted among the various stakeholders in the province on: Health Gov, USAID SO3 TA Program, Resource Mobilization, SDIR tools, LCE orientation and advocacy to the convenor NGOs. Health is considered as a priority concern by the provincial government including majority of the municipal local government units. The reelected governor who in her first term focused on hospital upgrading interventions is now poised to put in her agenda, the achievement of better health outcomes under the framework of Fourmula One to ensure a more robust public health system.

The theme of *"Enhancing public health through PIPH"* will be the rallying mission for Year 2. To this end, the HealthGov will focus its support for the following: (1) completion of the PIPH and preparation of an implementation plan, (2) ensuring better access to health care services through more sustainable health care financing, (3) establishment of Avian Influenza Early Warning and Surveillance System, (4) compliance with informed choice and voluntarism and (5) enhancing coordination mechanisms among the different LGU offices for effective health governance.

Albay

Albay is the second of the two F1 Rollout Sites. The province received TA from HealthGov in Year 1 through the provision of advocacy support to the new governor of the province and MHOs on HSR, SDIR and PIPH. The governor with the mayors' support, are committed to formulate their long-term investment plan for health. Activities such as the SDIR and PIPH were commenced in the latter part of Year 1 to respond to this request.

The HealthGov's technical assistance for the province for year 2 will take off from the soon-to-be-formulated MIPH/Zonal and Province-Wide Investment Plan for Health. The focus of this plan is anchored on the governor's topmost health agenda and provides the theme for Year 2: *"Achieving universal coverage for PhilHealth insurance."* Technical assistance will cover (1) PIPH completion and operationalization, (2) strengthening the capacity of the CHD and PHO to advocate for improved health care financing, (3) enhancing health care financing and service delivery to the poor through universal health coverage, (4) strengthening compliance with informed choice and voluntarism, (5) updating the province's CSR plan.

Bulacan

In year 1 of the project, scoping missions and data-gathering were undertaken to understand the health program situation of the province. Advocacy and orientation of the project was done with the various provincial stakeholders (LGU, NGO, CSOs) in partnership with the regional agencies primarily the CHD. The SDIR was undertaken from May through July of this year as an immediate response to its expressed desire in identifying the municipalities that are weighing down the provincial health indicator average and determining important activities to address the gap.

Based on the results of the SDIR, the province's theme for technical assistance and interventions is "*Achieving the Performance Standards at the Local Level".* The theme underscores the important role that municipalities and civil society, as evidenced by the immediate mobilization of the BKB, play in "turning the reds into greens" or bringing under-delivering areas up to standard. In that context four clusters of interventions are anticipated namely: (1) establishing the MIPH/PIPH preparation process, and the resulting document as the principal basis for guiding the effort of "turning the reds into greens", (2) SDIR, CSR + planning, assessment and monitoring, (3) developing CSO- NGOs, through the BKB, as active partners of the LGU in health work, (4) build the capacity of Bulacan LGUs to promote awareness of local health programs and favorable health-seeking behavior and (5) control of Avian Influenza

Cagayan

For year one, HealthGov was able to provide an orientation to key provincial partners on the HSR/ F1, USAID TA Program, the PIPH process in tandem with the SDIR tool, resource mobilization, The PHO and selected NGOs/CSOs also participated in the cluster workshop for the CSO/NGO orientation. Somehow, the political dynamics that followed after the election stalled the progress of other planned activities in the province. A new round of orientations had to be done resulting from this circumstance. The orientation of the new Governor is expected to be done before the end of August.

"Improving health implementation performance at the local level" will be the rallying point of HealthGov's technical assistance to Cagayan in year two. The aim is to help the province lessen the gap in its performance. Specifically, HealthGov plans to help the province in the following: (1) preparation of a 5-year plan for health, (2) CSR monitoring and planning, (3) review and assessment of the province's health governance system, (4) improve access to quality health care services through improved health care financing for the poor, (5) conduct of a comprehensive performance review through the SDIR, (6) control of avian influenza, (7) advocacy for better health governance.

Tarlac

In Year 1, project interventions and technical assistance focused on scoping, data- gathering, analysis of emerging needs, orientation of the governor and other key LGU officials, and the start-up activities for the conduct of the SDIR leading to the development of a long-term investment plan for health. The latter is in response to the new governor's strong desire to provide a strong foundation for the health program of the province.

The theme for Tarlac's health directions in the second year will be *"Improving the health system at the local level".* Towards this, technical assistance will cover: (1) improving the province's health planning and investment programming system, (2) achievement of universal health coverage, (3) reducing the unmet needs in family planning, (4) increasing multi-stakeholder participation in local policy and decision-making towards better health service delivery.

Nueva Ecija

Given the situation of the health sector in Nueva Ecija, the Project has helped the province to address its substandard performance on some vital health indicators by extending technical assistance with the assessment and situational analysis i.e. SDIR. Furthermore, the local NGOs were oriented on the health sector reforms and capacitated to effectively engage in partnership with LGUs in mandated participatory mechanisms such as the Local Health Board and Local Development Council.

The TA theme for year 2 is *"Harmonizing RHU and hospital services for improved public health service delivery"*. Technical assistance will cover: (1) formulation of a province- wide investment plan for health, (2) strengthening the ULHS, (3) increasing the number of PhilHealth accredited RHUs, (4) improving the capacity of RHUs and referral hospitals to generate and manage their own financial resources, (5) increasing the number of active local health boards.

Project management

The project management activities essentially cover the administrative aspects of operating the Luzon office team which are: (1) personnel training and (2) overseeing the regional office operations. The first will ensure effective and efficient technical assistance to the LGUs and regional partners. The second is meant to improve effective monitoring of the various activities especially in the area of scheduling and assessing the results of the activities.

Regional activities

Luzon covers four regions (I, II, III, and V). The regional cross cutting activities will cover the continuing coordination with the regional government agencies which serve as project partners in providing the necessary technical assistance and support to the target provinces in Luzon. These agencies are: CHD, PopCom, PHIC, DILG and other regional agencies that become essential in the course of planning for the activities in the provinces. In Year 1, the Luzon team has established good working relationships with most off these agencies despite some of the possible barriers that surfaced in the course of engaging their partnerships.

For most LGUs, the technical programs that are lined up for Year 2 already include the following: the PIPH which is the flagship program of the Department of Health, the SDIR in support of the PIPH, Resource Mobilization, CSR Program – (e.g. monitoring, assessment, planning), ICV, and advocacy activities especially in the realm of NGOs/CSOs.

Specifically, this would cover (1) orienting the technical program with these agencies including necessary capability-building of skills that will allow them to take on the lead role even after HealthGov's project life, (2) agreeing on technical assistance they can provide to the LGUs, (3) linking up other technical assistance providers to the government agency (CHD) so they may also eventually broker the services with the LGUs when the need becomes manifest. In instances wherein there seems to be some disconnect between the DOH Central directions and the CHD, for example on PIPH development directions, timetable, budgetary concerns, as is emerging in the case of CHD 2 and 3, HealthGov will facilitate clarification sessions so that there is a better implementation of such TA program on the ground.

Another aspect of the regional coordination as mandated by the Department of Health is the existence of the Regional Implementation and Coordination Team (RICT) to carry out this coordination mechanism. Where there are no RICTs in place, HealthGov will advocate with the partner agencies in the region to establish this mechanism so that technical assistance programs to the LGUs can be harmonized effectively in terms of scheduling and selection of capacity-building activities.

Coordination with the various USAID Cooperating Agencies will be improved. The agencies involved in the region are: TBLINC (Bulacan, Pangasinan, Albay); PRISM (Bulacan, Pangasinan, Tarlac); A2Z (all provinces) and HealthPRO (all provinces).

5.3 Visayas Regional Implementation Plan

In Year 2, HealthGov will intensify its presence in and continue to provide technical assistance to, the five provinces in the Visayas (F1 – Capiz, Negros Oriental; Others – Aklan, Bohol, Negros Occidental) supported by the project. HealthGov's TA and support will be extended (directly or indirectly) to component cities and municipalities. This TA is directed at strengthening LGUs' capacity to do in-depth analysis of their problems; identify practical solutions; and generate political, financial, and technical support for their initiatives and plans to achieve local health indicators, thereby contributing to national health outcomes.

The Visayas implementation plan takes cognizance of the importance to further enhance the capability of key members of the regional and provincial (and some LGU) health staff to ensure long-term results and sustainability, keeping in mind some challenges identified in Year 1, primary of which is the absorptive capacity of regional/provincial health personnel to effectively delivery TA services.

In Year 2, HealthGov in the Visayas will advocate for business development in areas where LGUs are in a position and ready to "outsource" services from other TA providers in the market. This is primarily due to the wide range of LGUs' needs for TA services amid the limitations of internal TA providers such as the CHD, PHO. This will be pursued

to ensure that LGU demands for and readiness to avail of TA services can be responded to.

Modalities of TA provision will vary, depending on the intended recipients or partners. These can come in the form of: a) product development; b) guidelines, modules, and tools design; c) workshops or orientation; d) training of trainers; e) coaching and mentoring, among others. Coordination mechanisms will be established and maintained at a regular basis to ensure coordinated activities, make certain parallel support, and provide timely feedback. The region expects expanded utilization of local technical assistance providers other than the CHD/DOH and other government agencies.

Summary of provincial TA plans

Capiz

Capiz is an F1 province and commenced implementing its PIPH in the first quarter of 2007. HealthGov's engagement in the province started with the scoping visits, consultations and courtesy call to the Governor and other key leaders of the province. As a result of the visits, the Governor of Capiz formally conveyed its priority areas for technical assistance.

Based on that communication, technical assistance for year 2 will cover: (1) CSR review and development of a province-wide strategic monitoring plan; (2) conduct of an SDIR review; (3) advocacy on HSR/F1 and PIPH to new LCEs; (4) pilot-testing of SDExH to enhance quality of service provision; (5) expanding the pooled procurement system to include drugs and other supplies for RHUs; 6) documenting and packaging best practices and marketing these for replication; (7) control of avian influenza and (8) strengthening NGO, CSO participation in health governance.

Negros Oriental

In its first year of operation in the province, HealthGov conducted a scoping activity to identify key technical assistance areas. Technical assistance focused on an assessment of service delivery performance using the SDIR, quality service improvement using the SDExH process and assessment of LGU CSR plans.

For year 2, technical assistance will cover: (1) furthering assistance in planning and implementation of CSR programs, (2) follow on assistance in service delivery improvement, (3) strengthening NGO-CSO participation in health governance, (4) continuing the SDExH process, (5) conduct of a community health and living standards survey and (6) control of avian influenza.

Aklan

Preparation of municipal investment plans for health and their integration ILHZ plans commenced in the first year of technical assistance. The planning process started with the conduct of service delivery performance reviews using the SDIR. HealthGov also conducted a provincial partnership building conference in which NGOs and other CSOs agreed to participate in health service delivery programs of government.

For the second year, technical assistance will cover (1) formulation of the PIPH including the review of health governance systems, (2) improving universal health coverage, (3) CSR planning and monitoring, (4) improving response to TB and avail influenza, and (5) crafting interventions to actively involve civil society in promoting positive health-seeking behavior and health governance.

Bohol

In its first year of operation, Health Gov assisted the province conduct a performance review of service delivery using the SDIR resulting in the preparation of acceleration plans, enhance LGU annual investment plans and review their CSR plans.

For the second year, technical assistance will cover (1) formulation and operationalization of the PIPH, (2) enhancing ILHZ operations, (3) improving universal health coverage, (4) encouraging greater CSO participation in health governance, (5) improving communications strategies to bring about behavior change in accessing health services and (6) setting-up community-based early warning reporting systems for avian influenza.

Negros Occidental

For its first year of operations, Health Gov provided technical assistance in the commencing work on the formulation of provincial, municipal and city investment plans for health and the review of CSR operations. For the second year, technical assistance will cover (1) preparation and completion of the PIPH, (2) the review of health governance systems, (3) planning and monitoring CSR operations, (4) attaining universal health coverage and (5) control of avian influenza.

5.4 Mindanao Regional Implementation Plan

The region's theme for its second year of operation is *"turning red into green'"*. Red refers to the health programs on FP, TB, MCH and micronutrients which are not performing well based on established indicators. Green stands for the ideal condition – the health programs achieving the desired or standard level of performance or coverage.

To achieve this, year 2 implementation will generally employ a dual approach to providing TAs:

- Strengthening and working with regional partners to mobilize LGUs "turn reds into greens", while;
- Working with LGUs to improve key health governance systems to support effective health service delivery.

The year 2 work plan for the Mindanao Region is guided by the basic principle of collaborating with existing local health actors, appropriate Offices of LGUs and other stakeholders to be encouraged to attain common health sector objectives.

The process of achieving the desired change is in itself transformative. It will make functional LGU mechanisms such as, but not limited to, the LHBs and ILHZs. It will strengthen LGU structures like the PHO technical division which oversees the

performance of the public health programs, the rural health units and even barangay health stations. It will cause the strengthening, and in some instances, establishment of, key systems like the HMIS, M&E and referral links to facilitate the integration of the currently fragmented health system thereby making health a "continuum of quality care in the eyes of the common people". It will strengthen or encourage systems that will involve CSOs, private sector and people's organizations in decision-making, community mobilization and service delivery.

Finally, it will also rally a significant number of LGUs in the island to chart-out tactical and strategic plans, mobilize resources and do collective action to achieve the desired objective of transforming red to green.

Following are the regional TA strategies:

- Provision of TA to CHD, DILG, PHO, PHIC, POPCOM, CSO in mobilizing broad-based LGU support to CSR, TB control, MCH and Micronutrient, PHIC universal coverage and facility accreditation, movement to transform red to green, through evidence-based participatory decision-making;
- Expanding the network of actors for health sector reforms in support to the above. This entails working closely with other USAID CAs, working collaboratively with other projects (EU in F1 areas, AUSAID-PALS in Misamis Occidental, AID in Sarangani, JICA, etc.), enjoining other sectors and government agencies to support HSR, strengthening CSO and community participation in local governance especially in decision-making, working closely with the different LGU organizations like the local chapters of the League of Municipalities of the Philippines, Association of Barangay Captains, Provincial Councilors League and Vice Mayors League;
- Replication of cross-cutting TAs like CHLSS, SDIR, investment planning for Health, EBL, multi-payor scheme for universal coverage, SDExH, LHA, CSR-related TAs, strengthening ILHZ health systems, and the like;
- Support product development with the users of the TA – With the completion of MIPH and PIPH process, HealthGov will continue to support CHDs in developing customized products for LGU partners;
- Enhancing the capacity of CHDs and other regional NGAs and provincial (PLGU, NGO partners, TAPs) partners to facilitate required TAs at the M/CLGU level. This can be done by orienting CHDs (through established Regional networks such as RICT) on the TA requirements of the established PIPH of the 11 provinces covered by the project;
- Peninsula-wide approach in Zamboanga: Employing common strategies to address common health problems but implementing diverse, situation-specific and dynamic local action;
- Building the capacity of ILHZ to be fully functional and to assume active role in managing crucial health reforms and as a support mechanism for C/MLGU health investment plans;
- Alternative and creative modes of TA delivery will be adopted to avoid training fatigue and dislocation of health staff (i.e. participants) from their daily routine. The region will also commence providing opportunities for regional technical assistance providers to be involved in HealthGov activities. Particular attention will be given to engaging strong institutional partners from both government and the private sector in technical assistance delivery;

- At the Provincial level and with HealthGov support, CHD and RGNAs will orient PLGUs (PHO, PPDO and concerned Line Agencies) and other allied external funding institutions on PIPH TA requirements and the modes of TA provision.

Summary of provincial TA plans

F1 Convergence Provinces

Generally, for F1 sites, HealthGov will play a crucial role in establishing the clear linkage between PIPH programs, plans and activities to the achievement of MDG health outcomes like reduction of maternal mortality, infant mortality, fully-immunized children and TB case detection and cure rates. By the end of 2007, a service delivery review and planning on the four programs will be facilitated by the LGUs (with HealthGov's technical assistance). These will be followed through by series of LGU initiatives using evidence as basis for continued interventions. Another crucial role that HealthGov will play in F1 areas is the institutionalization of CSR. Both provinces were under the LEAD for Health project and had undergone a number of technical assistance on CSR.

Misamis Occidental

Based on the overall health situation and PIPH status of implementation of the Province and discussions with PHO, PPDO and PALS management team, three (4) strategic TAs are established for year 2. Generally, the TAs identified hope to re-emphasize or focus the activities on reforms on governance, health care financing and regulation to complement the "service delivery" focus of PIPH. These four are (1) improving planning systems through the CHLSS for effective client segmentation and increased sustained PHIC coverage, (2) enhancing CSR planning and monitoring, (3) strengthening the ILHZs and (4) engaging CSOs and NGOs to champion for better health governance and service delivery.

South Cotabato

The technical assistance program for the province will center on empowering its people and government agencies to strengthen their primary health care network and health information system. The program includes (1) interventions to improve performance in CSR, (2) institutionalizing CSR planning and monitoring, (3) introducing evidence-based legislation for CSR and other health concerns, (4) building a strong health data bank based on the CHLSS, (5) developing a TA provider that will focus on CSR.

F1 Rollout Provinces

Zamboanga Peninsula

For the three Zamboanga provinces – Zamboanga del Sur, Zamboanga del Norte and Zamboanga Sibugay – a peninsula-wide approach in Local Health Sector Reform is proposed. Year 2 TA areas for the three provinces will concentrate on the following:

- Completion and finalization of the investment plans for health to include the integration of CSR core attributes to the PPAs. The major tasks involved are (1) technical review; (2) Planning for province-wile health systems, and; (3) formulation of monitoring and evaluation design to track local progress in PIPH implementation.

- Laying the foundation for the institutionalization of CSR. Three processes will be facilitated, the CSR monitoring, CSR planning and community health living standard survey.
- Increasing LGU Financing for Quality Service through Universal health coverage. This involves the accreditation of health facilities on OPB, TB-DOTS and MCP and the strengthening of the referral system as component of the hospital reforms.
- Establishing the local health accounts, and
- Support the CHD, DILG, PHO, PHIC, POPCOM and CSOs, mobilize broad-based action to support CSR, other core health programs (TB, MCH, FP, HIV/AIDS and micronutrients), PHIC universal coverage, through evidence-based participatory decision-making.

Compostela Valley

The Province is still in the process of establishing an effective local government having been recently created. The new Provincial Governor envisions health and economic development as his priority programs. Specifically, the Local Chief Executive hopes to embark on hospital development. In the second year, HealthGov will focus providing appropriate TA on the following areas: (1) the development of investment plans for health (municipal, inter-local and provincial), (2) conduct of technical review and planning for province-wide health systems, (3) CSR assessment and planning, (4) increasing LGU financing for health through universal health coverage, (5) institution of evidence-based legislation and policy formulation, (6) enhancing the role of CSOs and NGOs in health governance and (6) piloting the Family Health Book.

Sarangani

One of the strengths of the Provincial Government is the emphasis given to planning and information system. In year 2, HealthGov will reinforce this strength by facilitating the PIPH development cycle and support to health staff KSA development for the operationalization of the PIPH as well as contribute to the overall improvement of the public health system. Specifically, through CHD and the Provincial Health Office, HealthGov will facilitate provision of the following technical assistance: (1) formulating the PIPH, (2) instituting evidence-based legislation, (3) promoting universal health coverage, (4) introducing effective service delivery assessment tools for better performance, and (5) mobilizing NGOs and CSOs to promote universal coverage and better health service delivery.

Other provinces

Agusan del Norte

The Province is known to have pioneered the multi-payer scheme for PhilHealth enrollment. The scheme has become the driver of various reforms in the province (e.g. hospital and drugs procurement) and had hastened the accreditation of RHUs on TB- DOTS and MCP. Only recently, the provincial governor has started rationalizing hospital services. Part of the move is to strengthen the two district hospitals (Cabadbaran and Nasipit).

In line with the PLGU's current thrust and attune to the good practice of the province in health reforms, the strategic thrust therefore of HealthGov's TA is to "Sustain the Driver

of Reforms and strengthen the capabilities of the ILHZs to manage key public health programs to complement the forthcoming hospital strengthening at the district level. To this end, the technical assistance plan for the province covers (1) strengthening the multi- payer scheme, (2) enhancing the capabilities of municipal and district social health insurance officers to establish systems of enrollment, premium collection, remittance and claims, (3) advocate for cost-sharing schemes, (4) strengthening ILHZs to manage key health sector programs, (5) CSR assessment and planning, (6) institution of evidence- based policy formulation and legislation, policy tracking and information evaluation for policy and legislation.

Bukidnon

The main thrust of TA provisions for the province will be geared towards the strengthening of public health system for broader benefits of the inhabitants of this highland province. The Provincial Government shows a firm direction to develop the hospital system as a premier institution providing quality health care for its inhabitants while pursuing the economic side of its operation. Along the process (of developing the PHS and hospital system), it has been observed that there is a widening gap between the hospital system and public health system.

For year 2, the strategic TAs will be geared towards laying the foundation for the harmonization of the two health systems and strengthening the functions of frontline health service delivery through:

- Enhancing MIPH and PIPH into an institutionalized process for public health planning including SDIR;
- Formalization of ILHZ as a key mechanism to promote and enhance public health system;
- Promoting culture-sensitive IP health interventions through IP-inspired SDIR;
- Strengthening Provincial-NGO/PO partnerships for public health perspective.

Davao del Sur

The Province is one of the more dynamic local governments in region with the emergence of new political figures. The current leadership is faced with the challenge of fragmented MLGU support. As a way of uniting the province and bringing-in tangible social services, the Provincial LCE hopes to embark on hospital rationalization through an integrated health system. The potential TA that HealthGov can thus provide in year 2 will be in the following areas:

- TA to CHD and LGU on the development of investment plans for health (municipal, inter-local and provincial). This involves the whole series of steps from situational analysis using SDIR and other SA tools, charting-out strategic interventions, resource mobilization and conduct of technical review and planning for province-wide health systems;
- Laying the foundation for the institutionalization of CSR. Three processes will be facilitated, the CSR monitoring, CSR planning and community health living standard survey (CHLSS). Follow-through TAs will also be provided based on the CSR plans which may include logistics procurement and distribution, forecasting of commodities, private sector partnerships, increasing access to all methods, improving health

service delivery by applying SDExH tools, informed choice and voluntarism and service referral network for both public and private;

- Strengthening province-wide health service delivery and support systems including monitoring, information management and evaluation, financial management, resource mobilization, budgeting, procurement and distribution and others;
- Increasing LGU financing for health through universal health coverage;
- Instituting evidence-based legislation; and
- Enhancing the role of CS and NGOs in health governance.

Misamis Oriental

Two major development trends have been observed in the Province. First, is the positive outlook of the Provincial Government to strengthen the hospital system in order to unite MLGUs while at the same time bring-in economic benefits and, second to strengthen public health service delivery through a functional ILHZ. The theme for its year 2 TA is *"breaking the grounds for a sustainable local health system"*. This will cover (1) Enhancement and operationalization of MIPH and PIPH, (2) Strengthening and institutionalizing the ILHZ as a key system to the delivery of health services, (3) strengthening provincial health service delivery and support systems, (4) CSR planning, monitoring and program implementation, (5) strengthening other health agencies to provide better support to the health sector, (6) institutionalization of evidence-based legislation and policy development and (7) strengthening NGO, CSO skills in advocacy for health.

6 Monitoring and Evaluation

During project year 2, HealthGov will focus on: (1) operationalizing the Project Management Information System (first and second quarters); (2) collecting baseline information at the municipal and city levels for HealthGov performance indicators (first quarter) and (3) collecting and reporting data in reports to USAID on HealthGov and Operational Plan indicators (second quarter and onwards).

HealthGov is focusing on two types of monitoring and evaluation indicators:

- USAID Operational Plan indicators, which are intermediate outcome indicators that measure the effects of USAID and other health initiatives on health outcomes in the Philippines, including indicators of utilization of FP-RH, MCH, TB and HIV/AIDS services; and,
- HealthGov performance outcomes or results, which are quantitative and/or qualitative measures of project performance in terms of local policy outputs and health systems

During FY2007, HealthGov was asked by USAID to include and report on 43 additional Operational Plan indicators that focus on health outcomes related to HIV/AIDS, MCH, TB and FP/RH. By the end of the FY07, HealthGov collected baseline data and first project year data for the 43 OP indictors, which was submitted to USAID (see **Annex 1** for list of OP indicators).

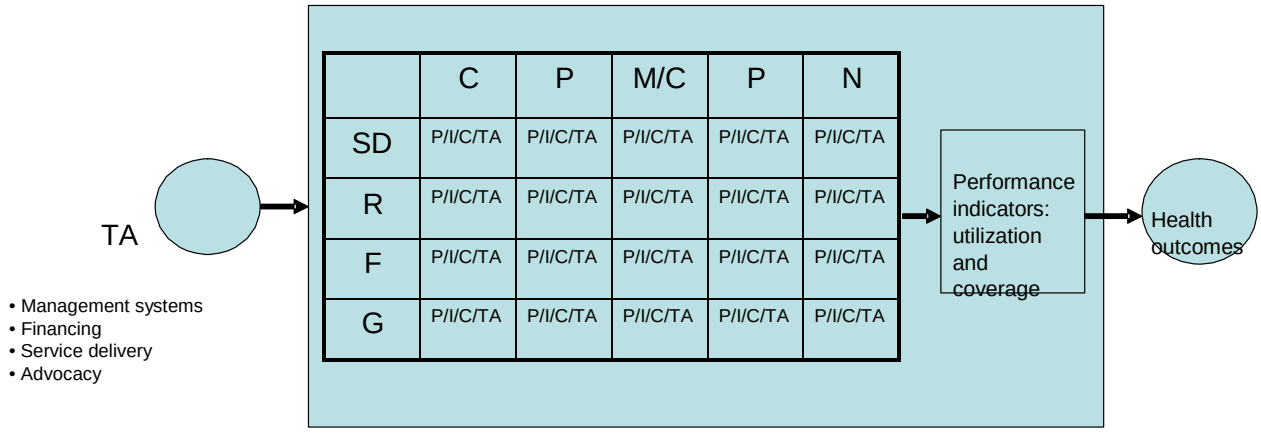
In addition to these OP indicators, HealthGov has 24 performance indicators that track project performance in improving key management systems; increasing LGU financing for health; improving health service provider performance; and improving advocacy. During FY07, HealthGov developed a set of supporting sub-indicators that defines the parameters of how each indicator will be measured. Since HealthGov was mandated during its first year to operate in all 23 provinces, during FY 2007, baseline data covering the 2005-2006 period was collected only at the provincial level. During the second project year, HealthGov will begin its shifting its attention to include municipalities and cities. During the first quarter of 2008 we will collect municipal and city-level baseline data that cover 2006-2007. **Annex 1** contains a table with the 24 HealthGov performance indicators (and their corresponding sub-indicators), provincial-level baseline data, and FY08 targets. This table will be updated to document the accomplishments for FY07 and will be submitted to USAID by the end of November.

6.1 Transforming HealthGov technical assistance into health outcomes

The purpose of the HealthGov project is to strengthen LGU commitment to and support for health services and LGU capacity to provide, manage and finance quality health services sustainably – especially FP, MCH, TB, HIV/AIDS and other infectious diseases such as AI and SARS. It includes building capacity of NGOs and civil society to advocate successfully for good health services and empowering LGU staff and building their capacity to gain commitment from public officials for improved health services, justify and obtain adequate financing for improved health services, analyze health needs and resources; design, adapt and use LGU systems to meet existing needs; and improve or create LGU systems to meet emerging needs.

How TA is transformed into health sector performance and health outcomes is depicted in the figure below. The TA that HealthGov provides revolves around management systems, financing, service delivery quality improvement, and advocacy. This TA to LGUs and other local stakeholders, through national and regional partners, is expected to impact on health sector performance and health outcomes. The impact will be achieved in an indirect way.

Transforming HealthGov Technical Assistance into health outcomes through strengthening local governance for health



Legend: C=consumer

P=provider
M/C-LGU=municipality/city
P-LGU=province
N=national agencies, NGOs/ CSOs

SD=service delivery
R=regulation
F=financing
G=governance

P=problem
I=intervention
TA=technical assistance required to implement intervention
C=cost of intervention and TA

With the mandate given by the LCEs, the TA will assist LGUs in the formulation of a PIPH that identifies the key interventions needed to impact on performance and health outcomes. These interventions, together with TA needed to implement the selected interventions, will be properly costed and investment requirements will be linked to financing sources to be mobilized by the LGUs. The LCE mandates the implementation of the plan. A monitoring system to track the implementation of the plan will be established to ensure that the plan is implemented according to the design and agreed timeframe. All these steps are designed to ensure that correct interventions are determined and properly implemented, resulting in improved health sector performance and health outcomes. Thus, while HealthGov will not be directly providing TA to LGUs in the actual implementation of specific interventions that directly impact on performance and outcomes, the TA ensures that the health system – through careful planning and implementation using the F1 approach – actually produces the desired outcomes.

6.2 HealthGov M&E Plan finalization

The M&E Plan prepared by the project will be further refined to reflect baseline data collected for all the indicators and the corresponding targets. Baseline data for both the OP indicators (consisting of 43 program area-level indicators) and the final 24 project performance indicators will serve as basis for the targets, which will be linked to the

expected key results of the implementation of the HealthGov project. Changes in the data collection plan initiated by the SOAG M&E Team, particularly on CA collaboration schemes, will also be reflected in the final M&E Plan. Further refinements are expected as soon as the F1 ME3 and the Score Card indicators have been finalized.

6.3 Continuing M&E data collection

Updating of the HealthGov performance indicator data will be done continuously by the project's regional teams, and starting the second quarter (once the PMIS is up and running) data will be reported quarterly and consolidated annually. Sources of data and information will include the training reports of HealthGov TAPs and health budget and expenditure data to be obtained from LGU financial and budget records and reports, among others. Other information regarding the local health system (health sector planning, health information system, procurement and logistics, ILHZ activities, health financing, etc.) will again be collected through interviews of key informants and review of relevant records and documents in the LGUs. Collection of remaining baseline municipal and city-level data will be completed by December 2007. Equivalent OP indicator values, which are available in the existing local health information system (FHSIS), procurement and logistics reporting system, PhilHealth records and LGU reports with the third quarter and end-of-2007 as reference periods, will be collected from the HealthGov provinces and municipalities and cities.

As the TA on SDIR progresses to cover more provinces and their respective component LGUs, various health program data collected for purposes of the program reviews will be compiled to update both the OP and HealthGov performance indicator values.

6.4 Operationalizing the data and information storage and management system

All data collected by HealthGov will be stored in data bases set up by the project, including:

(1) HealthGov Performance Management Information System (PMIS), which is a data base that will be maintained by the HealthGov M&E Team and field staff; and,

(2) HealthGov Training Management Information System (TMIS), which stores a more detailed set of information about the training activities of the project, such as training design, schedules, participant profile, training costs and training outputs.

Both data bases will be managed and maintained by the HealthGov M&E Team, which is composed of the M&E Advisor, MIS Specialist and Communications Specialist, supported by the IT Specialist and others. While the Training Data Base is already in place and currently available for training data inputs, the creation of the PMIS has just been contracted out to a local IT firm and is currently in the start-up phase.

The IT firm, with guidance from the M&E Team, will improve the existing project website in terms of expanding web content and inclusion of the PMIS and TMIS data base portals. The PMIS data base will include OP and HealthGov performance indicator values, as well as quarterly activity indicators and benchmarks. HealthGov staff will have

access to both the PMIS data and TMIS data bases. Training data, on the other hand, will continuously be entered in the USAID TraiNET/Web data base

Establishment of the PMIS and improvement of the project website will continue during the first and second quarters of Year 2. The following activities have been scheduled: (1) orientation on the PMIS of project staff (October 2007); (2) dry runs in data uploading/downloading (November/December 2007); (3) training of the regional and provincial coordinators on data uploading/downloading (January 2008); and (3) actual uploading of all project data into the system (starting January 2008).

Annex 1

HEALTHGOV PERFORMANCE INDICATORS AND USAID OP INDICATORS

List of 43 selected OP indicators and data source/s

	INDICATOR	Data Sources
	PROGRAM ELEMENT INDICATORS: HIV-AIDS	
1	Number of individuals reached thru community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	Household Survey for provincial-level data; Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
2	Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
3	Number of individuals trained in HIV- related community mobilization for prevention care and/or treatment	Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
4	Number of people trained in strategic information management with USG assistance on HIV/AIDS	Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
5	Number of monitoring plans prepared by the USG for HIV AIDS	USAID and other CAs
6	Number of local organizations provided with technical assistance for HIV-related policy development	Community Based Organizations (CBO
7	Number of individuals trained in HIV-related policy-development	Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
8	Number of individuals trained in institutional capacity-building for HIV/AIDS	Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
9	Number of service outlets providing counseling and testing according to national and international standards	Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
10	Number of individuals trained in counseling and testing according to national and international standards for HIV/AIDS	Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
11	Number of individuals who received counseling and testing according to national and international standards	Facilities (public and private), Community Based Organizations (CBOs) in HIV-high risk cities
12	Ratio of LGU public health expenditure for HIV/AIDS to total LGU Public health expenditures.	LGU

	PROGRAM ELEMENT INDICATORS: TUBERCULOSIS	
1	Case notification rate in new sputum smear positive pulmonary TB cases in USG-supported areas	LGU (NTP reports)
2	Number of people trained in DOTS with USG funding	LGU (NTP reports)
3	Number of TB cases reported to NTP by USG-assisted non-DOH sector	LGU (NTP reports)
4	Number of people covered by USG-assisted health financing programs for TB	LGU (NTP reports)
5	Number of people trained in strategic information management with USG assistance for TB	LGU (NTP reports)
6	Number of monitoring plans prepared by the USG (CAs) for TB	USAID and other CAs
7	Average population per USG-supported TB microscopy laboratory	PPMD, Facility (public)
8	Percent of USG-supported laboratories performing TB microscopy with over 95% correct microscopy results	NTRL/QI, DOH Central
9	Percent of LGUs in CA sites with at least one DOTS facility accredited by PhilHealth for TB Out-Patient Benefit Package	LGU (NTP Reports)
10	Percent of private health facilities accredited as DOTS facilities	LGU (PHO)
	PROGRAM ELEMENT INDICATORS: MATERNAL AND CHILD HEALTH	
1	Number of people trained in maternal/newborn health through USG-assisted programs	Facilities (public and private)
2	Number of deliveries assisted by skilled birth attendants through USG-assisted programs	NDHS; FHSIS
3	Number of people trained in child health and nutrition through USG-assisted programs	Facilities (public and private)
4	Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-assisted programs	Household Survey (new); FHSIS
5	Number of children < 12 months old who received DPT3 from USG-assisted programs	NDHS; FHSIS
6	Number of children under 5 years of age who received Vit A through USG-supported programs	NDHS; GP report; FHSIS
7	Number of cases of child diarrhea treated in USG-assisted programs with: (a) ORT only (b) Zinc only (c) ORT and Zinc	NDHS; FHSIS
8	Number of people covered by USG-supported financing programs for MCHN	NDHS; PhilHealth
9	Number of people trained in strategic information management with USG assistance for MCHN	Facilities (public and private)
10	Number of monitoring plans prepared by the USG CAs for MCH	USAID and other CAs

	INTERNAL INDICATORS: MATERNAL AND CHILD HEALTH	
11	Number of pregnant women with at least 4 ANC visits by skilled providers from USG-assisted facilities	Household Survey (new)
12	Percent of fully immunized children (All vaccines including Hepa B and measles)	NDHS; FHSIS
	PROGRAM ELEMENT INDICATORS: FAMILY PLANNING AND REPRODUCTIVE HEALTH	
1	Couple years of protection (CYP) in USG-supported programs	FPS; FHSIS
2	Number of people trained in FP/RH with USG funds	Facilities (public and private)
3	Number of people that have seen or heard a specific USG-supported FP/RH message	Household Survey (new)
4	Number of people covered by USG-supported financing programs for family planning	NDHS; PhilHealth
5	Number of people trained in strategic information management with USG assistance for FPRH.	Facilities (public and private)
6	Number of monitoring plans prepared by the USG (CAs) on FP-RH	USAID and other CAs
	INTERNAL INDICATORS: FAMILY PLANNING AND REPRODUCTIVE HEALTH	
8	Number of counseling visits for FP/RH as a result of USG assistance	Facilities (public and private)
9	Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the service delivery point	Facilities (public and private)

Source of indicator list: USAID OH

Annex 2 A

PROVINCIAL TA PLANS FOR LUZON

"Expanding access of the poor to quality health services through equitable health care financing"

PROVINCE OF ALBAY TECHNICAL ASSISTANCE PLAN

Background

Albay, one of the provinces of the Bicol Region (Region V) with a population of over 1.2 million people has the resources needed for rapid development. Located roughly 500 kilometers from Manila, its capital Legazpi City serves as an important business and cultural hub of Southern Luzon. Its potential engines of growth are tourism, light manufacturing and agro- industry. However, it is in the typhoon belt, prone to flooding and under the constant threat of destructive volcanic activity. Ironically, it is that same activity which provides the province with energy to realize its full development potentials. In 2006, thousands of its inhabitants were displaced by natural calamities. Such displacements regularly trigger emergency health concerns.

Albay - general information

Region:	Bikol
Population (2005):	1,234,213
Land area (Hectares):	305,345
Districts:	3
Municipalities:	18
Cities:	3
Barangays:	720
No. of RHUs:	20
Poverty Rate (2003):	34%

Overview of provincial health situation

When compared to national health indicators (based on the 2005 FHSIS), the province is faring as good as or better than others. For example, maternal (MMR) and infant (IMR) mortality rates, FIC, response to diarheal diseases (CDD) and respiratory infections (ARI) affecting children aged 0-59 months are better than the national average.

Albay
Selected health indicators

• U5MR (2003, NDHS)	43
• FIC rate (2006 NCDPC)	80.2
• LGU Health & Nutr Exp (2004)	P181 M
• Percent to total LGU Exp	9.8%
• CMW (2006 NDHS)	3.61
• Attended Births (2005 FHSIS)	52.7%
• Births at Home (2005 FHSIS)	84%
• HIV/AIDS Reach (M/F2006 HG)	39,000
• LGU HIV/AIDS Exp (2006 HPDP)	0
• PHIC Coverage (2006)	611,000
• Women w/4 ANC (2006 HG)	50%
• CYP (2003 CDLMIS)	36,854
• SDP w/ CC S/out Reps (2006 HPDP)	10
• MMR (2005 FHSIS /1000 LB)	.61
• IMR (2005 FHSIS /1000 LB)	9.4
• TB Cases (2005 /100,000)	184.4

On the other hand, Albay has one of the highest incidences of TB in the country and it has yet to achieve the national averages of 64% of women giving birth in a health facility, and 62% of pregnant women receiving pre-natal care. In 2006, the province experienced 16 epidemics. In that same year, the FIC was estimated to have gone down by about 16% compared to the previous year, a setback attributed to "supply problems". The province's malnutrition rate is also still high at 20%. These indicators suggest the persistence of vital health challenges that need to be addressed.

A series of typhoons in 2006 resulted in the damage of a number of the province's health facilities and made others inaccessible. This is expected to adversely impact on the delivery of health services and ultimately the health status of the community.

Albay's health office is led and staffed by an energetic team. The LGU leadership is eager to ensure that the province's health investments correspond to the needs of its constituents. However, the share of the provincial budget for health is below average and the province has yet to invest in the control of emerging infectious diseases such as HIV/AIDS and avian influenza.

Current health programs

The province's health plan for 2007 focused on priority areas such as immunization, nutrition, control of diarrheal disease and environmental sanitation. The latter includes provision of safe water and sanitary toilets, particularly to the 188,000 low income and mainly rural households. There are also programs for disease surveillance, psychosocial stress debriefing, treatment of diseases and the rehabilitation of health facilities. All these programs are geared toward addressing the basic minimum response to situations especially during disasters and epidemics. Health programs for the most vulnerable sector of the population (63% women and 78% children) are on-going. The province, with the assistance of some municipalities, has helped enroll almost 183,000 families in PhilHealth's Sponsorship program. Of this total, some 102,000 are indigent families, or 87% of the province's total indigent population. To address morbidity and mortality from non-communicable diseases like hypertension and diabetes mellitus, the Healthy Lifestyle Program is being implemented.

Health governance

Provincial and municipal health investment plans may be characterized as short-term and un-coordinated. There appears to be little effort to recover these investments or to mobilize resources from non-regular sources to fund health programs and activities. Because few health facilities are accredited with PHIC, reimbursable expenses of provincial as well as municipal facilities, which could be used to upgrade those facilities, is very low. Besides financing issues, the maintenance of appropriate levels of stocks of medical supplies is hampered by problems of distribution. Legislative support given to health-related concerns still needs to be developed and nurtured. Advocacy on health issues and IEC initiatives have so far been limited to replications of those from the DOH central office. Only one LGU has conducted a public hearing on a health issue (smoking). Related to this, civil society participation in local governance through special bodies has been limited. Recently, with HealthGov assistance, a group of NGOs expressed its interest to DILG to be involved in the Local Health Board.

Summary of TA provided in Year 1

Working with the CHD, HealthGov supported the orientation of LCEs of the province and municipalities on health sector reform. With the mandate to proceed with investment planning secured, the Project provided support to the CHD and PHO to carry out an enhanced health program implementation review (using the SDIR tool) and start preparations of a PIPH. The PIPH process involves municipalities, cities, as well as local NGOs in the planning exercise. It is based on DOH guidelines and developed into a structured process with the assistance of HealthGov specialists and experts. NGO fora were conducted leading to agreements on ways to involve civil society and NGOs in local health sector governance. Regional NGAs, like PHIC, Popcom and DILG also participated in the meetings and workshops.

Technical assistance for Year 2

1 PIPH completion and operationalization

HealthGov will continue to assist the PHO in completing the PIPH, secure a mandate for its implementation, and support the province in submitting the PIPH to CHD and DOH Central Office as required. To support PIPH completion, HealthGov will provide the following TA:

- Provide guidance and tools, and capacitate LGU health staff in the consolidation, technical review and writing of the PIPH;
- Provide training and support to the Provincial Planning Team in securing the legitimization and mandate to implement the PIPH.

In operationalizing the PIPH, the TA will be geared towards the following:

Governance
- Formation of the Local Implementation and Coordination Team (LICT);
- Formation/reactivation of the Inter-Local Health Zones;
- Installation of a two-way referral system (RHU-hospitals).

Regulation
- Assessment of RHUs' compliance to accreditation/certification of health facilities.

Service Delivery
- Annual review of service delivery implementation;
- Training on use and implementation of tools to improve service performance and coverage (e.g. TNA on core competencies of service providers, tools for facilitative supervision and monitoring of service delivery, guides for mentoring and coaching of field health staff, etc).

Financing
- Review and implementation of the public finance management plan and resource mobilization;
- Installation and operationalization of financial management systems;
- Efficient use of capitation fund and fast tracking collection of PhilHealth reimbursements of LGUs;
- Implementation of user fees and charges at the RHUs and hospitals.

1 Strengthening the capacity of the CHD and PHO

The objective of this TA is to strengthen the capacity of the CHD and PHO to encourage and mobilize LCEs to improve their health care financing by providing quality health service delivery especially for the poor. The TA will comprise:

- Developing a provincial social marketing plan and advocacy geared towards encouraging, motivating and mobilizing LCEs to invest in improving access by the poor to quality health care;
- Capacitating and assisting the PHO and CHD in implementing the social marketing plan and advocacy. This will involve helping them formulate their social marketing operational plan, develop communication messages and identify effective communication channels;
- Organize advocacy support and lobby to mayors to increase their budget for health facility improvement, health program implementation, skills improvement of health personnel and widen coverage for health insurance of its poor constituents.

2 Improving health care financing and health service delivery of LGUs

While HealthGov's TA plan for the province will be based on the MIPH and PIPH, it will also be anchored on the Governor's topmost health priority which is universal health coverage of

Albayanos. He has earmarked P16 million for this purpose and called upon the mayors to contribute an additional P16 million to raise P32 million for the PhilHealth enrollment of indigents.

To support the health agenda of the governor, HealthGov will help the PHO and LGUs assess the current health care financing and health service delivery systems and develop a TA plan for improving these with the goal of providing wider access of the poor to quality health care.

HealthGov, through DOH, CHD and PhilHealth, will provide TA for the following activities:

- Consultative meetings with PHO and MHOs to determine current status the PhilHealth indigency program of the province;
- Planning workshop with LGUs to pursue PhilHealth universal coverage;
- LCEs Orientation on Social Health Insurance and PhilHealth Indigency Program, including means testing and other possible locally generated data for identifying the poor and unmet need (e.g. CHLSS);
- A series of meetings with the governor, mayors, MHOs and other LGU officials to prepare an action plan to achieve PhilHealth universal coverage;
- Evaluation of all RHUs in order to determine preparedness for PhilHealth accreditation**;**
- Preparation of Provincial Health Accounts;
- Workshops on the OPB, TB DOTS and MCP accreditation to inform them of the deficiencies and gaps, formulation of specific action plans, and articulation of the roles of MHOs, PHNs, and DOH Reps to support PhilHealth accreditation.

3 TA on Service Delivery

In collaboration with CHD staff, HealthGov will provide TA to the provincial, municipal and city health offices in strengthening compliance to the ICV policy of the FP program. This will be achieved by providing support to the Regional FP Coordinators and PHO FP Program Managers in orienting frontline health providers on ICV. The project will also coach the PHO FP Program Manager and Supervising PHNs on the ICV monitoring tool and assist them in adopting it as part of the routine supervisory tool.

4 TA on CSR

HealthGov will assist the PHO evaluate and update the provincial CSR plan. The Project will also help secure legislative support for the plan and it will support advocacy to mayors to do the same for their respective CSR plans. In addition, HealthGov will help the PHO develop a CSR monitoring tool.

"Achieving performance standards at the local level"

PROVINCE OF BULACAN TECHNICAL ASSISTANCE PLAN

Background

The province of Bulacan links Metro Manila to the resource-rich provinces of Central and Northern Luzon, hence its label of the *Gateway to the North*. It has benefited immensely from its location. Industries, services and other economic activities that rely on access to Metro Manila have located in the province. The concentration of economic activity, coupled with its rich indigenous resource base, sustains a vibrant local economy. Bulacan has one of the lowest poverty rates in the country. A major challenge though is the burgeoning population, which is growing at a rate of close to 5% per annum.

Bulacan
General information

Region:	Central Luzon
Population (2005):	3,218,644
Land Area:	262,500 hectares
Districts:	4
Municipalities:	21
Cities:	3
Barangays:	569
RHUs:	55
Classification:	1
Poverty (2003):	8.5%

Overview of provincial health situation

Nationwide Bulacan ranks ninth in terms of Human Development Index. It has a very high FIC rate and its maternal and child mortality rates are far below the national average. The mortality rate for children under five years is low and the incidence of TB cases is almost equal to the national average. The malnutrition rate is less than 4%.

Bulacan
Selected health indicators

• U5MR (2003, NDHS /1000)	31
• FIC rate (2006 NCDPC)	100
• LGU Health & Nutr Exp (2004)	P425 M
• Percent to total LGU Exp	11.7%
• CMW (2006 NDHS)	2.86
• Attended Births (2005 (NDHS)	67.7%
• Births at Home (2005 FHSIS)	61.1%
• LGU HIV/AIDS Exp (2006 HPDP)	0
• PHIC Coverage (2006)	374,000
• Women w/3 ANC (2006 HG)	95.9%
• CYP (2003 CDLMIS)	276,730
• SDP w/ CC S/out Reps (2006 HPDP)	11
• MMR (2005 FHSIS /1000 LB)	0.3
• IMR (2005 FHSIS /1000 LB)	7.4
• TB Cases (2005 /100,000)	159.6

Still, the TB detection rate is lower than the standard. The province's population management program requires strengthening, with the CPR falling below the standard of 60%. According to FHSIS data, the rate of treated diarrhea cases, while above the national average, is an alarmingly low 34%. Likewise, the rate for treated acute respiratory infections trails far behind the national rate of 95%. The percentage of pregnant mothers given TT2 plus is only 35%, way below the national standard of 85%. Another alarming indicator is the province's low level of investment in the control of HIV/AIDS.

Current health programs

Bulacan's major health programs are (a) Family Planning/Reproductive Health; (b) Maternal and Child Care and Nutrition; (c) TB control; (d) control of sexually transmitted diseases and HIV/AIDS; (e) control of communicable diseases, and; (f) the management of health facilities (hospitals and RHUs). A relatively new program is universal health coverage, focusing on providing health insurance coverage to the poor. As of 2006, the province had covered over 300,000 indigent family members with health insurance from PHIC. While the province has not been up to standard in some of its program indicators, it continues to allocate appropriate amounts for health care: the province allocated over P450 million for health care in 2006.

Health facilities and systems

The province has 8 government and 67 private hospitals, 57 RHUs and 543 BHS. Of the 608 government facilities, 152 or 25% are SS accredited. These include 54 RHUs, 91 BHS and all the provincial hospitals. The number of PHIC accredited facilities is low: 21 RHUs are accredited for OBP, 3 for MCP and 11 for TB DOTS. There are 840 RHU personnel, including 54 doctors and 468 nurses. They are supported by about 3,200 barangay health workers, a massive health service delivery force that has yet to be fully tapped.

The province prepares annual work and investment plans for health, including a procurement plan for medical supplies and services. However, these plans are not province-wide but cover only provincial government concerns. The provincial development council (PDC) is functional and actively participates in the preparation of annual investment plans. Procurement of essential drugs and commodities is done through the Bids and Awards Committee: it has the capability to conduct on-line bidding. The distribution of drugs and commodities to health facilities is done through a provincial delivery system. The FP commodities are distributed on a quarterly basis and Vitamin A on a semi-annual basis. For TB, the RHUs get their supplies from the district hospitals.

As noted earlier, the province allocates close to P450 million for health. However, much of this covers expenditures for hospital operations. Only 1.27% of the health budget is spent for maintenance and operating expenditures for public health.

Summary of technical assistance provided in Year 1

In the first year of the project, scoping missions were undertaken to understand the health program situation of the province. This was enriched by data gathering that captured the health governance and operations indicators to assess the baseline situation.

The governor, the Local Finance Committee, members of the Sanggunian and NGOs and CSOs were oriented on the HSR Agenda and F1. The new governor expressed his support for health and requested assistance from HealthGov.

HealthGov assisted the province in carrying out a Service Delivery Implementation Review, an expressed need of the province. The 24 MHOs including municipal nurses, midwives, and planning and budget officers participated in the SDIR, which resulted in the preparation of 24 acceleration plans. These plans are to be presented to the mayors and the governor.

A Provincial Partnership Building Workshop was conducted in September to capacitate local NGOs and CSOs to be partners in pursuing health reforms. As a result of the workshop the Bantay Kalusugan sa Bulacan (BKB, or Bulacan Health Watch) was created. BKB promises to be a major player in the implementation of health sector reform in the province. The significance of the BKB may be seen in its immediate participation in the Knockout Tigdas and Garantisadong Pambata programs.

Technical assistance proposed for Year 2

Based on the results of SDIR, the province's theme for technical assistance and interventions is "achieving the performance standards at the local level". This theme underscores the important role that municipalities and civil society play in improving health outcomes in low performing areas. In this context four clusters of interventions are anticipated as follows:

The following key interventions are planned:

1 Preparation of Provincial Investment Plan for Health

- Supporting the MIPH/PIPH preparation process and using the resulting plans as the basis for health sector reform. The preparation process includes SDIR, CSR planning, assessment and monitoring, ULHS assessment and planning, improving the management systems, universal health coverage and planning for the upgrading of health facilities. The intention is to complete the PIPH for the province and the MIPH for the municipalities/cities in the second quarter of Year 2 in response to the request of the governor and the PHO.
- Conducting an assessment of the province's CSR program using tools developed by HealthGov together with the DOH. This TA will be part of the PIPH and will prepare the province for the new AO on CSR:
  - A workshop on crafting the CSR assessment tool and an orientation on its use. This includes discussions of strategies and technologies for promoting commodity self reliance, all FP methods, strategies for integrating FP into MCH and safe motherhood services, client segmentation, budgeting and finance, forecasting, procurement and logistics, and linkages with private sector suppliers;
  - Transfer of technology, led by the PHO with CHD support through planning workshops, meetings, consultations and other TA. The CSR assessment tool will be developed and pre-tested by the CHD and PHO, with HealthGov support;
  - ICV monitoring throughout the year: HealthGov will incorporate ICV orientations in all major training activities.

1 Developing CSOs/NGOs as active partners of the LGUs in health work

By supporting activities of BKB and other NGOs, civil society involvement in improving health governance and policy formulation will be strengthened. Activities to be supported include constituency building of health advocacy groups, increasing representation on local health boards and other special bodies, monitoring activities such as community feedback to improve service delivery, and networking for resource mobilization to upgrade facilities. In the PPBW conducted in Pampanga the specific areas of advocacy selected were control of dengue and rabies.

2 Build LGU capacity to promote awareness of local health programs and favorable health-seeking behavior

SDIR provided information on the status of local health programs up to the barangay level. The PHO (with support from HealthGov) will organize planning workshops for barangay captains to make the data available as inputs to the barangay level planning. The status of municipal health programs will be reported to the League of Municipalities as part of the evidence-based decision making advocacy supported by HealthGov. The SDIR data are critical in the planning process and in the efforts to improve health indicators.

3 Control of Avian Influenza

Bulacan has been identified as a high risk area for AI, being close to the Candaba swamp and having a high concentration of poultry farms. HealthGov assistance will focus on the establishment of a community-based barangay early warning system.

"*Improving health implementation performance at the local level"*

PROVINCE OF CAGAYAN TECHNICAL ASSISTANCE PLAN

Background

Cagayan is considered the warmest of all the provinces in the Philippines. It is about 480 kilometers north of Manila and the second biggest province after Isabela in terms of population. Based on the 2000 population census, Cagayan had a population of 993,580 with a population density of 118 persons per sq. km. The province has 28 municipalities, one component city and 771 barangays. The incidence of poverty is 16.5% (2004).

Owing to its strategic location, it serves as the regional center for Region Two. Tuguegarao City, the component city which also serves as its capital houses all the regional offices of government for Region Two. It is accessible by land transportation as well as by air transport with an airport at Tuguegarao.

Overview of provincial health situation

Vital health indices for 2006 show that Cagayan's maternal mortality rate is lower than the regional average. However, overall mortality and the infant mortality rate are higher. Overall, the province's performance in health is below national standards. At the regional level, Cagayan scores lower in nutrition, immunization, prenatal and post partum care. The province excelled in its performance in rabies immunization compared to other provinces in the region. Rabies due to dog bites and including human rabies is one of the biggest health concerns of the province. It has the highest number of reported cases of dog bites and human rabies in the country.

Cagayan
Selected health indicators

• Birth Rate	18.65
• Death Rate	4.48
• Maternal Mortality rate	.52
• Infant Mortality Rate	6.71
• Births attended by trained personnel	71.07%
• Births attended by hilots	26.05%
• Home deliveries	75.78%
• Pregnant women with 3 or more visits	65.58%
• Pregnant women w/ complete iron dosage	62.45%
• Post Partum Women complete iron dosage	61.02
• FIC	88.15
• TB Cases	1806

Current health programs

The province focuses on hospital operations. Its public health responsibilities are dispensed through the field health operations, including a provincial clinic. The PHO staff provides technical assistance to all RHU health programs. These programs include: a) maternal and child health which includes nutrition, family planning and reproductive health; b) prevention of communicable diseases, and; c) non-communicable diseases. The health budget has continued to increase in the past three years. The 2007 health budget is 32 percent of the total provincial budget. PHO resources for public health are focused on the "Club 82" (consisting of the 10% of the 820 barangays that are considered poor).

Health facilities, human resources and systems

Cagayan has 12 private hospitals and 16 government hospitals: seven hospitals are PHIC-accredited. The province also has 30 RHUs and 216 BHSs and 13 RHUs are SS I certified. None of the BHSs are SS certified. There are 30 doctors 50 nurses, 332 midwives, 49 sanitary inspectors, 26 medical technologists, 3,682 BHWs and other health volunteer workers, and 849 TBAs. The provincial staff is complemented by 6 DOH medical staff (PHTO).

Implementation of the provincial five-year strategic plan developed with CHD assistance is ongoing. Cagayan has started to update the strategic plan for health using the integrated health planning system and the CHD is assisting the municipalities come up with their strategic plans for health.

The Sanchez Mira ILHZ is the only functional ILHZ in the province, but it needs further strengthening. The PHO has expressed its desire to help integrate and improve linkages between RHUs and district hospitals and improve health performance.

Cagayan has an Annual Procurement Plan (APP) for essential drugs and commodities. Procurement is done through the PBAC. Since all procurement must go through a bidding process there were delays in purchasing of commodities. The program coordinators acted as the delivery team that went to the field to distribute the commodities. Essential drugs and commodities are being distributed on a quarterly basis.

There is no CBMIS in place, and CDLMIS is no longer used to track and record the procurement and distribution of FP supplies. The simplified recording system is used instead.

As of Sept 2006 Cagayan had 56,205 enrollees under the PHIC sponsored program. This is far below the target of covering all indigents, considering that the poverty incidence is 16.5%. The identification of indigents to be covered under the sponsored program needs to be reviewed and improved to ensure that the real poor are targeted.

Advocacy

The relationship between the local executive and legislative branches of the province needs to be enhanced, to bring about positive changes in health service delivery. There are a number of NGOs and CSOs that can be tapped to improve access of health care services. The climate for NGO/CSO participation has been positive with the active participation of NGOs/CSOs in the provincial and municipal health boards. CSOs/NGOs are challenged to expand their constituencies and to be inclusive with other civic organizations, interfaith groups, academe and professional health associations.

Summary of technical assistance to the province in Year 1

In its first year of assistance, HealthGov has a) oriented key provincial officials (including the governor and Sanggunian members) and staff on health sector reform, F1 and the USAID TA program; b) oriented PHO staff and other key provincial officials on the PIPH process and the SDIR tools; c) conducted a training session on resource mobilization for the provincial finance committee and PHO staff; d) facilitated the participation of the PHO and selected NGOs/CSOs in the cluster orientation workshop for CSOs/NGOs, and; e) assisted in the conduct of a provincial CSO/NGO forum.

Proposed technical assistance for Year 2

“Improving health implementation performance at the local level” will be the rallying point of HealthGov’s TA to Cagayan in the second year. The aim is to help the province narrow the gaps in its performance level. Specifically, HealthGov plans to help the province in the following areas:

1 Five year investment plan for health

HealthGov together with the CHD will assist the provincial planning team and the municipal planning teams in the various planning workshops and processes following the prescribed PIPH formulation process.

2 CSR monitoring tool and CSR plans

HealthGov will support the CHD and POPCOM in orienting the PHO and municipalities on the CSR monitoring/assessment tool. The implementation of the tool will provide an important input to the preparation of CSR plans. HealthGov will also assist in the preparation of the municipal and provincial CSR plans as part of the overall provincial investment plan for health.

3 Systems review

The CHD, with support from HealthGov, will assist the PHO in assessing the provincial health delivery and management systems, including the human resource management system, logistics, procurement and distribution system, knowledge and information system, and monitoring and evaluation.

4 Improving access of the poor to quality health care services

In collaboration with PhilHealth, HealthGov and the CHD, particularly the PHTL, will organize an inter-agency advocacy committee that will conduct campaigns among key municipal officials for increased coverage of indigents. HealthGov will introduce the CHLSS as a means of identifying the poor. To improve service delivery, the inter-agency advocacy committee will also advocate among municipalities for the improvement of facilities for PhilHealth accreditation.

4 Implementing critical interventions for priority programs through SDIR

HealthGov will assist the province in the conduct of SDIR as part of the local investment planning process. The results will serve as a means of improving health performance in the more immediate term by identifying and implementing critical interventions.

5 Early warning and surveillance system for avian influenza

HealthGov will assist the province of Cagayan in establishing an early AI warning and surveillance systems in identified barangays of Aparri. HealthGov will help identify the areas, assist in the design and conduct of community meetings and other orientation meetings that will facilitate the set-up of a functional early warning and surveillance system.

6 Advocacy

HealthGov will continue to communicate and advocate for better health governance through its various activities with multi-stakeholder partners. The strengthening of health champions among the executive and legislative branches of the LGUs will be a key activity and best practices are shared among these leaders. HealthGov will also continue to support other activities supportive of NGO/CSO participation in health development.

"Enhancing health systems through the Province-wide Investment Plan for Health"

PROVINCE OF ISABELA TECHNICAL ASSISTANCE PLAN

Background

Isabela, the most populous province of region 2, is located 400 kilometers north of Manila. Ilocanos comprise 68.71% but the province has a concentration of tribal ethnic groups. The province has a substantial number of poor, accounting for about one quarter of the population, despite being rich in natural resources.

Isabela
General information

Region:	2
Population (2000):	1,287,575
Population density:	120 per sq. km.
Districts:	4
Municipalities:	35
Cities:	2
Barangays:	1,055
RHUs:	39
Classification:	1
Poverty rate (2004):	23.9%

Overview of the provincial health situation

Isabela has the highest birth rate in the region. The status of other health indicators shows that it is not the worst performer in the region. However, Santiago City, showed the worst performance in terms of maternal and infant mortality rates.

The leading causes of death for all ages are CVD, pneumonia, cancer and accidents. The top leading causes of morbidity are acute respiratory tract infections, influenza, CVD and heart diseases, diarrheal diseases and gastro-intestinal diseases. TB is the fifth leading cause of mortality and the tenth cause of morbidity.

Selected health indicators (2006)

- Infant deaths: 146 (5.71)
- Foetal deaths: 27 (1.05)
- Maternal deaths: 15 (58.59/1000LB)
- Under five deaths: 195 (7.61/1000LB)
- % of pregnant women given TT dose:
  - 35 MLGUs: 61%
  - Cauayan: 57%
  - Santiago City: 71%
- CPR
- 35 MLGUs: 53.54
- Cauayan City: 71.38
- Santiago City: 67.93
- CDD Cases see: 9028 (16.34%)
- CDD Cases Treated: 9028(16.34%)
- Malnutrition rate: 12.72%
- TB Cases detected : 896
- Cure rate: 81.6 %
- Leprosy cases: 41

Rabies due to animal bites is a major concern of the LGUs. In 2006, data showed that there were 3,151 dog bites, 66 cat bites, 12 cases of human rabies and 106 others. Some areas in Ramon Isabela are identified as critical areas for the entry of Avian Influenza owing to the presence migratory birds.

Health programs

Isabela is an F1 roll-out site. Health is a considered a priority concern by the provincial and municipal governments. Major public health programs are: 1) Maternal and Child Health; 2) Control of Communicable Diseases; and 3: Control of Non-communicable Diseases. The province has a health insurance coverage program for indigents.

The provincial budget for health for 2007 is P229 million. This is 21.6% of the total regular provincial budget. The hospital services get the lion share of the health budget with only about 10% dedicated to field health services. From the 20% Development Fund, 53.6 million has been allocated for health during the same year.

Health systems

Isabela is currently using a 5-year provincial strategic plan introduced by the CHD. The municipalities also have strategic plans using the integrated health systems approach. The provincial and municipal strategic plans are due for updating. The governor did not convene the LHB during her first term but is committed to organize the board during her second term.

There is a need for additional resources for health service improvement to augment the province's regular funds. It has relied mainly on its IRA share. Almost all RHUs and BHSs do not have any cost recovery measures, except for asking for donations from clients.

The PHO uses the FHSIS reports that the RHUs submit quarterly for monitoring purposes. However, health officials expressed problems with the quality of data gathered from the FHSIS and other health information systems. Some programs like EPI and NTP have their own reporting forms aside from the FHSIS, which are collected by the program coordinators. Discrepancies between these different reporting systems have to be rectified.

The province has no ILHZs. Previous attempts to set up ILHZs did not succeed as some LCEs were unwilling to commit resources.

Isabela has a procurement plan for hospitals. The procurement system has issues with the timeliness of procurement and distribution of essential drugs and with the projection of actual requirements, leading to shortages in the supply of some medicines. The field health office is not involved in the procurement of drugs but it facilitates the distribution of commodities received from the DOH/CHD and other donors like UNICEF and the Global Fund. It adopts an integrated system in the distribution of commodities.

Health facilities and human resources

For the curative aspect of health services, there are 12 public hospitals with 65 doctors, 113 nurses, and 355 other medical staff. The province has a total bed capacity of 295. (2006). For preventive and primary health care, there are 509 barangay health stations, 39 main health centers/RHUs with 41 rural health doctors, 94 nurses, 388 midwives, 39 sanitary inspectors, 3,194 BHWs and 666 TBAs (2006). There are seven social hygiene clinics or RHUs providing counseling and testing of STD and AIDS.

Summary of technical assistance provided in Year 1

Initiating an engagement with the province for collaboration was the first task in year one. This was accomplished through courtesy visits and orientations on F1 and the USAID TA program among key provincial officials. These officials included representatives from the PHO, PPDO, PHTO, budget office, the Treasurer and the Provincial Administrator. The local finance committee participated in an orientation on resource mobilization and health financing. The PHO staff and DOH Reps were oriented on the SDIR tool and the PIPH process. The PHO and selected NGOs attended the NGO/CSO cluster orientation.

Technical assistance proposed for Year 2

The theme of the TA in Isabela for the second year of the Project is "Enhancing health systems through the Province-wide Investment Plan for Health". Specific TA to support this theme will be as follows:

1 Preparation and implementation of PIPH

HealthGov will provide TA for the completion and the implementation of the PIPH and the operational plan. This will include the conduct of an in-depth systems review and facility mapping.

2 Improving the health financing system

- HealthGov together with CHD will orient the PHO and MLGUs on the application of CHLSS to identify the poor;
- HealthGov in collaboration with CHD and PhilHealth will facilitate the assessment of the status of accreditation and identification of measures to increase the number of facilities accredited by PhilHealth;
- Advocacy for the sustained provincial support to the indigency program and for increased municipal support to the program.

3 Establishment of an early warning and surveillance system for AI

HealthGov will assist the CHD and PHO in the establishment of an effective early warning and surveillance system for avian influenza in selected barangays of Ramon. The Project will help in the design of the community-based system and conduct orientations of municipal and barangay officials, including health workers, in the development and implementation of the system.

4 Informed Choice and Voluntarism

HealthGov will support the CHD in providing TA to LGU officials to strengthen compliance with the ICV policy of the Family Planning program. This will be achieved by providing support to Regional FP Coordinators and PHO FP Program Managers in orienting frontline health providers on ICV. The project will also mentor the PHO FP Program Manager and Supervising PHNs on the ICV monitoring tool and assist them in adopting it as part of the routine supervisory tool.

5 Coordination mechanisms for effective health governance

Part of the advocacy agenda for the province is the enhancement of coordination mechanisms for health, including Provincial and Municipal Development Councils and Health Boards and other health committees.

HealthGov will continue to provide support for partnership building for health between and among government agencies, NGOs and CSOs. The Project will also continue to advocate for the participation of NGOs/CSOs in health planning and other relevant LGU activities.

“Strengthening the Unified Local Health System approach for better health outcomes”

PROVINCE OF NUEVA ECIJA TECHNICAL ASSISTANCE PLAN

Background

The Province of Nueva Ecija is situated in the eastern rim of the broad Central Luzon Plains. Its access to Metro Manila is a distinct geographic and economic advantage. The province is composed of 26 municipalities and 6 cities and an aggregate total of 849 barangays. Agriculture is the primary economic activity. Due to rapid urbanization in nearby provinces, Nueva Ecija is fast becoming the “Food bowl and rice granary of Central Luzon”. The main agricultural products are rice, onion, garlic, corn, melon and mango. Agricultural production covers an area of about 298,742 hectares of fertile land that is nourished by the Great Pampanga River and its many tributaries.

Nueva Ecija General information

Region:	Central Luzon
Population (2007):	1,912,472
Land area:	550,718 (hectares)
Districts:	4
Municipalities:	26
Cities:	6
Barangays:	849
RHUs/CHO:	52
Classification:	1
Poverty (2004):	27.30

Health situation

Cancer and cardio vascular diseases are the main causes of mortality. Infant mortality increased from 2.91 in 2005 to 5.34 in 2006 for every 1000 live births. Respiratory disease, pneumonia and pre-mature delivery were the leading causes of infant deaths.

Nueva Ecija Selected health indicators

FIC rate (2006, FHSIS)	77.38
LGU exp on health and nutrition (2004)	P358 M
Percent of total LGU expenditures	10.9%
CMW (2006 NDHS)	2.97
Attended Births (2005 FHSIS)	20.6%
Births at Home (2005 FHSIS)	79.4%
LGU HIV/AIDS exp (2006 HPDP)	0
PHIC coverage (2006)	329,119
Women w/3 ANC (2006 HG)	70.8%
CYP (2006 CDLIMS)	77,152
SDP w/CC S/out Reps (2006 HPDP)	55
MMR (2006 FHSIS /1000 LB)	0
IMR (2006 FHSIS /1000 LB)	5.34
TB Cases (2006 FHSIS /100,000)	104

The contraceptive prevalence rate (CPR) in Nueva Ecija dropped from 76% in 2005 to 38% in 2006. The TB case detection rate (CDR) improved slightly from 45% in 2005 to 53.6% in 2006, still below the 70% performance standard. On the other hand, the TB cure rate in 2006 was much higher than in 2005 and increased from 70.5% to 86.6%.

The PHO identified the fragmentation of health service delivery due to the challenges of devolution as the main reason for the declining vital health indicators of the province. The disintegration of health services between the RHUs and hospitals was aggravated by insufficient resources available to local governments. Compounded by history, local elected officials are accustomed to giving and receiving short-term assistance, which leads to the lack of strategic planning for health as a long-term investment.

Health programs

To address the inadequacies of health facilities and maximize the use of available resources, inter-LGU cooperation and coordination in health service delivery is paramount. By pooling limited resources for health services through the establishment of functional ILHZs, LGUs can augment their investments for health through networking, referral systems and cost-sharing schemes. However, crucial to the success of the health system is the capability of core referral

hospitals to meet the needs of municipalities. Such hospitals are the main point of referral for hospital services from the catchment areas.

Nueva Ecija has attempted to re-integrate hospital and public health services through the creation of ILHZs. However, only two Unified Local Health Systems (ULHS) are considered functional at present - the San Jose District and Guimba District. The province used to have 6 active ULHS.

Moreover, health facilities in the province have outdated equipment and face an inadequate supply of drugs and medicines. The exodus of health workers, particularly of public doctors and nurses, compounds the situation. It significantly contributed to a decrease in the ratio between public health workers and the population beyond the accepted standards. The occupancy rate of the 9 public hospitals in the province is declining because hospitals are forced to pass on patients to private hospitals due to the lack of competent personnel and poor facilities. The condition of RHUs on the other hand is also not promising. Only 10 out of the 46 RHUs are Sentrong Sigla certified and PHIC accredited.

Local Health Boards were formed but most are not actively providing inputs to LCEs. In many cases, civil society is not represented on the Board despite the legal mandate for representation on the local development councils and special bodies.

Technical Assistance provided in Year 1

Given the health situation, the Project has extended TA to the PHO and DOH Reps and equipped them with appropriate tools for assessment and situational analysis. Using SDIR, the CHD and PHO have guided the RHUs and core referral hospitals to evaluate the public health and hospital programs by focusing on vital health indicators and standards. In effect, SDIR has enhanced the program implementation review conducted regularly by the PHO. SDIR outputs were utilized in the preparation of the 2008 AIP for Health and form an important input for the development of the PIPH.

In preparation for PIPH formulation, the PHO technical staff, CHD program coordinators and DOH Reps already underwent training as facilitators. Furthermore, local NGOs were oriented on health sector reform and F1 and were capacitated to effectively engage in partnership building with LGUs using participatory mechanisms such as the Local Health Board and Local Development Council.

Technical assistance proposed for Year 2

HealthGov TA in the second year is supporting the aim of the CHD and PHO to better integrate the hospital and public health services and create an efficient system for the delivery of health services. This will be achieved by reviving and strengthening the district health concept with an inter-LGUs partnership as the basic framework. As part of the development of the PIPH, an ILHZ development plan will be prepared that contains critical interventions to revive and strengthen the unified local health system.

HealthGov TA will focus on the following:

1 PIPH preparation

- Support for the development of the provincial 2008 AIP for Health;

- Development of a resource mobilization plan, based on a review of the current sources of financing for health;
- TA for the preparation of the PIPH documentation;
- Development of a monitoring and evaluation tool to track progress in the implementation of the PIPH.

2 ULHS strengthening

- Support for the organization and strengthening of ILHZs, including assistance for strategy formulation, organizational development, strengthening inter-LGU cooperation and formulation of an implementation and sustainability plan;
- TA on financing of ILHZs including the development of guidelines and implementing rules on cost-sharing schemes and managing common funds as well as procedures for disbursement, auditing and reporting; assistance on the development of planning guidelines for PhilHealth Universal Coverage;
- Strengthening the referral system: developing participatory assessment and monitoring tools to gauge the effectiveness of the two-way referral system;
- Assistance to the PHO and the civil society to lobby for political support for ILHZs through the issuance of resolutions.

3 Increasing PhilHealth accreditation of RHUs

- TA for the implementation of the acceleration plan of the SDIR;
- Assistance in the implementation of a continuous quality improvement system, using the SDExH tool.

4 Strengthening public health financing

- Development of policy guidelines on sub-allotment of appropriations to core referral hospitals;
- TA on reviewing the drug procurement system of hospitals, evaluation of procurement regulations, forecasting, inventory control, and improvement of the annual procurement plan;
- Orientation of the CHD, PHO, DOH Reps and the Provincial Finance Committee on public finance, management and planning for health, including guidelines for the establishment of improved systems for procurement and logistics, financing, and planning and budgeting.

5 Strengthening advocacy and civil society participation in health

- Assistance to the PHO and civil society and private sector representatives for the development of plan for public participation in health;
- Support for the development of orientation materials and capacity building of CSOs/NGOs. The capability building program includes constituency building, networking and negotiation, and understanding local legislative processes.

"The poor at the center of development"

PROVINCE OF PANGASINAN TECHNICAL ASSISTANCE PLAN

Background

Pangasinan is a rapidly developing province with rich natural resources and tourism potential. The fast-paced growth is marked not only by infrastructure development but also by a rapidly increasing population. The province has been recognized in the past for implementing best practices in procurement and its effort in CSR for which it won the Rafael Salas Award on Population in 2004. It was also cited as the Most Outstanding Province in TB Control in 2007.

Pangasinan General information	
Region:	1
Population (2005):	2.6 m
Land area:	536,818 ha.
Districts:	6
Municipalities:	44
Cities:	4
Barangays:	1,364
RHUs:	68
Classification:	1st class

Provincial health situation

The present administration is determined to continue the reforms in health with a focus on poor constituents, senior citizens, the disabled and the marginalized. To be able to do this, the provincial government will tap the health facilities composed of 16 government and 44 private hospitals, 68 RHUs and 416 Barangay Health Stations. The number of health care facilities is inadequate given the average ratio of RHU to population of 1:35,000. Fifteen of the facilities are OPB accredited, 45 for MCP and 36 for TB DOTS.

Situation analysis

The PIPH of Pangasinan was crafted in 2005 and approved in mid-2006. A Project Management Core Team composed of PPHO, PHO, PBO, PTO, PHIC, PHTL was created but it is not yet functional. PIPH funding from the European Union totals P159 million, part of which has been released. The participating municipalities committed P33 million in counterpart funding.

Pangasinan Selected health indicators	
• U5MR (2006, FHIS, PHO)	4.82
• FIC rate (2006 FHIS, PHO)	83
• LGU health & nutr exp (2006)	P230 M
• Percent to total LGU exp	21%
• Attended Births (2005 (NDHS)	43,347
• Births at Home (2005 FHSIS)	36,621
• STD exp (2006, PHO)	P16,000
• PHIC coverage (2006)	64,084
• Women w/3 PNC (2006, PHO)	74.5%
• MMR (2006 FHSIS /1000 LB)	0.39
• IMR (2005 FHSIS /1000 LB)	9.19
• TB Case Detection Rate	72%
• TB Cure Rate	89%

A Provincial Logistics Management Information System is in place but the Pangasinan Population Office (PPO) expressed the need for a review of the PLMIS. For example, 27 LGUs monitored were not buying FP commodities and there are also problems in forecasting as manifested in stock outs of 26 service points for pills and 22 for injectables. The province would therefore also like to review its medical supply distribution system.

Pangasinan continues to face some key challenges in health service delivery, regulation, financing and governance. While improvements were made in the past few years, health needs are evident in a number of critical indicators such as the IMR, which is one of the highest in the region.

Status of health programs

The province's 2007 population is estimated to be 2.6 million and with a growth rate of 2.41%, the province's population will double in 29 years. CPR is high at 56%, but still below the standard of 60%. Unmet needs for FP average at 20% and is highest in Manleluag ILHZ (26%) and Layug (20%). The leading causes of mortality are lifestyle and degenerative diseases such as hypertension, cardiovascular diseases, while the leading causes of illnesses are infectious in origin such as acute respiratory infections, diarrhea and tuberculosis.

The province is performing poorly in maternal care. In 2006, 20 maternal deaths were recorded, caused by HPN in pregnancy, post partum hemorrhage and abruptio placenta. The province's accomplishment on pregnant women with three or more pre-natal visits (74.5%), pregnant women with at least 1PP (70.8%), and pregnant women given TT2 plus (66.1%) also fell short of the national standards. The province EPI accomplishment of 83% did not meet the EPI national standard and the number of children missed for Measles vaccine and DPT 3 totaled 24,409. There are about 15 municipalities with a malnutrition prevalence rate of more than 10%.

Pangasinan's TB program is performing well, with a TB Case Detection Rate of 72% and TB cure rate of 89%, both of which surpass the national standard. The EQA system in place in 6 ILHZs. In the area of STI and HIV/AIDS, 7 urbanized areas are currently implementing STI programs by using IEC materials and implementing advocacy activities.

Social insurance contributions remain low in proportion to out-of-pocket expenditures. The public-private mix also needs to be addressed, as well as the distribution of personnel and facilities: most clinics and doctors are located in the bigger cities and municipalities.

Technical assistance provided in Year 1

Pangasinan is the only F1 convergence site in Luzon. Key officials of the province were oriented on the USAID TA programs and in September HealthGov and other CAs met with the governor to discuss possible areas for assistance. The governor pointed out that poverty alleviation is his priority concern with health reform as one of its critical components. A Provincial Partnership Building Workshop was held resulting in a covenant between the Pangasinan Federation of NGOs (PFNGOs) and the PHO to support to the health program of the province.

Technical assistance proposed for Year 2

Consistent with the provincial focus on health sector reform to support poverty alleviation, TA in the second year of the Project will focus on the following three areas:

1 Poverty mapping and client classification

The Living Standards Survey was implemented in Pangasinan in an earlier health project, designed to provide the province with a means to identify the poor and their health needs. HealthGov TA will draw upon data that it the province has generated through the LSS to strengthen the province's capability to assess who and where the poor are and how they can be assisted, particularly in terms of health services. Provincial officials and civil society will be oriented on the significance of the LSS, not only for targeting the poor but also for health policy development at the local level.

2 CSR assessment and CSR planning

HealthGov will provide TA to help Pangasinan assess the province's experience in CSR and to develop the capacity of the PHO to support CSR planning and implementation and to ensure adequate levels of commodities in health facilities.

3 NGO/CSO capacity building for effective participation in governance for the poor

The Pangasinan Federation of NGOs (PFNGO) is assured of its membership in the Provincial Health Board, an opportunity for civil society to participate in health governance. HealthGov TA will focus on: (1) assisting PFNGO in identifying the appropriate structure needed by the organization; (2) identifying suitable areas for partnerships and drawing up mechanisms for these partnerships, and; (3) equipping PFNGO with the tools and skills to advocate for policies that will ensure appropriate levels of public investment in health and ordinances supportive of health sector reform agenda.

"Improving access to public health through quality healthcare financing and Contraceptive Self Reliance"

PROVINCE OF TARLAC TECHNICAL ASSISTANCE PLAN

Background

Tarlac is a landlocked province in close proximity to Metro Manila. It is classified as a 1st class province with 3 congressional districts, 17 component municipalities, 1 city and 512 barangays. In addition to rice production the province is home to several industrial estates including the former Clark Airbase. These economic hubs have propelled the province towards sustained economic growth.

Tarlac
General information

Region:	Central Luzon
Population (2007):	1,247,040
Land area:	3,053 (sq. km.)
Districts:	3
Municipalities:	17
Cities:	1
Barangays:	512
RHUs/CHOs:	36
Classification:	1

Health situation

The province registered a 96% TB Case Detection Rate in 2006, surpassing the 70% national performance standard. The cure rate was pegged at 80%. However, MMR increased by 0.4 in 2006, while IMR is at 4.62 for every 1,000 live births. Almost 89% of children are fully immunized. However, malnutrition persists in 5th and 6th class municipalities where support for the nutrition program is inadequate. Owing to poor hygiene practices, unsafe water supply, and unsanitary toilets, a high prevalence of diarrhea cases was observed among preschool children. There is a significant reduction in new (70% to 50%) and current users (90% to 60%) of FP methods in 2006, coinciding with the reduction of donated contraceptives from the national government.

Health programs

The health outcomes of Tarlac are generally satisfactory compared to the region. Notwithstanding its performance, the province continues to seek to improve the state of health of its constituency. The province aims to reduce maternal morbidity and mortality by providing quality prenatal care to pregnant women and by increasing TT2 coverage from 60% to 80% by 2007 to protect postpartum mothers and newborn babies from complications and other communicable diseases. It also aims to increase FIC coverage from 89% to 95% and reduce the incidence of neonatal tetanus among new born infants. Moreover, Tarlac is committed to improve the nutritional status of preschool children by addressing parasite infestation, maintaining or even surpassing the 90% GP and OPT coverage, increasing household consumption of iodized salt, ensuring availability of fortified products and conducting continuous advocacy on food fortification and proper nutrition. Determined to eliminate TB as a major cause of mortality, the province aims to reduce the prevalence and mortality from TB by at least 25% by the end of the year.

Tarlac
Selected health indicators

• U5MR (2006, FHSIS /100,000)	84.5
• FIC rate (2006, FHSIS)	88.9
• LGU health & nutr. Exp. (2004, DOF)	P245 M
• Percent to total LGU Exp	15.4%
• CMW (2006 NDHS)	3.00
• Attended Births (2005 FHSIS)	45%
• Births at Home (2005 FHSIS)	55%
• LGU HIV/AIDS exp. (2006 HPDP)	0
• PHIC Coverage (2006)	539,882
• Women w/3 ANC (2006 HG)	51.2
• CYP (2003 CDLMIS)	99,856
• SDP w/ CC S/out Reps (2006 HPDP)	14
• MMR (2006 FHSIS /1000 LB)	.04
• IMR (2006 FHSIS /1000 LB)	4.62
• TB Cases (2006 FHSIS /100,000)	175.66

With the declining supply of free contraceptives, Tarlac aims to intensify universal access to family planning information and services whenever and wherever these are needed. The FP focuses on assisting couples and individuals to achieve desired family size within the context of responsible parenthood and ensuring that quality FP services are available in all LGUs, health facilities, NGOs and the private sector. This will be done by helping municipalities to be contraceptive self-reliant (CSR) and by encouraging civil society and private sector participation in FP/RH programs.

To further improve access of the poor to public health services, the province aims to enroll all families in PhilHealth to reduce out-of-the-pocket expenditures. Although the provincial government enrolls indigents in PhilHealth, this policy requires the support of all municipalities. Poor quality of health services and outdated facilities defeat the purpose of attaining universal coverage. The thrust of the PHO is to assist the 18 RHUs to become PhilHealth accredited as TB DOTS and MCH service facilities. Only 18 of 36 RHU/CHC are currently PhilHealth accredited.

Due to the rapid turnover of health personnel, the local governments are confronted with the challenge to upgrade the professional capabilities of newly hired health workers to effectively address public health concerns.

Summary of technical assistance provided in Year 1

In the first year HealthGov provided TA to assess service delivery performance using the SDIR process. SDIR harnessed the data usually collected through the FHSIS to assess levels of performance from the barangay to the municipal levels. The SDIR results are used to prepare LGU acceleration plans for the different health programs.

In collaboration with the CHD, HealthGov oriented the LCEs on HSR/F1 and the local health situation, to increase their awareness of critical health issues and challenges in the province.

In preparation for the PIPH, HealthGov conducted a Training of Facilitators among PHO technical staff, CHD program coordinators and DOH Reps, to equip them with knowledge of F1 and the PIPH and harness their facilitating skills using the Technology of Participation (TOP). Local NGOs were also oriented on health sector reform and capacitated to effectively engage LGUs in partnership for health governance.

Technical assistance proposed for Year 2

In response to the province's identified needs, the HealthGov TA will focus on building the capability of LGUs in strengthening health planning, healthcare financing, and commodity self-reliance. The objectives and activities of the technical assistance are as follow:

1 Health planning and investment programming

The Project will assist the PHO in the completion and analysis of SDIR results to inform the planning and investment programming process, establish a monitoring system for the implementation of the acceleration plan, improve the database for health indicators and improve the SDIR tools based on lessons learned. The SDIR outputs will provide baseline information for the PIPH.

The Project will assist the PHO in the conduct of a provincial health summit with LCEs, legislators, service providers and civil society to firm up their commitment to health. HealthGov will actively support the province in the completion of the PIPH and the preparation of a resource mobilization plan. Technical assistance will also be provided to equip the local health planners with a monitoring and evaluation tool to review implementation of the AIP.

2 PhilHealth universal coverage

To increase interest among municipalities to invest in social insurance, HealthGov will provide assistance to the province to link LGUs with PHIC and introduce healthcare financing options. The Project will also assist in evaluating the current status of healthcare financing and in preparing planning guidelines.

HealthGov will assist LGUs in client classification. An instrument will be developed to ascertain the health and living standards of the community and identify beneficiaries for the Indigent Program of PhilHealth. The health and living standard index can also provide directions on how to address unmet needs.

Through the CHD and PhilHealth, HealthGov will assist LGUs to evaluate RHUs and local hospitals to determine their preparedness for PhilHealth accreditation, and formulate specific action plans for accreditation.

3 CSR planning and implementation

The Project will assist CSR planning in the LGUs by equipping the CHD, LGU health staff and other officials with guides and tools to ensure that quality family planning services and products continue to be available to local consumers.

HealthGov will also support the CHD and PHO on ICV compliance, by assisting them in the preparation of an ICV monitoring plan and by training them to orient service providers at the municipal level.

4 Multi-stakeholder participation in local decision making

The Project will work with the PHO and local civil society groups to develop a province-wide advocacy plan for participatory health sector reform. With HealthGov support, local NGOs will conduct a multi-stakeholder forum on health to firm up the support of stakeholders involved in policy and behavioral change initiatives, particularly related to healthcare financing and family planning and CSR.

The Project will build the capacity of civil society organizations to improve their advocacy skills in constituency building, social mobilization, networking and negotiation, and understanding local legislative processes and the role of the local health board. The Project will also support capacity building efforts for local health champions and advocates to increase their effectiveness.

Annex 2 B

PROVINCIAL TA PLANS FOR THE VISAYAS

"Strengthening health systems to achieve quality health service delivery"

PROVINCE OF AKLAN TECHNICAL ASSISTANCE PLAN

Background

Aklan's Boracay Island is a major international tourist destination. This has directly helped sustain its agriculture and service sectors. It is heavily dependent particularly in its agriculture which accounts for 75% of provincial GDP. There is no large-scale manufacturing in the province but there are many family-owned cottage industries and these include weaving pina or sinamay cloth, and making bamboo, rattan, and abaca into furniture or handicrafts. The provincial poverty incidence is high at 65%, with an employment rate of 62%.

General information

Region:	Western Visayas
Population (2000):	451,314
Annual Growth Rate:	2.05
Land Area:	181,789 (hectares)
District:	1
Municipalities:	17
Barangays:	327
No. of RHUs:	19
Classification:	2
Poverty incidence (2003):	65%

Overview of the provincial health situation

The most common cause of illness and death in Aklan are both communicable and degenerative diseases. TB is the 5th leading cause of death in Aklan. The maternal mortality rate of the province in 2005 was 38.74/100,000 live births but it increased to 123.87/100,000 live births in 2006. The most common causes of maternal deaths are uterine atony, abruptio placenta and hemorrhage. Most of these occur during home deliveries due to a shortage of birthing clinics. The infant mortality rate for 2006 is 10.29/1,000 LB with pneumonia as the leading cause of death, followed by pre-maturity and congenital anomaly. Cases of STI are relatively high compared to other provinces in Region 6 because it's a tourist destination. The Provincial Local AIDS Council is very active and provides support to the Social Hygiene Clinic. Dengue cases and rabies are a growing concern of the province.

Selected health indicators

U5MR (2006, FHSIS /1,000)	6.96
FIC rate (2006 FHSIS)	80
LGU Health & Nutr Exp (2004)	P170M
Percent to total LGU Exp	20.1
CMW (2006 NDHS)	3.42
Attended Births (2006 (FHSIS)	66.23
Births at Home (2006 FHSIS)	78.58
LGU HIV/AIDS Exp (2006 HPDP)	P0.06M
PHIC Coverage (2006)	55,117
Women w/4 ANC (2006 HG)	42.6
0-59 received Vit. A	71.1
CYP (2003 CDLMIS)	117,849
SDP w/ CC S/out Reps (2006 HPDP)	17
MMR (2006 FHSIS /100,000 LB)	123.97
IMR (2006 FHSIS /1,000 LB)	10.29
TB Cases (2006 FHSIS /100,000)	81
CPR (2006 FHSIS)	46

Current Health Programs

The current health programs of Aklan cover MCH, FP, TB, nutrition, HIV/AIDS, and control of communicable and non communicable diseases, all regular programs of the DOH. The recent assessment of health program implementation through the SDIR showed that most program indicators of the province are below the national performance standard. These include indicators on MCH, immunization, FP and micronutrient supplementation. The province performs well in the TB program with a 92% cure rate and 81% case detection except for Numancia (59%), Tangalan (65%) and Balete (66%). A designated space for the external quality assurance laboratory for TB microscopy is not provided. The SDIR analysis showed that the non-achievement of performance standards can be attributed to poor quality of services due to lack of training of health providers and lack of support for the upgrading of equipment and facilities. Poor motivation of health providers due to only partial implementation of Magna Carta benefits, and absence of a comprehensive plan to monitor, supervise and provide TA support to municipalities were also mentioned. For the consumers, misconceptions and lack of knowledge

on the benefits of programs such as family planning, immunization, prenatal care, delivery at the health facility and skilled workers were cited as reasons. Aklan has been a recipient of UNFPA assistance in reproductive health, particularly family planning. UNFPA has assisted two municipalities in the establishment of their Popshops (franchised from DKT) to make affordable contraceptives available in the market. However, The CPR of the province remains low at 46.

With the assistance from the Governor and Congressman, a total of 55,117 indigent households were enrolled under PHIC's indigent program for 2007, which comprises 28% of the total number of households in the province.

Health Facilities

The province of Aklan has 19 RHUs (the municipalities of Ibajay and Kalibo have 2 RHUs). All are Sentrong Sigla 1 certified and one RHU is certified as Sentrong Sigla 2. For PHIC accreditation, seven RHUs are TB-DOTS, six are OPB and two are MCP accredited. The province has eight government hospitals, four private medical hospital, 213 private medical clinics and 128 Barangay Health Stations.

Health Systems

Aklan has 4 Inter Local Health Zones (ILHZs), which are SEC registered and have functional Technical Working Groups. However systems such as referral and integrated planning are not fully operational. The province lacks a system for the procurement of essential drugs and medicines. In terms of planning and budgeting, the process does not involve other stakeholders, and is based on a predetermined budget allocation. The Local Health Boards at all levels are functional, but inequity in the distribution of the resources for public health and hospitals is a concern. The provincial health information system needs to be strengthened in the areas of data collection, analysis and utilization.

Summary of Technical assistance provided by HealthGov in Year 1

During the first year of the project, Aklan received TA from HealthGov in the formulation of Municipal Investment Plans for Health. The MIPHs were integrated into the ILHZ plan and consolidated into the PIPH. A series of TA was provided, starting with the SDIR conducted in July 2007, where all 17 municipalities reviewed and assessed their health service delivery implementation based on the performance standards. SDIR served as an input to the situational analysis for the preparation of the MIPH/PIPH and at the same time as the basis for formulating interventions to improve service delivery. The entire assessment and planning process was preceded by TA to the province on securing the mandate to plan and the formation and capacity building of Provincial Planning Facilitators (PPF) composed of the DOH Reps, PHO technical staff and ILHZ representatives. The PPF were tasked to facilitate in the preparation of the MIPH, ILHZ IPH and the PIPH. The results of the TA on CSR provincial assessment enhanced the situational analysis and critical interventions in family planning services of the MIPH.

The LGUs presented their MIPH to the Municipal Health Board for endorsement and to the Sangguniang Bayan for approval and inclusion in the municipal annual investment plan for 2008. TA was provided to the PPF and ILHZs in the development of the ILHZ investment plan for health in September 2007. The 4 ILHZs were able to complete their ILHZ plan that will be consolidated into the PIPH.

To increase multi-stakeholders participation in the health system, TA was provided to the PHO and USWAG (provincial NGO/CSO convenor) during a provincial partnership building workshop with NGOs and CSOs held in September 2007.

Technical assistance proposed for Year 2

Responding to the call for TA as indicated in their MIPH, ILHZ and PIPH, the theme for HealthGov's TA to the province during the second year of the project is "***strengthening health systems to achieve quality health service delivery***". HealthGov's TA will focus on strengthening the provincial health systems, which includes institutionalization of investment planning for health, increased and sustained enrolment of IPs and expansion to the informal sector, health facility compliance with the accreditation requirements of PHIC for TB-DOTS, OPB and MCP, drug procurement and logistics management, monitoring systems for service delivery improvement, improving the response to selected infectious diseases such as TB, specifically on external quality assurance in TB microscopy, and the community early reporting system for AI in selected high risk areas in the province.

The following major TA will be provided to the province:

1. PIPH development and implementation

- Completion of the PIPH and securing the mandate to implement in November 2007, followed by support in operationalizing the plan;
- Strengthening partnerships with NGOs/CSOs in the implementation of the health investment plans. These interventions will result in the active participation of NGO/CSO in local special bodies, such as the Provincial and Municipal Health Boards and Development Councils;
- Resource Mobilization, specifically to identify alternative sources of funding such as user fees, other local revenues, and grants or loans. TA will be provided to key staff on the preparation of project proposals and feasibility studies and on linking LGUs with potential donors;
- Review of the following systems:
  - Health information system, especially on data collection, analysis and utilization;
  - Referral system – the existing referral system of Aklan has not been fully operationalized yet. HealthGov's will provide TA in reviewing and enhancing the referral system for full implementation. Follow-up TA will also be provided to ensure that the system is functional and is being institutionalized at the LGUs, ILHZ and provincial levels;
  - Logistics management systems;
  - Monitoring and evaluation – monitoring the MIPH/PIPH implementation is critical. TA will be provided on developing the monitoring tool and its application. This also includes the institutionalization of SDIR process at the barangay, municipal and provincial levels as a standard assessment tool for service delivery improvement.

2. Universal Health Coverage – This has been identified as one of the priority programs of the province in its health plans with the full support of the Governor.

- TA will start with an orientation and training of CHD, PHO, and LGU officials on PHIC guidelines for planning for Universal Coverage, including the use of Community Health and Living Standards Survey (CHLSS) (Note: should the province decide to adopt the tool a separate set of TA will be provided);
- TA in the formation of a team to implement;

- Formation and training of a team on the preparation of a provincial roll-out plan to achieve universal coverage for LGUs;
- TA on presentation of universal coverage plans to LCEs, including policy advocacy to generate support and budget allocations.

3. Contraceptive Self Reliance – the results of the assessment showed gaps in the areas of provincial CSR planning and implementation. TA will be provided in the development of operational guidelines consistent with the new AO on CSR.

- TA to the CSR-TWG 6 and PHO on the CSR tools and preparation of enhanced LGU CSR plans;
- TA to the CSR-TWG on updating LGU CSR Plans and the preparation of a provincial roll out plan;
- TA in procurement and logistic management.

4. Improving response to TB and AI

- TA in setting up the external quality assurance in sputum microscopy at the provincial level (in close collaboration with TB Linc);
- TA on setting up the community-based early reporting system for AI.

5. Behavioral Change Communication (BCC)

In close collaboration with HealthPRO, TA will be provided to identify strategic interventions that will engage civil society in promoting: a) positive health seeking behaviors of consumers; b) improved health providers' provision of quality and accessible services; and, c) LGU systems and policies that will respond to the needs of consumers and providers. TA to the LGUs will also include assistance in the development of a comprehensive community-based plan to actively promote all health services.

"PIPH – a roadmap to strengthen local health management systems thereby contributing to the improvement of health outcomes"

PROVINCE OF BOHOL TECHNICAL ASSISTANCE PLAN

Background

Bohol is the 10th largest island in the country. Agriculture is the major source of employment and livelihood for 54% of the population and accounts for approximately 45% of land use. The island has a wide variety of natural resources and rich biodiversity of flora and fauna which led to the creation of the Bohol Environment Code. Bohol is among the top 20 poorest provinces in the country with a poverty incidence rate of 48.4% (1997) and an unemployment rate of 12.6%. The population density is 276 persons per sq. km., which is higher than the national average of 254.

Bohol
General information

Region	Central Visayas
Population (2000)	1,137,260
Annual Growth Rate (2000)	2.92%
No. of Congressional Districts	3
No. of Municipality	47
No. of Barangays	1,094
Land area (sq. km.)	4,117.26
No. of Households	221,499
Average HH size	5
Number of RHUs	50
No. of BHS	332
No. of BHWs	6,974

Overview of the provincial health situation

Selected health indicators
(2006, FHSIS)

Maternal Mortality Rate	0.51
Infant Mortality Rate	9.30
FIC rate (2005)	74%
Births at Home	77%
Births in Facility	21.62
Births (others)	1.37
Deliveries w/ Health Professionals	79.84
Women with 4 ANC	89.4
Total Fertility Rate (2000)	3.62
Contraceptive Prevalence Rate	27.90%
TB Cure Rate	91%

The main health issues of the Bohol include the incidence of under-nourished children, increasing infant mortality, limited access to safe and potable water, rising number of cases of lifestyle and degenerative diseases, high incidence of dental carries and peridontal diseases, and unattended health needs of disabled persons.

Pneumonia ranks as the leading cause of infant deaths accounting for 9.30/1000 in 2006. Most children aged 4 and below are susceptible to illness, mostly diarrhea and pneumonia. The incidence of dengue is increasing. Bohol has the highest number of cases of animal bites in the region, accounting for seven reported deaths from human rabies in 2005. FIC is low at 74%. Most deliveries are home-based.

The contraceptive prevalence rate is very low at 27%, compared to the national figure of 65%. This has a significant impact on the family planning program considering that almost half of the province's female population is of childbearing age (15-49 years). Most of the newly hired RHU personnel are not trained on CBT-FP.

Health programs

The vision of the provincial health office is that of "Healthy Boholanos in-charge of their own health development in partnership with the provincial leadership in accomplishing its socio-economic goals and objectives". The province's major health programs include 1) maternal and child care; 2) reduction of malnutrition; 3) reduction of dental carries; 4) reduction of incidence of

lifestyle diseases; 5) programs to address disability; 6) family planning and 7) infectious and non- infectious disease control.

The province is a pilot area in Region 7 for the TB in Children Project which is implemented in the Tagbilaran City Health Office and Panglao RHU. It is also a pilot area for the Quality Assurance TB Project. For easy access to TB services, the PPMD was established in Tagbilaran City, which played a vital role in advocacy as well as the task forces which contributed to an increase in the CDR.

While there are no identified HIV-AIDS cases, the province had organized an HIV/AIDS Multi-sectoral Council that promotes information and education campaigns. Training on STI was conducted in the 1990s by DOH. Screening tests for HIV/AIDS are sent to Cebu City. There is no STI clinic in the province except for one in the City Health Office which caters only to Tagbilaran residents and provides services only 3 times a week for a fee.

PhilHealth enrollment totals 37,999 households, or 59% of the target of 63,667. The provincial government provides subsidies to the LGUs for enrolment. The province has 47 RHUs and 1 City Health Office, two tertiary hospitals, 14 secondary hospitals and 16 primary hospitals. Thirteen of the hospitals are TB Dots accredited. Eighteen of the RHUs are OPB accredited and six are TB DOTS accredited. There are no MCP accredited facilities.

Health systems

Currently Bohol has nine ILHZs but the PHO has initiated a plan to reduce it to five. Carmen ILHZ is the most progressive due to the support of the BIARPS Project, which will end this year. The province uses FHSIS for its reporting and monitoring system. However, there is a need to review and enhance data collection and analysis to ensure that it can be utilized appropriately.

The Provincial TBDC is functional and there is a plan to establish district TBDCs. Provincial procurement of commodities is done through the PGSO based on the Annual Health Procurement Plan prepared separately by the PHO and the district hospitals, charged to the Drug Revolving Fund. Procurements are usually done through competitive bidding with national and local drug distributors and suppliers, as well as PITC. Delays in the delivery of drugs procured from PITC were reported. The LGUs procured minimal quantities of FP and other health commodities from their General Fund budget but no procurements were made by the province. The province merely relied on the supplies provided by the DOH and other donors/projects like UNFPA and BIARSP who had set up Popshops in 4 municipalities and Health Plus in1 ILHZ (Carmen). The Botica ng Barangay program is also being expanded.

While the PHO submits an annual investment plan it is only based on his identified priority projects, rather than it being part of a comprehensive plan. Local Health Boards are functional at both the local and provincial level.

Technical assistance provided by HealthGov in Year 1

As a result of initial consultations with key PHO staff and a meeting with the Governor in September 2007, HealthGov's presence in the province in Year 1 commenced with providing assistance to enhance the 2008 AIP for Health and to include critical interventions. HealthGov provided TA on program implementation review, using the SDIR methodology. A core team from the PHO and DOH Reps was oriented and trained on the use of SDIR, to enable the team to facilitate the process at the municipal level. The assistance resulted in a service improvement

acceleration plan, which was integrated into the AIPs of the local governments. In addition, working together with CSR-TWG 7, TA was provided for the LGUs to formulate a one-year CSR plan, identify critical interventions and calculate corresponding budget needs, which were also integrated into the AIP. Both TAs were provided with inputs from other CAs (PRISM, TB LINC).

Technical assistance proposed for Year 2

Unlike the two Other Provinces in the Visayas, HealthGov TA for Bohol in Year 2 will take on a different track. Recently, the PHO revisited its strategic vision, mission, goals and objectives for health. Among the important insights is the complementation of preventive and curative health care delivery. The proposed streamlining of the ILHZs is a critical step in the efficient delivery of services. Although the PHO has initiated this plan the process of doing so is not yet clear to all stakeholders. In the second year TA to Bohol will therefore focus on assisting the province ***formulate and implement a province-wide investment plan for health as a roadmap to strengthen local health management systems, thereby contributing to the improvement of health outcomes.*** The goal is to complete the PIPH. Critical activities will include the following:

1 MIPH/PIPH (November 2007 – September 2008)

- Formulation of the MIPH, ILHZ IPH, and PIPH;
  - LCE orientation to get the mandate to plan;
  - Formation and TOT for provincial planning facilitators;
  - On-site formulation of MIPH, including baseline assessment, SA, critical interventions, costing, systems review, and financial planning;
  - Integration at the ILHZ level and preparation of the ILHZ IPH;
  - Integration and consolidation of the PIPH;
  - Implementation support and monitoring and evaluation
- Contraceptive Self Reliance
  - Reactivation of CSR-TWGs (at province and municipal level);
  - Support for the CSR-TWG on the CSR planning tools based on new AO;
  - TA to the provincial CSR-TWG in the preparation of the provincial CSR roll out plan;
  - TA to support the implementation of the CSR roll out plan;
  - Monitoring and compliance on ICV.

2 Streamlining of the ILHZ

- Collaboration with CHD 7 on assisting the PHO in the streamlining process; TA on the formulation of the road map for the streamlining process;
- Assessment of the existing ILHZs to rationalize the streamlining;
- TA on designing the consultation process;
- Formulation of the ILHZ management system (e.g. referral system).

3 Attaining universal health coverage. Access to affordable health care services is a major focus of the 10 point agenda of the Governor and he has allocated funds to augment LGU budgets for enrolment (January – September 2008)

- TA on the orientation of CHD, PHO, and LGU officials and key staff (trainers) on the guidelines for planning for PhilHealth Universal Coverage, including the use of the Community Health and Living Standards Survey (CHLSS) as a means to identify the poor;
- Formation and training of the provincial team on the development of LGU PHIC plans and the preparation of the provincial roll out plan;
- Technical support for the implementation of the provincial roll out plan;

- TA on the presentation of the PHIC plans to LCEs, including policy advocacy for support and budget allocation.

4 Advocacy: NGO/CSO partnership building. This will be facilitated by the Project to ensure that civil society becomes an active participant in local development planning, monitoring and evaluation of health programs and services.

5 TA on Behavior Change Communication. Intensifying the information and education campaign on various health issues, programs and services is one of the major areas identified during the performance implementation review. TA in this area will be provided in collaboration with HealthPRO.

6 Setting-up a Community-based Early Reporting System for AI. Some parts of Bohol and the island of Cabilao have been identified as high risk areas for AI.

"Strengthening LGUs response to CSR towards better health for all Capizenos"

PROVINCE OF CAPIZ TECHNICAL ASSISTANCE PLAN

Background

The province of Capiz prides itself as being the "Seafood Capital" of the country. It has established itself as one of the country's major producers of fish, mainly from fish farms. This is due to the vast and fertile areas suitable for agri-aqua marine production. Poverty, however, is high (51%) even as the local government and the business sector continue efforts to reduce it. The average annual family income is P99,313.

Capiz
General information

Region:	Western Visayas
Population (2006):	696,496
AGR:	1
Land Area:	262,500 hectares
Districts:	2
Municipalities:	16
Cities:	1
Barangays:	473
No. of RHUs:	18
CHO:	1
Classification:	2
Poverty (2003):	51%

Overview of the provincial health situation

Despite the inflow of foreign assistance to the province, the health indicators still manifest poor performance in health compared to national standards. SDIR results showed that these indicators include CPR which is currently at 48% (compared to a performance standard of 65%). This is attributed to misconceptions of couples on the side effects of methods and religious beliefs, lack of a monitoring system for FP acceptors and weak support from the LGUs to buy commodities and supplies especially for the poor. The FIC rate is also low at 74% while the performance standard is 95%: this is caused by lack of knowledge on the benefits of immunization and lack of competence of health personnel, especially newly hired ones. The leading causes of morbidity in Capiz include ARI/URI/URTI, pneumonia and hypertension. For mortality, pneumonia is the leading cause followed by heart diseases and hypertension. The maternal mortality rate increased from 69/100,000 lb in 2005 to 119/100,000 lb in 2006. The most common causes of maternal deaths are post partum hemorrhage due to hypertension, placenta acreta and uterine atony. The infant mortality rate is 10/1000 lb, and the most common causes are pneumonia, prematurity, sepsis, congenital anomalies and gastroenteritis. The non-achievement of indicators was also attributed to the insufficient facilities, equipment, medicines and supplies at the RHU level, and poor motivation of staff because the Magna Carta benefits are not fully provided. Weaknesses in health human resource planning, and monitoring, supervision and provision of technical assistance were also cited.

Selected health indicators

• U5MR (2006, FHSIS /100,000)	16.90
• FIC rate (2006 FHSIS)	74
• LGU Health & Nutr Exp (2004)	P94.5 M
• Percent to total LGU Exp	11.6%
• CMW (2006 NDHS)	3.61
• Attended Births (2005 (NDHS)	59.1%
• Births at Home (2005 FHSIS)	77.4%
• LGU HIV/AIDS Exp (2006 HPDP)	P0.23M
• PHIC Coverage (2006)	208,550
• Women w/4 ANC (2006 HG)	60.6%
• CYP (2003 CDLMIS)	41,688
• SDP w/ CC S/out Reps (2006 HPDP)	0
• MMR (2006 FHSIS /100,000 LB)	119
• IMR (2006 FHSIS /1,000 LB)	10
• TB Cases (2005 /100,000)	133.3
• CPR (2006 FHSIS)	48%

Current health programs

Health is one of the priority programs of the Governor consistent with his provincial thrust ("Sustaining the progress of Capiz and giving priority to peoples' development"). Capiz has formulated a 5-year health investment plan (2006–2010) called the Capiz Integrated Health

Services Development Program (CIHSDP), and it has funding assistance of Php150 million from the European Commission. As noted in the PIPH, planned interventions are focused on improving health services, specifically in MCH, TB, immunization and infectious diseases, through capacity building, infrastructure development, and governance. Initiatives of the province to bring about CSR health reforms include the formulation of provincial CSR policies and guidelines and setting up of Pop Shops to supply affordable, quality contraceptives in 15 of the 17 LGUs. In addition, some LGUs have allocated budgets for the procurement of contraceptives.

PhilHealth enrollment for 2007 for the indigent program increased to 25,738 families from 16,518 in 2006. The province allocated a total budget of P3 million as counterpart to the P7 million budget from the city and municipalities as payment for PhilHealth premiums.

Capiz has been a recipient and pilot province for other foreign funded programs such as World Vision-CIDA (for TB), UNFPA's 6th Country Program, JOICFP (for FP) and UNICEF CPC (for nutrition).

Health facilities and systems

Capiz has 18 RHUs (including 2 Municipalities with 2 RHUs) and one CHO. All RHUs and 30 BHSs are Sentrong Sigla level 1 certified. For PHIC accreditation, 16 RHUs are accredited for TB-DOTS, 17 for OPB and three for MCP. Of the total 188 Barangay Health Stations, 33 are accredited as birthing clinics. In addition, 17 RHUs are now receiving capitation funds from PhilHealth. Capiz has 12 hospitals, 10 of which are public facilities.

The province is clustered into five ILHZs. Capiz implemented its province-wide plan starting in the first quarter of 2007, made possible by the release of mobilization funds by DOH and the impending fund release this year from the EC. The province's drug procurement and logistics systems are in place. Capiz was the first LGU in the country to avail medicines under Parallel Drug Importation in 2001. Currently, the province is importing 9 drugs under this program with more than 40 other drugs procured from local pharmaceutical companies. The PHO successfully negotiated with multinationals to lower their selling price of drugs. The medicines are delivered to the hospital pharmacies to improve access of the patients to low cost medicines. The "Central Warehouse" concept is already being implemented and the PHO is introducing pooled procurement. Hospitals buy medicines from the PHO using their own funds to avail of bulk discounts. The province's referral and health information systems are also functional.

Summary of Technical Assistance in Year 1

HealthGov's engagement in the province started with scoping visits, consultations and a courtesy call to the Governor and other key leaders of the province. Following the visits, the Governor requested TA from USAID in the following areas: (1) CSR review and development of a province-wide strategic monitoring plan; (2) conduct of an SDIR review; (3) advocacy on HSR/F1 and PIPH to new LCEs; (4) pilot-testing of SDExH to enhance quality of service provision; (5) expanding the pooled procurement system to include drugs and other supplies for RHUS; and 6) documenting and packaging best practices and marketing these for replication.

TA provided was on SDIR resulting in a municipal acceleration plan, which served as the basis to refine the municipal investment plan of the LGUs. At the same time, the PHO formulated a support plan based on the acceleration plan that requires TA from the province and this was used in the preparation of the 2008 operational plan for the PIPH. Capiz subsequently adopted

the SDIR tool in the assessment of hospitals and funded this out of its own resources. Since 9 out 17 LCEs are new, the PHO recognized the need to advocate for continued support for CIHSDP in terms of performance benchmarks and budget commitment. HealthGov provided TA in the development of advocacy materials and in the conduct of an LCE orientation. As a result, the Governor, 11 LCEs and 8 SPs signified their commitment to support health reforms.

In coordination with CSR-TWG 6, HealthGov provided TA in the conduct of a provincial CSR assessment in August 2007. The initial results showed that the province needs assistance in building the technical capacity of health service providers, institutionalization of policies and guidelines on the inclusion of family planning supplies in the pooled procurement, information systems and advocacy. The province-wide pooled procurement system for essential hospital drugs was assessed with the end view of providing TA to expand these systems to include essential drugs and supplies for RHUs.

Technical assistance proposed for Year 2

Based on the programs indicated in the PIPH, one area that is not given sufficient emphasis is the provinces' and LGUs' response to CSR. HealthGov recognizes the various initiatives of the province in instituting CSR health reforms and in the second year the focus of the TA will be on achieving CSR full implementation, and monitoring and evaluation and will revolve around "*strengthening LGUs' complete response to CSR towards better health for all Capizenos*". HealthGov will provide TA in developing and institutionalizing LGU systems and structures to ensure political commitment to eliminate unmet need for FP. TA will also be provided to ensure that LGUs provide a safety net of free contraceptives for the poor, improved access to all other FP methods, expansion of private sector sources, and integration of FP with other services to women. By doing this, it can contribute towards achieving better health for all Capizenos.

More specifically, the following TAs and interventions will be implemented, in close coordination and consultation with the PHO and CHD:

1 **Contraceptive Self Reliance**

- Updating of the LGU CSR plans consistent with the new AO on CSR;
- Formulation of a Comprehensive CSR Advocacy Campaign Plan directed at different target groups (LCEs, private sector, community). The capacity of "CSR advocates" will be build through ToT and by strengthening multi-stakeholder participation in expanding and strengthening CSR responses. This TA will be provided in close coordination with HealthPRO;
- Monitoring compliance to ICV.

2 **SDIR follow-up**. TA will be provided to assist in the comprehensive tracking of health programs using the results of SDIR and in reviewing the implementation of health programs, especially on CSR, and other health priorities in MCH, TB and HIV/AIDS. Assistance will be provided to the PHO in the conduct of SDIR, which is scheduled at the provincial level once a year and at the municipal level quarterly.

3 **Strengthening NGO and CSO participation.** TA will be woven into all other interventions in the province and at different levels of partnerships building between public to public and private to public. HealthGov will assist NGO/CSO accreditation with local special bodies, (i.e. Provincial and Municipal Health Boards and Development Councils and other local committees). HealthGov will also assist LGUs engage the NGO/CSO community in building

a constituency for health and participation in health planning, policy formulation and health service delivery.

4. **Service Delivery Excellence in Health (SDExH)** (January 2008 – September 2008). To ensure that all components of the CSR plans, and the PIPH as a whole, are implemented by motivated and competent health personnel, TA on SDExH will be provided. The TA entails a ToT from CHD and PHO teams on the design, modules and processes, and support during the conduct of workshops with LGUs/ILHZs. The extent of roll-out (whether province-wide or a number of ILHZs only) will be determined during the first quarter of the year.

5. **Control of Avian Influenza** (January 2008 – September 2008). The province of Capiz (Roxas City in particular), was identified by the Bureau of Animal Industry (BAI) as a high risk area requiring close surveillance for AI. TA from HealthGov will focus on the development of operational guidelines in setting up a Community-based Early Reporting System for AI.

6. **Developing an ILHZ as TA provider** (April 2008 – September 2008). The PHO has indicated the need for additional technical resources due to staff limitations and increasing demand for services. HealthGov's TA will focus on developing operational guidelines and core competencies and institutionalization of the ILHZ in response to TA needs indicated in the CSR plans. To develop their competence, TA will be provided in the form of ToT and coaching and mentoring until the ILHZ staff become effective TA providers. On the organizational side, TA on institutionalization (policy on securing legal mandate) on expanding the role and function of the ILHZs and the corresponding systems and guidelines will be provided. Testing of this model will start with a feasibility study of the concept.

"Improving health outcomes through broadening participation among stakeholders"

PROVINCE OF NEGROS OCCIDENTAL TECHNICAL ASSISTANCE PLAN

Background

Known as the "Sugar Bowl" of the Philippines, the province of Negros Occidental is producing more than half of the country's total sugar production. An estimated 44% of households is dependent on agriculture as the major source of income. Food constitutes 53% of the total household expenditures and average annual family income is P73,923, which is low since the provincial poverty threshold is P11,113.

Negros Occidental
General information

Region	Western Visayas
Population	2,565,725
AGR (NSO 2000)	1.13%
Land area	7,926.07 sq. km.
District	6
Municipalities	19
Cities	12
Barangay	661
RHUs	31
Classification	First Class

Overview of provincial health situation

The health performance of the province of Negros Occidental is generally satisfactory compared to regional standards and targets. Maternal Mortality and Infant mortality rates are lower compared to both regional and national targets. However, the provincial average of FIC of 83% (2006) is still below the national target of 95%. Recent SDIR results showed that low FIC is attributed to missed children, defaulters and weak logistical support for far flung areas. In spite of children 6-11 months old and children 12-59 months old with severe pneumonia given Vitamin A, pneumonia remains the number one cause of infant death. 13% of children is reported as being malnourished. The provincial average of pregnant women given quality pre-natal care by skilled attendants is also low. One of the reasons for this cited by LGUs was that mothers are not well informed of the importance of pre-natal care. The current CPR of 35% is a sharp decrease from 45% in 2004 and 2005. The TB cure rate is high at 90%, but TB is still the third leading cause of mortality among adults. Dengue outbreaks have been declared in two towns this year (although all towns and cities have reported cases). More than 2,000 cases and 43 deaths were reported during the first semester of 2007 with Bacolod registering the highest record of 12.

Negros Occidental
Selected baseline health indicators

MMR (2006 FHSIS/1000LB)	1/1000
IMR (2006 FHSIS/1000LB)	7.60/1000
Women with 4 ANC (2006 HG)	60%
FIC Rate (2006 FHSIS)	83%
TB Cure Rate	90%
TB Case Detection Rate	110%
TB New Smear Positive Cases (2006)	3,355
CPR	35%
LGU Health and Nutrition Exp.	P12.5M PHIC
Coverage (2006)	11%
Crude Birth Rate	19.55/1000 pop
Crude Death Rate	4.80/1000 pop

Negros Occidental has registered 16 HIV/AIDS cases, yet the province's system for contact tracing is poor. There were two reported AIDS deaths in 2006. HACTs were organized and made functional in three District Hospitals. The provincial government and DOH provide most of the medicines for HIV cases and the province has provided funding for medicines and capability building of health personnel.

Current health programs

The province's major health programs are on: (a) maternal and child care; (b) family planning/reproductive health; (c) control of TB and other infectious diseases; (d) control of

sexually transmitted diseases and HIV/AIDS; (e) control of communicable and non-communicable diseases; (f) control of emerging and re-emerging diseases and; (g) healthy lifestyle and environmental sanitation. Other innovative strategies and programs implemented by the province include the formulation of the Field Health Operation Protocol Manual, Referral System Manual (which will be presented for final deliberation in October 2007); the provision of regular financial and TA support to ILHZs; the sustained Voluntary Blood Donation Program; the Expanded Newborn Screening Program, and Negros Occidental Health Surveillance System (NOCHESS), which monitors 14 diseases. Monitoring is done weekly and LGUs are provided with monitoring reports so that appropriate action can be taken to control or contain the spread of diseases. In spite of this innovative system an outbreak in dengue was still unabated. In support of all these programs, the provincial government has allocated a P12.5 million budget (30% of GAD budget) and P558,275 (from the 20% Social Development Fund) for 2007.

Health facilities and systems

Negros Occidental has 19 RHUs and 12 City Health Units, 29 of which are Sentrong Sigla Level I Phase 1 certified, seven are SS Level 1 Phase 2 certified, 16 are PHIC OPB accredited, 14 are TB-DOTS and 3 are MCP accredited. There are 539 BHS distributed in 661 barangays. There are 27 hospitals in the province, 17 of which are government owned, 8 are private and 2 are community hospitals (in a joint project with Negros Oriental). Based on provincial records, health facilities are inadequately staffed.

The LGU health management system is in place. In 2004 the province formulated a 5-year Strategic Plan (2005-2010) which is translated into annual plans. However, the Provincial Plan is mainly a consolidated plan of the LGU level plans. The Provincial Health Board is functional and was awarded as the Most Outstanding PHB in Region VI. The Board is meeting every quarter. A new NGO/CSO representative has yet to be chosen given the current accreditation and re-accreditation process after new government officials were installed.

The province is using FHSIS as its reporting and monitoring system although problems of late submission of reports still need to be addressed. Program implementation review is another concern since this is not done on a regular basis. There are six functional ILHZs, five of which are SEC-registered. Of the six ILHZs, five Zonal Action Officers (ZAOs) are Chief of Hospitals. The ILHZs are maintaining pooled funds which they use to support the requirements of the Zone. The zone will also be a key player in making the referral system operational. Complementing the public health is the improvement and strengthening of the hospitals. This is being supervised by the Economic Enterprise Development Division (EEDD).

Summary of TA provided in Year 1

The scoping activities conducted in February of this year, courtesy calls and consultation meetings, and actual data gathering activities all provided inputs to an in-depth understanding of the health situation of Negros Occidental. HealthGov provided an orientation on HSR and F1 in July. The orientation provided a venue for the LCEs (17 out of 31 are new) to be informed on the local health situation and served as an initial advocacy effort to generate support for health reforms and the formulation of the PIPH. TA in the review of health program implementation using SDIR as a tool was provided to the province. This comprehensive analysis of health program performance led to the formulation of the baseline and situational analysis for the PIPH. Consistent with HealthGov's thrust of building the capacity of the provinces and LGUs, a team of provincial planning facilitators (PPF) was formed and underwent a ToT to assist LGUs in the formulation of their health investment plans. HealthGov provided continuing TA to members of

the PPF in the formulation of the municipal and city IPH and the ILHZ integrations carried out on-site. Further, in response to the very low CPR, TA on the conduct of a CSR provincial assessment was provided to determine the status of CSR implementation. This was initiated by the CSR-TWG of CHD 6 with the participation of all LGUs. Parallel to this, the Project supported the province in strengthening multi-stakeholder participation in health sector planning and implementation by orientating NGO and CSO representatives on HSR and F1.

Technical assistance proposed for Year 2

The province's health vision and strategic directions is the delivery of quality, timely, primary health care services (by the LGUs). This should go hand in hand with the provincial thrust of strengthening hospital services, thereby providing safety net for the poor and ensuring that they (poor) have access to these services. In that context, Year II TA in the province will revolve around the theme of *"improving health outcomes through broadening participation among stakeholders."* Technical assistance to the province will stem from the implementation of the PIPH which will put emphasis on health care financing reforms.

1 **PIPH**

- Completion of the PIPH and securing the mandate to implement, followed by operationalization;
- Building partnerships between government and NGOs/CSOs in the operationalization of the health investment plans;
- Resource mobilization, focused on alternative sources of funding and utilization. TA will commence in January 2008 and provide training to key staff in proposal and feasibility study development, and linking LGUs with potential partners or donors;
- Systems Review:
  - Health Information System, data collection, analysis and utilization;
  - Referral systems, in terms of reviewing, assessing and enhancing their implementation. This is supporting plans of the province to rationalize and strengthen hospital operations and at the same time strengthen the delivery of primary health services by the RHUs;
  - Logistics Management System;
  - Monitoring and Evaluation, including the institutionalization of SDIR at the barangay, municipal and provincial level.

2 **Contraceptive Self Reliance.** The assessment policy advocacy, ensuring budget support for the procurement of contraceptives, education of field staff, client segmentation, capability building and sustained monitoring as major concerns. TA on CSR will focus on the following:

- Orientation to the CSR-TWG 6 and PHO on the CSR tools consistent with the new AO and based on assessment results to formulate enhanced LGU CSR plans;
- TA to the CSR-TWG in updating LGU CSR Plans and the preparation of a provincial CSR roll-out plan;
- Technical support for the implementation of the CSR roll-out plan.

3 **Attaining Universal Health Coverage.** Initiatives to achieve universal health coverage will not only result in increased and sustained IPs coverage, but also improved availability of quality services (i.e. accredited facilities, trained service providers, availability of essentials drugs, etc.):

- Orientation of CHD, PHO, and LGU officials and key staff as trainers on the guidelines for planning for Universal Coverage, including the use of CHLSS. (If the province decides to adopt CHLSS as their means test tool, a separate set of TA will be provided);
- Formation of the provincial team to implement plans to achieve PHIC universal coverage;
- Training of the provincial team on the development of LGU PHIC plans and the preparation of the provincial roll-out plan;
- Technical support in the implementation of the provincial roll-out plan.
- Presentation of PHIC plans to LCEs, including policy advocacy to generate support and secure budget allocations.

4 **TA on Behavior Change Communication.** In close collaboration with HealthPRO, TA will be provided to identify strategic interventions that will engage civil society in promoting: a) positive health seeking behavior of consumers; b) improved provision of quality and accessible services by service providers; and, c) LGU systems and policies that will respond to the needs of consumers and providers. TA to the LGUs will also include assistance in the development of a comprehensive community-based plan that will actively promote all health services.

5 **Avian Influenza.** TA will focus on setting-up a Community-based Early Reporting System for AI in Himamaylan City, identified as a high risk area in the Visayas that requires close surveillance.

"Sustaining CSR reforms and strengthening the LGU response to CSR"

PROVINCE OF NEGROS ORIENTAL TECHNICAL ASSISTANCE PLAN

Background

Negros Oriental has been cited as one of the most livable islands in the world. Its capital, Dumaguete City, although relatively small in size, is known as the university town due to the presence of four colleges and universities. Negros Oriental is also becoming a notable tourist destination in the Visayas. With its vast fertile land resources, the province's major industry is agriculture. Primary crops include sugarcane, corn, coconut and rice. In coastal areas fishing is the main source of income. And there are cattle ranches and fish ponds. There are also mineral deposits like gold, silver and copper. The province has an unemployment rate of only 9.1%.

Negros Oriental
General information

Region:	Central Visayas
Population	1,126,061 (2000)
Land Area	5,402 sq. km.
District	6
Municipalities	20
Cities	5
Barangay	557
No. of RHUs	28
Classification	First Class

Overview of the provincial health situation

With some exceptions health outcomes in Negros Oriental are still low compared to the national performance standards. This is despite the flow of financial and technical assistance to the province and its stated goal to improve the health status of its population. The Maternal Mortality Rate is high at 74 per 100,000 LB (2006). The STA BAYABAS ILHZ recorded the highest rate of 115.53. The results of SDIR showed that the most common cause of maternal deaths is post partum hemorrhage, uterine atony and placenta retention. Most of the affected mothers are those who have not completed 4 ante-natal visits, and deliveries done at home. FIC is also below the national target of 95% and the incidence of malnourishment in children is 11%. The TB Cure Rate is 88% and the Case Detection Rate 69%. A passive case finding policy of the TB program is one of the primary reasons for low case detection. RHUs are not making any extra efforts to increase case finding. On the other hand, RHUs achieved the external quality assurance for sputum microscopy target of 95%. The influx of tourists in the province is high but there is no Social Hygiene Clinic: cases of STI are not documented. The CPR is 56% despite the implementation of Popcom's (Region 7) Responsible Parenting Movement piloted in 500 barangays. The reasons include a shortage of trained personnel to provide permanent sterilization, inadequate master-listing of target clients, poor follow-up of drop-outs and lack of IEC materials. In general, the non-achievement of health indicators is attributed mostly to lack of information which resulted in poor health seeking behavior of the customers, fast turn-over of health personnel and inadequate training of newly-hired staff, non-residency of RHMs in the area of assignment. Some RHMs are covering 3 barangays and they are unable to provide full coverage of services for MCH pre-natal care and delivery.

Selected health indicators

FIC Rate	73
Deliveries by trained Health workers	57.42%
Facility-based deliveries	28% MMR 74/100,000LB
IMR	7/1,000 LB
CPR	56%
TFR	3.5 (2005)
CDR	69%
Cure Rate	88%

Priority programs

The priority programs of the province for the health sector include: (a) maternal and child care; (b) Expanded Program on Immunization (EPI); (c) nutrition (GP); (d) family planning; (e) control of communicable and infectious diseases; (f) control of sexually transmitted diseases and HIV/AIDS; (g) control of emerging and re-emerging diseases; (h) healthy lifestyle and environmental sanitation, and; (i) hospital development. Negros Oriental is an F1 province and the priority programs form part of the 5-year PIPH. Implementation of the PIPH is supported by the DOH with funding from the EC. In support of all these programs, the provincial government has allocated P307 million for 2007.

Health facilities and systems

Among its health facilities are 10 hospitals, including 3 tertiary care hospitals located in Dumaguete City and 7 secondary level hospitals distributed in the province. There are also 6 primary community hospitals which are mostly underutilized, resulting in overcrowding of the tertiary hospitals. These primary community hospitals can be restructured as birthing facilities and accredited for MCP, OPB and TB DOTS. Primary community hospitals could be developed as birthing facilities so that they can avail of the Maternity Care Package of PhilHealth. In DOTS Center and an Outpatient Benefit Package can also be availed of. Of the 28 RHUs, the following are PhilHealth accredited: MCP (2); OPB (23), TB DOTS (7), SS Phase I Level 1 (22) and SS Phase II Level II (3).

To realize its vision, the province has operationalized its PIPH. Implementation is divided in 6 functional ILHZs and each ILHZ is implementing its own LGU support plan and program. The referral system is operational, following an orientation and the conduct of a facility mapping workshop. The province is using FHSIS for its reporting and monitoring system. Other available systems include surveillance and epidemiology system, drug procurement system and upgrading the FHSIS/HOMIS. Concerning the hospitals, there is a need to reorganize and strengthen the different hospital committees as follows: Therapeutic Committee, Infectious Control Committee, Waste Management Committee and Disaster Committee.

Summary of technical assistance provided in Year 1

The scoping activities and review of the PIPH, and the additional data gathered during the first year served as basis for HealthGov's cooperation with Negros Oriental. Negros Oriental is one of the 16 F1 Convergence Sites and the province has already developed a 5-year (2006–2010) investment plan. TA from HealthGov was therefore focused on activities and interventions that help improve service delivery, continuous quality improvement and Contraceptive Self-Reliance.

With TA from HealthGov, the province carried out a comprehensive program implementation review (using SDIR), which resulted in the formulation of acceleration plans for the province, municipalities and cities. The Provincial Acceleration Plan also served as the basis for the preparation of the 2008 PIPH Operational Plan. To ensure continued quality service and attain customers' satisfaction, representatives from the PHO, DOH and LGUs were given training on SDExH. SDExH was started in four municipalities of the Metropolitan ILHZ and a standard assessment tool was used to assess the quality of services provided at the LGU levels. SDExH will be replicated by the PHO in other ILHZs. In response to the reduction of unmet needs and FP commodity shortfall, all LGUs have formulated CSR plans and the province also formulated policy guidelines on CSR. To determine implementation of the CSR Plan and enforcement of the policy guidelines, an assessment was conducted in August 2007 in coordination with CHD-TWG

7. The collection, consolidation and analysis of the plan was completed in October and the results will be used to augment LGU and provincial plans.

Technical assistance proposed for Year 2

The implementation of the PIPH in Negros Oriental focuses on improving health services, specifically for MCH, TB, immunization and infectious diseases, through capacity building, infrastructure development, and governance. However, one important area that is not given sufficient emphasis in the PIPH is the local response to CSR. Therefore, HealthGov's TA in Negros Oriental in the second year of the Project will revolve around sustaining CSR reforms and strengthening the LGU response to CSR by ensuring political commitment to eliminate unmet needs, the provision of a safety net for the poor, improving access to all other FP methods, expanding private sector sources, and integration of FP with other services for women. To enable this, technical assistance will be provided in close coordination and consultation with the PHO and CHD and other USAID CAs (in particular PRISM).

1 **Contraceptive Self Reliance** (December 2007 – September 2008)

- Updating of the LGU CSR Plans consistent with the new AO on CSR;
- Formulation of a Comprehensive CSR Advocacy Campaign Plan for LCEs, the private sector and the community. This will include building the capacity of "CSR advocates" through ToT, and strengthening multi-stakeholder participation in planning and implementing CSR responses. TA will be provided in coordination with the HealthPRO;
- TA on monitoring compliance to ICV.

2 **Institutionalization of SDIR.** TA to support the integration of SDIR in the local planning process (November 2007 – March 2008).

3 **Strengthening NGO and CSO participation.** This will include ensuring that NGOs/CSOs are accredited and represented in the local special bodies: the municipal and provincial development councils and health boards. HealthGov will assist LGUs engage NGOs/CSOs in building a constituency for health and participation in health planning, policy formulation and health service delivery.

4 **Service Delivery Excellence in Health (SDExH)** (October 2007 – September 2008). Follow-on TA on gap analysis and preparation of service improvement plans for the 4 pilot municipalities in Metropolitan ILHZ. ToT will be provided to the PHO and DOH Reps to prepare them for the implementation of SDExH in other areas. Implementation of SDExH will ensure that all components of the CSR plans, and the PIPH as a whole, are implemented by motivated and competent health personnel.

5 **Community Health and Living Standards Survey (CHLSS)** (January 2008 – September 2008). Initially requested by the province in Year 1, TA will support the province's plan to achieve universal PHIC coverage. This will start with: a) an orientation and training of key CHD and PHO staff on the guidelines, processes and planning tools of CHLSS; b) assistance for CHD and PHO staff in the conduct of orientation and planning workshops with LGU counterparts, and; c) over-all TA to support the province-wide roll-out.

6 **Control of Avian Influenza** (December 2007 – June 2008). The Bureau of Animal Industry (BAI) has identified the City of Bais, Tanjay and Siaton in particular as high risk areas in the Visayas requiring surveillance for Avian Influenza. HealthGov TA will focus on setting-up a Community-based Early Reporting System for AI.

Annex 2 C

PROVINCIAL TA PLANS FOR MINDANAO

"***Strengthening the drivers of reforms"***

PROVINCE OF AGUSAN DEL NORTE TECHNICAL ASSISTANCE PLAN

Background

The province of Agusan del Norte is one of the 4 provinces in the Caraga region. It was a part of the once undivided Agusan province (the other one is Agusan del Sur). The province is composed of 10 municipalities and 1 newly-approved component city (Cabadbaran City) with two congressional districts and167 barangays. It has an estimated population of 317,675 in 2006. There are 54,775 households with an average family size of 5. 2006 rude Birth Rate is 23.5%. The Crude Death Rate is 3.46%. Of the 10 municipalities, only three (Nasipit, Las Nieves and Buenavista) are classified as belonging to 1^{st}-3^{rd} class municipalities. All the rest belongs to 4^{th} – 6^{th} municipalities.

Overview of the provincial health situation

Agusan del Norte's 2006 MMR is 27/100,000 live births while the IMR and UFMR is 33/100,000 LB and 86.8/100,000 LB respectively. There are 86 BHS serving 167 barangays. There are 6 government hospitals operated by the province, 1 city hospital (Butuan City) and five (5) private hospitals, three (3) of which are located in Butuan City. All the 11 RHUs are SS certified and OPB accredited.

The Province is known to have pioneered the multi-payer scheme (MPS) for PHIC enrollment. The scheme has become the driver of various reforms in the province. It catalyzed the fast accreditation of RHUs on OPB. For two years, only 1 RHU was OPB accredited. But with the implementation of the MPS, within nine months, 9 RHUs were accredited. The scheme is regarded by PHIC as a "good practice". At present, the RHUs are in the process of completing the TB-DOTS and MCP accreditation.

The MPS produced almost P4 million of additional funds for the LGUs. 80% of the CDF were utilized to augment the MOOEs of RHUs. There are a number of RHUs which tripled their MOOEs because of the CDF. Health workers were also benefited financially from the capitation fund as they get an average of 20% from the total capitation.

Despite the increase in the MOOEs brought about by the capitation fund, the FP and MCH indicators remain very low as indicated by the following examples based on 2007 2^{nd} quarter cumulative report:

- Pregnant women with at least 3 antenatal visits attended by skilled attendants – 28% with the new city of Cabadbaran having the lowest accomplishment (9%).
- Pregnant women had at least 2 doses of tetanus toxoid immunization – 27%%
- Pregnant women that have taken complete dose of iron supplementation – at least 6 months (reported after the 180 tablets) – 31%
- Postpartum Women given complete iron dosage – 27%

On the other hand, the CPR of the province stands at 36.3% which is way below the national target.

Situational analysis

HG provided TA to CHD, PHTL, PHO and PPDO in reviewing the province's PIPH. The health sector frame was introduced as a tool for SA and assessing interventions. This enabled the LGUs to examine very closely their own health situation critically and strategically using more comprehensive instruments. Below is the summary of the analysis of the health situation done by the PHO technical staff, DOH representatives and PPDO using the health sector frame on FP, TB, MCH and Micronutrient programs:

Service Delivery
- Good practices not sustained by providers like CBMIS
- Lack of IEC to community coupled with problems on accessibility, geographical terrains, cultural barriers, poverty
- Program implementation review is not comprehensive
- Problem on how to identify the poor
- Lack of NSV and BTL providers, quality of care needs to be improved
- No continuing skills enhancement program; health personnel needs to be trained on new FP manual while training has yet to be done on NFP
- A model of community-based referral system has yet to be fully implemented province-wide

Regulations
- Some facilities have to be accredited on TB-DOTS and MCP
- No manual of operation for ILHZ (hospital and RHUs)
- National policies not adopted locally
- Many health workers are not yet informed on ICV

Health Care Financing
- Difficulty of 1st to 3rd class municipalities in paying PHIC premium
- Sustainability of the multi-payer scheme
- No budget for PHO technical staff

Governance
- Lack of policies to support and sustain current initiatives in health
- ILHZ have the potential to be an effective mechanism for health sector reform but the LCEs have yet to show genuine support
- Health data/information not utilized for governance
- No working M & E systems (CHD, PHO, RHU)
- Participation of organized women's groups and NGOs need to be replicated province-wide
- Congressional support not yet harnessed

This analysis became the guiding framework of the PHO technical staff, PPDO and DOH reps when they assisted the MLGUs in reviewing the goals, strategic interventions and PPAs of their respective MIPH during the conduct of technical review.

The past and recent developments all point to the prospect of strengthening the ILHZs.
- Decision of the governor to close down the provincial hospital and strengthen the two district hospitals (Cabadbaran and Nasipit) which are core referral hospitals. ILHZs were established based on the core referral concept. The Governor plans to strengthen the two- way referral systems in each ILHZ.
- The recent city-hood of Cabadbaran and the application for city-hood of Nasipit are added factors. Both LGUs can provide leadership on health in each ILHZ.
- High interest of PHO and CHD to support ILHZ strengthening
- PIPH were done at the ILHZ level indicating ownership of ILHZs over the plans

- Presence of strong and organized community-based organizations in ILHZs.
- In an effort to sustain the multi-payer scheme, LGUs appointed municipal and district social health insurance officers.
- Interest of the Congressional Representative to support the health sector reform.

Technical assistance for Year 2

In line with the PLGU's current thrust and attune to the good practice of the province in health reforms, the strategic thrust therefore of HealthGov TA is to *"Strengthen the drivers of reforms".* The "drivers" refer to both the multi-payor scheme and the ILHZs.

Due to the augmentation from capitation funds, the capacity of the MLGUs to respond to the logistics pull-out was increased. All LGUs are now procuring contraceptives. They have therefore poised themselves to undertake higher forms of CSR implementation towards a sustained health service delivery in family planning.

1 Strengthening CSR

- CSR Assessment and Monitoring Tool (consistent with new AO on CSR): The tool developed in region 10 will be utilized. PHO will organize a CSR monitoring tool orientation and action planning for the conduct of province-wide monitoring. Province- wide monitoring will be conducted from January to March. By end of March, MHOs and DOH Reps will present results to MLGUs (LCEs, SP, LHB). The expected output is the mandate to do CSR planning. The PHO will consolidate province-wide results and present them to PLGU. It is expected that PLGU will give the mandate to do CSR planning. Likewise, CHD will consolidate region-wide results and submit to central DOH.
- Enhancement of CSR plans: The monitoring results will be used as inputs to the enhancement of CSR plan. The CSR planning processes will be similar to PIPH process (a sequence of steps starting from mandate to plan). This will be started by April and will end mid-June just in time for the first budget call. There will be period of revisions and negotiations between and among LGUs. CBMS results will be utilized in forecasting the FP logistics needs with emphasis on the safety net for the poor.
- Monitoring and evaluation tool to track progress of CSR implementation: HealthGov will facilitate designing of monitoring and evaluation design and tools with the regional and provincial CSR TWG. The tools will be integrated in the IPH monitoring system. This will also include the designing of feedback system to LGUs and LGU organizations (e.g. LMP) through an EBL process.

2 Strengthening the PHIC multi-payer scheme

Conduct of review of the multi-payor scheme (MPS): HealthGov's production partners are the duly constituted (with an EO from the governor) team of provincial personnel. The team will conduct the review of the MPS. They will be supported by PHIC and CHD 13 (LHAD and provincial health team). A private sector and an NGO representative will also be invited to become members of the group. It is also expected that the congressional office of the province will also send in a representative.

The first step is the development of review guidelines and tools as well as planning guidelines and tools. After the review, a planning process will be done utilizing the results of the review. The review and planning guidelines/tools will be presented by the team to the provincial governor through the local health board for approval.

The team will then facilitate the conduct of activities which combine self-assessment (RHUs and the PLGU-managed hospitals) and conduct of FGDs to key informants (MHOs, hospital directors, PHIC, LCEs, PHNs, midwives).

The results of the review will be presented to the governor and LCEs. Key areas for enhancements will be identified. It is expected that the governor and the LCEs will give the mandate to plan. A planning workshop will be facilitated by the team (which conducted the review) using the guidelines and tools developed with the technical assistance of HealthGov.

3 Capability-building of municipal and district Social Health Insurance Officers to establish systems of enrollment, collection of premium payments from cardholders, remittances and claims

This TA will be provided by HealthGov to the LGUs through PHIC 13, CHD 13. This TA requires a product development process which will be a collaborative effort between HealthGov and the TA production partners. HealthGov will provide TA to the production partners in the development of training/capability design.

The partners will conduct a two-day training workshop for SHIOs with technical backup from HealthGov. Afterwards the development partners will conduct continuing mentoring and coaching by to the SHIO. They will also conduct regular SHIOs meetings to address issues and gaps in the establishment of the systems mentioned above.

4 Assist PLGU, MLGU, PHIC, CHD, SHIO advocate that cardholders (through ABC) cost-share premium payments (with technical assistance from HealthPRO)

5 Strengthening ILHZs capacity to manage key public health programs (TB, FP, MCH, AI and micronutrients). Technical assistance will include:

SDIR of key public health programs: PHO, with the technical support from CHD will orient the ILHZ, RHUS, CSO and DOH representatives on SDIR. Afterwards, an action plan will be developed to implement SDIR processes. Data gathering will then be done by RHU, DOH representatives and CSO. The final process will be the analysis and formulation of acceleration plans.

- Establishment and/or strengthening of ILHZ-managed health systems: (HMIS, Facilitative supervision, IPH monitoring & evaluation using SDIR, user fees for Cabadbaran, Nasipit and Buenavista, Community-Based Referral system, SDExH and RHU retention fund scheme – optional). HealthGov will provide TA to the production partners in the identification and planning for the establishment and/or strengthening health systems. The plans will be presented to the LCEs through the LHBs for endorsement and approval. It is recommended that instead of hiring TAP on a piecemeal basis (per health system), an organization will be contracted out to take care of the entire ILHZ systems strengthening. A multi-disciplinary team will be formed by the organization. Team member expertise will include public health, research, information system, governance, community organizing, M & E and the like. Continuing technical assistance to ILHZs and RHUs through coaching, mentoring, one-on-one consultation, developmental dialogues, partnership/technical meetings, exit conferences and small workshops will be provided by CHD and PHO.
- Provide TA to CHD, DILG, PHO, PHIC, POPCOM, CSO in mobilizing broad-based local action for specific health agenda and to support the ILHZ systems: Consistent to the over-arching agenda of converting red to green, year 2 focus is on CSR and improvement of quality of care and program performance of core health programs (TB,

MCH, FP and Micronutrient). This includes establishing local service standards and incorporating consumer expectations in the service delivery system.

6 Component TAs

Evidence-Based Legislation and Evidence-Based Policy-Making: regional partners (with technical back-up from HealthGov) will orient PLGU (Governor, vice governor, SP, LMP/MLCEs, CSOs) on EBL principles, MDG status, health economics and LGUs' role in HSR. The results will be forwarded to LGUs for action. This could be done during LMP meetings, SB/SP sessions, LHB meetings, local development council meetings, ABC meetings and the like. This is the data utilization part. DILG will provide technical oversight on the process, while PHO/RHU/CHD provides technical content.

Part of the process is the championing of policy agenda by CSOs, NGOs, POs and other identified health champions. What follows is the crafting of ordinances, resolutions, EOs and other pieces indicating official decisions by the LGUs at all levels. DILG provides technical oversight in the whole process with technical backup from PHO, PPDO, RHUs, CHD and PHIC.

Policy tracking and analysis: this is to determine if policies crafted are implemented and desired changes are achieved. Essentially the steps are the same with EBL/EBPPM, except the creation of a legislative tacking committee per municipality by an official LGU enactment. The steps also are different but the mode of delivery by partners remains substantially the same.

Packaging of the information and data generated for advocacy cum advocacy skills training: the data or information may come from the HIS, results of monitoring, SDIR, partnership meetings and the like. The mode of TA delivery to partners includes conduct of workshop by TAP to regional, provincial and municipal partners to design customized advocacy activities and materials using issue-specific topics as content (e.g. SDIR red to green, CSR-related issues, universal coverage and facility accreditation). TAP will also assist the stakeholders in the development of audience-specific advocacy guidelines.

"***Harmonization of the two health systems and strengthening the functions of frontline health service delivery"***

PROVINCE OF BUKIDNON TECHNICAL ASSISTANCE PLAN

Background

Bukidnon is a highland province landlocked in Central Mindanao. It is the largest province in the region and eighth largest in the entire country, covering a land area of 829,378 hectares. The Province is a fast growing economy having strategically situated and serves as the main economic route between two major Cities (Davao and Cagayan de Oro City) in Mindanao. The past years witnessed the steady rise of business establishments coupled with dynamic agricultural production with new investments pouring in for banana plantations. The province's population is more than 2 percent per year.

General Information Province:	Bukidnon
Classification:	First Class
Land area:	829, 378 ha.
Projected 2007 Pop:	1,254,165
No. of municipalities:	20
No. of cities:	2
Total Income:	1.087 b pesos
Budget for health (52%):	570m pesos
Barangays:	464
Number of RHUs:	22
Number of BHS:	349

Tribal governance

Bukidnon is home to seven (7) indigenous peoples comprising 40% of the Province total population. Interestingly, more than half of them are still keeping their traditional health practices from maternal and child care, nutrition to using herbal medicines for common illnesses. Developing appropriate IP health programs is one of the thrusts for year 2 TA interventions in the Province.

Selected health indicators

- Number of Deaths, All Ages / Mortality Rate: 3,563
- Number of Infant Deaths: 179
- Number of Under-Five Deaths - Under-Five Mortality Rate: 240
- Maternal Deaths - Maternal Mortality Rate(Actual Number): 30
- Low Cure Rate and detection rate for TB. Only the RHU of the San Fernando Municipality reached 100% cure rate. Two (2) big LGUs (Mun of Quezon and Malaybalay City) only managed to obtain 50% cure rate for 2006. Almost half of the total LGUs (10) have attained between 62.50%-79.48% cure rate. Notably, the Municipality of Dangcagan has the lowest cure rate at 14.28%
- TB-DOTS accredited RHUs have low or no claims at all from PHIC
- High crude birth rate
- High malnutrition rate
- Only 13 out of 22 RHUs are TB-DOTS accredited.
- 2006 Operation Timbang Results: Below Normal-Very Low: 2,033 (1.13%)
- Below Normal-Low: 20,203 (11.20%)

Health profile

The brief health situation of the Province is shown in the box above. Specifically, the health data in 2006 reveals a significant number of maternal mortality and infant deaths as shown in the box above. The 10 Leading Causes of Mortality, for all ages are as follows: CVD, Injuries, Pneumonia, Cancer, TB, Diseases of the Kidney, Diabetes Mellitus, Septicemias, Diseases of

the Livery, Bleeding Peptic Ulcer. While the 10 Leading Causes of Infant Deaths are: Prematurity, Sepsis, Pneumonias, Congenital anomalies, Diarrhea with Dehydration, Hypoxia, Respiratory Distress Syndrome, Placental Insufficiency, Disorders of Amniotic Fluid and Membrane

Health system and programs

The Bukidnon health system may be summarized as follows: a) public health system which is primarily handled by BHS/RHUs/CHOs and by three inter-local health zones, and; b) the Provincial Hospital System composed of the 8 District Hospitals. Table 1 below shows the total number of hospitals in the Province with the private sector playing the major role of managing 33 while the Provincial Government operating 8 hospitals. Significantly, majority of the hospitals accredited by PHIC are privately-managed. Almost all however, or 7 Provincial Hospitals are also PHIC accredited.

The Bukidnon health system is envisioned to be a premier institution of the Province to provide a comprehensive health care delivery to the constituency through an effective, efficient, accessible and equitable health care through the following health programs: Provincial Indigency Health Program (PHIP), Provincial Hospital Development Project, Public Health Integration Program. In addition, it has a Bukidnon Health System: An Economic Enterprise which seeks to generate more revenues for social services.

Health issues and concerns

Generally, major issues were identified that are crucial in determining critical TAs for year 2 as follows:

Service delivery:

- Lack of effective communication and education program on FP and, inadequate communications skills of frontline health providers.
- Poor monitoring and/or referral systems for broader FP coverage
- Lack of access for affordable drugs and medicines
- Insufficient knowledge by RHMs and BHWs on wide-range FP methods for informed choice.
- Significant number of deliveries are still not attended to by skilled workers
- No LGU funding support for upgrading KSA of health staff especially RHMs on MCH and FP counseling
- Unable to develop culture-sensitive health interventions that would mainstreamed IPs and other grassroots communities for improved health practices
- Difficulties in complying (i.e. documentation requirements and standards compliance) with PhilHealth accreditation of TB-DOTS and MCP facilities.
- Poor referral system

Governance, regulation and financing issues on health:

- Inter-facing between PHS and RHUs needs to be strengthened.
- Health information system needs to be enhanced for effective program planning.
- Health Investment Planning for Health needs to be enhanced specifically on expanding resource generation and financial management
- CSR policies in terms of procurement and distribution needs to be clearly established especially at the provincial level.
- Weak linkage of government and private sector

Technical assistance provided in Year 1

Early interventions in the Province mostly relate to the establishment of effective rapport and commitment by the LGU to undertake the health governance process. The first major accomplishment in the Province was the signed commitment gathered from the LMP-Bukidnon chapter (signed by all the Mayors present during the meeting) to undertake health reforms with the "aim of improving the quality of care and achieve desired health outcomes through appropriate policies and investment plans".

In year 1, HealthGov provided overall direction to the health programs of the Province and component Municipalities and Cities. One of the significant achievements was the commitment obtained from the LMP to take an active role in health development of the Province.

Technical assistance proposed for Year 2

The main thrust of TA provision will be towards strengthening the provincial public health system. Although public health integration and strengthening ILHZ are one of the program priorities of the Provincial Government, there are no concrete policies or mechanisms (i.e., systematic or integrated information system, clear referral system, inter-facing between PHS and RHUs/CHOs) towards that end. Thus, for year 2, the strategic TAs will be geared towards laying the foundation for the "harmonization of the two health systems and strengthening the functions of frontline health service delivery". The following TA is planned:

1 Enhancing MIPH and PIPH into an institutionalized process for public health planning
This TA is geared towards the achievement of the following:

- 22 technical M/CIPH finalized/packaged and submitted to respective local bodies for integration to AIP
- PTMT organized and mandated to supervise TA process and requirements for PIPH
- Cross-cutting concerns identified for Provincial consolidation
- Provincial Support systems to C/MIPH and ILHZ-IPH developed
- Information, M&E, Advocacy strategies formulated
- PIPH integrated to AIP and obtained LCE's mandate for implementation

In early part Y2, a TAP will be tapped to guide CHD and Provincial partners in enhancing and institutionalizing the PIPH.

2 Formalization of ILHZ as a key mechanism to promote and enhance public health system
For year 2, the target is to establish a functional ILHZ. Specifically, the TA process hopes that by end of year 2, a smooth referral system will be in place. The Project will support the CHD and PHO gather the support of the League of Municipalities in strengthening the role of ILHZ as a major component of the Province-wide health system.

3 Promoting culture-sensitive IP health interventions through IP-inspired SDIR
Based on initial consultations between tribal leaders and elders together and some provincial health personnel, a potential TA area would be harnessing expertise from CHD and NGOs to develop appropriate IP health programs through documentation and assessment of IP health practices and, eventually the development and testing of a culture-sensitive health program.

4 Strengthening Provincial-NGO/PO partnerships for public health perspective

By end of year 2, it is hope that the foundation for a functional partnership will be established and sustained through the mainstreaming of NGO advocacy and participation into the overall planning and development cycle of the LGUs.

"A healthy and productive citizenry working together for a better quality of life"

PROVINCE OF COMPOSTELA VALLEY TECHNICAL ASSISTANCE PLAN

Background

Classified as a first class, Compostela Valley has 11 Municipalities with a total land area of 4,666.93 sq. km. The annual PGR is 2.38% and the projected population for 2006 is 670,535. The population density is 144 persons per sq. km. The Province carries a Vision for "A healthy and productive citizenry working together for a better quality of life".

In 2006, the Province had a CBR of 21.4 per 1,000 population, a CDR of 4.5 per 1,000 population, an MMR of 167.1 per 100,000 live births, an IMR of 22.9 per 100,000 live births and a young child mortality rate of 4.7 per 1,000LB.

Each of the 11 municipalities has a health center with an average ratio to population of 1:60,958. It has 119 BHS' with a ratio to its population of 1:5,635. It has a total of 10 hospitals of which 4 are government-owned and 6 private. The 4 government hospitals have a bed capacity of 70 while the private hospitals have a total bed capacity of 198 with a combined ratio to population of 1:3,387. It has only 16 doctors, 12 dentists, 23 nurses, 160 midwives, 19 medical technologists, 18 RSIs.

Health Programs Indicators (Provincial & Regional), 2006

Health Indicators	Prov.	CHD 11
% Fully Immunized Child	77.5	75.8
% Measles Drop-Out Rate	-1.3	-1.3
% DPT drop-out rate	2.6	5.2
% OPV Drop-out rate	2.5	4.5
% Child protected at birth	67.2	69.1
% Low birth weight	2.0	2.2
% Excl. BF for 6 months	25.4	48.5
% Prev. Malnourished	11.6	10.7
% 6-71 months given Vit. A	83.0	85.5
% Pregnant women with 5 PNV	26.7	25.8
% Pregnant women given iron for 6 months	22.0	18.5
% Fully immunized mother	72.9	54.3
% Deliveries attended by skilled HPs	41.1	50.0
% Contraceptive Prevalence Rate	62.4	55.2
% Total fertility rate	2.6	2.4
% PP women initiated BF	88.4	89.1
% Quality prenatal care	19.7	15.8
% Quality Postpartum care	51.4	48.7

Health situation analysis

The following are salient findings from the situational analysis on FP, TB, MCH and micronutrients:

Service Delivery

- Low health-seeking behavior of consumers due to inaccessibility, lack of information or misinformation, socio-cultural barriers and poverty.
- Inadequate supplies, medicines and equipment compounded with the lack of support to health personnel in terms of mobility, salary, incentives, training (especially for newly-hired), supervision and career advancements.
- Inadequate number of health personnel in relation to its population and number of LGUs/facilities, as substantial number health personnel are migrating while vacant positions has no "takers";
- LSI has yet to be finally encoded, analyzed, utilized and installed;
- Recurring delays in the procurement and distribution of health logistics.

Regulation

- Inadequate regulatory policies as evidenced by inadequate policy support to public health, quality service delivery of facilities, and province-wide support systems, i.e. information system, planning-monitoring/evaluation-supervisory, referral system and ILHZs.

Health Care Financing

- LGUs are generally IRA-dependent
- Low PHIC indigent enrollment

Governance

- Stakeholders Participation has been low and limited;
- Health data/information not timely, usually unreported and poorly utilized for analysis, decision-making and action;
- Maternal death reviews and PIR were inadequately undertaken and PIR results are under-utilized.
- Provincial CSR policy guidelines were formulated but were poorly implemented;
- MLGUs have insufficient budget for FP commodities while delays in procurement/distribution recur;
- LCEs demonstrated poor support to inter-local health collaboration (ILHZ).

The following are observed gaps in health management systems:

- Poor health planning anchored on shallow health situation analysis. There was no systematic and in-depth identification of priorities in strategic areas for health investments, exploration of alternative means of financing and rationalizing internal resources;
- Most of the CSR plans were not implemented since CSR did not gain local-level support. Both CHD and PHO were indecisive in pursuing CSR implementation.
- HIS encumbered gaps, i.e. inaccuracy, under-reporting, delays and dismal under-utilization by the LCEs, LHB and SBs/SPs for decision-making and action.
- Supervision, Monitoring/Evaluation and Planning of programs, as with the Referral system, are poorly exercised;
- Ordinances, resolutions and executive orders for health are almost absent. A number of them were not monitored/reviewed.

The following are key opportunities for the health sector reform:

- The presence of influential associations, i.e. AMHOP, the LMP, the PCL and other organizations as potential champions for public health.
- DOH/F1 donors-set “Conditions” for LGUs to comply with PHIC universal coverage. HealthGov can provide TA to enable the province LGU to meet preset “conditionalities”.
- The province is the pilot site for the implementation of Family Health Book.

Technical Assistance proposed for Year 2

In Year 1, HealthGov provided in-depth orientation and capability-building to CHD XI, thru its Regional F1 Planning Team, including SA tool utilization (SDIR) towards PIPH development. The Governor issued a mandate to undertake PIPH.

Cognizant of the provincial health situation, challenges, opportunities and the results of provided TAs (Year 1), the following are proposed for Year 2:

1 TA for the Completion of Province-wide Investment Plans for Health

Municipal and Province-wide Investment Plans for Health have been prepared and initially reviewed. Each level is now enhancing their respective IPH. TA provision will cover initial and final Technical Review to ensure PIPH completeness and technical soundness (depth). An assessment of province-wide systems that support and enhance integrated health will need to be undertaken.

2 TA to establish improved province-wide system

TA in this area will be provided both at the provincial and ILHZ levels. The TA will include:

- Development of a monitoring tool to track progress in PIPH implementation
- Strengthening Health Information System (HIS
- This refers to the strengthening of inter-local collaboration for health (ILHZs) as mechanism for effective referral.

3 TA to establish local CSR response

In close collaboration with CHD XI, this TA covers establishing and operationalizing a local CSR response system. The TA includes assistance in the evaluation and use of previously conducted LSI Survey:

- Capacitating the CHD and PHO to Review CSR implementation in the province, using tools consistent with a new CSR DOH AO
- Enhancement of CSR plans
- Developing and operationalizing a Monitoring & Evaluation (M&E) tool to track progress of an Enhanced CSR Plan implementation

4 TA to increase LGU financing for health through universal coverage

This TA includes 1) formulating guidelines for planning and implementing universal health coverage; and 2) supporting the implementation of those guidelines.

PHO will develop a proposal on universal health coverage. It will contain projection of households by PHIC program groups, estimations (premium subsidies, reimbursements and capitation payments, investment requirements for accreditation) and expansion of IPP enrollment and options for ensuring use of PHIC revenues for health at hospital and RHUs. LSI data results analysis will form part of the decision-making.

An operational plan will be outlined to ensure proximate “buy-in” by municipal LGUs, congressional representatives, ABC, PCL, LFC, civic organizations and the like. Under the guidance of the HealthGov and the CHD, the PHO will spearhead the negotiations efforts on the cost-sharing scheme.

5 TA provision to institute evidence-based legislation

This TA seeks to strengthen the legislative branches of provincial, municipal and barangay governments by introducing them to evidence-based policy formulation/tracking and legislation. HealthGov and regional offices of the CHD, DILG, PHIC and the POPCOM will tailor an EBL training curriculum and will be implemented under the ambit of the Provincial Board.

Accurate and timely health information will be packaged to be utilized by the LCEs, LMP, PCL, the SP/SB Panlalawigan, Local Health Boards, LDCs and other Local Special Bodies and the Association of Barangay Captains. The DILG is expected to provide technical

oversight while the PHO, RHUs and CHD provide technical content. The CSOs, NGOs and POs role will be to champion the policy agenda on health.

6 Enhancing meaningful role of NGOs/CSOs in local health governance

This TA involves maximizing the current NGO/CSO representation in all local special bodies by capacitating them in the use of timely and accurate health information for policy advocacy. As its number of representation has been limited, an NGO/CSO Constituent Assembly be explored.

7 Pilot implementation of the Family Health Book

This TA will be undertaken in coordination with CHD 11, HPDP and other CAs (PRISM, HealthPRO and A2Z).

"A healthy and productive people of Davao del Sur"

PROVINCE OF DAVAO DEL SUR TECHNICAL ASSISTANCE PLAN

Background

The Province has 11 municipalities with a total land area of 3,934.01 square kilometers and a population of 450,000. The majority of the population consists of Visayan migrants. Other prominent migrant groups are the Ilonggos and the Ilocanos. Several ethnic groups exist in the province, among them B´laans, Bagobos, Manobos and Tagacaolos. These early settlers occupied the slopes, and base of Mt. Apo, and have developed their own cultures which have been preserved to this day.

Provincial Health Situation

The Province carries a Vision for "A healthy and productive People of Davao Del Sur". It carries a Mission to "Adopt an integrated and comprehensive approach to health development which shall endeavor to make services available to all people at affordable cost".

In 2006, the Province had a crude birth rate (CBR) of 20.6 per 1,000 population, a crude death rate (CDR) of 2.4 per 1,000 population, a maternal mortality (MMR) rate of 55.031 per 100,000 live births, an infant mortality rate (IMR) of 9.1 per 100,000 live births and a young child mortality rate (YCMR) of 5.9 per 1,000 LB.

Each of the 15 Municipal LGUs has its main health center with a ratio to its population of 1:58,812. It has 149 BHS with a ratio to its population of 1:5,921. It has 43 hospitals of which 7 are government-owned while the other 36 are private. Government owned/run hospitals have a combined bed capacity of 200 while that of the private has a total of 926 beds. Combined the bed to population ration is 1:783.

While it has 15 municipal LGUs and a projected 2006 population of 882,175, it has only 15 doctors, 14 dentists, 32 nurses, 205 midwives, 14 Medical Tech, and 22 sanitary inspectors.

Also notable is a list of Provincial Health Program Indicators against that of the regional-level indicators.

Health Programs Indicators (Provincial & Regional), 2006

Health Indicators	CHD-11	Prov.
% Fully Immunized Child (% of population)	75.8	73.0
% Measles Drop-Out Rate	-1.3	9.9
% DPT Drop-out rate	5.2	5.1
% Child protected at birth	89.1	86.6
% Low birth weight	2.2	3.3
% Excl. BF for 6 months	48.5	61.1
% Prev. Malnourished	10.7	6.9
% 6-71 months given Vit. A	85.5	93.2
% Pregnant women with 5 PNV	25.8	29.6
% Pregnant women given iron for 6 months	18.5	13.7
% Fully Immunized Mother	84.3	90.6
% Deliveries attended by skilled HPS	58.0	65.5
% Contraceptive Prevalence Rate	55.2	51.8
% Total fertility rate	2.4	2.3
% PP women initiated BF	89.1	89.7
% Quality prenatal care	15.8	12.8
% Quality Postpartum care	48.7	45.6

Health situation

The Provincial Health Office of Davao del Sur in previous years was recognized as one of the top performers in the delivery of public health services.

But the Province has never had a stable, system-wide method to finance health activities. New health funding pressures continue to emerge as these depend upon LCE priorities. The Province also faces a shortage of health workers in the rural areas. Policy makers and administrators are

not guided by health performance standards. Many public health functions have been performed without the benefit of informed choices and up-to-date technologies.

A PIPH has been developed by the province. Situational analysis, objectives, strategies, targets, programs and interventions as well as its investment requirement have been outlined in this plan. The following are additional salient points on the situational analysis done by the LGUs:

Service Delivery
- Low health seeking behavior of consumers due to inaccessibility, lack of information or misinformation, socio-cultural barriers, poverty and low health practices especially among the poor, especially the underserved population;
- Gross inadequacy of supplies, medicines and equipment compounded by delays in procurement and the lack of support to health personnel in terms of mobility, salary, incentives, training, supervision and career advancements;
- Inadequate number of health personnel in relation to its population, number of LGUs/facilities and geographic disposition, as substantial number health personnel are migrating while vacant positions have no "takers".
- For the past 10 years, identification of the poor was done by politicians.

Regulations
- Inadequate regulatory policy support.

Health Care Financing
- IRA-dependence of LGUs.
- PHIC indigent enrollment has been low.

Governance
- Stakeholders Participation has been low and limited. Representations to the local special bodies were not properly observed and maximized;
- Health data/information are not gathered and reported in a timely manner. These data are underutilized for decision-making and action;
- Maternal death reviews and PIR are inadequately undertaken and PIR results poorly utilized.
- There are no Provincial CSR policy guidelines;
- MLGUs do not allocate sufficient budget for FP commodities while delays in procurement/distribution recur;
- LCEs demonstrated poor support to inter-local health collaboration (ILHZ).

The following are observed gaps in health management systems:
- Health planning is poorly done. Analysis is shallow and articulation of issues has not been strong enough to warrant appropriate levels of funding support from the provincial government. There is also no effort to look into alternative sources of financing for health.
- CSR plans were initially drafted but not finalized nor implemented since CSR did not gain local-level support. Both CHD and PHO were indecisive in its completion
- HIS gaps, i.e. inaccuracy, under-reporting, delays and dismal under-utilization by the LCEs, LHB and SBs/SPs for decision-making and action.
- Supervisory, Monitoring/Evaluation, Planning and Referral are poorly exercised as there were no action plans and no LGU support mechanisms;
- Ordinances, resolutions and EOs for health are generally, almost absent.

Technical assistance proposed for Year 2

In Year 1, HealthGov provided in-depth orientation and capability-building activities for CHD XI, thru its Regional F1 Team/PIPH Planning Team, in SA tools towards PIPH development. TA was also provided in conducting initial technical review to ensure the completeness of PIPH. HealthGov found a Champion for Health within the ranks of the opposition, an SP Member who chairs the Committee on Health and Social Services. He facilitated the realignment of political forces and influential individuals and caused sweeping implementation of PIPH development process.

The Health Sector Reform – F1 Health Program was adopted by the Province with the recent issuance by the Governor of a Mandate for PIPH Planning (Executive Order No. 13), forming the Provincial Planning Committee, chaired by the Opposition and composed of "gate keepers" of the warring factions from various health groups, associations and facilities.

Cognizant of the provincial health situation, challenges, opportunities and the results of TA provided in the first year, the following TAs are proposed for Year 2:

1 TA for the completion of PIPH
This technical assistance aims to complete the PIPH plan document. The process involves the conduct of workshops to analyze the situation, using the F1 framework, determine budgetary requirements and interventions to address health sector gaps including governance systems that impact on health service delivery.

2 TA to establish improved province-wide system
This TA seeks to strengthen inter-local collaboration for health. It will have three main elements namely, strengthening the monitoring system to track progress in health sector activities, including PIPH implementation, strengthening the health information system through the introduction of such tools as the LSS and the local health accounting system; and strengthening the ILHZ as a mechanism for an effective referral system.

3 TA to increase LGU financing for health through universal coverage
This TA includes the provision of guidance in planning for universal health coverage using PHIC standards and methods, the introduction of tools and systems to hasten accreditation of health facilities and proper use of capitation funds, and the introduction of tools and systems for the proper identification of the poor, to minimize leakage.

4 TA provision to institute evidence-based legislation
This TA, to be designed specially for the local legislators and their support staff will introduce tools on evidence-based legislation and policy formulation/tracking. A component of this TA involves the CSOs and NGOs in health policy advocacy and lobbying. HealthGov will coordinate this activity with both the CHD and the DILG.

5 Enhancing meaningful role of NGOs/CSOs in local health governance
In close collaboration with the CHD, mechanisms/processes will be established, installed and be made operational at the Provincial level. This mainly involves maximizing the current NGO/CSO representation in all local special bodies by capacitating them in utilizing timely and accurate health information, engaging in effective policy organizing and negotiation. As its number of representation has been limited, an NGO/CSO Constituent Assembly be

explored and established in collaboration with the Provincial Legislative Council, the Governor and the DILG.

"Upscaling the province-wide stakeholders' Kurambus participation towards health investment"

PROVINCE OF MISAMIS ORIENTAL TECHNICAL ASSISTANCE PLAN

Background

Misamis Oriental is an agricultural province of Northern Mindanao with Cagayan de Oro City as its regional center. The province has a total population of 664,338 as of 2000 with land area of 289,168 hectares. Its population is expected to increase drastically in the next several years due to the high development growth of Cagayan de Oro City, from which development spills over. With 422 total barangays, it has 25 RHUs and 175 BHS clustered into five ILHZs. Out of the total provincial budget of more than P800M for 2007, only 14% are allocated to health. The provincial government owns seven district and medicare hospitals.

Overview of the Provincial Health Situation

The province registered 12,320 births in 2006. The crude birth rate was 18.9 per 1000 population while the Infant mortality rate is 5.5 per 1000 live births. The maternal mortality rate in 2006 was 0.49 per 1,000 live births. The CPR has reduced from 53% to 47% in 2006. On TB, the case detection rate has improved from 59% in 2005 to 66% in 2006 but the performance is still below the international target of 70%. On the other hand, the cure rate has improved from 89% in 2005 to 92% in 2006 and is way above the standard 85%.

Health Programs

The priority of the present provincial administration is hospital development. Out of the total health budget of more than P115M, more than 65% goes to hospital operations and rehab and maintenance, to meet the standards of PHIC accreditation. In 2007, massive renovations were done in two hospitals to upgrade the facilities to meet the requirements of a secondary hospital. The province is negotiating for a P200M loan to finance the upgrading of all seven hospitals.

Through its indigency program, the province spent P31M to enroll 100,105 families under the government health insurance system. These comprise 29% of the total families of the province. The province ranks second nationwide in terms of number of enrolled indigents.

The health workers conducted various MCH activities that included four-visit services (48% performance) for pregnant women with the provision for TT2 (52% performance) and iron (32% accomplishment). For post partum care, iron and Vitamin A were provided and more than half of these mothers were introduced to breastfeeding. A number of the children were also covered by full immunization (FIC) program with performance level of 82%. The province targeted 122,988 children (6-17 months old) for Vitamin A supplementation and was able to hit 94%. More than 1,000 children were also provided with iron supplementation for six months.

The provincial government through the PHO started a unique program dubbed as "Tabang Medico", a mobile hospital with complete facilities which benefited 46,000 persons. With the initial budget of P2.5M for the aforementioned project, the province also received a donation in cash and medicines amounting to P1.7M.

To support its barangay health program, the province constructed 23 barangay health stations each amounting to P140,000.

Situation Analysis

Service Delivery
- Inadequate supplies especially on FP, Vitamin A and iron supplements.
- Unmotivated staff, causing poor program designs and implementation.
- Poor information systems to support services, policies and management decisions.
- Unskilled personnel especially the newly hired at the LGU level to deliver the services especially in the field.

Financing
- Cost of health services are highly subsidized and covers even those who can afford.
- Use of PHIC capitation and reimbursement funds needs to be rationalized.

Regulation
- There is no sustained effort to improve service standards of LGU facilities to meet PHIC accreditation.
- There is a need to formulate policies and legislation to support health programs.

Governance
- Lack of participation of the health sector-wide stakeholders in decision-making, planning, management, monitoring and feedback.
- Lack of data and evidence to do sound decision and to formulate policies
- Absence of technical assistance to implement effective systems such as the two-way referral system, client segmentation, user fees, financial management, logistics and procurement.
- LGUs have limited technical leadership and capability to do performance review which is hampered by lack of resources and limited budget.

Inter-Local Health Zones
- Needs more policy support in terms of systems, funding and operations.
- The referral system needs to be strengthened.

There are developments that positively impact on health reform in the province, including:
- The desire of PHO technical coordinators to pursue the public health plans of the province with the technical assistance from CHD and HealthGov.
- The election of the new LMP officers who have shown interest in health programs. Theirs is a key role in mobilizing the various stakeholders and resources.
- The initiative of several LGUs to pursue the ILHZ strategy in their catchment areas.
- The desire of the provincial LGU to pursue hospital upgrading and the need for two-way referral system with the RHUs.
- Creation of the Provincial TWG/committee to support the implementation of PIPH and other health-based plans.
- The latest move of the CHD to converge the DOH representatives in the ILHZs instead of working individually per RHU. Both CHD and PHO wanted to have the ILHZs strengthened.

Technical assistance in Year 1

In Year 1, HealthGov provided technical assistance to CHD in the areas of situational (data) analysis and identification of strategic interventions using the SDIR as the tool. Back to back workshops were conducted to bring together the municipal LGU planning teams who firmed up the analysis and plans following the steps of PIPH development.

Technical assistance in Year 2

In response to the situation and plans of the province especially the PHO, through CHD, HealthGov will focus its follow-through assistance on the following areas:

1 Legitimization of the MIPH
The assistance will focus on the technical review and refinements of the draft MIPH and supporting data, situational analysis and critical interventions ready for presentation to the LHBs for endorsement to the Sangguniang Bayan.

2 Consolidation of MIPH and provincial plans into the PIPH
This will include the consolidation of the MIPH from the 25 LGUs capturing the common plans of the various LGUs. The consolidation of the five ILHZs will also form part of the PIPH which may include the common and cross-border concerns of the LGUs within each of the ILHZ catchment area. The plans of the private sector and the CSO will be integrated into the consolidated plan. A planning-workshop will be conducted for this.

3 Strengthening of the province-wide health systems
The assistance will focus on the strengthening of the two-way referral system that will support the viability of the RHUs in relation to the hospital systems of the province. This effort also will reinforce the information system that is essential to decision-making and monitoring. The assistance also includes application of the SDExH to improve the quality of service and achievement of client satisfaction.

4 Establishing local CSR response
CSR Assessment and Monitoring Tool (consistent with new AO on CSR). The tool developed by region 10 with TA from HealthGov and other CAs was actually piloted by POPCOM 10 in Misamis Oriental. The same tool (now enhanced by incorporating the five core attributes), will be utilized. PHO will organize a CSR monitoring tool orientation and action planning for the conduct of province-wide monitoring to be participated in by all MHOs, PHNs and DOH representatives. PHO, PHT, DOH representatives and MHOs conduct province-wide monitoring from January to March. By end of March, MHOs and DOH reps will present results to the respective municipal LGUs (LCEs, SP, LHB). The expected output is the mandate to do CSR planning.

Enhancement of CSR plans. The CSR monitoring results will be used as inputs to the enhancement of CSR plan. The CSR planning processes will be similar to PIPH process (a sequence of steps starting from mandate to plan). This will be started by April 2008 and will end mid-June 2008 just in time for the first budget call. There will be a period of revisions and negotiations between and among LGUs at ILHZ level and between PLGU and MLGUs at the province level. CSR plans with corresponding budget will start to be implemented on the last quarter of 2008. CHLSS/CBMS results will be utilized in forecasting the FP logistics needs with emphasis on the safety net for the poor.

M & E tool to track progress of CSR implementation. HealthGov will facilitate the design of monitoring and evaluation tools with the regional and provincial CSR TWG. The tools will be integrated in the IPH monitoring system. This will also include the designing of feedback system to LGUs and LGU organizations (e.g. LMP) through an EBL process.

5 TA to mobilize broad-based local action for health

Consistent to the over-arching agenda of converting red to green, year two will focus on CSR and in improving quality of care and program performance and/or coverage of core health programs (TB, MCH, FP and Micronutrient) to convert red to green. This includes establishing local service standards and incorporating consumer expectations in the RHU service delivery system.

6 Evidence-based legislation and policy-making

This TA, to be designed specially for the local legislators and their support staff will introduce tools on evidence-based legislation and policy formulation/tracking. A component of this TA involves the CSOs and NGOs in health policy advocacy and lobbying. HealthGov will coordinate this activity with both the CHD and the DILG.

7 Advocacy skills training

The mode of TA delivery to partners includes conduct of workshop by a designated TAP to regional, provincial and municipal partners to design customized advocacy activities and materials using issue-specific topics as content (e.g. SDIR red to green, CSR-related issues, universal coverage and facility accreditation); and for the TAP to assist stakeholders in the development of audience-specific advocacy guidelines.

"Enhancing key systems for improved and sustained health programs and services"

PROVINCE OF MISAMIS OCCIDENTAL TECHNICAL ASSISTANCE PLAN

Background

The Province best accomplishments are in eco-tourism and agricultural and economic development. The Provincial Planning and Development Office is tasked by the Provincial Governor to take the lead role for a sector-wide development planning, establish mechanism for progress monitoring and institutionalize data/information management for decision making processes and integrated planning.

Land Area:	1,939.32 sq. km.
Population:	486,723
Pop. density:	250.97
No. of cities:	3
No. of municipalities:	14
No. of barangays:	490
Topography:	Hilly, rugged terrain
Class:	2nd class province
Most Mun:	4th-5th Class
Income:	612m (25% social services including health)

Health Profile

The table below gives a brief of the province's health profile.

Key health indicator	Performance
Crude Birth Rate	17.89 / 1,000 pop
Crude Death Rate	6.01 /1,000 pop
Infant Mortality Rate	13.55 /1000 live births
Maternal Mortality Rate	0.46
TB CURE RATE	89.13%
• Post Exposure Treatment	-99.2%
• Cases Treated	-100%
Maternal and child Health:	
-Postpartum Care with at least IPP visit	40.38%
-Deliveries attended by skilled Health Personnel	67.75%
-FP New Acceptors (All methods	52.23%
-FP Current Users (All Methods)	102%
-Fully Immunized Children	87.91%
-Pregnant women given Tetanus Toxoid	80.53%
-Vitamin A Supplementation	94.18%
-Malnutrition Rate	13.61%
PHIC enrolment:	
-Province	78,728
-Mun. of Bonifacio (highest)	9,752 (63%)
-Mun. of Baliangao (Lowest)	1.521 (19%)

Misamis Occidental as an F1 Province is well going ahead in the facilitation of basic reforms and systems development for an improved and sustainable health development service. The Provincial Investment Plan for Health (PIPH) formulated by the Provincial Government reflects reforms and interventions to strengthen governance, service delivery,

Generally, the 5-year Plan (2006-2010) envisions at improving accessibility and availability of basic and essential health care services in all ILHZ, improve health system performance at all ILHZ, and ensure availability, affordability of low-cost quality drugs. Specifically by 2010, the Provincial Government hopes to attain a functional drug management system at all levels, a functional information system in 4 ILHZ and, a human resource development System at the Provincial level. Correspondingly, budgetary requirements are allocated each year of which the service delivery and financing components got the biggest share at 48% and 45%, respectively of the total budget of 270 million pesos.

In July 2007, as a major step in strengthening the ILHZ, an Executive Order was issued expanding the membership of the Provincial Health Board from the original members of five (5)

to fifteen (15) including the Chairmen of the 4 ILHZs and representatives from an NGO and Women's Federation.

In support to MDGs, the Provincial Government formulated an Executive Agenda outlined on the theme "CHAMPS" (Competence, Health, Agriculture, Maintenance of Peace and Order, Protection and preservation of the Environment and Sustainable Social Services). Among its target is the reduction of malnourished children and increase in mothers' use of pre-natal care.

On the other hand, as a recipient of the Philippines-Australia Local Sustainability (PALS) Program, the Provincial Government has also instituted reforms on its planning and management of local resources (physical, human and financial) for "the promotion of sustainable community livelihoods."

Year 1 accomplishments

The project pilot-tested the Service Delivery Excellence for Health (SDEXH) in Oroquieta City ILHZ. The results of the pilot-tests are being consolidated to form part in the overall improvement and development of the SDExH tool for replication in other HealthGov areas.

In the last quarter of year 1, an NGO forum was facilitated to initially plan a Province-wide partnership for health. Several NGOs in the province expressed willingness to support and provide technical assistance on the operationalization of PIPH and the overall health systems delivery of the Province. The Misamis University-Community Extension Program is identified as a potential TAP in facilitating CHLSS.

Year 2 TA plan

Based on the overall health situation and PIPH status of implementation and recommendations, TA in four strategic areas is proposed:

1 Improving Planning systems (thru CHLSS) for effective client segmentation and increased and sustained PHIC coverage

For year 2, HealthGov's initial TA is to facilitate the Community Health and Living Standard Survey (CHLSS) to assist the Provincial Government enhance their development planning process through accurate and effective data gathering and management. Specifically, HealthGov will develop the planning module, training design, household enumeration procedures and supervision and data analysis and utilization. The training will be in the form of "Training of Trainers (ToT) to prepare LGUs especially the Municipality to generate, consolidate and package data for presentation to LCEs. Other major TA to be extended is the installation of computer software for data banking (for data storage, analysis and retrieval) and utilization.

2 Enhancing CSR Planning and Monitoring to provide safety net for the poor

The Province has already formulated their CSR plans facilitated by the LEAD for Health Project. HealthGov will start with the assessment on the adoption of these plans and establish lessons learnt and identify innovations. The enhanced CSR planning will ensure that LGUs develop appropriate policies and/or procedures to provide safety net for the poor and "beyond safety net" (cost recovery systems for publicly delivered commodities to non- poor, private provider mapping, public-private referral system; private sector expansion through development of high volume providers for IUD and VSC). Using CHLSS data,

HealthGov will facilitate LGUs to develop policies to ensure sponsored-enrollment for the most deserving sector of the population and, policies and schemes for cost-recovery.

Based on earlier experience on CSR planning, HealthGov will develop, together with the Regional Implementing Coordinating committee (RICT), the CSR planning package incorporating among others, methodology in assessing CSR implementation experience of the LGUs and identifying weaknesses and improvements particularly on CSR forecasting and procurement and distribution procedures or policies.

3 Strengthening function of ILHZ for Province-wide Replication of SDEXH.

The Province as an F1 area is expected to embark on hospital facility upgrading (for 3 District Hospitals, RHUS, CHOS and the Provincial Hospital). The HealthGov TA along this line is to complement and enhance existing public health systems by motivating ILHZ to assume greater responsibility on public health systems such as referral, information management and disease surveillance.

The key health systems that will be installed in the ILHZs will be anchored on the overall framework of Service Delivery Excellence for Health or SDEXH. The initial TA provided by the project is the piloting of the Oroquieta Inter-local Health Zone. The SDEXH framework and tools were developed with the active participation of the TMC of Oroquieta-ILHZ. The Provincial government through the PHO and PPDO expressed their desire to adopt the framework for the rest of the ILHZ and RHUs. HealthGov will develop the SDEXH package and provide training for the trainers to replicate the whole process to the public health facilities of the Province. The most crucial TA is the development of on-site mentoring and/or coaching methodology through the regular monitoring and supervisory visits.

4 Championing for Health

One of the desired objectives of PIPH is to establish functional provincial partnerships with NGOs/POs Women's Federation and other appropriate private organizations for a sector- wide approach to health. The Provincial government recognizes the critical role of these organizations not only to mainstream community and grassroots' perspective in health systems delivery but as well as for a continuing advocacy for equitable health services. The TA along this line is to assist in the development of partnership mechanisms and built-in advocacy strategy in the context of PIPH implementation.

"Right investment towards a healthy community"

PROVINCE OF SARANGANI TECHNICAL ASSISTANCE PLAN

Background

Sarangani is Mindanao's front door to BIMP-EAGA. It is the southernmost province in mainland Mindanao. Its local economy is one of the more vibrant in Mindanao, relying mainly on fishing and crop agriculture. It houses one of the biggest commercial plantations (Dole Philippines) in the Southeast Asia region and a thriving agro-industrial sector which processes its fish and crops. Classified as a first class province, Sarangani consists of two districts and seven municipalities.

Sarangani General information	
Region:	Central MIndanao
Population (2005):	801,248
Districts:	2
Municipalities:	7
Cities:	0
Barangays:	140
No. of RHUs:	7
No. of CHOs:	0
Classification:	1

Health situation

Heart Disease is the leading cause of death in the province, followed by hypertension and cancer. Acute respiratory infections is the number cause of morbidity followed by fever and diarrhea. The province has TB cases, MMR and IMR that are lower than the national level. However the percentage of fully immunized children is way below the national level of 84 percent. Close to 90 percent of births take place at home and less than half of the births are attended by trained personnel.

Sarangani Selected health indicators	
• U5MR (2006, CHD /1000)	5
• FIC rate (2006 CHD)	55.16
• LGU Health & Nutr Exp (2007)	71,399,538
• Percent to total LGU Exp(2007)	10.3%
• CMW (2006 NDHS)	3.20
• Attended Births (2005 (NDHS)	41.2
• Births at Home (2005 FHSIS)	87%
• LGU HIV/AIDS Exp (2006 HPDP)	0
• PHIC Coverage (2006)	99,530
• Women w/3 ANC (2006 HG)	68.2
• CYP (2003 CDLMIS)	52,632
• SDP w/ CC S/out Reps (2006 HPDP)	0
• MMR (2006 CHD /1000 LB)	0.7
• IMR (2006 CHDS /1000 LB)	4
• TB Cases (2005 /100,000)	127.2

Background on Year 1 activities

Most of the key activities in year 1 were aimed at the development of PIPH. Since Sarangani is an F1 roll out province, strengthening CHD XII as the key player had provided a positive impact in gaining much progress in the development of PIPH.

Technical assistance for Year 2

For the second year of project implementation, the TA for the province of Sarangani will focus on the strengthening the capacity of the province to manage its unique health delivery system. The unique set up of its health facilities will be evaluated to determine interventions to improve operations and utilization of resources. The TA will focus on capacitating local health planners to identify the real health needs and develop the right critical interventions. The TA will also reinforce the LGUs' competence in recognizing approaches to prioritize limited resources to address their health concerns more effectively.

1 Institutionalizing PIPH Guidelines

HealthGov will continue to support the province's finalization and legitimization of its PIPH. The project will support the conduct of further workshops and follow on activities leading to the documentation of the PIPH and its acceptance by the legislative body.

2 Capacity building for evidence-based legislation-decision making

This TA, to be designed specially for the local legislators and their support staff will introduce tools on evidence-based legislation and policy formulation/tracking. A component of this TA involves the CSOs and NGOs in health policy advocacy and lobbying. HealthGov will coordinate this activity with both the CHD and the DILG. This TA may be delivered either through the CHD or through an academic institution.

3 Promoting Sustainable Sponsorship to Indigency Program-

This technical assistance includes the provision of guidance in planning for universal health coverage using PHIC standards and methods, the introduction of tools and systems to hasten accreditation of health facilities and proper use of capitation funds, and the introduction of tools and systems for the proper identification of the poor, to minimize leakage.

4 Service delivery improvement tools

This TA involves the training of the CHD team and key LGU officers in the tools designed to improve health service delivery. These tools include: SDExH; SDIR; strengthening service providers training system; TA on informed choice and voluntarism (ICV); and strengthening Service delivery monitoring and supervision

The training will include application of the tools and are expected to yield specific results such as implementation reviews (for the SDIR), completion of acceleration plans, strengthening of ILHZs (for SDExH), organizing ICV orientations, establishment of monitoring and evaluation mechanisms, to cite examples.

5 Health Service coverage expansion through partnership with CSO/NGO

This TA is to be designed to mobilize NGOs who operate in areas not covered by the LGU health workers. These organizations have health related activities that can be enhanced and steered to complement and fill in the limitations of the LGU health program implementers.

"Moving onward to a sustainable health self-reliance program"

PROVINCE OF SOUTH COTABATO TECHNICAL ASSISTANCE PLAN

Background

South Cotabato is a landlocked province located in the southern part of the island of Mindanao, Philippines. It is accessible by sea and by air through the modern seaport and International Airport of General Santos City. It is also accessible from all parts of Mindanao, by land. The province has a land area of about 3,706 sq. km. The province comprises ten municipalities and one city, and a total of 199 barangays. Koronadal City is the provincial capital and seat of the provincial government. It also serves as the regional center for South Central Mindanao. The province has a poverty rate higher than the national average.

South Cotabato General information	
Region:	Central MIndanao
Population (2005):	801,248
Land Area (sq. km.):	3,706
Districts:	2
Municipalities:	11
Cities:	1
Barangays:	199
No. of RHUs:	10
No. of CHOs:	1
Classification:	1
Poverty Rate (2003):	37%

Overview of the health situation

The Province of South Cotabato is one of the 16 provinces identified to implement the Health Sector Reform Agenda through the support of EC. Primarily, this project aims to improve quality and efficiency of investments for health reforms and improve health outcomes for Filipinos particularly the poor.

South Cotabato Selected health indicators	
• U5MR (2006, CHD /1000)	12
• FIC rate (2006 CHD)	80
• LGU Health & Nutr Exp (2007)	111,287,026
• Percent to total LGU Exp(2007)	18.25%
• CMW (2006 NDHS)	2.89
• Attended Births (2005 (NDHS)	16,348
• Births at Home (2005 FHSIS)	72%
• LGU HIV/AIDS Exp (2006 HPDP)	0
• PHIC Coverage (2006)	411,044
• Women w/3 ANC (2006 HG)	74.1
• CYP (2003 CDLMIS)	4
• SDP w/ CC S/out Reps (2006 HPDP)	85,162
• MMR (2006 CHD /1000 LB)	0.77
• IMR (2006 CHDS /1000 LB)	8.25
• TB Cases (2005 /100,000)	173.6

South Cotabato has an 85% Cure rate for TB patients enrolled in DOTS, higher than the national cure rate target of 80%.

The Garantisadong Pambata (GP) accomplishment is 94%.

In the Family Planning program, the Contraceptive Prevalence Rate is now 59.48%. In 2006, there were 51,147 Current Users for all FP methods.

All (11) RHUs and all Govt. Hospitals are PHIC accredited. All Rural and City Health Units are accredited to SS Phase I Level I. For SS Phase II Level I, eight (8) RHUs are now accredited while the other 3 RHUs are on the process for accreditation.

The Provincial Coordinating Council for Health Concerns (PCCHC) which is the umbrella organization of NGOs, POs and other agencies is regularly conducting meetings to discuss various health issues and concerns.

While the health performance indicator for FP program showed a satisfactory result, some operational performance indicators were seen as poor in promoting a sustainable CSR

response. The segmentation of client, the identification of network of commodity providers and the forecasting of demand for the safety net and beyond safety net group were among the gray areas that need further enhancement.

Background on Year 1 activities

Generally, TA during the first year dwelt on the result of analysis based on the consultation conducted with their health technical staffs. This was facilitated by the use of the SA tool and validated through follow up visits in the 11 LGUs.

Technical assistance for the province of South Cotabato

The following cluster of TA identified for the province of South Cotabato is based on the review of their Province Wide Investment Plan. The emphasis is on how to empower its people to strengthen its primary health care network and health information system.

1 Empowering LGU to sustain CSR response

The TA will include interventions at three levels. First level involves the enhancement of the information system through the Community Health Living Standard Survey. The second level involves profiling and mapping of facilities to establish referral system and service network for FP. The third level involves identifying institutions that may possess the capacity to provide training to health implementers. Activities that will be supported will be the development of tools for the CHD and Provincial Staff's use in assessing the Human Resource Capabilities and Training Needs to determine the training curriculum requirements. This will create a market for would be service providers.

By the end of second year, major improvements are expected in the following areas:

- A clear picture between FP services demand and market interplay will provide the much needed management information for the LGUs like budget forecast for safety net group. It is expected also that some cost recovery scheme will start to evolve and these areas must be ushered in by follow up TAs for the DOH Reps whose membership in the health board is significant.
- Improvement of the LGU health facilities as FP service providers is predictable. Due to the identified health demand and expected revenue from FP services either from PhilHealth reimbursement or from user's fee will create a field of competition both from private and public service providers.
- Increasing interest of the academe and other organizations as TA providers and the interest of both public and private health professionals to enroll in the training programs as FP service providers.
- A draft tool which is co produce with the province for roll out to other project sites.

2 Reviewing the gains in CSR and institutionalization of LGU CSR response

A training tool that address the core attributes of CSR will be co produced by HealthGov and the Province. This TA involves:

- Co-production by HealthGov and the PHO of draft CSR TA module/tools to be implemented in 11 LGUs.
- Preparation of a Provincial 5-year CSR plan.
- Determination of budgetary requirements and its inclusion in the provincial budget.

3 Evidence-based legislation and decision-making for CSR

The Proposed TA will center on orienting LGUs on MDG/MTPHP/NOH, LHA (as planning and management tool), and the mobilization of key actors in attaining CSR (and other health related) indicators. A team composed of point persons from CHD, Popcom, DSWD and DILG will conduct roll out activities to the different municipalities and city. To be oriented are the Mayors, the Local Finance Committee and the SBs and SPs. HealthGov will provide continuous technical support in the actual roll out. Activities like write shop/policy crafting for program managers and legislators will be provided based on needs and request. This activity will be focus on the importance of local CSR response including the inclusion of CSR in the ELA.

4 Building a strong data bank

This TA involves the introduction of the CHLSS to the province as a tool for generating reliable information for planning, policy formulation means testing and others. An initial activity is to train trainers (CHDs, DOH Rep, PHIC, DSWD, Popcom) on the use of CHLSS tool. The pool of trainers conduct roll-out trainings and actual use of tools to the MLGUs (Health staffs and BHWs/BNS). The approach for the roll out will start with orientation and skills training on the use of survey tool. This will be followed by actual survey and data encoding of results. The data will be validated and used in workshops where trainees will be oriented on their utility for policy formulation and legislation.

5 CSR Assessment and Monitoring Tool

Parallel to all TAs will be the installation of an assessment and monitoring tool to track progress in CSR implementation. TAPs will train trainers on the use of CSRAM tool.

6 Establishment of TA provider for an LGU sustainable CSR response

TA providers for sustained LGU CSR response will be developed gradually. They are expected to be extensively engaged in the installation of a CSR monitoring tool, planning and other key CSR activities. Their involvement will provide the opportunity for ensuring their sustained interest to be involved in future CSR activities.

"Improving Health Governance in Zamboanga del Norte"

PROVINCE OF ZAMBOANGA DEL NORTE TECHNICAL ASSISTANCE PLAN

Background

Zamboanga del Norte is rich in both resources and culture. It also has a rich history. Despite these, it has the highest poverty incidence in the country, based on the 2003 NSO Income and Expenditure Survey. It has rich fishing grounds, has some of the best beaches in the country and has had its share of tourist arrivals. Despite these, the poverty has persisted.

Population	919,744
MMR	57.11
IMR	68
Crude birth	27.30
Crude death	6.15
Crude rate natural increase	21.16
Total fertility rate	3.52
Life expectancy at birth	
Male	65.40
Female	70.20
Number of Hospitals	16
Private	4
Government	11
Total bed Capacity 683	
Classification of Hospitals - Govt	
Tertiary	1
Secondary	2
Primary	8

Health situation

Zamboanga del Norte's MMR of 57.11/100,000 live births is lower than that of the regional MMR of 73.60/100,000 live births. Infant mortality rate (IMR) is 68/100,000 which is also lower than the national figure.

The CPR of the province stands at 57.11%. The pill users got the highest percentage among all other family planning users with 45.52. LAM got the highest figure from among the NFP methods with 14.04%. While there are many new acceptors on pills (25.57%), there are many women now who are also becoming interested in injectables (10.07%). TB case detection rate stand at 57% which is still very low compared to the national standard of 70% with TB case notification rate of also 57%.

MCH indicators are also very low as indicated by the following examples:

- Pregnant women with at least 3 antenatal visits attended by skilled attendants – 59.03%
- Pregnant women had at least 2 doses of tetanus toxoid immunization – 59.37%
- Pregnant women that have taken complete dose of iron supplementation – at least 6 months (reported after the 180 tablets) – 75.33%
- Postpartum Women given complete iron dosage 60 tablets – 52.11%
- Deliveries at health facilities – 20.56%
- Infants receiving DPT3 – 79.66%
- Children under five years of age with diarrhea given ORS – 19.89%

Other MCH indicators are comparatively high as compared with the other provinces in the peninsula but still low as compared with the desired performance/coverage.

- Deliveries attended by skilled workers – 93%
- Exclusive Breastfeeding up to 6 months – 90.03%
- Lactating Mothers given Vitamin A within 1 month after delivery – 79.9%
- Children under five years of age with pneumonia given antibiotics – 97.16%

The province has performed excellently however in encouraging postpartum women to have at least two visits to clinics for check up (101.5%). FIC is also high at 95% and more than 86% of eligible children aged 6-7 months were provided with vitamin A capsules over the last six months.

Considered the greatest health challenge is how the health service delivery systems can serve the poor more.

Health facilities and health insurance coverage

There are 16 hospitals in the province, five of which are privately owned while 11 are operated by the government. Of the eleven, 10 are operated by the provincial government, while one (1) tertiary hospital is under the DOH. Of the 10 provincial hospitals, eight (8) are primary while the two (2) are secondary hospitals.

The PHIC enrollment in 2006 was quite high at 49,594 households. The facility accreditation on the other hand is lagging behind. Only 12 are OPB accredited, only 1 is TB-DOTS accredited and none so far is accredited under the maternity care package.

Technical assistance for Year 2

1 Completion and finalization of the Investment Plans for Health
Technical assistance will be provided to the province to enable it to complete the province- wide investment plans for health. This will involve a series of activities leading to documentation of the municipal, ILHZ and provincial plans, their legitimization and integration into the PIPH. These will then be subject of review by DOH. This finalization process will be undertaken in close coordination with the DOH/CHD and the PHTOs. A component of this TA is the preparation of health systems development plans, focusing on health information systems, PIPH and CSR monitoring and the referral system.

2 Implementing the Province-Wide Systems.
These systems will be implemented both at the provincial and ILHZ levels. Doing this will strengthen the ILHZs. TA will be provided to enable the province to implement the systems development plans.

3 Laying the foundation for local CSR response
CSR Assessment and Monitoring Tool (consistent with new AO on CSR). The tool developed in region 10 will be utilized. PHO will organize a session in which the CSR monitoring tool will be introduced. The session will include the preparation of an action plan conduct province-wide monitoring activities. That session will be participated in by all MHOs, PHNs and DOH representatives. PHO, PHT, DOH representatives and MHOs will then conduct a province-wide monitoring from January to March, using the tool introduced. The results of the monitoring activity will be presented to LGUs and will be used as basis for preparing CSR plans.

HealthGov will facilitate the design of CSR monitoring and evaluation tools with CHD. The tools will be integrated into the IPH monitoring system. The design will include mechanisms to feedback information and analysis to LGUs, leagues of LGUs and the CSO/NGO.

4 Increasing LGU Financing For Health through Universal Coverage
This TA includes 1) formulating guidelines for planning and implementing universal health coverage; and 2) supporting the implementation of those guidelines.

PHO will develop a proposal on universal health coverage. It will contain projection of households by PHIC program groups, estimations (premium subsidies, reimbursements and capitation payments, investment requirements for accreditation) and expansion of IPP

enrollment and options for ensuring use of PHIC revenues for health at hospital and RHUs. LSI data results analysis will form part of the decision-making.

An operational plan will be outlined to ensure proximate "buy-in" by municipal LGUs, congressional representatives, ABC, PCL, LFC, civic organizations and the like. Under the guidance of the HealthGov and the CHD, the PHO will spearhead the negotiations efforts on the cost-sharing scheme.

5 TA on mobilizing broad-based local action to support health sector reform

Evidence-based legislation and policy-making. Regional partners will orient PLGU (Governor, vice governor, SP, LMP/MLCEs, CSOs) on EBL principles, MDG status, health economics, LCE role in HSR with technical backup from HealthGov. Using information generated through the HIS, key health issues and the need for policy and legislated responses to these issues, will presented before LMP meetings, SB/SP sessions, LHB meetings, LDC meetings, ABC meetings and other venues. This will be undertaken in close coordination with the CHD as well as the DILG which has a module on legislation. CSOs and NGOs will be mobilized to champion the formulation of critical policies and legislation.

The TA will also introduce policy tracking mechanisms especially to NGOs and CSOs engaged in local health advocacy work.

To strengthen CSO and NGO capability in advocacy work, the TA will include trainings and orientation on the design, planning and execution of campaigns advocating for reforms in the local health sector and the passage of policies and legislation to improve health service delivery.

"***Improving the health governance in Zamboanga Sibugay"***

PROVINCE OF ZAMBOANGA SIBUGAY TECHNICAL ASSISTANCE PLAN

Background

Zamboanga Sibugay is among the country's newly created provinces with Ipil as the capital. It has a total land area of 3,228.3 km² comprising 16 municipalities with 389 barangays and 1 congressional district. The estimated population in 2006 is 556,744 with 92,791 households. It is ranked 29th among the provinces of the Philippines in terms of both population and population density with population growth rate 2.09%.

Vital statistics	
Population	556,744
No. of barangays	389
No. of BHS	110
No. of HH	92,791
No. of RHUs/MHC	16
No. of hospitals	
Government	4
Private	11
Doctor	16
Nurse	24
Dentist	9
Medical Technologist	12
Sanitation Inspector	17
Active BHW	1114
Dental AIDE	4
Trained birth attendants	546
No. of LB	10,500
Male	5,400
Female	5,100
Birth weight	
>2500 gms	9817
<2500 gms	471
Unknown	212
Deliveries attended	
Doctor	648
Nurse	137
Midwife	4,329
Hilots	
Trained	4529
Untrained	833
Others	24

Overview of the provincial health situation

Zamboanga Sibugay has a crude birth rate (CBR) and crude death rate (CDR) of 18.86/1,000 population and 20.18/1,000 population respectively. Both are lower than the regional CBR of 20.18/1,000 population and CDR of 3.31 population.

The 2006 provincial maternal mortality rate of 57.14/100,000 live births (LB) is much lower than the regional MMR of 73.60/100,000/LB. The maternal health output indicators such as 3 or more ante-natal visits, birth attendance by skilled health workers and place of delivery are much lower than the program performance standards.

The infant and under-five mortality rates are 4.48/1,000 LB and 7.33/1,000 LB respectively which are much lower than the regional figures of 8.78 and 12.46 respectively. The province's FIC of 83.67% which is lower than the performance standard of 95%.

Challenges and opportunities

Of the sixteen municipal mayors, only four supported the Governor during the 2006 election. Support for the PIPH by the municipal LCE is critical. The challenge is how to bring about this cooperation. Zamboanga Sibugay is a newly created province. Installation and strengthening of the local health system is need.

The conditions set by DOH and F1 donors to LGUs revolve around PHIC universal coverage. HealthGov can provide TA to LGUs to meet the criteria.

Summary of technical assistance provided in Year 1

HealthGov provided technical assistance to CHD 9 to develop tools to formulate the PIPH. The CHD has become a TA provider to the province. Subsequent TAs to the municipalities and ILHZ

were conducted by the provincial and sub-provincial teams which were organized and supervised by the PHO.

The province is already well ahead in terms of preparing the PIPH. Activities conducted include orientation of the LGUs where the mandate to plan was given both by the provincial governor and mayors.

Remaining tasks include conduct of internal technical review, consolidation of plans including the provincial level plan, facility mapping, formulating the annual operational plan and province-wide health systems plan.

Technical assistance proposed for Year 2

1 Completion and finalization of the Investment Plans for Health

Technical assistance will be provided to the province to enable it to complete the province- wide investment plans for health. This will involve a series of activities leading to documentation of the municipal, ILHZ and provincial plans, their legitimization and integration into the PIPH. These will then be subject of review by the DOH. This finalization process will be undertaken in close coordination with the DOH/CHD and the PHTOs. A component of this TA is the preparation of health systems development plans, focusing on health information systems, PIPH and CSR monitoring and the referral system.

2 Implementing the province-wide systems

Implementation of these TAs will be done not only at the provincial but more so at the ILHZ level. This TA involves the implementation of a monitoring tool to track progress in PIPH implementation, strengthening the province's health information system to support legislation, monitoring, policy reform and advocacy, strengthening the referral system.

3 Laying the foundation for local CSR response

PHO will organize a session in which the CSR monitoring tool will be introduced. That tool will be consistent with the new AO on CSR. The session will include the preparation of an action plan conduct province-wide monitoring activities. That session will be participated in by all MHOs, PHNs and DOH representatives. PHO, PHT, DOH representatives and MHOs will then conduct a province-wide monitoring from January to March, using the tool introduced. The results of the monitoring activity will be presented to LGUs and will be used as basis for preparing CSR plans.

HealthGov will facilitate the design of CSR monitoring and evaluation tools with CHD. The tools will be integrated into the IPH monitoring system. The design will include mechanisms to feedback information and analysis to LGUs, leagues of LGUs and the CSO/NGO.

4 Increasing LGU financing for health through universal coverage

This TA includes the provision of guidance in planning for universal health coverage using PHIC standards and methods, the introduction of tools and systems to hasten accreditation of health facilities and proper use of capitation funds, and the introduction of tools and systems for the proper identification of the poor, to minimize leakage.

5 TA for mobilizing broad-based local action to support health sector reform

Regional partners will orient PLGU (Governor, vice governor, SP, LMP/MLCEs, CSOs) on EBL principles, MDG status, health economics, LCE role in HSR with technical backup from HealthGov. Using information generated through the HIS, key health issues and the need for

policy and legislated responses to these issues, will presented before LMP meetings, SB/SP sessions, LHB meetings, LDC meetings, ABC meetings and other venues. This will be undertaken in close coordination with the CHD as well as the DILG which has a module on legislation. CSOs and NGOs will be mobilized to champion the formulation of critical policies and legislation.

The TA will also introduce policy tracking mechanisms especially to NGOs and CSOs engaged in local health advocacy work.

To strengthen CSO and NGO capability in advocacy work, the TA will include trainings and orientation on the design, planning and execution of campaigns advocating for reforms in the local health sector and the passage of policies and legislation to improve health service delivery.

"Improving health governance in Zamboanga del Sur"

PROVINCE OF ZAMBOANGA DEL SUR TECHNICAL ASSISTANCE PLAN

Background

Zamboanga del Sur has some of the oldest settlements in the country. It is rich in history and culture. It has the potential of being one of the major tourist destinations of the country, if not for the challenges in peace and order. It has a total land area of 473,491 hectares and is composed of 26 municipalities, 1 component city (Pagadian City) and 687 barangays.

Overview of the provincial health situation

Zamboanga del Sur's 2006 MMR of 73.69/100,000 LB is higher than the region's while its IMR and UFMR are lower. The province' program performance or coverage on FP, TB, EPI and nutrition are below the national standards.

In 2006, it had a Crude Birth Rate of 20/1,000 population which approximates the regional CBR of 20.18/1,000 population. The Crude Death Rate is 2.74/1,000 population which is lower than the regional Crude Death Rate of 3.31/1,000 population.

Interestingly for FP, the figure on the current users for pills (which stands at 41% in 2005) is overshadowed by the current acceptors of LAM at 65% (previously 12%). One of the disturbing figures is on Diarrhea. FHSIS shows that only 15% of children under 5 years with Diarrhea are given Oral Re-hydration Solution. MCH indicators reflect poor performance:

- Pregnant women with at least 3 antenatal visits attended by skilled attendants – 68%.
- Pregnant women had at least 2 doses of tetanus toxoid immunization – 63%
- Pregnant women that have taken complete dose of iron supplementation – at least 6 months (reported after the 180 tablets) – 47%
- Lactating Mothers given Vitamin A within 1 month after delivery – 61%
- Pospartum Women given complete iron dosage 60 tablets – 47%

Health facilities and providers

There are only 163 BHS with only 159 midwives in the province. All municipalities have RHUs/MHCs. However, only 11 out of 26 RHUs are SS certified. Five RHUs are without doctors, six are without medical technologists while two have no nurse and dentist. There are 891 trained birth attendants in the province. More than 50% of the deliveries are attended by hilots, some of them untrained. The rest are attended to by professionals, mostly by midwives. Only 9 out of 26 RHUs are accredited for OPB, 3 for MCP and none for TB-DOTS.

Only 24,864 households (17%) are enrolled in the indigency program. The municipal LGUs provided premium payments to 21,727 HH, while the provincial LGU covered 3,137 HH.

Situational analysis

Service Delivery

- Poor health seeking behavior of consumers compounded by problems of accessibility, lack of information, socio-cultural barriers and poverty.

- Inadequate supplies, medicines and equipment and lack of support to health personnel in terms of mobility, salary, incentives, training (especially for newly-hired), supervision and career advancements.
- Problem on how to identify the poor
- Problem on providers of NSV and BTL
- Problems on delayed procurement and distribution of logistics

Regulation
- No protocol on maternal care.
- No TB-DOTS facility is PHIC-accredited, only 6/26 are OPB and 3/36 are MCP accredited and there are birthing home licensing problems.

Financing
- LGUs are IRA dependent. Insufficient budget for medicines, supplies, logistics, TEVs, equipment, facility and skills upgrading and personnel incentives
- PHIC enrollment (with capitation) very low

Governance
- Stakeholder participation is low.
- Health data/information is not utilized for governance.
- Maternal death reviews and PIR have stopped.
- Provincial CSR policy guidelines already approved but budget not released.
- Many municipalities have no budget for FP commodities.
- Inter-LGU monitoring on EPI and inter-LGU surveillance is not fully implemented.
- ILHZs do not have the full support of LCEs.

In addition, there are systems-related gaps and political challenges observed. Below are some highlights:
- The number of LGUs that increased budget for Health is declining. Budgets are simply recycled and there is no systematic way of identifying priority and strategic areas for health investments, exploring alternative means of financing and sourcing funds, and rationalizing internal LGU resources
- Most of the CSR activities did not gain local level support and were not implemented.
- The HIS is saddled with gaps. There are issues on accuracy, under-reporting, delay and most especially under-utilization by the LGUs.
- There are few ordinances, resolutions and executive orders on health.

Other challenges/opportunities
- The potential of the leagues (e.g. LMP, PCL) as a powerful collegial body to champion public health is neither recognized nor harnessed. Currently, the LMP chair is the son of the provincial governor.
- CSO and community participation in decision-making is not institutionalized at all levels. The content and the processes by which pieces of legislations are identified and developed manifest a lack of community perspective. There are CSO representatives in the local special bodies but their participation in local governance needs to be enhanced.
- The conditions set by DOH and F1 donors to LGUs revolve around PHIC universal coverage. HealthGov will provide TA to LGUs to enable them to meet the criteria.

Summary of technical assistance provided in Year 1

HealthGov assisted in the development of the PIPH. In the process it has equipped the CHD to be become a TA provider. Subsequent TAs to the municipalities and ILHZ were provided by the provincial and sub-provincial teams.

The province is already well ahead in terms of preparing the PIPH. Remaining tasks include conduct of internal technical review, consolidation of plans including the provincial level plan, facility mapping, AOP 2008 and province-wide health systems plan.

Technical assistance for Year 2

1 Completion and finalization of the Investment Plans for Health

Technical assistance will be provided to the province to enable it to complete the province- wide investment plans for health. This will involve a series of activities leading to documentation of the municipal, ILHZ and provincial plans, their legitimization and integration into the PIPH. These will then be subject of review by the DOH. This finalization process will be undertaken in close coordination with the DOH/CHD and the PHTOs. A component of this TA is the preparation of health systems development plans, focusing on health information systems, PIPH and CSR monitoring and the referral system.

2 Implementing the Province-Wide Systems

Implementation of these TAs will be done not only at the provincial but more so at the ILHZ level. This TA involves the implementation of a monitoring tool to track progress in PIPH implementation, strengthening the province's health information system to support legislation, monitoring, policy reform and advocacy, strengthening the referral system.

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PHO will organize a session in which the CSR monitoring tool will be introduced. That tool will be consistent with the new AO on CSR. The session will include the preparation of an action plan conduct province-wide monitoring activities. That session will be participated in by all MHOs, PHNs and DOH representatives. PHO, PHT, DOH representatives and MHOs will then conduct a province-wide monitoring from January to March, using the tool introduced. The results of the monitoring activity will be presented to LGUs and will be used as basis for preparing CSR plans.

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To strengthen CSO and NGO capability in advocacy work, the TA will include trainings and orientation on the design, planning and execution of campaigns advocating for reforms in the local health sector and the passage of policies and legislation to improve health service delivery.

Annex 3

TIMELINES, MILESTONES, AND RESOURCES

HealthGov Performance Targets: October 2006 - September 2008

Notes: NA = Not Applicable, either because the activity measured by the indicator has not yet started or the indicator is not relevant at that LGU level

TBD = To be determined, number will be set by the end of the 2nd Quarter of FY08

Indicator Code	Indicator/Sub-Indicator	Baseline		Targets Year 1 (FY07)		Targets Year 2 (FY08)	
		Prov (2006)	Cities/Mun (2007)	Prov	Cities/Mun	Prov	Cities/Mun
		23	*536*	*23*	*536*	*23*	*536*
IR1.1 Strengthening key LGU Management Syustems to sustain delivery of selected services							
1.1A # of LGUs with health sector investment plan							
a.	# of LGUs with any health sector investment plan as of the current year	20	TBD	20	NA	23	TBD
b.	# of LGUs with province-wide Investment Plan for Health (PIPH) as of the current year	5	NA	5	NA	12	NA
c.	# of LGUs with PIPH Implementation Plan as of the current year	5	NA	5	NA	6	NA
d.	# of LGUs with PhilHealth Universal Coverage Plan as of the current year	NA	TBD	NA	NA	NA	TBD
e1.	Province has CSR Plans of component LGUs as of the current year	15	NA	15	NA	18	NA
e2.	Province has Annual Investment Plans of component LGUs as of the current year	12	NA	13	NA	23	NA
e3.	Province has PhilHealth Universal Coverage Plans of component LGUs as of the current year	13	NA	13	NA	18	NA
1.1B # of LGUs with improved health information system							
a.	# of provinces with at least 75% of component LGUs that submitted the last FHSIS quarterly report of the current year on time	7	NA	9	NA	9	NA
b.	# of provinces with an average delay of less than 2 weeks in the submission of the last FHSIS quarterly reports of the current year by component LGUs	10	NA	10	NA	10	NA
c.	# of component LGUs that submitted the last FHSIS quarterly report of the current year on time to the PHO	NA	TBD	NA	NA	NA	TBD
d.	# of LGUs that have ever conducted CBMS or CB Health and Living Standard Information Survey as of the current year	8	TBD	8	NA	10	TBD
1.1C # of health-related ordinances, resolutions, and executive orders issued (Cumulative)							
a.	# of health-related ordinances, resolutions, and executive orders passed as of the current year by the LGUs (Baseline data refers to those passed from 2004 to 2006; baseline for provinces refers to # in only 18 provinces)	109	TBD	NA	NA	144	TBD
b.	# of health-related ordinances, resolutions, and executive orders implemented as of the current year by the LGUs (Baseline data refers to those implemented from 2004 to 2006; baseline for provinces refers to # in only 13 provinces)	96	TBD	NA	NA	131	TBD
1.1D # of LGUs with a procurement and distribution system for essential drugs and commodities							
a.	# of LGUs that have procured EDC on time during the current year (whether the actual procurement was done as scheduled in the APP)	9	TBD	NA	NA	9	TBD
b.	# of LGUs that have procured adequate quantities of EDC during the current year (whether the planned EDC quantities were actually procured	12	TBD	NA	NA	12	TBD
c.	# of LGUs that have distributed EDC to all health facilities on time during the current year (according to the distribution schedule or plan, whether quarterly or semestral)	9	TBD	NA	NA	9	TBD

Indicator Code	Indicator/Sub-Indicator	Baseline		Targets Year 1 (FY07)		Targets Year 2 (FY08)	
		Prov (2006)	Cities/Mun (2007)	Prov	Cities/Mun	Prov	Cities/Mun
		23	*536*	*23*	*536*	*23*	*536*
1.1E	**# of LGUs with functioning ILHZs**						
a.	# of provinces with established Inter-local Health Zones as of the current year (Cumulative)	20	NA	20	NA	20	NA
b.	# of LGUs which are members of ILHZ (Cumulative)	NA	TBD	NA	NA	NA	TBD
c.	# of provinces with at least 50% of ILHZ-member LGUs contributing resources for undertaking zonal health activities during the year	12	NA	NA	NA	14	NA
d.	# of ILHZ-member LGUs contributing resources for undertaking zonal health activities during the year	NA	TBD	NA	NA	NA	TBD
e.	# of provinces with at least 75% of ILHZ meeting regularly during the year	8	NA	8	NA	10	NA
f.	# of ILHZ-member LGUs attending ILHZ meetings regularly during the year	NA	TBD	NA	NA	NA	TBD
1.1F	**# of Technical assistance providers engaged to provide TA to LGUs (Cumulative)**						
a.	# of TAPs (represented by # of persons) providing technical assistance to the LGUs	0	NA	100	NA	250	NA
IR1.2	***Improving and expanding LGU financing for key health services***						
1.2A	**# of LGUs that increased the share of their health budget over total LGU budget**						
a.	# of LGUs that increased the share of their annual health budget over total annual LGU budget (Baseline: between 2006 and 2007 for provinces and between 2007 and 2008 for mun/cities)	10	TBD	10	NA	15	TBD
1.2B	**# of LGUs that support health programs and activities from the 20% Development Fund**						
a.	# of LGUs that support health programs and activities from the 20% Development Fund during the year	21	TBD	21	NA	23	TBD
b.	Total amount of allocation from the 20% Development Fund during the current year	P367 million	TBD	P378 million	NA	P389 million	TBD
c.	# of LGUs that have increased allocation from the 20% Development Fund over the previous year	15	TBD	15	NA	20	TBD
1.2C	**Amount (in pesos) of in-country public financial resources budgeted for FP-RH in project LGUs**						
a.	Total amount budgeted for FP-RH by the LGUs during the current year (Baseline is for 20 provinces only)	P13.09 million	TBD	P13.09 million	NA	P13.74 million	TBD
1.2D	**# of LGU health facilities accredited and receiving PHIC reimbursements (Cumulative)**						
a.	Total # of LGU health facilities accredited and receiving reimbursements for Outpatient Benefits	372	NA	372	NA	384	NA
b.	Total # of LGU health facilities accredited and receiving reimbursements for TB DOTS	131	NA	131	NA	143	NA
c.	Total # of LGU health facilities accredited and receiving reimbursements for Maternity Package	65	NA	65	NA	77	NA

Indicator Code	Indicator/Sub-Indicator	Baseline		Targets Year 1 (FY07)		Targets Year 2 (FY08)	
		Prov (2006)	Cities/Mun (2007)	Prov	Cities/Mun	Prov	Cities/Mun
		23	*536*	*23*	*536*	*23*	*536*
1.2E	**# of LGUs availing of loans or grants for health activities in 2006**						
a.	# of LGUs that have availed of loans/borrowings for health activities (e.g., LOGOFIND, JBIC, ETC.) during the year	7	TBD	NA	NA	9	TBD
b.	# of LGUs that have secured any form of grants (e.g., WB, ADB, UN, GTZ, etc.) for health activities during the year	5	TBD	NA	NA	12	TBD
1.2F	**# of LGUs which have completed market segmentation as a basis for introducing user fees (Cumulative)**						
a.	# of LGUs adopting a scheme to identify the poor as basis for introducing user fees for non-poor as of the current year	NA	282	NA	NA	NA	294
1.2G	**# of LGUs employing user fees for non-FP services (cumulative)**						
a.	# of LGUs charging user fees for TB services as of the current year	NA	46	NA	NA	NA	268
b.	# of LGUs charging user fees for MCH services as of the current year	NA	73	NA	NA	NA	268
c.	# of LGUs charging user fees for HIV/AIDS/STI services as of the current year	NA	59	NA	NA	NA	268
d.	# of LGUs charging user fees for services involving other infectious diseases as of the current year	NA	39	NA	NA	NA	268
1.2H	**# of LGUs using revolving funds for some aspects of their health services (Cumulative)**						
a.	# of LGUs using revolving funds as of the current year	10	TBD	10	NA	12	TBD
b.	# of LGUs using trust funds as of the current year	13	TBD	13	NA	16	TBD
IR1.3	***Improving service provider performance***						
1.3A	**# of LGUs paying directly for service provider training (Cumulative)**						
a.	# of LGUs paying directly for service provider training as of the current year	3	TBD	3	NA	6	TBD
1.3B	**# of LGUs with recognition and rewards system for health service providers (Cumulative)**						
a.	# of LGUs with recognition and rewards system for health service providers as of the current year	15	TBD	15	NA	18	TBD
1.3C	**# of LGUs with service delivery quality improvement system (LGU conducting SDExH)**						
a.	# of provinces that have conducted SDExH during the year	0	NA	0	NA	8	NA
b.	# of LGUs that have participated in SDExH during the year	NA	0	NA	NA	NA	240
1.3D	**# of LGUs conducting an annual Service Delivery Implementation Review**						
a.	# of provinces that have conducted enhanced PIR using SDIR tool during the year	0	0	20	NA	23	NA
b.	# of LGUs that have participated in the conduct of enhanced PIR using SDIR tool during the year	0	0	20	NA	23	TBD
1.3E	**# of LGUs with monitoring system for informed choice and voluntarism compliance (cumulative)**						
a.	# of LGUs that have been conducting monitoring and reporting compliance on FP informed choice and voluntarism (ICV) as of the current year	2	47	2	NA	23	268

Indicator Code	Indicator/Sub-Indicator	Baseline		Targets Year 1 (FY07)		Targets Year 2 (FY08)	
		Prov (2006)	Cities/Mun (2007)	Prov	Cities/Mun	Prov	Cities/Mun
		23	*536*	*23*	*536*	*23*	*536*
	IR1.4 Increasing advocacy on service delivery and financing						
	1.4A # of LGUs where public hearings in aid of legislation for health sector issues have been held						
	a. # of LGUs where public hearings on the PIPH or any health sector plan have been conducted by the Sanggunian and/or other LGU officials in several parts of the LGUs during the year	5	TBD	5	NA	12	83
	1.4B # of LGUs in which Local Chief Executives publicly promote the value of improved public health						
	a. # of LGUs in which LCEs have ever delivered a public speech focused on health in a public forum during the year (Baseline: During the last term 2004-2007 of the LCEs)	14	TBD	NA	NA	15	55
	b. # of LGUs in which LCEs has ever announced in public any plan of increasing funding for health during the year (Baseline: During the last term 2004-2007 of the LCEs)	18	TBD	NA	NA	19	55
	c. LCE has ever announced the enrolment of indigents in Philhealth insurance as his health governance focus during the year (Baseline: During the last term 2004-2007 of the LCEs)	17	TBD	NA	NA	18	276
	1.4C # of LGUs showing evidence of community input to health-related deliberations at the local level (Cumulative)						
	a. # of LGUs where community groups, NGOs and civil society organizations (CSOs) are represented in a functional Health Board and or other special body as of the current year	19	TBD	NA	NA	23	TBD
	b. # of LGUs where community groups, NGOs and CSOs have ever participated in public hearings on health	9	TBD	NA	NA	12	TBD
	1.4D # of municipalities/ cities providing inputs to health sector program or budget deliberations at provincial level						
	a. Number of LGUs that have ever provided inputs to province-wide health sector program or budget deliberations as of the current year	NA	225	NA	NA	NA	375
	1.4E # of favorable positions taken by the leagues on public health issues						
	a. Number of position papers or resolutions prepared by the Leagues during the year	7	NA	NA	NA	23	NA

Annex 4

Provincial Technical Assistance Plans

Luzon

Achieving Universal PhilHealth Coverage

PROVINCE OF ALBAY TECHNICAL ASSISTANCE PLAN

Background

Albay is one of the provinces of the Bicol Region (Region V) and is situated in the southernmost tip of the Luzon landmass. It has a total land area of roughly 3,053.45 sq. km. It is politically subdivided into 3 cities, 15 municipalities and 720 barangays. It has also 3 congressional districts.

Albay has a great potential for development because of favorable agro-climatic conditions for crops and animal production, tourist attractions and presence of geothermal power along with various transportation and communication facilities. It is also situated at the hub of the other six provinces of Bicol and the gateway to the Visayas. However, Albay is prone to natural and man-made disasters such as volcanic eruptions, typhoons, floods and epidemics. Health is, thus, a major concern.

Demographic Profile

Population	1,234,213
Population Density	484 persons per sq. km
Population Annual Growth Rate	1.7 per 1,000 population
Political Subdivision:	3 Congressional Districts
	18 Municipalities + 3 Cities and 720 Barangays
Poverty Rate (2004)	34

The Provincial Health Office of Albay envisions a healthy Albayanos served by happy health workers and apolitical leaders, living in a progressive, peaceful, clean and green tourism province provided with updates modern means of transportation and communication. This vision is propped by the vision pillars of the provincial government, to wit:

- healthy and responsive environments
- adequate funds for health
- proactive political leaders
- prioritization of health programs
- networking and people empowerment

Its mission is to provide integrated, comprehensive, sustained quality health care to all Albayanos with bias to the poor.

Health Program

The province has an estimated population of 1,234,213. This is 1.7% increase over the estimated population of 2006. Albay has a young population but an increasing number of the elderly is expected due to the rising trend in life expectancy since the 1995 census. The general life expectancy at birth is 69.2. The population density is 484 persons per sq. km. It has an average annual growth rate of 1.7 per 1,000.

In 2006, there were 5,226 deaths or a crude death rate of 5.04 per 1,000 population. Further there was a recorded of 11 maternal deaths or 0.50 per 1,000 live births. The common causes were post-partum hermorrhages, eclampsia, retained placenta and ectopic pregnancy. There were also a total of 216 infant deaths representing an infant mortality rate of 11.84 per 1,000 livebirths. The common causes were pneumonia, septicemia, acute respiratory distress syndrome and prematurity.

Most of the leading causes of morbidity are communicable diseases – respiratory and gastro-intestinal related infections. Deaths were mainly due to respiratory disorders and non-communicable diseases related to lifestyles.

Health concerns remain to be on infectious diseases caused by viral, bacterial and protozoan micro-organisms. Some are endemic like TB and rabies. There were 16 epidemics recorded in 2006.

Health programs for the most vulnerable sector of the population (63% women and 78% children) were implemented throughout the province. There was 20% prevalence rate of malnutrition in 2006. These malnourished children were mostly found in Manito, Libon, and Malilipot which registered a higher number of malnourished children compared to the other barangays and municipalities. The coverage for immunization measured as fully immunized children (FI) has decreased by 16%. The decrease is attributed to the decrease in the amount of commodities sent to the province in the light of its phase-down reduction.

For non-communicable diseases like hypertension and diabetes mellitus, the Healthy Lifestyle Program is being implemented by the LGUs.

The province's plan for 2007 is focused mostly in areas of major concern like immunization, nutrition, control of diarrheal disease and environmental sanitation which includes concern for safe water availability and sanitary toilet construction especially in 187,839 households. Other concerns are treatment of diseases, disease surveillance, psychosocial stress debriefing and health facilities rehabilitation. All these are geared toward addressing the minimum response to be made available especially in times of disasters including epidemics.

Also, with the rapid growth in population, an effective delivery of primary health care services should be provided to the people. The local governments then have to consider the prioritization of investing in health since health services have been lodged to the local government units.

Along with it, there is a need to allocate additional budget for manpower, infrastructure, medicines and equipment. Likewise, there is a need to strengthen IEC and advocacy in all aspects of health. Strong political will as well as strong commitment and support to health by the provincial, municipal and barangay officials are needed to attain the vision of "Health for the Albayanos".

Situation Analysis

The performance of health service delivery in the province has not been very satisfactory as revealed by the updates shown above. The strong typhoons that ravaged Albay towards the end of 2006, not only brought physical damages to properties, but also brought disastrous effects to the health condition of the people. The lack of financial support by LGUs to health as well as the poor coordination among LGUs not only hinder a better delivery performance of health programs, it also impact on weakening the capacity of health service providers to facilitate the achievement of better health outcomes for the province.

The succeeding data and information gathered by the HealthGov through its scoping missions to the province, reveal the status of LGU's health governance, budget and financial systems. Understanding them will help understand and clarify the province's existing health situation.

Health Plans

The LGUs, both provincial and municipal levels while all craft their investment plans for health, these are short-term and individually formulated by LGUs. This means, that health investments plans of MLGU are not inputted into the province's investment plan for health. Moreover, budget for health is largely taken from the LGUs respective IRA allocation only. Efforts to raise funds for health, like improving fiscal management through collection of user fee charges, maximization of funding assistance from donor agencies have not been taken as a fund-raising measure for health. This would explain the low budget allocated for the health sector.

On the coordination, organizational and political aspects, the province has a new governor in the person of Gov. Joey Salceda who has already expressed support to pursue health sector reform by developing catalytic institutions which he said will help improve the capacity of the province to respond to the health needs of the people. Along this line, he will be giving clear mandate to the PHOs, MHOs and the municipal LGUs to already craft the provincial investment plan for health (PIPH). The planning exercise is expected to come out with the zonal and province-wide health investment plan taken from the municipal-level health investment plan.

Financing for Health

Likewise, not all LGUs get to receive PHIC reimbursements which could be a good source of income for LGUs. This is because some LGUs do not comply with the accreditation requirement of the PHIC. This reimbursement from the PHIC is one measure by which LGUs can earn to support health care.

The dismal funds earmarked for health likewise disable the health sector to enhance skills of health service providers or provide for their benefits like the Magna Carta for Health. Moreover, regulation and/or improvement of RHUs health facilities to meet people's health care requirement cannot be provided support, e.g., SS certification, TB DOTS accreditation, etc. The lack of attention given to facilities' improvement also contributes to poor health service delivery.

Ordinances and Resolutions

In addition, there is also lack of legislative support given to health related concerns which could have very well strengthened or supported the implementation of health programs.

Health Information System

Furthermore, the provinces health information system suffers from poor submission of reports which could have served as basis for drawing out information and strategies to improve health service delivery.

Procurement and Distribution

On procurement of essential drugs and commodities, while it passes through the Bids and Award Committee, distribution still remains a problem due to unavailability of vehicles. With it as the problem, sometimes drugs and commodities are distributed on a per program basis.

Service Delivery

The province has 3 inter-local health zones, namely the FIRST AID for District I, CRADLEMAN for District II, and JOLLIPPOGUI for District III. ILHZs I and III are functional in the sense that the Technical Committees are meeting regularly. Meanwhile, ILHZ I has been nominated recently to compete in the regional search for best ILHZ while ILHZ II is newly formed.

Advocacy

Meanwhile, health advocacy and IEC initiatives in the province are only replications from the DOH central office. No localized advocacies have been launched so far.

On conduct of public hearings on health sector issues so far, only one LGU was reported to have conducted a public hearing on a health-related issue, but specific only to the banning of smoking in public areas. On public officials discussing health-related issues, smoking, selling of condoms in commercial establishments and passing of resolutions on HIV-AIDS, and the promotion of the value of improved public health by LCEs are among those that have been tackled.

NGO/CSO Participation

As far as CSO and NGO participation is concerned, grassroots civil society organizations and NGOs while accredited they are not represented in the local health board. NGOs and POs in the province have been playing significant roles in community development and addressing the many issues confronting the basic sectors, and one of which is health. At present, there is an existing regional alliance of NGOs and POs whose focus is on reproductive health, the BIRHA, which is headed by the MIDAS. However, while such groups exist in the province, sad to say, they are not represented in the local decision-making mechanisms of LGUs, e.g. provincial health board, local development council. Some, however, are represented in special bodies in the municipal LGUs where they operate.

Recent developments, however, already see some of these grassroots civil society groups like the MIDAS, ASCODE, BIRHA, COPE seeking renewal of their accreditation and have already

expressed with the DILG their intention to seek representation in the local health board. This came out as a result of the HealthGov's initiatives to mobilize the participation of CSOs/NGOs in the local health governance. NGOs headed by MIDAS, the appointed lead convenor for CSOs/NGOs for HealthGov, have already sat down with the provincial health officer to discuss preparation for a partnership forum. In preparation for this event, the NGOs will be coming up with their health agenda which they will work to incorporate in the PLGUs health and development plan.

The partnership forum between the PLGU and NGOs/CSO will happen on September 11-12 or after the PIPH planning workshop. This would mean that NGOs will not be able to participate meaningfully in the PIPH formulation. Meaning, their intention of integrating the NGOs/CSOs common health agenda into the LGUs may not be achieved but only their respective individual agenda as some of them will be involved in the PIPH planning workshop on Aug 28-30 and September 3-5.

Technical Assistance in Year 1

The province received TA from HealthGov in Year 1 through the provision of advocacy support to the new governor of the province and MHOs on HSR, SDIR and PIPH. In the orientation to LCEs on HSR and PIPH, the governor sealed a covenant with the Mayors expressing their commitment to formulate their investment plan for health which shall be consolidated into a province-wide investment plan for health. In preparation for the SDIR/PIPH planning process, HealthGov provided capacity building activities on the conduct of data-gathering for SDIR and PIPH facilitation to the PHO's program coordinators and DOH reps who will be facilitating the PIPH process.

The forthcoming investment planning for health would be the first time that will be conducted through a participatory process and the timeline more strategic. The existing practice of LGUs is to come up with a plan based on an allocated annual budget. The process is likewise not participative, and does not involve other stakeholders. The MIPH/PIPH planning workshop that will be conducted in two batches on August 28-30 and September 3-5 is also expected to come out with a Zonal and Province-Wide Plans in accordance to ILHZ and the province's perspectives, respectively.

Technical Assistance for Year 2

The HealthGov's technical assistance for the province for year 2 will take off from the soon-to-be-formulated MIPH/Zonal and Province-Wide Investment Plan for Health. However, as an entry point, HG will anchor on the new governor's topmost health agenda which is the universal coverage of the Albayano's for PhilHealth insurance. In his speech before the mayors on August 21, 2007, the governor urged the local chief executives present to invest in health. He challenged them to co-share with the provincial government in order to effect the universal coverage for Philhealth insurance in Albay. To achieve this, the province he said would be needing 32M. The governor asked the LCEs to shoulder half of the amount as he already earmarked 16M from the provincial budget to support this goal.

By pursuing this as the approach for Albay, HG will even more get strong backing from the governor. In addition, if supported with strong advocacy support towards enlightening municipal chief executives on the capitation funds as one revenue-generating measure, this will be an effective motivational factor for them to enroll as many of their constituents to PhilHealth insurance, improve their RHU facilities and service delivery systems and be able to provide

quality health care services to their clients. Also, coupled with advocacy towards improving the health-seeking behavior of clients, these initiatives will pave the way towards the achieving the goal of effecting better health outcomes for the people of Albay.

Meanwhile, within HealthGov perspective, the outcomes of these interventions would also directly respond to significant or relevant HG and OP indicators that correspond to the aspects of governance, financing, regulation and service delivery.

Hence, with this as the perspective of HG for Albay, the theme "Achieving Universal Coverage for PhilHealth Insurance" will be adopted.

HealthGov's TA in Year 2 will therefore focus on the following:

1. Social Preparation and Capacity Building of Partners

Objective:

This is aimed at leveling with partners and getting them to act together with us towards pursuing the goal of the TA plan for the province. In doing so, HG will prepare and assist partners strengthen their capacity to rally RHUs/MHOs and mobilize them towards achieving universal PhilHealth coverage as approach to enhance public health service delivery.

HG interventions are designed to develop/enhance the capacity of partners, specifically the DOH-CHD and PHO to sustainably provide the necessary technical assistance requirements in the pursuit of the theme and its related TA needs.

Mode of Intervention

In pursuit of these objectives, consultations and orientation meetings with the DOH-CDH and PHO will be organized to level-off, plan out how the objectives of TA plan will be carried out and identify gaps and concerns of partners relative to how critical interventions will be carried out. In response to this, capacity-building activities will therefore be provided.

Technical Assistance

In view of the above, HG's technical assistance would be toward:

- Clarifying with the DOH-CHD and PHO the pursuit of the universal coverage for PhilHealth insurance as one approach to rally LCEs to improve, strengthen and revitalize health service delivery.
- determining issues and gaps that hinder the implementation/availment of universal coverage for PhilHealth insurance, at the same time assessing capacity needs of partners to respond to them.
- developing/enhancing the technical capacities of partners to carry out the technical requirements for TA implementation.

Critical Activities

The following activities will be required to carry out the TA:

- Consultative meetings with DOH-CHD, PHO, and PHIC re pursuit of or adoption of universal PhilHealth insurance coverage as approach to revitalize and improve public health service delivery in the province. One agenda that may also be taken up in the meetings is the reactivation of the provincial health board or the Albay Composite Team (ACT) which should also include other stakeholders like the CSOs/NGOs

- Planning with DOH-CHD and PHO (or the ACT) re PhilHealth universal coverage implementation. The plan should address the following aspects:

  a. Social marketing to LCEs of the concept of universal PhilHealth coverage (UPHC) or investing in health
  b. TA identification and planning vis-à-vis UPHC
  c. Assessment and accreditation of RHU facilities to SS and PHIC
  d. Capacity-building needs of the entire TA package for universal PhilHealth coverage

- Conduct of TNA of DOH-CHD and PHO's concerned technical team

- Capacity Building
  - training on the technical aspects like tools development, survey, market segmentation, projection of households by PHIC groups, estimation of premium subsidies, estimation on reimbursements and capitation payments, estimation of investment requirements for accreditation and expansion of IPP enrolments, options for ensuring use of PHIC revenues for health at hospitals and RHUs, etc.

  - training on use and implementation of tools (e.g. TNA on core competencies of service providers, tools for supervision and monitoring of service delivery, etc)

  - training on procurement, communication planning and advocacy, facilitation and process documentation

2. TA Plan Implementation for Universal PhilHealth coverage

Objective

The first year of TA implementation is aimed at assisting project partners provide the necessary TA to the MHOs with regards to advocacy and the establishment of a socialized user fee scheme.

Advocacy:

a. act as conduit of PHIC in rallying municipal LGUs/LCEs to pursue the universal coverage for PhilHealth insurance; and in mobilizing RHUs to comply with the accreditation requirements of Sentrong Sigla and PHIC.
b. conduct of market segmentation
c. develop a socialized user fee scheme
d. develop the LGUs Local Health Account

Mode of Intervention

HG assistance may be direct or indirect and may take the form of advocacy, linkaging, and networking with the LMP and stakeholders like the NGOs/CSOs and mobilization of TAPs.

Technical Assistance

- Ensure the formulation of a provincial health communication and social marketing plan for LCEs, consumers, service providers. HG can also facilitate the organization of LCE forums, round-table discussions or "kapihan" which can be used as venue to get the support of and generate consensus among LCEs towards pursuing the universal coverage to PhilHealth insurance and co-sharing;

- Secure the support of the LMP-Albay in promoting universal coverage to PhilHealth insurance and co-sharing among LGUs;

- Provide TAPs who will guide the partners in helping LGUs/RHUs craft a socialized user fee scheme and put up their local health accounting systems; also in tools development *(e.g. market segmentation survey tool, TNA tools for health service delivery),* utilization of tools, data analysis and utilization;

Critical Activities

1. Advocacy

- Implementation of the provincial health communication plan and establish a speakers' bureau and advocacy team within the ACT among RHUs that will lead to the IEC/advocacy. IEC will have the consumers, service providers and support groups or agencies as audience.

- Organize a trained technical team within the ACT or DOH-CHD and PHO that will be responsible for providing the identified TAs to LGUs/RHUs

2. Financing

- Developing a user fee system per municipality
- Establishing the local health accounts per LGU

3. Assessment of the first year of TA implementation and Identification of Follow-on Steps with project partners

Achieving Performance Standards at the Local Level
PROVINCE OF BULACAN TECHNICAL ASSISTANCE

Background

The province of Bulacan is one of the seven (7) provinces comprising the Central Luzon Region. It is bounded by the provinces of Aurora and Quezon on the east, Nueva Ecija on the north, Pampanga on the west, Rizal on the southeast, and Manila Bay on the southwest. Dubbed as the "Gateway to the North", Bulacan links Metro Manila to the resource-rich provinces of Central and Northern Luzon.

The province occupies an area of 2,625 sq. kms. and is composed of 21 municipalities, 3 cities (Malolos, San Jose del Monte and Meycauayan) and 569 barangays. The province has four congressional districts. The province population in 2007 is 3,218,644 with a total 660,490 households as of 2007 with average household size of 4.98. Bulacan's population grows at an average rate of 4.93% and at this rate the population is projected to double in fourteen (14) years.

The average family income by year is P 179,572 (NSO, 2000) and one of the highest in the country. The poverty incidence stands at 8.5%. The Human Development Index is 0.663 in 2003. The employment rate stands at 89.7 (838,000) while unemployment is at 10.30 and underemployment at 5.7

Health Program

The province's vision is to be "progressive, peaceful and self-reliant where its people are living models of its historical heritage and cultural excellence with strong middle class as the core of the citizenry with equal access to opportunities and services." In part, this shall be achieved through its mission of providing an efficient delivery of health and social services. To this end, the province has a roster of indicators covering its health facilities and health personnel as follows:

Health Facilities
The province has eight (8) government and sixty seven (67) hospitals, 57 Rural Health Units and 543 Barangay Health Stations.

Of the six hundred eight (608) government facilities, only one hundred fifty two (152) or 25% are accredited by Sentrong Sigla. The details are shown:

Tale 1: Sentrong Sigla Accredited Facilities

Type of Facility	Total Number	Total Accredited
Rural Health Unit	57	54 (94.73%)
Barangay Health Station	543	91 (21.92%)
Hospital	8	8 (100%)
Total	608	152 (25%)

Source: PHO, CHD-3

The PHIC accreditation is also low: for OBP-21 out of 57 RHUs, for MCP-3 out of 57 RHUs and for TB DOTS -11 out of 57 RHUs.

Health service delivery

The Provincial Government has two groups in charge of health service delivery – the 8 government owned hospitals and the public health group who oversee the operations of 57 Rural Health Units and 543 Barangay Health Stations
There are moves to upgrade the PHO1 position to a Department Head, this being the case, the Public Health Office will now be a department.

There are 840 RHU health personnel; the Barangay Health Workers on the other hand total 3,257. The details as to classification are shown below:

Table 2: Classification of Health Manpower Resources in Bulacan RHUs

Health Personnel	RHU
Physicians	54
Nurses	78
Midwives/Nurse Aides	468
Rural Sanitary Inspectors	52
Dentists	41
Dental aide	25
Nutritionists/Dieticians	13
Medical Technologists	40
Non-Technical	69
Number of BHWs	3,257

Standard number of BHW - 1% of population or 1 is to 20 persons

Situation Analysis

In 2000, Bulacan was highest in the Human Development Index (HDI) , the measure of a province's performance with regards length of life, per capita income and educational attainment of its people. In 2003, while having better indicators than most provinces, Bulacan slid to number 9 in terms of HDI. This change is reflected in some of the following indicators:

Table 3: Bulacan Health Indicators

Indicators	
Crude Birth Rate (per 1000 pop)	21.16
Crude Death Rate (per 1000 pop)	3.26
Infant Mortality Rate	4.74

Maternal Mortality Rate	0.06 per 1,000 LB (Standard is zero maternal death related to birth)
Malnutrition Rate	3.39 (Standard=0 malnutrition)
FAMILY PLANNING	
- Contraceptive Prevalence Rate	40% (Standard = 60%)
FIC	76,231 or 83% (Standard = 95%)
TB Morbidity Rate	
-Case Detection Rate	63% (Standard = 75%)
-Cure Rate	82% (Standard = 85%)
PHIC enrollment	58,175

Source: PPDO-Bulacan, PSWDO-Bulacan, PHO-Bulacan

Health Systems

With regard to health systems the detailed situations are:

Health sector planning and budgeting

The province has the following plans connected with health: Procurement Plan, Technical Assistance Plan, Work and Financial Plan, Strategic Plan, PHO-Public Health Plan and Annual Investment Plan. However, these plans are not province-wide and done on an annual basis.

Health financing

The province has invested in health. For 2005-2006 the budget totaled P343,386,616.55 (25.89% of total budget) and this further increased in 2006-2007 to a tune of P458,393,826.93 (29.19% of total budget). However, the 2006 MOOE budget for public health is only P 6,773,000 or 1.27% of the total health budget. As per its mandate, and like other provinces, the province has allocated most of its health budget in hospital upgrading and operations. The gap is in allocating more funds for public health.

Procurement & Logistics

Province's procurement of essential drugs and commodities is done through the Bids and Awards Committee. The distribution of drugs and commodities to health facilities is done through the provincial delivery system. The FP commodities are distributed on a quarterly basis and for Vitamin A on a semi-annual basis. For TB, the RHUs get from the district hospitals.

The province has employed on-line bidding for transparency. However, the system is not foolproof because there are suspicions that some employees ended up as the suppliers of medicines and hospital equipment. The matter is being investigated.

While the province enjoys higher performances in terms of IMR, MMR, FIC and YB cure rate as compared to other provinces, it did not reach national standards.

A closer look also revealed that the provinces' performance is pulled down by low performing municipalities which are identified in the Service Delivery Implementation Review.

This situation analysis presents the accomplishment per major programs and the reasons for such:

1. Family Planning/Reproductive Health

- The province's 2007 population is estimated to be 3.2 million, one of the highest in the country. The population growth rate of 4.9% is largely attributed to in-migration. The province falls below the standard of 60% CPR, with a performance of 40.5 % for 2006. Current users total 135,194. Twenty three of the 24 LGUs did not reach the standard and they are enumerated below. Those municipalities and cities with 47% below performance are enumerated below. The reasons cited range from the need to have advocacy to LCEs to maintaining and or providing funding for FP commodities, strengthening IEC on FP and crafting the needed policies and strategy for CSR.

Table 4: CPR Performance in Bulacan vs National Standard, Gaps and LGUs Where Weak

Indicator	Performance Standard	Accomplishment	Municipalities that Did Not come Up with the Standard
Contraceptive Prevalence Rate	60%	40.5% (179,212)	47% below (16 LGUs) Baliuag, Bocaue, Calumpit, Guiguinto, Hagonoy, Malolos, Marilao, Meycauayan, Norzagaray, Obando, Pandi, Paombong, Plaridel, Pulilan, San Rafael, Sta. Maria
			48%-59% Accomplished (7 LGUs) Angat, Balagtas, Bulacan, Bustos, San Ildefonso, SJDM, San Miguel

Source: PHO-Bulacan, SDIR, 2006

2. Maternal and Child Health and Nutrition

With a performance of 75% in pregnant women with three or more pre-natal visit, the province falls below the 90% standard and 19 LGUs were weak in this. Likewise, for the indicator pregnant mothers with TT2 plus, the province's average of 35% was very low compared to the national standard of 85%. Fifteen (15) LGUs are in the "red" category or those who did not meet the standard.

The province did very well in the exclusive breastfeeding for four months with a 90% accomplishment versus the standard of 80%. Children with pneumonia treated with Cotri is also high with 99.6% average (standard is 100%).

Bulacan got high scores in deliveries attended by skilled health workers with a 92% performance (national standard is 80%).

The province also did not meet the FIC national standard of 95% with its performance of 83%. Seventeen (17) LGUs failed to pass the standard.

Even in children that have diarrhea, only 25 % were given Oresol. All 24 LGUs failed in this regard.

The reasons cited for these weaknesses are both on the service providers and the consumers. For the service providers there is a need for TA in developing skills in forcep delivery, in management of EMOC, updates on MCH among health personnel and TA on CUP. Advocacies for funds and policies will enhance the programs.

For the consumers, it is more of the health seeking behaviors to be developed. There is also a need for an effective IEC on the MCH programs.

Table 5: MCH Performance in Bulacan vs National Standard, Gaps and low performing LGUs

Indicator	Performance Standard	Accomplishment	Municipalities that Did Not Reach the Standard
Pregnant women with three or more pre-natal visits	90%	75% (80,277)	71% below Accomplishment (10 LGUs) Angat, Sta. Maria, San Rafael, DRT, Hagonoy, San Ildefonso, Norzagaray, Paombong, Bocaue, Calumpit 72%-89% Accomplished (9 LGUs) Obando, Plaridel, Meycauayan, Pandi, Bulacan, Marilao, Balagtas, Bustos, Malolos
Pregnant women with TT2 plus	85%	35%	63% below

		(37,819)	Accomplishment (10 LGUs) Marilao, Angat, Plaridel, Guiguinto, Malolos , Norzagaray, San Ildefonso, Pandi,San Rafael, Paombong 64%-79% Accomplished (5 LGUs) Bocaue, Pulilan, Sta. Maria, Bustos, Bulacan
Deliveries attended by skilled Workers	80%	92% (59,197)	63% below Accomplished (1 LGU) DRT 64%-79% Accomplished (1 LGU) Marilao
FIC	95%	83% (73,231)	75% below Accomplished (10 LGUs) Hagonoy, Bulacan, Guiguinto, Sta. Maria, San Ildefonso, Angat, San Rafael, Norzagaray, Paombong, Bocaue 76%-94% (7 LGUs) San Miguel, Obando, Balagtas, Pulilan, Meycauayan, Bustos, SJDM
Infants Receiving DPT3	95%	77% (70,224)	75% below Accomplished (16 LGUs) Calumpit, Hagonoy, Plaridel, Malolos, DRT, Marilao, San ildefonso, Guiguinto, Angat, San Rafael, Sta. Maria, Bocaue, Bulacan, Paombong, Norzagaray 76%-94% Accomplished (7 LGUs)

			San Miguel, Obando, Balagtas, Meycauayan, Pulilan, Bustos, SJDM
Exclusively Breastfed for Four Months	60%	84%	47% below
			(1 LGU) Calumpit
		(50,307)	48%-59%
			(2 LGUs)
			Calumpit, Hagonoy
UFC with diarrhea given ORS-Oresol	100%	20.3%	79% below
		(25,102)	All LGUs
Children Under Five Year old with pneumonia seen and given Cotri	100%	99.6%	80%-99%
		Seen-9,030	(1 LGU)
		Treated-8,996	Marilao

Source: PHO-Bulacan, SDIR 2006

3. TB Control

With regard to TB control, the province also falls below the national standards of case detection and cure rates. The accomplishment rate is 63% versus the national standard of 70%. Seventeen (17) LGUs failed to meet the standard. As regards the TB cure rate the province has an 82% accomplishment versus the 85% standard and 14 LGUs are weak in this area. The municipalities and cities with performance 56% and below will be prioritized for case detection and those with performance 68% and below for cure rate.

For the weakness in this program again we can both look at the service providers and the consumers. For the service providers it is more on capability on basic sputum microscopy, training on MOP, etc. Another aspect that needs attention is the accreditation of facilities.

On the consumers, again it is the health seeking behavior. Some patients, if they already feel well dropped from the treatment even if is not completed. Others do not seek treatment at all for fear of being avoided by their neighbors.

Table 6. TB Case Detection and Cure Rate, Bulacan 2006

Indicator	Performance Standard	Accomplishment	Municipalities that Did Not Reach the Standard
Case Detection Rate	70%	63%	56% below (11 LGUs) Pandi, Pulilan, San Rafael, Obando, Meycauayan, Bulacan, San Ildefonso, Marilao, Plaridel, Guiguinto, Sta. Maria 69-56% (6 LGUs) Calumpit, Malolos, Baliuag, Angat, San Miguel, Bocaue
Cure Rate	85%	82%	68% below (4 LGUs) Bocaue, Bustos, San Miguel, Guiguinto 68%-84% (10 LGUs) Meycauayan, Plaridel, Paombong, San Ildefonso, Balagtas, Bulacan, Pandi, Angat, Calumpit, Obando

Source: PHO Bulacan, SDIR 2006 results

4. STI, HIV and AIDS

Nine of the province's highly urbanized and urbanizing municipalities and city are now implementing STI programs. IEC materials and advocacy activities are needed and will focus on these municipalities.

Table 7: Data on STI Program

Indicators	Standard	Accomplishment	Municipalities with STI Programs
No of smears collected	Less than 11% GC	9412	Baliuag, Bocaue, Bustos, Guiguinto, Marilao, Plaridel, Meycauayan, SJDM, San Rafael
Positive GC given treatment		147	
Positive NGC given treatment		807	

Source: PHO-Bulacan, SDIR, 2006

5. Other Infectious/Emerging Diseases

The province has named rabies control, leprosy control and avian influenza as the diseases to watch and have put in place some measures to monitor/address these.

Rabies is an emerging concern; 5 people died last year. The basic problem with rabies control program is the consumers, specifically in per ownership responsibility.

There are ordinances regarding pet ownership but these are not enforced.

There is not much problem with the control of leprosy as this is not serious in magnitude.

The protection from Avian Influenza is an emerging concern. Dr. Joy Gomez, the PHO-Public Health said that the focus before was more of protection of the birds and not that of human beings. Since this is a new concern a lot of TA is needed in this as will be mentioned in the later part.

Table 8: Emerging diseases in Bulacan

Indicator	Standard	Accomplishment	Top Ten Municipalities with Highest Incidence of Dog Bites
Rabies Control		5127	SJDM, Malolos, Hagonoy, Baliuag, San Miguel, Bulacan, Calumpit, Plaridel, Sta Maria, Pandi and Guiguinto
• Animal Bite Seen			
• Given post exposure		41%	SJDM, Malolos, Hagonoy, Baliuag, San Miguel, Bulacan, Calumpit, Plaridel, Sta Maria, Pandi and Guiguinto
• Human Rabies		5	Balagtas, SJDM, Bocaue, San Miguel
Leprosy Control			
• Undergoing Treatment		35	
• PR		0.11	
Avian Influenza		Manual of Operations to be finished Sept. -Training on Disaster Preparedness -Surveillance Sys at Barangay Level to be installed	Municipalities around Candaba Swamp

Source: PHO-Bulacan, SDIR Results, 2006

Technical Assistance

In year 1 of the project, scoping missions were undertaken to understand the health program situation of the province. This was further enriched by data gathering that captured the health governance and operations indicators to set the baseline situation. As became necessary, HealthGov even went to the extent of conducting surveys among the MLGUs for this purpose. While waiting for the national election, the working relationships with the PHOs, Population Office under the PSWDO, Provincial Administrator's Office were cultivated. This was also true with the CHD, Phil health, DILG and Regional Population Commission Office.

This year, the former Governor, the new Governor, the Local Finance Committee and the NGOs and CSOs were given an orientation on the Health Sector Reform Agenda and the Fourmula 1. The new governor has expressed his support to the health program of the province and gave Health Gov mandate to plan.

The province received technical assistance from HealthGov in the conduct of the Service Delivery Implementation Review (SDIR) which was expressed as a need during the project orientation. The 24 MHOs together with the nurses, midwives, planning and budget officers including NGOs attended the SDIR. The SDIR served as a starting point for the situational analysis of the province necessary for the development of a long-term Province-wide Investment Plan for Health which is does not have for many years now.

It was the turn of the province's 13 board members and their staff to be oriented on the health sector reform and the Fourmula 1 last August 27, 2007 at Century Resort in Angeles, Pampanga.

On September 17-19, the Provincial Partnership Building Workshop will be conducted to capacitate the NGOs and CSOs to be partners in pushing forward health reforms and ensuring health outcomes.

Moving on the Year 2, given that the Situational Analysis of the SDIR activity, showed a considerable shortfall in majority of the indicators, the rallying theme for the interventions and technical assistance is **Achieving the Performance Standards at the Local Level.** Quite encouragingly, it is timely that the new Governor has health as one of his priorities underscoring the importance of MLGUs taking an upper hand in their health programs.

With the recently concluded SDIR, the "red" (shortfalls) were already identified. The task on hand is "turning the reds into greens" which means meeting the national standards for the major programs. To achieve this, there are essentials that must be prioritized.

For year 2, there will be four major clusters of interventions in Bulacan:

1. Development of the MIPH/PIPH as a tool to has a long term perspective of turning the reds into greens. SDIR which is a tool for situational analysis is part of the MIPH/PIPH. The two major activities of CSR Assessment and Monitoring and CSR Planning are also part of MIPH/PIPH. The referral-system is part of the CSR and is currently prime moved by the PRISM project. Monitoring of ICV as a continuing intervention.
2. Cross-cutting advocacy activities directed to all key sectors and players in the health program.
3. Behavior change communication targeting the Barangays
4. Control of Avian Influenza

The technical assistance for these key interventions will be provided as follows:

1. MIPH /PIPH

1.1 Service Delivery Implementation Review (SDIR)

The province is currently reviewing the Acceleration Plan and Identifying the TAs.
The TA provided to the Province was both in the design of the SDIR tools and SDIR. Prior to the workshop which was the main event of the SDIR process, a Training of Facilitators was done to equip the PHO and the CHD with the facilitating skills to conduct the process. The TA currently being done is to review the acceleration plan and to identify the TA which will spillover to Year 2 of the project.

The succeeding intervention shall also include assisting the province in monitoring of the identified PPAs incorporation in the AIP, implementation of the critical interventions and the monitoring of the achievement of the OP indicators in MCH, FP, TB and HIV-AIDS.

Bulacan is now nearing completion of the SDIR. After reviewing the Acceleration Plans of the 21 municipalities and three cities the TAs will be identified. A planning with other CAs will follow to identify the TA programs to be handled by the province, as well as, the USAID projects handled by the different present CAs in Bulacan i.e. HealthGov, PRISM, TB Linc,A2Z and HealthPro.

The plan is to complete the PIPH for the province and the MIPH for the municipalities/cities in the first three months of Year 2 in response to the request of the governor and the PHO. HealthGov will provide TA on the processes for the completion of the MIPH and PIPH.

The activities that will facilitate these are:
- CHD Orientation on PIPH which have been undertaken by the DOH with assistance from HealthGov.
- The training of PHO staff and DOH-REPs for the conduct of the PIPH formulation.
- Conduct of meetings, consultations, workshops among local planners which will be organized and facilitated by CHD, DOH-REPs and PHO staff with Inter-CA support especially under the lead of HealthGov.
- The output for this are Individual LGU AIPs submitted to LDIP for 2008

Related to MIPH, PIPH implementation this year, the other related interventions are:

1.2 Commodity Self-reliance

1.2.1 CSR Assessment and Monitoring – Beyond MIPH and PIPH, in Bulacan the CSR Program assessment is needed. This will use the CSR Assessment and Monitoring tools developed by HealthGov together with the DOH. With a low CPR of 40.5%, the province requests that a CSR Assessment and Monitoring be conducted this year (2007). The objective will be to find out the status of CSR implementation that LEAD started and plan the needed activities to improve this indicator.

This will be done with the following activities:

- The tool will be finalized and approved by DOH CSR TWG as a national tool

- CHD, PHO and other partners will formulate and execute implementation plans
- DOH and CSR TWG will finalize guidelines for implementation including analysis
- HealthGov to assist CHD in the roll-out of this tool in
- Health Gov will assist DOH in monitoring the implementation and analysis at the field level activities led by HPDP

1.2.2 CSR Plan Review and Updating – This will make use of the CSR Planning tools developed by the project

- A CSR orientation will be held among the LGUs where the following will be taken up: the strategies for promoting all FP methods, strategies for integrating FP into MCH and safe motherhood services, strategies for protecting the poor which will include client segmentation, budgeting and finance, forecasting, procurement and logistics, and the linkaging with private sector suppliers. Strategies may will explore cost recovery systems for publicly delivered commodities to non-poor, private provider mapping, public-private referral system; private sector expansion through development of high volume providers for IUD and VSC

- The transfer of technology will be led Health Gov provincial coordinator and specialist, the CHD, and PHO through planning workshops, meetings, consultations and coaching. The finalized CSR planning tools will be endorsed to the LCEs for approval.

- There will be coordination with Inter-CA groups on other CSR tool based on CSR TA Plan approved by DOH and Inter-CA TWG.

1.3. Referral Systems - Public-Private, Public-Public

Three of the municipalities are being piloted currently for the client referral systems. In relation with CSR, HG will monitor developments in this area. Follow-on TA will be given to the province in the implementation of the referral system.

1.4 Informed Choice and Voluntarism

This will be incorporated in all the appropriate activities in Bulacan. HealthGov will also provide TA in ensuring compliance and monitoring on Informed Choice and Voluntarism in FP. The instrument was twice pre-tested in Bulacan with the assistance of the PC and the Program Coordinator on FP. The Luzon Team also coordinated with CHD in providing a lecturer for this topic. During the first year of Health Gov, the lecture on ICV was included in the SDIR Workshops in Bulacan and will continue to do so in Year 2.

2. Advocacy

NGOs and CSOs take an active role in the governance of the province but this is not true in the health sector. The governor and the PHO welcomes the involvement of the CSOs and NGOs on health activities to better achieve health outcomes of the province which is the rallying point for the interventions in Year 2.

The initial activity to facilitate this is the conduct of the Provincial Partnership Building Workshop which will be followed by capability building activities to equip NGOs and CSOs to participate and be part of the decision making process.

On this front, there are important aspects - first is knowing where they are needed and how they will participate. It is suggested the NGOs and CSOs do a Needs Assessment for them to determine what they need to be able to participate. HealthGov through its partner PNGOC shall provide TA for the conduct of this activity including the design of an assessment tool. It might be also necessary for HG to provide resource topics in certain advocacy areas that will be identified from this activity.

If the activities of the NGO and CSO will be clear and essential to the Provincial Government thrust, they can secure a grant from the provincial government and a space where they can regularly meet. The Health Gov PC can assist them in this regard.

3. Behavior Change Communication Targeting the Barangay

The problem of Bulacan lies not only in the service providers and the facilities but also as the SDIR has surfaced on consumer behavior. One third of the province's 3.2 million people are migrants from other provinces. Because of the province's strategic location, it is a magnet for low skilled and low educated people who see Bulacan as a place where they can work and raise their families. Usually these people are hired to do manual labor in the poultry and hog farms, quarry and cement sites, laborers in the market place and domestic help. Another fact is that some municipalities/cities like Norzagaray and San Jose del Monte have become relocation sites of Metro manila's squatters. Seeing this situation the PHO has planned for the creation of a Health Education and Promotion officer in all the municipalities. HealthGov will coordinate with HealthPro for the TA on this area of intervention:

1. Assistance in the Identification of criteria for municipal HEPOs
2. Providing TA for PHO to be able to training these municipal HEPOs
3. Providing TA to PHO in teaching MHEPOS in crafting, producing and distributing IEC materials in programs that need strengthening (FP, TB, FIC. Responsible Pet Ownership, Avian influenza, Tuberculosis Control, MCH.)
4. Providing the tools in the Development of a Communication Plan for the barangays
5. TA in the identification of policies on communication and promotion that will respond to the needs of both the consumers and providers.

4. Avian Influenza

Bulacan is a high risk area being very near the Candaba swamp. Another reason is the existence of many poultry farms which is a major industry. The TA from HealthGov will be in the following items:

1. Providing comments on the Manual of Operations that the Provincial Agriculture Office has produced.
2. Providing comments/ guidance on the training surveillance system and related activities that the province will put up.
3. Assistance in the installation of a barangay warning/surveillance system

With these four major technical assistance categories, the province hopes to start achieving the national standards on the major health programs in Year 2.

Improving Health Implementation Performance at the Local Level
PROVINCE OF CAGAYAN TECHNICAL ASSISTANCE PLAN

Background

Cagayan is located about 480 kilometers north of Manila. With a population of 993,580 (2000 census), it is the second biggest province in Region 2 next to Isabela in terms of population. It has a population density of 118 persons per sq km, and has 1 component city, 28 municipalities, and 771 barangays. Economically, it stands better than the average province in the country with a poverty incidence of 16.5% in 2004. Owing to its strategic location, Cagayan serves as the regional center for Region 2. Tuguegarao City, its provincial capital, is a component city where the government regional offices of Region 2 are located. Cagayan is accessible by land as well as air transportation with the airport based in Tuguegarao.

Health Program

Vital health indices inidcate that Cagayan has a birth rate of 18.65, a death rate of 4.48, maternal mortality rate of .52 per 1,000 live births, and an infant mortality rate of 6.71 per 1000 live births.

The province's health program indicators in 2006 are as follows:

Family Planning/Reproductive Health (2006)

Method	New acceptors		Current users	
	Number	Percent (%)	Number	Percent (%)
Condom	743	4.38	60,460	50.41
Injectable	1,675	9.87	6,465	5.39
IUD	1,696	9.99	11,241	9.37
LAM	8,069	47.53	2,978	2.48
NFP	54	.32	92	.08
Pill	4,108	24.20	32,627	27.21
Male sterilization	8	.04	74	.07
Female sterilization	624	3.67	5,983	4.99
TOTAL	16,977	100.00	119,920	100.00

Maternal and Child Health and Nutrition (2006)

Particulars	Number	Percent
Births and Deliveries		
Total livebirths	17,436	
Male	9,059	51
Female	8,377	48.04
Total deliveries	17,463	
Normal deliveries	11,013	63.06
Births attended by trained personnel	12,407	71.05
Births attended by trained *hilots*	4,584	26.25
Normal deliveries	17,170	98.00
Home deliveries	13,223	75.78
Hospital deliveries	3,730	21.36
Maternal and Infant Deaths		
Maternal deaths	9 (.52/1,000 livebirths)	

Particulars	Number	Percent
Nutrition		
Eligible population	37,721	
Pregnant women given complete iron dosage	20,434	62.45
Postpartum women give iron dosage	17,113	61.02[1]
Women 15-49 given iodized capsules	6,097	3.12[2]
Lactating mothers given Vitamin A	17,858	63.63[1]
Children 6-11 mo given Vitamin A	10,628	75.79[3]
Children 12-59 mo given Vitamin A	84,371	75.32[4]
Children 60-71 mo given Vitamin A	8,304	
Immunization		
Eligible population	28,048	
Fully immunized children	24,715	88.12
Children given 3rd dose of hepa B vaccine	22,798	81,29

[1] Percent of 28,046 eligible population
[2] Percent of 195,389 eligible population
[3] Percent of 14,023 targeted population
[4] Percent of 112,185

Particulars	Number	Percent
Infant deaths	117 (6.71/1,000 live births)	
Neonatal tetanus deaths	4	
Still births	27	
Prenatal and Postpartum Care		
Eligible population	32,721	
Pregnant women with 3 or more visits	21,458	65.58
Pregnant women given TT2 plus	19,458	59.47
Women with at least 1 postpartum visit	18,732	66.8[1]
Control of Diarrheal Diseases (CDD)		
Eligible population	37,956	
Cases given ORS (0-59 mo)	4,269	11.25
Acute Respiratory Infections (ARI)		
Eligible population		
Pneumonia cases seen	2,723	20.08

Particulars	Number	Percent
TB Control		
No. of TB symptomatics examined	4,896	
No. with 3 sputum specimens	4,817	
No. diagnosed as smear-positive	807	
New smear-positive target	1,162	
Accomplishment	833	
Case detection rate	72	
No. of relapses	26	
Smear-negative cases	585	
Total TB cases	1,499	
HIV/AIDS		
Eligible population	233,719	
No. with vaginal discharge	456	
No. with urethral discharge	8	

Other Infectious Diseases

Rabies, including human rabies, due to dog bites is one of the biggest concerns of the province. Cagayan has the highest number of reported cases of dog bites and human rabies.

Situation Analysis

Cagayan's vital health indices for 2006 show that the province has a better maternal mortality rate compared with the regional average. However, overall mortality and infant rates are higher than the regional average. Cagayan has a lower performance accomplishment in nutrition, immunization, and prenatal and post partum care. The province, however, excelled in its rabies immunization performance compared with other provinces in the region.

Health Governance

Like his predecessor, the newly elected governor of Cagayan supports health as a priority development concern. Following his proclamation in July, the new provincial LCE put in place a number of organizational changes. The current PHO II is due for retirement in November 2007. While he is serving a three-month clearing period, an officer-in-charge was installed in August 2007. A health consultant was engaged in August 2007 to help the provincial government set its health program directions. In addition, the PHO has designated a new F1 focal person. The PHO focuses not only on the hospital system but also provides TA to the RHUs in the implementation of health programs.

PHO resources are focused on Club 82 which consists of 10% of the 820 barangays considered poor. It is hoped that initial ECCD funding for Club 82 will spill over to other barangays. The Minimum Basic Needs tool plus 33 other indicators (impact, input, and process indicators) were used to identify Club 82.

Political support for health is reflected in the financial support the health sector receives. Despite the decreasing total budget, health budget continued to increase in the past three years. In 2007, the total health budget amounted to 32.12% of the total provincial budget.

Share of the health sub-sector in the total LGU budget, 2007

General Fund	Health Budget (PhP)	Total Budget (PhP)	%
Personal Services	133,504,349.00	321,398,432.00	41.53
MOOE	26,377,070.00	176,246,022.00	14.96
Capital Outlay	0	0	0
Total	159,881,419.00	497,644,454.00	32.12

Cagayan is currently implementing its provincial five-year strategic plan developed with CHD assistance. The province has also formulated its annual investment plan for health, gender and development plan, provincial physical framework plan (PPFP), and the operational plans of various departments. The provincial LGU conducts a program implementation review every semester. The need to update the provincial strategic plan and the PPFP has been identified.

Cagayan has started to update its strategic plans for health using the integrated health planning system. The CHD is assisting the different municipalities to come up with their strategic plans for health. The municipal strategic plans could be developed into a province-wide investment plan for health which could be used to source out funds from external financial institutions.

On the average, the health budget at the MLGU level amounts to only about 10% of the total budget. The average annual maintenance and other operating expenditure (MOOE) of the health sector is only about PhP850,000. There is, therefore, a need to increase the local budget for health services. The LGUs need to look for other financial sources outside of their existing budgets to fund their health requirements. Finance committees of the LGUs could be provided with training on resource mobilization. The local chief executives, members of the SB, and other policy makers need to realize the need to invest in health.

There used to be 15 municipalities with functional local health boards. This could be changed with the newly elected municipal officials.

Interlocal Health Zones

The Sanchez Mira Inter-local Health Zone is the only functional ILHZ in the province, and it needs strengthening. This ILHZ comprises the municipalities of Sta. Praxedes, Claveria, Pamplona, and Sanchez Mira. Preparations are ongoing for the creation of two other ILHZs to cover urban areas. The PHO leadership has expressed the desire to help integrate and improve linkage between the RHUs and district hospitals. The province may need some assistance in the organization of the ILHZs.

Procurement and Logistics

The province has an annual procurement plan for essential drugs and commodities. Essential drugs and commodities were procured through the bidding process that the Provincial Bids and Awards Committee supervises. This process contributed to delays in obtaining the commodities, which resulted in stockouts. Procurement was done quarterly, on time, at the same time but in inadequate quantity. Although the commodities were procured regularly, the purchase programmed for the previous quarter was the one utilized in the succeeding quarter.

The procured supplies were provided primarily to the poorest 82 barangays known as Club 82. The PHO reported, however, that the volume of commodities was insufficient to cover the total requirements of these barangays.

The program coordinators acted distributed the essential drugs and commodities quarterly, on time, and separately by program components, except for Vitamin A for the *Garantisadong Pambata* campaign. Supplies were distributed based on the allocation schedule prepared by the PHO. In the case of dental and medical missions, essential drugs and commodities were distributed based on the requests from the MLGUs.

Health Information System

In 2006, 28 municipalities (excluding Tuguegarao) submitted complete quarterly FHSIS reports to the Provincial Health Office. On the average, 27 or 98% of the municipalities were late in submitting the FHSIS report to the PHO. Report submission of most municipalities was delayed by one week while a few municipalities were quite delinquent in the submission of FHSIS report. Accuracy of data reported is also an issue raised on the reports provided to the PHO. There might be a need to discuss the issues on the reporting system and recommend measures to improve data collection and accuracy.

CBMIS is not in place. CDLMIS is no longer being used to track and record the procurement and distribution of FP supplies. A simplified recording system is being used instead.

Health Financing

There were 56,205 enrollees under the sponsored program as of September 2006. This is way below the target of covering all indigents numbering at least 163,940. There is still a need to increase enrollment and attain universal coverage of all the indigents. The identification of indigents to be covered by the sponsored program likewise needs to be reviewed and improved to ensure that the real poor are targeted.

Payments for PhilHealth benefits as of September 2006:

- Summary of released PhilHealth capitation fund: PhP850,053.64
- Summary of benefits paid: PhP5,081,417.49
- TB-DOTS packages: PhP31,951.96
- Maternity care package: PhP4,373,297.79
- Family planning: PhP488,965.33
- Child care: PhP87,202.41

User fees

Provincial-run hospitals charge user fees. The province charges fees for non-FP services such as HIV/AIDS. Five MLGUs are using revolving funds for FP commodities (Allacapan, Lasam, Alcala, etc). There is a need to review and improve the system of identifying the indigents to exempt them from the user fees. In most cases the MSWD comes up with the list of indigents and these are certified by the barangay chairpersons.

Service Delivery

Health facilities

There are 12 private hospitals and 16 government hospitals. These consist of 1 provincial, 1city, 4 municipal, 1 retained, and 2 Medicare hospitals. 1

There are seven hospitals accredited by PHIC. These are as follows:

Alfonso Ponce Enrile Memorial Hospital, Gonzaga, Cagayan
Baggao Medicare Community Hospital, Aparri
Cagayan Valley Medical Center, Tuguegarao
Lasam District Hosp
Northern Cagayan District Hospital, Piat
Tuao District Hospital
Tuguegarao People's Emergency Hospital

There are 30 RHUs and 216 BHSs. Thirteen RHUs are SS I-certified and not of the 216 BHS is SS certified. The Tuguegarao City RHU is SS II-certified. Cagayan Valley Coalition Against TB (CAVACAT), an affiliate of PhilCAT, is involved in public-private mix DOTS (PPMD), and public to-public (P2PMD, i.e., hospital to RHU, and engaging other private practitioners in LGUs in TB treatment of TB). There is a need to improve the quality of health care services at the RHUs, have them PhilHealth- accredited, and access to these services improved. These will ensure that PhilHealth enrolment becomes more meaningful for those enrolled. Quality service is not totally dependent on the availability of equipment and skilled manpower. Client satisfaction is a major consideration in measuring quality of care. The SDExH, HealthGov's technical assistance

package for improving quality of services, could be implemented initially in a selected RHU with its component BHSs.

DKT has put up Pop Shops in Alcala in collaboration with the MHO; BHWs and BNSs serve as distributors of FP commodities to the barangays. TA in monitoring contraceptive use may be required when commodities are purchased from the private sector, and in the setting up of outlets.

There are 17 sentinel sites in Cagayan actively involved in the surveillance of highly infectious diseases. There are no surveillance systems, however, of avian influenza.
Some places in Aparri where migratory birds are present are considered critical areas as these birds could bring in the deadly avian influenza.

Human resources

Number of health workers by type

o Physicians:	30
o Nurses:	50
o Midwives:	332
o Sanitary inspectors:	49
o Medical technologists:	26
o BHWs and other volunteer health workers:	3,682
o TBAs:	849
o PHTL:	1
o DOH Reps:	5

Cagayan has four “doctorless towns” (Tuao 2, Lasam, Rizal, and Pamplona), and “many doctors are about to go.” Seven PHNs have gone abroad. There is a need to bring in nurses from the RHUs who are trained as program implementers. There is also a need to re-train nurses. The PHO field health office has only five program coordinators as a number of them has left for other countries.

The province does not have an approved Civil Service Merit Plan that would allow provision of incentives and benefits to health workers. Health workers in both provincial and municipal LGUs receive only partial Magna Carta benefits. An exception are two MLGUs (Penablanca and Lasam) which give full benefits. Health workers receive salary and laundry allowance but no hazard pay. The Magna Carta cannot be fully implemented since the personal services item of the province is beyond 45%.

Advocacy

Most NGOs have a good working relationship with health officials at the municipal and barangay levels.

There are a number of NGOs and CSOs that can be tapped to improve access of health care services. Among these NGOs are Process Luzon, World Vision, CAVACAT, North Luzon Cooperative, and Cagayan Colleges, Association of Municipal Health Officers of the Philippines (AMHOP), and local chapters of the Philippine Nurses Association and PMA. They operate a

population, health, and environment project in Baggao town. Process Luzon lately conducted a poverty mapping based on selected health, education and other indicators. Health forums among these NGOs/CSOs could provide venue for better coordination advocacy for stronger NGO/CSO contribution in health sector development. The climate for NGO/CSO participation has been positive with the active participation of NGOs/CSOs in the provincial and municipal health boards. There is also a need to strengthen NGO-LGU partnership integrating and sustaining NGO engagements within the health sector reform/F1 aside from inter NGO/CSO collaboration.

Cagayan has a local radio program called *Usapang pangkalusugan* (health talk) aired every Friday at 3 pm as an information campaign to disseminate disease prevention strategies. Another radio program *Cagayan: Ang lalawigan* (the province of Cagayan) aired every Sunday at 9-10 am sometimes focuses on relevant health issues. The province has produced IEC materials in English for general health information. There is need to sustain and strengthen behavior change communication and health promotion.

Goals and Objectives:

The goal of Cagayan is to attain better health for all its constituents. It aims to improve its health vital indices and hit better levels than the regional average for infant mortality and overall mortality rates. Maternal rates should be further decreased.

Specifically, it aims to improve performance to approximate nationally set performance standards as follows:

Performance Indicators	2006 Performance	National Standards/ Targets
Pregnant women with at least 3 antenatal visits attended by skilled attendants (doctors/nurses/ midwives) – 1 visit per trimester	65.58	90%
Pregnant women had of tetanus toxoid immunization first pregnancy – *at least 2 doses* succeeding pregnancy – *3 or more*	59.47	85%
Pregnant women that *have taken complete dose* of iron supplementation – at least 6 months (reported after the 180 tablets)	62.45	90%
Lactating Mothers given Vitamin A within 1 month after delivery	63.63	90%
Fully Immunized Children (1 dose of BCG, 3 doses of Polio, 3 doses DPT,*)*, 1 dose of measles before reaching age 1) by 2007 plus *3 doses of hepatitis*	88.12	95%
Children given Hepa	81,29	95%
Children 6 to 71 months given Vitamin A capsules last 6 months (Last GP of 2006)		95%
6 months - 11 months given Vit. A	75.79	95%
12 months - 59 months given Vit. A	75.32	95%

Technical Assistance

For year one, HealthGov was able to provide an orientation of the health sector reform and USAID technical assistance to key provincial partners. Likewise, an orientation among the PHO staff and other provincial staff on the PIPH process and the SDIR tools was also conducted. A session on resource mobilization with the staff of the PHO and members provincial finance committee was also done. The PHO and selected NGOs/CSOs also participated in the cluster workshop for the CSO/NGO orientation. As an offshoot of the cluster CSO/NGO orientation, a provincial CSO/NGO forum is set on the first week of September. The political dynamics that followed after the election that resulted in the organizational changes in the provincial health office somehow stalled the progress of other planned activities. The newly appointed OIC PHO II together with the new focal point for F1 was given an orientation on the USAID technical assistance and on the activities that were already conducted for Cagayan with HealthGov. Two members of the Sangguniang Panlalawigan, the chairman of the SP Committee on health and a member of the committee were likewise oriented on the USAID technical assistance. The orientation of the new Governor is expected to be done before the end of August. It is also expected that the governor will issue the mandate to plan before the end of September.

Improving health implementation performance at the local level will be the rallying point of HealthGov's technical assistance to Cagayan in year two. The aim is to help the province lessen the gap in its performance level along various performance indicators with the set national standards. Specifically, HealthGov plans to help the province through the following:

1. Governance

Five-Year Investment Plan for Health

To help improve health management systems, HealthGov together with the CHD will assist the PHO in the preparation of a five year provincial investment plan for health. This is timely as the province will need to update its five year strategic plans. The planning process will help the province and the municipalities identify critical interventions that will help improve the health implementation performance on various priority health programs. After the issuance of the mandate by the provincial governor, HealthGov will assist in ensuring that the provincial planning committee for health be constituted. HealthGov together with the CHD will orient the committee on the investment planning process and formulate a plan of action for the preparation of the investment plan for health. HealthGov together with the CHD will assist the provincial planning team together with the municipal planning teams on the various planning workshops and processes to ensure that they formulate an investment plan that is responsive to the call for the improvement of health implementation performance at the municipal/city level. As discussed with the CHD and PHO, the planning for Cagayan in the first quarter of 2008 after the Isabela Plan is completed.

Improving integration of RHUs and District Hospitals

The provincial plan is expected also to help address the problem of the disintegration of service delivery at various levels of health care resulting form the devolution. As such, CHD and HealthGov will ensure that such concern will be addressed adequately in the plan.

After the plan preparation, HealthGov and the CHD will assist the province in implementing interventions for strengthening of two way referral systems and the desired integration of RHUs and hospitals. Assistance will be through the design and conduct of assessment and planning sessions towards the integration of RHUs and hospitals and eventual formation of ILHZs.

CSR Monitoring Tool and CSR Plans

The CSR monitoring tool will be introduced between October to December 2007. It will be done through the orientation of the PHO staff and DOH Reps who will in turn serve as the resource persons who will orient the MHOs and PHNs. CHD and HealthGov will conduct planning meetings with the PHO staff and DOH Reps to monitor implementation of the CSR monitoring tool. The implementation of the CSR monitoring tool will help provide inputs in the preparation of CSR plans that will be integrated in the over all investment plan that will commence preparation in the latter part of first n quarter of 2008.

The provincial plan would likewise address the issue on the health information system and self reliance on contraceptive and other essential drug commodities. With the halt in the provision of free FP and commodities and other essential drugs, the province will need to address this concern and ensure the sustained provision of the health services even after donors shall have totally stopped the provision of free commodities. HealthGov will help ensure that the health plan will contain a CSR plan. HealthGov together with the CHD and the provincial planning team will conduct CSR orientation for MHOs and PHNs that were not yet oriented and advocate for the inclusion of CSR plans in the municipal plans.

Other contracting agencies such as HealthPro and A2Z will be invited to provide some technical inputs for the plan.

Advocacy

HealthGov will continue to communicate and advocate for better health governance through its various activities with local partners. Ensuring that local partners such as the PHO staff and the CHD become active advocates for the improvement of health governance systems will be the first advocacy agenda of the HealthGov PC.

Once the CHD and this PC agree on the technical assistance to the provided to the province and on the approach in how the TAs will be delivered, all activities for TA provision will flow automatically.

Working on what has already been done along NGO/ CSO and LGU partnership building involvement in the health sector, HealthGov will continue to work with PNGOC to support other similar activities supportive to NGO/.CSO participation in health development. HealthGov will advocate for the participation of CSO/NGOs in the investment planning for health.

HealthGov will collaborate with HealthPro in its agenda for improving health seeking behaviors of the community people and at the same time towards improving service delivery and improvement of client satisfaction.

2. Financing

Adoption of more, better and sustainable financing mechanisms for health

The technical assistance on the preparation of the investment plan for health will include the provision of inputs on resource mobilization and health financing for the local finance committees and the provincial and municipal planning teams. HealthGov will introduce concepts on cost recovery schemes such as establishment of user fees as part of its technical inputs for the planning teams. This will help the team include in the plan the institutionalization of more sustainable mechanisms for funding health programs. Along with the introduction of user fees, HealthGov will also provide some inputs on the client segmentation as a safety net for indigents who could not afford to pay for health services.

Increasing PhilHealth Enrollment

Decreasing out of pocket expense for health and increasing health insurance is one of the objectives Fourmula one. The provincial Governor has expressed that one of their objectives is to increase Philhealth enrolment. HealthGov together with the CHD particularly the PHTL will organize an inter-agency advocacy committee that will conduct more intensified campaigns among key MLGU officials for increased enrollment under the indigency program. PhilHealth will be tapped as a member of the inter-agency committee. HealthGov together with the CHD will conduct an orientation and training for the advocacy team members where Philhealth and other possible resource persons will be invited to help capacitate the members of the advocacy committee. Organization of the advocacy committee is expected to happen before the end of 2007.

User Fees and Client Segmentation

HealthGov together with CHD will likewise work for the conduct of advocacy activities towards the adoption of sustainable financing schemes particularly the use of user fees and client segmentation to protect the poor who cannot pay by health facilities (Hospitals, RHUs and BHSs). HealthGov and CHD can organize the provincial advocacy team that help push for the realization of the alternative financing interventions to attain better, more and sustained financing for health in the province and municipalities and advocate for increase in PhilHealth enrolment. In particular, they will advocate for the adoption of user fees and client segmentation as a means of safeguarding the indigents from the user fees at the same time advocate for the enrollment of indigents under the sponsored program of PhilHealth. HealthGov will assist in orienting the team, and assisting them in the preparation of an advocacy plan directed to the MLGUs. HealthGov will likewise assist the team in identifying and organizing the content of advocacy the sessions.

Healthgov together with the PHO and CHD will work together to provide more detailed orientation for MHOs, PHNs, RHMs and MPDC, Budget Officer and other key MLGU officials for municipalities who will seek assistance in the establishment of user fees and use client segmentation. HealthGov together with the PHO and CHD will likewise provide hands on assistance in the actual establishment of user fees and client segmentation. For the client segmentation, HealthGov can introduce developed tools for client segmentation by conducting an orientation on the tools. HealthGov can also provide hands on training on the actual implementation of the tools as part of technology transfer.

3. Service Delivery

Implementing Focused Critical Interventions for Priority Programs

The province recognized the need to conduct a more integrated implementation review as part of its planning process. HealthGov will assist the province in he conduct of the SDIR as part of its investment planning process and more importantly serve as a means of improving its health performance in the more immediate term. An important output of the SDIR is the acceleration plan which identifies the immediate critical interventions to address the gaps in service delivery focusing on those areas where performances are distinctly low. HealthGov will likewise assist in the monitoring of the implementation of the acceleration plans.

The province can opt to adopt the SDIR as a part of their health management systems tools to be conducted annually. They can include it in their investment plan as part of the interventions for improvement of service delivery

Early Warning and Surveillance System for Avian Influenza

Some parts of Cagayan, particularly Appari, had been identified as a critical area for the entry of Avian Influenza owing to the presence of migratory birds. As part of the national agenda of keeping the country Avian Influenza free, HealthGov will assist Cagayan in establishing the early warning and surveillance systems in identified barangays of Aparri. HealthGov will help identify the areas, assist in the design and conduct of community meetings and other orientation meetings that will facilitate the organization of functional early warning and surveillance systems.

4. Regulation

Facility improvement needs to be addressed as part of the scheme in raising overall health performance and a means of ensuring the availability of facilities that can provide services to an increased number of PhilHealth enrollees. Philhealth enrollment is also expected increase as this is one of the objectives of HealthGov providing TAs.

The inter-agency advocacy committee described earlier will also take on the task of advocating among MLGUs for the improvement of facilities for Philhealth accreditation. HealthGov will also work with the CHD in mobilizing the DOH Reps to give more focused assistance to LGUs in working out facility improvements based on Philhealth Accreditation standards. This will be done through the conduct of meetings among the DOH Reps to assess status of accreditation of facilities, identify gaps and issues relative to the accreditation of facilities and the measures to help step increase the number of Philhealth accredited facilities. HealthGov can assist in the design and facilitation of such meetings with the DOH Reps.

Enhancing Health Systems through PIPH
PROVINCE OF ISABELA TECHNICAL ASSISTANCE PLAN

Background

Isabela, the most populous province of region two is located 400 kilometers north of Manila. Its population of 1,287,575 in 2000 is about 46% of the population of region two. Its population density is 120 persons/sq. kilometers population growth rate of 2.25 from 1995-2000. Three of its component local government units in 2000 have reached population above 100000. These are Ilagan, Santiago City, and Cauayan City. The population male-female ratio shows that there are more males (51.29%) than females(41.71 %)

Ilocanos comprise 68.71% or the largest group followed by the Ybanags consisting of 14.05%, the Tagalogs, 7% and the remaining 7% were either gadding , Yogad and other ethnic groups.

It has 35 municipalities and two cities. The total families based on the 2000 census are 261,365. The average family income(at current) prices was P113,405 and average family expenditure was P90,924.00. The poverty rate in 2004 was 23.9%

Labor Force data in 2003 showed that 71.9% of those aged 15 years and over are employed. Of those employed 62.8% were in the agriculture sector, 28.41% in the services sector and 8.8 percent in the industry sector.

The literacy rate is 92.06% with females showing a slightly higher literacy rate of 92.33 percent compare to males with only 91.83 percent.

Health Program

Health is a considered as a priority concern by the provincial government including majority of the municipal local government units. Since its devolution in 1991, the province became mostly responsible for hospital services the municipal local government units took charge of public health services. The following describe the local health situation as of 2006:

Family Planning

- The aggregate CPR of the 35 MLGUs is 53.54% in 2006. Cauayan City has a CPR of 71.38 % while Santiago has 67.93%. Use of pills followed by injectables are the FP methods that majority of current users practice. There was improvement in the CPR over the last two years. Cauayan and Santiago City showed higher increases. The CPR showed an increase from 41.23% in 2005

MCH

- Total live births for 2006 is 31,074 with more males than females. Only less than 2% are attended by untrained hilots and others with majority attended by trained health professionals. About 80% are home deliveries.
- There were 27 infant deaths or a mortality rate of 5.71/1000 live births while under five deaths is 195 or 7.71/1000 livebirths. The top leading causes of infant deaths were prematurity, pneumonia, and septicemia
- About 75% of morbidity cases for infants were due to pneumonia.

- There were 15 maternal deaths or 58.59 maternal mortality rate. The causes of maternal deaths are postpartum hemorrhage, hypertension, eclampsia, retained placenta and uterine atony.

Nutrition

- The total number of BNVL and BNL is 19,004 with a malnutrtion rate of 12.72%. The province is a hall of fame awardee. There are however six MLGUs with malnutrition rates above 20% that need more assistance. These are Divilacan, Palanan, Sto Tomas, San Isidro, Dinapigue, Maconacon and Burgus

TB

- TB is the 5th leading cause of mortality and the 10th cause of morbidity. In 2006, 896 were detected positive of TB. All of these cases were provided treatment. The total number of TB patients undergoing treatment is 1,666. The cure rate reported for 2006 is 81% and a success rate of 91%.
- Full DOTS coverage was completed in 2000 covering 2 cities health offices and 36 RHUs. Case finding activities are being guided by the Revised Quality Assurance System(QAS) procedures.
- The national TB program (NTP) adopts the DOTS strategy which aims to treat and cure smear + cases through supervised treatment which is locally known as “tutok gamutan”. Several program indicators are being used with targets formulated by the WHO.

HIV and AIDs

- The reproductive tract infections reported for 2006 are as follows: Gonorrhea - 206, on-gonoccocal- 218, Candidiasis-48,Scabies-1,Trichomoniasis-31 and Genital warts-1.
- Leading cause of death all ages are CVD, Pneumonia, cancer and accidents. The top leading cause of morbidity are Acute respiratory tract infections, influenza, CVD and heart diseases, diarrheal diseases and gastro-intestinal diseases.
- Preventive and primary health care is the responsibility of the RHUs. The provincial health manages the curative side of health care which are the hospitals although, the field health unit of the provincial health office provides technical assistance to the RHUs.

Other Infectious Diseases

- There are 41 leprosy cases undergoing treatment in 2006. Six of these were new cases.
- Rabies due to animal bites including human rabies is a major concern of the LGUs. In 2006, rabies data showed that there were 3,151 dog bites, 66 cat bites, 12 human rabies and 106 others.

<u>Situation Analysis</u>

Isabela is a roll out province for Fourmula one. Isabela has the highest birth rate in region 2 with Santiago city registering a birth rate of 24.65 compared to the regional average of 21.36. The status of other health indicators shows that it is not the worse province in the region. However, Santiago City, showed the worst performance in terms of maternal and infant mortality rates in the region. Santiago City’s maternal mortality rate(.96) is the highest in the region. Its infant

mortality rate (16.24) is way above the regional average of 6.46. The over all performance of Isabela is considered as slow.

Support for the Health Sector, Planning, and Budgeting

The province is currently using the provincial 5-year strategic plan introduced by CHD. The municipalities likewise have strategic plans using the integrated health systems approach. The provincial and municipal strategic plans are due for updating. This is a timely undertaking as the preparation of the Province wide Investment Plan for Health (PIPH) is an expected output for the province considering that Isabela is a roll out site for Fourmula one.

The incumbent governor gives health second priority next to agricultural development. The province sees its mandate as primarily for hospitals hence its support for the public health is minimal. The Governor has cited that she has inherited the hospitals and she is tied to the upgrading of the hospitals which was initiated by the previous administration The Governor did not convene the LHB during her first term but committed to organize the board during her second term.

The provincial health budget amounting to P229.11 million is 21.6% of the total provincial budget. The hospital services get the giant share of the health budget with only about 10% dedicated for field health services. In 2005, the budget was P18.3 M or 12.81 of the total health budget. In 2006, it increased to 209.8 M but decreased to 11.15% of the total health budget. In 2007, the percentage share in the total budget further dipped down to 10.6% of the total health budget despite its increase to 24.4 million.

A scrutiny of the health budget showed PS and other mandatory operating expenses eat up most of the budget. The Field Health Services MOOE have only P 800,000 or 3.27% of the total budget as that could be used for all other programs and services except nutrition. Nutrition has a separate allocation within the health budget amounting to 946,800 for 2007.

Table 1: Field Health Service Budget, 2005 to 2007

	2005	2006	2007
1.Program appropriation- for the maintenance and operation of hospital services and health facilities including maternal and child Care, services, nutrition services, environmental health services and disease control services	17,783487.17	22,416,789.00	22,650,070.00
PS	16,955953.72	20,631,789.00	19,783,270
MOOE	827,633.35	1,785,000.00	2,866,800.00

Other MOOE			
Other expenses	3,470	50,000	50,000
Field health Development Program	105,045	396,000	800,000
Nutrition Program	444,958	550,000	946,800
Grand Total for Field Health Services	18,336, 960.17	23,412,789	24,446,870

The share of the Health sector in the 20% development fund increased during the time of Governor Padaca to about 30% from 10% during the previous administration. The allotment of 45 million each year since 2005 for PhilHealth contributions accounted for the large increase in the health sector share in the 20% development fund of the province.

The following shows the allocation of the 20% development for the health sub sector.

Table 2: Allocation of the EDF for the Health Sector, 2003 to 2007

Health Programs	2003	2004	2005	2006	2007
Philhealth				45 M	45 M
CPC VI					1.3 M
ECCD					2.0 M
Hospitals				8.2 M	8.0 M
Social Services(Protection/control/Development of various social concerns/Health care services	10.924 M	10.924 M	45.9 M		
Total	10.924	10.924	45.9	53.2 M	56.3 M
Total 20% Development Fund	143.42 M	150.18 M	150.5 M	173M	192 M

Two MLGUs visited expressed lack of financial resources to meet the total requirements for health. This could be an issue in most MLGUs. There is a need for additional sources to augment what the LGUs can share from their IRA and local sources. Almost all RHUS and BHSs do not have any cost recovery measures except asking for donations from clients they serve. Lack of knowledge on possible cost recovery schemes and how to go about it could be the reason why almost all RHUs and BHSs have not installed any other cost recovery measures other than asking donations. The lack of cost recovery systems makes the RHU and BHS depend solely on the annual MLGU budget for health which is very limited.

CSR Plans

There are 14 municipalities and one city (Cauayan)with budgets for FP in 2007. The municipal budget for FP range from 10,000 (Naguilian) to more than 5 million (Cauayan).In 2006, there

were only 4 MLGUs who spent for FP contraceptives. Twelve municipalities had CSR orientations. However, only Jones and Luna reported that they have signed CSR plans. Luna also reported that it has a functional TWG for CSR. Lack of technical assistance in preparing the CSR plans could be the reason why only two MLGUs have a CSR plan. Lack of orientation/advocacy on CSR could also be the reason why more than half of the MLGUs including Santiago City do not have budget for FP.

Health management information system

The PHO uses the FHSIS reports that the RHUS submit quarterly. However, they expressed problems on the quality of data gathered from the FHSIS and other health information system. The RHUs submit monthly reports to the CHD and prepare and submit quarterly FHSIS report and submit this to the PHO. Sometimes, there are discrepancies on the data between the one submitted to the PHO and the consolidated reports that goes to the CHD. Some programs like EPI, NTP and other programs have their own forms aside from the FHSIS which are collected by the program coordinators. Sometimes, entry in the program monitoring forms differs with the one in the FHSIS, the official reporting form.

Organizational relationships

The weak leadership in the Provincial Health Office and minimal financial support for field health services could have contributed to the province's slow performance. A new chief for the provincial hospital was appointed in place of Dr. Glen Baggao, the PHO 1. Dr. Baggao was moved to head the Cauayan District Hospital. Dr.Chat Aumentado serves as the OIC for Field health services. A recent reorganization with the reshuffling of all chiefs of hospitals was effected by the province August 1, 2007.

There are no ILHZs organized in the province. Attempts to organize ILHZs did not succeed as some LCEs did not like to commit resources for the ILHZ.

Health Insurance

The following are the number enrolled under the sponsored program, the capitation fund released and benefits paid under the Philhealth. This information however does not say whether those enrolled by the MLGUs are included or not which has to be further verified.

Summary of PHILHEALTH Enrollees	May 2007	162,998.00
Summary of Released PCF	Sept 2006	7,713,247.83
Summary of Benefits Paid	Sept 2006	9,099,458.85

Capitation funds for enrollees paid by the provincial government went back to the province for the improvement of hospital services. Capitation funds for enrollees paid by the MLGUs which is minimal went back to the respective MLGUs.

Procurement and Distribution of Drugs and Medicines

The province has a procurement plan for hospitals. Issues raised on the procurement system include problems on the timeliness of procurement/distribution of the essential drugs and the projection of actual requirements leading to shortage in supplies of some medicines. The field health office is not involved in the procurement of drugs. However, it facilitates the distribution of commodities received from the DOH/CHD and other donors like the UNICEF, and Global Fund. It adopts an integrated system in the distribution of commodities. The provincial governor raised

that ensuring that government hospital doctors prescribe drugs available in the hospital pharmacy is one the problems related to procurement and distribution of medicines.

Health service delivery

Management of Health Services

Hospital services is the primary function of the provincial health office through the province managed hospitals. The public health services are devolved to the MLGUs through the RHUs. The province provides technical assistance to the MLGUs in the delivery of public health services. The 20 DOH Representatives from the CHD provide technical assistance to the MLGUs and provide a direct link between the MLGUs and the DOH. The DOH Representatives serve as generalists providing assistance to the RHU staff. The technical staff of the PHO on the other hand is specialists covering all the MLGUs. One staff for instance serves as the EPI coordinator covering all the MLGUs.

Health facilities and Human Resources

For the curative aspect of health services, there are 12 public hospitals with 65 doctors, 113 nurses, 355 other medical staff. The total bed capacity of 295 (2006 data).

For preventive and primary health care, there are 509 barangay health stations, 39 main health centers/RHUs with 41 rural health doctors, 94 nurses, 388 midwives, 39 sanitary inspectors, 3,194 BHWs and TBAs-666 (2006 data).

There are seven social hygiene clinics/RHUs providing counseling and testing of STD and AIDS.

There are 18 RHUs ,5 BHS and I hospital Sentrong Sigla accredited for phase 1. For Phase 2, only two RHUs are accredited. These are Ilagan II and San Mateo.

The PhilHealth Accredited facilities are seven for Out Patient Benefit and eight for TB DOTS. Considering the large number of enrollees, there is a need to increase the number of PhilHealth Accredited facilities. For hospital services, all 12 government hospitals are PhilHealth accredited.

Health services in the RHUs and BHSs are provided for free. As such, there is no difference whether one is a PhilHealth card holder or not. It is only in the hospitals where there is a difference between a PhilHealth card holder or not. One issue however is that sometimes doctors would more expensive drugs found in private pharmacies and not the available drugs found in the hospital pharmacy. This was raised by the provincial governor in relation to drug procurement and distribution that she wants addressed.

Provision of Magna Carta Benefits remains to be a clamor among health workers.

As of 2006, there were 12 municipalities providing full payment of SL benefits, 24 partial and one municipality not providing at all. For RATA, 34 municipalities are providing while three do not provide. For hazard pay, 30 municipalities do not give any payment; 6 give partial benefit and only one provide full benefits.

Some areas in Ramon Isabela are identified as critical areas that for the entry of Avian Influenza owing to the presence migratory birds that frequent these areas.

Goals and Objectives

Improving the overall health for the Isabelinos at a faster rate is a major challenge to the provincial and municipal local government units. Specifically, the major goals for 2008 will be as follows:

1. Reducing the number of maternal and infant deaths. Santiago City has to double its efforts to reduce maternal and infant deaths. This would mean improving access and quality of the basic services of health services.

2. Continuing efforts to arrest the increase of TB cases through intensive casefinding and treatment of TB.

3. Reducing malnutrition rates more focusing on the municipalities with high malnutrition rates.

4. Improving contraceptive prevalence rate.

5. Sustain and or further reduce prevalence of STDs

6. Surveillance and management of other highly infectious diseases.

To attain above objectives, the following specific objectives and targets have to be attained:

a. Increase FIC coverage from 79.65% to 95%
b. Increase the percentage of infants given 3rd dose of HEPA B from 78.95% to 90%
c. Increase the percentage of infants exclusively breastfed from 90.03 to 95%
d. Improve performance in the provision of prenatal and postpartum care by increasing the following:
   - percentage of women with 3 or more Prenatal visits
   - percentage of pregnant women given TT2 plus
   - percentage of women with deliveries with at least one postpartum visit
e. Reduce the cases of diarrhea among children
f. Improved care and management of Pnuemonia to arrest mortality due to pneumonia
g. Intensify casefinding and treatment of TB cases
h. Improve care and management of reproductive tract infections; and intensify IEC on STD and AIDs
i. Intensify surveillance and management of notifiable diseases
j. Increase support for nutrition activities in municipalities/barangays with high malnutrition rates.

The following are among the concerns that could affect the achievement of the above goals and objectives:

- Poor leadership at the PHO
- Turn over of workers related to the election of new local chief executives
- Poor implementation of magna carta benefits
- Poor mobility due to lack of transportation and funds for travel expenses

- Lack of financial resources to meet the requirements of RHUs and BHSs in providing quality services.

Technical Assistance

Initiating an engagement with the province for technical assistance was the first task in year one. This was done through courtesy visits and orientation on Fourmula one and the USAID Technical Assistance among key provincial officials. The key officials oriented were representatives from the PHO, PPDO, PHTO, Budget office, Office of the treasurer and Office of the Provincial Administrator. The local finance committee were also given a session on resource mobilization and health financing. The PHO staff and the DOH Representatives were also oriented on the SDIR tool and the PIPH process. The PHO and selected NGOs attended the NGO/CSO cluster orientation. A local multi-stakeholder health forum is set on the last week of September as an offshoot of the cluster orientation.

The organization and orientation of the provincial planning team for the preparation of the PIPH is expected to be completed before the end of September.

As a FOURmula ONE roll out site, the theme of the technical assistance in Isabela for year two would be "Enhancing Health Systems through the Province Wide Investment Plan for Health". Specific technical assistance to support this theme will be as follows:

1. Governance

Preparation Of The Province Wide Investment Plan For Health(PIPH).

The preparation of the PIPH is expected to contribute greatly in enhancing overall health management systems especially for public health at the provincial and municipal levels.

HealthGov will work with CHD 2 in providing technical assistance to Isabela in the PIPH formulation. As such, HealthGov needs to level off with the CHD 2 particularly the Chief of the Local Health Development Division, head of planning unit and chief of the Health Operations Division and the PHTL for Isabela on the PIPH process and the specific technical assistance that HealthGov will provide. This will help capacitate the DOH team specifically in terms of providing directions and leadership in the PIPH formulation processes for Isabela. HealthGov will assist the CHD provide technical assistance to Isabela in all the planning processes.

Part of the technical assistance that HealthGov will provide in the planning process will be the conduct a training of facilitators to ensure that the PHO technical Staff and the DOH Reps will be able to serve as effective facilitators for the MLGUs in the whole planning process.

Since municipalities are expected to be the main participants in the planning process, HealthGov will assist the CHD and the PHO advocate to the local chief executives of the municipalities, including other the key officials such as the SB chairman for health, the MDPC, the MHOs, and the Budget officer among others to rally their full participation in the planning process. HealthGov will assist the PHO in the conduct of design and implementation of the orientation/advocacy sessions with local government officials.

HealthGov will also conduct a workshop on financing and resource mobilization, and conduct orientations on some new concepts for health systems improvement. These inputs could help

the planning team be able to enrich their plans and ensure that interventions for effective health governance are incorporated in their PIPH.

The PIPH should be able to address the following concerns surfaced during the scoping mission: issues related to the health information system, financing issues, procurement and distribution of essential drugs for hospitals; accreditation of RHUs and BHSs, and CSR planning among others.

HealthGov will advocate for the participation of the CSO/NGO in the PIPH preparation. HealthGov will likewise invite A2Z, HealthPro, and PhilHealth to provide relevant inputs for the PIPH preparation.

HealthGov will continue to work closely with PNGOC in providing support for partnership building for health between and among GOs, NGOs andCSOs.

2. Financing

Adoption Of Better And More Sustainable Health Financing Systems With Provision Of Safety Nets For The Indigents

The initial step to be undertaken will be to market the concept of user fees among the key and potential advocates at the provincial level particularly the PHO technical staff and the DOH Reps. HealthGov will work with the CHD for the conduct of an orientation among the potential advocates on the concept of user fees and client segmentation. Client segmentation will serve as the safety net for the indigents from the user fees to be imposed. It is expected that the participants would have been convinced of the idea of establishing user fees and would serve as advocates who will influence MHOs, PHNs, and BHWs. HealthGov can assist the PHO in the design and initial conduct of orientation sessions on user fees and client segmentation for MHOS, PHNs and BHWs. These frontline workers can be the most effective advocates who can influence policy towards the establishment of user fees and client segmentation.

Inclusion of this intervention in PIPH as a means of achieving sustainable financing mechanisms for health is a the desired outcome of the advocacy activities. Its inclusion in the PIPH helps ensure improved financing systems for health.

HealthGov can provide further orientation and training on how to go about establishing user fees to responsive/willing MLGUs. The orientation and training will be done with the DOH Reps and PHO technical staff as part of their training. The PHO technical staff and the DOH Reps are expected to take on the task of providing training technical assistance to additional MLGUs who would like to establish user fees and client segmentation.

HealthGov will work out with the PHO and CHD customized technical assistance to the MLGUs who would seek assistance for the establishment of user fees in their RHU or BHSs.

CSR planning and monitoring at the MLGU level as a means of contributing to overall improvement in health management systems is one area that healthGov can provide technical assistance as part of the PIPH formulation. It is expected that the PIPH will include a CSR plan. HealthGov together with the CHD will assist the PHO orient MHOs and PHNs on CSR planning and provide hands on assistance in the CSR Planning process. HealthGov together with the CHD will also conduct an orientation on the CSR monitoring tool as a part of the inputs to the

planning team. Inclusion of CSR monitoring in the PIPH will help ensure the implementation of a monitoring system for CSR.

The expected output of this intervention is an increase in the number of MLGUs having CSR plans and using the CSR monitoring tool as part of the management system for the family planning program

3. Service Delivery

Utilizing Effective Systems In Addressing Implementation Gaps In Service Delivery.

HealthGov will assist the province in the use of an effective system in addressing implementation gaps in service. After an orientation on the SDIR tool, the provincial health office decided to undergo the SDIR and come up with an acceleration plan that will address implementation gaps focusing on areas with distinctly low performances. The SDIR orientation and data gathering will be completed before the end of September. HealthGov together with the CHD will assist the PHO in the conduct of the three day workshop(four batches-covering 35 MLGUs and 2 cities). The municipal acceleration plans are expected to be incorporated into the AIP for health 2008 and also an input to the 2008 interventions in the PIPH.

It is expected that the first run of the SDIR which will happen in October 2007 will serve as a hands on training for the PHO staff and DOH Reps in the conduct of the tool. The PHO can continue to use the tool as part of their health management systems particularly in assisting the MLGUs plan critical interventions to address implementation gaps. The SDIR will also serve as part of the situational analysis for the PIPH preparation. Inclusion of the use of this SDIR tool in the PIPH will help ensure its institutionalization.

HealthGov will provide full assistance in documenting the SDIR process and Outputs. The SDIR data can serve as baseline data for the service delivery that will be used in the plan preparation.

Establishment Of An Effective Early Warning And Surveillance System For Avian Influenza

Isabela has a critical role to play in helping keep the Philippines Avian Influenza free. Some barangays of Ramon isabela is are periodically visited migratory birds, which are considered as possible carriers of the deadly disease. HealthGov will assist the CHD and PHO in the establishment of an effective early warning and surveillance system for avian influenza in selected barangays of Ramon, Isabela. HealthGov will help in the design and conduct of orientation of municipal and barangay officials including health workers in Ramon Isabela on the surveillance of avian influenza. After the orientation, healthGov will assist in organizing the early warning and surveillance systems in the selected barangays..

HealthGov will collaborate with HealthPro in providing assistance to Isabela on IEC concerns.

4. Regulation

Stepping Up Accreditation of Facilities

Ensuring the availability of Philhealth accredited facilities that provide quality health care services to the large number of PhilHealth card holders is one major concern that HealthGov will be providing assistance. HealthGov will help mobilize the PHO, CHD and Philhealth to work together to address this concern. As an initial step, HealthGov will facilitate a joint meeting

among the CHD, PHO and the PhilHealth to assess the status of accreditation and identify measures for stepping up the number of facilities accredited by Philhealth. The expected output of the meeting will be the commitment of these agencies to work together as an inter-agency committee that will plan and implement an advocacy plan for accreditation. Once this is attained, HealthGov will facilitate a planning meeting with inputs from resource persons from PhilHealth and CHD. It is expected that an advocacy plan of action will be formulated. The advocacy plan of action will be directed to key MLGU officials with the end in view of getting MLGUs commitment and action to work out for the accreditation of their facilities particularly their RHUs and BHSs. LGUs commitment could mean committing some resources to make the facilities attain the standards for PHilhealth accreditation.

Simultaneous with the advocacy work, HealthGov will work with the CHD to mobilize the DOH Reps to provide assistance to the RHUs in understanding the accreditation requirements and drawing up a plan for facility improvement. HealthGov together with the PHTL will capacitate the DOH Representatives through the conduct of an orientation and action planning. Regular meetings will be called to assess progress and results of advocacy activities.

HealthGov in collaboration with PhilHealth will also assist the LGUs understand and make maximum use of the capitation funds for the continuing improvement of the facilities. Information on capitation funds will be part of the advocacy sessions to be conducted for the MLGUs.

The end result of the above activities will be an increase in the number of RHUs and BHS becoming PhilHealth accredited facilities.

Upgrading of facilities for Philhealth accreditation is expected to be part of the interventions that will be included in the PIPH. As such, financial resources needed for the upgrading of facilities is expected to be made available.

Enhancing Health Systems through the Province-wide Investment Plan for Health
PROVINCE OF NUEVA ECIJA TECHNICAL ASSISTANCE PLAN

Background

The Province of Nueva Ecija is situated in the eastern rim of the broad Central Luzon plains. It is bounded by and strategically located along three regional boundaries: the provinces of Pangasinan (Region 2) in the North; the province of Aurora in the East; the province of Tarlac in the West; and the provinces of Bulacan and Pampanga in the South. Three mountain ranges protect and serve as natural barrier of the province; Sierra Madre on the East; Caraballo on the West; and Cordillera on the North. The province is composed of 27 municipalities and 5 cities and an aggregate total of 849 barangays. It has a total land area of 550, 718 hectares where 63% of which are alienable and disposable lands and the remaining 37% are forestlands.

Agriculture is the primary industry of the province. Due to rapid urbanization in nearby provinces adjacent to Metro Manila, Nueva Ecija is fast becoming the "Food Bowl and Rice Granary of Central Luzon". The primary agricultural products are rice, onion, garlic, corn, melon and mango. Its agricultural production covers an area of about 298,742 hectares of fertile lands nourished by the Great Pampanga River and its many auxiliaries.

The province is composed of 26 component municipalities and 6 cities. It has a total of 849 barangays. For a long time, the governorship and key elected positions in the province are controlled by the Josons. However, the political dynasty of the Josons was interrupted by the election of Gov. Aurelio "Oyie" Umali in the May 2007 local elections. In the said elections, the Josons suffered a major loss although the former governor's son, Edward Thomas Joson and his brother, Edno Joson managed to be elected as vice-governor and congressman respectively. Despite of the Josons' loss, the political party they established – the BALANE Party – remains the majority party controlling the Sangguniang Panlalawigan and most of the municipalities.

Situation of the Health Sector

Vital Health Indices Way Below

Health workers in Nueva Ecija wish to see the day that every Nuevo Ecijano is provided with adequate health service. However, such dream is still far from reality. In 2005, the province ranked fifth nationwide on non-immunized children on DPT3. It improved its ranking in 2006 with 77.38% fully immunized children (FIC), but still ranking no. 16 nationwide in terms of low performers on non-immunized children. The contraceptive prevalence rate (CPR) plunged from 75.9% in 2005 to 38% in 2006. Health workers attributed such low performance to inadequate supplies of vaccines and commodities and problems with their health information systems which resulted to under-reporting. The TB case detection rate (CDR) went a little higher from 45% in 2005 to 53.6% in 2006. However, such accomplishment is still way below the 70% performance standard. Nonetheless, the TB cure rate in 2006 is several notches higher than that in 2005 from 70.5% to 86.6%. Although there is ample provision of medicines with buffer stocks for 2007 from DOH, LGU support for the procurement of anti-TB drugs must be sustained.

In the case of micronutrients supplementation, only 8% of the eligible population of pregnant women was given complete iron dosage in 2006 while 40.85% of postpartum women had completed iron dosage supplementation. Only 19% of the eligible population of children ages 6-11 months was provided Vitamin A supplement. On the other hand, 348.9% of the eligible population of children ages 12-59 months was given Vitamin A; 9% of lactating mothers was given Vitamin A supplementation. Only 0.2% of women with ages 15-49 years were provided iodized oil capsules.

The province has 1 DOH-maintained hospital, 3 provincial hospitals, 6 district hospitals, 3 community hospitals, 1 military hospital, 51 rural health units, and 161 barangay health stations.

Deterioration of Health Services due to the Disintegration of the Local Health Systems

The Provincial Health Office (PHO) identified the disintegration of health service delivery due to unmanaged devolution as the culprit for the declining vital health indicators of the province. Since most LGUs are 3rd to 5th class municipalities, they have not yet fully appreciated the value of devolution and still look up to DOH as a direct service provider more than a technical assistance institution. Depending heavily on internal revenues allotment (IRA), LGUs are adversely affected by the fiscal decentralization. Since the IRA is not enough to match the needed requirements for local healthcare spending, the local health facilities took the cudgels for the deterioration of health services, lesser availability of essential drugs and medicines, and inadequate human resources. With patronage politics playing heavily in the province, local elected officials are used to giving and receiving dole-outs which lead to the lack of strategic thinking for health as a priority investment. Medical missions are misused as political gimmicks. Ironically, drugs and medicines are more accessible during medical missions while RHUs are languishing with the absence of bare essentials like cotton balls.

The province has an annual procurement plan for TB, FP and Micronutrients drugs and commodities. However inadequate the quantities are, these drugs and commodities are procured on time every quarter. Procurement is done through the PBAC. Drugs and commodities acquired by the province are for augmentation purposes only. Hence, the responsibility to make the supplies adequate is in the hands of municipal governments.

The PHO implements the policy “no report, no supplies.” Hence, drugs and commodities purchased by the province including those that were given by DOH are distributed on a come-and-get basis except if there were scheduled medical missions in which case, the augmentation drugs and commodities were directly handed over to out-patients.

The bed occupancy rate for the 9 provincial-run hospitals decreased from 81% in 2004 to 74% in 2006. The number of OPD cases also went down from 186,000 in 2004 to 178,000 in 2006. The decline in the number of patients treated in public hospitals was attributed to the increase in referrals from public hospitals to private hospitals. Core referral hospitals are forced to pass on patients to private hospitals because of lack of competent personnel and poor facilities.

Moreover, only 10 RHUs are Sentrong Sigla certified and PHIC accredited out of the 46 RHUs being technically supervised by the Provincial Health Office. Not all Sentrong Sigla maintaining RHUs have PHIC accreditation and vice versa.

The health facilities in the province are faced with the lingering problems of outdated equipment and inadequate supply of medicines needed to properly respond to patients’ condition. The exodus of health workers particularly of public doctors and nurses compounded the situation of

the public health facilities. It significantly contributed in the decreasing ratio between public health workers and the population beyond the accepted standards.

According to the PHO, only 10 of the 32 component cities and municipalities submitted their 2006 FHSIS report on time. DOH Representatives estimate that around 50% of the RHUs were delinquent in submitting reports. In most cases, the data separately collected from the RHUs by the PHO and the DOH Reps did not jibe which led to confusing and even conflicting information. Data retrieval from RHUs could have been easy if only the district health systems are in place. FHSIS reports may be submitted by catchment municipalities to the district hospital which in turn shall submit the ILHZ consolidated report to the PHO. Moreover, the use of information technology still has to be optimized. Most of the MHOs lack computers for processing and storing health data. Automation can contribute to the timely transmittal and accurate analysis of data needed for local health system planning.

To address the inadequacy of health facilities and maximize the available resources, inter-LGU cooperation in health service delivery is paramount. Nueva Ecija has six unified local health systems (ULHSs). However, only two are functional and these are the San Jose District with seven catchment municipalities and the Guimba District with four catchments municipalities. The lack of support from and appreciation of LCEs for inter-LGU cooperation for health services and the highly divisive and often violent political culture were pointed out as reasons why the inter-local health zone concept was not sustained.

The local health board is regarded as having an important role to play in the establishment of functional ILHZs since the LHB serves as the recommending body for the creation of ILHZ to the local chief executives. However, most of the Local Health Boards were formed for compliance but were not regularly convened to provide inputs to LCEs. In many cases, there were no representatives from civil society despite the fact that R.A. 7160 otherwise known as the Local Government Code of 1991 mandates CSO/NGO representation to local development councils and special bodies.

Challenges in Sustaining Better Financing for Health

The provincial health budget increased from PhP178,896,631in 2004 to PhP 204,518,997 in 2007. This increase may be due to the fact that 2007 is an election year. Actually, there was no significant increase in the MOOE of health personnel and a large chunk (72%) of the appropriated budget was for personal services.

Despite of this, the province's health workers did not receive the full benefits of the Magna Carta for Health Workers. Furthermore, only a few municipalities are giving full Magna Carta benefits to their health workers. This has led public health workers to moonlight to augment their income, to the detriment of patients particularly indigents. For instance, since medical officers particularly the resident physicians are only required to complete 48 duty hours, they often abused the system by going on duty for two days straight and spending the remaining working days doing private practice, leaving the poor hospital without a physician for the rest of the week.

Nueva Ecija has a local health insurance program that was envisioned at the beginning to provide health financing to the indigent residents. But since its conception in 2003 the program has evolved to include provincial employees and non-indigent as beneficiaries. NEPHCARE is exclusively for the residents of Nueva Ecija. It was created by virtue of Provincial Ordinance 349 No. 49 s 2003 to provide quality health care financing for Nuevo Ecijanos. As of last year, it has 5,000 principal members, 10% of whom have utilized the insurance and received

reimbursements. At the first phase of its implementation, membership was solely for indigent or locally sponsored residents, and this has been expanded to cover government and private employees. Through the years, it has accumulated 12,000 patronizing members.

NEPHCARE can be viewed as a complement of the National Health Insurance Program. But some observers maintain that the program is more a political expediency. With a new governor around, it must be determined definitively if the new governor is keen on continuing the province-sponsored local health insurance program. At the moment, the new administration is still studying the scope, marketability, and sustainability of NEPHCARE.

Technical Assistance

Given the situation of the health sector in Nueva Ecija, the Project has helped the province to address its substandard performance on some vital health indicators by extending technical assistance to the PHO and DOH Representatives in equipping them with appropriate tools for assessment and situational analysis. Through the Service Delivery Implementation Review (SDIR), they have guided the RHUs and core referral hospitals to evaluate their public health and hospital programs respectively by zeroing in on the vital health indicators and standards. SDIR has enhanced the program implementation review being conducted by the PHO on an annual basis. The RHUs and core referral hospitals were made to identify critical interventions to be reflected on their acceleration plans. The SDIR outputs wi be utilized for the preparation of the 2008 Annual Investment Plan for Health in the immediate and the five-year Province-wide Investment Plan for Health in the strategic.

Furthermore, the local NGOs were oriented on the health sector reforms focusing on the FOURmula ONE framework and capacitated to effectively engage in partnership with LGUs in mandated participatory mechanisms such as the Local Health Board and Local Development Council.

The technical assistance being provided by the Project is in line with the thrust of the CHD to integrate the hospital and public health services for a more efficient and holistic delivery of health services. It may be achieved through the revival and strengthening of the district health concept as the mechanism to address fragmentation of health services but with inter-LGU partnership as the basic framework. Acknowledging its limitation to solely address all the technical and augmentation needs of the local health systems, the PHO of Nueva Ecija explicitly expressed the necessity of bringing back the unified approach to local health services.

Furthermore, given the economic status of most LGUs of the province, municipalities should have more compelling reasons to promote and adapt inter-LGU cooperation through the establishment of functional inter-local health zones. By pooling together their limited resources for health services, they are in effect augmenting their respective investments for health through networking, referral system and cost-sharing scheme. For instance, the four non-functional ULHS can draw lessons from the San Jose and Guimba District Health Systems wherein catchments municipalities are cost sharing with the provincial government in hospital operations by providing assistance in some repairs and augmenting human resource requirements. Hopefully with a renewed impetus on the unified local health systems approach, the province and municipalities of Nueva Ecija will be able to effectively and efficiently address unmet health needs of their constituents.

Objectives of the Technical Assistance

The technical assistance for Nueva Ecija for Year Two will proceed in line with the thrust of renewing interest in the unified approach to local health systems and strengthening as a best practice the functional inter-local health zones of the province.

The Project will extend technical assistance to CHD Region 3 and to the province of Nueva Ecija to further equip them in achieving the following objectives:

- To increase the number of functional ULHSs by providing technical assistance to improve governance and stewardship for local health systems;
- To increase the percentage of RHUs that are Sentrong Sigla-certified and PhilHealth-accredited from 31% to 85% by extending technical assistance to upgrade healthcare management and service capabilities of local health facilities and acquire better financing options to augment the health budget;
- To increase the number of active local health boards and to broaden civil society and private sector participation by extending technical assistance to the same for expanding the constituency for local heath sector reforms.

The achievement of these objectives will lead toward addressing effectively in the immediate term the gaps and problems in achieving better health outcomes.

Strengthening LGU management systems (IR 1.1)

Development of the 2008 Annual Investment Plan for Health through the PIPH Approach

The need for improvement of the province-wide health systems to address the fragmentation or disconnection of health service delivery at different levels of governance shall be addressed by the PIPH development. Focusing on strengthening the linkage between primary health care services and core referral hospitals, the PIPH process will enable the province and municipalities to craft a more integrated and comprehensive 5-year health plan that will respond to emerging needs of the local health sector. Moreover, one of the significant outputs of the PIPH development is an operational plan for local health systems development. Through the formulation of the PIPH, concrete activities, projects and programs will be identified to address the problems and issues that hinder the efficiency and effectiveness of an ULHS-approach.

Beginning with the formulation of the 2008 annual health investment plan, the Project shall assist the planning team designated by the governor and mayors in crafting the various technical plans as required in the PIPH development through the following:

(1) Training of Facilitators.

The main objective of the Facilitators' Training is to equip the designated Planning Team to include PHO technical staff and CHD/DOH Representatives with basic facilitation skills using the Technology of Participation (ToP). The would-be facilitators shall be trained how to facilitate the PIPH workshops on Local Health Situational Analysis and Goal Setting and Determining Strategies and Critical Interventions. During the actual PIPH development workshop seminar, specialists from HealthGov and CHD shall be present on stand-by mode for mentoring purposes

to assist the facilitators in fulfilling their task to guide the participants in the formulation of an Annual Investment Plan for Health for 2008.

(2) Write-shop on PIPH Development

As a follow-through activity, technical assistance shall be extended in a form of a write-shop on packaging the PIPH technical plans into a cohesive investment plan document which can serve as a social marketing tool to attract investors and donors. Such activity may be done at the regional level and participants will be from the provinces of Bulacan, Tarlac and Nueva Ecija. The assistance can be provided by an STTA provider.

(3) Monitoring and Evaluation Tool to Track Local Progress in PIPH Implementation

In view of the task to monitor the LGU's mandate to implement the annual investment plan for health, the Project shall conduct a Luzon-wide orientation seminar on PIPH Monitoring and Evaluation Tool to the CHDs concerned to equip them with the practical knowledge and skills to re-echo the same to their catchments provinces. The objective of this assistance is to equip the local health planners with the benefit of reviewing the implementation of the AIP for Health of the current year that will serve as inputs for the AIP of the succeeding year. The said CHD orientation shall be conducted on July 2008 in time for the preparation of the 2009 annual investment plan.

<u>Renewing the Unified Local Health Systems Approach to Service Delivery</u>

The thrust of the Provincial Health Office right now is to revive the ULHS-approach to health service delivery. Technical assistance shall be provided to CHD, PHO and DOH Representatives in order for them to effectively assist the 4 non-functional ULHS and 2 functional ULHS to revive and strengthen the district health system approach using inter-LGU cooperation and public-private partnership as operational framework.

(1) Training of Trainers and Advocates of the ILHZ Development

A refresher orientation course shall be extended to CHD, PHO, DOH Representatives to upgrade their knowledge and skills on promoting and managing inter-local health zones. The core topics are as follow:

- Organizing ILHZ – pertains to the critical steps in the setting up, organizational development and monitoring and evaluation of an ILHZ. It contains various models of ILHZ organization with their pros and cons based on the lessons learned in ILHZ development.
- Financing ILHZ – pertains to practical guide on cost-sharing schemes and managing common funds as well as procedures for disbursement, auditing and reporting.
- Strengthening the Referral Systems – the topic content is based on the DOH Standard Manual on the Two-Way Referral Systems. It defines the role and responsibility of the health care facilities and health providers within the system. Moreover, it illustrates the referral flow of patients as well as the use of referral slips and recording systems.
- Promoting ILHZ – pertains to lobbying for political support through issuances of resolutions and an executive order supporting ILHZ development, and concretizing agreements by signing a memorandum of agreement. This also includes a Guide for Building Partnership for Health which highlights multi-sectoral involvement as an effective approach to the establishment of an ILHZ.

This technical assistance shall be provided to CHD, PHO and DOH Representatives on the second quarter of 2008. After the conduct of the Training for Trainers, the CHD and PHO are expected to provide orientation workshops at the municipal level on the ILHZ development which the intention to muster support from LCEs to engage in inter-LGU cooperation for health services.

(2) Formulation, Implementation and Monitoring of Operational Plan for ILHZ Development

The Project shall provide continuing technical assistance through mentoring services to the PHO and DOH Representatives to help assist ILHZ in the formulation, implementation and monitoring of the operational plan for ILHZ development.

Improving Health Data Management System

The PHO has indicated in the 2007 investment plan as one of its priority the conduct of a capability building activity to enhance the efficiency of health workers in health management information system.

(1) Training/Mentoring on Simplified and Electronic Database Management System

The Project aims to assist the PHO and ILHZ in improving their information management systems by building or harnessing the capabilities of the PHO and ILHZ to address data gaps which are still common in most FHSIS reports, systematize the collection, storage and retrieval of data information, and clarify the flow of information from the RHUs to ILHZ/PHO through an improved reporting system. To facilitate easy access to information and data-crunching and analysis, the Project together with CHD shall provide technical assistance in terms of training or mentoring the data encoders or the FHSIS coordinator on simplified reporting system and developing an electronic health database system at the provincial and ILHZ level.

Improving and expanding LGU financing for health (IR 1.2)

Resource Mobilization Plan as incorporated in PIPH

One of the desired outputs of the PIPH development is a concrete resource mobilization plan that indicates in particular the activities to be done in tapping potential sources of funds. All LGUs that participated in the PIPH formulation shall be encouraged to come up with their own resource mobilization plan.

In line with the PIPH, a thorough review of the current sources of financing for health (grants, loans, internal sources, etc.) by the LGU concerned shall be conducted.

(1) Guideline Development for Planning for Philhealth Universal Coverage.

In this case, PHILHEALTH should still be promoted particularly to municipalities to expand coverage and improve benefits since reimbursements and capitation funds are clear sources of finance augmentation for health services and to lessen out-of-the-pocket expenses particularly for the poor. Technical assistance for that matter may come in the form of developing with CHD, PHO and DOH Representatives the Guidelines for Planning for Philhealth Universal Coverage.

Then, the CHD, PHO and DOH Representatives shall assist municipalities that will demonstrate interest in the PHILHEALTH universal coverage shall be assisted in the preparation of a financial plan.

Improving service provider performance (IR 1.3)

Follow Through and Monitoring of the Outputs of the Service Delivery Implementation Review

The ILHZ is as good only as the quality of services provided by the referral hospitals and health facilities of catchments municipalities. The Project shall continue to assist the CHD, DOH Representatives and the PHO in monitoring the implementation of the acceleration plan crafted by each RHU/municipality and provincial-run hospitals. In the last quarter of 2008, SDIR shall be again conducted jointly by the CHD, DOH Representatives, PHO and MHO to assess the progress in the achievement of health outcomes based on agreed program indicators.

Technical assistance from HealthGov will focus on improving the SDIR tools and developing a monitoring tool to follow up the implementation of the acceleration plan.

Strengthening the Unified Local Health Systems through Sentrong Sigla Movement

Given the fact that only 31% of RHUs are maintaining Sentrong Sigla - Phase I Seal of Excellence, technical assistance shall be extended to CHD, PHO and DOH Representatives to assist RHUs which are interested to invest on a quality assurance program.

(1) Overview Orientation Seminar on SDExH

An overview of the capability building packages including Certification and Recognition Program (CRP), trainings on Continuous Quality Improvement (CQI) and Standard Based Management and Recognition (SBM-R) shall be provided to CHD and PHO for them to have a glimpse of what the SDExH is all about so that they may be able to promote to LGUs which are much willing to invest their time, human and financial resources in service delivery excellence to attain Sentrong Sigla status– Basic Certification Standards at the very least.

Increasing advocacy for health (IR 1.4)

Advocacy Plan as incorporated in PIPH

One of the desired outputs of the PIPH development is a comprehensive advocacy plan to be jointly crafted by public health personnel and civil society organizations in the province and municipalities. The Project shall assist the PHO, MHO and NGOs and Private Sector in the formulation of such plan. A multi-stakeholder forum on health shall be conducted by local NGOs to firm up the commitment of the stakeholders involved in pursuing the planned advocacy program to address policy issues and behavioral change.

Development of Advocacy Orientation Materials for CSO/NGO

The lack of a critical mass among civil society organizations to pursue local health reforms is one of the impediments to an effective advocacy program.

The Project shall assist civil society organizations involved in health to hone their advocacy skills to include other related-skills needed for effective advocacy such as constituency building, claim-making, networking and negotiation.

The Project shall assist NGOs in understanding the rudiments of local legislation and equip them with the sharpness and ability to assess the balance of forces and interests in a given playing field.

Furthermore, the Project shall assist NGOs in monitoring the status and outcomes of their advocacies such as how many legitimate NGOs managed to become members of Local Health Boards and Development Councils, how many inputs and recommendations from CSOs are deliberated at the LHB or legislative bodies and are passed into ordinances, to mention a few.

Given their critical contribution to the decision making process, there is a need for NGOs and CSOs sitting in the local health boards to be more responsive towards the development of the local health systems through the ILHZ approach.

Concretely, HealthGov shall provide technical assistance to CSO and NGO through the development of HSRA Advocacy Orientation Materials for CSO and NGO.

The Poor at the Center of Development
PROVINCE OF PANGASINAN TECHNICAL ASSISTANCE PLAN

Background

Pangasinan is one of the largest province in Northern Luzon with an east-west configuration that extends into a peninsular form jutting into the China Sea. Its boundaries are Lingayen Gulf, La Union and Benguet on the north, Nueva Viscaya on the northeast, Nueva Ecija on the east, Tarlac on the south, and Zambales and China Sea on the west.

The province occupies an area of 5,368.18 sq. kms. (536,818 hectares) and is composed of 44 municipalities, 4 cities (Dagupan, San Carlos, Urdaneta and Alaminos) and 1,364 barangays spread over six congressional districts.

The projected population in 2006 is 2,650,312. As of 2000, households total 477,819 with an average household size of 5.09. Pangasinan's population grows at an average rate of 2.41% and at this rate, the population is projected to double in twenty nine (29) years. Eighty six percent (86%) of the population are Roman Catholics, 3 % are Inglesia ni Kristo, 3% are Aglipayans, 1% is Methodists, 2% Evangelicans, 1% Jehovah's Witness and 2% belongs to tribal religions and 2% other religions.

The average monthly family income is P15,333.00 (NSO, 2001) . In 2003 the poverty incidence stood at 25.8%. Employment rate is at 93.20 and unemployment rate at 6.80

Health Program

Health has been a priority agenda of the province in the administration of Governor Victor Agbayani which lasted for 9 years. This can be seen from the reforms and programs in the areas of family planning, hospital reforms and active cooperation with Health Sector Reform programs with the Department of Health and partner foreign donor agencies. This cooperation culminated in the preparation of the Province-wide Investment Plan for Health in 2006 and poised for operationalization in 2007 up to the next 4 years. Some of the health system and program indicators are presented below:

The present administration of Gov. Espino is determined to help the poor, the senior citizens, the differently abled and the marginalized.

To be able to do this, the provincial government will tap the health facilities which are composed of 16 government and 44 private hospitals, 68 Rural Health Units and 416 Barangay Health Stations.

All the government hospitals are licensed in addition to 25 of the 44 private hospitals.

For PHIC, 15 facilities are OPB accredited, 45 for MCP and 36 for TB DOTS.

The RHUs are manned by 862 personnel and the hospital by 720. The details are as follows:

Table 1: Human Resources in Pangasinan RHUs and Hospitals, 2006

Health Personnel	RHU	HOSPITAL
Physicians	71	196
Nurses	102	275
Midwives/Nurse Aides	504	169
Rural Sanitary Inspectors	85	6
Dentists	46	9
Nutritionists/Dieticians	8	14
Medical Technologists	46	24
Total	862	720

Source : PHO-Pangasinan

The indicators for health and those related to it are as follows:

Table 2: Health Indicators for Pangasinan, 2006

Indicators	
Crude Birth Rate (per 1000 pop)	20.49
Crude Death Rate (per 1000 pop)	4.94
Infant Mortality Rate	9.19
Maternal Mortality Rate	0.39 per 1,000 LB
Malnutrition Rate	
Pre-School (except Dagupan City	8.0
School children (except Dagupan City)	15.91
FAMILY PLANNING	
- Contraceptive Prevalence Rate	56 % (Standard = 60%)
FIC	76.9% (Standard = 95%)
TB Morbidity Rate	105.7
-Case Detection Rate	72% (Standard = 70%)
-Cure Rate	89% (Standard = 85%)
PHIC enrollment	64,084 (2006)

Source: PHO, PHIC

Situation Analysis
Health sector planning and budgeting

There are 32 LGU plans, 33 HIS-CBMIS, 33 CSR + plans, 23 local health legislations, 23 CSR budget approvals in place.

The Province-Wide Investment Plan for Health was crafted in 2005. The Memorandum of Agreement approving the implementation of PIPH was signed by Governor Agbayani mid-2006.

The former Governor formed the Project Management Core Team composed of PPHO PHO, PBO, PTO, PHIC, PHTL. This team was the small group the Governor will consult with regards PIPH but this team never managed to meet. Neither was an Executive Order created to give this Team a legal mandate.

Financing
The PIPH provided financing totals P 163.6 million with breakdown as follows: PLGU counterpart - P26,001,759.00, MLGU counterpart - P 32,827,674.66, regular DOH-P41,658,267.00, DOH-EC-P 10,896,000, EC Grant-P26,001,759.00, PHIC-P25,577,370.00 and US-AID/TB Linc P 3,950,000.00. A total of P32,827,674.00 will be the counterpart of the 21 LGUs in the 3 ILHZ that will be piloted.

Presently, the P 2.1 million start-up funds from DOH was already released and being used. The problem is in the release of the 1st tranche of P 10 million which was due May 2007 and the 2nd tranche of P 25 million which was due September 2007. The new governor has written DOH about this.

Meanwhile, the provincial government is engaging Health Gov in crafting their Public Finance and Management Plan. While Pangasinan is an F1 site, the immediate task on hand is to assist the province in the CSR Assessment and Monitoring, Assessment Planning and in market classification.

Logistics procurement and distribution
MSH through LEAD has assisted the province in the Provincial Procurement Plan. The PPO staff in charge with this has expressed the need for the procurement plan to be reviewed to determine areas for assistance.

Obviously there are problems in procurement itself as 27 LGUs were monitored not buying FP commodities as of July 2006. There also seems to be problems in forecasting as manifested in stock outs of 26 service points for pills and 22 service points for injectables in addition to problems on distribution from the municipalities to the barangays.

The new Governor wants a centralized procurement. He is criticizing the autonomy of hospitals in deciding what and where to buy. The procurement is handled by the General Services. Under his administration, Gov. Espino wants the PHO to have a hand. This is an area for TA.

Health service delivery
The health service delivery on the government side is done by the 16 government –owned hospitals and the public health office. The public health office oversees the 68 RHUs and 468 Barangay Health Stations.

Health Facilities
There are 16 government and 44 private hospitals. All these government hospitals are licensed. The RHUs total 68 and there are 416 Barangay Health Stations.

Fifteen (15) hospitals are OPB accredited, 45 in MCP and 36 in TB DOTS.

The province continues to face its key challenges in terms of health needs, service delivery system, regulation, financing and governance. While some improvements have been experienced in the past few years, Pangasinan's health needs are evident in a number of critical indicators such as Infant Mortality Rate which is one of the highest among other provinces in the region. This can be attributed to poor prenatal and postnatal care and also to poverty.

The contraceptive prevalence rate is moderately high at 56 % but with considerable high unmet family planning needs. The leading causes of mortality are lifestyle and degenerative diseases such as hypertension, cardiovascular diseases, while the leading causes of illnesses are infectious in origin such as acute respiratory infections, diarrhea and tuberculosis. There are about 15 municipalities with malnutrition prevalence of more than 10 percent. The number of health care facilities is inadequate given the average ratio of RHU to population at 1: 35,000. The level of social insurance contribution remains low in proportion to out-of-pocket expenditures. Public-private mix needs to be addressed too and the distribution of personnel and facilities. Most clinics and doctors are located in the bigger cities and municipalities.

1. Family Planning/Reproductive Health

The province's 2007 population is estimated to be 2.6 million. The population growth rate of 2.41%, the province's population will double in 29 years. The province has a high CPR of 56%, However, this still falls below the standard of 60%. Four (4) ILHZs did not perform well.-W. Pangasinan, Pilgrims, Mangabul and Layug.

Unmet needs for FP average at 20% and are highest in Manleluag ILHZ at 26% and Layug at 20%.

As of July 2006, twenty seven (27) municipalities/city did not procure FP commodities.

Indicator	Performance Standard	Accomplishment	ILHZ that Did Not come Up with the Standard Performance
1. Contraceptive Prevalence Rate	60%	56%	W. Pangasinan, Mangabul, Pilgrims and Layug
2. Unmet Needs for FP	Western Pangasinan	11,261	24%
	Manleluag	5,962	26%
	Palaris	11,209	17%
	Mangabul	1,835	19%

Pilgrims	9,245	16%
Layug	7,295	20%
Total	46.807	20%

2. Maternal and Child Health and Nutrition

The province also did not do well in Maternal Care. In 2006, 20 maternal deaths were recorded. The diagnosis are shown below.

Maternal Deaths in 2006 Diagnosis	Number
HPN in Pregnancy	13
Post Partum Hemorrhage	6
Abruption Placenta	1
Total	20

The province also fell short of the national standards on pregnant women with three or more pre-natal visits, pregnant women with at least 1PP, and pregnant women given TT2 plus.

Indicator	Standard	Accomplishment	Low performing Municipalities-
Pregnant women with four or more pre-natal visits	80%	74.5% (65,263)	Infanta, Aguila, San Manuel, Natividad, Sta. Barbara, San Fabian, Balungo, Bugallon, Mabini and Basista LGUs That Needs Improvement- anda, Sual, San Nicolas, Sta. maria, Binalonan and Vilasis
Pregnant women with TT2 plus	85%	66.1% (57,848)	
Post Partum with at least 1 visit (2005)		70.8% (52,277)	

The province also did not meet the FIC national standard and the number of children missed for Measles vaccine and DPT 3 totalled 24,409.

Indicator	Standard	Accomplishment	Unmet needs
EPI	95%	82%	
Unmet Need for DPT 3			12,714
Unmet Needs for			11,695

Measles

3. TB Control

The accomplishment for TB case detection rate and cure rate both surpassed the national standard, probably because of the EQA system in place in 6 ILHZ.

Indicator	Standard	Accomplishment	Unmet needs
Case Detection Rate	70%	72%	
Cure Rate	85%	89%	
TB DOTS Center	60%	32%	
EQA System		In 6 ILHZ	
Mortality		26.52%	

4. STI, HIV and AIDS

Seven of the province's highly urbanized and urbanizing municipalities and city are now implementing STI programs. IEC materials and advocacy activities will focus on these municipalities.

Basic Statistics	
Municipalities/City With SHC	Urdaneta City, Mangaldan, San Jacinto, Bolinao, Natividad, Sison and Tayug
Number of Registered Sex Workers	723
Number of Sex Workers Examined	29
Number of Smears Examined	8,025
Number of STI Cases	908
Number of Cases Treated	
-Gonorrhea Cases	19
-NGU	484
-Trichomonosiasis	16
-Bacterial Vaginosis	362
-Candidiasis	53
PR of STI	0.67 (Standard is less than 1%)

5. Other Infectious/Emerging Diseases

The province has named rabies control, leprosy control and CARI as the diseases to watch and have put in place some measures to monitor/address these.

Indicator	Standard	Accomplishment	Top Ten Municipalities with Highest Incidence of Dog Bites
Rabies Control		990	San Carlos, Malasiqui, Binmaley, Sta. Maria, Mangaldan, San Jacinto, Mangaldan, , Bugallon, Labrador, Urbiztondo
• Animal Bite Cases Seen			
• Given post exposure		119	
• Human Rabies		No report	
Leprosy Control			
• Case Detection	Should not be more than 5%	2.30%	
• PR		0.11	
ARI		7,629 cases in 2006	

Technical Assistance

Pangasinan is the only F1 site in Luzon. In year 1, scoping missions and data gathering were done prior to the election period in May. The Health Gov staff interviewed the personnel of PHO, CHD-1, PPO, PPDO, Treasurer's Office, Budget Office, Sangguniang Panlalawigan Office and PHTO for this purpose.

Data gathering went as far as the level of 46 LGUs with the PHO staff helping.

Early on, Health Gov has assisted in providing the tool for the Implementation Plan and roadmap. The Finance and Budget specialists have also helped in the technical assistance needed for the Public Finance Management Plan required for the PIPH operational plan.

After that, the PHO and PHTO staff were oriented on Health Gov, US-AID SOAG, CSR Monitoring tools, SDIR tools and LCE orientation.

Health Gov PC has also attended meetings with other CAs-TB Linc, PRISM and A2Z.

One of the big accomplishments of its first year was the training of convenor NGOs and as a result the Provincial Partnership Building Workshop will be held in September 2007. The convenor NGOs are doing mapping and working on the accreditation of other NGOs...

In Year 2, the Theme, "The Poor at the Center of Development" seems apt because it coincides with governor's pronouncements for this health program priorities. In this connection poverty mapping/ client classification will be pursued by HealthGov to identify who are the poor and where they are.

To be able to accomplish this vision, the following are the TA:

1. Poverty Mapping/Client Classification

This will make use of the CHB/LSS tool. The implementation of poverty mapping/client classification would necessitate the involvement of the 21 LGUs of the three prioritized ILHZ. The TA would cover the following:

- Previously the PPO was oriented on the LSS
- HG will facilitate and provide the tools for the Assessment of LSS status
- The PHO, PSWDO, Housing Office and PPDO and other partners oriented and will formulate and execute implementation plans
- If needed, the draft of new CHB/LSS questionnaire shall be written
- The LCEs will be oriented by PHO, PPO, PSWDO and other partners
- HG shall facilitate training on how to do LSS
- Surveys conducted by the LGUs, will be encoded and analyzed by the province
- LGUs use survey results will be used as basis for policy decision. The HG will provide TA for this.
- HG shall assist the province in planning for the monitoring activities

Still related to this is the CBMIS tool being used in the province for the identification of their unmet needs. The CBMIS was institutionalized and developed by MSH under DOH Matching Grant Program in 2001. The CBMIS is a tool that allows health care providers to identify eligible program for EPI, Vitamin A and FP who don't avail or have no accessibility to health service. The CBMIS was piloted in Bayambang, Malasiqui, Mangaldan, Asingan, Laoac, Binalonan and Urdaneta City.

In 2006, the system was re-introduced under LEAD and included TB DOTS. The pilot areas were Layug, Pilgrims excluding San Carlos City and some pilot areas for Manleleuag, Mangabul and Western Pangasinan ILHZ. Again, this time the system allows the health care systems provider to identify unmet needs for EPI, Vit. A and TB DOTS.

The CBMIS covered 100% of Layug, and 89% of Palaris and Pilgrims

- Aguilar and Bolinao are still consolidating the outputs. There are problems however in recording and reporting. Some of the data needs validation and the survey stalled because of lack of survey forms.

With this, there is a need to strengthen CBMIS. HealthGov can provide TA primarily in the design of:

- a system to upgrade the Family Profile
- a system of reporting to the PHO
- a system in the establishment of a data bank
- a tool for analysis of data on unmet needs
- a system to monitor and validate data

2. Service Delivery Implementation Review

The SDIR as designed shall determine the status of the health program outcomes especially for FP, MCH, TB, Nutrition, EPI. The analysis of hindering and facilitating factors for the actual health outcomes shall help Pangasinan identify the appropriate critical interventions and resource requirements to implement future interventions in the second year of PIPH implementation. This process will determine the services needed to be strengthened for the poor

Part of this SDIR is a review of CSR implementation which can be called Responsible Parenthood and that of LSI.

2.1 CSR Assessment and Monitoring – This can be done with the SDIR but will use the CSR Assessment and Monitoring tools that the province will approve for its use. The CSR in Pangasinan is implemented for more than three years already and the province requests that a CSR Assessment and Monitoring be conducted this year (2007). The objective will be to find out the status of CSR implementation that LEAD started and plan the needed activities to improve the 56% CPR indicator.

This will be done with the following activities:

- The tool which will be finalized and approved by DOH CSR TWG as a national tool will be adopted to the province's needs. Ms. Muego said it needs further editing to capture where Pangasinan is.
- CHD, PHO, HG and other partners will formulate and execute implementation plans
- DOH and CSR TWG will finalize guidelines for implementation including analysis
- CHD roll-out in Pangasinan with back-up technical support by HealthGov
- Health Gov will assist DOH in monitoring the implementation and analysis at the field level activities led by HPDP

Note-The PHO2 requests that CSR be renamed in Pangasinan so it will be more acceptable to the new Governor..

2.1.2 CSR Planning – This will use the CSR Planning tools

- After the CSR Assessment and Monitoring is done, a CSR Planning will be held. It will include a CSR re-orientation where the following will be discussed: the strategies for promoting all FP methods, strategies for integrating FP into MCH and safe motherhood services, strategies for protecting the poor which will include client segmentation, budgeting and finance, forecasting, procurement and logistics, private sector suppliers.
- This planning session will also tackle strategies "beyond safety net" which include cost recovery systems for publicly delivered commodities to non-poor, private provider mapping, public-private referral system; private sector expansion through development of high volume providers for IUD and VSC
- The transfer of technology will be led Health Gov provincial coordinators, Health Gov specialists CHD, PHO through planning workshops, meetings, consultations and coaching. The finalized CSR planning tools will be used
- .There will be coordination with Inter-CA groups on other CSR tool based on CSR TA Plan approved by DOH and Inter-CA TWG.

2.1.3. Referral Systems - Public-Private; Public-Public
Three of the municipalities are being piloted to the referral systems. In relation with CSR, HG will monitor developments in this area. Follow-on TA will be given to the province in the implementation of the referral system.

2.1..4. Informed Choice and Volunteerism'-This will be incorporated in all the training activities in Pangasinan, HealthGov will also provide TA in ensuring compliance and monitoring on Informed Choice and Voluntarism in FP

3. Capacity-building of NGOs/CSOs for effective participation in governance for the poor

The PHB of Pangasinan will have the representative of the Pangasinan Federation of NGOs as its member. This is an opportunity to promote the participation of civil society/ non-government organizations in health governance in Pangasinan. This will be essential especially in advocating for budgets and ordinances that support the goals and activities as enumerated in their pro-poor health goals for EPI, FP, MCH, Nutrition, NTP and the other health programs in the LGUs. Currently, plans are underway for the Provincial Partnership Workshop, an initial step in ensuring participation of NGOs/CSOs in the LGUs.

The NGOs/CSOs will be the vanguards to ensure the poor of the province are benefited.

4. Assessment of current Phil Health Program to achieve universal coverage

Currently, there are still five municipalities in the province that have no Phil Health enrollees. Advocacy must be done to the LCEs of these towns. The TA of HG can be to help the province go through an assessment program together with PHIC. Here considerations for financing, accreditation status of facilities, scheduling of targets, promotion to consumers will be taken up.

PROVINCE OF TARLAC TECHNICAL ASSISTANCE PLAN

Background

The province of Tarlac is located 125 kilometers northeast of Metro Manila in the central plains of Central Luzon, landlocked by four (4) provinces - Pangasinan in the North; Nueva Ecija in the East; Pampanga in the South and Zambales in the West. It is classified as a 1st class province with 3 congressional districts, 17 component municipalities, 1 city and 511 barangays. It is a melting pot of different cultural groups – with four distinct ethnicities namely Pampangos, Ilocanos, Pangasinenses and Tagalogs.

The socio-demographic profile of the province is as follows:

Total Land Area: 3,053.45 sq. kilometers
Population: 1,068,783 (NSO 2000)
Population Density: 350
Population Growth Rate: 2.65 (5 yrs)
Indigenous Population: 22,920
Ave Family Size: 4.96
Ave Family Income: 12,542
Percent Urban: 32.5
Literacy Rate: 94.02

Health Program

The vision and mission on health of the province is HEALTH FOR ALL TARLACEÑOS which will be carried out by Provincial Health Office, in partnership with the people, by ensuring accessibility and availability of quality basic health services that will transform Tarlacenos into self-reliant and self-managing communities. The new governor, Vic Yap, has indicated his support for this vision and views the health program as essential to the development goals of the province.

The health outcome performance of Tarlac is generally satisfactory when compared to the regional targets. Notwithstanding, it aims for continuous improvement which can be categorized in terms of the following goals:

- To reduce the incidence of infectious and degenerative diseases and promote health by increasing investments for public health programs
- To institutionalize local health systems within the context of local autonomy and develop mechanisms for inter LGU cooperation
- To ensure quality, accessibility and safety of health care facilities and services, and
- To expand the National Health Insurance Program (NHIP) province wide to improve access to health services

Some vital health indices of the province are as follows:

	(%)
• Crude Birth Rate	21.4
• Crude Death Rate	4.5
• MMR	0.04/100,000 pop
• IMR	4.62/1,000 lb
• FIC	89 (95)
• CPR	34.49 (60)
• TB Case Detection Rate	96 (70)
• TB Cure Rate	80 (85)

Maternity and Infant Mortality Rate
The Maternal Mortality Rate (MMR) has increased in 2006 and the leading cause of mortality was postpartum hemorrhage. Given this data, the province is committed to reduce maternal and perinatal morbidity and mortality and to provide quality prenatal care to pregnant women and protect postpartum mothers and newborn babies from complications and other communicable diseases by increasing TT2 coverage from 60% (2006) to 80% by 2007.

Fully Immunized Children
To protect children from diseases treatable by proper immunization, the PHO shall increase FIC coverage from 89% to 95% by the end of 2007 and reduce incidence of neonatal tetanus among new born infants.

Contraceptive Prevalence Rate
There is a significant reduction in new (70+% to 50+ %) and current users (90% to 60+%) of FP methods in 2006 coinciding with the reduction of donated contraceptive products from the national government. With the declining supplies of free contraceptives, the province aims to intensify universal access to family planning information and services whenever and wherever these are needed. FP program shall focus on assisting couples and individuals achieve family size within the context of responsible parenthood and ensuring that quality FP services are available in all LGUs, health facilities, NGOs and the private sector. These can be done by helping municipalities to be contraceptive self-reliant (CSR) and by encouraging civil society and private sector participation in FP/RH program.

To cite an example, the Municipality of Moncada has adapted a POPSHOP of DKT to cater to the contraceptive demands of its communities and neighboring municipalities as well.

Micronutrients and Food Fortification
High prevalence of underweight preschool children was noticed mostly in 5th and 6th class municipalities where support for the nutrition program is inadequate. Owing to poor hygiene practices, contaminated water, unsanitary toilets, high prevalence of diarrhea cases was observed among preschool children.

Given the said condition, the PHO aims to improve the nutritional status of underweight preschool children and pregnant and lactating mothers by reducing the prevalence rate of below normal preschool children from 7.4 (2006) to 6.5 (2007), by further decreasing the percentage of micronutrient deficiencies (VAD IDA IDD) among the preschool children, pregnant and lactating mothers by 20 %, by addressing parasite infestation among preschool children, by maintaining

or even surpassing the 90% GP coverage, by increasing consumption of iodized salt by households from 85% to 90 %, by ensuring availability of fortified products in all sari-sari stores, groceries, food establishment, school canteens, by conducting continuous advocacy on food fortification and proper nutrition, and lastly by maintaining or surpassing the 90 % OPT coverage

TB Detection Case and Cure Rate
Determined to eliminate TB as a major cause of mortality, the PHO desires to reduce prevalence and mortality from TB by at least 25% by year 2007, improve access to quality services provided to TB patients, enhance health seeking behavior of TB symptomatic patients, strengthen management and TB control services at all levels by increasing and sustaining financing support for the program.

Dog bite cases has risen from 1700 cases in 2005 to 1900 in 2006.

Situation Analysis

Health Plans
In terms of health systems to help carry out the health programs, the province completed in 2006 a 5-year health plan with an iteration of planned investments and expenditures but this is still for review and approval.

Health Information System
70% of municipalities/city submits the FHSIS report on time. However, problems continue to saddle the health information system: These problems are manifested in the improper accomplishment of FHSIS reporting forms and delayed submission of reports. For municipalities not submitting on time, reports are usually 10 to 15 days delayed. This is due to the long distance and accessibility of some municipalities from the provincial center. The inadequate provisions for monitoring and evaluation such as problems on the service vehicle, absence of computer for database processing, insufficient travel allowance gravely affect the effectiveness of health monitoring and information systems.

Ordinances and Resolutions
Within the last 3 years, 4 provincial ordinances and 1 resolution were passed by the Provincial Legislative Board that pertains to family planning, maternal and child health, HIV/AIDs and Avian influenza.

Procurement and Distribution
The PHO has an annual procurement plan. Essential drugs are procured on time and most often than not, in adequate quantities. Drugs and commodities are procured and distributed separately by program. Procurement is done through the bids and awards committee.

Inter-Local Health Zones
The province has two Unified Local Health Systems organized and functional for the last 3 years. Concepcion and Camiling Districts have 4 catchments areas respectively. Catchments municipalities regularly contribute resources for undertaking common zonal health activities.

Financing for Health
189,611,185 pesos or 30% of the provincial budget for 2007 was appropriated for health services. The province has a total budget of PHP 617,000,000.

The province has a pending loan from the Land Bank of the Philippines for the construction of additional building for and repair of the existing provincial hospital.

At present, the province is recipient of donations from PCSO (x-ray machine), and the Global Fund, which is assisting the Tarlac City Health Center as a public-private mixed DOTS (PPMD) unit. Furthermore, the Center for Disease Control is assisting in the design of an electronic database for the TB registry of the province.

Some RHUs are employing collection of users fees and utilization of PHILHEALTH capitation fund to augment their resources for the improvement of local health facilities and services.

Service Delivery
The number of accredited facilities for Sentrong Sigla is the following:

1 provincial hospital
2 District hospitals
22 Rural Health Units
10 City Health Centers

All province-run public hospitals and 18 of 36 RHU/CHC are PHILHEALTH accredited and receiving reimbursements.

Program implementation review (PIR) was last undertaken in October 2006 and was done on a per health program basis.

All 17 component city and municipalities are giving full Magna Carta benefits to their health workers.

Advocacy
The province is largely dependent from the IEC materials being distributed by DOH. The Provincial Health Board is newly organized with the Tarlac Medical Society sitting in as the NGO/CSO representative to the Board. The PHO intends to mobilize the NGO communities towards the thrust to increase enrollees to the PHILHEALTH indigent program.

Where Tarlac wants to go in the immediate term

The PHO has already identified the core strategy to combat the deficiencies in relation with vital health indicators. Addressing the gaps in local health systems in the immediate, the PHO wants to focus its intervention in improving healthcare financing, human resource development, contraceptive self-reliance response, and managing health data information.

- The PHO II envisioned that all families are enrollees to Philhealth to reduce out-of-the-pocket expenditures particularly among the poor. Although the provincial government enrolls poor families to Philhealth, he believes that such initiative must be viewed by municipalities concerned as just part of the provincial thrust to augment their respective healthcare financing but the core responsibility to ensure universal coverage lies with the municipal governments. Hence, there is a need to encourage municipalities to adopt and increase enrollees under the Indigent Sector Program. Dr. Ricardo Ramos, PHO II, intends to actively promote Philhealth by orienting LGUs on the benefits of National Health Insurance Program and to mobilize civil society and the private sector to lobby to local executives to finance the indigent program.

- All RHUs are Philhealth accredited. Poor quality of health services and outdated facilities defeat the purpose of having a Philhealth universal coverage. The thrust of the PHO and the DOH Representatives is to assist 18 RHUs to become Philhealth accredited and to upgrade the Philhealth accreditation of the rest of the RHUs and CHCs to include TB DOTS and MCH packages. Assuming that all RHUs and CHCs are Sentrong Sigla certified and Philhealth accredited, consumers will be enticed to seek the service of public health facilities.

- Health personnel are all adequately trained. Due to rapid turnover of health personnel and the lack of funds for continuing capability building, the local health systems are confronted with the challenge to upgrade the professional capabilities of health technical staff to effectively address pressing concerns and emerging demands. It was observed that some municipal health workers encountered difficulties in target setting and computing eligible population, and lacked the familiarity with the DOH performance standards. The CHD has already asked the PHO and PHTL to submit list of personnel particularly at the municipal level with corresponding capability building needs.

- Municipalities are contraceptive self-reliant. The PHO intends not to procure contraceptives to augment the FP commodities of municipalities despite of the very low CPR to encourage municipalities to be contraceptive self-reliant. The PHO observed that municipalities became too dependent on donated contraceptive products. With the reduction and eventual phase-out of foreign subsidies on family planning products, the municipalities must take the responsibility to continue to provide access to quality family planning products and services.

- Electronic Health Registry for the whole province. At present Tarlac is identified as a pilot for the Electronic TB Registry Project of Global Fund. However, in general, the use of information technology has not been optimized. Having granted by the governor its request for additional units of computer, the PHO right now is in the process of converting to electronic data the FHSIS.

Technical Assistance

To help the province achieve its goals for the improvement of the local health systems including the desired investments in public health programs, given the immediate concerns, the technical assistance of HealthGov shall focus on building the capability of the PHO to implement its core strategy components as mentioned above. Concretely, the PHO shall be capacitated on how to get the involvement of municipal and city governments in strengthening healthcare financing, human resource development, contraceptive self-reliance response, and health data information management.

To sharpen the analysis of health situation and planning for the next steps, the Project has already provided technical assistance on enhancing the program assessment tools through the Service Delivery Implementation Review (SDIR) wherein the actual service performance is assessed vis-à-vis the identified health indicators in order to get a clear picture of what has been achieved or not. Furthermore, with the use of the situational analysis framework, hindering and facilitating factors are surfaced given certain context. By probing deeper to the causes of low performances in certain indicators, the service providers shall be guided to think of interventions that will arrest the problems that are obstacles to the achievement of standard performance. The SDIR outputs shall be the basis for inputs to the Province-wide Investment Plan for Health (PIPH) wherein in such process, the service providers will be able to undergo situational analysis culminating in the formulation of a province-wide and municipal-wide investment plan for health in which critical interventions are concretized to particular programs, projects and activities.

Furthermore, still in the context of PIPH, the resource mobilization plan will also help LGUs identify the internal and external sources of funds that may mobilized to finance health outside the usual shares from the 20% local development fund.

On the other hand, getting the municipalities to invest in Philhealth universal coverage shall be addressed by particular technical assistance to CHD and PHO that may revolve around the formulation of healthcare financial plan, promotion and advocacy and social marketing strategies.

In terms of ensuring that all RHUs and CHCs are Philhealth accredited and maintaining Sentrong Sigla certification, the Project shall be of assistance to the interested LGUs by providing to CHD and PHO the avenues to enhance their capacities in extending quality assurance packages as embodied in the Service Delivery Excellence for Health Program.

In connection with harnessing the professional capabilities of public health workers, technical assistance can be provided to PHO to conduct training needs assessment to come up with an inventory of trainings that may be provided by DOH, other NGAs or the academe. The Project may act as a broker between health service providers and training resource institutions. Furthermore, within the ambit of its expertise, the Project may even provide direct capacity building seminars to CHD Program Managers to capacitate them to roll out the same to local health workers.

Furthermore, the PIPH may be able to address gaps on human resource development by prompting the LGU to invest in capability building activities.

To improve CPR which is tremendously low, the Project shall assist municipalities to become contraceptive self-reliant through the CHD and PHO by extending technical assistance on public-private partnership on family planning programs, development of CSR monitoring tools and CSR planning methodologies.

To ensure that the LGUs will buy in to invest in health service delivery improvement, the Project shall capacitate civil society to engage LGUs in participatory mandated mechanisms such as the local health boards and development councils. Technical assistance shall also be given to health champions and advocates, starting with the CHD and the various leagues of local legislators, on participatory evidence-based local legislation making which may be rolled out by the same to PHO, civil society organizations, health reform-oriented local elected officials. Furthermore, to consolidate all advocacies forwarded by multi-stakeholders, the Project shall facilitate through the initiatives of the PHO and local civil society groups the crafting of a province-wide advocacy plan.

Towards the goal of improving their health information management system, the Project can provide assistance in identifying tools, processes and other support systems that will help the health personnel address the problems that slows down the ability to gather, analyze and utilize health information for planning and monitoring/evaluation purposes. The initial assessment can be done through in the context of SDIR and situational analysis.

In this connection, the HealthGov project proposes to conduct the following specific activities to concretize the technical assistance plan for Year 2 for the Province of Tarlac:

1. Strengthening LGU management systems (IR 1.1)

Development of the PIPH/MIPH

The PIPH process will enable the province to enhance its existing 5-year provincial health plan based on the HSR/F1 framework that will allow for critical interventions in the key results areas of governance, regulations, financing, and service delivery. It is expected that this process shall improve the integration of the local health system and inter-LGU cooperation that will yield better health outcomes for all Tarlaceños.

(1) Training of Facilitators.

Facilitators' Training Seminar shall be conducted to equip the designated Planning Team to include PHO technical staff and CHD/DOH Representatives with basic facilitation skills using the Technology of Participation (ToP) as applied to Local Health Situational Analysis, Goal Setting and Determining Strategies and Critical Interventions.

The trained facilitators shall utilize their acquired skills on the conduct of PIPH development workshop seminar which shall be participated by the Municipal Health Officer, Public Health Nurse, Planning Officer, Budget Officer and Chair of the Committee on Health of the Local Sanggunian. HealthGov and CHD shall continue to assist the facilitators in fulfilling their task to guide the participants in the formulation of an Annual Investment Plan for Health for 2008. The actual workshops should be accomplished by the 2nd week of October 2007.

(2) Development of Guidelines for Internal Technical Review

The Project shall continue to mentor the planning team and trained facilitators in going through the tedious process of technical review.

(3) Write-shop on PIPH Development

As a follow-through activity, technical assistance shall be extended in a form of a write-shop on packaging the PIPH technical plans into a cohesive investment plan document which can serve as a social marketing tool to attract investors and donors. Such activity may be done at the regional level and participants will be from the provinces of Bulacan, Tarlac and Nueva Ecija. The assistance can be provided by an STTA provider.

(4) Monitoring and Evaluation Tool to Track Local Progress in PIPH Implementation

The Project shall conduct a Luzon-wide orientation seminar on PIPH Monitoring and Evaluation Tool to the CHDs concerned in view with the task to track the progress of the implementation of the annual investment plan for health. The said orientation to CHD shall be conducted on July 2008 which will be roll out to catchments provinces the succeeding month just in time for the preparation of the 2009 annual investment plan.

Capacity-building for improving health information collection, analysis and utilization

To facilitate easy access to information and data-crunching and analysis, the Project together with CHD Region 3 shall provide technical assistance to the PHO and DOH Representatives on **basic health data management and developing an electronic health database system** at

the provincial and municipal level. The TA shall be roll out to MHOs by the PHO and DOH Representatives in January 2008 which shall coincide the consolidation of the FHSIS yearly report.

Contraceptive Self-Reliance Response (CSR)

HealthGov will assist the province to facilitate the conduct of CSR assessment, planning and monitoring at the municipal level. The result of the CSR review will be the basis for future activities related to CSR in the province.

(1) Orientation on CSR Planning, Assessment and Monitoring Tools

The objective of this technical assistance is to ensure that quality family planning services and products continue to be available to the local consumers. The PHO and DOH representatives shall roll out the activity to municipalities on the 2nd quarter of 2008.

(2) Forum on Public-Private Partnership on Family Planning and Contraceptive Self-reliance

With the eventual pull-out of free contraceptive products, the unmet needs of the poor will be the ones that will be gravely affected. In coordination with PRISM, the Project shall provide venues for discussion to the LGUs, civil society and the private sector to strengthen public-private referral system, private sector expansion through development of high volume providers for IUD and VSC, and other FP products.

2. Improving and expanding LGU financing for health (IR 1.2)

Resource Mobilization Plan in the context of PIPH Development

After the critical interventions and PPAs are identified, a **capability building seminar on resource mobilization** shall be facilitated by the Project to the PIPH planning team and local finance committee of participating municipalities to identify the internal and external potential sources of funds and financing for health-related PPAs that may be pursued in the annual investment plan for health. This technical assistance activity shall happen in October 2007.

Assessment of current Philhealth program to achieve universal coverage

Currently, the province has indicated that it has a 75% PHILHEALTH coverage of the indigent population. The goal of the province is to achieve universal coverage. The Project can then help the province to go through an assessment program together with PHIC as basis for coming up with a financial plan for universal coverage. The assessment program will cover activities such as reviewing accreditation status and quality of services provided by health facilities (standards and regulation), assessing the financing capacity of LGUs, promotion and social marketing to name a few.

The specific technical assistance to be provided to the PHO and DOH Representatives is the **Guidelines for Planning for PhilHealth Universal Coverage.** The roll-out activities to the municipalities shall commence on June 2008.

3. Improving service provider performance (IR 1.3)

Follow Through and Monitoring of the Outputs of the Service Delivery Implementation Review

The Project shall continue to assist the CHD, DOH Representatives and the PHO in monitoring the implementation of the acceleration plan crafted by each RHU/municipality and provincial-run hospitals. In the last quarter of 2008, SDIR shall be again conducted jointly by the CHD, DOH Representatives, PHO and MHO to assess the progress in the achievement of health outcomes based on agreed program indicators. Technical assistance shall be provided by HealthGov to CHD, DOH Representatives and the PHO through the **development of monitoring system and upgrading of the SDIR tools** based on the lessons learned.

Improving the Capability of Public Health Workers by Strengthening the Service Providers Training System

The SDIR tools include baseline data on health personnel capability in MCH, FP, TB and HIV AIDS. Based on this data, some LGUs need core competency training for midwives and FP Competency Based training. The Project shall assist the DOH, CHD, DOH Representatives and the PHO in the **development of the FP-CBT manual**. Once the manual is available, HealthGov shall assist DOH and CHD to conduct a trainers training.

4. Increasing advocacy for health (IR 1.4)

Capacity-building of NGOs/CSOs for effective participation in governance structures

The PHB has been recently organized with the Tarlac Medical Society already sitting in the board. This will serve as an opportunity to promote the participation of civil society/ non-government organizations in health governance matters in the LGUs. There are continuing consultations with the PHO/PHTL together with the PNGOC for the activities that will help build the participation of NGOs/CSOs in the LGUs.

(1) Workshop on the Development of a Multi-stakeholder Province-wide Advocacy Plan

The Project shall facilitate through the initiatives of the PHO and local civil society groups the crafting of a province-wide advocacy plan. This will happen on October to November 2008.

(2) Trainers Training on Participatory Evidence-Based Local Legislation Making

The technical assistance shall improve capacity of LGU health staff, civil society and local health champions to advocate for sufficient resources for and sound policies on health. This will be essential especially in advocating for budgets and ordinances that support the goals and activities as enumerated in their health goals for EPI, FP, MCH, Nutrition, NTP and the other health programs in the LGU. The CHD and the leagues of local sanggunians are the target groups that will cascade the said capability building activity down to the provincial and municipal levels. The trainers training shall be conducted on the 2nd quarter of 2008.

Visayas

PROVINCE OF AKLAN TECHNICAL ASSISTANCE PLAN

Background

The Province of Aklan is in Region VI encompassing the northeastern portion of Panay Island and the entirety of nearby Boracay Island group. The province is bordered by Sulu Sea on the northwest, by the Sibuyan Sea on the northeast and the east, by the Province of Antique on the west and by the Province of Capiz in the South.

The province is composed of one congressional district and seventeen (17) municipalities. Within the province are the 327 barangays. Total population is 451,314 (AGR of 2.05%, 88,213 households - Source: NSO Year 2000). Poverty incidence is 65%, with an employment rate of 62%.

Health Program Situation

The Governor has expressed that health is his priority; however, there seems to be no budget equity. Budget allocation is towards hospital reforms and lesser on the preventive aspect or on public health. A "Strategic Preventive Health Care Plan" for 2008-2010, formulated by the PHO Technical Team, envisions to achieve "*A quality health care that is responsive, relevant and accessible through joint efforts of the different stakeholders for a health-empowered Akeanons*." And to achieve this, they will "*provide a sustainable, effective and efficient delivery of health care services with competent & committed health care providers and stakeholders, complimented with a developed & enhanced health zones"*. The goal on service delivery is to "Improve accessibility and availability of basic and essential health care for all, especially the poor", with the following as the defined strategies: a) making available basic and essential health service packages; b) Assuring the quality of both basic and specialized health services; c) Intensifying current efforts to reduce public health threats through Social Mobilization, Case Finding & Treatment, Health Promotion & Advocacy, Networking, Coordination & Collaboration, Capability Building and Monitoring & Evaluation.

There are 19 RHUs (municipalities of Ibajay and Kalibo have 2 RHUs) in Aklan. All are Sentrong Sigla 1 accredited and 7/15 RHUs are TB-Dots accredited, now receiving their capitation funds. Only the RHU of Nabas is Sentrong Sigla 2 accredited. The province has eight government hospitals, four private medical hospital, 213 private medical clinics and 128 Barangay Health Stations. The province is clustered into 4 Inter Local Health Zones (ILHZs) – Eastern Aklan ILHZ, Altavas and Batan ILHZ, Southwestern ILHZ, and Northwestern Aklan ILHZ. These ILHZs are SEC- registered and with functional Technical Working Group

With assistance from the Governor (Php5 M fund) and Congressman (Php5 M fund), a total of 5,052 indigent families were enrolled under PHIC's indigents program in Year 2005.

Aklan has likewise been a recipient of the UNFPA project on reproductive health and family planning, piloted in 10 municipalities. Recently, the project focused their funding on HIV/AIDs in the Municipalities of Makato and Malay. The project has assisted the pilot municipalities in the establishment of their Popshops franchised by DKT to make available affordable contraceptives in the market.

Situation Analysis

Among the many health problems in Aklan, the persistence of maternal mortalities and their correlation with quality of health services has been a major concern. The province also has a high rate for infectious diseases particularly dengue and typhoid cases; rabies and diarrhea cases are on the rise, there's a problem on water and sanitation, and reproductive health concerns. Some of the contributory factors are: insufficient funds for public health programs, poor motivation of the provincial technical staff to conduct regular field monitoring, low morale among health providers due to non-full implementation of their magna carta benefits. Health human resource planning and development is the major concern for the provincial health office. The absence of a comprehensive plan to monitor, supervise and provide TA support to municipalities likewise contributed to these low health outcomes.

Some of the province's health indices are:

- Maternal Mortality Rate: 123.97/100,000 Live Births for 2006
- Infant Mortality Rate: 10.29/1,000 livebirths (0 performance standard0
- Contraceptive Prevalence Rate – 43.3 % (65% performance standard)
- TB Cure Rate – 92% (85 % performance standard)
- Fully Immunized Children – 80% (95 % performance standard)
- Prevalence of underweight pre-school children – 11.065% (12 % performance standard)

The maternal mortality of the province in 2005 is 38.74/100,000 live births but increased in 2006 at 123.87/100,000 live births. The most common causes of death are uterine atony, abruptio placenta and hemorrhage. Most of the maternal deaths are home deliveries due to the lack of birthing clinics in the area. Deliveries attended by midwives accounts to 48 % and for hilots at 33 %. Pregnant women with three or more prenatal visits are low at 30.6 % (performance standards is 85%). The PHO expressed the need to conduct maternal death review and a need for education for pregnant women on the importance of prenatal and for birthing clinics to be established in the RHUs.

Infant mortality data for 2006 is 10.29/1,000 LB with pneumonia as the leading cause of death, followed by prematurity and congenital anomaly. The FIC rate of the province is still low at 80 % compared to the performance standards of 95 %. One of the many reasons cited in the non-achievement of the performance standard is the absence of a system for reporting on immunization from private physicians. There is also prevailing misconceptions of some mothers on immunization and lack of knowledge on the importance and benefits of at least 4 prenatal check ups. Another is access problem (distance of health facilities providing quality services).

There were 420 out of 457 active TB cases treated in the year 2006. TB Case detection rate is 81% and cure rate at 92%. But a closer look at some municipalities show poor case detection rate (Numancia 59%, Tangalan 65% and Balete 66%). TB is the 5th leading cause of death in Aklan. The main challenge is in case holding as patients in low-performing areas failed to finish the full course of treatment. Another is the lack of accredited TB DOTs facility in the province (7/19 RHUs are TB-Dots accredited). The lack of training of the CVHW and a need to organize them with focus in low performing areas is also cited. Another possible challenge in TB control is the constant out migration of physicians.

CPR is 46% (Year 2006). The province is a UNFPA site for its Reproductive Health Program. For the new acceptors, the most popular family planning method is LAM (72.1%) followed by

pills (12.41%) and injectables at (9.32 %). One of the reasons cited for a low CPR is the lack of training of health personnel. In addition, lack of access to quality, affordable contraceptives has contributed to this low performance. There are only 2 Popshops in the province (muncipalities of Malay and Makato). The province has no available data on couples with FP unmet needs. They have trained 6 service providers for BTL and basic FP for MHOs. Quarterly BTL operation is being supported and undertaken by Mary Stopes in the province. Municipal CSR plans were formulated last September 2006 (except Malay). Some LGUs have committed CSR budget but the PHO has no idea how many have fully implemented their CSR plans.

Technical Assistance

The province received TA from HealthGov in Year 1 in the areas of SDIR (training of PHO and DohReps on the design, processes and tools, conduct of municipal SDIR), advocacy to new LCEs on HSR and province-wide investment plan for health (PIPH), with 9/17 LCEs in attendance and resulting to their signing of their commitment to support health programs and giving the mandate to plan. In the past, the province has attempted to conduct province-wide planning in 2005, with every barangay formulating their health plans, integrated at the municipal level. However due to the limited budget allocation of the province, the process stopped there. Current practice of LGUs is to come up with a plan based on an allocated annual budget. The process is likewise not participative, and does not involve other stakeholders.

Responding to the call for TA from the PHO, HealthGov will assist the province in year 2 through "building on the strength... exploring opportunities…." in order to achieve better health outcomes of the province. One of the strengths and flagship program in health with the full support of the Governor is on achieving Universal PhilHealth Coverage for their indigents. However, based on discussions with the Governor, PHO and assessment results showed that there are still indigents asking for financial assistance and out of pocket expenditures are still high due to the unreadiness of the health systems, facilities and personnel in responding to this call. HealthGov's TA will be built on this strength to convince the Governor to take on the challenge by exploring opportunities of improving health systems in response to achieving Universal PhilHealth Coverage.

For Year 2 HealthGov's assistance will revolved around introduction and development of systems, standards, guidelines and tools to achieve PhilHealth Universal Coverage and ensuring compliance of the requirements to secure PhilHealth benefits.

LGUs' response to this, started with the improvement in the planning system through the conduct of the investment planning for health with emphasis on the situational analysis as basis for the critical intervention, exploring alternative sources of funds other than IRA and integration of the plans at the ILHZ and Province with the participation of NGOs/CSOs and planning team from the municipalities. The completed Municipal Investment Plan for Health will be integrated at the ILHZ level and eventually to the PIPH. By September 30, 2007, Aklan's PIPH will be completed, ready for presentation to the Provincial Health Board and the Governor to secure the mandate to implement.

The following TA will be provided to the province:

1. Introduction and development of systems and standards in achieving universal PhilHealth Coverage

   Living Standard Index (LSI) as a tool in identifying the poor – This tool will be introduced to the province as a means of identifying the poor and population eligible to be given subsidy for PhilHealth premium and combined with other health related information. HealthGov will conduct orientation of the tool to the CHD and PHIC for them to discuss to the PHO and DOH Reps for implementation. After the results have been gathered, TA on the development of guidelines and tools for the analysis, dissemination of results, planning and monitoring will be provided to the CHD, PHIC and PHO.

   In planning, TA on the development of a five-year plan to expand and sustain coverage for PhilHealth, with attention to the indigent population will be provided. This will be done in close collaboration with provincial/regional PhilHealth and CHD. The plan will include an estimate of PhilHealth eligibles (SP, IPP, private formal sector, government formal sector), estimates of LGU premium subsidy requirements and possible sharing scheme, estimates of PHIC reimbursements and capitation funds that will flow back to LGUs, estimates of investment requirements to upgrade facilities and staff to qualify for PHIC accreditation including identification of financing options, and estimates of investment requirements for expanding enrolment and sharing arrangements among province, municipalities and PHIC.

2. Ensuring compliance of the requirements to secure PhilHealth benefits

   a. Capacity building of health personnel to deliver quality services

   Service Delivery Excellence in Health (SDExH) – Poor motivation and low morale of health personnel in the province affects the delivery of quality services. Thus, SDExH would be introduced in the province to provide the Governor and the PHO the guide on how to support the needs of the health personnel in the delivery of quality services. HealthGov will conduct orientation of the tool to the CHD for them to discuss to the PHO and DOH Reps for implementation. After the results have been gathered, TA on the development of guidelines and tools for the analysis, dissemination of results, planning and monitoring will be provided to the CHD and PHO. This can be pilot tested in one ILHZ and if proven effective it will be replicated in the entire province.

   The output of SDExH will determine the support needed and capability building needs of the health personnel. In the SDIR, training profile of health personnel were also gathered to be analyzed based on the competency needs of the position. HealthGov will be providing TA to address the competency-based needs of the health personnel. TAPs will be utilized as resource persons to this endeavour.

   b. Improvement of systems to comply with the quality standards for accreditation

   Improving health information collection, analysis and utilization - This is one of the barriers affecting the planning and decision-making for health programs. The project can provide assistance in identifying tools, processes and other support systems that will help the province address the problems that slows down their ability to gather, analyze and utilize health data for planning and monitoring/evaluation.

Accreditation process and the quality standards requirements – HealthGov will provide venue for the CHD, PHIC, PHO and LGUs to discuss the accreditation process, benefits from PHIC and the quality standard requirements for the facility to be accredited. The output will be action plan with budget allocation of the LGUs to be inputted into the AIP for 2009. Furthermore, TA will be provided in the development of monitoring tools to track down the progress of implementation.

Referral Systems - Public-Private; Public-public – to ensure quality health care delivery among the clients, improvement of the referral systems will be provided as TA by HealthGov. The TA could be on the introduction and development of guidelines in identifying the referral facilities such as birthing clinics, BEMOC/CEMOC, per ILHZ and introduce guidelines for the review and improvement of the draft referral system of the province.

Resource Mobilization

The inadequacy of available LGU resources needed to address the health needs of their municipalities makes it imperative for the key health managers to identify other sources of funds such as charging of user fees, generation of other local revenues, grants or loans' identification, including accessing these. TA to key staff on project proposal making or feasibility study preparation will be done and linking the LGUs with possible donors, both local and international.

Capacity-building of NGOs/CSOs as effective partners in governance structures - this is another initiative that the province would like to explore. The province has realized the need to involve NGOs/CSOs on health activities to better achieve health outcomes of the province. TA on this would be along the development of guidelines, tools and systems to institutionalize multi-stakeholder participation in the LGU structure such as the LHBs and LDCs. NGOs/CSOs would also be capacitated to become active members of the local special bodies.

Attachment A

Priority Program Targets and Indicators

Program	Major Goal	Strategic Thrusts	Health Status Objectives	Risk Reduction Objective	Services and Protection Objectives
Maternal and Child Health	Safe & Healthy Pregnancy are ensured	1. Institutionalization of Maternal Death Registry 2. Ensure adequate logistics for pre-natal, natal & post-natal services 3. Intensify pre-pregnancy package of services for women of reproductive age 4. Implementation of the Community-Based Emergency Obstetric Care	Reduce Maternal & Infant Mortality & Morbidity	Increase the proportion of pregnant women who have at least 3 prenatal visits to professional health providers to 70%.	1. Increase the proportion of pregnant women receiving iron supplementation to 80%. 2. Increase the percentage of births that are attended by health workers to 80%. 3. Increase the percentage of couples provided with family planning service. 4. Increase the percentage of RHUs providing Integrated Reproductive Health services with core elements to 50%.
Child health	A. Enhancement of child health care program implementation B. Increase collaboration / networking with LGUs, community and other stakeholders on health	1. Ensure quality health services at the peripheral levels 2. Ensure implementation of IMCI in health facilities with trained health workers 3. Strengthen enforcement of the laws for children	Reduce morbidity & mortality among neonates, infants and children	1. Increase the coverage of oral prophylaxis among children to 80% 2. Increase the level of tooth brushing habit of children to 60% 3. Increase the percentage of malnourished children under 6 years old registered	1. Increase the percentage of sick children who are treated appropriately for the diagnosis made by the health workers to 80%. 2. Increase the percentage of health facilities with available stocks of essential drugs for CARI and CDD program. 3. Increase the coverage of infants who are fullyimmunized before the first birthday to 90%. 4. Increase the percentage of infants exclusively breastfed up

		in feeding programs	to 6 months by 60%. 5. Increase the percentage of community members who know and practice home management of common childhood illnesses. 6. Increase percentage of trained health workers providing comprehensive newborn and infant care. 7. Ensure 100% orientation of newly-hired personnel.
TB	1. Increase & maintain case detection rate for smear TB positive 2.Increase & maintain cure rate of smear positive TB 3.Decrease mortality rate from TB 4.Decrease morbidity rate from TB	1.Increase BCG immunization coverage 2.Increase the proportion of symptomatic patients undergo sputum examinations to 95% 3.Increase the proportion of patients undergo completed sputum follow-up examination to 100%	1.Increase the number of Rural Health Units PhilHealth accredited to 80%. 2.Increase the proportion of health personnel trained on DOTS to 95% 3.Increase the proportion of identified TB cases getting full course of treatment to 100%
STI / HIV – AIDS	1. Contain the prevalence of HIV/AIDS among the general population	1. Reduce the transmission of STIs in the general population	1. Treat all cases identified. 2. Expand the Pop shop strategy / mechanism in all health zones

	2. Contain the prevalence of HIV/AIDS among the high risk or more vulnerable population 3. Reduce the incidence of gonorrhea among the high risk or more vulnerable population	2. Increase the proportion of more vulnerable group who have knowledge of the different ways of preventing transmission of sexually transmitted illnesses	
Dengue	1. Reduce morbidity from dengue infections 2. Reduce mortality from dengue fever & dengue hemorrhagic fever	1. Reduce the number of Dengue Fever suspects by 50%. 2. Reduce the risk of human exposure to Aedes mosquito by maintaining the no. of houses positive for Aedes larvae to less than .066 per 100 houses 3. Increase the number of HH respondents practicing removal of mosquito breeding places	1.Ensure surveillance and investigation of all reported cases.

Province of Bohol Technical Assistance Plan

Background

Bohol is the 10th largest island in the country, nestled securely at the heart of the Visayas, between the southeast of Cebu and Southwest of Leyte. It belongs to Region VII (Central Visayas). It is 803 kms south of Manila and 79 kms southeast of Cebu.

Bohol is accessible by air and sea travel; it is the closest province to Cebu with travel time of 1 hour and 30 minutes by fast craft and 20 minutes by plane.

It has a total land area of 4,117.26 sq.kms with a population of 1,137,268 (as of 2000) with a population growth trend of 1.83%.

Politically it is divided into three (3) congressional district; has forty seven (47) municipalities and one (1) city, Tagbilaran City , its capital City. Literacy rate is 93%.

Health Program Situation

The vision of the provincial health office is that of " Healthy Boholanos incharge of their own health development in partnership with the provincial leadership in accomplishing its socio economic goals and objectives for the province and their mission is to " ensures and safeguard the health of the Boholano community through an effective and sustainable delivery of promotive, preventive, curative and rehabilitative health services in partnership with the National Government Agencies. Municipal, Barangay LGUs and Non Government Organizations.

This vision and mission is translated into various program and services. Budget allocation is provided by the provincial government out of the 20% development fund. Much more, the governor is taking initiatives to source out assistance from other countries. The latest was the donation of hospital equipments from Spain and China. Delivery of quality social services is one of the goals in the governor's 10 point agenda in 2010. Specific to health is the enrollment of more indigents to the universal health coverage and improvement of the hospitals to provide quality services to the boholanos.

Situation analysis

The provincial health office programs and services are geared towards 1. reducing morbidity and mortality; 2. provision of affordable and accessible quality health services; 3. that the provincial health office will be operating as economic enterprise to achieve self reliance and 4. establishment of a coordinated health management information system to improve data collection and utilization for decision making.

However these goals are affecting by some limiting factors:

Most LGUs did not undergo CSR planning and are not providing budget for FP commodities except for the province and three (3) municipalities covered by the UNFPA Project and was supported in putting up the DKT PopShop. New Acceptors of various family planning for 2006 is 16,862 while the current users is 41,334.

The planning process needs to be revisited as well. Plans are driven by allocation set the local government units. There is no clear and comprehensive investment plan for health.

TB program implementation is good with the support of JICA and World Vision with the latter supporting one (1) barangay in ten (10) municipalities organizing barangay task force for TB case finding, treatment and follow-up. They have three (3) trained sputum microscopy validators at the provincial level. TB Cure Rate is more than 85%. However there is still a need to intensify the case detection process because people are still affected by the social of stigma of having while many would prefer going to the private facilities. The high costs of medicine as prescribed by the private providers limits the patients to sustain it and not able to be cured.

While there are no identified HIV-AIDS cases , the province had organized its HIV/AIDS Multisectoral Council that promotes information and education campaigns.RH advocacy group is organized at the province. However, there is no budget allocation to sustain the initiatives of the council after funding support from LGUs is finished.

Most of the newly hired RHU personnel does not have training in CBT-FP.However UNFPA is supporting project municipalities on training Community Managed Maternal Care

On Maternal Child and Health care. Number of livebirths is 23, 453 of which 12, 173 are males and 11,280 are females. These deliveries were attended by doctors- 6,491; nurses- 106; midwives- 12,462; trained hilots- 4,071; untrained hilots- 87 and by others- 236. Normal home deliveries is 15,755;in hospitals- 5,252 and others 299. Others, home- 599, hospitals 543 and others 5.

Type of pregnancy: normal is 16,206 while at risk is 7,003 and those not known is 184.Number of maternal deaths is 12; number of infant deaths 218; number of stillbirths (late fetal) 85; number of neonatal deaths is 11. The three (3) leading causes of maternal deaths , number and rate per 100 live births is post partum hemorrhage- 3 (13%); uterine atony-2 (9%) and pre eclampsia -2 (9%). Other causes of maternal deaths are post partum eclampsia . Placental retention, prolong labor 2nd stage, toxemia of pregnancy and some were of unknown causes.

The ten (10) leading causes of Infant deaths , number and rate per 1000 livebirths are: pneumonia -53 (4.18%); prematurity -24 (1.89%); diarrhea/AGE-14 (1.10%); sepsis neonatorum-14 (1.10%); sepsis unspecified -13 (1.03); congenital anomaly -10 (.79%) ; neonatal deaths, unspecified-9 (.71%); respiratory failure-8 (.63%); disease of the heart- 8 (.63%) and asphyxia unspecified-7 (.55%).

PhilHealth enrolment is shared with the provincial government with a total of 37,999 HH. The governor will enroll more indigents but will also collect the capitation fund. Despite the benefits gained by LGUs in the enrollment of their constituency, still they cannot sustain nor expand it because accordingly of limited funds they have.

While Bphol has 18 RHUS which are OPB accredited and six (6) TB DOTS there are MCP accredited facilities Bohol has two (2) Tertiary hospitals; Fourteen (14) secondary hospitals and sixteen (16) primary hospitals. There thirteen (13) TB Dots accredited facilities. The Integrated Midwives Association is running a Lying –in Maternity Clinic assisted by PRISM

Currently there are nine (9) ILHZs existing but the PHO is proposing to reduce it to five (5) zones to maximize the sharing of resources and to better supervise them. Carmen ILHZ is the most progressive due to the support of BIARPS however the project is also ending in 2007.

There is a need to review and strengthen the FHSIS data collection and analysis for a more effective planning and decision making.

Technical Assistance

The technical assistance to Bohol for year 2 will focus on intensifying their current programs and services. Just recently, the PHO had conducted their strategic planning: revisited their VMGo and its relevance to the current needs of time, its connectivity to the millienium development goals and that of the provincial medium term development plans. Among the significant insights they have is the complementation of the preventive and curative sectors of their operations. The currently proposed streamlining of the interlocal health zones is one area where they can collaborate and better serve the public. There is the need to synergize the LGUs involved and eventually institutionalize the local health zones. However this would mean , individual mobilization of LGUs by reviewing their current implementation performance, devising strategies to better serve their constituency and putting all these together in their municipal investment plan for health. These plans will form part of the health zone and the provincial investment plan for health. It needs to emphasized in these plans the areas for collaboration in the health zone level to mention sharing of resources. Before coming up with the overall provincial investment plan, the following is expected to happen to reach such level.

For Year 2, HealthGov will focus on:

1. **Formulation of the MIPH-PIPH**. The assessment results done using the SDIR will be used to formulate the MIPH. Individual MIPH will be consolidated to the ILHZ investment plan and integrated as the provincial investment plan for health. TAs will be provided in forming a core group that will assist the various LGUs in the formulation and consolidation to the provincial level. To support this initiative:

- **Advocacy** to the legislative group will be pushed for the allocation of funds and that corresponding ordinances and resolutions will be issued to provide the legal framework of the plans.
- **Capacity building** interventions for the personnel will be identified to enhance knowledge and skills and enhance their morale.
- **Contraceptive self reliance**. There is a need to follow on the CSR plans to be formulated this September. The LGUs will need assistance in the implementation and monitoring by setting up policies and guidelines, client segmentation and advocacy to ensure that a budget is allocate. On the PHO level, they need assistance in consolidating these individual LGU CSR plan and eventually monitoring and evaluation.

Given the strong opposition of the church in Bohol for artificial family planning, there is a need to intensify the informed choice and voluntarism in Family Planning. The ICV needs to be institutionalized and ensure LGU compliance on it. Technical assistance on capability building for PHO technical, MHOs and DOHreps will be provided to ensure that implementation will be on the right and complements to the position of the church.

2. **Streamlining of the Inter Local Health Zones**. In 2006, the PHO had already started the consultation to the various zone management board for the initiative and accordingly there was no resistance. But it was set aside in 207 because of the election. Currently, there are new local chief executives that there is a need to orient them and refresh the retained officials.

Technical assistance can be provided on the development process of their organization such as enhancing the capability of the management board in the planning process and in the formulation of their zone plan as contributed by the initiative in item #1.

3. **Expanding coverage to the PHIC**. Increase in enrollment to the universal health coverage is one of the major agenda of the governor. While he is providing subsidy to the LGUs there is still a need to advocate to the LGUs to intensify the expansion to more beneficiaries. TA can be provided in advocacy and formulation of a plan that will ensure the sustainability and clarify schemes for community based financing.

4. **Referral System :** RHU- Hospitals; Public to Private-Public facilities. The Integration of technical and hospital services in the PHO level. Based on the strategic planning of the PHO in August 16-17, 2007, they had recognized the significance of a more coordinated and collaborative efforts. This can be influenced in the streamlining initiatives of the ILHZ.
On a separate venue, there is a need to enhance the coordinative and collaborative system between public and private facilities and providers to ensure real time monitoring of cases and referrals for complicated cases and use of more advanced facilities and equipments.

5. **Partnership building with NGOs/CSOs and other GAs**. NGOs and CSOs involvement in program and project implementation is strongly recognized in Bohol However there is a need for their active involvement in the local development councils. The areas for concrete assistance will be identified after the partnership building workshop in September. A conscious effort on involving other government agencies will be emphasized.

6.**Avian Influenza.** Some parts of Bohol and island of Cabilao is identified as high risk area for AI. An orientation for the DOHreps in Bohol was conducted in August. Areas where healthgov could be of assistance is on information desimmination and advocacy on the LGUs to organize community based report system; and formulation of surveillance and preparedness system for LGUs and hospitals.

7. **Health Management Information System.** The current collection, storage and processing of data into usable information needs improvement. More so that it needs to be made accessible to the various users and stakeholder.

Role of CAs:

The result of the MIPH/ILHZ plan and the PIPH will outline the more tangible needs of the LGUS and an opportunity for the different CAs to come in. Nevertheless, this does not limit collaborations in some other areas if not the many.

PROVINCE OF CAPIZ TECHNICAL ASSISTANCE PLAN

Background

The province of Capiz is situated on the northern Panay Island in Western Visayas (Region VI). It is a second class province with a projected total population of 696,496 (Yr 2006, AGR of 0.95%?). Its economy is largely agriculture base, with an average family income of Php 99,313 per annum. Poverty incidence is 51%. Capiz is composed of 16 municipalities and one component city, Roxas City. It has 473 barangays and proportionately divided into two (2) political districts. The province is clustered into five Inter Local Health Zones (ILHZs), three of which are already SEC-registered.

Province Health Program Situation

The province is one of the 16 F1 Convergence Sites of the DOH. In March 2006, key health stakeholders in the province submitted its 5-year (2006–2010) Capiz Integrated Health Services Development Program (CIHSDP) which embodies the health sector reform's (HSR) four implementation components: governance, health financing, service delivery and regulation. This is a 4 year project with funding assistance of Php150 M, from the European Commission, for training, equipment, civil works and purchase of medicines. The province has likewise been a recipient and pilot province for other foreign funded programs such as World Vision-CIDA (for TB), UNFPA's 6th Country Program and JOICFP (for FP) and UNICEF CPC (for nutrition).

There are 19 RHUs province-wide, 15 and three of which are accredited for TB-Dots and MCP respectively. Of the total 188 Barangay Health Stations (BHS), 33 are birthing clinics. In year 2006, 16,518 families were enrolled under the PhilHealth Indigents Program; this year, the number of enrollees has increased to 25,738 families. The province allocated a total budget of P3M as counterpart and P7M from the city and municipalities. Seventeen RHUs are now receiving capitation funds.

Last July 16, 2007, the Governor led the twelve (out of 17) Local Chief Executives (LCEs) in sealing their commitment to adopt and support the CIHSDP by signing a health manifesto. This activity was supported by HealthGov. Based on the Governor's pronouncement during his 1st day of assumption into office, his administration's thrust is: *"Padayunon…Uswag Capiz"* (Sustaining the progress of Capiz), with emphasis on: education, agriculture, employment, revenue generation, and health.

Situational Analysis

Despite the pouring in of foreign assistance for the province, except for a few programs, health outcomes are still low compared to the national performance standards:

- MMR - 119/100,000 lb in Y2006, increased from 69/100,000 lb (Y2005)
- Provincial average of pregnant women with at least 4 ante-natal visits attended by skilled attendants is low at 47% (performance standards is 85%)
- Deliveries by skilled personnel and deliveries at health facilities is also low at 65 % and 37 % respectively.
- The municipalities with maternal deaths are both low in pre natal visits, deliveries by skilled attendants and deliveries in health facilities. Jamindan has the lowest deliveries in health

facility at only 2%. The most common cause of maternal death is post partum hemorrhage due to hypertension, placenta acreta and uterine atony.

- IMR is 10/1000 lb. Roxas City has the most number of infant deaths. The most common causes of deaths are pneumonia, prematurity, sepsis, congenital anomalies and gastroenteritis.
- Provincial data showed that almost 100% of 0-59 months old with pneumonia are given treatment in the different RHUs. However, in spite of this, pneumonia is still the most common cause of death.
- FIC is 74% (Y2006). Not one of the municipalities reach 95% (FIC performance standards).
- There were 1,324 active TB cases treated in the year 2006 at a rate of 190/ 100,000 population. Case Detection Rate is 85% and Cure rate is 95%, all above the national standard of 70% and 85% respectively. TB is the 9th cause of death among adults.
    - CPR is 48%

Further analysis of these indicators gathered from their SDIR results show that at the supply side, foremost is the lack of facilities, equipment, medicines, and supplies that cause the inadequacy of quality health services. Another is due to low staff morale and poor motivation due to non-full implementation of the Magna Carta benefits. The lack of competencies and capacities of the RHUs staff especially the newly hired in providing maternal and child health services resulted to low confidence of mothers in seeking health services at the RHU level. The lack of health human resource planning, and monitoring, supervision and provision of technical assistance are some of the reasons for the non achievement of the performance standards.

On the demand side, with the province still having isolated barangays, access to quality services is limited. Despite the numerous IEC campaigns undertaken, the lack of information on the importance of prenatal care from the first trimester and postpartum is still a challenge. Misconception of mothers on vaccination is one of the main reasons of low FIC turn out. In some cases, pregnant m1others seek the services of hilots and private providers due to lack of confidence with RHMs. Current efforts of the province to address these concerns are the voluntary blood donation program that ensures safe blood supply for any obstetrical emergency that may arise, and maternal death reviews. Another opportunity for LGUs is the PHIC's Maternity Care Package (MCP) that provides outpatient benefits for pregnant mothers.

For TB, the main challenge is in caseholding as patients in low-performing areas failed to finish the full course of treatment. CVHW lack proper supervision from Rural Health Midwives (RHM) to follow-up treatment defaulters. The lack of training of the CVHW and a need to organize them with focus in low performing areas is also cited. Another possible challenge in TB control is the constant out migration of physicians.

Reasons for the low CPR are: the fast turn-over of health personnel which requires constant need for training on FP, lack of monitoring of the acceptors from the private sectors and clients who buy contraceptives outside of popshop is not included in the masterlist, lack of support from the LGUs to buy needed commodities and supplies for those who can not afford to buy. Misconceptions of couples on the side effects of the methods and religious beliefs are still sited as reasons for the low CPR. The province initiative is the franchising scheme called the PopShop to address the LGUs' contraceptive supply concerns as donated commodities run out. To support the PopShop operations, client generation and case holding activities have to be continued. At the same time, internal replication within the province of Adolescent Reproductive Health best practices like the school based Teen Centers will be supported. Youth RH counselor, and HIV/RTI trainings and advocacy activities will be backed by the project.

Priority Program Targets and Indicators

Program	Critical Targets	Indicators
1. MCH	At least 50% of deliveries are facility based and attended to by trained personnel	10% increase per year in facility-based deliveries 5% increase per year in deliveries attended by trained service providers 4 RHU/year accredited in PhilHealth MCP 2 RHU/year accredited in Sentrong Sigla II All RHU able to provide complete dental services 0.2%/year decrease in maternal mortality rate All RHU referring for newborn screening 4%/year increase in FIC
	At least 85% of facilities providing quality services	6%/year increase in tetanus toxoid 2 plus coverage among pregnant women
2. NTP	At least 70% case detection and 85% TB cure rates	Case detection rate target constantly reached Cure rate target constantly reached All RHU assessed to be qualified for accreditation in PhilHealth DOTS package
	At least 85% of facilities providing quality services to achieve PhilHealth accreditation	RHUs refer all xrays of sputum(-) TB symptomatics to the monthly meetings of the TB Diagnostic Committee
3. Rabies Control	Rabies free Capiz	At least one functional pet registration and immunization center established per ILHZ 20%/year reduction in rabies deaths in the province
4. Environmental Sanitation	Diarrhea not among the top 5 leading causes of provincial morbidity	0.5%/year increase in households with sanitary toilets All municipal water sources tested for potability on a quarterly basis 10%/year increase in soil transmitted helminthiasis case detection and treatment
5. Nutrition	At least 10% reduction in malnutrition prevalence by 2010	Children 0-71 months old weighed annually show decreasing malnutrition prevalence Annual increase in literate parent caregivers
6. Reproductive Health	At least 2% increase in CPR per year	RHU's FP commodities revolving fund growing with increasing sales Increasing no. of clients procuring contraceptives from RHUs
7. Pneumonia	At least 0.2%/year reduction in pneumonia morbidity and mortality	Pneumonia management standard drugs available in all RHU IMCI strategy implemented in all RHU
8. Lifestyle Diseases	Decreasing morbidity and mortality due to leading lifestyle diseases	All LGUs with daily exercise activities
9. Financing	At least 50% of indigents are covered with health insurance All hospitals selling medicines	All LGUs deliver on annual budget commitments for insurance premiums Increasing hospital income from health insurance

Program	Critical Targets	Indicators
	that are at least 15% cheaper than in commercial outlets	claims Increasing pharmacy sales result in revolving drug fund growing by at least 5% per year All government hospitals participating in provincial pooled-procurement of drugs LGU accessing cheaper medicines available under the parallel drug importation program
10. Regulation	All government hospital pharmacies selling quality assured products	Minilab functional and providing medicine testing services to both public and private pharmacies
11. Governance	Province's hospital rationalization scheme implemented	BDH and MGH with upgraded secondary level capabilities; RMPH with upgraded tertiary level capabilities serving as referral hospitals

Technical Assistance

The Capiz Integrated Health Systems Development Plan (CIHSDP) aims to address the health problems of the province by focusing on critical interventions such as: expanding the grassroots public health service delivery program, improving the services, facilities, systems in the management of provincial government-operated hospitals, increasing PhilHealth enrolment, rationalizing the health workers benefits, expanding the parallel drug importation to municipal level and diversifying fund sources.

In February of this year, the Governor of Capiz formalized their TA request to HealthGov through a letter for the following immediate TAs: (1) CSR review and development of a province-wide strategic monitoring plan; (2) conduct of an SDIR review; (3) advocacy on HSR/F1 and PIPH to new LCEs; (4) pilot-testing of SDExH to enhance quality of service provision; (5) expanding the pooled procurement system to include drugs and other supplies for RHUS; and 6) documenting and packaging best practices and marketing these for replication.

Out of the six TA requested by the province, two have been completed – Service Delivery Implementation Review (SDIR) with the acceleration plan as the output. The province appreciated the process and adopted in the assessment of hospitals and funded out of their own resources. Another completed TA was on the advocacy to new LCEs, 9 out of 11 Mayors are newly elected and also the governor. The output of the workshop was the commitment of the LCEs to support the programs and initiatives on health in the province.

Since Capiz is an F1 site, most of their planned interventions will be funded by EC except for CSR. In this manner, HealthGov will continue to provide the TA needs of the province to better achieve their health goals and outcomes through "sustaining the gains…. broadening horizons …" focusing on the full implementation, monitoring and evaluation of CSR.

The province has started working on CSR initiatives during the LEAD for Health project in the setting up of their Popshops and provincial guidelines, thus, there is a need sustain the gains of the program. Based on the assessment conducted there are still areas were TA is needed by the province to fully implement CSR. Broadening horizons would mean exploring innovative strategies and opportunities to better achieve the CSR goals and health outcomes of the province. CSR full implementation indicates that there is political commitment to eliminate unmet

need for FP, LGU-provided safety net of free contraceptives, improved access to all other FP methods, expansion of private sector sources and integration of FP with other services to women.

TA on CSR has started with the conduct of a CSR provincial assessment and workshop outputs showed that the province needs assistance in building the technical capacity of their health service providers, institutionalization of policies and guidelines, information systems and advocacy. TA will be coursed through the CHD for them to assist the province in their TA needs. The following will be the sequence of TA provision:

1. Ensure political commitment to eliminate unmet need for FP and improved access to all other FP methods

Improving health information collection, analysis and utilization – CSR Monitoring Tools are being administered by the DOH Reps in the municipalities to track down progress of LGU implementation. Since the province has limited capacity to do the analysis, HealthGov will provide TA in identifying tools, processes and other support systems to analyze and utilize the information for planning and monitoring/evaluation. Furthermore, Service Delivery Implementation Review (SDIR) can be conducted regularly with the assistance from the PHO to track down the progress of LGU implementation of their CSR Plans.

Training on Advocacy - Health providers expressed the need for capacity building on advocacy to be able to get the support of the legislators and local chief executives along achieving full implementation of CSR. The following were the specific areas identified: budget allocation for priority interventions (e.g. MCH accreditation, CSR, regular conduct of SDIR); Advocacy to pass ordinance requiring facility based delivery to reduce maternal mortality, expanding access to a comprehensive family planning package, and the activation / strengthening of the Provincial Health Board and other local health boards in the province. In addition, TA on message development and BCC training will likewise be given.

Strengthening multi-stakeholder participation in governance structures – this is another initiative that the province would like to explore. The province has realized the need to involve NGOs/CSOs on health activities to better achieve health outcomes of the province. TA on this would be along the development of guidelines, tools and systems to institutionalize multi-stakeholder participation in the LGU structure such as the LHBs and LDCs. NGOs/CSOs would also be capacitated to become active members of the local special bodies.

Informed Choice and Voluntarism in FP – Although ICV is one of the important components of the Philippine FP Program, the DOH and the LGUs have not institutionalized the use of a monitoring tool to ensure LGU compliance. HealthGov, together with partners and other CAs under the guidance of USAID, crafted the guide and a compliance monitoring tool, followed by a training of trainers from the DOH and CHDs. As a continuing support to ICV compliance, HealthGov will provide TA to the provinces in its roll out, which includes the training of PHO, DoHReps, MHOs and others on ICV guide and compliance monitoring tool.

2. Ensure LGU-provided safety net of free contraceptives and expansion of private sector sources

Training on forecasting, procurement and distribution – to provide safety net of free contraceptives, training on this was expressed by the health personnel during the assessment workshop to ensure accurate forecasting for procurement and distribution. HealthGov will

provide capacity building, follow-on coaching and mentoring will be given by the PHO for the LGUs.

ILHZ as TA provider – the province will explore the possibility of developing the ILHZ as TA providers for a fee) for specific services required by other LGUs. The ILHZ can jumpstart as TA provider for the CSR needs of the province. This can be pilot-tested in one or two ILHZs that have rich experience on CSR and are ready and willing to take on this challenge. HealthGov's assistance will be on the development of the assessment tools, guidelines and systems to ensure the implementation, monitoring and evaluation of this initiative. The ILHZ can organize a speaker's bureau or pool of trainers to become its core manpower in providing TA. HealthGov will provide capacity building for this pool of trainers on topics related to CSR.

3. Ensure integration of FP with other services for women

TA on this can jumpstart through the introduction of Service Delivery Excellence in Health (SDExH) - One of the reasons sited in the non-achievement of performance standard is the poor motivation and low morale of health service providers due to the non-implementation of magna carta and lack of systems of recognition and rewards. Thus, SDExH would be pilot tested in the ILHZs as an integrated approach to enhance quality of service provision in the province. If proven effective it will be replicated in the entire province. TA will be on the orientation of the tool and development of guidelines and systems of implementation, monitoring and evaluation.

Integration of FP with other services for women- HealthGov can provide TA on this through the development of guidelines and modules where FP can be integrated and this will be introduced to the CHD and PHO for review, enhancements and implementation. Monitoring tools will also be developed to ensure compliance.

4. Setting up of a community based early reporting system for Avian Influenza

This will be implemented in identified high risk municipalities and barangays. The Bureau of Animal Industry-BAI has determined three areas in the Visayas for close surveillance. These are Olango Island of Cebu, Himamaylan of Negros Occidental and Roxas City of Capiz. In this regard, Capiz will be provided with TA that may include some of the following:

- Scanning activities to know more on current activities related to AI in birds and humans such as early detection, prevention, surveillance and policy support
- Exploratory discussion with the regional partners from the CHDs and the Department of Agriculture on early reporting system for AI
- Participate in the finalization of early reporting system for AI
- Participate in the TOT for the community based early reporting system

PROVINCE OF NEGROS OCCIDENTAL
TECHNICAL ASSISTANCE PLAN

Background

The province of Negros Occidental (with Bacolod City as its capital) is one of the six provinces that comprise Western Visayas or Region VI. The province occupies the Northwestern half of Negros Island with Negros Oriental at the Southeastern part. The province is known as the "Sugar Bowl" of the Philippines, producing more than half of the country's total sugar production. It is classified as a First Class province. Residents of Negros are called "Negrenses". Negros Occidental is predominantly a Hiligaynon-speaking province. However, on the east coast of the province, facing Cebu Island, a few cities and towns are Cebuano-speaking. Total land area is 7,926.07 sq. kms (7th largest). Population is 2,565,725, the 2nd largest province (AGR 1.13%; source: NSO Y2000) or a total of 503,663 households. There are 19 municipalities and 12 cities, plus the highly urbanized city of Bacolod. There are six congressional districts and a total of 661 barangays.

Health Program Situation

The Vision of the Provincial Health Office is "Healthy and empowered Negrense". Their mission is to "ensure accessible, affordable and sustainable quality health care services through multi-sectoral participation, community empowerment and good governance". The Provincial Governor shares the belief that a *"Healthy Negrense is a Healthy Negros"*. The Governor's support to Health is manifested in the province's seven-point agenda and an approved P12.5 M budget (30% of GAD budget) and P558,275 (20% SDF) for CY 2007.

The LGU Health management system is in place. The province has formulated a Five-Year (CY2005-2010) Strategic Plan translated into an Annual Plan. The Provincial Health Board has been very functional and was even awarded as the Most Outstanding PHB in Region VI. The Board is meeting every quarter with the Governor as the Chair. Another new NGO/CSO representative has yet to be chosen given the current accreditation and re-accreditation process after the new set of Government officials were installed.

There are six functional Inter-Local Health Zones (ILHZ) organized and chaired by Mayors. Of the six ILHZs, five are SEC-registered. Almost all RHUs have achieved Sentrong Sigla certification. The RHUs (out of 31) with PHIC accreditation are as follows: 16 - OPB; 14 TB DOTs; 3 MCP.

Other innovative strategies implemented by the province include the formulation of the Field Health Operation Protocol Manual, Referral System Manual, provision of regular support to ILHZs, sustained Voluntary Blood Donation Program, NOCHESS and Expanded Newborn Screening program.

Situational Analysis

The health outcome performance of the province of Negros Occidental is generally satisfactory compared to the regional targets. Attainment of better health outcomes is anchored on the following provincial goals: a) promotion of primary health care services; b) provision of specific support services for health; c) maintain delivery of health services in special areas (cultural

minorities, provincial capitol, in times of disasters & natural calamities and underserved areas). Some of the barriers to achieving these goals are manpower ratio, accessibility of areas, limited logistical and financial support from LGUs, inadequate funds, and delayed reporting and reconciliation of data collected and reported in the FHSIS.

Some vital health indices of the province are as follows:

- Maternal Mortality Rate: 93/100,000 LB (Leading Cause: Post partum hemorrhage)
- Infant Mortality Rate: 7.60/1000 LB (Leading Cause: Pneumonia)
- Crude Birth Rate – 19.55/1000 pop
- Crude Death Rate – 4.80/1000 pop
- Nutrition – 13% are malnourished
- CPR – 35%
- Unmet FP Needs – 19%
- TB Cure Rate – 90%
- TB Case Detection Rate – 110%
- TB Morbidity Rate (2004) – 199

The province and the LGUs have formulated their CSR plans two years ago (with LEAD support). However, a recent provincial assessment on CSR, which was supported and provided with TA by HealthGov in Year 1, showed some gaps in the implementation such as non-release of LGU budget to procure commodities, insufficient downloading of information, client segmentation issues, and policy advocacy. The current CPR of 35% is a sharp decrease from 45% in years 2004 and 2005.

Leading cause of maternal mortality is post partum hemorrhage. Deliveries not done in the facilities is likewise one of the factors contributing to these maternal deaths. The provincial average of pregnant women given quality pre-natal care by skilled attendants is low at 60% (performance standards of 85%). Mothers are not well informed of the importance of pre natal care both for them and their child. Mothers/pregnant women still prefer home deliveries. The provincial average of Fully Immunized Child (FIC) in 2006 is 83%. In spite of children 6-11 months old and children 12-59 months old with severe pneumonia given Vitamin A, pneumonia remains to be the number one cause of infant death. TB cure rate is high at 90%, but TB is still the 3rd leading cause of mortality among adults. A dengue outbreak has been declared in at least two towns this year, with more than 2,000 cases and 25 deaths reported during the first semester of 2007. Not all RHUs met PHIC's accreditation requirements (16 - OPB; 14 TB DOTs; 3 MCP). This directly (or indirectly) contributed to the low performance on MCH services.

Number of reported HIV/AIDs cases in the province is high. The province's system for contact tracing is poor. There are two reported AIDS death, while a total of 16 HIV cases have been assisted by the PHO. Health education advocacy remains to be a powerful strategy in preventing the spread of STI and HIV. HIV-AIDS Core Teams (HACT) were established in three hospitals (Kabankalan District Hospital, Cadiz District Hospital & Silay Provincial Hospital). The provincial government and DOH provide most of the medicines for HIV cases. The province has provided funding in the amount of Php300,000.00 for medicines and capability building of health personnel.

On reporting and monitoring system, the PHO have initiated the integration of CBMIS into the FHSIS, which they found to be effective but was not continued when the LEAD Project ended. Delay in report submission continues to be a problem. An annual program implementation review is done but not in a comprehensive manner.

Technical Assistance

Through the PHO, HealthGov provided TA to the province and LGUs in Year 1 on three major areas: a) conduct of an SDIR; b) provincial assessment on CSR; and c) the formulation of the MIPH, ILHZIPH and PIPH which will be completed by September 30, 2007. The orientation and training of PHO staff, MHOs on the SDIR processes and tools guided the LGUs' key health staff in thoroughly analyzing their health situation. Results of the SDIR is a comprehensive situational analysis of health program performance, particularly on FP, MCH, TB, nutrition, EPI. To start the process of MIPH to PIPH formulation, HealthGov provided TA to the province in orienting new LCEs on HSR and advocated for the formulation of the investment plans for health. The result of the orientation was the LCEs (27/31 in attendance) giving the mandate to formulate their investment plans for health (M/CIPH). A CSR provincial assessment was conducted in July 2007, results of which will serve as input to the investment plans for health. As a move to institutionalize the planning process, a capability building workshop for the provincial planning facilitators was done by HealthGov, in close collaboration with CHD. Members of the PPF were tasked to assist LGUs complete their MIPH,

In general, technical assistance to province and the LGUs will be towards supporting the implementation of their MIPH, ILHZ IPH, which they have completed, with HealthGov TA, in Year 1. The mandate to implement the PIPH will be secured during the month of October 2007 and will be made operational thereafter. Turning out to be a major component of their investment plans for health is the delivery of quality, timely, primary health care services (by the LGUs), to go hand in hand with the provincial thrust of strengthening hospital services, thereby providing safety net for the poor and ensuring that they (poor) have access to these services. This is in consonance with the province's health vision and strategic directions. The Governor and the LGUs have likewise signified interests to undertake initiatives to achieve universal PhilHealth coverage, which will not only result to increasing and sustaining the IPs coverage, but also readying availability of quality services (i.e. accredited facilities, trained service providers, availability of essentials drugs, etc.). This is an important component if the LGUs are to ensure that the poor's basic health needs are covered. Currently, the province provides subsidy to LGUs in enrolling their indigent population. Access to this is on a first-come, first-served basis.

Given all these, ***HealthGov's TA to Negros Occidental and their LGUs in Year 2 and beyond will rally around Expanding and Sustaining PhilHealth Coverage.*** This TA, done in close collaboration with the provincial/regional PHIC and CHD, will result to an increased and sustained coverage for enrolment of the IPs, expanded to the less formal sector, RHUs and BHS upgraded and accredited for OPB, TB-Dots and MCP, client segmentation fully operational, tools to identify the poor and program beneficiaries institutionalized, advocacy campaigns that seek to change health seeking behaviors sustained, and mechanisms to promote health governance in place. It is envisioned that at the end of HealthGov's TA to the provinces, both will achieve health outcomes of ensuring the poor's health coverage, access to quality services offered at accredited facilities (e.g. safe deliveries ensured thereby preventing unsafe delivery practices, reducing home-based cases and attended by TBAs), and supported by policies that will not only institutionalize systems, but ensure sustainability of reforms.

Although this intervention has been included in the PIPH and LGUs' MIPH, these did not include a detailed support plan. Therefore, HealthGov's **TA will start with an orientation and training of CHD and PHO key staff (trainers) on the guidelines for planning for PhilHealth Universal Coverage** (up to December 2007). This will include a projection of households by PHIC program groups, estimations of premium subsidies, reimbursements and capitation payments, investment requirements for accreditation and expansion of IPP enrollment, including,

options for ensuring use of PHIC revenues for health at hospital and RHU level. In the same orientation/TOT, **TA on the use of the Community Health and Living Standards Survey (CHLSS),** an alternative tool that provides not only a basis to identify the indigent population (poor) or means test consistent with PHIC requirements, but also information on unmet needs will be integrated. In order to measure progress and success, milestones will be set by the LGUs and the province (e.g. % increase in the number of PHIC enrolment, # of RHUs accredited for MCP, TB-Dots, guidelines and policies in place for the use of capitation and reimbursement funds, etc.) **TA on Local Health Accounts** will also be provided to give the key decision makers the basic concept and uses of LHA. The advocacy component will be intrinsic in the orientation design.

Subsequent **TA** to the province will be provided in the **provincial roll-out** (starting January 2008 and beyond), which entails LGU planning, by ILHZ, facilitated by the CHD and PHO trainers. At this point, additional **TA** will be provided on **Resource Mobilization**, specifically fund sourcing and utilization. Active resource mobilization is necessary to ensure full implementation of the plan. The inadequacy of available LGU resources needed to address the health needs of their municipalities makes it imperative for the key health managers to identify other sources of funds such as charging of user fees, generation of other local revenues, grants or loans' identification, including accessing these. TA to key staff on project proposal making or feasibility study preparation will be done and linking the LGUs with possible donors, both local and international.

A support system that will help the provinces achieve their vision of achieving and sustaining PHIC coverage is the referral system. The province has a Referral System and HealthGov will assist in review the plan to further enhance it, thus the **TA on Referral Systems** in terms of reviewing, assessing and enhancing these for implementation. This is in line with the current plans of the Governor, as disclosed by the PHB Health Committee Chair, to continuously rationalize and strengthen hospital operations to ensure quality services (curative) and at the same time strengthening the delivery of primary health services (preventive) by the RHUs. In the implementation, there will be follow-on TA to ensure that gaps are being addressed, and the use of the system is institutionalized at the LGUs, ILHZ and provincial levels.

CHLSS can likewise be used as a tool to determine program beneficiaries, specifically on CSR -- another area wherein the provinces' health indicators remain low (35% CPR). As part of the province's goal of providing safety net for the poor, **TA on Updating the Provinces and LGUs' CSR Plans** consistent with the new AO on CSR and adopting the PIPH approach will be provided. Initial results showed gaps in the areas of policy advocacy, ensuring budget support to procurement of contraceptives, education component (orienting all field staff), client segmentation, capability building and sustained monitoring as some of the major concerns. Note that TA modality will follow those previously described in the F1 provinces (i.e. TOT of CHDs, PHOs in updating CSR plans, mini-planning workshops by ILHZs, institutionalization of CSR monitoring and integration of an ICV monitoring and compliance plan). Similarly, **TA on the formulation of a Comprehensive CSR Advocacy Campaign Plan** will be provided to the PHOs, together with the regional CSR-TWGs. Both plans are targeted to be completed by March 2008. HealthGov will work closely with HealthPro. **Follow-on TA, coaching and mentoring** will be provided to key PHO and LGU health staff **throughout the implementation of both plans** (up to end of Year 2).

In the implementation of their M/PIPH and all sub-plans, monitoring the progress is very critical. Thus, a **TA** to the PHO and DohReps **on monitoring** LGU performance will be provided. This entails developing the tool together with the PHO and CHD, institutionalization of the monitoring system, and continuing assistance during its application.

An over-arching critical intervention that will directly (or indirectly) result to the achievement of the provinces' goals and improvement of health outcomes is a **TA on Behavior Change Communication** (BCC). HealthGov, in close collaboration with HealthPro, will provide TA in the identification of strategic interventions that will: a) influence health seeking behavior of consumers; b) improve health providers' provision of quality and accessible services; and, c) influence decision makers to put in place systems and policies that will respond to the needs of both the consumers and providers. In addition, TA will be provided to LGUs in the development of a comprehensive community-based plan that will actively promote health services by skilled providers at facilities equipped to provide basic, primary health care.

A regular, comprehensive program implementation review is necessary for planners and decision makers to determine performance progress. The significant contribution of the SDIR as a tool to review and assess performance was recognized by both provinces and LGUs. As a result, they have included in their plans the regular conduct (annual) of SDIR. In this regard, **follow-on TA on SDIR** will be provided to continuously coach and mentor PHO team and to ensure that the use of SDIR is institutionalized, health information collection, analysis and utilization is improved.

To ensure that all components of the plans (PHIC, CSR), and the PIPH as a whole, are implemented by motivated and competent health personnel, **TA on Service Delivery Excellence in Health (SDExH)** will be provided to both provinces starting on April 2008 onwards. Discussions as to extent of roll-out (whether province-wide or a number of ILHZs only) will be firmed up by early next year. This will be followed by the **TA on the formulation of an SDExH provincial roll-out plan** that will run beyond Year 2.

Similar to the province of Capiz, exploratory talks have been made with key health officials of Negros Occidental as to the possibility of testing a model that will look into the possibility of developing the core competencies of ILHZs and readying them to become TA providers (for a fee) in the province. Therefore, **TA** will be provided **to Negros Occidental** in exploring the possibility of **developing the ILHZ as a TA Provider** (for a fee) for specific services required by LGUs, including the province itself. The TA will take the same track as described in the portion of Capiz and will be implemented simultaneous to Capiz, starting on the 1st quarter of 2008 and is expected to run beyond Year 2.

In addition, specific to the province of **Negros Occidental (Himamaylan City** in particular), the Bureau of Animal Industry-BAI has identified the area as one of the three areas in the Visayas as high risk and for close surveillance for Avian Influenza. In this regard, the province will be provided with **TA in Setting-up a Community-based Early Reporting System for AI.**

Province of Negros Oriental Technical Assistance Plan

Background

Among its health facilities are ten (10) hospitals, three (3) are tertiary care hospitals located in Dumaguete City and the seven (7) secondary level hospitals are distributed in the province. There are six (6) primary community hospitals which are mostly underutilized resulting to the overcrowding of tertiary hospitals. These primary community hospitals can be restructured as birthing areas and be accredited for MCP, OPB and TB DOTS.For primary community hospitals, maybe they can be restructured as birthing areas so that they can avail of the Maternity Care Package of Philhealth. In DOTS Center and an Outpatient Benefit Package can also be availed of.

The Provincewide Investment Plan for Health (PIPH) of Negros Oriental which covers 5 years is supported by the European Commission and embodies the four implementation components of the Health Sector Reform Agenda (HSRA): governance, health financing, service delivery and regulation. Through the implementation of the plan, it will ensure (1) access to quality, integrated, comprehensive, continuous, affordable health care services, goods and facilities in partnership with the community; (2) effective and efficient allocation, generation and mobilization of resources; (3) improvement in the unified technical direction and operational coordination of all providers at all levels and sectors province-wide; and (4) strengthened regulatory functions at provincial and municipal level through ordinances and legal mandates.

1. CSR Monitoring - An initial assessment to determine the status of CSR implementation provincewide was conducted using the CSR monitoring tool. The gaps that were identified during the assessment will be addressed with the concerted efforts of regional and local partners. These will include technical assistance in Logistics and Procurement System, policy advocacy and advocacy for increase budget for CSR. It is very crucial that at the PHO level, CSR monitoring will be institutionalized and be a part of the Monitoring and Evaluation System of the LGU.

2. Living Standard Index and Local Health Accounts - this is a tool for classifying households/clients to determine who can avail of public subsidies and who can be referred to alternative financing. This will be utilized as a means to respond to one of the goals of the province which is the expansion of the coverage of the PHIC Program especially among the indigents. This can also be applied to determine the clients who should be continuously served with the phaseout of donated contraceptive supplies. On the other hand, there is

also a need to establish at the provincial level Local Health Accounts which will give a picture of the health expenditures and different financing sources of the province.

3. PHIC Universal coverage – One of the specific goals of the province is increasing indigent enrolment and leading to universal coverage. This will be a planning workshop with the LCEs and other decisionmakers on the estimates of PHIC program eligibles using LSI tool, subsidy requirement and sharing arrangement among LGUs, estimates for PHIC reimbursements and capitation funds and decisions of LGUs in the use of capitation funds and estimates of investment requirements to upgrade health facilities for PHIC accreditation.

4. Service Delivery Excellence in Health (SDExH) - SDExH is an approach that can be used by LGUs to determine if health providers are performing according to standards both for quality and level of performance and at the same time if clients of health services are satisfied. SDExH is standard-based-quality assurance, service-focused and customer/client oriented. It also involves various sectors and promotes continuous quality improvement in health care.

5. Enhancing partnerships between public health providers and civil society - HealthGov will work with local NGOs and civil society partners that operate in the LGUs for wider stakeholder participation in health. This will be done in different levels of partnership depending on local situation and context. This will include active participation of NGO/CSO in local special bodies, i.e Provincial/Municipal Health Boards, Provincial/Municipal Development Council and other local committees. HealthGov will also engaged the NGO/CSO in building a constituency for health and participation in health planning and policy formulation and health service delivery.

Mindanao

PROVINCE OF AGUSAN DEL NORTE
TECHNICAL ASSISTANCE PLAN

I. Background

The province of Agusan del Norte is one of the 4 provinces in the Caraga region. It was a part of the once undivided Agusan province (the other one is Agusan del Sur). The province is composed of 10 municipalities and 1 newly-approved component city (Cabadbaran City) with two congressional districts. There are 167 barangays in the province.

The province has an estimated population of 317,675 in 2006. There are 54,775 households with an average family size of 5.

Of the 10 municipalities, only three (Nasipit, Las Nieves and Buenavista) are classified as belonging to 1st-3rd class municipalities. All the rest belongs to 4th – 6th municipalities.

For 2006, it has a Crude Birth Rate of 23.5%. The Crude Death Rate is 3.46%.

A PIPH-type of planning process was already conducted by the province facilitated by CHD Caraga. The "PIPH" however has lots of gaps.

Firstly, the PIPH did not go through the LGU planning process. Without the legitimization that the law-prescribed planning process would have ascribed to the PIPH, the plan was not assured of LGU funding and support. Moreover, the PIPH missed the opportunity to build on the provincial government's public health care financing initiative which had the municipalities' backing. Secondly, the PIPH was based on the plan of the interlocal health zones; thus it did not reflect the health plans of the different municipalities that would have funded the implementation of PIPH. Lastly, the PIPH did not undergo a technical review process. Hence, the obvious lack of coherence in the activities delineated in the plan.

Through PPDO and CHD HealthGov provided TA to the MLGU in the legitimization of the plans. HealthGov also assisted PHO and CHDs in conducting technical review with the municipal stakeholders.

A resource mobilization workshop was also facilitated to identify sources of financing and to establish complementary means of financing.

II Health Situation

Agusan del Norte's 2006 MMR is 27/100,000 live births while the Infant mortality rate (IMR) and under-five mortality rate (UFMR) is 33/100,000 LB and 86.8/100,000 LB respectively.

The CPR of the province stands at 36.3%.
Despite the increase in the MOOEs brought about by the capitation fund, the MCH indicators are also very low as indicated by the following examples based on 2007 2nd quarter cumulative report

- Pregnant women with at least 3 antenatal visits attended by skilled attendants – 28% with the new city of Cabadbaran having the lowest accomplishment (9%). This had to be validated.
- Pregnant women had at least 2 doses of tetanus toxoid immunization – 27%%
- Pregnant women that have taken complete dose of iron supplementation – at least 6 months (reported after the 180 tablets) – 31%
- Postpartum Women given complete iron dosage – 27%

There are 86 BHS serving 167 barangays. There are 6 government hospitals operated by the province, 1 city hospital (Butuan City) and five (5) private hospitals, three (3) of which are located in Butuan City. All municipalities have RHUs/MHCs. All these facilities have doctors and nurses.

All the 11 RHUs are SS certified and OPB accredited

III. Situational Analysis

HealthGov provided technical assistance to CHD 13, PHTL, PHO and PPDO in reviewing the province's PIPH. One of these is the introduction of the health sector frame as a tool for analysis and assessing interventions.

This enabled the LGUs to examine very closely their own health situation critically and strategically using more a comprehensive instrument.

Below is the summary of the analysis of the health situation done by the PHO technical staff, DOH representatives and PPDO using the health sector frame on FP, TB, MCH and Micronutrient programs:

Service Delivery
- Good practices not sustained by providers like CBMIS
- Lack of IEC to community stakeholders coupled with problems on accessibility and geographical terrains, cultural barriers,
- Program implementation review is not comprehensive, looks at program performance only
- Problem on how to identify the poor
- Problem on provider of NSV and BTL
- Quality of care needs to be improved
- No continuing skills enhancement program by the LGUs; health personnel needs to be trained on new FP manual
- Training has yet to be done on NFP
- A model of community-based referral system has yet to be fully implemented province-wide

Regulations
- Some facilities have to be accredited on TB-DOTS and MCP
- No manual of operation for ILHZ (hospital and RHUs)
- National policies not adopted locally
- Many health workers are not yet informed on ICV

Health Care Financing
- Difficulty of 1st to 3rd class municipalities in paying PHIC premium
- Sustainability of the multi-payer scheme

- No budget for PHO technical staff
- No revolving fund for FP commodities

Governance
- Lack of policies to support and sustain current initiatives in health
- ILHZ have the potential to be an effective mechanism for health sector reform but the LCEs have yet to show genuine support
- Health data/information not utilized for governance
- No working M & E systems (CHD, PHO, RHU)
- Participation of organized women's groups and NGOs need to be replicated province-wide
- Congressional support not yet harnessed

These comprehensive analyses became the guiding framework of the PHO technical staff, PPDO and DOH representatives when they assisted the MLGUs in reviewing the goals, strategic interventions and PPAs in their respective investment plans for health during the conduct of technical review.

With regards to CSR, a rapid monitoring of PRISM yields the following results:
- The provincial LGU has CSR plan, approved with the local legislative body- Sanguniang Panlalawigan. Appropriated 300,000.00 for contraceptives. Purchased contraceptives through PRISM linkage.
- It was also found out that PLGU allocated PhP 700,000 as provincial counterpart to any LEAD for Health activities. With the exit of the project, the fund was used to other purposes.
- All the municipalities have draft CSR plans and CSR forecasting outputs. They have budget allocations depending upon the capacity of the LGU. Municipalities of Kitcharao, Nasipit, Carmen, Magallanes, have approved forecasting budgets.
- All of the LGUs have started procuring contraceptives
- CSR action is focused mainly on logistics procurement and distribution

The capacity of the LGU to procure contraceptives has been boosted due to the capitation funds from PHIC.

The multi-payer scheme produced almost PhP 8M of additional funding for the LGUs. 80% of the funds were utilized to augment the MOOEs (including procurement of drugs and medicines) of the RHUs.

There are a number of RHUs which tripled their MOOEs because of the capitation fund, while the rest has doubled their MOOE budgets.

The health workers were also benefited financially from the capitation fund as they get an average of 20% from the total capitation.

The multi-payer scheme resulted to fast accreditation of the RHUs on OPB. Within a period of more than two years, only 1 RHU (Kitcharao) was OPB accredited. But with the implementation of the multi-payer scheme, within six months, 9 RHUs were already accredited or on the verge of being accredited (all documents submitted to PHIC central office).

At present, most of the RHUs are doing their best efforts to be accredited on TB-DOTS and MCP.

The scheme also triggered the initial implementation of hospital systems reforms initiated by the provincial government.

The scheme is regarded by PHIC as one good practice.

IV. Proposed Strategic Direction and TA Interventions

Other significant considerations:

- Decision of the provincial governor to close down the provincial hospital and strengthen the two district hospitals (Cabadbaran and Nasipit). These are core referral hospitals and the ILHZs were established based on the core referral concept. The Governor calls to strengthen the two-way referral systems in each ILHZ.
- The recent city-hood of Cabadbaran and the application for city-hood of Nasipit are added factors. Both LGUs can provide leadership on health in each respective ILHZs.
- High interest of PHO and CHD to support ILHZ strengthening
- PIPH were done at the ILHZ level.
- Presence of strong and organized community-based organizations in each of the ILHZ. These are ideal elements in mobilizing broad support to FP, MCH, TB and micronutrient programs in areas of decision-making, community involvement and health service delivery.
- In an effort to sustain the multi-payer scheme, LGUs appointed municipal and district social health insurance officers.
- Multi-payer scheme has been proven so far as the driver of local health systems reforms.
- Interest of the Congressional Representative to support the health sector reform of the province.

Given all the considerations, Year 2 technical assistance areas will concentrate on the following:

1. Laying the foundation for the institutionalization of LCR
   1.1 CSR monitoring
   1.2 CSR planning

2. Strengthening the PHIC multi-payer Scheme. Key result areas include: o
   Expansion of coverage and premium payers to include card holders
   o Utilization benefits both by subsidy payers and card holders and
   o Impact on key public health program performance/coverage (with SDIR)

   Technical Assistance includes:
   2.1 Conduct of review on the multi-payor scheme
   2.2 Capability-building of municipal and district Social Health Insurance Officers to establish systems of enrollment, collection of premium Payments from cardholders, remittances and claims

3. Strengthening ILHZs capacity to manage key public health programs (TB, FP, MCH, AI/SARS and micronutrients). Technical assistance will include:
   3.1 SDIR
   3.2 Establishment and/or strengthening of ILHZ-managed health systems
   - HMIS
   - Facilitative supervision
   - M & E
   - Community-Based Referral system

- ƒ User fees (Cabadbaran, Nasipit, Buenavista, Magallanes) and Hospital and RHU retention fund scheme
- ƒ SDExH

4. Mobilization of broad local support for FP (LCR), TB control, MCH and Micronutrient, PHIC universal coverage and facility accreditation, movement to transform red to green, through evidence-based participatory decision-making. This is spearheaded by the LCEs including the legally-mandated structures and mechanisms (SP/SB, LHB, ILHZ, LDC, LMP, PCL, office of the Congressional Representative, etc.) and CSO involvement in decision-making, mobilizing community participation and service delivery.

Laying the foundation for the institutionalization of CSR

1. CSR Assessment and Monitoring Tool (consistent with new AO on CSR)

Exercising its lead role among CAs on CSR, HealthGov had initiated a TA plan to CHD 10 in enhancing its CSR monitoring tool.

This tool will be utilized in Agusan del Norte for year 2 as part of the laying the foundation for the institutionalization of CSR.

Mode of TA delivery
To jumpstart the process, HealthGov will initiate a meeting with PRISM and HealthPro to plan how the CSR monitoring tool will be implemented in Agusan del Norte through CHD. This will come after Central DOH or the DOH-CSR TWG has given the signal to implement the CSR tool developed in region 10.

DOH and CAs will orient CHD, POPCOM and PHIC (especially the regional CSR TWG) on the tool and the implementing guidelines. CHD will make an action plan on how to implement the tool.

CHD, POPCOM and PHIC through the regional CSR TWG will conduct a one-day orient to PHO, PHTL, DOH Representatives.

PHO will organize a one day CSR monitoring tool orientation and action planning for the conduct of province-wide monitoring. This will be participated in by all MHOs, PHNs and DOH representatives.

PHO, PHT, DOH representatives and MHOs conduct province-wide monitoring from January to March.

By end of March, MHOs and DOH representatives will present results to the respective municipal LGUs (LCEs, SP, LHB). The expected output is the mandate to do CSR planning is given by the municipal LGUs. There are problem areas however, where LGUs will provide instantaneous interventions based on the monitoring results.

Likewise, PHO will consolidate province-wide results and present them to PLGU (Governor, SP, LHB). It is expected that PLGU will give the mandate to do CSR planning.

CHD will consolidate regiona-wide results and submit to DOH central and HealthGov and PRISM.

2. CSR planning

The next step in the sequence of CSR activities is the CSR planning. The CSR monitoring results will be used as inputs to the plans. This will be started by April 2008 and will end mid- June 2008 just in time for the first budget call. There will be period of revisions and negotiations between and among LGUs in the ILHZ and between PLGU and MLGUs.

Final CSR plans with corresponding budget will start to be implemented on the last quarter of 2008. Since forecasting of actual FP logistics needs of an LGU population depends on determination of households eligible for LGU subsidy, the results of the CHLSS (another related TA) will be utilized. This means that the results of the survey should be made available during the budgeting period (from June to October 2008).

Mode of TA delivery
Central DOH, HealthGov, PRISM and HealthPro will orient the CHD, POPCOM and PHIC (RD, ARD, LHAD and the regional CSR TWG) and the PHO on the CSR planning tool. CHD will mobilize the regional CSR TWG to lead the CSR planning processes as facilitators together with the PHO. PHO will select from among the technical staff for training (e.g. FP coordinator).

HG and PRISM will train regional CSR TWG and PHO technical staff as facilitators on CSR planning. Training will include basic skills in facilitating.

Regional CSR TWG and PHO technical staff will formulate action plan and set schedule with the province for the conduct of CSR planning in each of the three (3) ILHZs.

Regional CSR TWG and PHO will facilitate CSR planning at the ILHZs. LCEs will be invited during the opening program where CSR orientation will be conducted. The municipal participants/planning team will be composed of the MHO, PHN, LFC, SB on Health and SB on Budget and Appropriation.

PHO technical staff and DOH reps provide coaching and mentoring to MLGUs in the refinement and finalization of the CSR plans with technical back-up from CHD and HG. HG and CHD will do field visits. Both will provide technical recommendations to the LGUs.

CHD and PHO will provide technical assistance in the refinement and finalization of the provincial CSR plan through the facilitators. There will be regular technical meetings that will be organized by the CHD to assess the progress, provide technical advises and provide logistics support.

PHO will lead in the negotiations with MLGU on the forecasting, cost sharing for logistics procurement, identification of private providers and suppliers (with technical assistance from PRISM) and the kind and level of effort needed to implement CSR province-wide.

PHO and RHUs will present the final version of the plan to their respective LGUs (provincial and municipal).

This will lead to the inclusion of the plans in the 2009 AIP (or inclusion in the 2008 supplemental budget), identification of enabling laws identified and scheduling for deliberations, mandate to implement and official pronouncement that CSR plans will be integrated in the PIPH.

3. A monitoring and evaluation tool to track progress of CSR implementation will also be designed and be integrated into the PIPH M & E tool.

This could be done through the following steps:

- HealthGov to facilitate designing of monitoring and evaluation design and tools with CSR TWG. This will also include the designing of feedback system to LGUs and LGU organizations on results of monitoring
- CSR TWG to orient PHO and provincial team on the M & E design and tools
- CSR M & E will be integrated to the PIPH M & E by the PHO. This will be done through a one-day consultative workshop to be participated in by MHOs, PHNs, LFC representative, CSO and DOH representatives
- PHO and PHT to conduct regular monitoring of the progress of CSR implementation as part of the PIPH M & E.
- PHO to establish feedback system to LGUs (LCE, LHB, LMP, PCL, ABC) with technical back-up from CHD and HealthGov. The establishment of the feedback system will be supported by EBL (another related TA)

Strengthening the PHIC multi-payer Scheme

1. Conduct of review on the multi-payor scheme

Production Partners
The governor will constitute a team of provincial personnel (PHO, PSWD, PPDO, and PBO) to conduct a technical review of the multi-payor scheme. This will be supported by PHIC and CHD 13 (LHAD and provincial health team). A private sector and an NGO representative will also be invited to become members of the group. It is also expected that the congressional office of the province will also send in a representative.

Mode of Delivery to Partners
HealthGov will provide technical assistance to the team mentioned above as productions partners.

The first step is the development of review guidelines and tools as well as planning guidelines and tools. After the review, a planning process will be done utilizing the results of the review.

The review and planning guidelines/tools will be presented by the team to the provincial governor through the local health board for approval.

The team will then facilitate the conduct of activities which combine self-assessment (RHUs and the PLGU-managed hospitals) and conduct of FGDs to key informants (MHOs, hospital directors, PHIC, LCEs, PHNs, midwives).

The results of the review will be presented to the governor and LCEs. Key areas for enhancements will be identified. It is expected that the governor and the LCEs will give the mandate to plan.

A planning workshop will be facilitated by the team (which conducted the review) using the guidelines and tools developed with the technical assistance of HealthGov. The workshop will be participated in by the municipal, ILHZ and provincial stakeholders. On the last day of the workshop, the governor and the municipal LCEs will participate so that final and collective decisions will be made.

Since SDIR is part of the review, it is expected that the whole process will be done before end of December. SDIR will be conducted either later part of November or early part of December.

2.2 Capability-building of municipal and district Social Health Insurance Officers to establish systems of enrollment, collection of premium payments from cardholders, remittances and claims.

This technical assistance will be provided by HealthGov to the LGUs through PHIC 13, CHD 13, PHO, PPDO, Office of the Governor, PSWD, CSO, private sector representative and office of the congressional representative.

This TA requires a product development process which is a collaborative effort between HealthGov and the TA production partners mentioned above.

Mode of Delivery to Partners
HealthGov will provide technical assistance to the production partners in the development of training/capability design. The design will include a two-day training and follow-through technical assistance.

The partners will conduct a two-day training workshop for SHIOs by the production partners with technical backup from HG.

Afterwards the development partners will conduct continuing mentoring and coaching by to the SHIO. They will also conduct regular SHIOs meetings to address issues and gaps in the establishment of the systems mentioned above.

This whole process will start early November and will be expected to be done by June 2008.

2.3 Assist PLGU, MLGU, PHIC, CHD, SHIO advocate to cardholders through ABC to cost-share premium payments (Note: this is part of the EBPDM process)

3. Strengthening ILHZs capacity to manage key public health programs (TB, FP, MCH, AI/SARS and micronutrients). Technical assistance will include:

Technical Assistance:

1. Service Delivery Implementation Review of key public health programs
   As a first step, HealthGov will orient CHD 13 and PHO on SDIR. Part of the outputs is an action plan by CHD and PHO in implementing SDIR at the level of the LGUs.

   PHO, with the technical support from CHD will orient the ILHZ, RHUS, CSO and DOH representatives on SDIR. Afterwards, an action plan will be develop to implement SDIR processes.

   Data gathering will then be done by RHU, DOH representatives and CSO. The final process will be the analysis and formulation of acceleration plans by the RHUs, ILHZ and CSO with the technical guidance of PHO and CHD

2. Establishment and/or strengthening of ILHZ-managed health systems
   - HMIS
   - Facilitative supervision

- M & E
- Community-Based Referral system
- User fees (Cabadbaran, Nasipit, Buenavista, Magallanes) and Hospital and RHU retention fund scheme
- SDExH

Production Partners
CHD, PHO, PPDO, ILHZ, Hospitals, PSWD, CSO, PHIC, PopCom, women organizations, office of the city/municipal mayors, office of the provincial governor, office of the congressional representatives, provincial treasurer's office, provincial budget officer, provincial accountant and provincial economic enterprise development office (PEEDMO).

Note: Participation of production partners depends on the nature of the technical assistance required (e.g. PEEDMO, PBO, PAO, PTO on user fee and income retention schemes)

Mode of Delivery to Partners
HealthGov will provide technical assistance to the production partners mentioned above in the identification and planning for the establishment and/or strengthening health systems.

The plans will be presented to the LCEs through the LHBs for endorsement and approval. HealthGov will provide TA to the PHO, RHUs and other production partners in the packaging of the systems.

It is recommended that instead of hiring TAP on a piecemeal basis (per health system), an organization will be contracted out to take care of the entire ILHZ systems strengthening. A multi-disciplinary team will be formed by the organization. Team member expertise will include public health, research, information system, governance, community organizing, M & E and the like.

Mode of Delivery to LGUs by Partners
Production partners (regional and provincial) to provide continuing technical to ILHZs and RHUs through coaching, mentoring, one-on-one consultation, developmental dialogues, partnership/technical meetings, exit conferences and small workshops with the technical backup of TAPs/HealthGov

4. TA to CHD, DILG, PHO, PHIC, POPCOM, CSO on mobilizing broad-based local action to support CSR, TB control, MCH and Micronutrient, PHIC universal coverage and facility accreditation, movement to transform red to green, through evidence-based participatory decision-making

For Year two, EBPDM TAs will focus on:

1. Evidence-Based legislation for local legislative councils. For this CHD, DILG, PHIC, POPCOM will capitalize on one of the mandated functions of the provincial board which is to review legislations by the sangguniang bayan. It will be advocated to the provincial board that they will produce a resolution mandating the SBs to craft legislations based on evidence. To achieve this, an EBL training curriculum will be implemented under the auspices of the provincial board.
2. Evidence-Based Policy-Making for LCEs, MHOs, Barangay Captains and CSOs. For CHD, DILG, PHIC, POPCOM will link with the provincial chapter of the LMP.
3. Policy-tracking (both for # 1 and 2)
4. Packaging of HIS results for advocacy cum advocacy skills training

Mode of TA delivery:
For Evidence-Based Legislation and Evidence-Based Policy-Making

- HG to hire TAP
- TAP and HG to orient DILG, CHD, POPCOM and PHIC
- Regional partners develop plan to implement EBL with technical back-up by TAP/HG
- DILG, CHD, PHIC to orient PLGU (Governor, vice governor, sangguniang panlalawigan, LMP/MLCEs, CSOs) on EBL principles, MDG status, health economics, LCE role in HSR with technical backup from TAP/HG.

  Outputs will include
  - o Orientation on the basic concept of evidence-based participatory local decision making;
  - o Identification of health issues/problems/gaps that require an EB process;
  - o Mandate to do activities to provide data/ information/ facts like survey (CHLSS), review (SDIR)

- Utilization of data/information/survey results/program review results/M & E results by the LCEs, LMP, SP/SB, LHB, LDCs. DILG provides technical oversight on the process with technical backup from PHO, RHUs, CHD and PHIC (content)
- Crafting of ordinances, resolutions, executive orders and other pieces indicating official decisions by the LGUs at all levels. DILG provides technical oversight in the whole process with technical backup from PHO, PPDO, RHUs, CHD and PHIC

  Outputs will include:
  - Policies, decisions legislations (Ordinances, resolutions, executive orders, memoranda, letters, etc.)
    1. Supporting specific programs/actions
    2. Solving particular health issue, gap or problem

Component TA

1. Policy tracking and analysis (a follow through TA from #3.1). See attached for technical definition and technical steps.

   Production partners
   1. Regional partners (DILG, CHD, POPCOM, PHIC)
   2. Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative)

   Mode of delivery to partners
   (Same as # 3.1)

   Mode of delivery to LGU partners
   Same as #3.1 except the creation of a legislative tacking committee per municipality by an official LGU enactment. The steps also are different but the mode of delivery by partners remains substantially the same.

   1.1 Packaging of HIS results for advocacy cum advocacy skills training
   Production partners

3. Regional partners (DILG, CHD, POPCOM, PHIC)
4. Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative, MHO representative)
5. TAP

Mode of delivery to partners

6. Conduct of workshop by TAP to regional, provincial and municipal partners to design customized advocacy materials using issue-specific topics as content (SDIR red to green, CSR-related issues, universal coverage and facility accreditation)
7. TAP facilitate the development of audience-specific advocacy tips. This will include inputs on and return demonstration of advocacy skills

Mode of delivery to LGUs by partners

8. Trained regional, provincial and municipal partners provide one-on-one coaching and mentoring to health workers and local partners in developing customized advocacy materials and steps
9. Trained regional, provincial and municipal partners provide technical backup (e.g. post-event mentoring and coaching)

PROVINCE OF COMPOSTELA VALLEY
TECHNICAL ASSISTANCE PLAN

Provincial Background

Brief History

The approval of the Republic Act No. 8470 on January 30, 1998 which wits ratified through a plebiscite held on March 7, 1998 marks the birth of Compostela Valley Province. This new province was carved out from the mother province of Davao del Norte.

Classified as a first class province, there are 11 Municipalities comprising the Province of Compbstela Valley, which are grouped into two districts. These are District I - Monkayo, Montevista, Maragusan, New Bataan and Compostela and District 2 Laak, Mawab, Nabunturan, Maco, Mabini and Pantukan. The Municipality of' Nabunturan was named capital town of the province. The first elected Governor is Atty. Jose R. Caballero.

Geography

The province of Compostela Valley is situated in Southeastern part of Mindanao island and north central part of Region XI. It is bounded by Agusan del Sur on the north, Davao Oriental on the east and south, Island Garden City of Samal on the southwest and Davao del Norte on the west and northwestern part.

It has a total land area of 4,666.93 square kilorneters and is bounded by Agusan del Sur on the north, Davao del Norte on the west, Davao Oriental on the east and southeast and Davao Gulf on the west and Southwest.

Demography

The average annual growth rate of Compostela Valley Province is 2.38% based on the 2000 NSO Census and the projected population for 2006 is 670,535. The population density is 144 persons per square kilometer. Compostela has the highest population density with 380 persons per swuare kilometers and New Bataan has the least with 71 persons per square kilometer (Table 1).

Ethnic/Tribal Groups:

Cebuanos are the dominant group with Ilocanos, Tagalogs and Ilonggos coming in as next big groups. For the tribal groups, there are Ata-talaingod, Dibabaonon, Manguwangan and with Mandaya and Mansaka as the dominant groups.

Provincial Health

Vision: A healthy and productive citizenry working together for a better quality of life.

Mission: Ensure genuine commitment and dedicated involvement, partnership and collaboration among the people, health workers, LGUs and health care providers in the quest for a better quality health for the people of Compostela Valley.

Health Situation

Table 1: Projected Population, Land Area and Population Density, 2006

Municipality/City	Projected Population		Land Area sq km	Population Density sq km
	Number	Percentage		
1. Compostela	71,263	10.6	187.5	380
2. Maragusan	53,085	7.9	394.3	135
3. Monkayo	99,186	14.8	692.9	143
4. Montevista	38,395	5.7	265.0	145
5. New Bataan	49,170	7.3	688.6	71
6. Laak	68,701	10.2	947.1	73
7. Mabini	37,046	5.5	412.3	90
8. Maco	75,324	11.2	244.4	308
9. Mawab	36,983	5.5	169.5	218
10. Nabunturan	69,964	10.4	245.3	285
11. Pantukan	71,418	10.7	420.1	170
Compostela Valley Province	**670,535**	**100.0**	**4,666.9**	**144**

Table 2: Vital Health Statistics, 2006

Municipality/City	CBR	CDR	MMR	IMR	YCMR
12. Compostela	24.7	5.8	284.6	27.9	6.3
13. Maragusan	23.2	3.8	162.7	17.9	5.7
14. Monkayo	18.5	4.3	217.5	21.2	4.9
15. Montevista	23.5	5.1	442.5	15.5	8.8
16. New Bataan	18.6	4.0	109.5	15.3	4.4
17. Laak	23.1	2.5	62.9	18.3	3.8
18. Mabini	19.4	4.0	139.5	26.5	4.2
19. Maco	19.3	4.6	274.7	33.0	2.7

20. Mawab	21.7	5.2	124.7	13.7	5.0
21. Nabunturan	18.5	5.4	77.3	31.7	3.1
22. Pantukan	26.1	4.8	-	23.1	4.3
Compostela Valley Province	**21.4**	**4.5**	**167.1**	**22.9**	**4.7**

CBR:Crude Birth Rate per 1,000 population;
CDR:Crude Death Rate per 1,000 population;
MMR:Maternal Mortality Rate per 100,000 livebirths;
IMR: Infant Mortality Rate per 100,000 livebirths;
YCMR:Young Child Mortality Rate per 1,000 livebirths.

Table 3: Ten Leading Causes of Mortality and Rate per 100,000 Population, 2006

Causes of Death		**Number**	**Rate**
1.	Accident, all forms	460	68.6
2.	Cerebrovascular diseases	371	55.3
3.	Pneumonia	292	43.5
4.	Hypertension	233	34.7
5.	Cancer, all forms	221	33.0
6.	Pulmunary Tuberculosis	204	30.4
7.	Renal failure	121	18.0
8.	Septicemia	118	17.6
9.	Fetal death in utero	110	16.4
10.	Diabetes mellitus	93	13.9

Table 4: Causes of Maternal Mortality and Rate per 100,000 livebirths, 2006

Causes of Maternal Deaths		**Number**	**Rate**
1.	Maternal Hypertension	8	55.7
2.	Postpartum hemorrhage	6	41.8
3.	Puerperal sepsis	6	41.8
4.	Complication of labor and delivery	3	20.9

5.	Pregnance with abortive outcome	1	7.0

Table 5: Ten Leading Causes of Infant Mortality and Rate per 100,000 livebirths, 2006

Causes of Infant Deaths		**Number**	**Rate**
1.	Pneumonia	37	257.6
2.	Septicemia/Sepsis	37	257.6
3.	Prematurity	35	243.7
4.	Respiratory Diseases of the newborn	31	127.2
5.	Birth asphyxia/intrauterine hypoxia	19	132.2
6.	Diarrhea and gastroenteritis	17	118.4
7.	Fetal condition caused by complications of pregnancy, labor and delivery	15	104.4
8.	Congenital malformations	13	90.5
9.	Meningitis	12	83.5
10.	Hemorrhagic diseases of the newborn	8	55.7

Table 6: Ten Leading Causes of Morbidity and Rate per 100,000 population, 2006

Causes of Infant Deaths		**Number**	**Rate**
1.	Acute upper respiratory infections	9,004	1,342.8
2.	Pneumonia	7,486	1,113.7
3.	Accidents/Injuries	7,027	1,048.0
4.	Urinary tract infections	6,590	982.8
5.	Diarrhea and gastroenteritis	5,972	890.6
6.	Hypertension	5,149	767.9

Table 7: Number of Selected Health Human Resources, 2006

Municipality/City	Doctor	Dentist	Nurse	Medical Technologist	RSI	RHM	Dental Aides
1. Compostela	1	1	2	2	1	12	1
2. Maragusan	1	1	1	1	1	20	1
3. Monkayo	2	1	3	4	2	25	-
4. Montevista	1	1	1	1	1	7	-
5. New Bataan	2	1	2	1	1	17	1
6. Laak	1	1	1	1	2	23	1
7. Mabini	1	-	1	1	1	9	-
8. Maco	1	1	4	2	1	12	1
9. Mawab	1	1	1	1	2	6	1
10. Nabunturan	1	1	2	1	2	14	1
11. Pantukan	1	1	1	1	2	13	1
12. PHO	3	2	4	3	2	2	1
Compostela Valley Province	16	12	23	19	18	160	9

Table 8: Health Programs Indicators by Municipality, 2006

Health Indicators	Provincial Rate
1. % Fully Immunized Child (Vs. 3% Of Population)	77.5
2. % Measles Drop-Out Rate	-1.3
3. % Child Protected At Birth	67.2
4. % Low Birth Weight	2.0

9.	% Pregnant Women Given Iron For 6 Months	22.0
10.	% Fully Immunized Mothers	72.9
11.	% Deliveries Attended By Skilled HP	41.1
12.	% Contraceptive Prevalence Rate	62.4
13.	% PP Women Initiated BF	88.4
14.	% Quality Prenatal Care	19.7
15.	% Quality Postpartum	51.4
16.	% Household With Sanitary Toilets	72.0
17.	% Household With Access To Safe Water	88.3

Table 9: Hospitals (Available)

Public Hospitals	Bed Capacity	Location
Montevista District Hospital	(50 beds)	Poblacion Montevista
Pantukan District Hospital	(50 beds)	Poblacion, Pantukan

Privately-owned hospital and clinics with 10-bed capacity or less in:		
1. Nabunturan	**4. Monkayo**	**6. Pantukan**
2. Compostela	**5. New Bataan**	**7. Mabini**
3. Mawab		

Context of Providing Technical Assistance to the Province

With the inception of the Health Sector Reform – FOURmula One-Province-wide Investment Plan for Health (HSR-F1-PIPH), the Provincial Government's perspectives and priorities have been influenced with the prospects of resource and interventions in-flow for health to the Province being an F1 roll-out site.

By 2008 towards 2009, the actual provision of such resources and interventions will further impact on their perspectives and priorities and at the same time compliment HealthGov's Technical Assistance for the Region and for the Province.

It is, therefore, imperative that at an early stage, HealthGov lead in positioning the strategic interest of SOAG. However, for this to be seen positively, HG should focus on TAs that will lay the foundation with which interventions can be built on. This can only be done through its PIPH.

However, there is one single gap that will need to be addressed soonest with whatever technical framework and tools to be used at our own disposal. This is on the utilization of the Service Delivery Implementation Review (SDIR) as a tool for situation analysis. CHD 11 is fully aware that a substantial number of health indicators embedded in the SDIR tool are not located in CHD's FHIS/RHIS. This will need to be ostensibly identified and addressed with the CHD.

Technical Assistance: Institutionalizing SDIR tool for Situation Analysis in the Development of a PIPH and Annual Operational Plans

Background

The Province of Compostela is an F1 roll-out site.

The CHD established and made operational an F1 Team to coordinate and facilitate the conduct of PIPH in the Province with strong collaboration with the HealthGov.

The HealthGov supported CHD 11 through the provision of key orientation workshops and capacity building exercises to its F1 Team and Provincial Health Teams to manage the conduct of Situation Analysis using the F1 framework and utilizing the Service Delivery Implementation Review (SDIR) tool and the eventual Investment Planning process using the PIPH tool.

Key interventions

PIPH development is a pre-determined focus of assistance for the province. Key interventions will directly focus in capacitating LGU service implementers on the use of the SDIR/SA tools. For each municipality, assessment of their health programs will be conducted in their own level. The actual planning process will be guided by the trained CHD staff. During the assessment and determination of investment needs, stakeholders like NGOs and CSOs (Consumers), key members of the Local finance Committee (LGU Planning and Budget Officers and Key Legislators) will form part of the process.

HealthGov's Technical Assistance (TA) will make investments contribute in achieving the National Objectives for Health (NOH) and Millenium Development Goals (MDG) health targets.

CHD 11 is HealthGov's major production partner. HealthGov will assist the CHD in facilitating the orientation of LCEs, other partner agencies and would-be investors in the PIPH. Under Year

2, the Technical Assistance will initially be limited to PIPH development by capacitating CHD XI. Succeeding TA activities on the review, refinement and legitimization of the PIPH will be implemented for the same year.

In as much as the SDIR/SA tools will yield the necessary data and information for the development of acceleration plan, TA on Service Implementation specifically SDExH will be engaged towards the 3rd quarter of the year.

Expected results

Aptly facilitated by CHD 11, a substantially implementable Province-wide Investment Plan for Health (PIPH) of the Province of Compostela Valley imbued with interventions that addresses local health problems (i.e. Maternal and Child Health) and contributes to achieving the health targets identified in the NOH and the MDG.

TA No. 1: PIPH Guidelines

A planning guide and templates based on the 12 steps of PIPH will be finalized in collaboration with CHD 11 – as HealthGov's partner. The CHD will lead in the delivery of the TA tools developed to the Provincial LGU.

CHD will orient PHO and CHD provincial health team on the planning guidelines and templates. An Action Plan will be formulated that provides steps on how and when to conduct a workshop. This Action Plan will be presented to the Governor and an executive order for the designation of Provincial Planning Team for PIPH development will be issued.

The Provincial Planning Team with technical support from the CHD will facilitate a one (1) day activity for the orientation of other key stakeholders(LCEs, SBs on Health, SBs on Appropriation and other partner agencies). There will be signing of Pledge of Commitment supporting the Health Sector Reform Program and the crafting of MIPH.

The PHO/CHD PHT Team will facilitate a two-day workshop with the provincial team, hospital representatives and MHOs with technical guidance from CHD. Introduction on the use of SDIR tool will provide the needed data for the drafting of interventions.

After collection of information required in the SDIR, coaching and mentoring on the interpretation of results utilizing the SA tools will happen by end of September 2007.
HG will facilitate the writeshop activity for the determination of goals which should be in harmony and consistent with the logical framework of MDG. This will be followed by the development of financial plan which will be finalized for presentation to the Local Finance Committee for consideration in the CY 2008 Executive Agenda.

As Compostela Valley is a roll out province, there will be technical review of the plan. Initially by the CHD technical team and eventually by the Joint Appraisal Committee which is chaired by DOH with membership coming from EC, USAID, WB other Funding Agencies and GOP line agencies like DOF and DBM.

Plan revisions will probably follow based on the recommendations of the Reviewing Committee, thus HealthGov will continuously provide technical assistance to the LGUs through CHD. These activities will continue until early part of January to March 2008 with some immediate

interventions that maybe carried out through funds provided by other funding sources and from LGU supplemental budget.

Mode of Delivery through the CHD:

1. The CHD F1 Team, in collaboration with the CHD PHT, facilitate the Provincial LGU's action in September 2007, where a Provincial Planning Team (PPT) is established, oriented on HSR-F1-PIPH and made operational by virtue of an Executive Order (E.O. that Mandates to Plan). The PPT will be composed of the:
   - the *Sangguniang Panlalawigan* (provincial legislative council) member who chairs the Committee on Health,
   - Provincial Health Officer (PHO),
   - the Provincial Planning and Development Officer (PPDO),
   - Provincial Budget Officer (PBO),
   - Selected municipal health officers (MHOs) and hospital chiefs,
   - DOH and PhilHealth staff, and
   - Representatives of non-government organizations (NGOs), and civil society groups.

   The Governor invites DOH through the CHD and partners to train the PPT on the principles and mechanisms of PIPH formulation. In close collaboration with the PPT, Provincial Technical Staffs and DOHReps, as trained by HealthGov will then provide the coaching/mentoring on PIPH development for the 11 Municipalities.

2. Availability of a Draft Action plan with set schedule of roll out activities utilizing the strategies learned from the PIPH tool orientation workshop.

Mode of Delivery to LGU Partners

1. LCEs oriented on HSR-F1-PIPH utilizing F1 as the overall frame. Covenant supporting Health Sector Reform Program with PIPH as the tool of participation.
2. 11 MIPH ready for consolidation at the Provincial level.
3. PIPH formulated, refined and packaged for presentation to Reviewing Committee.
4. Signed Memorandum of Agreements between component LGUs and Donors.
5. Mandate to Implement issued.

TA No. 2: Capability Building for Evidence-based Participatory Governance

Capacity building for LCEs and key LGU and Health Officials will be accomplished in two parts. The first mode of delivery will be through CHD in partnership will other agencies like PopCom, DSWD and DILG. The 2nd will be through a commissioned Technical Assistance Provider (TAP) who may become partners in capability building.

Mode of delivery through the CHD:

1. HealthGov will identify and commission a Technical Assistance Provider (TAP).
2. HealthGov together with the commissioned TAP will orient the CHD F1 Team. The TA will be focus on the CHD Tool Kits and CSR produced by Inter CA TWG with DOH, CHD and PHIC.
3. Related topics like policy links on utilization of LSI in means testing will be incorporated in the TA package.

The initial step entail the forging of an agreement among the identified members of a Team with roles and responsibilities of each partner- member clearly outlined and agreed upon by all participating agencies. This team composed of point persons from CHD, PopCom, DSWD and DILG will conduct roll out activity to the 11 municipalities. Target LGU partners are the Mayors, the Local Finance Committee and the SBs and SPs. HG will provide continuous technical support in the actual roll out.

Support activities like writeshop/policy crafting for program managers and legislators will be packaged base on needs and request. This will focus on the importance of a high quality CSR response where output like ordinances/budget support for other component program will be included in the ELA.

To trial test this activity; a generic session will be conducted. After the conduct of SDIR in Sept 2007, the SA with emphasis on Family Planning and MCH program will be presented to the targeted LGU partners like the LCEs, LFC and SBs. The result of analysis of these programs according to four components of FOURmula one will be the working document in the development of TA for Evidence-based Participatory Governance.

The following concerns are the areas where the Core Team will help the participants develop policies and guidelines for implementation:

1. Budget requirement and allocation for the forecasted logistics of unmet needs in FP, TB, Vit A.
2. Policy on providing support to safety net groups./and those beyond safety net.
3. Budget allocation for Indigency program
4. Policy issues or ordinance regarding cost recovery schemes like user's fees.

By the end of November, 2007, draft policies will be available for presentation to the partner LGUs. These reports will be readied for the next step. Among these steps is through public hearings, through the LGU Health Board processes and through the MDC/PDC concurrence sessions and processes.

The result will thus be an evidence of support to the program which will form part of the planned institutionalization of an effective and efficient LGU CSR response.

Mode of assessing the impact of these policies and ordinances will be monitored utilizing the M & E registry.

Mode of delivery through Academe/Institution or other TA provider Organizations:

Training curriculum for capability building for Evidence-based Participatory Governance will include modules on the utilization of LHA as a managerial tool, Basic principles of Public Finance Management Planning for Health that includes guidelines for the establishment of procurement and logistics system, financing systems: planning and budgeting systems, setting of financial outcomes (funds flow, trust funds, revolving funds and special accounts); resource mobilization (alternative options for financing, alternative modes of non-traditional financing schemes, revenue enhancement programs, and public-private partnership arrangements).

This will also include modules on Internal Audit system for an effective and efficient flow of transactions of the LGU.

HealthGov will package the training curriculum and the output from enrolment in the training program.

For the province, a training needs analysis of targeted LGU partners should be engaged to determine the sequence of modules to be offered in a semester.

Mode of Delivery to LGU Partners:

1. LCEs/SB/SP/LFC oriented on MDG/MTPHP/NOH,HSR& F1 framework, LHA and health economics before the end of the year 2007.
2. Evidence-based policies and legislations supporting local *CSR response* and incorporated in the Executive-Legislative Agenda (ELA), increased budget for health, increased use of health facilities and increased revenue from user's fees.
3. Highlights (Jan-Aug, 2008) documented through monitoring and follow-through HG activities on the 11 Municipal LGUs. Indicators are routinely monitored based on availability and compared against initial baseline.

TA No. 3: Service Delivery Improvement tools

This TA will utilize the following tools:

- SDEX
- SDIR/SA
- Strengthening service providers training system
- TA on informed choice and voluntarism
- Family Health Book
- Strengthening Service delivery monitoring and supervision

Since this tool is in its refinement stage, the approach will be engaged directly to the implementers in close collaboration with the CHD F1 Team.

This will have two implications:

One, the targeted core of trainers (CHD and PHO Program Coordinators) can participate very well in the fine tuning of the tools which should be adaptable to the uniqueness of each LGU.

And two, the direct intervention will provide immediate results as to the impact of tools in improving service delivery.

The mode of delivery at this stage will be directed to both the partner CHD and partner LGUs. The Trained Core Trainers will develop a plan of action for a well managed, efficient and controlled implementation schedule where activities do not disrupt the delivery of regular programs.

Implementation of tools will be undertaken within February to July 2008, while in the remaining quarters, documentation of results and tool enhancement are made.

HG-CHD partners of the 11 LGU will be coached and mentored on the development of an acceleration plan. The working document will be the SDIR/SA results utilized in the preparation of their respective MIPH. The CHD will facilitate the implementation of the acceleration plan which will be a section plan of the QA/QI plan of their MIPH.

Parallel to this activity will be the drafting of an M & E plan to record developmental changes in service delivery.

Mode of Delivery to Partners:

1. 1st -2nd quarter, 2008: Core Trainers undergone full training requirement on the Service Delivery Improvement Course.
2. Within the same period, the Core of Trainers drafted an Action Plan that outlined the implementation schedule for the 11 Municipal LGUs.

Mode of Delivery to LGU Partners:

1. January to February 2008: Municipal Health Staffs oriented on Service delivery improvement programs.
2. February to July 2008: Acceleration plan developed each of 11 Municipal LGUs.
3. July to August 2008: Monitoring and Evaluation Registry undertaken.

TA No. 4: Strengthening the Provincial and Municipal Health Boards and Establishment of the Inter-Local Health Collaboration for Health.

The Provincial Health Office also deemed a priority the functionality of its local health boards (LHBs) where public health management functions and roles are being implemented and aptly addresses policy support to addressing current health problems and concerns.

Participation of Non Government Organizations (NGOs), Communities and Civil Service Organizations/Societies (CSO/Ss) will substantially be incorporated at this level. It will be tiresome and tedious process, and often duplicating, to establish a separate NGO/CSO collaboration mechanism. It is at this level that such collaboration will be institutionalized and made operational. This will entail the increase of number of representation and the establishment of Constituent Assembly of NGOs/CSOs as its collective body where perspectives are agreed, formulated and submitted to the Local Health Board for consideration. The basic principle of LHB governance will need to be evidence-based, conflict mediation and consensus building.

These LHBs will be strengthened to support the efforts of the LGUs on their desire to improve service delivery and service utilization by constituents within each RHU and BHS. This will take cognizant on the important role to government district hospitals to support the on-going improvements of the RHUs services and increase utilization by its LGU constituents.

The Provincial Health Office, through the Provincial Planning Team mandated by the Governor will oversee this strengthening effort and will be supported by the Technical support from CHD 11 and HealthGov. HealthGov will work with the PLGU through the CHD.

Delivery Mode to CHD and LGU partners:

1. October to December 2008: Anchored on the Provincial health and organizational situation of the PIPH, will establish an Assessment and Planning Tool.
2. January to March 2008: Implement the Assessment and Planning Tool.
3. April to June 2008: Establish an Action Plan/Policies Formulation (incorporated in the PIPH).
4. July to September 2008: Implement/Monitor the Action Plan

PROVINCE OF DAVAO DEL SUR
TECHNICAL ASSISTANCE PLAN

Provincial Background

The Province is in southeastern Mindanao. It is bounded on the north by Davao Province, on the east by Davao Gulf, on the west by Cotabato Province, Sultan Kudarat and South Cotabato, and on the south by the Mindanao Sea. Geographically, Davao City is in Davao del Sur. It is a highly urbanized city.

Digos City is the capital of the Province. The Province has 11 municipalities with a total land area of 3,934.01 square kilometers and a population of 450,000.

The Land

The western part of the province is dominated by Mt. Apo which is the country´s highest peak. Mount Tanglao and Mount Latian are two other landmarks in the hinterlands. Wide fertile valleys are found between the mountain ranges and the narrow coastal plains in the east.

The weather is basically warm with no marked seasons. Rainfall is evenly distributed throughout the year.

Municipality / City	Projected Population		Land Area	Population Density/Sq. Km.
	Number	Percentage	Sq. Km.	
1. Bansalan	60,200	6.8	200.47	300.3
2. Digos City	145,523	16.5	317.96	457.7
3. Hagonoy	51,005	5.8	132.19	385.8
4. Magsaysay	50,191	5.7	75.76	662.5
5. Matanao	54,544	6.2	173.75	313.9
6. Padada	28,032	3.2	45.38	617.7
7. Sta Cruz	78,262	8.9	334.74	233.8
8. Don Marcelino	38,834	4.4	449.1	86.4
9. Jose Abad Santos	66,439	7.5	835.98	79.4
10. Kiblawan	47,986	5.4	237.45	262.9
11. Malalag	38,754	4.4	187.01	207.06
12. Malita	116259	13.2	186.17	206.1
13. Sarangani	21,381	2.4	181.36	200.7

14.	Sta. Maria	52,980	6.0	285.1	315.6
15.	Sulop	31,785	3.6	178.44	197.5
16.	Davao del Sur Province	882,175	100	3,934.01	224.2

A Brief History

Davao del Sur was created from the old province of Davao in 1967. Davao derived its name from the Bagobo word Daba-Daba referring to the Sacred Brass of the tribe´s legendary chieftain, Datu Duli, who lived in Mount Apo.

The letter "o" was added to the word, making it Daba-o Daba-o which, to the Bagobos, means justice and the datu´s fairness to his people. As years went by, the word was shortened to Dab-o and eventually, Davao.

Davao City was founded by a Spanish expedition led by Jose Oyanguren in 1848. He named the village Nueva Vergara after his hometown in Spain. It became a city on October 16, 1936.

Legislative Districts

The Legislative districts of Davao del Sur, namely the first and second districts are the representations of the Province of Davao del Sur in the Philippine House of Representatives. Davao del Sur was part of the representation of Davao Province until 1965, when it was created and granted its own representation, which until 1984, included Davao City.

It then became part of the representation of Region XI from 1978 to 1984. In 1986, it was divided into two congressional districts.

The People

The majority of the population are Visayan migrants. Cebuano is the most widely spoken language. Other prominent migrant groups are the Ilonggos and the Ilocanos.

Several ethnic groups exist in the province, among them B´laans, Bagobos, Manobos and Tagacaolos. These early settlers occupied the slopes, and base of Mt. Apo, and have developed their own cultures which have been preserved to this day.

The Bogobos, for example, are known for their colorful dresses woven from Abaca fiber and ornamented with beads, shells, metal disks and embroidery in geometric patterns. They also wear bells as anklets or costume accessories so they jiggle when the walk or dance.

Commerce and Industy

Because of its favorable climate and fertile soil, Davao del Sur is primarily an agricultural

province. It is popularly known as Coconut Country since coconut is its major commercial crop. Its rice and corn production is more than sufficient for its population. Other crops grown are bananas, cacao, ramie, coffee, fruits and vegetables.

Davao City is the commercial center of southern Mindanao. Foreign and domestic vessels load and unload goods at its port. Davao Gulf is the major fishing grounds of the city. There are eleven coastal municipalities facing the Philippine Sea. Logging has supported a wood-processing industry but rapid forest depletion is a cause of concern.

Getting There and Away

Regular buses ply the route from Davao City to General Santos. Buses depart from Manila to Davao City via Bicol, Samar, and Leyte daily. Buses from Cagayan de Oro are also available daily. Flights are also available from Manila and Cebu. Ferries going to Davao City from Manila via Cebu and Zamboanga city are also available.

Health Situation

Table 2: Vital Health Statistics, 2006

Municipality/City	CBR	CDR	MMR	IMR	YCMR
23. Bansalan	18.5	3.4	89.6	5.4	4.9
24. Digos City	21.6	3.8	31.8	12.1	8.9
25. Hagonoy	19.2	1.2	0	1.0	3.9
26. Magsaysay	17.5	3.7	0	6.8	7.9
27. Matanao	16.9	1.5	0	0	0
28. Padada	17.4	4.6	0	10.2	3.6
29. Sta Cruz	21.5	1.8	0	10.1	11.4
30. Don Marcelino	22.9	1.9	0	24.6	7.7
31. Jose Abad Santos	23.4	2.0	64.2	21.8	12.0
32. Kiblawan	18.3	2.8	0	3.4	8.3
33. Malalag	15.2	1.7	0	0	0
34. Malita	23.2	1.1	37.0	6.3	2.6
35. Sarangani	26.7	1.3	174.8	5.2	9.3
36. Sta. Maria	21.6	1.6	348.1	5.2	0
37. Sulop	18.9	3.4	0	11.6	0
Davao del Sur Province	**20.6**	**2.4**	**55.03**	**9.1**	**5.9**

CBR: Crude Birth Rate per 1,000 population;
CDR: Crude Death Rate per 1,000 population;
MMR: Maternal Mortality Rate per 100,000 livebirths;
IMR: Infant Mortality Rate per 100,000 livebirths;
YCMR: Young Child Mortality Rate per 1,000 livebirths.

Table 3: Ten Leading Causes of Mortality and Rate per 100,000 Population, 2006

	Causes of Death	Number	Rate
11.	Heart Disease	362	41.0
12.	Malignant Neoplasm, all forms	182	20.6
13.	Cerebrovascular Diseases	168	19.0
14.	Pneumonia	131	14.8
15.	Accidents, all forms	126	14.3
16.	Hypertensive Diseases	84	9.5
17.	Disease of the Digestive System	84	9.5
18.	Tuberculosis, Respiratory	78	8.8
19.	Disease of the Genitourinary System	76	8.6
20.	Chronic Lower Respiratory Disease	60	6.8

Table 4: Causes of Maternal Mortality and Rate per 100,000 livebirths, 2006

	Causes of Maternal Deaths	Number	Rate
6.	Complication of labor and delivery	5	27.4
7.	Oedema, Proteinuria and Hypertensive Disorder in Pregnancy	4	22.0

Table 5: Ten Leading Causes of Infant Mortality and Rate per 100,000 livebirths, 2006

	Causes of Infant Deaths	Number	Rate
11.	Pneumonia	18	100.2
12.	Respiratory Disease Syndrome	11	61.2

13.	Heart Disease	10	55.7
14.	Septicemia/Sepsis	10	55.7
15.	Anemia	8	44.5
16.	Congenital malformations	5	27.8
17.	Meningitis	5	27.8
18.	Asphyxia	5	27.8
19.	Diarrhea, all forms	4	22.3
20.	Cancer, all forms	1	5.6

Table 6: Ten Leading Causes of Morbidity and Rate per 100,000 population 2006

	Causes of Infant Deaths	**Number**	**Rate**
11.	Acute lower respiratory infections	4,646	526.7
12.	Respiratory Tuberculosis	887	100.5
13.	Diarrhea and Gastroenteritis	797	90.3
14.	Pneumonia	642	72.8
15.	Hypertensive Diseases	529	60.0
16.	Urinary Track Infection	320	36.3
17.	Heterophysis	253	28.7
18.	Malaria	220	24.9
19.	Malnutrition	151	17.1
20.	Intestinal Parasitism	78	8.8

Table 7: Number of Selected Health Human Resources, 2006

Municipality/City	Doctor	Dentist	Nurse	Medical Technologist	RSI	RHM	Dental Aides
13. Bansalan	1	1	3	1	2	17	1

14.	Digos City	2	1	5	1	3	27	1
15.	Hagonoy	1	1	2	1	2	12	1
16.	Magsaysay	1	1	2	1	1	12	1
17.	Matanao	1	1	2	1	1	11	1
18.	Padada	1	1	1	1	2	7	1
19.	Sta Cruz	1	1	3	2	1	19	1
20.	Don Marcelino	1	1	1	0	1	15	1
21.	Jose Abad Santos	1	1	2	1	1	18	1
22.	Kiblawan	1	1	2	1	1	10	1
23.	Malalag	1	1	2	1	1	7	1
24.	Malita	2	1	2	1	2	27	1
25.	Sarangani	0	0	1	0	2	4	1
26.	Sta. Maria	1	-	3	1	1	11	2
27.	Sulop	1	1	2	1	1	8	1
Davao del Sur Province		**16**	**14**	**32**	**14**	**22**	**205**	**16**

Table 8: Health Programs Indicators by Municipality, 2006

	Health Indicators	**Provincial Rate**
18.	% Fully Immunized Child (Vs. 3% Of Population)	73.0
19.	% Measles Drop-Out Rate	6.3
20.	% Child Protected At Birth	80.1
21.	% Low Birth Weight	2.2
22.	% Exclusive BF For 6 Months	37.8
23.	% Prevalence Of Malnourished	15.3
24.	% 6-71 Months. Children Given Vitamin A	78.7
25.	% Pregnant Women with 5 Prenatal Visit	14.3
26.	% Pregnant Women Given Iron For 6 Months	9.7

27.	% Fully Immunized Mothers	56.1
28.	% Deliveries Attended By Skilled HP	34.7
29.	% Contraceptive Prevalence Rate	52.3
30.	% PP Women Initiated BF	90.8
31.	% Quality Prenatal Care	6.7
32.	% Quality Postpartum	33.7
33.	% Household With Sanitary Toilets	69.1
34.	% Household With Access To Safe Water	83.3

Context of Providing Technical Assistance to the Province

The inception of the Health Sector Reform – FOURmula One-Province-wide Investment Plan for Health (HSR-F1-PIPH) and the non-inclusion of the Province as an F1 roll-out site have also influenced the Provincial Government's perspectives and priorities. Despite of not receiving substantial funding support for their adoption of the health sector reform under the FOURmula One (F1), unlike the F1 and F1 roll-out sites, Davao del Sur Governor Douglas RA Cagas still hopes to substantially gain from the Technical Assistance and other form of support that CHD 11 will provide with the HealthGov.

The health situation, including the health facilities of the Province speaks of a disintegrated health service delivery and myopic perspectives in governance for health.

With this situation, it is only fitting that HealthGov lead in positioning the strategic interest of SOAG into the process of the health sector reform in the Province. This will lay the foundation with which interventions to address health situation, problems and gaps can be built on. Again, this is done through a PIPH.

However, there is one single gap that will need to be addressed soonest with whatever technical framework and tools to be used at our disposal. This is on the use of the Service Delivery Implementation Review (SDIR) as a tool for situation analysis. CHD 11 is fully aware that a substantial number of health indicators embedded in the SDIR tool are not located in CHD's FHIS/RHIS. They have explicitly been reluctant for its use and integration into the health system of the CHD. This will need to be addressed with the CHD.

Technical Assistance: Institutionalizing SDIR tool for Situation Analysis in the Development of a PIPH and Annual Operational Plans

<u>Background</u>

The Province is not an F1 roll-out site but CHD 11 included it, along with Davao del Norte and Davao City, as recipient for an amount of support, as the Province engage its reform process using the F1 framework and using the PIPH as its investment planning tool.

CHD's established and made operational F1 Team already enlisted the Province to form part of its recipient Provincial areas for the development of a PIPH with strong TA support from HealthGov. HealthGov, on its part, has initially provided support to CHD 11 through the provision of HSR-F1-PIPH orientation workshops and SDIR/PIPH capacity building exercises to its F1 Team and Provincial Health Teams (July 2008) to manage the conduct of Situation Analysis using the F1 framework and utilizing the Service Delivery Implementation Review (SDIR) tool and the eventual Investment Planning process using the PIPH tool.

Despite the capability-building support provided to CHD through its F1 Team, the said F1 Team has still lacking of organizational and perspective cohesiveness to make itself effective in supporting the Province analyze their health situation and plan to address them through a well-developed Province-wide Investment Plan for Health (PIPH). This is an area of concern that is also wanting of HealthGov support.

Key interventions

PIPH development is a pre-determined focus of assistance for the province through the CHD. Key interventions will directly focus in capacitating LGU service implementers on the use of the SDIR/SA tools. This is an area where HealthGov will ensure that the CHD through its F1 Team, along with its service offices, have "realigned their paradigms" specifically their knowledge, skills and attitudes for them to be effective in their function to assist Davao del Sur and other Provinces under the region.

Through lead technical facilitating role of the CHD, each municipality assesses their health situation and programs towards the investment planning process. During the assessment and determination of investment needs, stakeholders like NGOs and CSOs (Consumers), key members of the Local finance Committee (LGU Planning and Budget Officers and Key Legislators) will form part of the process.

HealthGov's Technical Assistance (TA) will help ensure investments contribute in achieving the National Objectives for Health (NOH) and the Millenium Development Goals (MDG) health targets.

As CHD 11 is HealthGov's major production partner, it will assist the CHD facilitate the orientation of LCEs, other partner agencies and would-be investors in the PIPH. This was done through the conduct of a Regional Health Summit (August 28-29, 2007.

In Year 2, the Technical Assistance will initially be limited to PIPH development, review, refinement, legitimization and implementation by supporting the capability and confidence building of CHD XI.

Succeeding TA activities on the review, refinement and legitimization of the PIPH will be implemented for the same year. In as much as the SDIR/SA tools will yield the necessary data/information for the development of acceleration plan, TA on Service Implementation specifically SDExH will be engaged towards April 2008.

Expected results

Aptly facilitated by CHD 11, a substantially well-developed Province-wide Investment Plan for Health (PIPH) of the Province imbued with interventions that:

1. Addresses local health problems (i.e. Maternal and Child Health);

2. Contributes to achieving the health targets identified in the NOH/MDG;
3. Establish, strengthen and institutionalizes Local CSR Response;
4. Incorporates substantial and meaningful NGO/CSO collaboration for health; and
5. Strengthens the Local Health Boards and Inter-Local Collaboration for Health.

TA No. 1: PIPH Guidelines

A planning guide and templates based on the 12 steps of PIPH will be finalized in collaboration with CHD 11 – as HealthGov's partner. The CHD will lead in the delivery of the TA tools developed to the Provincial LGU.

CHD will orient PHO and CHD provincial health team on the planning guidelines and templates. An Action Plan will be formulated that provides steps on how and when to conduct a workshop. This Action Plan will be presented to the Governor and an executive order for the designation of Provincial Planning Team for PIPH development will be issued.

The Provincial Planning Team with technical support from the CHD will facilitate a one (1) day activity for the orientation of other key stakeholders(LCEs, SBs on Health, SBs on Appropriation and other partner agencies). There will be signing of Pledge of Commitment supporting the Health Sector Reform Program and the crafting of MIPH.

The PHO/CHD PHT Team will facilitate a two-day workshop with the provincial team, hospital representatives and MHOs with technical guidance from CHD. Introduction on the use of SDIR tool will provide the needed data for the drafting of interventions.

After collection of information required in the SDIR, coaching and mentoring on the interpretation of results utilizing the SA tools will happen by end of September 2007.
HG will facilitate the writeshop activity for the determination of goals which should be in harmony and consistent with the logical framework of MDG. This will be followed by the development of financial plan which will be finalized for presentation to the Local Finance Committee for consideration in the CY 2008 Executive Agenda.

Plan revisions will probably follow based on the recommendations of the Reviewing Committee, thus HealthGov will continuously provide technical assistance to the LGUs through CHD. These activities will continue until early part of January to March 2008 with some immediate interventions that maybe carried out through funds provided by other funding sources and from LGU supplemental budget.

Mode of Delivery through the CHD:

3. The CHD F1 Team, in collaboration with the CHD PHT, facilitate the Provincial LGU's action in September 2007, where a Provincial Planning Team (PPT) is established, oriented on HSR-F1-PIPH and made operational by virtue of an Executive Order (E.O. that Mandates to Plan). The PPT will be composed of the:
   - the *Sangguniang Panlalawigan* (provincial legislative council) member who chairs the Committee on Health,
   - Provincial Health Officer (PHO),
   - the Provincial Planning and Development Officer (PPDO),
   - Provincial Budget Officer (PBO),
   - Selected municipal health officers (MHOs) and hospital chiefs,

- DOH and PhilHealth staff, and
- Representatives of non-government organizations (NGOs), and civil society groups.

The Governor invites DOH through the CHD and partners to train the PPT on the principles and mechanisms of PIPH formulation. In close collaboration with the PPT, Provincial Technical Staffs and DOHReps, as trained by HealthGov will then provide the coaching/mentoring on PIPH development for the 11 Municipalities.

4. Availability of a Draft Action plan with set schedule of roll out activities utilizing the strategies learned from the PIPH tool orientation workshop.

Mode of Delivery to LGU Partners

6. LCEs oriented on HSR-F1-PIPH utilizing F1 as the overall frame. Covenant supporting Health Sector Reform Program with PIPH as the tool of participation.
7. 16 MIPH ready for consolidation at the Provincial level.
8. PIPH formulated, refined and packaged for presentation to Reviewing Committee.
9. Signed Memorandum of Agreements between component LGUs and Donors.
10. Mandate to Implement issued.

TA No. 2: Laying the foundation for the institutionalization of Local CSR

1. CSR Assessment and Monitoring Tool (consistent with new AO on CSR)

Exercising its lead role among CAs on CSR, HealthGov had initiated a TA plan to CHD 10 in enhancing its CSR monitoring tool. This tool will likewise be utilized in Davao del Sur for year 2 as part of the laying the foundation institutionalize local CSR.

Mode of TA delivery

- HealthGov will initiate a meeting with PRISM and HealthPro to plan how the CSR monitoring tool will be implemented in the Province through CHD. This will come after Central DOH or the DOH-CSR TWG has signaled the implementation of the CSR tool developed in CHD Region 10.
- DOH and CAs will orient CHD, POPCOM and PHIC (especially the regional CSR TWG) on the tool and the implementing guidelines. CHD will make an action plan on how to implement the tool.
- CHD, POPCOM and PHIC through the regional CSR TWG will conduct a one-day orientation to PHO, PHTL and DOH Representatives at the Regional level.
- PHO will organize a one day CSR monitoring tool orientation and action planning for the conduct of province-wide monitoring. This will be participated in by all MHOs, PHNs and DOH representatives.
- PHO, PHT, DOH representatives and MHOs conduct province-wide monitoring from April to June 2008.
- By end of June, MHOs and DOH representatives will present results to the respective municipal LGUs (LCEs, SP, LHB). Desired output will be a Mandate to Do CSR Planning by Municipal LGUs. There are problem areas however, where LGUs will provide instantaneous interventions based on the monitoring results.
- PHO will consolidate province-wide results and present them to PLGU (Governor, SP, LHB). It is expected that PLGU will give the mandate to do CSR planning.

- CHD will consolidate regional-wide results and submit to DOH central and HealthGov and PRISM.

2. CSR planning

- The next step in the sequence of CSR activities is the CSR planning. The CSR monitoring results will be used as inputs to the plans. This will be started by April 2008 and will end mid-June 2008 just in time for the first budget call. There will be period of revisions and negotiations between and among LGUs in the ILHZ and between PLGU and MLGUs.
- Final CSR plans with corresponding budget will start to be implemented on the last quarter of 2008. Since forecasting of actual FP logistics needs of an LGU population depends on determination of households eligible for LGU subsidy, the results of the CHLSS (another related TA) will be utilized. This means that the results of the survey should be made available during the budgeting period (from June to October 2008).

Mode of TA delivery

This mode of delivery describes the operational flow where HealthGov provides TA primarily to the CHD and will cascade the Rovincial and down to each Municipal LGU.

- Central DOH, HealthGov, PRISM and HealthPro will orient the CHD, POPCOM and PHIC (RD, ARD, LHAD and the regional CSR TWG) and the PHO on the CSR planning tool. CHD will mobilize the regional CSR TWG to lead the CSR planning processes as facilitators together with the PHO. PHO will select from among the technical staff for training (e.g. FP coordinator).
- HG and PRISM will train regional CSR TWG and PHO technical staff as facilitators on CSR planning. Training will include basic skills in facilitating.
- Regional CSR TWG and PHO technical staff will formulate action plan and schedule with the province for the conduct of CSR planning. LCEs will be invited during the program where CSR orientation will be conducted. The municipal participants/planning team will be composed of the MHO, PHN, LFC, SB on Health and SB on Budget and Appropriation.
- PHO technical staff and DOH reps provide coaching and mentoring to MLGUs in the refinement and finalization of the CSR plans with technical back-up from CHD and HG. HG and CHD will do field visits. Both provide technical recommendations to the LGUs.
- CHD and PHO will provide technical assistance in the refinement and finalization of the provincial CSR plan through the facilitators. There will be regular technical meetings that will be organized by the CHD to assess the progress, provide technical advises and provide logistics support.
- PHO will lead in the negotiations with MLGU on the forecasting, cost sharing for logistics procurement, identification of private providers and suppliers (with technical assistance from PRISM) and the kind and level of effort needed to implement CSR province-wide.
- PHO and RHUs will present the final version of the plan to their respective LGUs (provincial and municipal).
- This will lead to the inclusion of the plans in the 2009 AIP (or inclusion in the 2008 supplemental budget), identification of enabling laws identified and scheduling for deliberations, mandate to implement and official pronouncement that CSR plans will be integrated in the PIPH.

3. A monitoring and evaluation tool to track progress of CSR implementation will also be designed and be integrated into the PIPH M & E tool.

This is done through the following:

- HealthGov to facilitate designing of monitoring and evaluation design and tools with CSR TWG. This will also include the designing of feedback system to LGUs and LGU organizations on results of monitoring
- CSR TWG to orient PHO and provincial team on the M & E design and tools
- CSR M & E will be integrated to the PIPH M & E by the PHO. This will be done through a one-day consultative workshop to be participated in by MHOs, PHNs, LFC representative, CSO and DOH representatives
- PHO and PHT to conduct regular monitoring of the progress of CSR implementation as part of the PIPH M & E.
- PHO to establish feedback system to LGUs (LCE, LHB, LMP, PCL, ABC) with technical back-up from CHD and HealthGov. The establishment of the feedback system will be supported by EBL (another related TA)

TA No. 3: Capability Building for Evidence-based Participatory Governance

Capacity building for LCEs and key LGU and Health Officials will be accomplished in two parts. The first mode of delivery will be through CHD in partnership will other agencies like PopCom, DSWD and DILG. The 2nd will be through a commissioned Technical Assistance Provider (TAP) who may become partners in capability building.

Mode of delivery through the CHD:

4. HealthGov will identify and commission a Technical Assistance Provider (TAP).
5. HealthGov together with the commissioned TAP will orient the CHD F1 Team. The TA will be focus on the CHD Tool Kits and CSR produced by Inter CA TWG with DOH, CHD and PHIC.
6. Related topics like policy links on utilization of LSI in means testing will be incorporated in the TA package.

The initial step entail the forging of an agreement among the identified members of a Team with roles and responsibilities of each partner- member clearly outlined and agreed upon by all participating agencies. This team composed of point persons from CHD, PopCom, DSWD and DILG will conduct roll out activity to the 11 municipalities. Target LGU partners are the Mayors, the Local Finance Committee and the SBs and SPs. HG will provide continuous technical support in the actual roll out.

Support activities like writeshop/policy crafting for program managers and legislators will be packaged base on needs and request. This will focus on the importance of a high quality CSR response where output like ordinances/budget support for other component program will be included in the ELA.

To trial test this activity; a generic session will be conducted. After the conduct of SDIR in Sept 2007, the SA with emphasis on Family Planning and MCH program will be presented to the targeted LGU partners like the LCEs, LFC and SBs. The result of analysis of these programs according to four components of FOURmula one will be the working document in the development of TA for Evidence-based Participatory Governance.

The following concerns are the areas where the Core Team will help the participants develop policies and guidelines for implementation:

5. Budget requirement and allocation for the forecasted logistics of unmet needs in FP, TB, Vit A.

6. Policy on providing support to safety net groups./and those beyond safety net.
7. Budget allocation for Indigency program
8. Policy issues or ordinance regarding cost recovery schemes like user's fees.

By the end of November, 2007, draft policies will be available for presentation to the partner LGUs. These reports will be readied for the next step. Among these steps is through public hearings, through the LGU Health Board processes and through the MDC/PDC concurrence sessions and processes.

The result will thus be an evidence of support to the program which will form part of the planned institutionalization of an effective and efficient LGU CSR response.

Mode of assessing the impact of these policies and ordinances will be monitored utilizing the M & E registry.

Mode of delivery through Academe/Institution or other TA provider Organizations:

Training curriculum for capability building for Evidence-based Participatory Governance will include modules on the utilization of LHA as a managerial tool, Basic principles of Public Finance Management Planning for Health that includes guidelines for the establishment of procurement and logistics system, financing systems: planning and budgeting systems, setting of financial outcomes (funds flow, trust funds, revolving funds and special accounts); resource mobilization (alternative options for financing, alternative modes of non-traditional financing schemes, revenue enhancement programs, and public-private partnership arrangements).

This will also include modules on Internal Audit system for an effective and efficient flow of transactions of the LGU.

HealthGov will package the training curriculum and the output from enrolment in the training program.

For the province, a training needs analysis of targeted LGU partners should be engaged to determine the sequence of modules to be offered in a semester.

Mode of Delivery to LGU Partners:

4. LCEs/SB/SP/LFC oriented on MDG/MTPHP/NOH,HSR& F1 framework, LHA and health economics before the end of the year 2007.
5. Evidence-based policies and legislations supporting local *CSR response* and incorporated in the Executive-Legislative Agenda (ELA), increased budget for health, increased use of health facilities and increased revenue from user's fees.
6. Highlights (Jan-Aug, 2008) documented through monitoring and follow-through HG activities on the 11 Municipal LGUs. Indicators are routinely monitored based on availability and compared against initial baseline.

TA No. 3: Service Delivery Improvement tools

This TA will utilize the following tools:

- SDEX
- SDIR/SA

- Strengthening service providers training system
- TA on informed choice and voluntarism
- Family Health Book
- Strengthening Service delivery monitoring and supervision

Since this tool is in its refinement stage, the approach will be engaged directly to the implementers in close collaboration with the CHD F1 Team.

This will have two implications:

One, the targeted core of trainers (CHD and PHO Program Coordinators) can participate very well in the fine tuning of the tools which should be adaptable to the uniqueness of each LGU. And two, the direct intervention will provide immediate results as to the impact of tools in improving service delivery.

The mode of delivery at this stage will be directed to both the partner CHD and partner LGUs. The Trained Core Trainers will develop a plan of action for a well managed, efficient and controlled implementation schedule where activities do not disrupt the delivery of regular programs.

Implementation of tools will be undertaken within February to July 2008, while in the remaining quarters, documentation of results and tool enhancement are made.

HG-CHD partners of the 11 LGU will be coached and mentored on the development of an acceleration plan. The working document will be the SDIR/SA results utilized in the preparation of their respective MIPH. The CHD will facilitate the implementation of the acceleration plan which will be a section plan of the QA/QI plan of their MIPH.

Parallel to this activity will be the drafting of an M & E plan to record developmental changes in service delivery.

Mode of Delivery to Partners:

3. 1st -2nd quarter, 2008: Core Trainers undergone full training requirement on the Service Delivery Improvement Course.
4. Within the same period, the Core of Trainers drafted an Action Plan that outlined the implementation schedule for the 11 Municipal LGUs.

Mode of Delivery to LGU Partners:

4. January to February 2008: Municipal Health Staffs oriented on Service delivery improvement programs.
5. February to July 2008: Acceleration plan developed each of 11 Municipal LGUs.
6. July to August 2008: Monitoring and Evaluation Registry undertaken.

TA No. 4: Strengthening the Provincial and Municipal Health Boards and Establishment of the Inter-Local Health Collaboration for Health.

The Provincial Health Office also deemed a priority the functionality of its local health boards (LHBs) where public health management functions and roles are being implemented and aptly addresses policy support to addressing current health problems and concerns.

Participation of Non Government Organizations (NGOs), Communities and Civil Service Organizations/Societies (CSO/Ss) will substantially be incorporated at this level. It will be tiresome and tedious process, and often duplicating, to establish a separate NGO/CSO collaboration mechanism. It is at this level that such collaboration will be institutionalized and made operational. This will entail the increase of number of representation and the establishment of Constituent Assembly of NGOs/CSOs as its collective body where perspectives are agreed, formulated and submitted to the Local Health Board for consideration. The basic principle of LHB governance will need to be evidence-based, conflict mediation and consensus building.

These LHBs will be strengthened to support the efforts of the LGUs on their desire to improve service delivery and service utilization by constituents within each RHU and BHS. This will take cognizant on the important role to government district hospitals to support the on-going improvements of the RHUs services and increase utilization by its LGU constituents.

The Provincial Health Office, through the Provincial Planning Team mandated by the Governor will oversee this strengthening effort and will be supported by the Technical support from CHD 11 and HealthGov. HealthGov will work with the PLGU through the CHD.

Delivery Mode to CHD and LGU partners:

5. October to December 2008: Anchored on the Provincial health and organizational situation of the PIPH, will establish an Assessment and Planning Tool.
6. January to March 2008: Implement the Assessment and Planning Tool.
7. April to June 2008: Establish an Action Plan/Policies Formulation (incorporated in the PIPH).
8. July to September 2008: Implement/Monitor the Action Plan

PROVINCE OF MISAMIS OCCIDENTAL
TECHNICAL ASSISTANCE PLAN

Background

Misamis Occidental is classified as a 2nd class Province with a total IRA of PhP376,527,201 and a local income of Php54,373,007. The Province has a total land area of 1,939.32 sq. km. and population of 486,723. The fan-shaped map of the province is dotted with 14 Municipalities and 3 Cities located mostly along coastal areas.

The Province boasts for their accomplishments on eco-tourism and agricultural and economic development Programs. The Provincial Planning and Development Office is tasked by the Provincial Governor to take the lead role for a sector-wide development planning, establish mechanism for progress monitoring and institutionalize data/information management for decision making processes and integrated planning.

It is also interesting to note that the Provincial Health Office has established functional partnership with the following institutions: World Vision – Province-wide; SAVE THE EARTH (Ozamiz Cty); MOFECO (Calamba); and, Himaya Foundation.

Health Profile

The Table below shows the vital health performance of the Province as of 2006:

Vital Health Performance	**Accomplishments**
Crude Birth Rate	17.89 per 1,000 pop
	-Highest-21.6% (Mun. of Aloran)
	-Lowest 6.18 (Mun. ofConcepcion)
Crude Death Rate	6.01 per 1,000 pop
	- Highest – 7.54 (Ozamiz City)
	- Lowest – 0.56 (Concepcion)
Infant Mortality Rate	13.55 per 1000 live births
	- Highest – 38.46 (Concepcion)
	- Lowest – 0.56 (Aloran)
Maternal Mortality Rate	0.46
	- Highest – 2.01 (Tangub City)
	- Lowest – 1.81(Oroquieta City)
TB CURE RATE	89.13%
• Post Exposure Treatment	-99.2%

Vital Health Performance	Accomplishments
• Cases Treated	-100%
Leading Causes of Mortality:	
1. Cardiovascular Disease	97.70%
2. Pneumonia	75.90%
3. Cancer, all forms	36.10%
4. Accidents/Violence	26.60%
5. PTB	25.30%
6. Peptic Ulcer	16.54%
7. Diabetes Mellitus	14.83%
Maternal and child Health:	
-Pregnant women with 3 or more Prenatal visits	68.97%
-Postpartum Care with at least IPP visit	40.38%
-Deliveries attended by skilled Health Personnel	67.75%
-FP New Acceptors (All methods	52.23%
-FP Current Users (All Methods)	102%
-Fully Immunized Children	87.91%
-Pregnant women given Tetanus Toxoid	80.53%
-Vitamin A Supplementation	94.18%
-Malnutrition Rate	13.61%
PHIC enrolment:	
-Province	78,728
-Mun. of Bonifacio (highest)	9,752 (63%)
-Mun. of Baliangao (Lowest)	1.521 (19%)

Misamis Occidental as an F1 Province is well going ahead in the facilitation of basic reforms and systems development for an improved and sustainable health development service. The Provincial Investment Plan for Health (PIPH) formulated by the Provincial Government reflects reforms and interventions to strengthen governance, service delivery, regulation and financing for health. Generally, the 5-year Plan (2006-2010) envisions at improving accessibility and availability of basic and essential health care services in all ILHZ, improve health system performance at all ILHZ, and ensure availability, affordability of low-cost quality drugs. Specifically by 2010, the Provincial Government hopes to attain a functional drug management system at all levels, a functional information system in 4 ILHZ and, a human resource development System at the Provincial level. Correspondingly, budgetary requirements are

allocated each year of which the service delivery and financing components got the biggest share at 48% and 45%, respectively of the total budget of 270 million pesos. According to the PHO, the Province still has to receive the bulk of its funding requirements for improvement of the Provincial and ILHZ health facilities from EC grants.

Recently (July 2, 2007), as a major step in strengthening the ILHZ, an Executive Order (EO No. 22-07) was issued expanding the membership of the Provincial Health Board from the original members of five (5) to fifteen (15) including the Chairmen of the 4 Inter-Local Health Zones and representatives from an NGO and Women's Federation. The 4 ILHZs (Concepcion, Oroquieta, Ozamiz and Tangub) are now conducting regular meeting in the operationalization of their respective ILHZ-Investment Plan for Health.

In support to MDG, the Provincial Government formulated an Executive Agenda outlined on the theme "CHAMPS" (Competence, Health, Agriculture, Maintenance of Peace and Order, Protection and preservation of the Environment and Sustainable Social Services). The CHAMPS outlined the development visions of the Provinci of o quantify and concretize the "CHAMPS" agenda, the Provincial Government set "Target 1000 by year 2010 for example on health, 1000 sanitary toilets constructed, children's malnutrition level reduced by 1000, 1000 mothers availed of complete prenatal care, etc. The "Target 1000" according to the Provincial Planning Coordinator is just a minimum indicator for all concerned Provincial Agencies to achieve by 2010.

On the other hand, as a recipient of the Philippines-Australia Local Sustainability (PALS) Program, the Provincial Government has also instituted reforms on its planning and management of local resources (physical, human and financial) for "the promotion of sustainable community livelihoods." PALS initially works in the province from 1999-2004 covering 6 Municipalities and 131 barangays. The Program is now on its extension and expansion phase which commenced in 2004 and will culminate in 2009 covering 184 barangays in eight Municipalities. While undertaking conventional capability building activities such as training, PALS also "provides opportunities where its local government and community partners can apply and harness their capacities in planning, management and monitoring through implementing projects." The core of PALS' development approach is to "strengthen participatory planning processes" at all levels for efficient use of resources and ensuring greater social and economic development outcomes.

Year 1 Accomplishments

The Province of **Misamis Occidental** is a recipient of various funding assistance and technical support from EC, WB and AusAID. As an F1 Province, the EC allocated 70 million pesos to support upgrading of health facilities at the Provincial (Provincial Hospital) and ILHZ levels. The WB also provided technical assistance in the development and enhancement of the PIPH and ILHZ-IPH.
The project came in during the third quarter of the year and pilot-tested the Service Delivery Excellence for Health (SDEXH) to Oroquieta City ILHZ (composed of the Oroquieta City, Lopez Jaena, Aloran, Panaon and Jimenez). Series of workshops for SDEXH were conducted with the TWG of the ILHZ and established a design for the installation of quality and professional health services for the RHUs and the CHOs. The results of the pilot-tests were being consolidated to form part in the overall improvement and development of the SDEXH tool for replication to the rest of the Mindanao-HealthGov areas. Generally, the Provincial Government is very appreciative of the initial TA provided and expressed interest for its adoption province-wide. The

Provincial Planning Coordinator even provided some input on the development of SDEXH tool in professionalizing and ensuring quality standards for the provincial district hospital systems.

In the last quarter of year 1, an NGO forum was facilitated to initially plan-out a Province-wide partnership for health. Several NGOs in the province expressed willingness to support and provide technical assistance on the operationalization of PIPH and the overall health systems delivery of the Province. The Misamis University-Community Extension Program is identified as a potential TAP in facilitating CHLSS.

The Province has formulated their PIPH for period 2006-2010. Recently, they reviewed accomplishments of their annual operation plan and concluded that most of the planned interventions specifically in the aspects of health financing, regulation and governance are not yet done. Likewise, the much awaited improvement of facilities and purchase of equipment for the Provincial Hospital (MOPH) and 4 ILHZ are still to be accomplished pending for the release of funds from EC.

Feedback on PIPH:

The Province together with the management committee of the 4 ILHZs also reviewed the feedback from DOH-F1 and WB on their established PIPH as follows:

¾ *Governance*

- Firm up provincial public finance management (PFM) plan with available technical assistance. Include activities particularly on procurement training.
- Need to strengthen LGU sectoral management initiatives:
  - ƒ Operationalization of local health systems (e.g. inter-local health zones, Inter LGU cooperation, public-private partnerships) and establishment of management systems
  - ƒ Strengthening of sub-national health human resource
  - ƒ Sectoral development approach for local health reforms
  - ƒ Utilization of local health information system

¾ *On Service Delivery*

Prioritize activities related to the achievement of Millenium Development Goals (MDGs), especially facility mapping and needs assessment of Basic/Comprehensive Emergency and Obstetric Care (BemOC/CemOC) facilities.

¾ *On Financing*

- ƒ Provide funds for LGU counterpart of the PhilHealth
- ƒ Include and implement a PhilHealth-approved survey tool for identifying the poor population applicable to different health activities, e,g. use of community-based monitoring system (CBMS) to constantly identify poor for both enrollment to Sponsorship Program and procurement of family planning commodities.
- ƒ Identification of the poor should be completed by 2007.

¾ *On Governance*

- Need to include improvements on public finance management system, and; training on procurement, internal audit, distribution system, and local government accounting system.
  List activities by Priority Programs/Projects/Activities.
- Organize proposed activities as per attached Priority Programs/Projects and Activities (PPAs)

¾ *Training Plan*

- To be refined in accordance with National Retooling and Retraining Plan, with TA from Health Human Resource Development Bureau
- Ensure consistency with AOP
- Schedule of majority of trainings are not the same as indicated in AOP
  - Indicate costs of all the trainings proposed as reflected in the AOP
- Consistency of all the trainings proposed in the training plan with the AOP.

¾ *General Comments/Suggestions*

- Ensure consistency with AOP
- Coordinate with provincial procurement designate/local bids & awards committee for assistance in finalizing APP
- Use the standard form of Project Procurement Management Plan (PPMP) as required by the World Bank for Trust Fund Provinces
- The BAC Secretariat shall consolidate all the Project Procurement Management Plans (PPMP) prepared by the Program Management Office (PMO) into an Annual Procurement Plan (APP). The APP shall bear the approval of the head of the procuring entity.
- The items to be procured as indicated in the PPMP should be grouped by package/lot. For example: all items pertaining to medical supplies/materials/equipments/drugs & medicines shall be one package. Lot 1: Drugs; Lot: Equipment; Lot 3: Supplies; Lot 4: Ambulances; etc.

Generally, it is important to note the comments made by DOH-Central and WB for consistency of project interventions and to highlight reforms on governance, financing and regulation where the PIPH of Province have shown some weaknesses.

HealthGov also conducted its own review on the PIPH and came up with the following observations:

- Governance got the thinnest slice of the budget pie; activities are more on health service delivery
- Support to the emerging functions of DOH Reps and PHO technical staff absent
- Other similar structural issues like role and capacity-building of PHO technical staff on F1 competencies (governance, health care financing) not clearly addressed
- May not address the staff turn-over issue, especially the technical staff
- The planning process did not sustain the participation of private sector and the community
- Needs to widen the participation of other stakeholders (presence of an NGO alliance)
- PIPH unable to harness Misamis Occidental strength, i.e., strong gender and development program

- No plan yet to support public financial system reforms. Provincial accountant believes some recommendations of an auditing consulting firm hired by EC are not doable
- All municipalities (former LEAD areas) have CSR plans. Municipalities have started procuring contraceptives. Needs to be monitored
- **Information system:** No systematic and/or institutionalized utilization of data by decision-maker/policy-makers.
- **Political dynamics:** The Provincial Governor was just recently elected President of the Provincial League of Governors. He is a social development oriented and advocate for reforms on health sector as well as the importance of integrated planning process and systems installation for equitable delivery of health services.

Year 2 Direction

Based on the overall health situation and PIPH status of implementation of the Province and discussions and direction setting with PHO, PPDO and PALS management team, three (3) strategic TAs are established for year 2 implementation. Generally, the TAs identified hope to re-emphasize or focus activities for rational reforms or changes on governance, financing and regulation to complement the "service delivery" focus of PIPH.

Strategic TA 1: Lay the Foundation for an enhanced CSR as a mechanism for a broader and responsive public health system for 1000 and 1 health achievements.

As an F1 Province and with the expected (although quite delayed) release of funds from EC for the purchase of equipment and upgrading of facilities reflected on their PIPH, the Provincial government will be most likely occupied in improving their service delivery and consequently equipping the skills of the health staff to manage various equipment facilities. It is a strategic opportunity for HealthGov to lay the foundation for an improved and sustained public health system in order to provide safety nets for the broader population. On the other hand, as assessed, there is a need to link and enhance the PIPH to be more responsive on health sector reforms based on F1 strategies.

It is a strategic opportunity that HealthGov starts with the development gains of the Province by working closely with the Provincial Planning and Development Office (PPDO) where PALS is also strategically attached. As initially gathered, the PPDO is undergoing "re-engineering" to respond effectively to the development goals of the Provincial Government ranging from infrastructure improvements, environment, economic to enhancing health service delivery. With the various development targets on hand, the PPDO is looking ahead for a more progressive role. This role, as gathered through initial consultation meetings with PHO and PPDO and, as also envisioned by the Governor, is to come-up with a reliable and efficient data-gathering methodology at household level and data-based management (i.e., systems for data banking, retrieval and utilization) for a comprehensive and integrated planning and monitoring processes at all levels.

For year 2, one of the strategic TA opportunities is to lay the foundation for an institutionalized CSR to facilitate 1000 and 1 (could be another 1000 or 100) health achievements of the Provincial Government's target on health sector. Although, CSR is focused on eliminating FP unmet need through institutionalized actions, the tool can be enhanced encompassing among others increased TB detection and cure rate, improved nutrition and enhanced planning and

monitoring process at Provincial, inter-local and Municipal and City levels. The CSR can introduce mechanism (i.e. issue-based advocacy) to induce political commitment to provide safety net for the poor; improve access to all other FP methods; expand private sector sources; and, integrate FP with other services to women (i.e. maternal and child care). Accordingly, CSR is beneficial to localities (specifically to LCEs) as it is geared to serve the best interest of their constituents.

Most importantly, the TA for CSR is to develop strategies for "beyond safety net" (cost recovery systems for publicly delivered commodities to non-poor, private provider mapping, public-private referral system; private sector expansion through development of high volume providers for IUD and VSC.

The main TA in facilitating institutionalization of CSR is to through CHLSS. It is hoped that an institutionalized CSR can trigger accomplishments on key indicators for "improved LGU management and financing systems" for health as well as improved service delivery. The crucial components in institutionalizing CSR are the processes of identification of clients deserving free goods and, securing financing and establishing efficient procurement and distribution systems. This can be achieved from the results of CHLSS. As reflected in the PIPH, a substantial budget (3.8 million pesos) to be provided by the M/CLGUS is allocated for purchase of FP commodities. Thus, as illustrated in the TA intervention matrix below, the expected output for year 2 will be the system of identifying the deserving sector of the society that should be provided free FP commodities and, institute the "users'-fee system for those who can afford to pay FP services. Eventually, the results of the CHLSS can al be used for legislative formulation and effective and integrated planning process at the provincial level to hasten and exceed the "1000" health service delivery targets established by the Provincial Government.

The identified TA fro HealthGov is to develop framework and guidelines CSR plans of the province, pilot-testing plan for CSR Monitoring tool, training module for RHU staff on CSR monitoring and, CSR procurement and distribution framework or methodology

The expected outputs for year 2 are as follows:

- Improved CSR monitoring tool
- LGU Policies to adopt tool
- Legislations / policies to increase and sustain budget for CSR commodities.
- Procurement and distribution policies developed
- Mandate to implement CHLSS and formation of implementation team
- CHLSS design and implementation plan
- Data generated helpful for decision-making process
- Poor identified and safety net provided
- Increased skills on data utilization

Mode of delivery: Generally, the mode of delivery is transfer overall facilitation of the planned interventions to PHO, CHD, MHOs and DoH reps. HG shall provide funds for start-up activities like planning orientation and training.

<u>Implementation steps:</u>

At first month of year 2, HG shall conduct orientation with the Provincial Governor and his officials (PHO, PPDO, DSWD, PopCom) with PALS Management and MUCEP (local TA

provider) about CHLSS-its contents and methodology. It is hope that after the orientation, the Governor shall give his imprimatur to implement CHLSS. During the orientation, it will be suggested to the Provincial Governor, to form a technical team compose of concerned Provincial Offices (PHO, PPDO, DSWD) including MUCEP and PALS representatives, to plan the implementation of the province-wide CHLSS survey. It is anticipated that other development concerns (for development planning) shall be incorporated in the household survey instrument. HG shall then prepare a good argument to avoid overloading the instrument with enormous information/indicators to be gathered.

Immediately after the orientation, HG shall then develop the CHLSS package consisting of the survey design; survey instruments that incorporate health concerns; data-gathering method; and, data analysis including software preparation. The CHLSS tool shall include mechanisms (referral system) on "immediate response" to health needs (i.e. TB symptoms, desire to use FP method and Vit. A supplementation) as gathered during the survey should also be developed especially at the Barangay and RHU level.

HG shall also prepare the orientation or training design for Provincial and Municipal teams and local TAP. After the orientation, PHO, PPDO and MHO shall orient the C/MLGUs on CHLSS process and the needed LGU support or counterpart. The mode of TA delivery is to highlight that the CHLSS undertaking is a Provincial Government's initiative to come-up with a reliable data at the community level for effective planning and formulation of service delivery programs. Once Municipal and City Mayors agreed to proceed with the plan, a Municipal team shall then be formed to supervise the overall CHLSS process. The Municipal team shall train BHWs and/or women volunteers to conduct the household survey. All these activities shall be completed in one-two months (November 2007) time depending on the commitment of support from MLGUs.

A simultaneous household survey shall be undertaken from December 2007-February 2008. Training on data consolidation and analysis shall follow which will be conducted by local TAP (MUCEP) between February and March 2008.

Generally, the mode of TA delivery is to transfer immediately the overall conduct of the activity to the Provincial Offices (PHO and PPDO) with technical support from local TA provider. The PALS Program can also be tapped (through their Municipal teams) to supervise conduct of household survey and provide overall coordination and technical guidance. HG shall also provide initial funds for the start-up activities of CHLSS such training and orientation for Provincial and Municipal teams; supervision and monitoring funds for local TAP, counterpart for the production of survey instruments; and, preparation of the data analysis software.

The Project will also encourage support from the LMP for necessary mandate and/or formulation of policies requesting respective LGUs to providing funding and manpower counterpart.

The BHW federation at the Provincial and Municipal level can be tapped in facilitating CHLSS at the community level. The PPDC suggested translating the LSI household survey instrument into Visayan.

By April-June 2008, data analysis and consolidation shall be facilitated by PLGU, TAPS and PALS shall facilitate data consolidation and analysis at the Provincial level. MHOs and ILHZ shall facilitate the process at the Municipal RHUs and City Health Offices. The

Generally, CHLSS as an action research process hopes to be institutionalized at the LGU decision making process utilizing concrete health information and socio-economic situation of the community. Thus, there is a need to form a workable structure involving local and regional stakeholders to facilitate the "research" cycle process from formulation of "research" design, data consolidation to data utilization or the action phase.

Strategic TA 2: Enhancing ILHZ towards a broader public health systems and quality health service delivery

As mentioned earlier that with the expected hospital facility upgrading for 3 District Hospitals and Provincial Hospital, there would an increasing focus on hospital care. The Technical Assistance along this line is to re-enforce and enhance existing public health systems by motivating ILHZ to assume greater responsibility on public health systems such as on referral, information management and disease surveillance. A trigger mechanism is to challenge ILHZs to come-up with an identity and strategies to be a significant factor in the realization of the Provincial and Municipal vision for health. As reflected on the PIPH, ILHZ wishes to obtain legal personality to become a more significant institution for health service delivery. Part of the plan is also to establish an office and purchase of necessary equipment. Thus, the interventions for year 2 will be geared towards enhancing the role of the ILHZ on information system, disease surveillance and replication/monitoring quality and service delivery excellence for health. As mentioned, earlier, the early TA provided by the project is towards SDExH which was successfully piloted for Oroquieta Inter-local Health Zone. The SDEXH framework and tools were developed with the active participation of the TMC of Oroquieta-ILHZ. The Provincial government through the PHO and PPDO expressed their desire to adopt the framework for the rest of the ILHZ and RHUs.

Strategic TA No. 1 shall complement in building the capacity of the ILHZ on health information management and disease prevention. With a strong role in public health system (i.e. referral, disease surveillance, TB case detection and FP service delivery), the ILHZ shall also complement with hospital operation which is expected to be fully equipped and upgraded to respond not only with common illnesses but as well as on complicated cases.

In enhancing public health systems through ILHZ and RHUs, the main strategy is to work with ILHZ-TMC, PHO and PPDO through integration of planned activities into their regular meetings. At the start of year 2, however, there is a need to facilitate a workshop for the members of the Technical Management Committee (TMC) to assess their organizational management capacity, health directions and skills requirements. The specific plan of action can be generated during the workshop. In relation to this, the Project shall provide a specific TA on defining organizational vision and objectives of the ILHZ as a preparatory step in obtaining legal identity. Initially, as gathered, one of the immediate plans of 4 ILHZs is to come-up with disease surveillance system as mandated by the Department of Health. It is recommended that HG support the training requirements with CHD as a starting point in enhancing the capacity of the ILHZ for a broader public health perspective. The training activities are (4 batches) are scheduled from November-December 2007.

The Province has already existing mechanism in coordinating and providing technical support to the 4 ILHZs. Likewise, with the early TA provided by the Project, the Oroquieta ILHZ is looking forward for a more coordinated effort in professionalizing and bringing-in high quality standards on health service delivery. The Provincial Health Office is now also organizing its effort to replicate the SDEXH process to the rest of the ILHZ. By end of the 1st quarter, the PHO with support from Oroquieta ILHZ, shall facilitate replication of SDEXH province-wide.

Strategic TA 3: Strengthen Provincial partnership for improved health system

One of the desired objectives of PIPH is to establish functional provincial partnership with NGOs/POs Women's Federation and other appropriate private organizations for a sector-wide approach to health. The Provincial government recognizes the critical role of these organizations not only to mainstream community and grassroots' perspective in health systems delivery but as well as for a continuing advocacy for equitable health services. The TA along this line is to assist in the development of partnership mechanisms and built-in advocacy strategy in the context of PIPH implementation. The common notion that MHOs or RHU health staff still had to "lobby" to their Mayors for funding of Municipal health plans" is quite ironic since supposedly it is an Executive Plan or agenda for the welfare of his/her constituents. Thus, for year 2, a partnership mechanism should reflect a continuing interaction and participation of NGOs and CSOs and LGUs as a built-in advocacy mechanism for quality and equitable health care services.

The next steps to be conducted during the first quarter of year 2 are:

- Ensure a workable partnership by establishing commonly defined annual partnership operational plan that relates to PIPH implementation. This is also opportunity for the NGOs to fully understand the PIPH and how they relate themselves into the implementation and sustainability of the plan.
- Establish plans and strategies for NGOs/Pos membership at appropriate Local Special Bodies.
- Include NGOs/POs in the planning process at ILHZ level and identify their role on major plans and activities of the ILHZ.
- Ensure documentation process (derive learning and insights for a sustainable and effective partnership)

Generally, all capacity building activities and/or training exercises shall be geared towards the acceleration of the PIPH. Most importantly, after each training session, a re-entry and progress monitoring plan should be developed stipulating concretely the systems and mechanisms that would be installed at respective levels to attain the goals of the PIPH.

<u>Overall Provincial Implementation Strategy:</u>

The 3 strategic TAs outlined several major activities to be facilitated in year 2. To ensure successful implementation of the planned interventions, HealthGov-Mindanao will establish first the mechanism for active role of local stakeholders (i.e. provision of manpower and technical support) in all aspects of the plan. The Project shall also encourage the Provincial Government to re-activate and review role and membership of the Provincial CSR-TWG in light of the PIPH implementation and development thrusts of the Province. Specifically, work and coordinate closely with PHO and PPDO all through-out the facilitation of identified TAs for a shared-learning process and ensuring timely response and innovations.

At the beginning of year 2 (October 2007), HG shall facilitate informal meeting with the PHO to gather information or results of their assessment of the status of PIPH implementation as well as their revise annual operational plan. HG will also immediately assess the level of provincial partnership with NGOs and how to jump start implementation partnership activities, such as the CHLSS and CSR monitoring.

MISAMIS ORIENTAL YEAR 2 WORKPLAN

I. BACKGROUND

Province of Misamis Oriental is composed of 23 municipalities and two component cities of Gingoog and El Salvador with the total population of 664,338. It has 422 barangays with 175 Barangay Health Centers and 24 RHUs. It has seven hospitals spread in the province

Health Situation. The province registered 12,320 births in 2006. The crude birth rate (CBR) was 18.9 per 1000 population. On the other hand, Infant mortality rate (IMR) was 5.5 per 1000 live births. The leading causes of infant deaths in 2006 are: pneumonia, septicemia, diarrhea, congenital anomalies, ARDS, sudden infant death syndrome and asphyxia neonaturom.

Causes of under-five mortality are: 1. Pneumonia, 2. Accidents, 3. Cancer, 4. Malnutrition, 5. Septicemia, 6. Intestinal Obstruction, 7. Coronary Artery Disease, 8. Bronchial Asthma, 9. Dengue Fever, 10. Hydrocephalus

For the under five mortality, the following illness were found as leading causes: 1. Pneumonia, 2. Accidents, 3. Cancer - all forms 4. Malnutrition, 5. Septicemia, 6. Intestinal Obstruction, 7. Coronary Artery Disease, 8. Bronchial Asthma, 9. Dengue Fever, and; 10. Hydrocephalus

The maternal mortality rate (MMR) in 2006 was 0.49 per 100,000 live births. The leading causes of maternal mortality (MMR) are: 1. Placental retention, 2. Uterine Atony, 3. Prematurity, 4. Accident, 5. Eclampsia.

The province target 122,988 children (6-17 months old) for Vitamin A supplementation and 114, 469 (94%) were provided. More than 1,000 children were also provided with iron for six months.

The province sponsored the enrollment of 81,135 families to Philhealth through its provincial indigency program spending a total amount of P22,416,840.00. This accomplishment ranked the province second nationwide with the most number of beneficiaries.

To support its barangay health program, the province constructed 23 barangay health stations amounting to P140,000.

To be guided on the delivery of basic health services, the Provincial Government formulated their vision as: “A God-fearing, productive and healthy citizenry, recipient of effective and quality gender-sensitive health care services, thus maintaining a strong and responsive Misamisnon.”

This vision is supported by a mission to provide effective delivery of health services through community-based efforts and financial support of GOs and NGOs with strong inter and intra-sectoral linkages.

Objectives. The objectives of the province are as follows:

1. To provide micronutrient supplementation and promote advocacy of food fortification.
2. To reduce morbidity and mortality of pneumonia cases through intensified health education and provision of drugs/medicines.
3. To promote oral rehydration therapy for the control of diarrheal diseases.
4. To reduce morbidity leading causes by 70% and mortality leading causes by 50%.

5. To provide dental health services thru provision of necessary dental supplies and equipment.
6. To improve nutritional status to 0-71 months old children thru promotion of proper nutrition.
7. To provide drugs/medicines to identified TB cases to prevent the spread of the disease.

II. YEAR 1 ACCOMPLISHMENTS

In early part of the first year, project efforts were focused on baseline data gathering, conducted orientation to LGUs and CHD and, facilitated planning meetings in preparation for LGU-level planning and interventions. It was only in the last quarter of the year that major project activities were conducted, such as; SDIR, MIPH and resource mobilization.

A one-day facilitators' meeting was facilitated with CHD 10 technical staff to facilitate the SDIR and MIPH. The SDIR was first facilitated as a take-point for the MIPH. The SDIR is an enhanced tool for the PIR commonly used by CHD. The SDIR identified issues and gaps of service delivery, governance, financing and regulation. All 26 MLGUs were able to complete the SDIR process and utilized their data in the formulation of their 6-year MIPH. After the MIPH planning workshop, a 2-day resource mobilization workshop was facilitated with members of the Local Finance Committee, MHOs and DoH representatives. The workshop enabled the LGU personnel established the funding requirements of their plans and resource generation options. In the latter part of the year, HG provided TA in the formulation of review criteria and guidelines for MIPH enhancement and integration to Municipal AIP.

III. SITUATIONAL ANALYSIS AND NEEDS ASSESSMENTS

Service Delivery.

On Family planning, the performance of the province in 2006 shows a CPR of 47.02%. Out of 17,226 acceptors, 6.31% adopted the natural family planning; 54% preferred LAM; 15.36% used pills; 13% used IUDl and 6.96% adopted DMPA. The current users totaled to 50,283 and majority of them preferred IUD and pills. Generally, the data shows the need to improve FP performance of the province.

Another consideration that should be looked into by the Provincial Health Office is the pronouncements made by the National Government to promote natural FP method, CHD and other RNGAs like Popcom 10 are revisiting their strategies to comprise all range of FP methods for a wider acceptability. The use of the natural family planning is increasing in number both from the government and the non-government groups. The education and information campaign waged by FP promoters have improved the motivation of the several couples to adopt the various methods. However, as assessed there is a need to improve or provide more access points with competent FP providers. This would enhance the desire and decision for mothers or couples to adopt desired FP method. Generally, there is also a need to study and formulate policies and systems to provide safety net for the poor like providing free FP commodities while charging fees for those who can afford. For wider acceptability and ensure sustainability, it is important that any FP service delivery methods should adhere to ICV principle.

The participation of NGOs, CSOs and Municipal-level people's organizations and relevant private entities is a significant factor for LGUs to increase budget allocation for FP services

and other to the overall public health program. Provincial partnership is one of the major TAs that will be facilitated by HG in year 2.

Other major factors that influence health seeking behavior of the community are as follows:

1. Insufficiency of knowledge and counseling skills by front-line (RHMs, BHWs) health workers on wide-range FP services and methods including NFP.
2. Ill-equipped RHU facilities that enhances a health worker to dispense the services
3. In-availability of training and retooling of personnel to update skills and manage operations of equipments and tools
4. Insufficient and/or dwindling FP commodities to match the demand of the service to motivated clients
5. Inadequate staffing to meet the demand of the customers beyond the standard work hours
6. Limited options of potential acceptors on FP services including lower and affordable/subsidized prices.
7. Lack of program for effective utilization of capitation fund and reimbursements from Philhealth and other financing schemes that redounds to improvement of services.
8. Lack of effective strategy on information, education and campaign (IEC) to promote FP
9. Lack of appropriate policies and/or ordinances that support FP services (i.e. client segmentation, incentives to BHWs, etc)

Maternal Child Health. Of the registered 12, 320 births in 2006. The crude birth rate (CBR) reduced by 1% in 2006 compared to 2005 with 18.9 per 1000 population. On the other hand, Infant mortality rate (IMR) decreased by 17.2 % compared to 2005 at 5.5 per 1000 live births.

The maternal mortality rate (MMR) in 2006 is lower by 5% compared to 2005 with 0.49 per 100,000 live births.

Out of 16, 800 pregnant women targeted for maternal care, only 63.08% were visited more than four times; only 62.03% were given TT2 and 39.1% were provided complete iron dosage. For post partum care, only 34.99% were given iron while 90.81% with Vitamin A, and; 65.07% were initiated to breastfeeding. 83.23% of children were fully immunized which is 1.90% higher than the 2005 performance.

The province provided Vitamin A to 114,469 (94% of target) children (6-17 months old). Only 1,000 children were also provided with iron for six months.

TB Program. The TB detection rate of the province is 66% while the cure rate is 92%.

Inter-Local Health Zone. The five zones have been revived to support the efforts of the member LGUs desire to improve the services of the RHU and BHS. This desire is linked to the important role to government district and medicare hospitals to support the on-going improvements of the RHUs services. Out of five ILHZs. Three are in the stage of revitalization and the two are already contributing resources to support their respective continuing operations. These ILHZs do not have the systems of management and policy-making schemes. The decision of CHD to set up a single office for the DOH representatives in each ILHZ would facilitate the institutionalization of the zone and this will hasten the establishment of an efficient client referral system with the core referral hospital.

Provincial Government's Direction. The Governor is engrossed of the hospital development. He wants his seven hospitals to increase income from P2M to P20M. Losing 17 of 25 Mayors, the situation is complicated by the domination of the LMP by the majority of mayors from the other side of the political fence. He wants to invest P210M for hospital rehab and expansion. There is a big divide between public health and hospital. But the opportunity to unify curative and preventive through the two-way referral system can be both beneficial to RHU (municipal) and hospital (provincial). This is the link between the mayors who are interested of public health and the Governor who is interested of health enterprise.

IV. YEAR 2 WORKPLAN

With the above-mentioned trends and analysis of accomplishments and gaps on the health delivery system of the Provincial Government, strategic TA provisions were identified for year 2 as follows:

- **Facilitate enhancement of the MIPH and its adoption to AIP.** Technical review team composed of PHO technical staff has been oriented on the guidelines and criteria of the review process which will be hopefully completed by end of September 2007 in time for the LGU budget cycle. By October 2007, the immediate to assist the PHO come-up with a Provincial consolidation to form part as the Provincial-IPH. In line with this, HG and CHD shall encourage the Provincial Government to form a Provincial Technical Working Group (PTWG), that shall compose of a CHD-representative, PHO, PPDO and other concerned Line Agencies, to facilitate formulation of PIPH and presentation and adoption to the Provincial Health Board. In the succeeding months, the PTWG shall be tasked to facilitate PIPH implementation at the Provincial level concerns. The PTWG shall be also responsible for the overall provision of the TA requirements and/or support systems, supervision and monitoring to the MIPH and ILHZ-IPH. This particular TA shall be completed before the end of October 2007 to catch-up with the budget cycle of the LGUs.

  In succeeding months, prioritized skills training for health staff shall be facilitated. Likewise, improved information and education program on FP shall have been formulated by the end of year 2.

- **Expand Philhealth coverage and provide safety net for the poor.** To improve accessibility to health services and improve health seeking behavior of poor communities, there is need to assist the LGUs to expand Philhealth coverage and formulation of policies and/or mechanisms to improve access of the poor to health commodities and basic health services. Along this line, by first quarter of the year, CHD and PHIC, with TA from HG, shall initiate discussion with PTWG, PLGU and MLGUs (through LMP) on appropriate mechanism and policies to increase Philhealth insurance coverage. The Regional Implementing and Coordinating Committee (RICT) is the best venue to provide continuing TA on this aspect. In Region 10, the RICT is functional and serves as the venue for instituting F1 reforms of the health. By 3rd quarter (after start-up implementation in Misamis Occidental Province)) , the CHLSS and CSR planning shall be introduced to the Province (through the PTWG) as tool for client segmentation and improving access and distribution of FP commodities. By the last quarter, the CHLSS will be initially implemented and CSR planning facilitated. By end of the year, the PLGU and MLGUs shall have identified appropriate policies to improve health service delivery to poor communities.

- Strengthen ILHZ. One of the priorities of the Provincial government is to institutionalize public health management functions and roles of the ILHZ. The five zones have been revived to support the efforts of the member LGUs on their desire to improve the services of the RHU and BHS. This desire is linked to the important role to government district and medicare hospitals to support the on-going improvements of the RHUs services. Out of five ILHZs, three are in the stage of revitalization and the two are already contributing resources to support their respective continuing operations. These ILHZs do not have the systems of management and policy-making schemes. The decision of CHD to set up a single office for the DOH representatives in each ILHZ would facilitate the institutionalization of the zone and hasten the establishment of an efficient client referral system with the core referral hospital.

  The first critical activity (Nov. 2007) is for CHD/RICT to facilitate ILHZ planning to review and enhance their roles and functions in light of the MIPH and PIPH implementation. The ILHZ planning shall enable each zone to identify common health needs/concerns and the needed resources and/or support from the covered LGUs. One important agreement that should be arrived during the planning is for each member LGU of the zone to commit to review their respective health targets and corresponding budget requirements. Other prioritized health issues and concerns (i.e. how to improve or institutionalize 2-way referral system, information system and disease surveillance) shall be discussed during regular ILHZ-Technical committee meetings of which the results and recommendations shall be submitted to respective ILHZ-Board for approval and adoption.

  By the start of the second quarter, CHD shall facilitate in setting-up a single office in each of the ILHZ for DoH representatives. As mentioned earlier, this could hasten appropriate systems improvement and installation. The implementation of this plan shall be discussed by the technical committee and submitted to the board for approval and allocation of resources.

- **Building active provincial partnership** - By the start of year 2, the Provincial-NGO partnership shall be institutionalized by the signing of partnership MOA. The MOA shall stipulate overall partnership roles in support to PIPH and other major health activities of the Provincial Government. As in other Provinces covered by HG, by November 2007, the partnership shall facilitate a planning workshop to identify concrete partnership actions towards strengthening of PIPH implementation, support to ILHZ plans and advocacy mechanisms for increased LGU funding support to various health programs especially CSR commodities. The partnership agreements shall govern or stipulate among others regularity of partnership meetings, resource identification, technical expertise complementation and/or support and, participation to major health plans of the Municipalities and the PHO.

PROVINCE OF SARANGANI TECHNICAL ASSISTANCE PLAN

Geography

The province is located at the southernmost tip of Mindanao and the Philippines. It is bounded by Sultan Kudarat in the west, South Cotabato in the North, Davao del Sur in the East and Celebes Sea in the South. It lies in between latitude of 5”31’ to 60”30’ North and longitude between 124”15’ to 125”13’ East.Between the eastern and western parts of the province is General Santos City which separates the western municipalities of Maitum, Kiamba and Maasim from the eastern municipalities of Alabel, Glan, Malapatan and Malungon.

Health Situation

Based on data obtained from the seven (7) Rural Health Units and five (5) LGU devolved hospitals, the province for CY2006 has recorded 20 cases of death per 10,000 population. Infant mortality rate was 40 deaths per 10,000 livebirths and Maternal

Causes of Morbidity	**2006**		**5 year ave (2001-2005)**	
	# of cases	Rate/10,000 population	# of cases	Rate/10,000 population
ARI	31,447	608.95	24,216	523.53
Fever	3,701	71.67	1,684	36.41
Diarrhea	3,527	68.30	3,443	74.43
Skin Infections	2,725	52.77	2,016	43.58
Pneumonia	2,778	53.79	3,303	71.42
Wounds	3,082	59.68	2,196	47.47
Hypertension	1,039	20.12	922	19.94
Influenza	1,350	26.14	1,591	34.40
Tuberculosis	717	13.88	562	12.15
Malaria	654	12.66	835	18.05

Deaths at 7 cases per 10,000 livebirths. Birth rate in the province is 19 per 1000 population.

Heart Disease being the leading cause has registered 141 cases of deaths as against an average of 110 cases in the last five years. It is followed by hypertension and cancer all forms with total registered cases of 139 and 94 death, respectively. For the same period, Acute Respiratory Infections ranked as the number one leading cause of morbidity, followed by Fever and Diarrhea. The leading causes of morbidity and mortality are presented in detail in the following table.

Causes of Mortality	2006		5 year ave (2001-2005)	
	# of cases	Rate/10,000 population	# of cases	Rate/10,000 population
Heart Disease	141	2.73	110	0.24
Hypertension	139	2.69	113	2.45
Cancer, all forms	94	1.82	95	2.05
Pneumonia	73	1.41	63	1.36
Accidents, all forms	56	1.08	55	1.19
Kidney Diseases	49	0.95	27	0.59
Tuberculosis	44	0.85	26	0.56
Senility	34	0.66	8	0.17
Myocardial Infarction	30	0.58	32	0.70
Diabetis Millitus	23	0.45	6	0.13

Pertaining to findings on child illnesses, pneumonia led the top causes of mortality among infants with 12 registered case in 2006 as against an average of 6 cases for the last five years.. This is followed by Congenital Malformation, Meningitis and diarrheal diseases.

Causes of Infant Mortality	2006		5 year ave (2001-2005)	
	# of cases	Rate/10,000 population	# of cases	Rate/1,000 LB
Pneumonia	12	1.21	6	0.69
Congenital malformation	5	0.50	2	0.22
Meningitis	4	0.40	1	0.11
Diarrheal Diseases	3	0.30	4	0.41
Unknown	3	0.30	2	0.22
Dengue	2	0.20	1	0.11
Nephrotic Syndrome	1	0.10	1	0.11
Asthma	1	0.10	1	0.11
Respiratory Distress Syndrome	1	0.10	2	0.22
Prematurity	1	0.10	2	0.22

Accomplishments in major health programs:

- The percentage of fully immunized children was 68.32%
- Fully immunized mothers was 55.16%
- 63.55% Households have access to sanitary toilet

- 72.36% Households have access to safe water
- For birth deliveries,only 43.69% were attended by health professionals

An assessment of the challenges faced in terms of the reform areas, as raised in the SDIR/SA workshops, yielded the following:

1. Governance

The need to improve the management system on the following areas

- Procurement and logistic management
- Human resource management and development
- Internal Management control
- Supervision, Monitoring and evaluation

2. Service delivery

Realignment of health interventions to address MDG and National objectives with emphasis on Family Health Programs.

These include strengthening programs on:

- Maternal and Child Health care as evidence by poor performances in EPI coverage,
- Supportive programs like nutrition and family planning
- And the need to improve quality programs on TB
- Readiness to address emerging diseases like HIV, AI and health related threats.

3. Financing

- sustaining indigency program
- improvement of marketing and enrolment strategy
- good information for client segmentation
- means test in line with PHIC requirement
- Cost recovery schemes

4. Mobilizing communities through community-based approaches

- Development of a coordination mechanism with CSO-NGO
- Linking health to the community through sector wide participatory approach

Technical assistance

Institutionalization of SDIR/SA tools in Planning and Development of PIPH + yearly operational plans

Background

In CHD XII, two provinces were included in the planned PIPH roll out. These are Sarangani and Sultan Kudarat. The CHD has now position itself on the major role it has to provide in support of

the two provinces. Realizing the need to capacitate this level of health organization, initial orientation and workshop activities were conducted by the HealthGov for CHD XII to equip them in assisting the two provinces in developing their PIPH.

Key interventions

Since PIPH development is a pre determined focus of assistance for the province of Sarangani, the key interventions will directly evolve on capacity building of the LGU service implementers on the use of the SDIR/SA tools. For each municipality, assessment of their health programs will be conducted in their own level. The actual planning process will be guided by the trained CHD staff. During the assessment and determination of investment needs, various stakeholders like NGOs and CSOs will be invited toparticipate.

The Technical Assistance of HealthGov will ensure that investment will have major contributions in the improvement of the targets set in MDG. With CHD as the major production partner, it will assist in facilitating the orientation of LCEs, other partner agencies and would be investors in the PIPH. Though the Technical Assistance will initially be limited to PIPH development through capacitating CHD XII, succeeding TA activities will be implemented for this year. In as much as the SDIR/SA tools will output produce the necessary data and information for the development of acceleration plan, TA on Service Implementation specifically SDExH will be engaged by 2nd quarter of the coming calendar year.

Expected results

Generally, the PIPH will serve as guide in prioritizing investment. The highest priority will delve on interventions which have direct connections in improving the MDGs and

Specifically, the HealthGov will be in a better position to assist the production partners like the CHD XII and partner NGOs to identify interventions that have greater impact on Maternal and Child health care. This can be best reflected in the utilization of their PIPH as evidenced by the availability of yearly investment plans.

TA 1 PIPH Guidelines

This TA package is designed to help the provincial LGU develop their Province wide Investment Plan for Health. This TA includes the tools which are all seen as vital instruments in the drafting of interventions both in all sector components of the approach spearheaded by the Department of Health which is the FOURmula one for Health. Being a project roll out province, the experiences made in the first 16 provinces will be incorporated in the TA package.

A planning guide and templates based on the 12 steps of PIPH crafting will be finalized in consultation with the delivery partners. The CHD will take the lead role in the delivery of the TA tools developed to partner LGUs.

CHD will orient PHO and CHD provincial health team on the planning guidelines and templates. At the end of the session, an action plan will be made indicating steps on how and when to conduct a workshop. This action plan will be presented to the Governor and an executive order for the designation of Provincial Core team for PIPH crafting will be issued.

The Core team with technical support from the CHD will facilitate a one (1) day activity for the orientation of other key stakeholders(LCEs, SBs on Health, SBs on Appropriation and other

partner agencies)There will be signing of Pledge of Commitment supporting the Health Sector Reform Program and the crafting of MIPH.

The PHO/CHD PHT Core team will facilitate a two-day workshop with the provincial team, hospital representatives and MHOs with technical guidance from CHD. Introduction on the use of SDIR tool will provide the needed data for the drafting of interventions.

After collection of information required in the SDIR, coaching and mentoring activities on the interpretation of results utilizing the SA tools will happen by end of September 2007.
HG will facilitate the writeshop activity for the determination of goals which should be in harmony and consistent with the logical framework of MDG. This will be followed by the development of financial plan which will be finalized for presentation to the Local finance committee for consideration in the CY2008 executive agenda.

Since Sarangani is a roll out province, there will be technical review of the plan. Initially by the CHD technical team and eventually by the Joint Appraisal Committee which is chaired by DOH with membership coming from EC, USAID, WB other Funding Agencies and GOP line agencies like DOF and DBM.

Since plan revisions is expected to happen based on the recommendations of the reviewing committee, HealthGov will continuously provide technical assistance to the LGUs through CHD. These activities may flow until early the 1st quarter of next year and some immediate interventions maybe carried out through funds provided by other funding sources and from supplemental budget release by the LGUs.

Milestones:

Mode of Delivery to Partners:

5. By the end of end of Sept 2007, the Provincial TWG is established which is composed of Provincial Technical Staffs and DOHReps who are trained to provide the coaching and mentoring activities on drafting of MIPH on 7 Municipalities.
6. Availability of a Draft Action plan with set schedule of roll out activities utilizing the strategies learned from the PIPH tool orientation workshop

Mode of Delivery to LGU Partners

11. LCEs oriented on PIPH utilizing F1 as the overall frame. Covenant supporting Health Sector Reform Program with PIPH as the main vehicle of participation.
12. 11 MIPH ready for consolidation into PIPH
13. PIPH package and ready for presentation to utilizing SDAH.
14. Memorandum of Agreements between component LGUs and other funding agencies forged.
15. Mandate to implement issued.

TA 2: Capacity building for evidence-based legislation-decision making

Capacity building for LCEs and key personnel responsible in steering their respective organizations will be accomplished in two parts. The first mode of delivery will be through CHD in partnership will other agencies like PopCom, DSWD and DILG. The 2nd will be through

identified TA providers within the area which can be strengthened to become partners in the voucher training system.

1. Mode of delivery through CHD:

TAP and HG will orient the Core Team. For now the TA will be focus on those produced between Inter CA TWG meetings with DOH, CHD and PHIC. These are the CHD Tool Kits and CSR plan. Related topics like policy links on utilization of LSI in means testing as will be incorporated in the TA package.

The initial step will be the forging of an agreement among the identified members of the Core Team with roles and responsibilities of each partner- member clearly specified and agreed upon by all participating agencies. This team composed of point persons from CHD, PopCom, DSWD and DILG will conduct roll out activities to the different municipalities and city. Target LGU partners are the Mayors, the Local Finance Committee and the SBs and SPs. HG will provide continuous technical support in the actual roll out.

Support activities like writeshop/policy crafting for program managers and legislators will be packaged base on needs and request. This activity will be focus on the importance of a high quality CSR response where output like ordinances/budget support for other component program can be included in the ELA.

To trial test this activity; a generic session will be conducted. After the conduct of SDIR sometime in Sept 2007, the SA with emphasis on Family Planning and MCH program will be presented to the targeted LGU partners like the LCEs, LFC and SBs. The result of analysis of these programs according to four components of FOURmula one will be the working document in the development of TA for evidence based legislation-decision making.

The following issues are the areas where the Core Team will help the participants develop policies and guidelines for implementation:

- Budget requirement and allocation for the forecasted logistics of unmet needs in FP, TB, Vit A.
- Policy on providing support to safety net groups./and those beyond safety net.
- Budget allocation for Indigency program
- Policy issues or ordinance regarding cost recovery schemes like user's fees.

By the end of November, 2007, draft write up of these policies will be available for presentation to the partner LGUs. These reports which are the product of their own discussion and deliberation will be readied for the next step. This could be through public hearings, or through their health board or through the MDC/PDC for concurrence.

The result will thus be an evidence of support to the program which will form part of the planned institutionalization of an effective and efficient LGU CSR response.

Mode of assessing the impact of these policies and ordinances will be monitored utilizing the M & E registry.

2. Mode of delivery through Academe/Institution or other TA provider Organizations:

Training curriculum for capacity building for evidence-based participatory decision making will include modules on uses of LHA as a managerial tool, Basic principles of Public Finance Management Planning for Health which includes guidelines for the establishment of procurement and logistics system, financing systems: planning and budgeting systems, setting of financial outcomes (funds flow, trust funds, revolving funds and special accounts); resource mobilization (alternative options for financing, alternative modes of non-traditional financing schemes, revenue enhancement programs, and public-private partnership arrangements).This will also include modules on Internal Audit system for an effective and efficient flow of transactions in an organization.

SocSKSarGen has many institutions that can be strengthened to offer the TA packages. HG needs to package the training curriculum and the expected output from enrolment in the training program.

For the provinces, a training needs analysis of targeted LGU partners should be engaged to determine the sequence of modules to be offered in a semester.

Milestones:

Mode of Delivery to Partners:

1. By the end of November 2007, the Core Team to orient the LCEs, SB/SP, and LFC oriented on MDG/MTPHP/NOH, HSR& F1 framework, LHA and health economics.

Mode of Delivery to LGU Partners:

7. LCEs/SB/SP/LFC oriented on MDG/MTPHP/NOH,HSR& F1 framework, LHA and health economics before the end of the year 2007.
8. Evidence Base policies-legislation-governance exemplified by support to *CSR response* available in ELA, increased budget for health, increase utilization of Health Facilities and increase revenue from user's fees.
   - Highlights (Jan-Aug, 2008) documented through monitoring and follow through HG activities on the 7 LGUs. Above indicators routinely monitored based on availability and compared against initial baseline.

Milestones:

Mode of Delivery to Partners:

2. By the end of November 2007, the Core Team to orient the LCEs, SB/SP, and LFC oriented on MDG/MTPHP/NOH, HSR& F1 framework, LHA and health economics.

Mode of Delivery to LGU Partners:

9. LCEs/SB/SP/LFC oriented on MDG/MTPHP/NOH,HSR& F1 framework, LHA and health economics,
10. Evidence Base policies-legislation-governance exemplified by support to PIPH,*CSR response* available in ELA, increased budget for health, increase utilization of Health Facilities and increase revenue from user's fees.

- Highlights (Q1-Q3, 2008) documented through monitoring and follow through HG activities on the 7 LGUs. Above indicators routinely monitored based on availability and compared against initial baseline.

TA3. Service delivery improvement tools

This TA will utilizes the following tools:

- SDEX
- SDIR/SA
- Strengthening service providers training system
- TA on informed choice and voluntarism
- Family Health Book
- Strengthening Service delivery monitoring and supervision

Since this tool is in its refinement stage, the approach will be engage directly to the implementers. This will have two implications. One, the targeted core of trainers (CHD and PHO Prog Coor) can participate very well in the fine tuning of the tools which should be adaptable to the uniqueness of each LGU. And two, the direct intervention will provide immediate results as to the impact of tools in improving service delivery.

The mode of delivery at this stage will be directed to both the partner CHD and partner LGUs. The Trained Core of Trainers will develop a plan of action for a well managed, efficient and controlled implementation schedule. That is, the activity will not disrupt the delivery of regular programs.

Implementation of tools will happen from Jan to June 2008 and the remaining quarters will be devoted to documentation of results and tool enhancement activities.

HG-CHD partners of the 7 LGU will be coach and mentored on the development of an acceleration plan. The working document will be the SDIR/SA results utilized in the preparation of their respective MIPH. The CHD will facilitate the implementation of the acceleration plan which will be a section plan of the QA/QI plan of their MIPH.

Parallel to this activity will be the drafting of an M & E plan to record developmental changes in service delivery.

Milestones:

Mode of Delivery to Partners:

5. By the end of 1st quarter, 2008 Core Trainer had undergone the full training requirements on Service Delivery Improvement Course.
6. The Core of Trainers had drafted an Action plan outlining the implementation schedule for the 7 Municipalities.

Mode of Delivery to LGU Partners:

7. Municipal Health Staffs oriented on Service delivery improvement programs.(Jan 2008)
8. Acceleration plan developed for every Municipality.(between Jan to June, 2008)
9. Monitoring and Evaluation Registry written.(end of June, 2008)

PROVINCE OF SOUTH COTABATOTECHNICAL ASSISTANCE PLAN

Introduction

This Technical Assistance plan covers a period from September of 2007 to August of 2008. The lines up key interventions were expected to promote the necessary foundations towards the institutionalization of various management and operational systems. All of which were anchored on the Millennium Development Goals and the National Objectives for Health.

Among the key instrument seen that will eventually promote ***health as a way of life*** is the participation of various Civic and Non Government Organizations in the implementation of health initiatives at the grassroots level. Seen to promote a snowball effect is their demand from the implementers and local government bodies to move forward towards a rationalized efficient and effective health delivery system. It is in this regard that measuring effects of such interventions will be best presented on ***evidences of results through legislations and good governance***.

Hence this plan will depart from the achievements and gains of Year 1. It is now understood that the necessary foundations for an interactive coordination for the delivery of Technical Assistance is cast. The Technical Assistance for Year 2 will focus on interventions that will steer the fragmented systems towards a reciprocating and cohering mode of delivery for the LGU. By the end of Year two, it is expected that LGUs will have a reliable health information system, an increasing allocation for health and logistic requirements and service providers available at all times. This is expected to redound to improving health statistics.

I. VITAL HEALTH STATISTICS

LEADING CAUSES OF MORBIDITY (all ages)

Causes	Number
1. Other Acute Respiratory Infection	5,082
2. Pneumonia	4,272
3. Diarrhea all forms	2,951
4. Influenza	1,607
5. Hypertension	1,340
6. Bronchitis	1,297
7. Renal & Glomerural Diseases	752
8. TB all forms	940
9. Malaria	469
10. Dengue	411

LEADING CAUSES OF MORTALITY (all ages)

Causes	Number
1. Cardio Vascular Disease	421
2. Cancer all Forms	238
3. Pneumonia	206
4. Septecemia/Sepsis	152
5. Accident all forms	151
6. Disease of Glomerural & Renal Diseases	128
7. Hypertension	117
8. Chronic Obstructive Pulmonary Disease	97
9. Diabetes	76
10. Gastric & Duodenal Ulcer	61

LEADING CAUSES OF INFANT DEATH

Causes	Number
1. Sepsis/Septecemia	31
2. Prematurity	18
3. Pneumonia	13
4. Asphyxia	3
5. Respiratory Distress syndrome	6
6. Tetanus	2
7. Accident	4
8. Meningitis	2
9. Congenital Heart Disease	4
10. Congenital Annomaly	6
Total	**89**

LEADING CAUSES OF MATERNAL DEATHS

Causes	Number
1. Eclampsia	3
2. Post partum Hemmorhage	1
3. Uterine atomy	1
4. Diffuse Post Partum eclampsia	1
5. Hypovolenic shock sec. to massive blood loss	1
6. Post partum bleeding sec. to retained placenta	1
7. Post partum eclampsia	1
8. Retained placenta	
9. Post Term Delivery, tc pre-eclampsia,tc septic shock	1
Total	**11**

Accomplishments on Priority Health Programs

The ***Task Force Kalusugan*** is regularly conducting regulatory operation due to reported increased in the proliferation of reported fake and counterfeited food, cosmetics, medical devices, drugs and medicines, and household hazardous substances. Other achievements are as follows:

- Establishment of 60 licensed botica ng barangay at various municipalities in the province which provides accessible, affordable and quality drugs and medicines to local constituents.
- Conducted regulatory operation to 120 licensed drug retail and hospital outlets.
- Conducted regulatory operation to 60 licensed food manufacturers and 20 food processors, 1 licensed cosmetic trader and 2 other traders' applicants on process.
- Initiated confiscation and destruction of adulterated, imported and unregistered food products. Sealed 65 cartons of imported Food Products of NOVO in Koronadal City.
- Conducted random sampling of 20 items of delivered drugs and medicines procured by the Provincial Government and 10 items by the City Health Office.
- Conducted Community Awareness programs:
  - For Pharmacists, owners and distributors (4)
  - For Food Processors and manufacturers (3)
  - BNB Aide Orientation Seminar (5)
  - Consumer Forum at NDMU re: Food Fortification (Private and Government Schools) (1)
  - BFAD updates during the Provincial Coordinating Council for Health Concerns (PCCHC) Meeting
  - General Assembly re: issues on dispensing/selling of Drugs in Sari-sari store.

- **South Cotabato has an 85%** Cure rate for TB patients enrolled in Directly Observed Treatment on Short Course Chemotherapy (DOTS), higher than the national cure rate target of 80%.
- For the Environmental sanitation program- In the province, **83 %** of Households have now access to safe water supply. Aside, record shows that **57 %** of Households in the province have sanitary toilets.
- The Garantisadong Pambata (GP) accomplishment is **94%**. **GP** is regularly conducted during the month of April and October and focus on Vitamin A supplementation among children 6- 71 months old. The program also includes activities such as deworming, expanded program on immunization (EPI), dental, iodized salt testing among households and breastfeeding.
- In South Cotabato, the Iodized salt implementation status is already **98%.**
- In the Family Planning program, the Contraceptive Prevalence Rate is now **54.29%**. For 2006, there are 51,147 Current Users for all FP methods.
- In terms of Social Health Insurance, at present South Cotabato has actual total number of indigents of 10,404 and saturation rate of 93.09%.
- In terms of facility accreditation and upgrading, all (11) RHU health facilities and all Govt. Hospitals are now PHIC accredited. All Rural and City Health Units are accredited to Sentrong Sigla Phase I Level I facilities by the DOH. For Sentrong Sigla Phase II Level I, eight (8) RHU's are now accredited while the other 3 RHUs namely Tantangan, Koronadal and Lake Sebu are on the process for accreditation.
- Since it is also our commitment to the National government to reduce the out of the pocket expenditures of our health services clienteles, we are in constant coordination with the

local Philhealth Insurance Corporation discussing how we can somehow cushion the effect of increasing health cost by developing and indulging into partnership programs.

- The Provincial Coordinating Council for Health Concerns (PCCHC) which is the umbrella organization of NGO's, PO's and other agencies is regularly conducting meetings to discuss various health issues and concerns. Currently, the PCCHC has passed Resolutions in support to provincial health programs:
  - Resolution requesting the Provincial Governor for the inclusion of budget for the establishment of Botica ng Lalawigan early next calendar year 2007.
  - Resolution requesting the Provincial Governor for the full implementation of Generics Law.
  - Resolution requesting the Municipal Government for an increase in budget for the Indigency Program.

FOURMula ONE for Health Project

The Province of South Cotabato is one of the 16 provinces all over the country identified to implement the Health Sector Reform Agenda through the support of European Commission. Health implementation will follow the FOURmula One as over-all framework, which focus on four strategic instruments for health reforms, i.e. Financing, Governance, Regulation and Service Delivery. Primarily, this project aims to improve quality and efficiency of investments for health reforms and improve health outcomes for Filipinos particularly the poor.

EC Budget support for the province of South Cotabato (CY 2006-2009)

	Fixed Tranche	**Variable Tranche**	**Total**
Year			
2006	6,178,229.00		6,178,229.00
2007	18,534,887.00	1,544,572.00	20,079,459.00
2008	18,534,887.00	4,633,717.00	23,168,604.00
2009	18,534,887.00	4,633,717.00	23,168,604.00
2010		4,633,717.00	4,633,717.00
Total	**61,782,890.00**	**15,445,723.00**	**77,228,613.00**

EC Grant DOH (TA)	**EC Grant**	**Total**
33,616,248.00	77,228,613.00	**110,844,861.00**

III. Technical Assistance for the Province of South Cotabato

Empowering LGU to sustain CSR response

Background

The Technical Assistance identified for the province of South Cotabato was based on the review of their Province Wide Investment Plan. The emphasis was on its thrust on how to empower its people to strengthen its primary health care network and health information system.

Broadly, the Technical Assistance will dwell on the result of analysis based on the consultation conducted with their health technical staffs. This was facilitated by Health Governance advocacy group utilizing the SA analysis tool and validated through follow up visits in the 11 LGUs. The result of which was included in the Mindanao Advocacy report which included the summary of the gathered information.

While the health performance indicator for Family Planning program showed a satisfactory result, some operational performance indicator was seen as poor in promoting a sustainable concept of an ideal CSR LGU response. The segmentation of client, the identification of network of commodity providers and the forecasting of demand for the safety net and beyond safety net group were among the gray areas that need further enhancement. These were identified as areas needing HealthGovernance support to eventually provide the remaining element in institutionalizing the system.

Key interventions

The technical Assistance will include interventions on a three level approach. **First** will be the enhancement of the information system by promoting to the Local Government Units the concept of Community Health Living Standard Survey which will enhance their existing CBMIsystem. This will incorporate indicators that will develop the means test consistent with the PhilHealth requirements. The buy in for the approach is expected considering that a budget allocation from European commission is assured. Initially, there will be a review of the status of SoCot CBMIS implementation.

Second, assistance in the profiling and mapping of facilities and establishment of a referral system and network will be formalized with the Provincial Government and CHD XII. This TA package will utilize information from the first level activity which is necessary in establishing the health FP demand in the province.

The **third** and final approach will focus on the establishment of a TAs provider. The HealthGov Technical Assistance will help the province in identifying possible institution or organization that will provide the curriculum for the trainings of health implementers. Activities that will be supported will be the development of tools for the CHD and Provincial Staffs use in assessing the Human Resource Capabilities and Training Needs to determine the training curriculum requirements. This will create a market for would be service providers for and of the neighboring provinces within the FP service referral network.

Expected results

By the end of second year, major outcome will be seen on the following areas:

1. A clear picture between FP services demand and market interplay will provide the much needed management information for the LGUs like budget forecast for safety net group. It is expected also that some cost recovery scheme will start to evolve and these areas must be ushered in by follow up TAs for the DOHreps whose membership in the health board is significant.
2. Improvement of the LGU health facilities as FP service providers is predictable. Due to the identified health demand and expected revenue from FP services either from PhilHealth reimbursement or from user's fee will create a field of competition both from private and public service providers.
3. Increasing interest of the academe and other organizations as TA providers and the interest of both public and private health professionals to enroll in the training programs as FP service providers.
4. A draft tool which is co produce with the province for roll out to other project sites.

Mode of assessment

Improve performances in service delivery is translated by quality services which is dependent on the capability of the Health Service Implementers, the increase in budget allocation for health, and a functioning health referral system.

Collectively, consistent improvement on the following health indicators both performances and operational indicators will redound to attaining the target of an *institutionalized LGU CSR response* even before the end of the project.

Reviewing the gains in CSR and putting the final elements onward to institutionalization of LGU CSR response

IV. Proposed Technical Assistance and Implementation Arrangement

TA1. Reviewing the gains in CSR and putting the final elements onward to institutionalization of LGU CSR response

A training tool that address the core attributes of CSR will be co produce by HG with the Province. This Technical Assistance intervention will dip its intervention directly into the implementers. This was decided after consultation and discussion with the provincial health staffs on the degree of CSR implementation in the province. The past year, CSR indicators provided a very good picture of accomplishment with performances better than the national mark. But after review of their operational and management structures, there were many areas that need some interventions. Among these are the required updated and reliable information that are needed in forecasting the logistic requirements and the means test consistent with the PhilHealth requirement.

1. The mode of delivery of the Technical Assistance will be course through the CHD and to the Provincial Staff who will be trained for 2 ½ days on the CSR core attributes. This includes education on the ff strategies:
    3. Strategies for promoting all FP methods
    4. Strategies for integrating FP into MCH and safe motherhood services
    5. Strategies for protecting the poor (client segmentation, budgeting and finance, forecasting, procurement and logistics, private sector suppliers

6. Strategies for “beyond safety net” (cost recovery systems for publicly delivered commodities to non-poor, private provider mapping, public-private referral system; private sector expansion through development
7. Additional inputs from PRISM as private sector providers.

2. Core of trainers will be organized to provide direct coaching and mentoring activities to the Municipal Health Staffs. Initially, the SDIR/SA tools will be utilized in reviewing program implementation with focus on the CSR indicators. The result of the analysis will be consolidated for some Governance issues where additional TAs might still be needed. (More on Evidence based legislation-governance).The activity will be province wide and the approach could either be on a per municipality or through established local health zones. Continuous technical back up to support the Core of trainer activities will be extended by the HealthGov. This activity will cover all the 11 municipalities and results are expected to be completed in 2 ½ months time.

3. There will be presentation of the SA and the corresponding interventions and TA needs to the Local Executive Board (expanded govt body with participation of NGO-CSO). This will happen immediately after the finalization of SA report. Venue of presentation will be during Local Health Board meetings. A minimum of 6 presentations if by Local Area Health Board and the Prov. Health Board and maximum of 12 if by Municipal/provincial Health Board.

4. HealthGov to position available TA as strategically beneficial to address the LGU needs. This package includes conduct of Community Health Living standard Survey (CHLSS): a tool that provides information on unmet needs (former CBMIS) and indicators for developing a means test consistent with PhilHealth requirements.

   - HG will discuss with the LGU the mode of conduct of survey, its cost and the time element which is very necessary in order not to disrupt LGUs’ implementation of regular activities. Since Funds for the proposed activity is included in the PIPH, HG will commit to provide the hiring of the TA provider.
   - Details of the TA activities are discussed under the other specific TA package.

Milestones:

<u>Mode of Delivery to Partners:</u>

7. By the end of September 2007, the Provincial TWG is established which is composed of Provincial Technical Staffs and DOHReps who are trained to provide the coaching and mentoring activities of CSR planning at the LAHDZ (Local Area Health Development Zones)level.
8. Availability of a Draft Action plan with set schedule of roll out activities utilizing the strategies learned from the CSR plan enhancement orientation workshop.
9. Draft CSR TA tools being finalized and validated.

<u>Mode of Delivery to LGU Partners</u>

16. Co produce Draft CSR TA module/tools trial tested in 11 LGUs. Evidence of implementation and acceptance documented by feedbacks/comments on tools and availability of draft CSR plans.Draft CSR time completed in 2 ½ months.

17. Final Provincial CSR plan collated covering a period of 5 years.
18. Budgetary requirements included in the PIPH.

TA2. Capacity building for evidence-based legislation-decision making for CSR

Implementation of LGU activites always follow the principles which is legal and within the accepted norms. Even Best health practices are documented and performances are pronounced based on set guiding principles. Some LGUs are making good at it but many needs to be strengthened in this particular area. The Proposed TA for South Cotabato will focus more on orientation on MDG/MTPHP/NOH, LHA accounts as planning and management tool and the interplay of consumers-providers/LGU-CHD in attaining CSR and health related indicators. The mode of delivery will be through CHD in partnership will other agencies like PopCom, DSWD and DILG.

TAP and HG will orient the Core Team. An agreement will be forged with roles and responsibilities of each partner- member clearly specified and agreed upon by all participating agencies. This team composed of point persons from CHD, PopCom, DSWD and DILG will conduct roll out activities to the different municipalities and city. Target LGU partners are the Mayors, the Local Finance Committee and the SBs and SPs. HG will provide continuous technical support in the actual roll out.

Support activities like writeshop/policy crafting for program managers and legislators will be packaged base on needs and request. This activity will be focus on the importance of a high quality CSR response where output like ordinances/budget support for other component program can be included in the ELA.

Milestones:

Mode of Delivery to Partners:

3. By the end of October 2007, the Core Team to orient the LCEs, SB/SP, and LFC oriented on MDG/MTPHP/NOH, HSR& F1 framework, LHA and health economics.

Mode of Delivery to LGU Partners:

11. LCEs/SB/SP/LFC oriented on MDG/MTPHP/NOH,HSR& F1 framework, LHA and health economics before the end of the year 2007.
12. Evidence Base policies-legislation-governance exemplified by support to *CSR response* available in ELA, increased budget for health, increase utilization of Health Facilities and increase revenue from user's fees.
    - Highlights (Jan-Aug, 2008) documented through monitoring and follow through HG activities on the 11 LGUs. Above indicators routinely monitored based on availability and compared against initial baseline.

TA 4: Building a Strong Data Bank of updated and reliable information

The Community Health and Living Standards Survey (CHLSS): a tool that provides information on unmet needs (former CBMIS) and indicators for developing a means test consistent with PhilHealth requirements will be engaged by January 2008.

HG will consult with the Provincial Government and the 11 municipalities on the implementation arrangement. Financial requirement, timing of implementation, partner implementers and the TA providers will be incorporated in the memorandum of agreement.

Initial activities is for TAP and HG to train trainers (CHDs, DOHRep, PHIC, DSWD,Popcom) on the use of CHLSS tool. The Pool of trainers conduct roll out trainings and actual use of tools to the MLGUs(Health staffs and BHWs/BNS). The approach for the roll out will start with orientation and skills training on the use of survey tool. This will be followed by actual survey and data encoding of results.

After all data are completed and encoded, session for validation and interpretation of results will be done for the 11 municipalities.

Trainers will assist in the finalization and presentation of results to the LCEs, SB/SP and LFC. The results will be utilized in resource mobilization and prioritization.

In all these activities, technical back up is provided by the HG.

Milestones:
Mode of Delivery to Partners:

1. By the end of January of 2008, the Core Trainers are orient on the use of CHLSS tool.
2. Availability of roll out training plan for 11 MLGUs' health staffs, BHWs and BNS.

Mode of Delivery to LGU Partners:

1. Availability of results of CHLSS with data on Unmet needs for FP, TB, MCH
   - Technical back up by CHD and HG during the conduct of CHLSS results validation and interpretation which will happen within Q1-Q2, 2008 timeframe.
2. Data interpreted and final results presented to the SB/SP, LFC
   - By end of Q2-2008, the presentation of results will be facilitated/supported by core of trainers and data will be utilized in the preparation of budget for 2009
3. Projected needs for CSR forecasted
4. Budgetary requirements and source for CY2009 PhilHealth Indigency Universal Coverage Program included in the executive budget.
   - The Core Trainers with the technical back up of CHD and HG will facilitate the drafting of PhilHealth Universal Coverage. Parallel to this are activities promoting the plan to NGOs and CSO for support and participation in co financing the program. This highlight will eventually be realized by Q3-2008.

TA 5: CSR Assessment and Monitoring Tool (consistent with new AO on CSR)

Parallel to all TAs will be the installation of a Monitoring and evaluation tool to track local progress in CSR implementation. This tool will be utilized in the assessing the degree of work implementation and the gaps and deficiencies in the execution of interventions.

The TAP and HG will train trainers (CHDs, DOHRep, PHIC, DSWD,Popcom) on the use of CSRAM tool. The Pool of trainers will conduct roll out activities to the 11 LGUs to develop a built in CSR A & M plan. This A & M plan covers all activities both operational, management and performances in program. This A & M will be fitted into place from Set 2007 to Sept 2008 with a regular implementation review on a quarterly basis.

Milestones:

Mode of Delivery to Partners:

3. By the end of January of 2008, the Core Trainers are orient on the use of CSR A & M tool.
4. Availability of roll out training plan for 11 MLGUs' health staffs, BHWs and BNS.

Mode of Delivery to LGU Partners:

5. Availability of results of A & M on performances on meeting the Unmet needs for FP, TB, MCH.
   - Technical back up by CHD and HG during the conduct of A & M will happen within Q1-Q3, 2008 timeframe.
6. Available M & E registry
   - This registry of activities and corresponding indicators is a highlight of key activities that cumulatively transpired from the conduct of CSR planning to drafting of action plans and writing and implementation of evidence based legislation-governance which form part of the CSR assessment and evaluation tool. Final registry will be available by Q2-2008.

7. Data interpreted and final results presented to the SB/SP, LFC
   - By end of Q3-2008, the presentation of results will be facilitated/supported by core of trainers and data will be utilized in the preparation of budget for 2009
8. Projected needs for CSR forecasted
9. Budgetary requirements and source for CY2009 PhilHealth Indigency Universal Coverage Program included in the executive budget.
   - The Core Trainers with the technical back up of CHD and HG will facilitate the drafting of PhilHealth Universal Coverage. Parallel to this are activities promoting the plan to NGOs and CSO for support and participation in co financing the program. This highlight will eventually be realized by Q3-2008.

Establishment of TA providers for an LGU-sustainable CSR response

The establishment of TA providers for a sustainable LGU CSR response will happen gradually on a step per need basis. Review, situate, install steps will be followed to generate ideal results based on real health needs. It is understandable that institutionalization of a CSR response by the LGU will not happen overnight. The installation of a CSR Assessment and Evaluation tool will somehow provide the necessary directions and redirections of interventions towards the objective of a sustainable *CSR response*.

PROVINCE OF BUKIDNON
TECHNICAL ASSISTANCE PLAN

I. BACKGROUND

A. Brief Profile

Bukidnon is a highland province landlocked in Central Mindanao by several local territories such as in the South by Davao City and Southeast by North Cotabato, in the West by Davao del Norte and Southwest by Agusan del Sur, in the North by Misamis Oriental and, in the East by the two Lanao Provinces. Bukidnon is the largest province in Region X and eighth largest in the entire country, covering an entire land area of 829,378 hectares.

The Province is divided into 3 districts, 2 Cities and 20 Municipalities comprising a total of 464 Barangays. The projected 2007 population is 1,254,165 with a growth rate of 2.41%.

Bukidnon is classified as first class Province with a total income considered as among the highest in Mindanao Provinces totaling to 1.087 billion pesos. Although, the bulk of their income is derived from IRA (835m), a substantial amount is considered local incomes from their economic enterprise ventures in the total amount of 253 million pesos. . Interestingly, the Provincial government allocated 52% or 570 million pesos of their income to health services.

Bukidnon is home to seven (7) indigenous peoples comprising 40% of the Province total population. Interestingly, more than half of them are still keeping their traditional health practices from maternal and child care, nutrition to using herbal medicines for common illnesses. Notably, majority continues to reach their native “mangongoyamo” (midwife) to assist in child delivery and, “baylan” (ritualist) for healing practices needing “higher spirits’” interventions. Although, a common notion abound on IPs’ perennial resistance for change or adopt modern methods of health care, by closer look, there also exists an avenue for the integration of good health practices into the IPs culture. One example for this, is the common belief to feed nutritional foods to a pregnant woman; preparation for child delivery; and, the use of herbal medicines which is already acceptable by the general society.

B. Tribal Governance

The IP community is led by a *datu* (chief). The *datu* earns his position by blood lineage from previous datu who might be his father, or by claim of ability whose authority is confirmed by a group elders and datus of other IP villages.

While the *datu* maybe perceived by an outsider to be a dictator with absolute authority, internally he consults a council of elders especially on matters of defense and survival of the tribe. This consultation extends to their relatives living in nearby villages. The value of consensus is a time-honored democratic process among ancient villages. The *datu* becomes a strict leader or a “dictator” in the implementation of agreed or established consensus among elders.

The IP community considers the *datu* as source of strength and confidence. A datu is expected to be benevolent to gain the loyalty of the tribe. He has to give most of his resources to protect

his followers from injustice, hunger and external dangers. Thus, it is strongly advisable to always consult the datu especially for outside development assistance.

C. Health Profile

The Bukidnon health system is characterized into: a) public health system which is primarily handled by BHS/RHUs/CHOs and by three inter-local health zones, and; b) the Provincial Hospital System composed of the 8 District Hospitals. Table 1 below shows the total number of hospitals in the Province with the private sector playing the major rule of managing 33 while the Provincial Government operating 8 hospitals. Significantly, majority of the hospitals accredited by PHIC are privately-managed. Almost all however, or 7 Provincial Hospitals are also PHIC accredited.

Table 1. Classification of Hospitals in the Province

Category	**Total**		**PHIC Accredited**	
	Private	Government	Private	Government
Primary	23	5	16	5
Secondary	9	1	9	1
Tertiary	1	2	1	1
Total	33	8	26	7

The Bukidnon Health System is envisioned to be a premier institution of the Province to provide a comprehensive health care delivery to the constituency through an effective, efficient, accessible and equitable health care. For a total health and development, the Provincial Government outlined five priority programs as follows:

a) Provincial Indigency Health Program (PHIP) – The Program was launched on February 1992 as a priority program of the Provincial Governor. The PHIP is a Provincial government-sponsored health insurance through PhilHealth and considered as the foundation of the Bukidnon Health System which aims at providing access to quality health care for the poor.

   The following criteria were established to avail of the Program as follows: a) 6 months residency in the barangay; b) less than Php 12,000 annual income; c) heads of family regardless of age; d) single parents; and, e) 60 yrs. and above with qualified dependents defined as - Legitimate children and legalized dependents below 21 yrs. Old; Physically and mentally disabled (all ages); and, parents and legal dependents over 60 yrs. Old

   The beneficiaries of the Program can enjoy unlimited access to Out-Patient services in the Provincial Health Stations/Hospitals from basic diagnostic tests and medicines and totally free hospitalization in Provincial Hospitals, including subsidy on bills not allowed by PHIC.

b) Provincial Hospital Development Project - In line with the vision of the Provincial Government to be a premier PLGU on health service, it embarks on a development program to establish hospitals and provincial health stations (PHS) on strategic "catchments areas." The PHS serves as an out-patient services extension of the hospitals providing OPB package of the sponsored health insurance. Fifteen PHS were established in areas without a hospital facility.

Table 2 below shows the location of the Hospitals and its status of operation.

Table 2. Provincial Hospital Operational Status

Name of Hospital	Hospital Category	Bed Capacity	Occupancy Rate 2004	Total # of Admissions	Total # of Consultations
1. BPH – Malaybalay	Tertiary	150	131.5%	10,253	26,626
2. BPH – Maramag	Secondary	95	268.76%	6,093	24,535
3. BPH-Manolo Fortich	Tertiary	37	Newly opened	Data not yet available	Data not yet available
3. BPH – Kibawe	Primary	10	413.75%	4,617	9,221
4. BPH – Kalilangan	Primary	10	168.1%	2,058	5,693
5. BPH – San Fernando	Primary	10	105%	962	9,107
6. BPH – Talakag	Primary	10	101.85%	1,555	13,405
7. BPH – Malitbog	Primary	10	29.5%	351	4,673
Average / Total		332	174.06%	25,757	93,260

c) Public Health Integration Program – This is in line with the development of a public health system in the forefront of providing health services specifically in remote communities. The ILHZ, RHUs and BHS are considered as the frontlines for primary health care. Bukidnon RHUs have exemplified health service delivery with the constant effort to bring quality health care to the people through preventive and curative aspects. All 20 RHUs are gearing towards accreditation for Maternal Care Package and TB-DOTS.

As shown on the SDIR results, there is need for an enhanced information management system to improve the planning and monitoring process of RHUs. Likewise, their established MIPH reflects a common desire to reduce morbidity and mortality for vulnerable population (maternal and child health and FP services) through increased financing support and regular purchase of supplies and logistics.

d) The Bukidnon Health System: An Economic Enterprise - The Provincial Government embarks on an enterprise program to generate more internal revenues to deliver broader social services. The Hospital system is among the major economic ventures of the province bringing in millions of pesos from PHIC reimbursement payments.

The present direction of the Provincial Government is for the completion of the hospital infrastructure and facilities towards full operationalization of the hospital system. It envisions attaining maximization of the provision of health care to the beneficiaries of the sponsored health insurance and full utilization of the Philhealth returns from payment of health services into the government facilities. To become more viable and obtain effective and efficient management, the Provincial Government aims to grant Fiscal autonomy of hospital operation and standardization of wages and benefits of health workers.

Since operation in 2002 up to March 2005, the total hospital income amounted to 121million pesos.

e. Strengthen Inter-local Health Zones - As a pillar for public health, the Provincial Government supports strengthening of the 3 Districts Inter-local Health Zones. However, there have been no concrete plans and/or policies that would strengthen the role of the ILHZ on public health sector. While there is evidently a functional Provincial Hospital operation and Provincial Health Stations, the full function of ILHZ remains to be realized.

D. Vital Health Accomplishments:

- Number of Deaths, All Ages / Mortality Rate: 3,563
- Number of Infant Deaths: 179
- Number of Under-Five Deaths - Under-Five Mortality Rate: 240

- Maternal Deaths - Maternal Mortality Rate(Actual Number): 30
- 10 Leading Causes of Mortality, All Ages:

  CVD, Injuries, Pneumonia, Cancer, TB, Diseases of the Kidney, Diabetes Mellitus, Septicemias, Diseases of the Livery, Bleeding Peptic Ulcer

- 10 Leading Causes of Infant Deaths:
  Prematurity, Sepsis, Pneumonias, Congenital anomalies, Diarrhea with Dehydration, Hypoxia, Respiratory Distress Syndrome, Placental Insufficiency, Disorders of Amniotic Fluid and Membrane

- 2006 Operation Timbang Results: Below Normal-Very Low: 2,033 (1.13%)
  Below Normal-Low: 20,203 (11.20%)

- Low Cure Rate and detection rate for TB. Only the RHU of the San Fernando Municipality reached 100% cure rate. Two (2) big LGUs (Mun of Quezon and Malaybalay City) only managed to obtain 50% cure rate for 2006. Almost half of the total LGUs (10) have attained between 62.50%-79.48% cure rate. Notably, the Municipality of Dangcagan has the lowest cure rate at 14.28%
- High maternal mortality rate (Actual No. 30)
- TB-DOTS accredited RHUs have low or no claims at all from PHIC

- High crude birth rate
- Only 13 out of 22 RHUs are TB-DOTS accredited
- In many of the Municipalities there is still high malnutrition rate

E. Health Issues and Problems

Generally, major issues were identified that are crucial in determining critical TAs for year 2 as follows:

On service delivery:

- Lack of effective communication and education program on FP and, inadequate communications skills of frontline health providers.
- Poor monitoring process and/or referral system for broader FP coverage
- Lack of access for affordable drugs and medicines
- Insufficient knowledge by RHMs and BHWs on wide-range FP methods for informed choice.
- Significant number of deliveries are still not attended by skilled workers
- No LGU funding support for upgrading KSA of health staff especially RHMs on MCH and FP counseling
- Unable to develop culture-sensitive health interventions that would mainstreamed IPs and other grassroots communities for improved health practices
- Difficulties in complying (i.e. documentation requirements and standards compliance) for Philhealth accreditation on TB-DOTS and MCP.
- Poor referral system

On Governance, regulation and financing issues on health:

- Inter-facing between PHS and RHUs needs to be strengthened. With the full operation of the PHS coupled with the enterprising outlook of the Provincial Government, there is a need to clarify or strengthen operational relationship of the two systems (PHS and ILHZ/RHUs).
- Health information system needs to be enhanced for effective program planning. The Province currently maintains a computerized data management for the BHIP health information system. There is a need to establish parallel data management system (i.e. centralized at PHO level with interlink at RHU and BHS) through computerization and use of internet.
- Health Investment Planning for Health needs to be enhanced specifically on expanding resource generation and financial management
- CSR policies in terms of procurement and distribution needs to be clearly established especially at the provincial level.
- Weak linkage of government and private sector. Specifically, unable to tap participation of various POs (BHW and Women's Federation, ABC) for advocacy and/or participation on public health programs (i.e. health promotion)

II. YEAR 1 ACCOMPLISHMENTS

Early interventions in the Province mostly relates to the establishment of effective rapport and commitment by the LGU to undertake the health governance process. The first major accomplishment in the Province was the signed commitment gathered from the LMP-Bukidnon chapter (signed by all the Mayors present during the meeting) to undertake health reforms "aim of improving the quality of care and achieve desired health outcomes through appropriate policies and investment plans". Specifically, the LMP committed to do the following:

- Issue a mandate to our respective staff to develop investment plans for Health
- Provide allocation as counterpart to support the municipal and inter-local health investment plans
- Ensure the participation of other agencies, private sector, civil society, NGOs, POs and community in health programs
- Establish Capacity Development Fund for Health
- Include TB, Nutrition, Maternal and Child Health, CSR in the updated executive and legislative agenda

In preparation for province-wide MIPH, all 20 RHUs and 2 CHOs undertook the SDIR co-facilitated by HealthGov and CHD 10. SDIR results served as the main basis in the formulation of M/CIPH. Again, the C/MIPCH workshop was facilitated by selected CHD 10 technical staff with TA from a hired external facilitator and HealthGov staff. Prior to conduct of the activity, a facilitator's orientation was conducted defining the context of MIPH and overall logical flow. Twenty (20) MLGUs and two city LGUs formulated their IPH. The main features of their IPH are the established goals for the next six years and yearly targets aim at reducing MMR, increased TB detection and cure rate, improved nutrition, improved information system, etc. The Provincial Health Office provided the technical review of the MIPH in preparation for Provincial consolidation. Immediately after the formulation of the MIPH, a workshop on resource mobilization was conducted which enables the LGUs identify a range of options for an expanded resource generation in support to their MIPH.

In year 1, HealthGov-Mindanao has facilitated establishing overall health direction of the Province and component Municipalities and Cities. One of the significant achievements was also the commitment obtained from the LMP to take an active role on health development of the Province. In support to MIPH and PIPH enhancement and consolidation, a Provincial Technical Management Team **(PTMT)** was initially formed. The PTMT (to be headed by the Vice Gov and members compose of CHD (PHTL), PHO-TWG, PPDO, PEDMO, Prov. Budget Officer, and DILG) shall be formally organized by early part of the year to provide continuous TA for the operationalization of MIPH and PIPH.

In year 2, the Project will employ the same strategy by closely working with appropriate LGU structure and RGNAs.

III. YEAR 2 PLAN

The main thrust of TA provision for the province will be geared towards the strengthening of public health system for broader benefits of the inhabitants of this highland province. As discussed earlier, the Provincial Government shows a firm direction and support to the hospital system as basic social services support and an economic venture for expanded resource generation. Along the process (of developing the PHS and hospital system), it has been observed that unseen competition in terms of economic opportunity (i.e. from PhilHealth reimbursements and capitation) emerges between the two systems. Likewise, although public health integration and strengthening ILHZ are one of the program priorities of the Provincial Government, there had been no concrete policies or mechanisms (i.e., systematic or integrated information system, clear referral system, inter-facing between PHS and RHUs/CHOs) established yet for a full support to public health programs, such as on increased financing and systems for procurement and distribution for CSR commodities; health programs and strategy for indigenous peoples; and, support for Philhealth accreditation.

For year 2, the strategic TAs will be geared towards laying the foundation for the harmonization of the two health systems and strengthening the functions of frontline health service delivery. Specifically, appropriate TAs shall be provided towards:

1. **Enhancing MIPH and PIPH into an institutionalized process for public health planning**

   The TA that will be provided in this aspect is geared towards the achievement of the following:

   -22 technical M/CIPH finalized/packaged and submitted to respective local bodies for integration to AIP
   -PTMT organized and mandated to supervise TA process and requirements for PIPH
   -Cross-cutting concerns identified for Provincial consolidation
   -Provincial Support systems to C/MIPH and ILHZ-IPH developed
   -Information, M&E, Advocacy strategies formulated
   -PIPH integrated to AIP and obtained LCE's mandate for implementation

   <u>The steps and activities to be undertaken under this TA are as follows:</u>

   At the end of year 1, HG had developed the technical review guidelines based on agreed parameters of the SOAG and PPAs. The review guidelines were translated into a questionnaire type designed to be self-administered by RHU staff. Example of the guide questions were:

   - Review clarity of goals and targets whether measurable and verifiable.
   - Are the planned interventions consistent with situation analysis and goals/targets? Does it respond to issues and challenges identified on EPIR workshop?
   - Are the interventions logically sequenced and progressing (Example: Assuming certain targets are achieved along the way and, not a repetition of same of same intervention over the years)
   - Are the planned activities clearly linked to intended health outcomes?
   - Is the proposed costs/budget reasonable and realistic?

The PHO technical staff and CHD provincial representative supervised the review and afterwards gathered an electronic and hard copy of the enhanced MIPH in preparation for Provincial consolidation.

At the Municipal and City level, the immediate task of the LGU health personnel with support from NGO partners is to facilitate MIPH adoption by the Local special bodies and integration into the AIP. The PHO technical and PHTL (CHD rep) are currently facilitating the technical review process of MIPH. By Beginning of year 2 (October '07), the PTMT shall be formally organized (i.e. with defined functions and responsibilities and mandated through an executive order to provide TA and technical supervision for the PIPH and ILHZ-IPH implementation.

After the technical review (based on review guidelines and criteria provided by HG) of MIPH facilitated by PHO Technical staff (expected to be completed middle of September 2007), the next step is for the PHO and the PTMT to come-up with a provincial consolidation outlining support mechanisms, cross-cutting concerns and TA requirements that can be derived from the Provincial Government's internal capacity (i.e., assistance on TB-DOTS and MCP accreditation, counterpart on human resource development, improvement of referral system). By first week of October 2007, the PTMT shall follow-up and provide assistance for the adoption of MIPH to AIP. Likewise, a parallel process (presentation of PIPH to Provincial Health Board for adoption and integration into the Provincial Development Plan) shall be undertaken by the PTMT together with the NGO partnership. By middle of October, it is hope that all M/CIPH and the PIPH shall be adopted by the Local Special Bodies for implementation and allocation of resources.

By November 2007 to January 2008 (depending on regular meetings of the 3 ILHZs, CHD and PTMT shall facilitate initial ILHZ planning based on the established/adopted PIPH and MIPH. The activity is an initial process to define roles and functions of ILHZ and identification of common health needs and support systems to MIPH. The individual ILHZ shall then develop their annual operation plan as the basis for the delivery of support and services to their district and covered RHUs. Between said dates, the ILHZ shall present their plans to the LMP and their respective Local Health Boards (LHBs) for legislative support and resource allocation.

The Provincial technical management team with NGO/PO partners shall lead the process in enhancing the PIPH into an overall framework in guiding successful implementation of MIPH/CIPH. Following the learning-by-doing principle, it is expected that by next planning cycle (May-Sep 2008), PIPH formulation features shall be in-placed or adopted by the Province.

2. Formalization of ILHZ as a key mechanism to promote and enhance public health system

The formalization of the 3 ILHZ is one of the desired health outcomes or priority programs of the Provincial Government to promote the public health system. It is also seen as a venue to plan and achieve common health concerns as well as a "peer" review process for adjustments of targets and inputs to contribute provincial health objectives and national health objectives.

For year 2, the main expected accomplishment will be a functional ILHZ with a clear mandate in the promotion of public health. Specifically, the TA process hopes that by end of year 2, a smooth referral system will be established, clear operational relationship with PHS will be defined, effective and accurate information system will be installed and, disease surveillance system will be operational. Specifically, by early part of the year, ILHZ shall have developed ILHZ-IPH outlining support systems for MIPH implementation (i.e. formulation of relevant policies and increased funding support).

The League of Municipalities of the Province (LMP-Bukidnon Chapter) is supportive to enhance the role of the ILHZ for improved public health system. On a recent meeting, they issued policy for the immediate re-activation of the ILHZ to respond to emerging needs and issues on public health including unified or collaborative response to common health concerns such as on disease surveillance, waste management, dengue prevention among others. The first step will be to facilitate a planning process based on the formulated MIPH with the end in view of enhancing ILHZ role on public health system working in harmony with the PHS and Provincial Hospital system.

Through the LMP and ABC appropriate policies and/or legislations shall be formulated defining referral and health management relationship between the provincial health systems (hospital and PHS) and the preventive and curative functions of the ILHZ and RHUs.

On the other hand, as a former LEAD Project, it is necessary to facilitate a brief review of CSR plans as a take-off point in ensuring sustainability on CSR procurement and distribution. The review can be done at the ILHZ level so that common issues and concerns regarding financing on CSR could be discussed and peer support mechanism established.

At the beginning of the year (Oct-Nov. 2007), the following activities shall be facilitated by CHD and PTMT:

-ILHZ-planning identifying common health concerns and changes or improvements of their systems. The initial planning exercise shall also define the overall functions and roles of the ILHZ in light of the PHS/Hospitals health systems of the Province.
-ILHZ with PTMT's and NGO Partners' support shall orient the LMP and the provincial Government ontheir formulated plans and resource requirements.

Formalization and strengthening the role of ILHZ is a continuing guided process to ensure active role and delivery of functions (as reflected on their annual operation plans) by respective ILHZ to their district and covered RHUs. After the initial planning exercise, the 3 ILHZs, through technical assistance and supervision by CHD and PTMT, shall continue to address issues and concerns that will enhance their capacity for health systems improvement and delivery of direct support to Municipal and City Health Investment Plans.

During their regular meeting, CHD and PTMT shall facilitate assessing existing management and operational relationships between the two health systems and, formulate appropriate course of action. If indeed there is a need to improve the inter-

facing between ILHZ/RHUs and the Provincial Health Stations/Hospitals, a specific workshop or discussions shall be devoted on discussing appropriate policies or legislations that would be raised to LMP, ABC and NGO partners for advocacy support. During this meeting, representatives from the Provincial Governor's Office or from the Provincial Economic Enterprise Development and Management Office (PEEDMO) shall be invited to formulate together appropriate policies and mechanisms for effective delineations of functions. Advocacy plan shall be then developed for the promulgation of appropriate policies or legislations.

This could be a long and a painstaking process for the Provincial LGU to eventually came-up with a harmonious health systems catering to a broader sector of the society as well as sustaining their economic endeavors. This process alone could take the whole of year 2 if prioritized by the ILHZ and the Provincial Government (during the initial assessment and planning exercise). However, if earlier things are clarified and pressing issues are resolved, during their succeeding meetings the ILHZ can start addressing other priority health actions such as improvement of information and surveillance system, referral system, ICV monitoring and expanded resource generation and CHLSS.

3. Promoting culture-sensitive IP health interventions through IP-inspired SDIR

The support that maybe provided to an IP community should be based on cultural integration and sensitivity to existing cultural practices. Any external support may come as an enrichment of existing traditional but can be considered as generally acceptable health practices. Based on initial consultation with tribal leaders and elders together with some provincial health personnel, a number of potential TA areas for external agencies to work for are established (enumerated below). However, for year 2, HG can initiate a single process that can lead to meaningful interventions in the succeeding years (i.e. probably leading to TA provision related the established "potential TA areas". The potential TA from HealthGov (on italics) can lead appropriate agencies with relevant specializations or expertise to develop the appropriate TA package to respond to IPs' needs.

- ***Consultation, documentation and/or assessment of existing tribal health systems through IP-inspired SDIR*** – With the well-defined SDIR tool already tested with the Bukidnon LGUs, innovations can be made to reflect the process of assessing IP health practices related to FP, MCH, Nutrition, TB and, generally IPs' health-seeking behaviour to formal health systems (i.e., RHUs and Hospitals). The enhanced SDIR can be facilitated (pilot-test) with one or two MLGUs that have predominantly IP population (i.e. Municipality of Lantapan, Impasug-ong). HG can provide TA in the enhancement of the SDIR process in partnership with CHD or NGO with a known expertise on IP health programs.

  <u>The TA that will be provided on this aspect is to promote culture-sensitive IP health interventions through IP-inspired SDIR</u> – This is a continuing process that eventually will lead to the development of a culture-sensitive health interventions. For year 2, HG hopes to start the ball rolling for the integration of IP health services to the overall Provincial Health system. The initial process could be through enhanced SDIR to assess existing IP health practices on FP, MCH, nutrition and health seeking behavior for curable illnesses.

By 2nd quarter of the year (or earlier if opportunity comes), HG shall initiate discussion with CHD and Provincial NGO partners on how best to approach mainstreaming improved health practices into the IPs' existing cultural practices. CHD and the provincial partners shall discuss if there is an existing internal capacity to address IP health needs. During such meeting, HG shall open the idea on whether the SDIR process can be enhanced to assess IP's traditional health practices. If a consensus is arrived to enhance and adopt SDIR, HG shall encourage forming of a technical team to formulate relevant assessment tools to be integrated into the SDIR. The tool should be designed in such manner that IPs can easily understand and generate accurate information and interpretation. A draft of the enhanced SDIR tool shall be pre-tested with selected tribal leaders and health practitioners for further development. By March or April, 2008, the tool will be piloted in selected Municipalities.

HG will orient CHD and Provincial partners on how to administer the improved SDIR process. By end of second quarter they should be able to generate information and analysis on how best to respond to IP's health needs and, identify potential interventions sensitive to culture and tradition of the IPs.

Initial assessment done by HG shows the potential IP-TA Areas, as follows:

- Further study on established scientific benefits on the use of various herbal medicines. Other practices which have proven beneficial effects can be facilitated for production, processing and marketing. of their indigenous medicines (with strong bias against bio-piracy)
- Development of balay hu bulong (village pharmacy) with emphasis on locally-developed medicines and herbs. This can be integrated into the "Botika ng Bayan" concept to be supervised by RHUs
- Development of tribal health centre that promotes hagud (indigenous massage and therapy) for minor pains, injuries, deformities and dislocations. It serves also as a venue for health education, sanitation and visits of government and non-government health workers in tandem with the local herbalist,
- Training for local hilots,baylan, mangongoyamo and mananawal basic external health practices.
- Program to replicate best practices to other IP communities. In the Municipality of Impasug-ong, the RHU initiated a program specifically for child delivery that caters to the cultural sensitivity of the IPs. The method is providing a simple shelter or lying-in for a pregnant IP mother to temporarily settle with her husband while waiting for her scheduled delivery. The practice shows significant turn-out of IP mothers seeking proper birth delivery and, opportunity for educating IP families on MCH.
- Formation and strengthening of the Tribal Health Committee to upscale health education, health system development and nutrition. This aspect can be raised for ILHZ's "common concerns" for planning
- Development of tribal herbal centres and farms. HG shall encourage CHD 10 and PHO to assess viability of a herbal centre in one of the Municipalities (Note: the Municipality of Lantapan reflected on their MIPH to showcase their LGU as the herbal centre of the Province.

4. Strengthening Provincial-NGO/PO partnerships for public health perspective

The main issue that would be addressed through a functional provincial partnership is the provision of a built-in mechanism for a continuing advocacy for improved Provincial health system. The perennial issues on short of funds for health; lack of manpower and staff development; impoverished health facilities; inaccessibility and inadequate supplies and medicines especially for FP, etc. would be hopefully eradicated by end of project life with the active participation and support of NGOs/POs and other private sector. With a continuing partnership planning and joint monitoring and evaluation process, constant information and lessons learned will be derived helpful for policy formulation; widening resource generation options; taking proactive and prompt response; and, most importantly complementation of expertise and resources for the common good of the locality.

By end of year 2, it is hope that the foundation for a functional partnership will be established and sustained.

By end of year 1 (Sep 2007), a provincial partnership with selected NGOs, POS and other private organizations shall have been established. The partnership will then be involved in the MIPH consolidation (2-3days meeting with PTMT) to PIPH within the first week of October 2007. It is expected that the partnership shall have defined the role and support of the NGO partners to PIPH implementation and promotion of a better health systems for the greater interest of the people of the province.

At the start of year 2 (October 2007), the Provincial partnership will assist the presentation of the PIPH to Provincial Health Board for adoption. It will be a major partnership activity that hopes to lay the foundation for a functional relationship for year 2 and beyond

Based on the adopted PIPH, by November 2007, the NGO convenor with the PTMT shall facilitate annual operation planning (AOP) workshop to concretely formulate plans and support systems for the operationalization of the PIPH. Before the workshop, HG shall orient NGO convenor and PTMT on the objectives of the planning workshop in the context of PIPH implementation and TA requirements as well as in the perspective of integrating advocacy mechanism and constituency building. The HG advocacy group with PNGOC shall develop a framework along this line and orient PTMT and NGO convenor in facilitating the workshop guided by the agreed framework.

Aside from identifying concrete support mechanisms for PIPH implementation, other potential areas for the partnership are: a) the institutionalization of the PIPH bringing-in community health perspective; b) advocacy strategies not irritating to LGUs, c) NGO expertise that can be further developed as a potential TA to the Provincial Government, d) participation on province-wide health activities; e) role on disease surveillance and referral system, etc). During the planning workshop, permanent NGO representatives shall be selected to represent the partnership into the ILHZ and PHO regular planning activities and appropriate levels of LGU decision-making process.

Once the partnership AOP is formulated, by Dec 2007, the plans shall be synchronized with ILHZ plans and PHO operational plans.

From January 2008 onwards, the NGO partnership shall be actively involved on provincial level health activities and campaigns. Along the way, built-in review of activities and accomplishments shall be undertaken during regular meetings of the PTMT and ILHZ to identify innovations of the plans and to further enhance the participation and role of NGO partnership.

Specifically, in the middle of year 2, the Provincial Partnership shall widen its linkage for a sector-wide approach to health. Various Provincial Line Agencies (i.e. DepEd, DSWD, Agriculture) will be invited in one of the Provincial Partnership meetings for a specific health concern or issues that can be best addressed with the participation of the concerned agency. The DepEd, for example can assist in improving nutritional levels of school-age children, the Seniour Citizens' Federation to assist on TB detection and, the College Student Associations can initiate education campaign on HIV/AIDS and STI. A broader participation of concerned sectors not only hastens implementation of health interventions at the community level but as well as laying the groundwork for a multi-sectoral approach to health.

TA to CHD, DILG, PHO, PHIC, POPCOM, CSO on mobilizing broad-based local action to support CSR, TB control, MCH and Micronutrient, PHIC universal coverage and facility accreditation, movement to transform red to green, through evidence-based participatory decision-making.

For Year two, EBPDM TAs will focus on:

5. Evidence-Based legislation for local legislative councils. For this CHD, DILG, PHIC, POPCOM will capitalize on one of the mandated functions of the provincial board which is to review legislations by the sangguniang bayan. It will be advocated to the provincial board that they will produce a resolution mandating the SBs to craft legislations based on evidence. To achieve this, an EBL training curriculum will be implemented under the auspices of the provincial board.

6. Evidence-Based Policy-Making for LCEs, MHOs, Barangay Captains and CSOs. For CHD, DILG, PHIC, POPCOM will link with the provincial chapter of the LMP.
7. Policy-tracking (both for # 1 and 2)
8. Packaging of HIS results for advocacy cum advocacy skills training

Mode of TA delivery:

For Evidence-Based Legislation and Evidence-Based Policy-Making

HG will hire TAP (either an organization or an individual). Qualifications should include vast knowledge in governance, actual experience in policy-making using evidence as basis, actual experience in facilitating EBL and EBPPM workshops and working knowledge on health systems especially health information systems. The TAP will be trained by HG governance team leader in coordination with the Mindanao team.

TAP will orient CHD, DILG, POPCOM, PHIC, NSO, NEDA and DBM on EBL/EBPPM with HG providing technical back-up.

Regional partners will develop action plan on how to implement EBL/EBPPM to the LGUs.

Regional partners will orient PLGU (Governor, vice governor, sangguniang panlalawigan, LMP/MLCEs, CSOs) on EBL principles, MDG status, health economics, LCE role in HSR with technical backup from TAP/HG. Actual data will be shown (may start with macro data like the status of MDG health indicators like MMR, FIC, TB, IMR)

Outputs will include

- Orientation on the basic concept of evidence-based participatory local decision making;
- Identification of health issues/problems/gaps that require an EB process;
- Mandate to do activities to provide data/ information/ facts like survey (CHLSS), review (SDIR) – "Mandate to generate evidence"

After the conduct of an evidence-generation activity, LGUs call for an analysis of the evidence. Preliminary technical analysis will be done by local partners (PHO/MHO, PPDO/MPDC, PBO/MPO and the like). The team will come up with technical analysis and recommendations.

The result will be forward to LGUs for further analysis. This could be done during LMP meetings, Sangguniang Bayan/Panlalawigan sessions, Health Committee meetings/hearings, LHB meetings, local development council meetings, ABC meetings and the like). This is the data utilization part. DILG will provide technical oversight on the process, while PHO/RHU/CHD provides technical content.

Part of the process is the championing of policy agenda by CSOs, NGOs, POs and other identified health champions in a given LGU.

What will follow is the crafting of ordinances, resolutions, executive orders and other pieces indicating official decisions by the LGUs at all levels. DILG provides technical oversight in the whole process with technical backup from PHO, PPDO, RHUs, CHD and PHIC.

Outputs will include:

- Policies, decisions legislations (Ordinances, resolutions, executive orders, memoranda, letters, etc.)
    1. Supporting specific programs/actions
    2. Solving particular health issue, gap or problem

Component TA
Policy tracking and analysis
This is to examine whether or not desired changes are achieved.

Production partners

b. Regional partners (DILG, CHD, POPCOM, PHIC)
c. Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative)

Mode of delivery to partners
(Same as EBL/EBPPM)

Mode of delivery to LGU partners

Same as EBL/EBPPM, except the creation of a legislative tacking committee per municipality by an official LGU enactment. The steps also are different but the mode of delivery by partners remains substantially the same.

Component TA
Packaging of HIS results for advocacy cum advocacy skills training

Production partners

1. Regional partners (DILG, CHD, POPCOM, PHIC)
2. Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative, MHO representative)
3. TAP

Mode of delivery to partners

a. Conduct of workshop by TAP to regional, provincial and municipal partners to design customized advocacy materials using issue-specific topics as content (SDIR red to green, CSR-related issues, universal coverage and facility accreditation)
b. TAP facilitate the development of audience-specific advocacy tips. This will include inputs on and return demonstration of advocacy skills

Mode of delivery to LGus by partners

i. Trained regional, provincial and municipal partners provide one-on-one coaching and mentoring to health workers and local partners in developing customized advocacy materials and steps
ii. Trained regional, provincial and municipal partners provide technical backup (e.g. post-event mentoring and coaching)

THE ZAMBOANGA PENINSULA
TECHNICAL ASSISTANCE PLAN

I Background

There are three provinces in the Peninsula. The provinces are all F1 rollout site and are already well ahead in terms of preparing the PIPH. Activities conducted to date include orientation of the LGUs where the mandate to plan was given both by the provincial governor and mayors, data gathering, service delivery implementation review (all programs), ILHZ level municipal and inter-local investment planning for health (formulation of goals and critical interventions), costing/financing the interventions and resource mobilization.

HealthGov provided technical assistance to CHD 9 in developing guidelines, tools and templates in MIPH and ILHZ planning for Health. Equipped with these instruments, CHD 9 becomes the TA provider to the three provinces on the investment planning for health development.

Subsequent TAs to the municipalities and ILHZ were conducted by the provincial and sub-provincial team of facilitators which were organized and supervised by the PHO after CHD 9 equipped them with the instruments on PIPH.

Remaining tasks include consolidation of plans including the provincial level plan, hospital rationalization plan, annual operational plan and the mandate to implement. It is expected that the first draft will be submitted on October, while the final version will be submitted before end of 2007.

II. Situational Analysis

HealthGov provided technical assistance to CHD 9 in developing tools for situational analysis following HSR/F1 principles, particularly the SDIR and the health sector frame.

This enabled the LGUs to examine very closely their own health situation critically and strategically using more comprehensive instruments.

Below is the summary of the analysis of the health situation in the three provinces (with specific focus on FP, TB, MCH and micronutrients) done by the LGUs themselves using the health sector frame:

Service Delivery

- Good practices not sustained by providers
- Lack of IEC to community stakeholders coupled with problems on accessibility and geographical terrains, cultural barriers,
- Community and other stakeholders not involved
- Program implementation review not systematically done, discontinued in other municipalities
- Inadequate supplies, medicines, vehicles, equipment, health personnel (either lack of taker or LGU budget), support (TEV, mobility, salary, incentives), training (especially for newly-hired) and supervision
- Problem on how to identify the poor
- Problem on provider of NSV and BTL
- HIS not utilized, M & E by PHO and CHD not fully functional
- Problems on delayed arrival of medicines and poor cold chain management

- Regulations
- Very few legislative support
- No local legislation to address problems on hilot delivery
- Birthing home licensing problems
- No facility is TB-DOTS accredited, only 6/26 OPB accredited and only 3/36 are MCP accredited
- ECCD not fully implemented, no protocol on maternal care
- No local EPI policies

- Health Care Financing
- LGUs are IRA dependent
- Lack of budget on medicines, supplies, logistics, TEVs, equipment, facility and skills upgrading and personnel incentives
- PHIC enrollment (with capitation) very low

- Governance
- Stakeholders Participation is wanting
- LGUs do not support PIRs, MDR (stopped already), LHB/ILHZ meetings and other health activities, lack of political will to implement FP, church pressure
- Health data/information not utilized for governance
- No working M & E systems (CHD, PHO, RHU)
- Provincial CSR policy guidelines already approved but budget not yet released
- Many municipalities have no budget for FP commodities
- Procurement and
- Delays in procurement and distribution, high cost of medicines
- Proposed ILHZ level LGU sharing; Inter-LGU monitoring on EPI and inter-LGU surveillance not fully implemented

These analyses became the bases of the LGUs in formulating their goals, strategic interventions and PPAs in their respective investment plans for health.

There are also a lot of systems-related issues and challenges observed by HealthGov. Below are some highlights:

- The number of LGUs that increased budget for Health (both for PS and MOOE) is declining. Aside from the conventional reasoning like lack of funds, the current health planning system contributed a lot to this. Budget are just recycled and there is no systematic way of identifying priority and strategic areas for health investments, exploring alternative means of financing and sourcing out for funds and rationalizing internal LGU resources.
    1. Most of the CSR plans were not implemented since CSR strategy did not gain local level support. The lack of a province-wide strategy and push from CHD and PHO contributed to this.
    2. After devolution, no training program for continuing capacity building is done by LGUs for the “old” personnel and no program for capacity development for newly hired ones.
    3. There are three established ILHZs but there are is significant inter-LGU cooperation undertaking. Resource sharing in personnel, material, financial resource sharing is not yet established. These are all indicative of the lack of political buy-in and leadership.

4. The HIS is saddled with gaps and doubts. Issues on accuracy, under-reporting, delay and most especially utilization by the LCEs, LHB and Sangguniang Bayan for decision, action and legislation.
5. Ordinances, resolutions and executive orders for health are generally wanting and reactive. AI/SARs (whose threats are more imagined than real) got the most number of passed and implemented pieces. There are a number of implemented pieces for the past 6 years but there is no system on policy tracking.
6. The procurement and distributions systems are also problematic. One of the oft-repeated concerns is the delay. Procurement is also done per health program.
7. The potential of the leagues (e.g. LMP, PCL) as a powerful collegial body to champion public health is not yet recognized much more harnessed.
8. CSO and community participation in decision-making is not felt at all levels. In the province for example, the content and the processes by which pieces of legislations are identified and developed clearly manifest of the lack of community perspective. There are CSO representatives (the province has just chosen a new one under the auspices of the Local Development Council) in the local special bodies, but whether or not they (CSO representatives) have done constituency and consensus process among themselves and with the community in general is not determined.
9. Other systems which supposedly will establish or reinforce an integrated province-wide health systems are either absent or weak (e.g. M & E, HMIS)

IV. Proposed Strategic Direction and TA Interventions

Apart from the analyses and observations reflected above, there are other factors, conditions and contexts that need to be considered in formulating strategic and tactical TA interventions. These include:

- Anticipation of the availability of financial and technical resources from other donors that will complement the technical assistance provided by HealthGov. As gleaned from the experiences of F1 convergence sites and based on the criteria set by DOH, most of the F1 interventions are directed towards health service delivery. There is therefore the challenge to assist LGUs integrate health service delivery input requirements with the core attributes of CSR.
- The surge of both the resources and activities has implications on the priorities and attention by the LGU. There is therefore a need to position early on the strategic interest of SOAG. For this to be seen positively, HG should identify TAs that will lay the strong foundation which later interventions can be built on. Being a systems project, HG can demonstrate that its TAs are strategic and beneficial to all. For example, universal coverage can increase LGU finance base to support more health program activities, evidence-based governance can pave the way robust LGU support to service delivery and CHLSS will result to a more focused and pro-poor approaches. Already, HG has started this by assisting LGUs develop investment plans for Health.
- Focus of intervention based on the lessons from F1 convergence sites is CSR.
- Readiness of the LGU considering the political personages and alignments, presence of champions and strength of LMPs.

- Readiness of CHD and other regional government agencies (DILG, POPCOM, PHIC) and CSOs.

Year 2 technical assistance areas will concentrate on the following:

5. Completion and finalization of the investment plans for health to include the integration of LCR core attributes to the PPAs and the subsequent formulation of monitoring and evaluation design to track local progress in PIPH implementation. Technical assistance will include:
   5.1 Provincial Planning
   5.2 Technical review of the investment plans
   5.3 Consolidation into PIPH
6. Laying the foundation for the institutionalization of CSR. TA include:
   6.1 CSR monitoring tool
   6.2 CSR planning
   6.3 Community Health Living Standard Survey
7. Increasing LGU Financing for Quality Service throughUniversal PHIC coverage
   7.1 Technical Guidelines for Planning and Implementing Universal PHIC coverage
   7.2 TA on PHIC accreditation on OPB, TB-DOTS and MCP

8. TA to CHD, PHO and CSO on mobilizing of broad-based local action to support CSR, TB control, MCH and Micronutrient, PHIC universal coverage and facility accreditation and movement/alliance to transform red to green, through evidence-based participatory decision-making.

ZAMBOANGA DEL SUR

I. Background

The province of Zamboanga del Sur was created in September 17, 1952 through the passage of R.A. No. 711. It was further subdivided into 2 provinces in February 28, 2001 through R.A. No. 8973. It has a total land area of 473,491 hectares. The province is composed of 26 municipalities and 1 component city (Pagadian City) and 687 barangays composing 2 congressional districts. Of the 27 LGUs, 15 municipalities and the component city are located along the coast line. It has 4 bays, Panguil, Illana, Dumanquillas and Maligay. The major rivers traversing the province are Salug Daku, Sibuguey and Labangan. It also has 3 lakes ranging from 20 has. to 722 has. in size and these are Maragang, Tigbao, Dasay, San Miguel and Lakewood, Lakewood

The province has an estimated population of 724,162 in 2006. It accounts for 22.51% of the total population of the Zamboanga Peninsula. There are 140,070 households with an average family size of 5.21.

Of the 26 municipalities, only four (Aurora, Dumalinao, Dumingag, Mahayag and Molave) are classified as belonging to 1^{st}-3^{rd} class municipalities. All the rest belongs to 4^{th} – 6^{th} municipalities.

For 2006, it has a Crude Birth Rate of 20/1,000 population which approximates the regional CBR of 20.18/1,000 population. The Crude Death Rate is 2.74/1,000 population which is lower than the regional Crude Death Rate of 3.31/1,000 population.

The province is an F1 rollout site and is already well ahead in terms of preparing the PIPH. Activities conducted to date include orientation of the LGUs where the mandate to plan was given both by the provincial governor and mayors, data gathering, service delivery implementation review (all programs), ILHZ level municipal and inter-local investment planning for health (formulation of goals and critical interventions), costing/financing the interventions and resource mobilization.

Remaining tasks include consolidation of plans including the provincial level plan, hospital rationalization plan, annual operational plan and the mandate to implement. It is expected that the first draft will be submitted on October, while the final version will be submitted before end of 2007.

II. Health Situation

Zamboanga del Sur's 2006 MMR of 96.96/100,000 live births is higher than that of the regional MMR of 73.60/100,000 live births.

Infant mortality rate (IMR) and under-five mortality rate (UFMR) are 7.25/1,000 LB and 10.70/1,000 LB respectively. The Zamboanga del Sur figures are lower than the regional figures.

The goal of the province is to reduce maternal deaths from 13 deaths to zero-death or reduce by half by 2012.

Part of the province's thrust is to intensify disease prevention and control for TB and vaccine preventable diseases. It also sets the target of 95% FIC.

The CPR of the province stands at 52.13%. The figure on the current users for pills (which stand at 41% in 2005) is being overshadowed by the current acceptors of LAM at 65% (previously 12%). These figures however, need to be validated.

The program performance/coverage indicators are also very low. For example, children given Vitamin A is only 60.29% (target is 26,620 vs. Actual 16,050). There is system in recording and reporting sick children given Vit. A.

Accomplishment for fully immunized children is 86.74%.

There is also high incidence of Diarrhea. The disturbing figure is on children. FHSIS shows that only 15% of children under five years of age with diarrhea given are given Oral Rehydration Solution (ORS). There is no data that show whether or not children are given other means of oral rehydration therapy.

MCH indicators are also very low as indicated by the following examples:

- Pregnant women with at least 3 antenatal visits attended by skilled attendants – 68%.
- Pregnant women had at least 2 doses of tetanus toxoid immunization – 63%
- Pregnant women that have taken complete dose of iron supplementation – at least 6 months (reported after the 180 tablets) – 47%
- Lactating Mothers given Vitamin A within 1 month after delivery – 61%
- Pospartum Women given complete iron dosage 60 tablets – 47%

Facilities and Providers

There are only 163 BHS serving 627 barangays, with only 159 midwives. There are 7 government hospitals and 6 private hospitals (located mainly in Pagadian City). All municipalities have RHUs/MHCs.

Only 11 out of 26 RHUs are SS certified.

However there are five municipalities without doctors – Josefina and R. Magsaysay (J-SMART ILHZ), Dimataling (Dumanguilla ILHZ), Labangan and San Pablo (Illana ILHZ).

There are also six (6) RHUs without Medical technologies (Josefina, Sominot, Pitogo, Tabina, Dumingag and Lakewood. Both the municipalities of Tigbao and Dumalinao have no nurse and dentist.

On the average, there are 4-5 BHWs in every barangay. There are also many trained birth attendants in the province numbering to 891.

More than 50% of the deliveries are attended to by hilots (trained – 6,469 and untrained - 662) and others (not determined) - 116. The rest are attended to by trained professionals (doctors – 870, nurses – 571, midwife 5,795).

The TB case detection rate is 74.6%, TB cure rate is 87.3%, while the success rate stands at 90%.

PHIC Coverage and Accreditation:

A total of 65,526 families are enrolled under the GMA 2.5M Plan. This accounts for almost half of the households in the province. On the other hand a total 24,864 HHs (17%) are enrolled by

21,727 HH, while the provincial LGU covered only 3,137 HH.

Only 9 out of 26 RHUs are accredited for OPB, 3 for MCP and 0 for TB-DOTS.

III. TA Plans

Completion and finalization of the Investment Plans for Health

1. Planning for Province-Wide Systems

   This TA package is designed to help the provincial LGU (1) Identify province-wide systems that will support the implementation of municipal and inter-local investment plans; (1) Identify inputs that ILHZ and MLGUs require from the province in terms of logistics, technical support and policy support; (3) set the direction of an integrated health system. Towards this end, the province will establish province-wide targets both in health outcomes and program performance/ coverage; and (4) develop operational plan to implement the above items.

   Since this type of TA is not fully developed yet, HealthGov will provide TA to CHD F1 team in designing planning guidelines and templates with CHD F1 team. This is done through a one-day technical meeting with the team.

   Equipped with the planning guidelines and templates, the CHD will take the lead role in the delivery of the TA tools developed to partner LGUs. CHD will orient PHO and provincial team (DILG, PPDO, PSWD, PBO, SP on Health, CSO, provincial accountant, provincial treasurer, representative of the governor and vice governor, provincial and district hospital chiefs) on the planning guidelines and templates. At the end of the session, an action plan will be made indicating steps on how and when to conduct a workshop.

   In line with this, PHO will facilitate a two-day workshop with the provincial team, ILHZ representatives, hospital representatives and MHOs with technical guidance from CHD. The participants will review existing systems as to functionality and utilization. They will also determine which systems need to be strengthened and/or need to be developed (if not yet existing) and what additional investments are needed at what level of governance.

   Expected outputs will include an agreed plan outlining the province-wide support systems, input requirements (logistics, financial, technical, policy) to support ILHZ and municipal plans, targets on outcomes and program performance and the PPAs, tasks, person responsible, timeframe and budget

   The plan will be presented as an integral part of the PIPH. It is expected that the first draft of PIPH will be submitted to DOH on or before October 15, 2007. However, it is also expected that there will be revisions. HealthGov will continually provide on-call technical assistance to the LGUs through CHD in the finalization of the PIPH including the provincial plan.

2. Technical Review of the investment plans for health

   This entails the following activities:

   - Review MIPH, ILHZ, and Provincial Plans based on agreed parameters (e.g. consistency with the structures of the plan, clarity of goals and targets, rational organization of the plan).

investment inputs (between provincial targets & targets of the MLGUs).

- Ensuring that municipal and ILHZ plans contain cross-cutting concerns (e.g. PHIC, financing, HIS, M & E, referral system, human resource development and the like)

Although these activities are very essential, these are not clearly laid out in the standard steps outlined in the PIPH guidelines. There is a need therefore for HealthGov to provide TA to CHD for the latter to be able to provide assistance to LGUs.

As a first step, HealthGov will facilitate a technical meeting the CHD (RD, ARD and regional F1 team) to formulate technical review parameters, review guidelines and processes, and templates. This could be done through a one-day technical meeting.

Then CHD will orient PHO, provincial and sub-provincial facilitators on the review parameters, guidelines, processes and templates. An action plan will be drawn out indicating the tasks, person responsible, time frame and resources required.

The PHO through the Provincial and sub-provincial teams will now spearhead in facilitating the technical review (ILHZ as venue) with technical guidance from CHD. This will be done by first gathering the municipal health planners (MHO, PHN, PPDO) in each of the ILHZ and then orienting them on the review parameters, guidelines, processes and templates. The municipal planners will be made to develop an action plan in each of the municipality which will indicate the tasks, persons/agency responsible and time frame and deadline for submission.

The provincial and sub-provincial technical teams will oversee the review and finalization of the plans by the respective MLGUs and ILHZs. This includes doing one on one discussion, mentoring and coaching to the municipal health planners.

One of the crucial steps in this process is the negotiations between PHO and RHUs in terms of setting province-wide targets, the amount of efforts needed to meet targets and the investment needed both from the province and municipal LGUs.

CHD will take particular responsibility in doing the technical review of the provincial plan. CHD will also provide continuing technical assistance in the consolidation of the different plans (MIPH, ILHZ PH and provincial plans) into a PIPH.

This process will lead to having final plans for submission to DOH (for F1 review) and to each of the LGU for adoption and integration into their annual investments plans.

However, it is expected that there will be revisions in the plans. HealthGov will therefore continually provide on-call technical assistance to the LGUs through CHD in the finalization of the PIPH which may last until end of December 2007. HealthGov will also conduct frequent visits to the CHD and to some of the LGUs to see how things are being implemented and will provide technical recommendations to the CHD and to the LGUs.

In the conduct of the processes above, the integration and/or inclusion in the PPAs should be ensured by HealthGov through CHD.

- Core Attribute: Improved access to all other FP methods
- PPAs:
  - Upgrading of hospital capabilities (facilities, staff training and equipment)
  - Referral system
  - Establish public and private network of providers
  - Monitoring of informed choice and voluntarism

- Core Attribute: LGU-provided safety net of free contraceptives:
  - PPA – Conduct of CHLSS as client segmentation tool

HealthGov through CHD will also ensure that PPAs will address the health service delivery gaps in TB, MCH and micronutrients. These include, but not limited to, facility upgrading for OPB, MCP and TB-DOTS accreditation, staff training on program-specific competencies, availability of supplies, equipment, providers training, mobilization of health workers to address program-specific gaps, BEMOC, CEMOC, etc.

3. Monitoring and Evaluation tool to track progress in the PIPH implementation
   This includes data collection and assessment methodology, impact analysis, etc.

   HealthGov has already conducted an initial meeting with CHD and this type of TA was identified as a need. This TA needs to be developed with the CHD with HealthGov providing technical assistance.

   Mode of TA delivery
   A two-day participatory tool development workshop will be organized by CHD to be participated in by provincial by a small group of LGU partners (PHO and one member of the local finance committee), ILHZ representative, RHU representative and CSO/NGO representatives. The output is an M & E plan and tools including indicators, process of collection, assessment methodologies, persons and/or agencies responsible, frequency and manner of collection, utilization and the like.

   PHO will facilitate a province-wide orientation (with the technical support from CHD and HealthGov) on the M & E tool to provincial and municipal level partners. This will also serve as the venue to critique and finalize the tool. The output is a final M & E tool with implementation guidelines. This activity will be done on January after the PIPH processes are accomplished and the plans approved at the LGU level.

   The provincial LGU will provide the necessary enabling law (either the governor will issue an executive order mandating all LGUs to implement the tool and/or the provincial board passing a resolution to this effect) through the EBL process (another related TA).

   CHD with the technical support of HealthGov will continually monitor the implementation of the monitoring tool.

   This will lead to a legislated M & E tool which will be implemented province-wide. Results of the M & E will also be feedback to various LGU mechanisms (LHB, SB/SP, ABC, LMP, PCL, LDCs) through a policy-tracking system (another related TA).

the monitoring tool through field visits. HealthGov will provide technical recommendations to CHD based on the results of field visits.

Laying the foundation for the institutionalization of CSR

1. CSR Assessment and Monitoring Tool (consistent with new AO on CSR)

Exercising its lead role among CAs on CSR, HealthGov had initiated a TA plan to CHD 10 in enhancing its CSR monitoring tool.

This tool will be utilized in Zamboanga Peninsula for year 2 as part of the laying the foundation for the institutionalization of CSR.

Mode of TA delivery

To jumpstart the process, HealthGov will initiate a meeting with PRISM and HealthPro to plan how the CSR monitoring tool will be implemented in the Zamboanga Peninsula through CHD. This will come after Central DOH or the DOH-CSR TWG has given the signal to implement the CSR tool developed in region 10.

DOH and CAs will orient CHD, POPCOM and PHIC (especially the regional CSR TWG) on the tool and the implementing guidelines. CHD will make an action plan on how to implement the tool.

CHD, POPCOM and PHIC through the regional CSR TWG will conduct a one-day orient to PHO, PHTL , DOH Representatives.

PHO will organize a one day CSR monitoring tool orientation and action planning for the conduct of province-wide monitoring. This will be participated in by all MHOs, PHNs and DOH representatives.

PHO, PHT, DOH representatives and MHOs conduct province-wide monitoring from January to March.

By end of March, MHOs and DOH representatives will present results to the respective municipal LGUs (LCEs, SP, LHB). The expected output is the mandate to do CSR planning is given by the municipal LGUs. There are problem areas however, where LGUs will provide instantaneous interventions based on the monitoring results.

Likewise, PHO will consolidate province-wide results and present them to PLGU (Governor, SP, LHB). It is expected that PLGU will give the mandate to do CSR planning.

CHD will consolidate regiona-wide results and submit to DOH central and HealthGov and PRISM.

2. CSR planning

The next step in the sequence of CSR activities is the CSR planning. The CSR monitoring results will be used as inputs to the plans. This will be started by April 2008 and will end mid- June 2008 just in time for the first budget call. There will be period of revisions and negotiations between and among LGUs in the ILHZ and between PLGU and MLGUs.

Final CSR plans with corresponding budget will start to be implemented on the last quarter of 2008. Since forecasting of actual FP logistics needs of an LGU population depends on determination of households eligible for LGU subsidy, the results of the CHLSS (another related TA) will be utilized. This means that the results of the survey should be made available during the budgeting period (from June to October 2008).

Mode of TA delivery
Central DOH, HealthGov, PRISM and HealthPro will orient the CHD, POPCOM and PHIC (RD, ARD, LHAD and the regional CSR TWG) and the PHO on the CSR planning tool. CHD will mobilize the regional CSR TWG to lead the CSR planning processes as facilitators together with the PHO. PHO will select from among the technical staff for training (e.g. FP coordinator).

HG and PRISM will train regional CSR TWG and PHO technical staff as facilitators on CSR planning. Training will include basic skills in facilitating.

Regional CSR TWG and PHO technical staff will formulate action plan and set schedule with the province for the conduct of CSR planning in each of the three (3) ILHZs.

Regional CSR TWG and PHO will facilitate CSR planning at the ILHZs. LCEs will be invited during the opening program where CSR orientation will be conducted. The municipal participants/planning team will be composed of the MHO, PHN, LFC, SB on Health and SB on Budget and Appropriation.

PHO technical staff and DOH reps provide coaching and mentoring to MLGUs in the refinement and finalization of the CSR plans with technical back-up from CHD and HG. HG and CHD will do field visits. Both will provide technical recommendations to the LGUs.

CHD and PHO will provide technical assistance in the refinement and finalization of the provincial CSR plan through the facilitators. There will be regular technical meetings that will be organized by the CHD to assess the progress, provide technical advises and provide logistics support.

PHO will lead in the negotiations with MLGU on the forecasting, cost sharing for logistics procurement, identification of private providers and suppliers (with technical assistance from PRISM) and the kind and level of effort needed to implement CSR province-wide.

PHO and RHUs will present the final version of the plan to their respective LGUs (provincial and municipal).

This will lead to the inclusion of the plans in the 2009 AIP (or inclusion in the 2008 supplemental budget), identification of enabling laws identified and scheduling for deliberations, mandate to implement and official pronouncement that CSR plans will be integrated in the PIPH.

3. A **monitoring and evaluation tool to track progress of CSR implementation** will also be designed and **be integrated into the PIPH M & E tool.**

This could be done through the following steps:

- HealthGov to facilitate designing of monitoring and evaluation design and tools with CSR TWG. This will also include the designing of feedback system to LGUs and LGU organizations on results of monitoring
- CSR TWG to orient PHO and provincial team on the M & E design and tools

- CSR M & E will be integrated to the PIPH M & E by the PHO. This will be done through a one-day consultative workshop to be participated in by MHOs, PHNs, LFC representative, CSO and DOH representatives
- PHO and PHT to conduct regular monitoring of the progress of CSR implementation as part of the PIPH M & E.
- PHO to establish feedback system to LGUs (LCE, LHB, LMP, PCL, ABC) with technical back-up from CHD and HealthGov. The establishment of the feedback system will be supported by EBL (another related TA)

4. Community Health and Living Standards Survey

The survey preparations will be started as early as December 2007. This will allow enough time for the conduct of the survey and the consolidation of the survey results. Results will be used as inputs to the CSR plans and to the program on universal indigency enrollment.

Survey will start on the second week of January and will be finished by end of March. Consolidation and validation will be done from April to June. Analysis and utilization of results will be made starting June until August to coincide with the budgeting period.

Mode of TA delivery

- HealthGov will engage the services of a TAP (probably RIMCU of Xavier University and/or Misamis University). HealthGov will train core team from TAP.
- TAP will orient LGUs, form technical team
- LGU-formed technical teams will be trained by TAPs
- Technical team train barangay level enumerators (preferably BHWs)
- Technical team provides technical supervision over enumerators; oversees validation, consolidation, finalization and submission and utilization of data
- TAP to continually provide technical assistance over the whole duration of the conduct CHLSS through mentoring and coaching
- Consolidated Survey results as inputs CSR planning, PHIC coverage and provision of services on TB, FP, MCH and micronutrients

CHLSS is also a health service delivery action tool that will generate information on unmet needs for family planning, TB-DOTS and MCH. Any information will be directly provided to the service provider (e.g RHM) by the enumerator while conducting the survey. It is expected that services will be given by health workers while the survey is ongoing.

<u>Increasing LGU Financing For Health through Universal Coverage</u>

Technical Assistance will include:

1. **Technical Guidelines for Planning and Implementing Universal PHIC coverage**
2. **Technical support to the implementation**

Initial technical assistance has already been done by HealthGov regarding this. Technical meetings were conducted among HG, CHD, PHIC and PHO where the concept and some technical guidelines were discussed.

Mode of TA Delivery

PHIC and CHD will organize a technical meeting among provincial stakeholders (Governor, PHO, LMP president, vice governor, local finance committee, CSOs) with HealthGov providing technical assistance.

PHO will take the lead in developing technical proposal on universal PHIC coverage with the technical assistance from CHD, PHIC and HealhGov. It will also take the lead role in developing advocacy plan for municipal LCEs/LGUs with technical support from CHD, PHIC and HealthGov.

The provincial stakeholders will implement the advocacy plan at the level of the municipal LGUs, congressional representatives, ABC, PCL, local finance committee, civic organizations and the like. The advocacy will revolve around the proposal formulated by the provincial stakeholders on universal coverage. The proposal will contain projection of households by PHIC program groups, estimation of premium subsidies, estimation of reimbursements (TB-DOTS and MCP) and capitation payments, estimation of investment requirements for accreditation and expansion of IPP enrollment, options for ensuring use of PHIC revenues for health at hospital and RHU level.

The provincial stakeholders will spearhead the negotiations with the mayors, congressional representatives, barangay captains, civic organization, NGOs/CSOs on the cost-sharing scheme with HG, PHIC, CHD providing technical and advocacy technical assistance.

The provincial stakeholders will also oversee the approval and implementation of the proposal. Activities may include, but not limited to, upgrading of facilities, training of personnel, payment of premium, accreditation of facilities (for OPB, TB-DOTS, MCP), identification of eligible households for government subsidy through CHLSS (another related TA), legitimization of CHLSS results through an EBL process (another related TA) and distribution of PHIC cards.

It is expected that by the end of September 2008, card distribution to indigent beneficiaries will already commence. It is also expected that 21 (baseline 9) out of 26 RHUs will be OPB accredited.

3. TA to CHD, DILG, PHO, PHIC, POPCOM, CSO on mobilizing broad-based local action to support CSR, TB control, MCH and Micronutrient, PHIC universal coverage and facility accreditation, movement to transform red to green, through evidence-based participatory decision-making

    For Year two, EBPDM TAs will focus on:

    9. Evidence-Based legislation for local legislative councils. For this CHD, DILG, PHIC, POPCOM will capitalize on one of the mandated functions of the provincial board which is to review legislations by the sangguniang bayan. It will be advocated to the provincial board that they will produce a resolution mandating the SBs to craft legislations based on evidence. To achieve this, an EBL training curriculum will be implemented under the auspices of the provincial board.

    10. Evidence-Based Policy-Making for LCEs, MHOs, Barangay Captains and CSOs. For CHD, DILG, PHIC, POPCOM will link with the provincial chapter of the LMP.
    11. Policy-tracking (both for # 1 and 2)
    12. Packaging of HIS results for advocacy cum advocacy skills training

Mode of TA delivery:
For Evidence-Based Legislation and Evidence-Based Policy-Making

HG will hire TAP (either an organization or an individual). Qualifications should include vast knowledge in governance, actual experience in policy-making using evidence as basis, actual experience in facilitating EBL and EBPPM workshops and working knowledge on health systems

especially health information systems. The TAP will be trained by HG governance team leader in coordination with the Mindanao team.

TAP will orient CHD, DILG, POPCOM, PHIC, NSO, NEDA and DBM on EBL/EBPPM with HG providing technical back-up.

Regional partners will develop action plan on how to implement EBL/EBPPM to the LGUs.

Regional partners will orient PLGU (Governor, vice governor, sangguniang panlalawigan, LMP/MLCEs, CSOs) on EBL principles, MDG status, health economics, LCE role in HSR with technical backup from TAP/HG. Actual data will be shown (may start with macro data like the status of MDG health indicators like MMR, FIC, TB, IMR)

Outputs will include

- Orientation on the basic concept of evidence-based participatory local decision making;
- Identification of health issues/problems/gaps that require an EB process;
- Mandate to do activities to provide data/ information/ facts like survey (CHLSS), review (SDIR) – "Mandate to generate evidence"

After the conduct of an evidence-generation activity, LGUs call for an analysis of the evidence. Preliminary technical analysis will be done by local partners (PHO/MHO, PPDO/MPDC, PBO/MPO and the like). The team will come up with technical analysis and recommendations.

The result will be forward to LGUs for further analysis. This could be done during LMP meetings, Sangguniang Bayan/Panlalawigan sessions, Health Committee meetings/hearings, LHB meetings, local development council meetings, ABC meetings and the like). This is the data utilization part. DILG will provide technical oversight on the process, while PHO/RHU/CHD provides technical content.

Part of the process is the championing of policy agenda by CSOs, NGOs, POs and other identified health champions in a given LGU.

What will follow is the crafting of ordinances, resolutions, executive orders and other pieces indicating official decisions by the LGUs at all levels. DILG provides technical oversight in the whole process with technical backup from PHO, PPDO, RHUs, CHD and PHIC.

Outputs will include:

- Policies, decisions legislations (Ordinances, resolutions, executive orders, memoranda, letters, etc.)
    1. Supporting specific programs/actions
    2. Solving particular health issue, gap or problem

Component TA
Policy tracking and analysis
This is to examine whether or not desired changes are achieved.

Production partners

d. Regional partners (DILG, CHD, POPCOM, PHIC)
e. Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative)

Mode of delivery to partners
(Same as EBL/EBPPM)

Mode of delivery to LGU partners

Same as EBL/EBPPM, except the creation of a legislative tacking committee per municipality by an official LGU enactment. The steps also are different but the mode of delivery by partners remains substantially the same.

Component TA
Packaging of HIS results for advocacy cum advocacy skills training

Production partners

1. Regional partners (DILG, CHD, POPCOM, PHIC)
2. Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative, MHO representative)
3. TAP

Mode of delivery to partners

c. Conduct of workshop by TAP to regional, provincial and municipal partners to design customized advocacy materials using issue-specific topics as content (SDIR red to green, CSR-related issues, universal coverage and facility accreditation)
d. TAP facilitate the development of audience-specific advocacy tips. This will include inputs on and return demonstration of advocacy skills

Mode of delivery to LGus by partners

i. Trained regional, provincial and municipal partners provide one-on-one coaching and mentoring to health workers and local partners in developing customized advocacy materials and steps
ii. Trained regional, provincial and municipal partners provide technical backup (e.g. post-event mentoring and coaching)

ZAMBOANGA SIBUGAY

I BACKGROUND

Capital: Ipil
Founded: February 22, 2001
Estimated Population:
2006— 556,744 (29th smallest)
Area: 3,087.9 km² (44th largest)
Divisions:
Highly urbanized cities—0
Component cities—0
Municipalities—16
Barangays—388
Congressional districts—1
Languages: Cebuano, Chavacano, Spanish and English

Geography

Zamboanga Sibugay has an approximate total land area of 3228.3 km² accounting for about 37.82% of the mother province of Zamboanga del Sur. It is geographically located at 123o 04' 49.75" longitude and at 7o 42' 14.89" latitude. To the north it intersects the common municipal boundaries of Kalawit, Tampilisan, and Godad in Zamboanga del Norte. In the west, it is bounded by the municipalities of Siraway, Siocon, and Balinguian, and the province of Zamboanga del Norte. On the south it is bounded by Sibuguey Bay. In the east, the municipalities of Bayog and Kumalarang both in the province of Zamboanga del Sur bound it. It is further bounded on the southwest by Zamboanga City.

Political

Zamboanga Sibugay is subdivided into 16 municipalities.

- Alicia
- Buug
- Diplahan
- Imelda
- Ipil
- Kabasalan
- Mabuhay
- Malangas
- Naga
- Olutanga
- Payao
- Roseller Lim
- Siay
- Talusan
- Titay
- Tungawan

These municipalities are further subdivided into 389 barangays. The province comprises a single congressional district.

Physical

Zamboanga Sibugay has a land area of 3,087.9 km². It is geographically located at 123°04'49"N and 7°42'14"E. It is bounded on the north and west by Zamboanga del Norte; on the east by Zamboanga del Sur; on the south by the Sibuguey Bay; and on the southwest by Zamboanga City.

The climatic condition of the province is moderately normal (climate type III). Annual rainfall varies from 1,599 mm to 3,500 mm. Temperature is relatively warm and constant throughout the year ranging from 22o C to 35o C. The province is situated outside the country's typhoon belt.

History

The area of Zamboanga Sibugay was formerly a part of Zamboanga del Sur. Attempts to divide Zamboanga del Sur into separate provinces date as far back as the 1960s. Several bills were filed in congress, but remained unacted. The new province was finally created by Republic Act No. 8973 on February 22, 2001.

II HEALTH SITUATION

Vital Statistics:

B. Demographic Information:
- Population - 556,744
- No. of barangays - 389
- No. of BHS - 110
- No. of HH - 92,791
- Ave. HH members -
- No. of RHUs/MHC - 16
- No. of hospitals
    - Government - 4
    - Private - 11

C. Health Workers:
- Doctor - 16
- Nurse - 24
- Midwife - 0(?)
- Dentist -9
- Nutritionist - 0
- Medical Technologist - 12
- Sanitation Inspector - 17
- Sanitation Engineer - 0
- Active BHW - 1114
- Dental AIDE - 4
- Trained birth attendants - 546

D. Natality:
- No. of LB - 10,500
    - Male - 5,400
    - Female - 5,100
- Birth weight
    - >2500 gms - 9817
    - <2500 gms - 471
    - Unknown - 212
- Deliveries attended
    - Doctor - 648
    - Nurse -137
    - Midwife - 4,329
    - Hilots
        - Trained - 4529
        - Untrained - 833
    - Others - 24

The 2006 estimated population of Zamboanga Sibugay is 556,744 which accounts for approximately 18% of the total estimated population of the region. Zamboanga Sibugay has a crude birth rate (CBR) and crude death rate (CDR) of 18.86/1,000 population and 20.18/1,000 population respectively. Both are lower than the regional CBR of 20.18/1,000 population and CDR of 3.31 population.

The 2006 provincial maternal mortality rate of 57.14/100,000 live births (LB) is much lower than the regional maternal mortality rate (MMR) of 73.60/100,000/LB. The leading causes of

maternal mortality in Zamboanga Sibugay are postpartum hemorrhage, eclampsia and retained placenta. The maternal health output indicators such as 3 or more ante-natal visits, birth attendance by skilled health workers and place of delivery are much lower than the program performance standards.

The infant and under-five mortality rates (IMR / UFMR) are 4.48/1,000 LB and 7.33/1,000 LB respectively. The Zamboanga Sibugay figures are much lower than the regional figures of 8.78 and 12.46 respectively. The 10 leading causes of infant mortality are pneumonia, congenital anomalies, tetanus neonatorum, septicemia, sepsis of newborn, diarrhea, seizure/convulsion, birth asphyxia, meningitis and respiratory distress syndrome.

Zamboanga Sibugay has an FIC of 83.67% which is lower that the performance standard of 95%. Vitamin A supplementation for infants and under 5 children also are much lower than the performance standard.

Overall, Zamboanga Sibugay has failed to achieve the program performance standards of the different health programs.

III TA Plans

Completion and finalization of the Investment Plans for Health

5. Planning for Province-Wide Systems

   This TA package is designed to help the provincial LGU (1) Identify province-wide systems that will support the implementation of municipal and inter-local investment plans; (1) Identify inputs that ILHZ and MLGUs require from the province in terms of logistics, technical support and policy support; (3) set the direction of an integrated health system. Towards this end, the province will establish province-wide targets both in health outcomes and program performance/ coverage; and (4) develop operational plan to implement the above items.

   Since this type of TA is not fully developed yet, HealthGov will provide TA to CHD F1 team in designing planning guidelines and templates with CHD F1 team. This is done through a one-day technical meeting with the team.

   Equipped with the planning guidelines and templates, the CHD will take the lead role in the delivery of the TA tools developed to partner LGUs. CHD will orient PHO and provincial team (DILG, PPDO, PSWD, PBO, SP on Health, CSO, provincial accountant, provincial treasurer, representative of the governor and vice governor, provincial and district hospital chiefs) on the planning guidelines and templates. At the end of the session, an action plan will be made indicating steps on how and when to conduct a workshop.

   In line with this, PHO will facilitate a two-day workshop with the provincial team, ILHZ representatives, hospital representatives and MHOs with technical guidance from CHD. The participants will review existing systems as to functionality and utilization. They will also determine which systems need to be strengthened and/or need to be developed (if not yet existing) and what additional investments are needed at what level of governance.

   Expected outputs will include an agreed plan outlining the province-wide support systems, input requirements (logistics, financial, technical, policy) to support ILHZ and municipal plans, targets on outcomes and program performance and the PPAs, tasks, person responsible, timeframe and budget

The plan will be presented as an integral part of the PIPH. It is expected that the first draft of PIPH will be submitted to DOH on or before October 15, 2007. However, it is also expected that there will be revisions. HealthGov will continually provide on-call technical assistance to the LGUs through CHD in the finalization of the PIPH including the provincial plan.

6. Technical Review of the investment plans for health

This entails the following activities:

- Review MIPH, ILHZ, and Provincial Plans based on agreed parameters (e.g. consistency with the structures of the plan, clarity of goals and targets, rational organization of the plan).

- Synchronization in terms of outcome and program performance targets and investment inputs (between provincial targets & targets of the MLGUs).

- Ensuring that municipal and ILHZ plans contain cross-cutting concerns (e.g. PHIC, financing, HIS, M & E, referral system, human resource development and the like)

Although these activities are very essential, these are not clearly laid out in the standard steps outlined in the PIPH guidelines. There is a need therefore for HealthGov to provide TA to CHD for the latter to be able to provide assistance to LGUs.

As a first step, HealthGov will facilitate a technical meeting the CHD (RD, ARD and regional F1 team) to formulate technical review parameters, review guidelines and processes, and templates. This could be done through a one-day technical meeting.

Then CHD will orient PHO, provincial and sub-provincial facilitators on the review parameters, guidelines, processes and templates. An action plan will be drawn out indicating the tasks, person responsible, time frame and resources required.

The PHO through the Provincial and sub-provincial teams will now spearhead in facilitating the technical review (ILHZ as venue) with technical guidance from CHD. This will be done by first gathering the municipal health planners (MHO, PHN, PPDO) in each of the ILHZ and then orienting them on the review parameters, guidelines, processes and templates. The municipal planners will be made to develop an action plan in each of the municipality which will indicate the tasks, persons/agency responsible and time frame and deadline for submission.

The provincial and sub-provincial technical teams will oversee the review and finalization of the plans by the respective MLGUs and ILHZs. This includes doing one on one discussion, mentoring and coaching to the municipal health planners.

One of the crucial steps in this process is the negotiations between PHO and RHUs in terms of setting province-wide targets, the amount of efforts needed to meet targets and the investment needed both from the province and municipal LGUs.

CHD will take particular responsibility in doing the technical review of the provincial plan. CHD will also provide continuing technical assistance in the consolidation of the different plans (MIPH, ILHZ PH and provincial plans) into a PIPH.

This process will lead to having final plans for submission to DOH (for F1 review) and to each of the LGU for adoption and integration into their annual investments plans.

However, it is expected that there will be revisions in the plans. HealthGov will therefore continually provide on-call technical assistance to the LGUs through CHD in the finalization of the PIPH which may last until end of December 2007. HealthGov will also conduct frequent visits to the CHD and to some of the LGUs to see how things are being implemented and will provide technical recommendations to the CHD and to the LGUs.

In the conduct of the processes above, the integration and/or inclusion in the PPAs should be ensured by HealthGov through CHD.

Below are some areas examples of CSR core attributes and the corresponding PPAs.

- Core Attribute: Improved access to all other FP methods
- PPAs:
  - Upgrading of hospital capabilities (facilities, staff training and equipment)
  - Referral system
  - Establish public and private network of providers
  - Monitoring of informed choice and voluntarism

- Core Attribute: LGU-provided safety net of free contraceptives:
  - PPA – Conduct of CHLSS as client segmentation tool

HealthGov through CHD will also ensure that PPAs will address the health service delivery gaps in TB, MCH and micronutrients. These include, but not limited to, facility upgrading for OPB, MCP and TB-DOTS accreditation, staff training on program-specific competencies, availability of supplies, equipment, providers training, mobilization of health workers to address program-specific gaps, BEMOC, CEMOC, etc.

7. Monitoring and Evaluation tool to track progress in the PIPH implementation
   This includes data collection and assessment methodology, impact analysis, etc.

   HealthGov has already conducted an initial meeting with CHD and this type of TA was identified as a need. This TA needs to be developed with the CHD with HealthGov providing technical assistance.

   Mode of TA delivery
   A two-day participatory tool development workshop will be organized by CHD to be participated in by provincial by a small group of LGU partners (PHO and one member of the local finance committee), ILHZ representative, RHU representative and CSO/NGO representatives. The output is an M & E plan and tools including indicators, process of collection, assessment methodologies, persons and/or agencies responsible, frequency and manner of collection, utilization and the like.

   PHO will facilitate a province-wide orientation (with the technical support from CHD and HealthGov) on the M & E tool to provincial and municipal level partners. This will also serve as the venue to critique and finalize the tool. The output is a final M & E tool with implementation guidelines. This activity will be done on January after the PIPH processes are accomplished and the plans approved at the LGU level.

The provincial LGU will provide the necessary enabling law (either the governor will issue an executive order mandating all LGUs to implement the tool and/or the provincial board passing a resolution to this effect) through the EBL process (another related TA).

CHD with the technical support of HealthGov will continually monitor the implementation of the monitoring tool.

This will lead to a legislated M & E tool which will be implemented province-wide. Results of the M & E will also be feedback to various LGU mechanisms (LHB, SB/SP, ABC, LMP, PCL, LDCs) through a policy-tracking system (another related TA).

CHD with the technical support of HealthGov will continually monitor the implementation of the monitoring tool through field visits. HealthGov will provide technical recommendations to CHD based on the results of field visits.

Laying the foundation for the institutionalization of CSR
1. CSR Assessment and Monitoring Tool (consistent with new AO on CSR)

Exercising its lead role among CAs on CSR, HealthGov had initiated a TA plan to CHD 10 in enhancing its CSR monitoring tool.

This tool will be utilized in Zamboanga Peninsula for year 2 as part of the laying the foundation for the institutionalization of CSR.

Mode of TA delivery
To jumpstart the process, HealthGov will initiate a meeting with PRISM and HealthPro to plan how the CSR monitoring tool will be implemented in the Zamboanga Peninsula through CHD. This will come after Central DOH or the DOH-CSR TWG has given the signal to implement the CSR tool developed in region 10.

DOH and CAs will orient CHD, POPCOM and PHIC (especially the regional CSR TWG) on the tool and the implementing guidelines. CHD will make an action plan on how to implement the tool.

CHD, POPCOM and PHIC through the regional CSR TWG will conduct a one-day orient to PHO, PHTL , DOH Representatives.

PHO will organize a one day CSR monitoring tool orientation and action planning for the conduct of province-wide monitoring. This will be participated in by all MHOs, PHNs and DOH representatives.

PHO, PHT, DOH representatives and MHOs conduct province-wide monitoring from January to March.

By end of March, MHOs and DOH representatives will present results to the respective municipal LGUs (LCEs, SP, LHB). The expected output is the mandate to do CSR planning is given by the municipal LGUs. There are problem areas however, where LGUs will provide instantaneous interventions based on the monitoring results.

Likewise, PHO will consolidate province-wide results and present them to PLGU (Governor, SP, LHB). It is expected that PLGU will give the mandate to do CSR planning.

CHD will consolidate regiona-wide results and submit to DOH central and HealthGov and PRISM.

2. CSR planning
The next step in the sequence of CSR activities is the CSR planning. The CSR monitoring results will be used as inputs to the plans. This will be started by April 2008 and will end mid- June 2008 just in time for the first budget call. There will be period of revisions and negotiations between and among LGUs in the ILHZ and between PLGU and MLGUs.

Final CSR plans with corresponding budget will start to be implemented on the last quarter of 2008. Since forecasting of actual FP logistics needs of an LGU population depends on determination of households eligible for LGU subsidy, the results of the CHLSS (another related TA) will be utilized. This means that the results of the survey should be made available during the budgeting period (from June to October 2008).

Mode of TA delivery

Central DOH, HealthGov, PRISM and HealthPro will orient the CHD, POPCOM and PHIC (RD, ARD, LHAD and the regional CSR TWG) and the PHO on the CSR planning tool. CHD will mobilize the regional CSR TWG to lead the CSR planning processes as facilitators together with the PHO. PHO will select from among the technical staff for training (e.g. FP coordinator).

HG and PRISM will train regional CSR TWG and PHO technical staff as facilitators on CSR planning. Training will include basic skills in facilitating.

Regional CSR TWG and PHO technical staff will formulate action plan and set schedule with the province for the conduct of CSR planning in each of the three (3) ILHZs.

Regional CSR TWG and PHO will facilitate CSR planning at the ILHZs. LCEs will be invited during the opening program where CSR orientation will be conducted. The municipal participants/planning team will be composed of the MHO, PHN, LFC, SB on Health and SB on Budget and Appropriation.

PHO technical staff and DOH reps provide coaching and mentoring to MLGUs in the refinement and finalization of the CSR plans with technical back-up from CHD and HG. HG and CHD will do field visits. Both will provide technical recommendations to the LGUs.

CHD and PHO will provide technical assistance in the refinement and finalization of the provincial CSR plan through the facilitators. There will be regular technical meetings that will be organized by the CHD to assess the progress, provide technical advises and provide logistics support.

PHO will lead in the negotiations with MLGU on the forecasting, cost sharing for logistics procurement, identification of private providers and suppliers (with technical assistance from PRISM) and the kind and level of effort needed to implement CSR province-wide.

PHO and RHUs will present the final version of the plan to their respective LGUs (provincial and municipal).

This will lead to the inclusion of the plans in the 2009 AIP (or inclusion in the 2008 supplemental budget), identification of enabling laws identified and scheduling for deliberations, mandate to implement and official pronouncement that CSR plans will be integrated in the PIPH.

3. A monitoring and evaluation tool to track progress of CSR implementation will also be designed and be integrated into the PIPH M & E tool.

This could be done through the following steps:

- HealthGov to facilitate designing of monitoring and evaluation design and tools with CSR TWG. This will also include the designing of feedback system to LGUs and LGU organizations on results of monitoring
- CSR TWG to orient PHO and provincial team on the M & E design and tools
- CSR M & E will be integrated to the PIPH M & E by the PHO. This will be done through a one-day consultative workshop to be participated in by MHOs, PHNs, LFC representative, CSO and DOH representatives
- PHO and PHT to conduct regular monitoring of the progress of CSR implementation as part of the PIPH M & E.
- PHO to establish feedback system to LGUs (LCE, LHB, LMP, PCL, ABC) with technical back-up from CHD and HealthGov. The establishment of the feedback system will be supported by EBL (another related TA)

8. Community Health and Living Standards Survey
   The survey preparations will be started as early as December 2007. This will allow enough time for the conduct of the survey and the consolidation of the survey results. Results will be used as inputs to the CSR plans and to the program on universal indigency enrollment.

   Survey will start on the second week of January and will be finished by end of March. Consolidation and validation will be done from April to June. Analysis and utilization of results will be made starting June until August to coincide with the budgeting period.

   Mode of TA delivery

   - HealthGov will engage the services of a TAP (probably RIMCU of Xavier University and/or Misamis University). HealthGov will train core team from TAP.
   - TAP will orient LGUs, form technical team
   - LGU-formed technical teams will be trained by TAPs
   - Technical team train barangay level enumerators (preferably BHWs)
   - Technical team provides technical supervision over enumerators; oversees validation, consolidation, finalization and submission and utilization of data
   - TAP to continually provide technical assistance over the whole duration of the conduct CHLSS through mentoring and coaching
   - Consolidated Survey results as inputs CSR planning, PHIC coverage and provision of services on TB, FP, MCH and micronutrients

CHLSS is also a health service delivery action tool that will generate information on unmet needs for family planning, TB-DOTS and MCH. Any information will be directly provided to the service provider (e.g RHM) by the enumerator while conducting the survey. It is expected that services will be given by health workers while the survey is ongoing.

<u>Increasing LGU Financing For Health through Universal Coverage</u>

Technical Assistance will include:

3. Technical Guidelines for Planning and Implementing Universal PHIC coverage
4. Technical support to the implementation

Initial technical assistance has already been done by HealthGov regarding this. Technical meetings were conducted among HG, CHD, PHIC and PHO where the concept and some technical guidelines were discussed.

Mode of TA Delivery
PHIC and CHD will organize a technical meeting among provincial stakeholders (Governor, PHO, LMP president, vice governor, local finance committee, CSOs) with HealthGov providing technical assistance.

PHO will take the lead in developing technical proposal on universal PHIC coverage with the technical assistance from CHD, PHIC and HealhGov. It will also take the lead role in developing advocacy plan for municipal LCEs/LGUs with technical support from CHD, PHIC and HealthGov.

The provincial stakeholders will implement the advocacy plan at the level of the municipal LGUs, congressional representatives, ABC, PCL, local finance committee, civic organizations and the like. The advocacy will revolve around the proposal formulated by the provincial stakeholders on universal coverage. The proposal will contain projection of households by PHIC program groups, estimation of premium subsidies, estimation of reimbursements (TB-DOTS and MCP) and capitation payments, estimation of investment requirements for accreditation and expansion of IPP enrollment, options for ensuring use of PHIC revenues for health at hospital and RHU level.

The provincial stakeholders will spearhead the negotiations with the mayors, congressional representatives, barangay captains, civic organization, NGOs/CSOs on the cost-sharing scheme with HG, PHIC, CHD providing technical and advocacy technical assistance.

The provincial stakeholders will also oversee the approval and implementation of the proposal. Activities may include, but not limited to, upgrading of facilities, training of personnel, payment of premium, accreditation of facilities (for OPB, TB-DOTS, MCP), identification of eligible households for government subsidy through CHLSS (another related TA), legitimization of CHLSS results through an EBL process (another related TA) and distribution of PHIC cards.

It is expected that by the end of September 2008, card distribution to indigent beneficiaries will already commence. It is also expected that 21 (baseline 9) out of 26 RHUs will be OPB accredited.

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    For Year two, EBPDM TAs will focus on:

    13. Evidence-Based legislation for local legislative councils. For this CHD, DILG, PHIC, POPCOM will capitalize on one of the mandated functions of the provincial board which is to review legislations by the sangguniang bayan. It will be advocated to the provincial board that they will produce a resolution mandating the SBs to craft

legislations based on evidence. To achieve this, an EBL training curriculum will be implemented under the auspices of the provincial board.

14. Evidence-Based Policy-Making for LCEs, MHOs, Barangay Captains and CSOs. For CHD, DILG, PHIC, POPCOM will link with the provincial chapter of the LMP.
15. Policy-tracking (both for # 1 and 2)
16. Packaging of HIS results for advocacy cum advocacy skills training

Mode of TA delivery:

For Evidence-Based Legislation and Evidence-Based Policy-Making

- HG to hire TAP
- TAP and HG to orient DILG, CHD, POPCOM and PHIC
- Regional partners develop plan to implement EBL with technical back-up by TAP/HG
- DILG, CHD, PHIC to orient PLGU (Governor, vice governor, sangguniang panlalawigan, LMP/MLCEs, CSOs) on EBL principles, MDG status, health economics, LCE role in HSR with technical backup from TAP/HG.

  Outputs will include
  - Orientation on the basic concept of evidence-based participatory local decision making;
  - Identification of health issues/problems/gaps that require an EB process;
  - Mandate to do activities to provide data/ information/ facts like survey (CHLSS), review (SDIR)

- Utilization of data/information/survey results/program review results/M & E results by the LCEs, LMP, SP/SB, LHB, LDCs. DILG provides technical oversight on the process with technical backup from PHO, RHUs, CHD and PHIC (content)
- Crafting of ordinances, resolutions, executive orders and other pieces indicating official decisions by the LGUs at all levels. DILG provides technical oversight in the whole process with technical backup from PHO, PPDO, RHUs, CHD and PHIC

  Outputs will include:
- Policies, decisions legislations (Ordinances, resolutions, executive orders, memoranda, letters, etc.)
  1. Supporting specific programs/actions
  2. Solving particular health issue, gap or problem

Component TA

2. Policy tracking and analysis (a follow through TA from #3.1). See attached for technical definition and technical steps.

   Production partners
   - Regional partners (DILG, CHD, POPCOM, PHIC)
   - Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative)

Mode of delivery to partners
(Same as # 3.1)

Mode of delivery to LGU partners
Same as #3.1 except the creation of a legislative tacking committee per municipality by an official LGU enactment. The steps also are different but the mode of delivery by partners remains substantially the same.

1.2 Packaging of HIS results for advocacy cum advocacy skills training

Production partners

- Regional partners (DILG, CHD, POPCOM, PHIC)
- Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative, MHO representative)
- TAP

Mode of delivery to partners

- Conduct of workshop by TAP to regional, provincial and municipal partners to design customized advocacy materials using issue-specific topics as content (SDIR red to green, CSR-related issues, universal coverage and facility accreditation)
- TAP facilitate the development of audience-specific advocacy tips. This will include inputs on and return demonstration of advocacy skills

Mode of delivery to LGUs by partners

- Trained regional, provincial and municipal partners provide one-on-one coaching and mentoring to health workers and local partners in developing customized advocacy materials and steps
- Trained regional, provincial and municipal partners provide technical backup (e.g. post-event mentoring and coaching)

ZAMBOANGA DEL NORTE

I Background

The third province in the peninsula is Zamboanga del Norte. It has a current population of 919,744. The province is an F1 rollout site.

It has 25 municipalities and two component cities, Dipolog the capital city and the historic Dapitan.

The poverty rate of the province is high at is 64.6%.

The current governor, Hon. Rolando Yebes got his mandate for the second term

The PHIC enrollment in 2006 is quite high at 49,594 households. The facility accreditation on the other hand is lagging behind. Only 12 are OPB accredited, only 1 is TB-DOTS accredited and none so far is accredited on maternity care package.

Among the USAid CAs, only HealthGov and A2Z are present in the area.

II Health Situation

Zamboanga del Norte's MMR of 57.11/100,000 live births is lower than that of the regional MMR of 73.60/100,000 live births.

Infant mortality rate (IMR) is 68/100,000. The Zamboanga del Norte figures is lower than the regional figures.

The CPR of the province stands at 57.11%. The pill users got the highest percentage among all other family planning users with 45.52. LAM got the highest figure from among the NFP methods with 14.04%. While there are many new acceptors on pills (25.57%), there are many women now who are also becoming interested in using injectacbles (10.07%).

TB case detection rate stand at 57% which is still very low compared to the national standard of 70%. The TB case notification rate stands also at 57%.

MCH indicators are also very low as indicated by the following examples:

- Pregnant women with at least 3 antenatal visits attended by skilled attendants – 59.03%
- Pregnant women had at least 2 doses of tetanus toxoid immunization – 59.37%
- Pregnant women that have taken complete dose of iron supplementation – at least 6 months (reported after the 180 tablets) – 75.33%
- Postpartum Women given complete iron dosage 60 tablets – 52.11%
- Deliveries at health facilities – 20.56%
- Infants receiving DPT3 – 79.66%
- Children under five years of age with diarrhea given ORS – 19.89%

Other MCH indicators are comparatively high as compared with the other provinces in the peninsula but still low as compared with the desired performance/coverage. Below are some of them:

- Deliveries attended by skilled workers – 93%
- Exclusive Breastfeeding up to 6 months – 90.03%
- Lactating Mothers given Vitamin A within 1 month after delivery – 79.9%
- Children under five years of age with pneumonia given antibiotics – 97.16%

There is one performance/coverage indicator though with displays excellent figure:

- Postpartum women with at least 2 clinics visits – 101.54%

The fully immunized child is also high at 95%, while under micronutrients 86.47% of the eligible children (children 6-7 months) are given Vitamin A capsules for the last 6 months (April).

However, there is no reporting system or recording system for sick children given vitamin A.

III Technical Assistance

As mentioned in the regional strategy, the TAs for Zamboanga del Norte are the same with that of the other provinces.

Completion and finalization of the Investment Plans for Health

Planning for Province-Wide Systems

This TA package is designed to help the provincial LGU (1) Identify province-wide systems that will support the implementation of municipal and inter-local investment plans; (1) Identify inputs that ILHZ and MLGUs require from the province in terms of logistics, technical support and policy support; (3) set the direction of an integrated health system. Towards this end, the province will establish province-wide targets both in health outcomes and program performance/ coverage; and (4) develop operational plan to implement the above items.

Since this type of TA is not fully developed yet, HealthGov will provide TA to CHD F1 team in designing planning guidelines and templates with CHD F1 team. This is done through a one-day technical meeting with the team.

Equipped with the planning guidelines and templates, the CHD will take the lead role in the delivery of the TA tools developed to partner LGUs. CHD will orient PHO and provincial team (DILG, PPDO, PSWD, PBO, SP on Health, CSO, provincial accountant, provincial treasurer, representative of the governor and vice governor, provincial and district hospital chiefs) on the planning guidelines and templates. At the end of the session, an action plan will be made indicating steps on how and when to conduct a workshop.

In line with this, PHO will facilitate a two-day workshop with the provincial team, ILHZ representatives, hospital representatives and MHOs with technical guidance from CHD. The participants will review existing systems as to functionality and utilization. They will also determine which systems need to be strengthened and/or need to be developed (if not yet existing) and what additional investments are needed at what level of governance.

Expected outputs will include an agreed plan outlining the province-wide support systems, input requirements (logistics, financial, technical, policy) to support ILHZ and municipal plans, targets on outcomes and program performance and the PPAs, tasks, person responsible, timeframe and budget

The plan will be presented as an integral part of the PIPH. It is expected that the first draft of PIPH will be submitted to DOH on or before October 15, 2007. However, it is also expected that there will be revisions. HealthGov will continually provide on-call technical assistance to the LGUs through CHD in the finalization of the PIPH including the provincial plan.

Technical Review of the investment plans for health

This entails the following activities:

- Review MIPH, ILHZ, and Provincial Plans based on agreed parameters (e.g. consistency with the structures of the plan, clarity of goals and targets, rational organization of the plan).

- Synchronization in terms of outcome and program performance targets and investment inputs (between provincial targets & targets of the MLGUs).

- Ensuring that municipal and ILHZ plans contain cross-cutting concerns (e.g. PHIC, financing, HIS, M & E, referral system, human resource development and the like)

Although these activities are very essential, these are not clearly laid out in the standard steps outlined in the PIPH guidelines. There is a need therefore for HealthGov to provide TA to CHD for the latter to be able to provide assistance to LGUs.

As a first step, HealthGov will facilitate a technical meeting the CHD (RD, ARD and regional F1 team) to formulate technical review parameters, review guidelines and processes, and templates. This could be done through a one-day technical meeting.

Then CHD will orient PHO, provincial and sub-provincial facilitators on the review parameters, guidelines, processes and templates. An action plan will be drawn out indicating the tasks, person responsible, time frame and resources required.

The PHO through the Provincial and sub-provincial teams will now spearhead in facilitating the technical review (ILHZ as venue) with technical guidance from CHD. This will be done by first gathering the municipal health planners (MHO, PHN, PPDO) in each of the ILHZ and then orienting them on the review parameters, guidelines, processes and templates. The municipal planners will be made to develop an action plan in each of the municipality which will indicate the tasks, persons/agency responsible and time frame and deadline for submission.

The provincial and sub-provincial technical teams will oversee the review and finalization of the plans by the respective MLGUs and ILHZs. This includes doing one on one discussion, mentoring and coaching to the municipal health planners.

One of the crucial steps in this process is the negotiations between PHO and RHUs in terms of setting province-wide targets, the amount of efforts needed to meet targets and the investment needed both from the province and municipal LGUs.

CHD will take particular responsibility in doing the technical review of the provincial plan. CHD will also provide continuing technical assistance in the consolidation of the different plans (MIPH, ILHZ PH and provincial plans) into a PIPH.

This process will lead to having final plans for submission to DOH (for F1 review) and to each of the LGU for adoption and integration into their annual investments plans.

However, it is expected that there will be revisions in the plans. HealthGov will therefore continually provide on-call technical assistance to the LGUs through CHD in the finalization of the PIPH which may last until end of December 2007. HealthGov will also conduct frequent visits to the CHD and to some of the LGUs to see how things are being implemented and will provide technical recommendations to the CHD and to the LGUs.

In the conduct of the processes above, the integration and/or inclusion in the PPAs should be ensured by HealthGov through CHD.

Below are some areas examples of CSR core attributes and the corresponding PPAs.

- Core Attribute: Improved access to all other FP methods
- PPAs:
  - Upgrading of hospital capabilities (facilities, staff training and equipment)
  - Referral system
  - Establish public and private network of providers
  - Monitoring of informed choice and voluntarism

- Core Attribute: LGU-provided safety net of free contraceptives:
  - PPA – Conduct of CHLSS as client segmentation tool

HealthGov through CHD will also ensure that PPAs will address the health service delivery gaps in TB, MCH and micronutrients. These include, but not limited to, facility upgrading for OPB, MCP and TB-DOTS accreditation, staff training on program-specific competencies, availability of supplies, equipment, providers training, mobilization of health workers to address program-specific gaps, BEMOC, CEMOC, etc.

Monitoring and Evaluation tool to track progress in the PIPH implementation

This includes data collection and assessment methodology, impact analysis, etc.

HealthGov has already conducted an initial meeting with CHD and this type of TA was identified as a need. This TA needs to be developed with the CHD with HealthGov providing technical assistance.

Mode of TA delivery

A two-day participatory tool development workshop will be organized by CHD to be participated in by provincial by a small group of LGU partners (PHO and one member of the local finance committee), ILHZ representative, RHU representative and CSO/NGO representatives. The output is an M & E plan and tools including indicators, process of collection, assessment methodologies, persons and/or agencies responsible, frequency and manner of collection, utilization and the like.

PHO will facilitate a province-wide orientation (with the technical support from CHD and HealthGov) on the M & E tool to provincial and municipal level partners. This will also serve as the venue to critique and finalize the tool. The output is a final M & E tool with implementation guidelines. This activity will be done on January after the PIPH processes are accomplished and the plans approved at the LGU level.

The provincial LGU will provide the necessary enabling law (either the governor will issue an executive order mandating all LGUs to implement the tool and/or the provincial board passing a resolution to this effect) through the EBL process (another related TA).

CHD with the technical support of HealthGov will continually monitor the implementation of the monitoring tool.

This will lead to a legislated M & E tool which will be implemented province-wide. Results of the M & E will also be feedback to various LGU mechanisms (LHB, SB/SP, ABC, LMP, PCL, LDCs) through a policy-tracking system (another related TA).

CHD with the technical support of HealthGov will continually monitor the implementation of the monitoring tool through field visits. HealthGov will provide technical recommendations to CHD based on the results of field visits.

Laying the foundation for the institutionalization of CSR

1. CSR Assessment and Monitoring Tool (consistent with new AO on CSR)

Exercising its lead role among CAs on CSR, HealthGov had initiated a TA plan to CHD 10 in enhancing its CSR monitoring tool.

This tool will be utilized in Zamboanga Peninsula for year 2 as part of the laying the foundation for the institutionalization of CSR.

Mode of TA delivery

To jumpstart the process, HealthGov will initiate a meeting with PRISM and HealthPro to plan how the CSR monitoring tool will be implemented in the Zamboanga Peninsula through CHD. This will come after Central DOH or the DOH-CSR TWG has given the signal to implement the CSR tool developed in region 10.

DOH and CAs will orient CHD, POPCOM and PHIC (especially the regional CSR TWG) on the tool and the implementing guidelines. CHD will make an action plan on how to implement the tool.

CHD, POPCOM and PHIC through the regional CSR TWG will conduct a one-day orient to PHO, PHTL , DOH Representatives.

PHO will organize a one day CSR monitoring tool orientation and action planning for the conduct of province-wide monitoring. This will be participated in by all MHOs, PHNs and DOH representatives.

PHO, PHT, DOH representatives and MHOs conduct province-wide monitoring from January to March.

By end of March, MHOs and DOH representatives will present results to the respective municipal LGUs (LCEs, SP, LHB). The expected output is the mandate to do CSR planning is given by the municipal LGUs. There are problem areas however, where LGUs will provide instantaneous interventions based on the monitoring results.

Likewise, PHO will consolidate province-wide results and present them to PLGU (Governor, SP, LHB). It is expected that PLGU will give the mandate to do CSR planning.

CHD will consolidate regiona-wide results and submit to DOH central and HealthGov and PRISM.

2. CSR planning

The next step in the sequence of CSR activities is the CSR planning. The CSR monitoring results will be used as inputs to the plans. This will be started by April 2008 and will end mid-June 2008 just in time for the first budget call. There will be period of revisions and negotiations between and among LGUs in the ILHZ and between PLGU and MLGUs.

Final CSR plans with corresponding budget will start to be implemented on the last quarter of 2008. Since forecasting of actual FP logistics needs of an LGU population depends on determination of households eligible for LGU subsidy, the results of the CHLSS (another related TA) will be utilized. This means that the results of the survey should be made available during the budgeting period (from June to October 2008).

Mode of TA delivery

Central DOH, HealthGov, PRISM and HealthPro will orient the CHD, POPCOM and PHIC (RD, ARD, LHAD and the regional CSR TWG) and the PHO on the CSR planning tool. CHD will mobilize the regional CSR TWG to lead the CSR planning processes as facilitators together with the PHO. PHO will select from among the technical staff for training (e.g. FP coordinator).

HG and PRISM will train regional CSR TWG and PHO technical staff as facilitators on CSR planning. Training will include basic skills in facilitating.

Regional CSR TWG and PHO technical staff will formulate action plan and set schedule with the province for the conduct of CSR planning in each of the three (3) ILHZs.

Regional CSR TWG and PHO will facilitate CSR planning at the ILHZs. LCEs will be invited during the opening program where CSR orientation will be conducted. The municipal participants/planning team will be composed of the MHO, PHN, LFC, SB on Health and SB on Budget and Appropriation.

PHO technical staff and DOH reps provide coaching and mentoring to MLGUs in the refinement and finalization of the CSR plans with technical back-up from CHD and HG. HG and CHD will do field visits. Both will provide technical recommendations to the LGUs.

CHD and PHO will provide technical assistance in the refinement and finalization of the provincial CSR plan through the facilitators. There will be regular technical meetings that will be organized by the CHD to assess the progress, provide technical advises and provide logistics support.

PHO will lead in the negotiations with MLGU on the forecasting, cost sharing for logistics procurement, identification of private providers and suppliers (with technical assistance from PRISM) and the kind and level of effort needed to implement CSR province-wide.

PHO and RHUs will present the final version of the plan to their respective LGUs (provincial and municipal).

This will lead to the inclusion of the plans in the 2009 AIP (or inclusion in the 2008 supplemental budget), identification of enabling laws identified and scheduling for deliberations, mandate to implement and official pronouncement that CSR plans will be integrated in the PIPH.

3. A **monitoring and evaluation tool to track progress of CSR implementation** will also be designed and **be integrated into the PIPH M & E tool.**

This could be done through the following steps:

- HealthGov to facilitate designing of monitoring and evaluation design and tools with CSR TWG. This will also include the designing of feedback system to LGUs and LGU organizations on results of monitoring
- CSR TWG to orient PHO and provincial team on the M & E design and tools
- CSR M & E will be integrated to the PIPH M & E by the PHO. This will be done through a one-day consultative workshop to be participated in by MHOs, PHNs, LFC representative, CSO and DOH representatives
- PHO and PHT to conduct regular monitoring of the progress of CSR implementation as part of the PIPH M & E.
- PHO to establish feedback system to LGUs (LCE, LHB, LMP, PCL, ABC) with technical back-up from CHD and HealthGov. The establishment of the feedback system will be supported by EBL (another related TA)

Community Health and Living Standards Survey

The survey preparations will be started as early as December 2007. This will allow enough time for the conduct of the survey and the consolidation of the survey results. Results will be used as inputs to the CSR plans and to the program on universal indigency enrollment.

Survey will start on the second week of January and will be finished by end of March. Consolidation and validation will be done from April to June. Analysis and utilization of results will be made starting June until August to coincide with the budgeting period.

Mode of TA delivery

- HealthGov will engage the services of a TAP (probably RIMCU of Xavier University and/or Misamis University). HealthGov will train core team from TAP.
- TAP will orient LGUs, form technical team
- LGU-formed technical teams will be trained by TAPs
- Technical team train barangay level enumerators (preferably BHWs)
- Technical team provides technical supervision over enumerators; oversees validation, consolidation, finalization and submission and utilization of data
- TAP to continually provide technical assistance over the whole duration of the conduct CHLSS through mentoring and coaching
- Consolidated Survey results as inputs CSR planning, PHIC coverage and provision of services on TB, FP, MCH and micronutrients

CHLSS is also a health service delivery action tool that will generate information on unmet needs for family planning, TB-DOTS and MCH. Any information will be directly provided to the service provider (e.g RHM) by the enumerator while conducting the survey. It is expected that services will be given by health workers while the survey is ongoing.

<u>Increasing LGU Financing For Health through Universal Coverage</u>
Technical Assistance will include:

Technical Guidelines for Planning and Implementing Universal PHIC coverage
Technical support to the implementation

Initial technical assistance has already been done by HealthGov regarding this. Technical meetings were conducted among HG, CHD, PHIC and PHO where the concept and some technical guidelines were discussed.

Mode of TA Delivery
PHIC and CHD will organize a technical meeting among provincial stakeholders (Governor, PHO, LMP president, vice governor, local finance committee, CSOs) with HealthGov providing technical assistance.

PHO will take the lead in developing technical proposal on universal PHIC coverage with the technical assistance from CHD, PHIC and HealhGov. It will also take the lead role in developing advocacy plan for municipal LCEs/LGUs with technical support from CHD, PHIC and HealthGov.

The provincial stakeholders will implement the advocacy plan at the level of the municipal LGUs, congressional representatives, ABC, PCL, local finance committee, civic organizations and the like. The advocacy will revolve around the proposal formulated by the provincial stakeholders on universal coverage. The proposal will contain projection of households by PHIC program groups, estimation of premium subsidies, estimation of reimbursements (TB-DOTS and MCP) and capitation payments, estimation of investment requirements for accreditation and expansion of IPP enrollment, options for ensuring use of PHIC revenues for health at hospital and RHU level.

The provincial stakeholders will spearhead the negotiations with the mayors, congressional representatives, barangay captains, civic organization, NGOs/CSOs on the cost-sharing scheme with HG, PHIC, CHD providing technical and advocacy technical assistance.

The provincial stakeholders will also oversee the approval and implementation of the proposal. Activities may include, but not limited to, upgrading of facilities, training of personnel, payment of premium, accreditation of facilities (for OPB, TB-DOTS, MCP), identification of eligible households for government subsidy through CHLSS (another related TA), legitimization of CHLSS results through an EBL process (another related TA) and distribution of PHIC cards.

It is expected that by the end of September 2008, card distribution to indigent beneficiaries will already commence. It is also expected that 21 (baseline 9) out of 26 RHUs will be OPB accredited.

TA to CHD, DILG, PHO, PHIC, POPCOM, CSO on mobilizing broad-based local action to support CSR, TB control, MCH and Micronutrient, PHIC universal coverage and facility accreditation, movement to transform red to green, through evidence-based participatory decision-making

For Year two, EBPDM TAs will focus on:

- Evidence-Based legislation for local legislative councils. For this CHD, DILG, PHIC, POPCOM will capitalize on one of the mandated functions of the provincial board which is to review legislations by the sangguniang bayan. It will be advocated to the provincial board that they will produce a resolution mandating the SBs to craft legislations based on evidence. To achieve this, an EBL training curriculum will be implemented under the auspices of the provincial board.

- Evidence-Based Policy-Making for LCEs, MHOs, Barangay Captains and CSOs. For CHD, DILG, PHIC, POPCOM will link with the provincial chapter of the LMP.
- Policy-tracking (both for # 1 and 2)
- Packaging of HIS results for advocacy cum advocacy skills training

Mode of TA delivery:
For Evidence-Based Legislation and Evidence-Based Policy-Making

HG will hire TAP (either an organization or an individual). Qualifications should include vast knowledge in governance, actual experience in policy-making using evidence as basis, actual experience in facilitating EBL and EBPPM workshops and working knowledge on health systems especially health information systems. The TAP will be trained by HG governance team leader in coordination with the Mindanao team.

TAP will orient CHD, DILG, POPCOM, PHIC, NSO, NEDA and DBM on EBL/EBPPM with HG providing technical back-up.

Regional partners will develop action plan on how to implement EBL/EBPPM to the LGUs.

Regional partners will orient PLGU (Governor, vice governor, sangguniang panlalawigan, LMP/MLCEs, CSOs) on EBL principles, MDG status, health economics, LCE role in HSR with technical backup from TAP/HG. Actual data will be shown (may start with macro data like the status of MDG health indicators like MMR, FIC, TB, IMR)

Outputs will include
- Orientation on the basic concept of evidence-based participatory local decision making;
- Identification of health issues/problems/gaps that require an EB process;
- Mandate to do activities to provide data/ information/ facts like survey (CHLSS), review (SDIR) – “Mandate to generate evidence”

After the conduct of an evidence-generation activity, LGUs call for an analysis of the evidence. Preliminary technical analysis will be done by local partners (PHO/MHO, PPDO/MPDC, PBO/MPO and the like). The team will come up with technical analysis and recommendations.

The result will be forward to LGUs for further analysis. This could be done during LMP meetings, Sangguniang Bayan/Panlalawigan sessions, Health Committee meetings/hearings, LHB meetings, local development council meetings, ABC meetings and the like). This is the data utilization part. DILG will provide technical oversight on the process, while PHO/RHU/CHD provides technical content.

Part of the process is the championing of policy agenda by CSOs, NGOs, POs and other identified health champions in a given LGU.

What will follow is the crafting of ordinances, resolutions, executive orders and other pieces indicating official decisions by the LGUs at all levels. DILG provides technical oversight in the whole process with technical backup from PHO, PPDO, RHUs, CHD and PHIC.

Outputs will include:
- Policies, decisions legislations (Ordinances, resolutions, executive orders, memoranda, letters, etc.)

1. Supporting specific programs/actions
2. Solving particular health issue, gap or problem

Component TA
Policy tracking and analysis
This is to examine whether or not desired changes are achieved.

Production partners

- Regional partners (DILG, CHD, POPCOM, PHIC)
- Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative)

Mode of delivery to partners
(Same as EBL/EBPPM)

Mode of delivery to LGU partners

Same as EBL/EBPPM, except the creation of a legislative tacking committee per municipality by an official LGU enactment. The steps also are different but the mode of delivery by partners remains substantially the same.

Component TA
Packaging of HIS results for advocacy cum advocacy skills training

Production partners

4. Regional partners (DILG, CHD, POPCOM, PHIC)
5. Provincial Partners (DILG, PHO, PPDO, office of the governor, office of the vice governor, SP secretary, CSOs, private sector representative, LMP representative, PCL representative, ABC representative, MHO representative)
6. TAP

Mode of delivery to partners

- Conduct of workshop by TAP to regional, provincial and municipal partners to design customized advocacy materials using issue-specific topics as content (SDIR red to green, CSR-related issues, universal coverage and facility accreditation)
- TAP facilitate the development of audience-specific advocacy tips. This will include inputs on and return demonstration of advocacy skills

Mode of delivery to LGus by partners

- Trained regional, provincial and municipal partners provide one-on-one coaching and mentoring to health workers and local partners in developing customized advocacy materials and steps
- Trained regional, provincial and municipal partners provide technical backup (e.g. post-event mentoring and coaching)