Strengthening Local Governance for Health (HealthGov) Project

Final Report

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List of Acronyms

AMSTL	Active Management of the Third Stage of Labor
ANC4	Four Antenatal Visits
AO	Administrative Order
AOP	Annual Operational Plan
ARMM	Autonomous Region of Muslim Mindanao
ARH	Adolescent Reproductive Health
BEmONC	Basic Emergency Obstetric and Newborn Care
BEST	Best Practices at Scale in the Home, Community, and Facilities
BHS	Barangay Health Station
BHW	Barangay Health Worker
CA	Cooperating Agency/ies
CBMS	Community Based Monitoring System
CCT	Conditional Cash Transfer
CEDPA	Centre for Population and Development Activities
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	City Health Center
CHD	Center for Health Development
CHITS	Community Health Information Tracking System
CHLSS	Community Health Living Standards Survey
CHO	City Health Office/Officer
CHT	Community Health Team
CPR	Contraceptive Prevalence Rate
CQI	Continuing Quality Improvement
CSO	Civil Society Organization
CSR/CSR+	Contraceptive Self Reliance/Contraceptive Self Reliance-Plus
DILG	Department of the Interior and Local Government
DO	Departmental Order
DOH	Department of Health
DQA	Data Quality Assessment
DQC	Data Quality Check
DSWD	Department of Social Welfare and Development
EBF	Exclusive Breast Feeding
EINC	Essential Intrapartum Newborn Care
EMR	Electronic Medical Record
ENC	Essential Newborn Care
EPI	Expanded Program of Immunization
F1	FOURmula One
FBD	Facility-Based Delivery
FHSIS	Field Health Service Information System
FIC	Fully-Immunized Child
FLSW	Freelance Sex Worker
FP	Family Planning
FPCBT	Family Planning Competency-Based Training
FPCMS	Family Planning Commodity Management System
FPCU	Family Planning Current Users
GIDA	Geographically Isolated and Disadvantaged Areas
GP	Growth Promotion

HCT	HIV Counseling and Testing
HealthGov	USAID Health Sector Development Program LGU Systems Strengthening Component
HealthPRO	Health Promotion and Communication Project
HPDP	Health Policy Development Project
HSRA	Health Sector Reform Agenda
HUP	Health Use Plan
ICV	Informed Choice and Voluntarism
IEC	Information, Education, and Communication
IHBSS	Integrated HIV Behavioral and Serological Surveillance
ILHZ	Intra-Local Health Zone
IRA	Internal Revenue Allotment
ISFP	Integrated Strategic and Financial Plan
IUD	Intrauterine Device
JAC	Joint Appraisal Committee
KP	*Kalusugan Pangkalahatan*
LAC	Local AIDS Council
LAPM	Long Acting/Permanent Methods
LCE	Local Chief Executive
LCG	Local Government Code
LDC	Local Development Council
LGU	Local Government Unit
LHB	Local Health Board
LRP	Local Response Plan
LTAP	Local Technical Assistance Partner
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCP	Maternal Care Package
MDG	Millennium Development Goal
MHO	Municipal Health Office/Officer
MNCHN	Maternal, Newborn, and Child Health and Nutrition
MOP	Manual of Operations
MWRA	Men and Women of Reproductive Age
NBB	No-Balance Billing
NCDPC	National Center for Disease Prevention and Control
NGO	Nongovernmental Organization
NHIP	National Health Insurance Program
NHPC	National Health Planning Committee
NHTS-PR	National Household Targeting System for Poverty Reduction
OICDI	Orient Integrated Development Consultants, Inc.
OPB	Outpatient Benefit Package
PhilHealth	Philippine Health Insurance Corporation
PHIC	Philippine Health Insurance Corporation
PHN	Public Health Nurse
PHO	Provincial Health Office/Officer
Php	Philippine Peso
PNAC	Philippine National AIDS Council
PNGOC	Philippine Nongovernmental Organization Council on Population and Welfare, Inc.
PIPH/	
PIPH/MIPH/	

CIPH	Provincial/Municipal/City Investment Plans for Health
PBSOS	PhilHealth Benchbook Standards for Outpatient Services
POPCOM	Commission on Population
PPDO	Provincial Planning and Development Office
PPO	Provincial Population Office
PPP	Public-Private Partnership
PRISM	Private Sector Mobilization for Family Health Project
RAV	Rapid Assessment of Vulnerabilities
RDC	Regional Development Council
RH	Reproductive Health
RHM	Rural Health Midwife
RHU	Rural Health Unit
RPO	Regional Population Office
SB	*Sangguniang Bayan*
SBA	Skilled Birth Attendance
SBM-R	Standards-Based Management and Recognition
SDExH	Service Delivery Excellence in Health
SDIR	Service Delivery Implementation Review
SHC	Social Hygiene Clinic
SHIELD	Sustainable Health Initiatives through Empowerment and Local Development
SMRS	Supply Management and Recording System
STI	Sexually Transmitted Infection
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TB	Tuberculosis
TB-DOTS	TB Directly Observed Therapy-Short Course
TB-LINC	Linking Initiatives and Networking to Control Tuberculosis
TOT	Training of Trainers
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAS	Vitamin A Supplementation
WAH	Wireless Access for Health
WHO	World Health Organization

I. Context and Chronology

HealthGov Fast Facts:

Life of Project: September 2006 to March 2013
Project Management Team: Chief of Party • Deputy Chief of Party • LGU Governance Team Leader • Health Programs Team Leader • Field Operations Team Leader • Finance and Administration Manager
Implementing partners: Jhpiego; Philippine Nongovernmental Organization Council on Population and Welfare, Inc. (PNGOC); Centre for Population and Development Activities (CEDPA); Orient Integrated Development Consultants, Inc. (OICDI)
Participating regions: Luzon, Visayas, Mindanao
No. of participating provinces: 25
No. of participating LGUs: 603
Total budget: USD 28, 521,227

BACKGROUND: HEALTH SECTOR DECENTRALIZATION AND THE LOCAL GOVERNMENT CODE. In the four decades between gaining independence from the U.S. in 1946 and the inauguration of President Corazon Aquino in 1986, the Philippine health sector remained highly centralized: though the Department of Health (DOH) created regional offices and a local reporting structure, management and resources were overwhelmingly concentrated in Manila. In the early 1980s, some initial steps were taken toward decentralization in line with the principles of the 1979 Alma Ata Declaration on Primary Health Care: the DOH began building partnerships at provincial, municipal, and barangay levels to support local involvement in planning, delivering, and evaluating health services (i.e., the District Health System). It wasn't until the People Power Revolution of 1983-1986, however, that health sector decentralization ultimately kicked into very high gear: a new political era brought in a new Philippine constitution along with, in 1991, the Local Government Code (LGC), which transferred responsibility for providing health services directly to local government units (LGUs). Mayors and legislative councils (*Sanggunian*) in some 1,500 municipalities became responsible for primary care delivery, maternal and child health (MCH) services, communicable and non-communicable disease prevention and control, nutrition services, and family planning. Governors in 81 provinces and their administrations became responsible for hospitals (except those retained by the DOH) and population development services. Some 150 highly urbanized and chartered cities, which are independent of provincial governments, were required to deliver and oversee all the services and facilities of both a municipality and province.

While the aim of the LGC was to bring health service delivery and governance closer to the people—making structures, plans, and processes more effective and accountable—in fact LGC implementation resulted in a high degree of structural and operational fragmentation, with especially adverse impacts in provinces having high concentrations of poor households and/or geographically isolated and disadvantaged areas (GIDA). The DOH functions of planning, policy-making, program implementation, and oversight no longer directly connected to public service delivery networks—hospitals and primary care facilities--which were operated by local governments. Because LGUs lacked the technical and financial capacities to manage health systems, breakdowns occurred in referrals, health management information collection, training and human resources development, and drug/commodity procurement. Persistent difficulties plagued effective health service devolution:

- Local health officials operated in isolation from LGU budgeting and planning processes (governed by the Department of the Interior and Local Government, DILG), and were unable to create alliances with key politicians to develop broad interest, buy-in, and ownership of LGU health sector investments. Health professional-political coalitions to deal with critical issues such as chronic under-staffing and under-funding of health infrastructure, irrational configuration of service delivery points, and mis/unaligned health

policies and plans from province to barangay level remained hard to form. The relatively short term of service for elected officials--three years—is another impediment to long-term planning and coalition building.

- Many local chief executives (LCEs) considered public health a low budget priority, lacking the political appeal of building bridges, roads, and other infrastructure. Many politicians also opposed spending on family planning/reproductive health (FP/RH) for religious reasons, and therefore would not promote or approve local budget allocations for those services.

- Many local executives and legislatures were not oriented to data-based decision and policy-making; moreover, health data collection and analysis systems and procedures did not meet information needs at the LGU, facility, or community levels.

- LGUs lacked awareness and skills to mobilize available funding for health beyond their internal revenue allotments (IRA) and local tax collection schemes—sources which include donors, corporate/private stakeholders, and nongovernmental interest groups.

- Citizen participation mechanisms such as Local Health Boards (LHB) existed in theory but often not in practice, meaning communities remained largely outside policy, financing, and health service design and implementation spheres of influence.

- There was little understanding among local governments, health providers, or civil society about the links between governance and health, and therefore weak advocacy to hold local government accountable for understanding and meeting priority health needs.

These and other problems—a burgeoning population, persistent and widespread poverty—constrained the Philippine health sector, and kept key health indicators, such as maternal and infant mortality, unacceptably high for a middle-income country approaching the year 2000. The "disconnect" in health finance under the LGC emerged as one major culprit in the slow pace of improvement: LGUs did not budget adequately for primary care at rural and municipal health centers and barangay health stations. At the same time, provincial governments had to take on financial and management responsibility for hospitals that were default providers of primary as well as specialized care. Overall per capita spending for public health remained very low: in 1997, it was less than Philippine pesos (Php) 300 per year, less than half the recommended level for low-income countries at the time. Almost half of the money spent on health came from direct out-of-pocket payments by individuals. The contribution of national health insurance (NHIP)—introduced in 1995—to health care spending was less than 10% from 1991-2000.

A related underlying cause of poor MCH outcomes was the chronic shortage of trained personnel at primary care levels: too few providers were willing to work at local levels given poor salaries and working conditions. Training opportunities—the responsibility of Centers for Health Development (CHD) in the country's (now 17) regions—were not adequately funded/organized to respond to gaps in provider knowledge and skills. High levels of turnover were symptomatic of health workers leaving for the private sector or for employment overseas. A great deal of responsibility for bringing citizens into the continuum of care rested with Barangay Health Workers (BHWs): minimally trained and compensated community volunteers who performed outreach for Barangay Health Stations (BHS) and Rural Health Units (RHU) at the lowest levels of the health system.

HEALTHGOV STRATEGIC DIRECTION: THE HEALTH SECTOR REFORM AGENDA AND FOURMULA ONE. In 1999, the DOH formulated and adopted a sweeping overhaul of the sector, designed to deal with the underlying factors in faltering public health performance. The Health Sector Reform Agenda (HSRA) set goals in five interrelated areas: (1) health financing; (2) public health service delivery; (3) local health systems strengthening; (4) hospital rationalization and development; and (5) sector regulation. In a related move, President Joseph Estrada in January 2000 signed Executive Order 205 s.2000 (later repealed), making Inter-Local Health Zones (ILHZs) to "ensure smooth coordination between and among cities, municipalities and barangays." ILHZs, however, required endorsement by provincial governors and city mayors based on management agreements between and among participating LGUs; national implementation has been uneven.

In 2005, after an initial period of HSRA implementation, the DOH issued AO No. 23: "Implementing Guidelines for FOURmula ONE for Health as the Framework for Health Reforms,"known as "FOURmula One," or "F1." FI narrowed the focus for all contributors to health sector reform over the period 2005-2010 to four primary objectives, shown in Table 1.

Table 1: FOURmula One for Health Framework

Finance Objective: Secure higher, better, and sustained financing for health

- Mobilize resources from extra budgetary sources
- Coordinate local and national health spending
- Focus direct subsidies to priority programs
- Adopt a performance based financing system
- Expand the national health insurance program

Regulation Objective: Assure the quality and affordability of health goods and services

- Harmonize licensing, accreditation, and certification
- Issue quality seals
- Assure the availability of low-priced quality essential medicines commonly used by the poor

Health Service Delivery Objective: Ensure access and availability of essential and basic health packages

- Ensure the availability of providers of basic and essential health services in localities
- Designate providers of specific and specialized services in localities
- Intensify public health programs in targeted localities

Governance Objective: Improve performance of the health system

- Improve governance in local health systems
- Improve national capacities to manage and steward the health sector
- Pursue the development of rationalized and more efficient national and local health systems

LAUNCH OF USAID'S HEALTH SECTOR DEVELOPMENT PROGRAM – LGU SYSTEMS STRENGTHENING COMPONENT. Awarded to Research Triangle Institute, International (RTI) in September 2006, USAID's LGU Systems Strengthening Component (HealthGov) was one element of multi-faceted[1] US government support for the F1 reform agenda. HealthGov was

[1] The Health Policy Development Project (HPDP, phase 1 2006-2012, phase 2 2012-2017) provides technical assistance to the DOH and related agencies on health policy formulation, including policy support for LGU health objectives. The Health Promotion and Communication Project (HealthPRO, 2007-2012) was USAID's lead vehicle for providing technical assistance in health advocacy to the DOH and LGUs. The Private Sector Mobilization for Family Health Project (PRISM, phase 1 2004-2009 and phase 2 2009-2014) supports the DOH and LGUs to strengthen

charged with transferring skills and knowledge to LGU stakeholders that would enable them to assess local health needs and priorities, and make decisions about mobilizing/allocating resources to meet those needs effectively. The process of knowledge transfer would have to be sufficiently demand-driven and high-quality to generate commitment from local government executives and legislatures to adopt changes to systems and practices, and to increase financial and other resources for health. In line with F1, RTI embarked on LGU system strengthening through four technical streams, shown in Table 2 below.

Table 2. HealthGov Technical Streams and Objectives

Technical Stream	Objectives
1. Strengthen key LGU management systems to sustain delivery of selected health services	• Improve the flow and analysis of health information for evidence-based decisions • Create stronger links between long-term strategic thinking and annual work planning as a result of more regular and systematic planning • Instill confidence among local health officers and staff in presenting their population and health plans and budgets before their LCEs and *Sanggunian* • Educate LCEs, *Sanggunian* members, and other LGU stakeholders on health issues, programs and projects, so that faster and better decisions are made • Reliable flow of essential drugs and commodities to health facilities based on better stock management, forward ordering and procurement processes • Make roles and relationships between the various LGU levels – e.g., mayor, *Sanggunian*, LHB, Municipal Health Officer (MHO) –clearer and better observed.
2. Improve and expand LGU financing for key health services	• LGUs increase their share of total public expenditure for health. • LGUs understand and can access mechanisms to gain health funding from new sources; barriers at the LGU level to diversifying funding sources are removed. • Scarce financial resources for health are better managed; LGU managers have reliable and timely data on expenditures against budget. • Zones at high risk for HIV/AIDS have a financially sustainable surveillance system that includes appropriate Most-At-Risk-Population (MARP) representation
3. Improve service provider performance	• Staff levels in LGU health facilities approach WHO standards. • Doctors, nurses and midwives have better working conditions and incentives to enhance their performance, such as increased opportunities for technical training. • Managers use supportive supervision to monitor quality closely and regularly • LCEs understand the causes and implications of health staff turnover/shortages
4. Increase advocacy on service delivery and financing	• Increased understanding by LGU officials of the importance of public health and adequate health spending for the development and welfare of their constituents • Increased confidence and ability of public sector health staff to advocate with LGU officials for their budget and other needs, including the ability to identify, analyze, and present data to support the issues for which they are advocating • LGUs formulate and disseminate policies and public statements favorable to the provision and uptake of quality public health services at the LGU level. • Increased ability of NGOs to monitor the quality of public health services and report areas with which they are dissatisfied.

public-private partnerships and provides technical assistance to the private sector. Linking Initiatives and Networking to Control Tuberculosis (TB LINC, 2006-2012) was a USAID-funded, DOH-led initiative to sustain the coordination and collaboration of TB control partners from both the public and private sectors.

MILLENNIUM DEVELOPMENT GOALS (MDGS) 4 AND 5 AT RISK: RAPID REDUCTION OF MATERNAL AND NEONATAL MORTALITY. In September 2008, the DOH issued AO 2008-0029 announcing a new Maternal Newborn and Child Health and Nutrition (MNCHN) Strategy to address lagging performance on maternal, newborn, and child health outcomes. The AO focused attention on the availability of basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC); incidence of skilled birth attendance (SBA) and facility-based delivery (FBD); and the uptake of FP methods, antenatal care visits (ANC), and fully immunized child (FIC) services. In response to the issuance of the Manual of Operations (MOP) for MNCHN, HealthGov, in close collaboration with HPDP and other cooperating agencies (CAs), began development of tools and training materials to operationalize the MNCHN strategy step-by-step at the local level. HealthGov's particular focus was strengthening systems that were critical to MNCHN program implementation.

Health Programming in the Autonomous Region of Muslim Mindanao. ARMM is a group of predominantly Muslim provinces in Mindanao: Basilan (except Isabela City), Lanao del Sur, Maguindanao, Sulu, and Tawi-Tawi. It is the only Philippine region to have its own government. USAID health projects in ARMM must address the particular cultural and political sensitivities there, such as ensuring that religious leaders and culturally appropriate messages are part of efforts to encourage healthy living and counter stigmas against health practices such as family planning. USAID's Sustainable Health Initiatives through Empowerment and Local Development Project (SHIELD)–ARMM was HealthGov's counterpart in Muslim Mindanao over the life of project.

EXPANSION OF HEALTH SERVICE ACCESS AND COVERAGE: THE AQUINO HEALTH AGENDA. In December 2010, as HealthGov was entering its last year of implementation, the DOH issued Administrative Order (AO) 2010-0036, on "Achieving Universal Health Care for All Filipinos." The impetus behind this AO was a national review of the benefit delivery ratio (BDR) [2] conducted by the Philippine Health Insurance Corporation ("PhilHealth"), which showed that the lowest wealth quintile of Filipinos also had the lowest BDR. PhilHealth also documented high rates of non-accreditation of government health facilities, which serve primarily the poor. The AO pointed to a wide disparity in health outcomes and sector performance across geographic areas and income groups, leading to the conclusion that approximately a third of Filipino families did not have equitable access to critical health services, despite achievements realized under F1.

Universal health care—*Kalusugan Pangkalahatan*, or KP—was now the focus of health sector reform, supported by three overarching strategies: (1) financial risk protection through expansion of NHIP enrollment and benefit delivery; (2) improved access to quality (accredited) health facilities and trained providers; and (3) attainment of the health-related MDGs. A DOH Department Order issued in August 2011 provided the guidelines for DOH managers at each level to align their budgets and activities behind the goals of KP implementation.

THE BEST ACTION PLAN: USAID'S BEST PRACTICES AT SCALE IN THE HOME, COMMUNITY, AND FACILITIES (BEST). At roughly the same time, USAID was preparing a five-year action plan (October 2011 to September 2016) "to improve the health of Filipino families by helping to expand access to integrated family planning/maternal, newborn and child health and nutrition (FP/MNCHN) services at the community and facility levels, and by strengthening the capacity of the LGUs and the private sector to plan, carry out, and monitor those services." BEST strategies

[2] BDR is defined as the cumulative likelihood that any Filipino is (a) eligible to claim (registered, paid contributions); (b) aware of entitlements and is able to access health services from accredited providers; and (c) is fully reimbursed by PhilHealth as far as total health care expenditures are concerned.

to apply and scale up high-impact interventions in family health were consistent both with HealthGov's focus on strengthening LGU capacity for health planning, management and financing, and improving data quality, accuracy and timeliness for local policy making, program monitoring, and quality improvements; as well as the new KP strategic thrusts. Therefore, USAID requested RTI to propose a sixth year (October 2011-September 2012) of activities that would bring proven HealthGov tools and approaches to the challenges of KP implementation, as well as ensure that primary care services reflected global standards for integration and quality.

MDG BREAKTHROUGH STRATEGY: DO NO. 2011-0188. In August 2011, the DOH Department Order (DO) 201l-0188 issued the execution plan and implementation arrangements for universal health coverage. The scale-up phase of implementation (2012-2013) called for "An MDG breakthrough strategy by focusing resources and effort in 12 areas with the highest concentration of National Household Targeting System for Poverty Reduction (NHTS-PR) households, women with unmet need for family planning, mothers giving birth outside facilities, children not fully immunized, children not given Vitamin A supplementation (VAS), and adults who are tuberculosis (TB) smear-positive." The order also called for mobilization of at least 100,000 Community Health Teams (CHTs)—to be trained and supervised by 21,070 specially-recruited, short-term public health nurses—to bring NHTS-PR clients into the continuum of primary care. HealthGov recalibrated its technical assistance to help LGUs respond to MNCHN demand-generation challenges, as well as service delivery and system strengthening needs.

A BOLD PUSH ON FAMILY PLANNING: AO 2012-2009. This DOH AO, issued in June 2012, put forward a "National Strategy towards Reducing Unmet Need for Modern Family Planning as a Means to Achieving MDGs on Maternal Health." The AO asserted every Filipino's constitutional right to determine the number of children he or she has, and framed the urgency of reducing unmet need for FP methods in a human rights context. The national strategy addressed both FP demand generation and service provision, and particularly focused on the access and availability challenges of NHTS-PR households. Aligned with the DOH emphasis on integrated service delivery, HealthGov identified essential LGU actions to reduce unmet FP need along the continuum of care. HealthGov had already completed pilot studies of FP integration into the expanded program of immunization (EPI) in Polomolok, South Cotabato in 2009. Results showed that by including FP information and services in post-partum activities, the number of new FP acceptors in a reporting period increased. A further study in Misamis Occidental led to redesign of the FP-EPI integration approach to include antenatal care referral messages. The modified approach was ultimately implemented by 239 out of 378 LGUs who expressed commitment to implement the FP/ANC-EPI integration.

RESPONDING TO DISASTER: HUMANITARIAN ASSISTANCE IN THE AFTERMATH OF TYPHOON BOPHA. On December 3, 2012, Super Typhoon Pablo (international name, "Bopha") hit the southern Philippine island of Mindanao, destroying homes, disrupting communications and power supplies, and causing widespread flooding and destruction. More than 1,000 fatalities were reported in Compostela Valley and Davao Oriental, and more than 200,000 people fled to evacuation centers. RHUs were damaged, and many BHSs were completely destroyed, along with their health supplies and records. Municipalities struggled to continue organizing and training CHT partners to provide assistance to families. At USAID's request, and collaborating with CHD 11 and the PHOs of Compostela Valley and Davao Oriental, RTI shifted HealthGov technical assistance (TA) to procure needed commodities and reestablish the logistics management system in the hardest-hit RHUs. HealthGov also trained/retrained CHT members in two municipalities of Compostela Valley, and two municipalities in Davao Oriental to sustain efforts to help poor families gain access to health care. Full details can be found in the report *Humanitarian and Technical Assistance Support to Typhoon Affected Municipalities of*

Compostela Valley and Davao Oriental 1 January to 31 March 2013, available through USAID's Development Experience Clearinghouse at www.dec.usaid.gov.

STEERING A CONSISTENT YET FLEXIBLE COURSE OVER SEVEN YEARS OF IMPLEMENTATION. From September 2006 to March 2013, HealthGov maintained its technical focus on a core set of LGU health sector stewardship interventions that were fundamental to achieving improved MNCHN, FP/RH, and HIV/AIDS outcomes. These interventions—described in Section II below—required differentiated approaches at each health system level, and across each sector and partner (public, private, DOH, DSWD, DILG, etc). Only by maintaining a flexible approach to each counterpart—accommodating varying degrees of political will, absorptive capacity, enabling environment, and competing pressures and mandates—did HealthGov succeed in keeping stakeholders moving forward together. This is not to say that provinces and constituent LGUs moved forward together in lock step: even with the urgency surrounding the HSRA, KP, BEST, and other national policy and planning directives that emerged over HealthGov's life of project, the pace of implementation remained a local matter, impacted by the quality of working relationships and commonality of goals among changing personnel represented in the matrix of roles and responsibilities shown in Table 3 below.

Table 3: HealthGov Implementing Counterparts

	Municipality/City	Province	Region
LGU Officials	LCE (mayor) *Sanggunian* Local Health Board (LHB) Barangay Captain Barangay Council	LCE (governor) *Sanggunian* Local Health Boards Local Development Council (LDC)	
Health Managers	Municipal Health Officer (MHO); City Health Officer (CHO); Public Health Nurse (PHN); Rural Health Midwife (RHM); BHW	Provincial Health Office Program Coordinators	CHD—regional director and assistant regional director Program Coordinator, Bureau for Local Health Development DOH Representatives
Other Partners	Municipal/City representative of DSWD; Commission on Population (POPCOM) Officer; Nutrition Scholar NGOs	Provincial Planning and Development Coordinator Provincial offices of DSWD, DILG, PhilHealth, Provincial POPCOM Office (PPO); NGOs	PhilHealth Regional Office (PRO) Regional POPCOM Office (RPO); Regional DSWD Office; Regional Development Council

II. HealthGov's Technical Program: A Continuum of Assistance

In its first year (October 2006 – September 2007), HealthGov worked to establish relationships with LGUs in 23 provinces, as well as six zones determined to be at high risk for the spread of HIV/AIDS. Provinces were selected by the DOH and USAID using criteria that included population size; health outcomes related to FP, MNCH, TB, HIV/AIDS, and child nutrition; poverty levels; LCE commitment to pursuing health reforms; and other donor activities in the province. Some provinces selected had already been working to implement F1 reforms, while others were new to the process (see Table 4 below).

Table 4: HealthGov Project Sites

F1Initial Province	F1 Roll-out Province	Other Provinces	HIV/AIDS High-Risk Zones
• Pangasinan • Capiz • Negros Oriental • Misamis Occidental • South Cotabato	• Isabela • Albay • Zamboanga del Norte • Zamboanga del Sur • Zamboanga Sibugay • Compostela Valley • Sarangani	• Cagayan • Bohol • Tarlac • Agusan del Norte • Nueva Ecija • Bukidnon • Bulacan • Davao del Sur • Negros Occidental • Misamis Oriental • Aklan	• 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

In 2010, two additional provinces (Northern Leyte and Western Samar) and two cities (Ormoc and Tacloban) in Eastern Visayas were added as HealthGov areas.

A central tenet of HealthGov implementation was delivery of evidence-based and data- and demand-driven assistance. Project teams therefore consulted in each province with CHD directors, other regional partners such as the Commission on Population (POPCOM), PhilHealth, the DILG, DSWD, and health NGOs on priority health concerns. Initial orientation and data-gathering meetings were held with the provincial governors and LGU officials, public health staff, and civil society organizations (CSOs) in project sites. HealthGov's analysis of the responsiveness of the provinces to and readiness for TA, and how local champions and CSOs could be engaged and capacitated to advocate for sufficient funding and a favorable policy environment for health, shaped annual work planning for the project, and was shared with all USAID health projects. Activities designed to produce the results under each of the four technical rubrics shown in Table 2 were mutually supporting; however, each had to be calibrated at the provincial level in response to local commitments and priorities, recent health sector developments, the dynamics of the local health system, and areas of special concern/focus for technical assistance.

Detailed and comprehensive yearly work plans and quarterly progress reports for the HealthGov life of project were submitted to USAID's Development Experience Clearinghouse. Priority activities in each of the four technical streams are summarized below.

1. Strengthen key LGU management systems to sustain delivery of selected health services.

1a. The Province-Wide Investment Plan for Health and the Annual Operating Plan. The PIPH, and its municipal- and city-equivalent efforts (MIPH/CIPH), were mandated under the F1 framework as a method to produce comprehensive assessments of the health needs in each province/locality, and to fully project required resources and investments to address those needs. The PIPH/MIPH/CIPH is a medium-term (five-year) projection of needed investments to bridge the gaps in service delivery indicated by health data; the Annual Operational Plan (AOP) is the corresponding yearly work plan to secure those investments.

At the close of HealthGov, all 25 project provinces had institutionalized health investment planning and annual operational planning. The project's PIPH/MIPH/CIHP and AOP training and technical assistance had the following components:

➢ *Service Delivery Improvement Review (SDIR)*: HealthGov, in collaboration with the National Center for Disease Prevention and Control (NCDPC) of the DOH conceptualized, developed, and introduced the SDIR as a methodology to provide program managers, service providers, and policy and decision-makers with information on the status of service delivery in a given municipality or city. It allows LGUs to identify and analyze the factors that contribute to and constrain the achievement of service delivery objectives and targets, particularly for MCH, micronutrient supplementation, family planning, tuberculosis prevention and control, and sexually-transmitted infections (STI)/HIV/AIDS prevention and control.

The SDIR process has two important outputs: 1) an "acceleration plan" that health personnel can use as an advocacy tool for local government officials; and 2) baseline municipal/city data on the indicators for health service delivery, governance, financing, and regulation. The acceleration plan specifies milestones to increase service delivery coverage and helps the PHO/CHO, CHD, and DOH Representatives to identify specific LGU TA needs.

SDIR implementation was highly participatory, involving all service providers, including BHWs, in gathering and consolidating local data by program area. HealthGov provided orientation, training, demonstrations, and follow-up to ensure the quality of the exercise in each LGU. At the close of the project, 23 HealthGov provinces were using the SDIR as both a diagnostic tool for understanding health service efficacy, and as a tool for PIPH planning.

➢ *Community Health Living Standards Survey (CHLSS).* Philippine policy directives on universal health care, MDG break-through strategies, and meeting unmet FP need put additional onus on LGUs to identify households eligible for PhilHealth subsidies, and to map communities/households that are not accessing essential primary care services as part of health investment planning. Multiple survey tools exist for LGUs to map constituents living standards, including:

- The Community Based Monitoring System (CBMS), advanced by the DILG, which looks at 13 core poverty indicators covering health, nutrition, access to basic amenities, shelter, peace and order, income, employment and education.

- The National Household Targeting System for Poverty Reduction (NHTS-PR) developed and used by the Department of Social Welfare and Development (DSWD) to determine household eligibility for its Conditional Cash Transfer (CCT) Program based on a limited number of living standard indicators for poverty.

CHLSS (and its earlier version, the Living Standards Survey, LSS) was implemented by the 5 original F1 provinces and used extensively to identify eligible households for enrollment in the PhilHealth Sponsored Program. In HealthGov's last year, one independent city, General Santos City, completed its CHLSS to guide health and development planning. Unlike both the CBMS and NHTS-PR, the CHLSS collects a significant amount of data on health-related MDG indicators. Combined with living standards indicators, the CHLSS generates data that allow LGUs to monitor MDG achievements at the local level (see Table 5 below). The CHLSS collects data on all households in the province or independent city: total enumeration. The resulting data facilitates province-wide or city-wide planning and policy-making using a common data set.

Importantly for the PIPH, CHLSS provides a means test to identify priority health program beneficiaries (the poor); identify unmet health needs for more focused service delivery and resource allocation; assess the coverage and efficiency of the enrollment of the poor in the PhilHealth sponsored program (CCT); provide population-based data to validate field health statistics; and provide comprehensive data for local development planning.

Table 5: CHLSS Parameters

Community Health	Living Standards
Newborn, infant and child health ☐Immunization, by type of vaccine ☐Vitamin A supplementation ☐Dental check-up **Maternal health** ☐Antenatal check-up ☐Skilled birth attendance ☐Facility-based delivery ☐Use of family planning methods **General health** ☐Chronic cough ☐Information on disability and chronic disease **Others** ☐Membership in health insurance ☐Type of health facility visited ☐Ownership of dogs and vaccination status of dogs	**Food security** ☐Number of meals served in the past two days ☐Number of days specific food items (meat, special seafood and processed food) were served in the past seven days ☐Number of days the household did not have enough food to eat in the past 30 days **Dwelling-related characteristics** ☐Ownership status of house and house lot ☐Type of construction materials used for roofing, flooring and walls ☐Structural condition of the house ☐Source of drinking water ☐Type of electric connection ☐Type of cooking fuel used ☐Source of drinking water ☐Type of toilet facility **Ownership of assets** ☐Ownership of agricultural land (irrigated and non-irrigated) ☐Ownership of commercial land ☐Ownership of household assets (transport, appliances and electronic equipment)
Basic Demographic and Socio-Economic Information	
Basic demographics ☐Name ☐Relationship to household head ☐Age ☐Sex ☐Civil status ☐Birth registration **Education** ☐Highest grade completed of all household members ☐Enrollment of 6-12 and 13-16 year-old children	**Livelihood** ☐Employment status (regular, own-account, family) ☐Whether economically active ☐Actively looking for work ☐Backyard gardening **Economic development** ☐Access to credit facility ☐Membership in cooperatives **Others** ☐Manner of garbage disposal ☐Solid waste management

➢ *Data Quality Check (DQC) and Data Quality Assessment (DQA) to clean and use accurate FP and MNCHN indicator data*.[3] The Field Health Service Information System (FHSIS) is the national system for collecting data on health programs, services, and outcomes. Its accuracy and utility depend largely on RHU and BHS staff, who collect and report essential primary care data for amalgamation at provincial level. Understanding the problems with data quality that arose in the wake of LGC implementation—incomplete, inaccurate, late, not useful/used data and reports—and given the importance of accurate and useful data for the PIPH process, HealthGov developed monitoring tools and training for LGUs to assess their baseline data quality and to validate corrected data going forward. These DQC tools were incorporated into the DOH's MOP for MNCHN programs (second edition, March 2011) and were endorsed by the DOH as among the key technical assistance instruments for LGUs to validate their data on MNCHN service indicators.

HealthGov also developed a set of complementary tools for LGUs to use in determining whether the DQC protocols are being consistently implemented over time. The Data Quality Assessment tools provide a scoring methodology for the full set of FP/MNCHN indicators[4] at RHU level: FP current users (FPCU) and contraceptive prevalence rate (CPR); four antenatal care visits (ANC4); SBA; FBD; FIC; exclusive breastfeeding (EBF); vitamin A supplementation (VAS). The DQA evaluates FHSIS reporting using the criteria shown in Table 6 below. HealthGov provided DQC orientation and training and backstop support to all CHDs and in ARMM. The model was endorsed by the DOH for national roll-out in all LGUs. At HealthGov's conclusion, 598 out of 603 project municipalities/cities had been trained and helped to conduct DQC. As of December 2012, 404 of 471 LGUs monitored were implementing DQC (see Table 7, next page).

Table 6: DQA Evaluation Criteria

Availability, completeness and correct utilization of recording and reporting tools at the RHU and BHS facilities
• Availability of FHSIS recording tools at the BHS and RHU facility and completeness of entries • Availability of FHSIS reporting tools at the BHS and RHU facility and completeness of entries • Completeness of general information entries in recording tools • Consolidation tools being utilized correctly • Reporting tools being utilized correctly
Consistency of BHS reported data with consolidated data at the RHU
• Data reported by BHS consistent with data consolidated at the RHU
Consistency of RHU consolidated data with reported data to the Provincial Health Office (PHO)
• Data consolidated at the RHU consistent with data reported to PHO
Discrepancy between reported and validated data decreased compared to baseline data
• Discrepancy between current year reported and validated FPCU, ANC4, SBA, FBD, FIC, EBF, VAS data decreased compared to baseline year

[3] Data quality check and cleaning activities involve checking the recording and reporting of FP and MNCHN indicators and correcting possible errors. Utilization of FP data refers to the use of corrected current user data to update forecasts of FP commodity requirements. All corrected (cleaned) data are then used for planning and M&E.
[4] DQC tools were first developed for FP current user data. The DQC tools for other MNCHN indicators were developed later, and field implementation in provinces followed.

Through the RHU-level DQCs, RHU staff, especially the RHMs, have accepted and internalized the need for correct recording and reporting of FP/MNCHN indicators under FHSIS. DQC steps have also helped the RHU staff define critical action steps to address issues and operational concerns with respect to how FHSIS FP/MNCHN indicators are recorded, maintained and reported—for example, ensuring a complete updated target list is generated every month along with a monthly scorecard. More importantly, LGUs and health personnel now have increased awareness and appreciation for correct information and positive behavior with respect to quality data: data integrity and DQC have become a way of life, not just a one-time activity for them.

"DQC has increased the awareness of health managers/supervisors and service providers on the importance of having quality data for planning and decision-making. After completion of RHU-level DQC of 2010 data, the province of Pangasinan has increased confidence in terms of the reliability and accuracy of data coming in from RHUs/CHOs. Thanks to HealthGov for guidiung us well in this TA undertaking" – Dr. Ana de Guzman, PHO of Pangasinan

Table 7: Number of Municipalities/Cities Trained and Monitored for DQC, and Number Implementing DQC as of December 2012

Province	Total number of municipalities/cities	Total number of municipalities/ cities trained	Total number of municipalities/cities monitored	Number of LGUs implementing DQC
Pangasinan*	48	48	46	40
Cagayan	29	28	26	26
Isabela*	37	33	32	29
Bulacan	24	24	23	18
Nueva Ecija	32	32	32	18
Tarlac	18	18	18	14
Albay	18	18	15	14
Aklan***	17	17	17	17
Capiz	17	17	16	16
Negros Occidental*	32	32	32	31
Bohol	48	48	48	46
Negros Oriental	25	25	25	25
Leyte**	43	43	43	35
Western Samar	26	26	26	21
Zamboanga del Norte	27	27	0	0
Zamboanga del Sur	27	27	0	0
Zamboanga Sibugay	16	16	0	0
Bukidnon	22	22	0	0
Misamis Occidental	17	17	17	4
Misamis Oriental	25	25	0	0
Compostela Valley	11	11	11	9
Davao del Sur	15	15	15	15
Sarangani	7	7	7	6
South Cotabato	11	11	11	11
Agusan del Norte	11	11	11	9
TOTAL	**603**	**598**	**471**	**404**

➢ *Family Planning and Commodity Monitoring System (FPCMS).* HealthGov developed the FPCMS to enable health and LGU officials to assess the availability of FP commodities in health centers, hospitals, and at provincial health offices and CHDs. The system generates data that can be used by health staff and managers as well as LGU leaders to make more informed decisions and policies regarding the financing, procurement, and distribution of FP commodities. FPCMS consists of training and tools to collect information on:

- Storage conditions for FP commodities
- Commodity Stock Status reporting
- Record-keeping for FP commodities
- Number of current users by method
- Feedback and suggestions

In July 2010, the NCDCP asked HealthGov to help fast-track national implementation of FPCMS, particularly the Commodity Stock Status module, which allows LGUs, CHDs, and central DOH offices to document the presence or absence of commodities in facilities nationwide. HealthGov responded with distance (teleconference) trainings for concerned FP personnel at CHD level: FP Coordinators, Provincial Health Team Leaders, and DOH Provincial Representatives. Key staff from central DOH offices were also trained to aggregate commodity stock data from all provinces. To support institutionalization of FPCMS nationally, HealthGov developed technical documentation of required processes, as well as monitoring and evaluation (M&E) tools to ensure quality of the exercise. The DOH discontinued the FPCMS with the development of the National Online Stock Inventory and Reporting System (NOSIRS), which is designed to track FP and other commodities

➢ *Supply Management and Recording System (SMRS).* In 2009 HealthGov implementing partner OIDCI studied logistics management practices in 23 project sites, documenting needs at LGU level. Together with USAID's DELIVER Project, HealthGov developed tools for the LGU SMRS as a companion to the FPCMS, and trained cadres of SMRS trainers at CHD level to spread the approach. SMRS transfers good practices in inventory management, stock recording, use-rate reporting for FP/MNCHN and other essential commodities (quantities received, quantities dispensed to clients, quantities issued to midwives or barangay health stations, quantities in stock, and keeping track of drug expiration dates). SMRS delivers accurate and timely information managers need to plan, finance, and make policy for commodity procurements. At the close of the project, the SMRS tools had been adopted by the DOH for national application; 594 LGUs had been trained; and 242 have fully implemented SMRS.

> "In Isabela, SMRS has helped established evidenced-based decisions and strengthened commodity security. Local health facilities can now plan and request for the next procurement of commodities based on updated data from SMRS. LGUs can now determine if the current commodity stock levels can still meet the needs of current clients particularly the NHTS families" – Dr. Rosa Rita Mariano, PHO of Isabela

Table 8 Summary of SMRS Monitoring				
Province	**LGUs**	**RHU/CHOs**	**RHUs/ CHOs monitored**	**RHUs/CHOs implementing**
Pangasinan*	47	68	66	32
Cagayan	29	31	28	9
Isabela	36	38	34	18
Bulacan	24	63	27	16
Nueva Ecija	32	62	32	5
Tarlac	18	39	18	8
Albay	18	19	17	5
Aklan	17	19	19	17
Capiz	17	17	16	6
Negros Occidental	31	31	31	18
Bohol	48	51	51	11
Negros Oriental	25	28	28	5
Leyte	43	46	46	24
Western Samar	26	26	26	14
Zamboanga del Norte	27	27	0	0
Zamboanga del Sur	27	27	0	0
Zamboanga Sibugay	16	16	16	7
Bukidnon	22	22	22	4
Misamis Occidental	17	17	17	3
Misamis Oriental	25	25	25	11
Compostela Valley	11	11	11	6
Davao Sur	15	15	15	12
Sarangani	7	7	7	6
South Cotabato	11	11	11	5
Agusan del Norte	11	11	0	0
TOTAL	**600**	**727**	**563**	**242**

Data from July 2011 to November 2012 shows incidence of stock outs on family planning and MNCHN commodities among LGUs implementing SMRS has reduced. RHU staff are now more confident with increased capacities in: (a) organizing and updating records (b) tracking commodity status and availability (MNCHN/FP commodities, drugs and supplies) and (c) forecasting commodity requirements because they now have reliable and updated evidence. SMRS likewise served as an advocacy tool for LGUs to lobby for better financing on procurement of commodities.

➢ *MNCHN and CSR/CSR+ planning, policy development, and tracking.* Over the period 2004-2008, the Philippines phased out its dependence on donors for contraceptive commodity supplies and instituted a policy of Contraceptive Self-Reliance (CSR): a set of measures to assure that supplies for FP services continue to be provided for increasing numbers of current and potential users to eventually eliminate unmet needs for FP. LGUs are responsible for meeting three overarching CSR objectives:

1. Assure no disruption in contraceptive supplies to current users during and after the phase-out of external donations, particularly among the poorest users.
2. Develop complementary means of financing contraceptives through a variety of options such as PhilHealth, employer benefits, out-of-pocket financing, etc.

3. Expand complementary private sources of contraceptive supplies through such options as self-help community-based distribution, NGO outlets, private and commercial providers, and workplace-based outlets.

Over the course of the course of CSR planning, LGUs and technical assistance partners realized the importance of tracking availability of tuberculosis drugs, micronutrients—e.g. Vitamin A and Zinc—and other commodities required for the MDG (MNCHN) Break-Through strategy. CSR thus evolved into "CSR+," taking into account forecasting, provision, and financing of both FP and MNCHN commodities and supplies.

"We believe that CSR/MNCHN TA significantly brought positive impact into our province. Out CPR using DQC'd data: increased from 16% in 2010 to 37% in 2012. Thirty percent of our FP unmet needs were addressed (3,865 out of 12,980); maternal deaths reduced from 11 in 2010 to 6 in 2012 and 6 LGUs are now regularly procuring MNCHN/FP commodities from own funds while others have started partly funding the MNCHN/FP commodities" – Dr. Carlos Cortina, Assistant PHO of Cagayan

In line with increasing recognition in the global health community of the importance of primary care service integration, HealthGov integrated assistance for LGU policy development and operational planning through the PIPH and AOP processes. HealthGov's *MNCHN and CSR Plan and Policy Formulation Guide* provided an integrated tool to generate a comprehensive status report on FP/MNCHN/CSR implementation (municipal/city-level or provincial level) and identify gaps and deficiencies requiring specific interventions in the areas of policy/regulation, MNCHN/FP service delivery, financing, governance, systems for sustainability, and M&E. Specifically, the tool helps LGUs: (a) review existing policies and assess whether there are mechanisms installed that will ensure that commitments to the policies are implemented; (b) assess budget allocations for and procurement of MNCHN/FP commodities and services; (c) facilitates availability of, access to, and utilization of grants from the central DOH to provide MNCHN services; (d) asses current PhilHealth enrollment and facility accreditation; (e) review the status of FP/CSR service delivery and MNCHN implementation status; and (f) review governance and systems for service sustainability, including monitoring mechanisms.

Table 9 below provides an overview of ten types of activities HealthGov supported for improved LGU medium-term investment and short-term operational planning in FP and MNCHN programs.

Table 9: LGU Actions For FP/MNCHN/CSR Investment and Operational Plans

	Family Planning	**Maternal Care**	**Child Care**
1. CHT Outreach at Barangay Level to bring Target Clients into Health Care System	1. Train and deploy CHT members to address unmet FP needs, provide adequate information on health risks, deliver health messages, and help families formulate their health implementation plan	1. Build capacity of CHT members and deploy them to guide mothers in seeking prenatal and postnatal care, and in accessing commodities; provide mothers with adequate information on maternal health risks and help them formulate health implementation plans, including birthing plans. Monitor maternal &	1. Train and deploy CHT members to address unmet needs for child care, including FIC, EBF, ENC and micronutrient supplementation; provide adequate information on health risks, deliver the message and help families formulate their health implementation plan

Table 9: LGU Actions For FP/MNCHN/CSR Investment and Operational Plans			
	Family Planning	**Maternal Care**	**Child Care**
		child deaths	
2. FP/ANC4-EPI Integration	1. Implement FP/ANC4-EPI integration (integrating FP and ANC4 into other than maternal health services: EPI, GP) to reduce unmet need for FP and deliver key health messages to mothers and Men and Women of Reproductive Age (MWRA) with unmet need will be identified during EPI registration)	1. Implement FP/ANC4-EPI integration (integrating FP and ANC4 into services other than maternal health to reduce unmet need for ANC and deliver key referral messages to mothers (pregnant women with unmet need for ANC will be identified during EPI registration)	
3. Informed Choice and Volunteerism (ICV) compliance	1. Provide orientation/ information to LGUs on the DOH AO on ICV compliance, including the roles and key activities on ICV compliance 2. Conduct IEC/ promotion of all modern methods including natural FP		
4. NHIP Implementation	1. Formulate the local NHIP plan to include key interventions such as increasing coverage/ enrollment, accreditation, provision of information to members and providers on benefits/access to PhilHealth benefits on FP/ Long-Acting and Permanent Methods (LAPM)	1. Formulate the local NHIP plan that includes key interventions such as increasing coverage/enrollment, Maternal Care Package (MCP) accreditation/MCP+ accreditation, provision of information to members and providers on benefits/access to PhilHealth benefits for maternal care	1. Formulate the local NHIP plan to include key interventions such as increasing coverage/enrollment, Outpatient Benefit (OPB) and TB Directly Observed Therapy Short Course (DOTS) accreditation, provision of information to members and providers on benefits/access to PhilHealth benefits for OPB and TB-DOTS
5. Training on MNCHN/FP (numbers of participant trainees	1. Conduct training, retraining, re-tooling and refresher courses on: FP Competency-Based	1. Conduct training on: BEmONC for nurses, midwives, doctors	

Table 9: LGU Actions For FP/MNCHN/CSR Investment and Operational Plans			
	Family Planning	**Maternal Care**	**Child Care**
determined in each LGU)	Training (FPCBT) 1 for nurses, midwives, doctors FPCBT2 for nurses, midwives, doctors LAPM for nurses, midwives, doctors		
6. Upgrade/ Accredit Facilities (number of facilities in each category determined in each LGU)	1. Facilitate and support accreditation of RHUs for: OPB: RHUs/Health centers MCP: RHUs/Health centers	1. Facilitate and support accreditation of RHUs for: OPB: RHUs/Health centers MCP+: RHUs/Health centers BEMONC: RHUs/Health centers	1. Facilitate and support accreditation of RHUs for: OPB: RHUs/Health centers RHUs/Health centers
7. Commodity Security	1. Allocate funds, procure FP commodities, and ensure that Conditional Cash Transfer (CCT) and NHTS-PR families have free access to these commodities 2. Secure FP commodity grants from the DOH and other funding agencies such as United Nations Population Fund (UNFPA) and other donors 3. Establish a reliable system for forecasting FP commodities. 4. Conduct advocacy/IEC activities among LCEs and *Sangunnian* to finance FP commodity procurement.	1. Allocate funds, procure MNCHN commodities, and ensure that CCT and NHTS families have free access to these commodities 2. Secure MNCHN commodity grants from the DOH and other funding agencies such as UNFPA and other donors. 3. Establish a reliable system for forecasting MNCHN commodities. 4. Conduct advocacy/IEC activities among LCEs and *Sangunnian* to finance MNCHN commodity procurement.	1. Allocate funds, procure MNCHN/ EPI commodities, and ensure that CCT and NHTS families have free access to these commodities 2. Secure MNCHN/EPI commodity grants from the DOH and other funding agencies such as UNFPA and other donors 3. Establish a reliable system for forecasting MNCHN/EPI commodities
8. MNCHN and CSR plan & Policy Implementation	1. Policy: Draft and enact an MNCHN/CSR Ordinance (including all related activities such as advocacy & consultation with the *Sanggunian*, etc.); Amend the ordinance if it needs enhancement or addendum to the policy 2. Budget: Allocate	1. Policy: Draft and enact MNCHN/CSR Ordinance (including all related activities such as advocacy & consultation with the *Sanggunian*, etc.); amend the ordinance if it needs enhancement or addendum to the policy	1. Policy: Draft and enact MNCHN/CSR Ordinance (including all related activities such as advocacy & consultation with the *Sanggunian*, etc.) amend the ordinance if it needs enhancement or addendum to the policy

Table 9: LGU Actions For FP/MNCHN/CSR Investment and Operational Plans			
	Family Planning	**Maternal Care**	**Child Care**
	adequate funding for FP commodities; lobby for additional/adequate financing for FP commodities 3. Procurement: Procure FP commodities and ensure distribution and free access of CCT and NHTS families to these commodities 4. Monitor and track implementation of FP/CSR/MNCH plan and policy commitments	2. Budget: Allocate adequate funding for MNCHN commodities; lobby for additional/adequate financing for MNCHN commodities 3. Procurement: Procure MNCHN commodities and ensure distribution and free access of CCT and NHTS-PR families to these commodities 4. Monitor and track implementation of FP/CSR/MNCH plan and policy commitments	2. Budget: Allocate adequate funding for MNCHN commodities; lobby for additional/adequate financing for MNCHN commodities 3. Procurement: Procure MNCHN commodities and ensure distribution and free access of CCT and NHTS-PR families to these commodities 4. Monitor and track implementation of FP/CSR/MNCH plan and policy commitments
9. Health Information	1. Conduct regular DQC and generate reliable data on CPR as bases for planning, financing, and policy development 2. Ensure sustained DQC activities and support through dedicated personnel and availability of forms	1. Conduct regular DQC and generate reliable data on ANC4, SBA, FBD, ENC as bases for planning, financing, and policy development 2. Ensure sustained DQC activities and support through dedicated personnel and availability of forms	1. Conduct regular DQC and generate reliable data on FIC, EBF, VAS as bases for planning, financing, and policy development 2. Ensure sustained DQC activities and support through dedicated personnel and availability of forms
10. Logistics	1. Establish and implement the SMRS to build LGU capacities in tracking FP commodities in health facilities, including related medical supplies	1. Establish and implement the SMRS to build LGU capacities in tracking MNCHN commodities in health facilities, including related medical supplies	1. Establish and implement the SMRS to build LGU capacities in tracking MNCHN commodities in health facilities, including related medical supplies

By the project close, 23 of the 25 HealthGov provinces had developed plans for ensuring self-reliance in FP and MNCHN commodity supply. A total of 257 LGUs were procuring FP and

MNCHN commodities with their own funds at the end of the project, as shown below. These 257 LGUs spent P118.3 million from 2009 to 2012 for the procurement of MNCHN/FP commodities, P38.3 million of this amoung was for FP commodities

Table 10 Number of LGUs Monitored with FP/CSR/MNCHN Policy, and Number Procuring FP and MNCHN Commodities

Province	Total number of municipalities/ cities monitored	No. LGUs with FP/CSR/ MNCHN Policy	No. of LGUs procuring FP commodities	No. of LGUs procuring both FP/MNCHN commodities
Pangasinan	46	7	18	18
Cagayan	26	4	4	5
Isabela	30	5	17	24
Bulacan	21	9	0	0
Nueva Ecija	31	0	2	2
Tarlac	18	1	0	0
Albay	11	6	6	6
Aklan	17	8	6	7
Capiz	16	4	2	8
Negros Occidental	31	12	15	15
Bohol	48	20	14	15
Negros Oriental	25	9	7	10
Leyte	43	0	11	21
Western	26	1	4	10
Zamboanga del Norte	27	25	12	13
Zamboanga del Sur	27	26	17	20
Zamboanga Sibugay	16	13	10	16
Bukidnon	19	12	9	12
Misamis Occidental	17	2	5	6
Misamis Oriental	25	5	9	11
Compostela Valley	11	5	11	11
Davao del Sur	15	2	4	13
Sarangani	7	6	5	5
South Cotabato	11	4	6	9
Agusan del Norte	11	0	0	0
TOTAL	**575**	**186**	**194**	**257**

1b. Improve key LGU management approaches to prevent and control HIV/AIDS.
HealthGov led implementation of USAID's HIV/AIDS program component in the Philippines from October 2006 to June 2011. In collaboration with other Cooperating Agencies (CAs), HealthGov provided technical assistance (TA) to 11 cities to support USAID's goal of helping the Philippine government maintain its low HIV prevalence status, which is less than three percent (3 percent) among the most-at-risk population (MARPs) and less than one percent of the general population. These cities are Angeles, Quezon, Pasay, Bacolod, Iloilo, Cebu, Mandaue, Lapu-lapu, Zamboanga, Davao and General Santos.

HealthGov conducted a baseline assessment of HIV/AIDS prevention programs in project sites, documenting LGU enabling policies, infrastructure, manpower complements and competences,

services and service delivery coverage, budget and logistics, linkages, and strategic and operational plans. The assessment revealed that half of the sites had non-functional Local AIDS Councils (LACs). Many LGUs had no plans to articulate strategic directions or provide dedicated funding for HIV treatment and prevention; effective program monitoring systems were also not in place. Among at-risk groups—such as freelance sex workers (FLSWs)—there was little knowledge on HIV prevention, HIV Counseling and Testing (HCT), as well as condom use. HealthGov provided foundational technical assistance to project sites to overcome these obstacles; ultimately, however, these efforts require the sustained and intensive leadership focus of the Philippine National AIDS Council (PNAC) along the HIV/AIDS prevention and control NGO community. Primary interventions conducted by HealthGov included:

- *LGU HIV Integrated Strategic and Financial Plan (ISFP).* HealthGov developed the ISFP model, in which all key LGU HIV program stakeholders participated—as the "mother plan" for comprehensive HIV/AIDS-related activities. The LGUs subsequently incorporated it in their respective comprehensive city-wide investment plan for health, which were reviewed and approved by the DOH and the Joint Appraisal Committee (JAC), composed of international donor agencies.

- *Inter-LGU collaboration*. HealthGov fostered tri-city collaboration for STI/HIV prevention among the cities of Cebu, Mandaue, and Lapu-Lapu, as well as inter-LGU learning and sharing between the cities of Angeles and Quezon City.

- *Resources leveraged from LGU and DOH to fund priority projects and activities*. The project helped to set up a special fund for the Angeles City Reproductive Health and Wellness Center; supported development of an operating mechanism for LGU performance-based grants to NGOs in Davao City; and provided support to the development and DOH approval of HIV funding in General Santos and Zamboanga cities.

- *Public-private partnerships*. HealthGov helped to establish and expand PPPs in project sites by supporting the LGUs in organizing owners and managers of entertainment establishments (Quezon City), installing a workplace-based STI/HIV/AIDS program (call centers in Davao City), and integrating STI/HIV/AIDS prevention and control activities to the workplace family health program initiative in General Santos City.

- *Local Response Plans (LRPs) to address pressing concerns for specific MARPs*. HealthGov also assisted LGUs in developing LRPs for men-having-sex-with-men (MSMs) for cities of Davao and Quezon, MSMs and FLSWs in General Santos, and the Needle Syringe Program (NSP) for IDUs in the tri-cities of Cebu, Mandaue and Lapu-Lapu.

- *Enhancement of the Manual of Procedures for Social Hygiene Clinics* to ensure improved quality of STI/HIV services.

- *Enhanced HIV/AID surveillance and rapid assessment of vulnerabilities*. HealthGov provided technical assistance to revise the Integrated HIV Behavioral and Serological Surveillance (IHBSS) and conduct of the Rapid Assessment of Vulnerabilities (RAV) to HIV in Bacolod City.

- *Trainings in interpersonal communication and HIV counseling, peer education.* HealthGov was able to train around 2,000 people in the LGUs. These trainees later accessed and provided information and services to as many as 60,000 people.

HealthGov's Final Report on its HIV/AIDS Program Component, submitted to USAID/Manila in September 2011, contains complete details on all activities in each project site, including steps necessary to produce an ISFP at LGU level.

Advocating for Joint LGU-NGO-Private Sector HIV/AIDS Prevention Efforts in General Santos City

General Santos City is in a region of Southern Mindanao known as SOCCSKSARGEN, an acronym derived from the names of four provinces and one component city: ***So***uth ***C***otabato, ***C***otabato, ***S***ultan **K**udarat, ***Sar***angani, and ***Gen***eral Santos City ("GenSan"). GenSan is classified as highly-urbanized, with an estimated population of 679,000 in 2012 (www.region12.dilg.gov.ph). GenSan is home to major national and international agro-industrial and fishery businesses, and is a regional gateway by air and sea. GenSan has three universities, and a fast-growing guest services— hotel, restaurant, and tourism—economic sector.

GenSan's STI/HIV/AIDS prevention program was begun in 1995; by the advent of HealthGov, a new model for prevention and treatment was needed. On the positive side, the City had many needed elements in place:

- Private companies—e.g., the large fishing businesses—willing to partner with LGUs on health development
- NGOs actively providing HIV/AIDS and reproductive health services
- LGU and NGO champions of HIV/AIDS education, prevention, and treatment
- A functional and supportive LHB, along with a supportive mayor and city council

On the debit side, these partners lacked a comprehensive, multi-sector prevention plan to spell out coordination mechanisms and partnering arrangements to sustain diverse activities. The City did not have a treatment hub, nor a plan or budget setting out needs for manpower, logistics, and commodities and services, such as voluntary counseling and testing, outreach and education, and drug treatment.

HealthGov helped stakeholders to conduct an HIV/AIDS program implementation review as the basis for an Integrated Strategic and Financial Plan (ISFP) the City could use to organize HIV/AIDS stakeholders. An advocacy campaign accompanied ISFP formulation to secure the support of all concerned actors, which included:

- City-NGO partnership meetings to ensure that civil society STI/HIV/AIDS programs were fully integrated into GenSan City implementation and monitoring plans
- Seeking ISFP endorsements from the LHB and local AIDS Committee as a prerequisite for approval by the local *Sanggunian* and mayor, including approval of a comprehensive HIV/AIDS ordinance
- An advocacy forum for leaders of the South Cotabato Purse Seiners' Association (SOCOPA) to engage private sector groups in implementing HIV/AIDS prevention and education programs among deep-sea fishers who may be clients of sex workers in the city
- Dialogues with GenSan's new mayor to secure approval for the ISFP
- Community events with LGU officials and other dignitaries—e.g., AIDS Candlelight Memorial and World AIDS Day—to publicize prevention programs.

2. Improve and expand LGU financing for key health services

2a. Orientation and training for local NHIP implementation using the BDR approach. In 2010, HealthGov—along with USAID's other health Cooperating Agencies—worked with the DOH and PhilHealth to review and measure the extent of actual NHIP service delivery benefits to beneficiaries using the BDR methodology. Results of the review showed that the NHIP was able to enroll and make eligible only 53 out of every 100 Filipinos, and of those enrolled, only 22 availed of the services from accredited facilities. Of those who availed benefits, only the equivalent of eight secured full financial protection from NHIP. The DOH decided to make the BDR the primary gauge of NHIP implementation in provinces and cities: "All DOH central offices and CHD shall learn to use and apply the principles and methods of the BDR approach" (DOH DO No. 2010 -0156).

Sources of LGU Health Funding

- DOH Official Development Assistance resources for local HSRA implementation
- DOH MNCHN grants for LGU use toward FP/MNCHN and MDG objectives
- DOH commodity procurements for distribution to LGUs
- PhilHealth reimbursements and capitation funds
- Monies for health, nutrition, and population from central government transfers and local revenues (IRA)
- Contributions from development partners

Consequently HealthGov, in collaboration with HPDP and PRISM2, developed orientation and planning tools to guide CHDs and LGUs in formulating their respective NHIP implementation plans, covering: increase enrollment of poor households, accredit facilities, increase client use of professional care, manage claims and reimbursements, and implement the no-balance billing (NBB) for the outpatient benefit care package (OPB), maternal care package (MCP), and newborn screening (NBS) services at appropriate facilities.

➢ *Increase enrollment of indigent households*. Specific assistance was provided to LGUs inn five provinces to develop and install a system based on local data (CHLSS) to identify indigent households and populations that are prioritized for enrollment in PhilHealth.

➢ *Increase client awareness of/demand for OPB, MCP, and NBB service packages.* Information targeted to clients about PhilHealth entitlements and responsibilities is largely delivered by CHT partners, who received training and support through HealthGov. LGUs and providers were also oriented to PhilHealth member service package content, quality, and reimbursement protocols as part of stepping up enrollment of indigent households.

Table 11 shows the number of CHDs and Provinces oriented in BDR by HealthGov, and number of LGUs with NHIPs. Table 12 shows the number of NHTS families and other poor families in HealthGov provinces who are enrolled in the PhilHealth sponsored program (as of November 2012). Table 13 shows the number of public health facilities accredited for OPB and MCP, and certified for NBS as of November 2012.

Table 11. Number of CHDs and Provinces Oriented in BDR and Number of Provinces and M/C LGUs with NHIP Plans

Province	No. of CHDs provided TA in BDR orientation and local NHIP Plan formulation	No. of CHDs with Support Plans for NHIP	No. of provinces provided with BDR Orientation and TA in local NHIP plan preparation	No. of provinces with NHIP plans	No. of M/C LGUs with NHIP plans
Luzon					
Pangasinan	1	1	1	1	48
Cagayan			1	1	29
Isabela	1	1	1	1	37
Bulacan			0	0	0
Nueva Ecija			1	1	28
Tarlac	1	1	1	0	0
Albay	0	1	0	0	0
Visayas					
Aklan			1	1	17
Capiz			1	1	17
Negros Occidental	1	1	1	1	31
Bohol			0	1	0
Negros Oriental	0	1	0	1	0
Leyte			1	0	2
Western Samar	1	1	1	1	4
Mindanao					
Zamboanga del Norte			1	1	0
Zamboanga del Sur			1	1	0
Zamboanga Sibugay	1	1	1	1	0
Bukidnon			1	1	0
Misamis Occidental			1	0	0
Misamis Oriental	1	1	1	1	0
Compostela Valley			0	0	0
Davao del Sur	0	0	0	0	0
Sarangani			1	0	0
South Cotabato	1	1	1	0	0
Agusan del Norte	0	1	0	1	0
TOTAL	**8**	**11**	**18**	**16**	**213**

Table 12. Number of NHTS Families and Other Poor Families Enrolled in the PhilHealth Sponsored Program (as of November 2012)

Province	Total Number of NHTS Families in (Lowest) Wealth Quintile 1 (Source: DSWD)	Number of NHTS families enrolled by the National Government (DOH) in the PhilHealth-sponsored Program	Number of families enrolled by the LGU (Province, M/C LGU, barangay)	% of NHTS families enrolled by the National Government (DOH) in the PhilHealth-sponsored Program
Luzon				
Pangasinan	148,601	138,430	64,881	93%
Cagayan	38,270	28,972	53,068	76%
Isabela	54,678	39,956	52,253	73%
Bulacan	73,683	57,938	64,983	79%
Nueva Ecija	96,863	78,372	19,832	81%
Tarlac	46,956	41,005	53,450	87%
Albay	88,242	78,388	94,769	89%
Visayas				
Aklan	34,924	28,670	53,098	82%
Capiz	39,855	36,474	48,962	92%
Negros Occidental	138,664	127,801	129,168	92%
Bohol	70,028	68,075	50,323	97%
Negros Oriental	88,548	87,435	6,673	99%
Leyte	132,377	122,988	145,051	93%
Western Samar	73,827	69,852	36,603	95%
Mindanao				
Zamboanga del Norte	113,816	105,772	538	93%
Zamboanga del Sur	170,181	113,860	22,596	67%
Zamboanga Sibugay	74,643	66,472	3,798	89%
Bukidnon	98,107	74,855	157,242	76%
Misamis Occidental	46,061	27,328	84,258	59%
Misamis Oriental	93,104	57,639	135,899	62%
Compostela Valley	58,148	48,594	11,388	84%
Davao del Sur	111,655	83,142	11,252	74%
Sarangani	44,469	38,594	10,111	87%
South Cotabato	70,771	60,122	25,712	85%
Agusan del Norte	49,437	42,664	35,924	86%
TOTAL	**2,055,908**	**1,723,398**	**1,371,832**	**84%**

Source: PhilHealth Database
Date of Extraction: November 5, 2012 (LGU) and November 6, 2012 (NHTS)

Table 13. Number of Public Health Facilities Accredited for OPB and MCP, and Certified for NBS

Province	Number of OPB-accredited facilities		Number of MCP-accredited facilities		Number of Newborn Screening (NBS)-certified facilities	
	Baseline July 2011	As of Nov 2012	Baseline July 2011	As of Nov 2012	Baseline July 2011	As of Nov 2012
Luzon						
Pangasinan	45	55	9	15	4	23
Cagayan	18	22	5	6	2	5
Isabela	25	27	8	17	3	9
Bulacan	32	32	7	3	2	1
Nueva Ecija	34	20	2	3	0	2
Tarlac	23	17	6	4	4	1
Albay	14	14	3	3	1	1
Visayas						
Aklan	18	17	0	4	0	13
Capiz	16	17	12	17	11	17
Negros Occidental	26	31	14	15	8	31
Bohol	39	41	7	8	4	37
Negros Oriental	19	20	2	2	1	7
Leyte	37	53	22	51	0	40
Western Samar	13	24	6	17	1	8
Mindanao						
Zamboanga del Norte	21	22	7	14	0	10
Zamboanga del Sur	22	28	16	23	3	12
Zamboanga Sibugay	12	13	7	7	4	7
Bukidnon	3	3	13	13	10	12
Misamis Occidental	17	17	2	5	1	4
Misamis Oriental	23	26	7	8	4	8
Compostela Valley	11	10	2	2	1	10
Davao del Sur	8	11	2	5	2	11
Sarangani	3	3	1	2	0	0
South Cotabato	10	10	0	3	0	0
Agusan del Norte	9	9	2	2	2	2
TOTAL	**498**	**542**	**162**	**249**	**68**	**271**

2b. Increase province-level access to DOH MNCHN grants for onward allocation to LGUs. MNCHN grants are funds from the DOH that augment LGU family health budgets to improve the delivery of MNCHN services. HealthGov provides technical assistance to provincial LGUs so increase access to these funds along with capacity to manage grants in line with DOH policies, and track and monitor grant use at LGU level. HealthGov trained province-level officials to use an MNCHN grants allocation tool based on the DOH's MNCHN strategy, and provided technical backstopping to CHD's as they worked with LGUs on developing policies and procedures necessary to support MNCHN grant utilization.

2c. Promoting sustainable financing for health care. HealthGov continually strengthened the evidence basis for LCEs, local legislators (*Sangguniang*), and Local Finance Committee members to take ownership of investing in priority FP and MNCHN programs, and ensure funding was included in LGU AOPs. HealthGov also identified the need to synchronize the health planning and budgeting process (PIPH/AOP) with the LGU planning and budgeting

timeline to ensure timely financial flows to critical activities; this synchronization was a major focus of HealthGov sustainable finance advocacy. A comparison of HealthGov province health, nutrition, and population-related expenditures as a percentage of LGU budgets in 2006 and 2010 (Table 14) shows that spending stayed roughly the same in 10 provinces, increased in 9, and decreased in 6. Data for 2010, however, from the Bureau of Local Government and Finance, is not complete, meaning the comparison has a margin of error.

Table 14 LGU IRA Allocations for Health, Nutrition, and Population

1. Pangasinan	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	3,635,827,821	75%	468,420,225	11.%
2010	6,516,614,679	69%	1,118,299,494	16%

2. Tarlac	IRA	As % of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,720,143,220	72%	284,886,186	14%
2010	2,095,140,136	80%	382,460,947	19%

3. Albay	IRA	As % of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,720,143,220	72%	284,886,186	14%
2010*	2,095,140,136	80%	382,460,947	19%

4. Capiz	IRA	As % of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,232,406,550	86%	198,745,720	17%
2010*	1,535,153,267	87%	190,493,193	13%

5. Cagayan	IRA	As % of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	2,143,296,351	84%	303,798,896	13%
2010	2,649,502,260	78%	291,657,838	13%

6. Isabela	IRA	As % of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	2,775,931,225	83%	333,806,457	11%
2010	1,891,421,145	80%	208,115,440	11%

7. Bulacan	IRA	As % of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	2,962,979,812	57%	568,877,008	12%
2010	4,294,613,508	60%	884,356,717	16%

8. Nueva Ecija	IRA	As % of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	3,165,380,427	77%	378,303,192	9%
2010*	4,090,839,162	78%	345,955,389	9%

9. Negros Occidental	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	5,051,862,720	75%	366,545,490	7%
2010*	6,612,201,985	84%	455,010,563	7%

10. Aklan	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	900,911,260	78%	75,790,550	8%
2010	1,206,791,526	70%	60,280,466	5%

11. Bohol	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	2,091,549,395	80%	279,951,103	12%
2010*	2,271,033,989	80%	257,320,268	12%

12. Negros Oriental	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	2,490,865,524	78%	409,538,437	16%
2010*	3,437,294,325	75%	572,954,133	16%

13. Leyte	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	2,490,865,524	78%	409,538,437	16%
2010*	3,437,294,325	75%	572,954,133	16%

14. Western Samar	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,777,868,826	91%	190,639,039	11%
2010**	1,414,611,398	91%	100,497,297	7%

15. Zamboan-ga del Norte	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	2,123,660,188	74%	230,211,326	10%
2010	709,795,162	89%	42,184,570	8%

16. Zamboan-ga del Sur	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,705,476,306	86%	95,020,360	6%
2010	1,447,300,045	84%	100,277,000	8%

17. Zamoan-ga Sibugay	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	993,012,457	85%	63,465,076	6%
2009	1,507,353,962	81%	162,455,576**	11%**
2010	No data	No data	No data	No data

18. Bukidnon	IRA	% of LGU income	Expenditures on HNP	% of LGU expenditures
2006	2,675,411,724	75%	133,479,105	4%
2010	2,773,358,464	83%	178,962,414	5%

19. Misamis Occidental	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,352,664,895	83%	176,327,891	12%
2010	411,943,929	83%	31,477,216	7%

20. Misamis Oriental	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,475,649,945	80%	138,714,659	9%
2010	577,128,257	68%	59,283,764	9%

21. Compos-tela Valley	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,096,869,581	74%	110,725,598	8.4%
2010	1,685,089,848	80%	133,688,916	8.0%

22. Davao del Sur	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,486,365,524	83%	142,668,515	9.0%
2010	2,226,184,466	85%	273,618,582	12.9%

23. Sarangani	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	877,247,071	89%	79,524,548	8%
2009	1,249,130,517	92%	150,512,275	12%
2010	No data		No data	

24. South Cotabato	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	1,371,880,288	81%	177,663,638	10%
2010	1,192,271,654	80%	107,611,951	10%

25. Agusan del Norte	IRA	% of LGU income	Expenditures on HNP	As % of LGU expenditures
2006	732,490,783	87%	126,496,777	17%
2010	289,410,009	79%	29,983,104	8%

3. Improve service provider performance.

HealthGov assistance to LGUs in management and finance system strengthening was always carried out in the context of scaling up integrated plans to improve family health outcomes generally, and achieving MDG targets specifically. In addition to stronger systems, service provider skills and knowledge are essential to both generate demand for high-impact FP/MNCHN services and ensure the quality of supply. In line with both USAID (BEST) and DOH strategies for service integration, universal coverage, and quality of care, HealthGov worked with LGUs to understand their individual challenges with regard to service access and coverage, and to collaborate with CHDs and provincial and regional counterparts to bridge gaps in their service networks. Interventions in this technical stream are summarized below.

3a. Improve FP/MNCHN outcomes. As HealthGov implementation matured, the project team designed more multidimensional assistance around FP strategies: increasing contraceptive prevalence rates (CPR) and reducing unmet need. On the demand side, clients require accurate and user-friendly information, affordability, and choices that meet preferences for number and spacing of children as well as FP methods. On the supply side, provider skills and knowledge, availability, and supplies are critical factors. HealthGov focused on assistance to LCEs, *Sangguniangs*, local finance committees, and LHBs to establish the enabling policies and practices, financing, and organizational structure for providers in RHUs/city health centers (CHCs) and communities to customize and implement interventions appropriate to local needs and their current situation. Activities included:

- *Integration of FP information and referral services into other MNCHN activities (e.g., ANC, EPI, postpartum care, and Vitamin A supplementation)*. HealthGov's FP service integration activities built on data reported by NDHS showing that providers were missing opportunities to reduce unmet FP needs by linking information and referral to child immunization, postpartum care, and vitamin supplementation. . By the project close, 496 of HealthGov's 603 municipalities/cities have trained personnel in FP/EPI integration. Table 15 shows the total training figures for FP/ANC-EPI integration.

- *Training and deploying CHTs to facilitate demand creation and bring poor families with unmet health needs into the continuum of care*.[5] National roll out of the CHT approach to helping poor households understand their opportunities and rights to access health care created a huge need for training—refresher and new provider—for these cadres.. CHTs also keep track of pregnant women and newborns in their catchment areas, referring them to ANC, skilled birth attendance at a facility, post-partum and essential newborn care, and other key MNCHN services.

CHDs are charged with training CHT partners and supplying them with the tools they need to track and monitor the FP/MNCHN health needs and service take-up of the households in their client lists. Over the course of CHT partner training and deployment, CHDs and PHOs began to express interest in a method for assessing CHT effectiveness in health profiling and service navigation, among other duties. HealthGov developed an assessment guide that generates information during visits and interviews with the CHT partner and the client household, as well as in focus group discussion scenarios. The guide was provided to all CHDs as part of HealthGov close-out.

HealthGov also developed and tested a tool that allows CHTs to continue working when data collection forms are not forthcoming from the central DOH or CHDs. The alternative is a columnar notebook configured to help CHTs identify those having unmet need for FP/MCH and TB services and make immediate referrals to appropriate health facility. The notebook also tracks. activities to be discussed by the community stakeholders—BHWs, rural health midwife (RHM) and public health nurse (PHN)—to determine which household members will require assistance to access FP information and services. Table 16 below shows the magnitude of training required for CHT partners in the last project year, for which HealthGov was a resource in development of CHT forms, in CHT training by CHDs, and CHT assessment. HealthGov provided CHT training in limited instances: Cagayan Province, Compostela Valley, and Davao Oriental.

[5] The deployment of CHTs is a cross-cutting intervention in FP/MNCHN. CHTs help create demand for FP services, encourage deliveries by SBAs in health facilities, promote mothers' health-seeking behavior for children under age five for child immunization, prevention and treatment of diarrhea, and micronutrient supplementation.

Table 15. Number of Health Providers Trained in FP/ANC-EPI Integration in HealthGov Provinces (as of November 2012)

Province	Number of Health Providers Trained DURING the One Day Forum						Number of Health Providers Trained/ Coached after the One Day Forum					
	Total No. of MHOs/ CHOs	No. of MHOs/ CHOs trained	% MHOs/ CHOs trained	Target No. of Nurses (at least 1 nurse per RHU)	No. of Nurses trained	% Nurses trained	No. of Nurses trained	Total No. of Midwives	No. of Midwives trained	No. of BHWs	No. of BHWs trained	No. of RN Heals trained
Luzon												
Pangasinan	47	27	57%	69	52	75%	0	376	291	10,316	0	0
Cagayan	26	11	42%	31	16	52%	0	199	68	3,550	0	0
Isabela	18	7	39%	39	35	90%	3	210	125	2,560	0	0
Bulacan	21	28	133%	63	57	90%	0	211	32	2,511	34	0
Nueva Ecija	23	24	104%	62	37	60%	0	201	50	2,532	50	0
Tarlac	24	18	75%	39	27	69%	0	131	41	1,948	169	5
Albay	14	6	43%	19	11	58%	0	158	0	3,269	11	0
Visayas												
Aklan	14	14	100%	19	29	153%	0	126	17	2,949	0	50
Capiz	15	15	100%	17	17	100%	0	166	18	4,854	0	55
Negros Occidental	25	25	100%	31	25	81%	0	494	0	6,036	0	0
Bohol	44	36	82%	51	56	110%	12	281	26	8,739	0	0
Negros Oriental	21	11	52%	28	25	89%	16	271	37	3,592	0	0
Leyte	37	31	84%	46	36	78%	1	302	22	5,501	0	0
Western Samar	26	0	0%	26	0	0%	0	159	2	--	1	0
Mindanao												
Zamboanga del Norte	14	6	43%	27	19	70%	0	171	8	1,750	0	0
Zamboanga del Sur	19	16	84%	27	22	81%	0	174	1	3,265	0	0
Zamboanga Sibugay	10	8	80%	16	7	44%	0	70	0	826	0	0
Bukidnon	14	25	179%	22	71	323%	0	187	46	4,053	30	0
Misamis Occidental	10	8	80%	17	92	541%	0	121	66	3,250	14	0
Misamis Oriental	20	13	65%	25	18	72%	0	135	61	3,285	6	0
Compostela Valley	6	7	117%	11	17	155%	0	47	162	604	46	0
Davao del Sur	10	11	110%	15	29	193%	0	112	164	2,645	48	0
Sarangani	4	5	125%	7	13	186%	0	60	1	800	0	0
South Cotabato	11	15	136%	11	20	182%	0	125	0	1,972	0	0
Agusan del Norte	7	11	157%	11	41	373%	0	74	36	1,158	49	0
TOTAL	**480**	**378**	**79%**	**729**	**772**	**106%**	**32**	**4,561**	**1,274**	**81,965**	**458**	**110**

Table 16 Number of CHT Partners Trained (barangay level) in HealthGov Provinces

Province	No. of CHT Partners to be trained	October 2011 to September 2012				Oct to Dec 2012	No. of CHT Partners trained at the barangay level (as of Nov 2012)	% CHT Partners trained at the barangay level
		Q1	Q2	Q3	Q4	Q1		
Luzon								
Pangasinan	7,430	0	1,828	2,186	1,003	5,467	6,470	87%
Cagayan	1,914	75	487	992	333	1,462	1,795	94%
Isabela	2,734	0	166	651	291	957	2,065	76%
Bulacan	3,684	0	439	1,522	1,429	1,982	3,411	93%
Nueva Ecija	4,843	164	845	146	3,753	1,469	5,222	108%
Tarlac	2,348	0	304	0	2,064	283	2,347	100%
Albay	4,412	610	257	0	0	0	867	20%
Visayas								
Aklan	1,746	0	0	0	1,143	0	1,143	65%
Capiz	1,993	0	0	1,624	1,422	938	2,360	118%
Negros Occidental	6,933	0	0	0	6,364	0	6,364	92%
Bohol	3,501	0	0	4,137	4,440	0	4,440	100%
Negros Oriental	4,427	0	0	4,032	4,067	0	4,067	116%
Leyte	6,619	360	4,997	1,502	5,115	3,594	8,709	132%
Western Samar	3,691	0	0	0	1,669	1,425	1,425	39%
Mindanao								
Zamboanga del Norte	5,691	3,607	1,373	646	0	348	5,974	105%
Zamboanga del Sur	8,509	0	1,851	2,580	0	454	4,885	57%
Zamboanga Sibugay	3,732	1,228	3,092	224	0	448	4,992	134%
Bukidnon	4,905	0	0	4,400	5,208	0	5,208	106%
Misamis Occidental	2,303	0	0	2,330	2,327	0	2,327	101%
Misamis Oriental	4,655	0	1,455	2,147	3,405	0	3,405	73%
Compostela Valley	2,907	0	1,048	359	562	0	1,969	68%
Davao del Sur	5,583	0	1,234	219	0	0	1,453	26%
Sarangani	2,223	39	0	0	0	1,956	1,995	90%
South Cotabato	3,539	0	0	0	2,727	0	2,727	77%
Agusan del Norte	2,472	575	229	71	500	0	1,375	56%
TOTAL	**102,795**	**6,658**	**19,605**	**29,768**	**47,822**	**20,783**	**86,995**	**85%**

Note: Number of CHT Partners to be trained is equal to number of NHTS households divided by 20 (average number handled by a CHT Partner).

➢ *Family Planning Competency-Based Training, Levels 1 and 2.* HealthGov held in-depth consultations with the DOH and NCDPC on updating the FP-CBT curriculum, which dated to the 1990s, as well as the need to revise the scope of work for trainers, and to plan and finance a national roll out of updated training. The DOH assembled a Technical Working Group comprised of representatives from the DOH, NCDPC, Family Health Office, Health Human Resource Development Bureau, FP trainers from accredited training centers, NGOs, UNFPA, HealthGov, HPDP, PRISM, and SHIELD. HealthGov, PRISM, and SHIELD—with short-term trainers provided by Health Development Initiatives Institute—sponsored two consultative workshops for representatives of CHDs, PHOs, LGUs, hospitals, and other stakeholders which resulted in revised FPCBT-1 and 2 training modules (FPCBT-2 includes IUD insertion for selected providers with potential for high-volume service provision).

Training the trainer on FPCBT Levels I and 2. The FPCBT TOT is a comprehensive and intensive 6-day training designed for nurses and midwives, from both public and private sectors who have undergone the FP-CBT Level 1 and Level 2 intra-uterine device (IUD) courses or their equivalent; have good communication skills; have experience training in or supervising FP/reproductive health (RH) services; and are committed to training. Participants to this training are those expected to conduct local training and provide technical assistance during the post-training follow-up monitoring. The following four tables show the training outputs for both FPCBT 1 and 2 for midwives and nurses in HealthGov provinces.

3b. Informed Choice and Voluntarism. In 2011, the DOH issued and approved the Guidelines on Ensuring Quality Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism (ICV) (AO No. 0005 s. 2011). The guidelines stipulate the institutionalization of an ICV compliance monitoring system at all levels of the health care delivery system: central DOH, CHD, and provincial, city and municipal LGUs. In support of the AO, HealthGov conducted a rapid baseline survey of health facility compliance with ICV policies and principles in the 600 municipalities and cities of its 25 provinces. A total of 668 health facilities in 580 LGUs were surveyed. Of the 668 health facilities surveyed, 224 were found to have exhibited either one or a combination of possible vulnerabilities. The results of the rapid assessment were presented to DOH-NCDPC and the CHDs were reminded of the approved AO for immediate compliance.

HealthGov immediately deployed some of its staff to conduct full-blown ICV compliance monitoring in facilities with potential vulnerabilities. HealthGov also took the opportunity to disseminate the approved AO and provided technical assistance to partner CHDs and PHOs in establishing an ICV compliance monitoring system. In its final year, HealthGov provided technical assistance to CHDs to establish Regional and Provincial/City ICV compliance monitoring systems for their catchment areas that looks at: (1) promoting ICV compliance implementation among public and private FP service providers and facilities by CHD and LGUs; (2) establishing and institutionalizing ICV compliance monitoring at the provincial and city levels; (3) ensuring implementation of provincial/city ICV monitoring plans; (4) updated recording and timely reporting; and (5) implementing corrective measures. Table 21 shows the number of CHDs/provinces with ICV compliance monitoring systems, and number of health facilities monitored for ICV compliance by HealthGov and partner CHDs/PHOs (as of November 2012)

Table 17. Training in FPCBT1 MIDWIVES (1)	Total LGUs (2)	Total RHUs (3)	Number of RHUs with data both for July 2011 and April 2012 (4)	Year 5 Q4 July 2011 SDC (5)	Year 6 Q1,Q2 April 2012 SDC (6)	Year 6 Q1,Q2 Target from May-Dec 2012 (7)	Year 6 Q3 April-June 2012 (8)	Year 6 Q4 July-Sept 2012 (9)	Year 7 Q1 Oct-Dec 2012 (10)	Total Q3 (Y6),Q4 (Y6),Q1 (Y7) (11)	Percent of total to targets (12)
PANGASINAN	49	64	49	133	226	80	0	27	0	27	34%
CAGAYAN	28	30	28	48	73	50	49	0	0	49	98%
ISABELA	31	33	18	55	56	60	0	26	0	26	43%
BULACAN	21	31	27	22	26	50	0	2	40	42	84%
NUEVA ECIJA	32	51	47	8	14	75	0	26	46	72	96%
TARLAC	18	36	25	37	43	42	42	1	0	43	102%
ALBAY	16	16	11	78	79	80	25	0	0	25	31%
AKLAN	17	19	14	20	22	84	0	48	0	48	57%
CAPIZ	17	17	13	79	83	30	0	0	0	0	0%
NEGROS OCCIDENTAL	31	31	30	147	173	180	0	100	0	100	56%
BOHOL	48	52	49	155	158	50	31	0	0	31	62%
NEGROS ORIENTAL	23	26	24	162	188	90	35	0	0	35	39%
LEYTE	40	43	36	145	176	30	47	0	0	47	157%
WESTERN SAMAR	21	21	17	32	32	34	18	18	19	55	162%
ZAMBOANGA DEL NORTE	22	22	21	46	47	20	18	0	0	18	90%
ZAMBOANGA DEL SUR	22	22	16	29	34	15	21	0	0	21	140%
ZAMBOANGA SIBUGAY	15	15	15	26	34	10	24	0	0	24	240%
BUKIDNON	22	22	21	68	64	60	3	24	0	27	45%
MISAMIS OCCIDENTAL	17	17	15	37	45	91	0	16	0	16	18%
MISAMIS ORIENTAL	23	23	20	22	37	84	0	29	0	29	35%
COMPOSTELA VALLEY	10	10	7	33	50	14	0	0	0	0	0%
DAVAO DEL SUR	15	15	14	89	39	25	0	0	34	34	136%
SARANGANI	7	7	6	34	35	-	0	0	0	0	-
SOUTH COTABATO	11	11	11	71	77	40	0	36	0	36	90%
AGUSAN DEL NORTE	11	11	11	49	56	22	14	0	4	18	82%
TOTAL	**567**	**645**	**545**	**1,625**	**1,867**	**1,316**	**327**	**353**	**143**	**823**	63%

Table 18. Training in FPCBT1 NURSES (1)	Total LGUs (2)	Total RHUs (3)	Number of RHUs with data both for July 2011 and April 2012 (4)	Year 5	Year 6				Year 7	Total Q3 (Y6),Q4 (Y6),Q1 (Y7) (11)	Percent of total to targets (12)
				Q4	Q1,Q2		Q3	Q4	Q1		
				July 2011 SDC (5)	April 2012 SDC (6)	Target from May-Dec 2012 (7)	April-June 2012 (8)	July-Sept 2012 (9)	Oct-Dec 2012 (10)		
PANGASINAN	49	64	53	48	51	20	0	3	0	3	15%
CAGAYAN	28	30	28	21	22	50	5	0	0	5	10%
ISABELA	31	33	27	32	32	13	0	4	0	4	31%
BULACAN	21	31	27	15	15	28	0	3	2	5	18%
NUEVA ECIJA	32	51	48	20	30	-	0	3	1	4	-
TARLAC	18	36	25	18	18	33	0	3	0	3	9%
ALBAY	16	16	13	24	24	-	0	0	0	0	-
AKLAN	17	19	16	14	18	5	0	3	0	3	60%
CAPIZ	17	17	14	27	28	9	0	0	0	0	0%
NEGROS OCCIDENTAL	31	31	31	43	37	101	0	1	1	2	2%
BOHOL	48	52	49	41	41	20	2	0	0	2	10%
NEGROS ORIENTAL	23	26	24	33	35	15	0	0	0	0	0%
LEYTE	40	43	40	47	47	-	8	0	0	8	-
WESTERN SAMAR	21	21	19	22	21	7	3	0	5	8	114%
ZAMBOANGA DEL NORTE	22	22	21	14	16	11	6	0	0	6	55%
ZAMBOANGA DEL SUR	22	22	18	17	18	8	11	0	0	11	138%
ZAMBOANGA SIBUGAY	15	15	15	13	13	6	16	0	0	16	267%
BUKIDNON	22	22	22	6	8	17	6	3	0	9	53%
MISAMIS OCCIDENTAL	17	17	17	14	14	17	0	1	0	1	6%
MISAMIS ORIENTAL	23	23	23	4	7	17	0	0	0	0	0%
COMPOSTELA VALLEY	10	10	10	16	18	4	0	0	0	0	0%
DAVAO DEL SUR	15	15	14	24	7	25	0	0	10	10	40%
SARANGANI	7	7	6	6	6	-	0	0	0	0	-
SOUTH COTABATO	11	11	11	23	24	3	0	12	0	12	400%
AGUSAN DEL NORTE	11	11	11	13	13	6	2	0	4	6	100%
TOTAL	**567**	**645**	**582**	**555**	**563**	**415**	**59**	**36**	**23**	**118**	28%

Table 19. Training in FPCBT2 MIDWIVES *(1)*	**Total LGUs** *(2)*	**Total RHUs** *(3)*	**Number of RHUs with data both for July 2011 and April 2012** *(4)*	**Year 5**	**Year 6**				**Year 7**	**Total Q3 (Y6), Q4 (Y6),Q1 (Y7)** *(11)*	**Percent of total to targets** *(12)*
				Q4	**Q1,Q2**		**Q3**	**Q4**	**Q1**		
				July 2011 SDC *(5)*	**April 2012** SDC *(6)*	**Target** from May-Dec 2012 *(7)*	**April-June 2012** *(8)*	**July-Sept 2012** *(9)*	**Oct-Dec 2012** *(10)*		
PANGASINAN	49	64	49	117	187	80	0	28	0	28	35%
CAGAYAN	28	30	28	31	41	20	0	19	0	19	95%
ISABELA	31	33	18	21	24	50	0	10	0	10	20%
BULACAN	21	31	27	1	1	-	0	0	21	21	-
NUEVA ECIJA	32	51	47	4	4	-	0	4	9	13	-
TARLAC	18	36	25	0	5	-	0	2	17	19	-
ALBAY	16	16	11	22	20	10	0	0	0	0	0%
AKLAN	17	19	14	6	7	50	0	0	17	17	34 %
CAPIZ	17	17	13	68	70	43	0	0	0	0	0%
NEGROS OCCIDENTAL	31	31	30	79	80	30	0	0	40	40	133%
BOHOL	48	52	49	53	58	40	0	0	29	29	73%
NEGROS ORIENTAL	23	26	24	80	98	20	0	25	0	25	125%
LEYTE	40	43	36	92	109	17	0	13	0	13	76%
WESTERN SAMAR	21	21	17	17	19	-	0	0	0	0	-
ZAMBOANGA DEL NORTE	22	22	21	9	10	25	0	19	0	19	76%
ZAMBOANGA DEL SUR	22	22	16	14	15	23	0	16	0	16	70%
ZAMBOANGA SIBUGAY	15	15	15	5	6	16	0	24	0	24	150%
BUKIDNON	22	22	21	12	9	75	0	21	0	21	28%
MISAMIS OCCIDENTAL	17	17	15	33	30	5	0	0	0	0	0%
MISAMIS ORIENTAL	23	23	20	14	21	21	0	25	0	25	119%
COMPOSTELA VALLEY	10	10	7	18	31	39	0	42	0	42	108%
DAVAO DEL SUR	15	15	14	72	19	8	0	0	25	25	313%
SARANGANI	7	7	6	8	9	-	0	0	0	0	-
SOUTH COTABATO	11	11	11	30	46	11	0	12	0	12	109%
AGUSAN DEL NORTE	11	11	11	33	32	37	0	17	0	17	46%
TOTAL	**567**	**645**	**545**	**839**	**951**	**620**	**0**	**277**	**158**	**435**	70%

Table 20. Training in FPCBT2 NURSES *(1)*	Total LGUs *(2)*	Total RHUs *(3)*	Number of RHUs with data both for July 2011 and April 2012 *(4)*	Year 5	Year 6				Year 7	Total Q3 (Y6),Q4 (Y6),Q1 (Y7) *(11)*	Percent of total to targets *(12)*
				Q4	Q1,Q2		Q3	Q4	Q1		
				July 2011 SDC *(5)*	April 2012 SDC *(6)*	Target from May-Dec 2012 *(7)*	April-June 2012 *(8)*	July-Sept 2012 *(9)*	Oct-Dec 2012 *(10)*		
PANGASINAN	49	64	53	45	45	20	0	2	0	2	10%
CAGAYAN	28	30	28	13	12	40	0	4	0	4	10%
ISABELA	31	33	27	13	14	-	0	6	0	6	-
BULACAN	21	31	27	6	6	29	0	1	2	3	10%
NUEVA ECIJA	32	51	48	8	8	-	0	0	11	11	-
TARLAC	18	36	25	12	11	33	0	2	4	6	18%
ALBAY	16	16	13	11	12	10	0	0	0	0	0%
AKLAN	17	19	16	13	15	9	0	0	0	0	0%
CAPIZ	17	17	14	13	13	15	0	0	0	0	0%
NEGROS OCCIDENTAL	31	31	31	25	28	10	0	0	0	0	0%
BOHOL	48	52	49	12	12	53	0	0	0	0	0%
NEGROS ORIENTAL	23	26	24	17	18	30	0	0	0	0	0%
LEYTE	40	43	40	40	42	6	0	6	0	6	100%
WESTERN SAMAR	21	21	19	14	13	-	0	0	0	0	-
ZAMBOANGA DEL NORTE	22	22	21	6	9	13	0	1	0	1	8%
ZAMBOANGA DEL SUR	22	22	18	8	9	13	0	0	0	0	0%
ZAMBOANGA SIBUGAY	15	15	15	4	5	9	0	7	0	7	78%
BUKIDNON	22	22	22	2	1	10	0	6	0	6	60%
MISAMIS OCCIDENTAL	17	17	17	12	13	10	0	0	0	0	0%
MISAMIS ORIENTAL	23	23	23	2	3	20	0	3	0	3	15%
COMPOSTELA VALLEY	10	10	10	12	13	9	0	6	0	6	67%
DAVAO DEL SUR	15	15	14	16	3	29	0	0	2	2	7%
SARANGANI	7	7	6	5	5	-	0	0	0	0	-
SOUTH COTABATO	11	11	11	12	14	9	0	0	0	0	0%
AGUSAN DEL NORTE	11	11	11	5	5	3	0	3	0	3	100%
TOTAL	**567**	**645**	**582**	**326**	**329**	**380**	**0**	**47**	**19**	**66**	17%

Table 21. ICV Compliance Monitoring	Number of CHDs with an ICV compliance monitoring and reporting systems		Number of provinces with an ICV compliance monitoring and reporting systems			Health facilities monitored for ICV compliance by HealthGov										Number of health facilities monitored for ICV compliance by CHD/PHO only
Province	No. of CHDs	No. of CHDs with an ICV compliance monitoring and reporting systems	Baseline	No. of HealthGov provinces	No. of Provinces with ICV compliance monitoring and reporting system	Baseline	Target No. of Health Facilities	October 2011-September 2012				Oct-Dec 2012	No. of Health Facilities monitored by HealthGov	% of Health Facilities monitored by HealthGov	No. of health facilities for ICV compliance by CHD/PHO
								Q1	Q2	Q3	Q4	Q1			
Luzon															
Pangasinan	1	1	1	1	1	4	15	0	0	15		2	17	113%	7
Cagayan			1	1	1	7	15	0	4	0	12	12	28	187%	0
Isabela	1	1	1	1	1	4	15	0	0	9	6	0	21	140%	33
Bulacan			1	1	1	0	15	0	1	11	3	0	15	100%	35
Nueva Ecija			1	1	1	0	15	0	2	11	2	0	15	100%	33
Tarlac	1	1		1	1	2	15	0	1	12	3	0	16	107%	0
Albay	1	0	1	1	0	3	15	0	3	9		0	12	80%	0
Visayas															
Aklan			1	1	1	6	15	0	6	20	6	0	32	213%	25
Capiz				1	1	10	15	0	0	10	7	0	17	113%	6
Negros Occidental	1	1	1	1	1	8	15	0	0	19	8	0	27	180%	16
Bohol	1	1	1	1	1	38	15	0	4	18	**9**	0	31	207%	0
Negros Oriental			1	1	1	10	15	0	3	11	7	0	21	140%	0
Leyte	1	0		1	1	0	15	0	1	9	5	0	15	100%	0
Western Samar				1	1	0	15	0	0	6	10	0	16	107%	0
Mindanao															
Zamboanga del Norte			1	1	1	27	15	0	11	4	0	0	15	100%	13
Zamboanga del Sur	1	1	1	1	1	17	15	0	17	0	0	0	17	113%	9
Zamboanga Sibugay				1	1	13	15	0	11	5	0	0	16	107%	11
Bukidnon			1	1	1	22	15	0	3	12	0	0	15	100%	2
Misamis Occidental				1	1	10	15	0	4	13	0	0	17	113%	3
Misamis Oriental	1	1		1	1	14	15	0	4	12	0	0	16	107%	3
Compostela Valley			1	1	1	3	15	0	1	12	3	0	16	107%	3
Davao del Sur	1	0		1	1	0	15	0	3	23	0	0	26	173%	0
Sarangani			1	1	0	7	15	0	0	0	15	0	15	100%	0
South Cotabato	1	0	1	1	0	6	15	0	0	0	15	0	15	100%	0
Agusan del Norte	1	1	1	1	1	11	15	0	5	9	2	0	16	107%	4
TOTAL	**12**	**8**	**17**	**25**	**22**	**222**	**375**	**0**	**84**	**250**	**113**	**14**	**467**	**125%**	**203**

3c. Service Delivery Excellence in Health (SDExH). SDExH **i**s a continuing quality improvement (CQI) approach which aims to improve service providers' acquisition and demonstration of desirable knowledge, behaviors, and skills for excellent quality service. It aims to enable health staff to assess, plan, and implement measures to improve the quality of health care in a continuing manner and to establish mechanisms for clients to participate in the provision and utilization of quality care and services. SDExH is a five cycle process, entailing: formulation of health service vision; setting local service standards; implementing these standards; measuring their progress in achieving the standards; and providing recognition and awards based on their achievements**.** SDExH Training Program is primarily patterned after the Public Service Excellence Program introduced in selected provinces in the mid-1990s and early 2000 through the USAID GOLD and Lead for Health Projects, and consequently adopted by the Civil Service Commission. It also makes use of Jhpiego's Standards-Based Management and Recognition (SBM-R) CQI program, which is currently implemented in 15 other countries, as well as the DOH *Sentrong Sigla* Certification standards.

Regional and provincial health technical staff and program coordinators are the key training facilitators at the local level. HealthGov conducted a highly participatory/consultative process of developing, vetting, and testing training materials and guidelines for SDExH modules, which were prioritized in HSRA F1 sites. Subsequently, in November 2008, PhilHealth's "Benchbook Standards for Outpatient Services (PBSOS)" was approved by the PhilHealth Board. SDExH is one of the PBSOS technical assistance packages included in DOH regional training of trainers and orientations on the PBSOS. The inclusion of SDExH in PBSOS demonstrates the important role of SDExH in the overall achievement of the accreditation standards of PBSOS categories on Clients Rights and Organizational Ethics, Client Care and Program Delivery, Leadership and Management, Safe Practice and Environment, and, in particular, on Performance Improvement where SDExH is proposed as one of the CQI FP-MNCHN approaches that can be used.At the close of the project, 44 facilities in 7 HealthGov provinces had adopted SDExH as their CQI approach. Table 22 shows where SDExH TA was conducted.

Table 22: LGUs/Offices Provided with Technical Assistance on SDExH

Center for Health Development	Province/Office /Hospital	Municipality/Hospital
CHD – Northern Mindanao	Misamis Occidental- Provincial Health Office / Misamis Occidental Provincial Hospital	Oroquieta City ILHZ: Aloran, Jimenez, Lopez Jaena, Oroquieta City Ozamiz ILHZ: Clarin, Tudela, Sinacaban, MHARS General Hospital, SM Lao Hospital
	Negros Oriental - Provincial Health Office/ Negros Oriental Provincial Hospital	Metropolitan ILHZ: Amlan, Bacong, Dauin, San Jose, Valencia, STABAYABAS ILHZ: Bayawan, Santa Catalina, Basay , Bayawan District Hospital
	Capiz	Bailan ILHZ: Bailan District Hospital, Pontevedra, Pres. Roxas, Pilar, Maayon
	Albay	JOLLIPOQUI ILHZ: Oas, Polangui, Guinobatan, Josefina Belmonte Duran District Hospital
	Bulacan	Angat, Dona Remedios Trinidad, San Rafael, San Jose del Monte
CHD – Southern Mindanao	Compostela Valley – Compostela Valley Provincial Hospital	CoMMMoNN ILHZ: Compostela, Monkayo, Mawab, Montevista, Nabunturan, New Bataan
	Agusan del Norte- Agusan Norte Provincial Hospital	BueNaCar ILHZ : Buenavista, Nasipit, Carmen, Nasipit District Hospital

➢ *Improve supportive supervision for PHNs to enable them to effectively supervise and monitor implementation of FP/MNCHN programs, including data quality checks.* The PHN is the most critical ally in ensuring that quality health services are delivered by the RHMs at the barangay health station. The quality of supervision exercised by PHNs over RHMs could spell the difference in the quality of services provided by RHMs. Thus it is important that PHNs are trained in supportive supervision and have a document that serves as their reference when implementing supportive supervision. HealthGov updated and enhanced the existing trainer's guide for PHNs on supervision, treating the PHN as both the "subject" and the "object" of training in a simulated working environment to achieve the 'missing element' on supervision. The trainer's guide is designed to actively involve the participants in the learning process as adult learners. Each of its four modules corresponds to a chapter in the corollary Resource Manual, which provides more detail on the context and framework of supervision, how the concepts of supportive supervision are integrated into health management and the goals of supportive supervision. The trainer's guide is intended for the use of trainers, nurse supervisors and CHD/PHO across the country.

The Resource Manual takes the PHN through the whole gamut of supervision – how to be a good communicator, decision maker, human relations facilitator, team player, and trainer are spelled out to ensure that the PHN becomes a well-rounded leader in the field. The link between supportive supervision and quality service delivery is also emphasized. The manual includes tools that can be used by the PHN when conducting supervision, such as a prioritization tool to identify priority RHMs/BHS for supervision and an integrated supervisory checklist. Table 23 shows PHN supportive supervision data through November 2012.

Table 23. Number of PHNs trained in Supportive Supervision

Province	Baseline	No. of Nurses (LGU target)	Oct 2011-Sept 2012				Oct-Dec 2012	No. of Nurses trained	% of Nurses trained
			Q1	Q2	Q3	Q4	Q1		
Luzon									
Pangasinan	0	84	0	0	0	74	0	74	88%
Cagayan	0	33	0	0	23	0	0	23	70%
Isabela	0	30	0	0	30	0	0	30	100%
Bulacan	0	32	0	0	0	26	0	26	81%
Nueva Ecija	21	35	0	0	36	0	0	36	103%
Tarlac	0	26	0	26	0	0	0	26	100%
Albay	0	20	0	0	0	0	0	0	0%
Visayas									
Aklan	0	28	0	0	0	0	20	20	71%
Capiz	0	36	0	0	0	0	35	35	97%
Negros Occidental	0	35	0	0	0	0	31	31	89%
Bohol	0	51	0	0	0	0	53	53	104%
Negros Oriental	0	28	0	0	0	0	24	24	86%
Leyte	0	37	0	0	0	0	20	20	54%
Western Samar	0	25	0	0	0	0	1	1	4%
Mindanao									
Zamboanga del Norte	0	32	0	0	0	0	0	0	0%
Zamboanga del Sur	0	33	0	0	0	0	0	0	0%
Zamboanga Sibugay	0	17	0	0	0	0	0	0	0%
Bukidnon	0	24	0	0	0	25	0	25	104%

Misamis Occidental	0	25	0	0	0	12	0	12	48%
Misamis Oriental	0	20	0	0	0	20	0	20	100%
Compostela Valley	0	14	0	0	0	0	0	0	0%
Davao del Sur	0	21	0	0	0	0	0	0	0%
Sarangani	0	15	0	0	0	0	0	0	0%
South Cotabato	0	22	0	0	0	0	0	0	0%
Agusan del Norte	0	17	0	0	0	0	0	0	0%
TOTAL	**21**	**740**	**0**	**26**	**89**	**157**	**184**	**456**	**62%**

Note: The targets above refer to those agreed to be trained in PHN Supportive Supervision by CHD, PHO and MHO/CHO during the One-Day Forum.

4. Increase advocacy for health.

HealthGov consulted extensively with LGU health officers, DOH and CHD officials, and NGOs/CSOs engaged in advocacy activities for health programs and projects to produce a *Handbook on Local Advocacy for Health.* The Handbook is a user-friendly reference for advocacy stakeholders who seek to influence decision-makers towards better-informed health policies, bigger health budgets, more effective health systems, and expanded, high-quality services—the essentials of good health governance. The handbook provides step-by-step procedures and practical tips, tools, and templates including the following:

- The Elements of an Advocacy Framework: Building Partnerships for Health
- Data Sets for LGU Scoping and NGO Scanning
- Guide for Engaging Stakeholders
- Template for LHB Inventory and Policy Scanning
- Samples of Activity Designs for Workshops and Presentation Materials
- Template for Political Mapping
- "Action Plan" Template
- Guide for Documenting LGU Advocacy Experiences and Results
- Tools and Templates for One-on-One Meetings and Orientation Activities for LCEs
- Tools and Templates for Policy Dialogues and Related Activities
- Tools and Templates for Making Public Hearings More Effective
- Tools and Templates for Maximizing LHB Deliberations on Health
- Tools and Templates for Using PIR Results for Advocacy
- Tools and Templates for Disseminating Information on Health Policies and Plans
- Tools and Templates for Mobilizing Health Champions to Mount Promotional Events
- Tools and Templates for Mobilizing LGU and Community Support for MNCHN
- Tools and Templates for Implementing Community Feedback Mechanisms

The Handbook provides many examples of applied advocacy techniques as a roadmap for replication around the country. Two of these examples are cited below as indicative of the advocacy activities carried out by HealthGov, with implementing partner PNGOC.

Providing Quality Maternal, Newborn and Child Health and Nutrition Services Accessible to Rural Women and Children in Polomolok, South Cotabato. In Polomolok, South Cotabato, several barangay LGUs decided to prioritize strong community structures that could guarantee proper and timely care for mothers throughout their pregnancy and delivery. While no maternal deaths were recorded in 2008, CPR in Polomok was low at 30%, and FBD was at 45%. Strengthening SBA and FBD indicators would entail transforming the roles of traditional birth attendants (TBAs) or *hilots*, who are considered leading providers of care during home

deliveries in rural areas, and who are often highly preferred by mothers over facilities. Women in rural areas are often poor, and depend on barangay assistance for access to MNCHN care.

From 2009 to 2010, HealthGov supported advocacy actions that were led by the MHO, PHO, and DOH representative in Polomolok to broaden LGU support and increase LGU investments for improved access to quality MNCHN services:

- *Barangay Captains' Forum* to orient on the local maternal and child health situation and challenges and DOH AO 2008-0029 Guideline on rapidly reducing maternal and newborn mortality, and to solicit support for the implementation of local MNCHN plan
- *Barangay Health Teams (BHTs) orientation and action planning sessions on MNCHN* to increase their awareness on the provisions of DOH AO 2008-0029 (MNCHN strategy), and sign a manifesto to support the implementation of the MNCHN strategy and local action plan. BHTs comprised the barangay captains, the RHMs, BHWs, and TBAs. The BHTs were identified as the community core team who will plan, implement, and monitor key activities to generate demand and help families, particularly women, gain access to MCH services, and to mobilize barangay officials and community support in terms of policy reforms, and funding for MNCHN activities at the barangay level.
- *MNCHN Orientation for TBAs* to promote understanding of key interventions on MNCHN and define their new role in line with the provisions of MNCHN strategy
- *Capacity building for health champions* such as the Study Tour of Barangay Officials, MHO and selected RHMs to the MCP-accredited birthing facility in Maramag, Bukidnon to learn from the experiences of local officials, RHU and BHS staff in operating the birthing facility, coaching the Barangay Captain and Kagawad on Health to formulate barangay policies, e.g. resolution or ordinance to promote facility-based deliveries
- *Health Policy Support*—The Barangay Councils of ten barangays approved barangay resolutions and ordinances to establish birthing clinics and promote FBD and deliveries by SBAs, and deputizing the Purok (village) Leaders to enforce and monitor implementation. Policies were also passed to allow the use of barangay vehicles to transport pregnant women in labor and emergency cases, to create livelihood projects for TBAs using barangay funds, and to charge user fees for barangay birthing facilities.
- *Community mobilization for FP/MNCHN Services*— The RHU staff held consultations with private health service providers to orient them on the MNCHN policy and agree on referral mechanisms among public and private service providers for maternal, newborn and child health services. BHWs and other community volunteers were mobilized to identify and create a master list of pregnant women and to motivate these women to visit the health center for prenatal consultation and formulation of their birth plan.

Result: Barangay birthing clinics opened and started offering safe and quality birthing services in several barangays including Sulit, Palkan, Koronadal Proper, and Upper Klinan. TBAs were oriented to bringing pregnant women into the continuum of MNCHN care.

Advocacy to LGU for Commodity Self-Reliance in Negros Oriental. The Province of Negros Oriental began struggling with CSR in 2006, when health officials realized that their plans were not materializing because they needed legislative support to establish supportive policy and budgets. LGUs would first have to formally assume responsibility to provide quality FP/MNCHN

planning services and commodities, as mandated by the central government. The development of the Province-wide CSR+ plan involved a series of advocacy activities, as follows:

- *Consultations with Regional and Provincial Partners.* Initial consultations were made with regional partners and the Provincial CSR TWG to discuss the CSR+ strategy and its implementation.

- *CSR Assessment.* The provincial SDIR in 2007 revealed very low performance in maternal and child care. Nine out of the 25 LGUs were below the provincial average of 69% for FIC and only 11% for Vitamin A coverage. For FP, eight LGUs had CPRs ranging from 20 to 26% compared to a provincial average of 40%; they became the priority LGUs.

- *Municipal/Province-wide CSR+ Planning Workshop.* A planning workshop was held for the *Sangguniang Bayan* (SBs) for Health, MHOs, PHNs, Municipal Planning and Development Coordinators (MPDCs) and Municipal Budget Officers (MBOs). At this point, the PHO/MHOs needed to secure budget support for the purchase of FP commodities, TB drugs, and Vitamin A for the poor; for distribution; and for other CSR-related interventions. There was also the need to have provincial and municipal CSR+ ordinances passed to support the LGU's CSR+ implementation.

  To assist the PHO/MHOs, HealthGov engaged a local NGO to mobilize local stakeholder support for the CSR+ plans. The Philippine Partnership for the Development of Human Resources in Rural Areas (PhilDHRRA) provided technical assistance to eight municipalities. Courtesy visits to the respective mayors and consultative meetings with LGU officials were held in each municipality by the LTAP team as the first step.

- *Mapping Support for CSR+/FP.* The first major activity done in the eight priority LGUs was mapping support for CSR+/FP from the LCE, LGU, NGOs, the private sector and the community. This was used as the baseline for preparing multi-stakeholder dialogues in support of policy formation.

- *Policy dialogues on CSR+/FP.* Policy dialogues followed involving SBs on Health, SBs on Appropriations, LHBs, LFCs, and NGO leaders to draft and present LGU municipal ordinances on CSR+ to the public.

- *Municipal Multi-Sectoral Forums or Community Consultations/Dialogues.* More forums and dialogues were held in priority LGUs to help PHOs/MHOs solicit inputs and feedback from the communities, secure support for the policy, and leverage municipal/barangay resources for CSR+/FP. Inputs from NGOs, POs, the private sector and CSOs were considered and integrated into CSR policies.

Results: Negros Oriental passed a CSR+ ordinance in 2009, and allocated supplemental funding to six ILHZs to help secure needed commodities. Six municipalities also passed ordinances and allocated funding. Through the advocacy effort, public awareness on CSR+/MNCHN program was raised, particularly through promotions on television, and interviews with LCEs that were broadcasted to wider audiences. NGO TA provided a platform for PPP formation and for cost-sharing among partners; LGUs actively took part in the process and allocated resources, such as hosting meetings at facilities and providing equipment.

III. Integrated and Purpose-Driven Capacity Building

HealthGov remained relevant and responsive to counterparts in a highly decentralized health sector by keeping counterpart attention focused on what LGU health data and other evidence spotlighted as priority concerns for officials. Understanding those concerns, project staff were able to help counterparts at all levels understand and discharge their responsibilities for improving outcomes. The project called on and developed the capacities of local TA partners to accelerate the pace of change and reform, and excelled at documenting and spreading its learning.

Connecting Data and Evidence to Decision Making and Innovation

HealthGov concentrated TA heavily on making the national FHSIS a reliable and useful tool for LGU planning and decision making. Transferring tools, skills, and knowledge to conduct quality assurance of FHSIS data on FP/MNCHN—checking, cleaning, recording, and using data properly—was a major undertaking and success of HealthGov, though the work is not completed. Through the project, the DOH has the training materials and technical documentation it needs to continue national scale up of the DQC/DQA process; the experience of project counterparts, such as that shown in the box at right, is also a powerful tool in convincing LGUs at each level to ensure FHSIS accuracy and utility in providing high-impact FP/MNCHN services.

> "The introduction of the DQC process by the DOH was very much welcomed by the province and its component LGUs, as a way to validate their FHSIS data, for them to have better quality data for reporting and for planning and decision-making. DQC focused on reviewing reported data and assessing if such data conformed with the FHISIS guidelines for recording and reporting—at first one would say that the task was fairly simple, but it wasn't—we realized that many LGUs in Pangasinan have a different understanding of the indicator definition and how they will be collected, recorded and reported. The truth reveals that many even did not truly understand the intention of such indicators and thus couldn't appreciate the true importance of accurate reporting."—Pangasinan Province "Impact of DQC Implementation," 2011 HealthGov Dissemination Forum

The key to more focused targeting and delivery of services for beneficiaries at the local level is obtaining information about who they are, where they are, and what are their needs. This is possible when locally generated data are available, which LGUs can process, analyze and use to provide such information. To support more focused delivery of services and local subsidies (such as PhilHealth premium subsidies), HealthGov helped LGUs to develop their capacity to analyze, disseminate, and use locally generated data to guide the determination of priority areas (municipalities and communities, including GIDA) and social groups (the poor, women of reproductive age, children under age 5) for more focused interventions in FP and MNCHN. Locally-generated data was provided by both the CBMS, promoted by the DILG and other national agencies, and the CHLSS supported by HealthGov. Through simple cross-tabulations, PHO and MHO staff can establish baselines for targeting public health programs and advocacy efforts to priority populations. HealthGov provided training on data processing, analysis, and technical writing to LGU staff, and involved the Planning and Development Coordinators (PDCs) and the provincial, municipal and city health officers in using data to understand the status and intersections of service delivery, PhilHealth enrollment, and local development planning.

HealthGov also engaged in an innovative PPP to materially change the way the FHSIS is managed in the field, at the local level: the Wireless Access for Health (WAH) initiative (see the box on the following page). HealthGov provided management and supervisory support to the

WAH team and the Tarlac Provincial Health Office (TPHO), where WAH has been piloted, as well as technical assistance and financial support to the conduct of the data analysis and utilization workshop for the WAH/EMR end-users. WAH will continue past the close of HealthGov, with these activities:

Systems Deployment and Training of Health Personnel. The goal of the WAH Initiative remains scaling up the use of the EMR in all RHUs in Tarlac Province by April 2013. At the end of December 2012, of the 39 RHUs, 33 have completed pre deployment, 30 have completed EMR deployment and Level 1 EMR training, and 27 have completed Level 2 EMR training. There are 29 RHUs submitting morbidity reports (Level 1); of these, 23 are now regularly submitting FHSIS reports (Level 2) to the PHO. The electronic submission of reports from RHUs to the PHO is one of the important goals of the project's effort to make FHSIS reporting more timely and efficient.

Outside of Tarlac, four additional clinics have undergone Level 1 training. This brings to 34 the total number of RHUs using the WAH/EMR platform. In this quarter, 72 health personnel underwent Level 1 training bringing to a total of 524 health personnel trained under the WAH.

- *WAH-EMR Software Development and Server Upgrading*. The WAH EMR format has been continually upgraded, and now allows, among other fields, Continuous synchronization of health facility IDs in accordance to DOH facility codes; laboratory reports; service use monitoring capacities; daily service reports, including tags for NHTS-PR families; and additional electronic validation mechanisms for FHSIS health program data.

- *Synchronized Patient Alerts by SMS (SPASMS)*. The SPASMS module continues to run in three RHUs. There are already around 2,347 clients enrolled in the program; the number of messages in the last quarter of 2012 doubled to 2,995 covering the 21 catchment barangays in the three municipalities. The WAH team sees a cautious but steady expansion of SPASMS starting in February 2013. Smart Communications is also expected to complete the site and technical assessment report for all RHUs in Tarlac and the adoption of the recommended plan of actions.

- *Mobile Midwife Module (MMM).* The MMM is currently deployed in Gerona covering eleven barangays, in Paniqui with 23 barangays, and in Moncada with twelve barangays. The challenge of synching data from mobile devices to the WAH-EMR server at the RHU continues to be the biggest stumbling block for the modules' expansion to other sites. Another attempt to sync data is expected to occur in late January and if successful, shall pave the way for a soft expansion of the pilot testing in two more RHUs in Gerona and Moncada.

- *Electronic Report Submission of FHSIS reports*. The WAH team has been working to ensure inter-operability between WAH software and the DOH's e-FHSIS. Twelve participants from four RHUs participated in a test and successfully uploaded electronic reports to the DOH website (versus sending by email). Twenty seven RHUs are expected to complete electronic FHSIS reporting by the end of March 2013.

- *Municipal and Provincial Inter-Connectivity of Health Clinics and Inter-Operability with Other Systems*. Having demonstrated WAH's inter-operability with the DOH's e-FHSIS, the team is now working with the provincial government and PhilHealth in synchronizing the system with the latter's Primary Care Benefit (PCB) package. The Governor of Tarlac has pledged the province's continuing support for this effort.

Wireless Access for Health: Using 3G Technology to Improve Health Care in the Philippines

FHSIS data is used for policy analysis and planning at all levels of the public health system. Most FHSIS data originate during patient care at barangay health stations, city health units, rural health units, and hospitals. It is up to the doctors, nurses and other health care providers at these facilities to treat patients, record their information, and assemble clinic-wide reports. Traditionally this information has been manually recorded on paper — a process that is not only time consuming, but also error prone. Accessing and managing information in this manner is labor intensive and the data can often be outdated or incorrect.

Supported by Qualcomm's Wireless Reach™ initiative, HealthGov put in place a multi-sector partnership to pilot a solution to data collection and reporting challenges. WAH reduces the time required for monthly reporting and improves access to accurate and relevant patient information for clinicians and decision makers. Specific technologies include:

- **3G Wireless Technology.** A high-speed 3G wireless data network brings fast and reliable Internet services to health clinics. Reports that used to be delivered by people using motorcycles or jeepneys can now be sent instantly via 3G directly to the people who need them most.

- **Low-Cost Hardware**. Computer hardware, such as netbooks, tablets and smartphones, are now affordable enough to become a standard tool for health care providers, even in regions where health care budgets are limited.

- **Open Source Software**. Community Health Information Tracking System (CHITS) is an open and freely available electronic medical record (EMR) system developed in the Philippines. CHITS was significantly expanded and enhanced to be compatible with FHSIS, and can be used in conjunction with other open source software, like Ubuntu Linux and MySQL, to develop a completely free and community supported system.

WAH has expanded the CHITS EMR platform to support data collection and reporting from barangays through the Mobile Midwife Platform and sends patient alerts through the Synchronized Patient Alert via SMS. As of March 2013, WAH has been successfully adopted in 32 clinics in the Tarlac Province and five clinics outside of Tarlac: Metro Manila, Luzon, Visayas, and Mindanao. Together, they serve more than 2,000 patients a day using the WAH platform. WAH partners are:

- Philippine Department of Health, through the National Epidemiology Center, the Information Management Service and the Center for Health Development (Region 3)
- RTI International
- Qualcomm Wireless Reach Initiative
- Smart Communications, Inc.
- Tarlac Local Government Units: Provincial Government, League of Municipalities, and City of Tarlac
- Tarlac Provincial Health Office
- Tarlac State University
- United States Agency for International Development
- University of the Philippines Manila, National Telehealth Center
- Zuellig Family Foundation

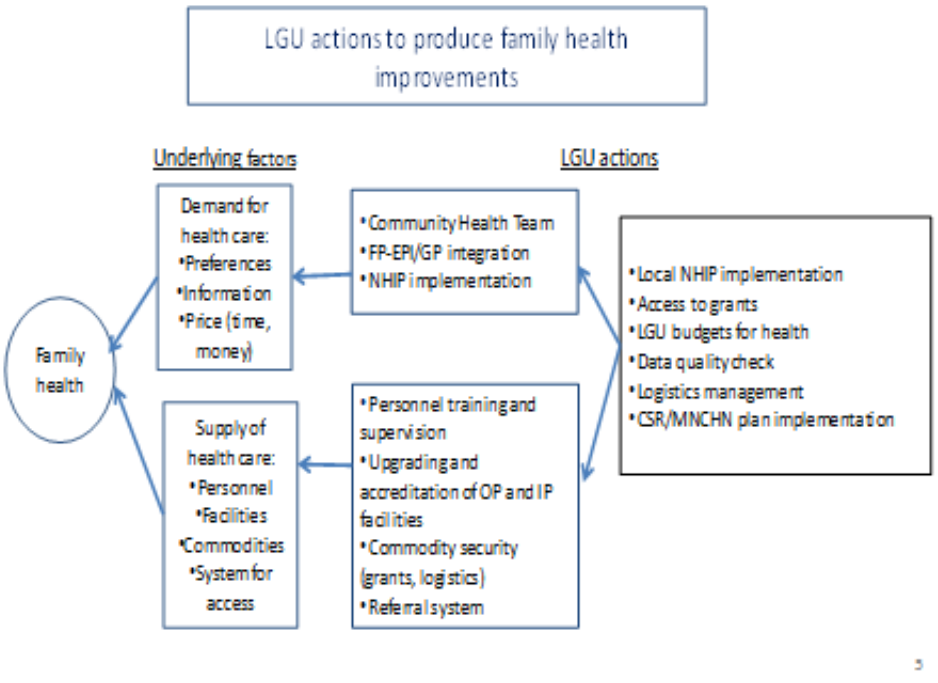
The WAH initiative continues to receive accolades from award-giving bodies in the Philippines. At the national level, WAH was awarded first place for Customer Empowerment in the first e-Governance awards for LGUs, organized by the National ICT Confederation of the Philippines and endorsed by the DILG. The Province of Tarlac bested more than thirty finalists that submitted nominations for the awards.

The Governor of Tarlac also presented during the HealthGov Dissemination Forum for Luzon Region, which was attended by almost one hundred health leaders and managers. The Governor shared Tarlac's experience with WAH/EMR and expressed the province's willingness and readiness to support the expansion of WAH into other provinces that might be interested in adopting and using this platform.

Assistance calibrated to level and type of LGU health system stakeholder.

HealthGov had to adapt its organizational structure to better engage and manage diverse and dispersed partners, such as officials in 12 CHDs, 603 LGUs, thousands of providers, dozens of community organizations, and representatives of the central DOH and other health CAs. HealthGov developed a model for calibrating TA based on the stakeholder's role and function in the health service delivery structure. The model, shown in Figure 1, shows the people and processes necessary for health impact (box at far right); the providers, facilities, and systems essential for FP/MNCHN functions (middle boxes); and the demand and supply factors that determine whether the health system inputs have impact.

Figure 1: Model for TA Calibration



Under the model, TA for CHDs stresses: Educating and advocating among CHD staff on the importance of high-impact (BEST) interventions to improve family health; Orienting CHDs on

USAID/HealthGov tools; Helping CHDs to train DOH representatives in the field, as well as RNHeals and P/M/CHO staff, to provide TA to municipal and city LGUs (with other CAs).

HealthGov TA to Provincial LGUs prioritizes: Helping CHDs to educate and advocate at the province level on the importance of high-impact interventions to improve family health; Ensuring that CHDs and PHOs are able to orient/train/coach municipal/city staff on USAID and HealthGov TA tools; Help CHD and province-level LGUs monitor municipal and city LGU performance indicators.

At the municipal/city LGU level, HealthGov focused on enabling counterparts to: Improve local NHIP implementation to increase financial protection of the poor; Upgrade and accredit OP and IP facilities in service delivery networks to improve access and quality of services , including development of a referral system attain health-related MDGs; Organize, train and deploy CHT partners to improve community service provision; Integrate FP into EPI services to generate more demand for FP; Implement ICV compliance monitoring and reporting; Train health providers in FP/MNCHN services including PHN supervision; Ensure FP/MNCHN commodity security through LGU financing, access DOH grants, local policy development, and improved forecasting and logistics management; Improve quality of field health statistics through DQC and WAH; Implement logistics management system.

Local Technical Assistance Partners (LTAPs)

HealthGov provided TA through its own in-house national and regional specialists, through CHDs (in particular, DOH Representatives), PHO staff, and consultants on the essential LGU actions needed to improve family health: PIPH/MIPH/CIPH and AOP, CSR planning, health policy development, service provider skill training and re-training, DQC, et cetera. Most of the TA required was new to LGUs, and sources of expertise were not always available from third parties, such as local universities, NGOs or consulting firms. However, the need to scale up training and technical assistance quickly motivated HealthGov to undertake a more systematic and wide reaching search for institutional TA partners, based on an assessment of the technical areas where they can play a useful and sustainable role in supporting LGUs and CHDs, which are tasked with LGU capacity building.

Figure 2. LTAP Solicitation Notice

HealthGov
Strengthening Local Governance for Health

The Strengthening Local Governance for Health (HealthGov) Project is a USAID-funded project supporting the government's efforts to provide improved basic health services in partnership with over 600 local government units (LGUs) throughout the Philippines.

INVITATION to submit EXPRESSIONS OF INTEREST for PRE-QUALIFICATION

Strengthening Local Governance for Health (HealthGov) Project

HealthGov invites eligible local organizations (universities, research institutes, non-government organizations, consulting firms) to submit Expressions of Interest (EOI) for Pre-Qualification for the provision of technical assistance to local governments, the Centers for Health Development of the Department of Health, and other local and regional stakeholders of the project. The required services include:

- Organization and deployment of Community Health Teams (CHTs) as agents to facilitate increased demand for Family Planning (FP)/Maternal, Neonatal, and Child Health and Nutrition (MNCHN) services
- Increasing FP demand through the integration of FP into the Expanded Program on Immunization and *Garantisadong Pambata*
- Training of health providers of FP/MNCHN services
- Training Public Health Nurses in supportive supervision
- Upgrading and accreditation of out-patient and in-patient facilities in service delivery networks
- Ensuring FP/MNCHN commodity security, including access to the DOH MNCHN grants
- Improving access to services through provider mapping and referral system
- Improving financial risk protection of the poor through local implementation of the National Health Insurance Program
- Improving data management for decision-making
- Improving logistics management system
- Strengthen commodity self-reliance/MNCHN plan implementation and monitoring

Interested organizations are requested to provide relevant information on their background, capabilities and resources. More detailed pre-qualification document requirements and forms shall be issued upon request via email (please send email request to the designated contact details below).

Your complete EOI/Pre-Qualification Documents, including a brief cover letter, must be sent or e-mailed to the address indicated below on or before **23 December 2011**:

E-mail: healthgovTAP@gmail.com
Fax: (+632) 706-1419
Mail: Chief of Party
HealthGov Project
RTI International
3203-3204 Tycoon Centre
Pearl Drive, Ortigas Center
1605 Pasig City

EOIs will be evaluated by HealthGov and only qualified organizations will be contacted. For inquiries, please contact Franco Calixto at (+632) 706-0681.

HealthGov solicited interest and applications from regional partners including academic and research institutions, NGOs, and individual experts (see box above). An Inter-CA capacity building approach envisioned selected LTAPs working alongside USAID project staff in a learning-by-doing mode on highly specialized TA; ultimately, the local TA partners will be contracted directly by the CHDs to routinely provide TA to the LGUs. The local partners in this way become the replication agents of the USAID CAs in providing assistance for health sector reform and strengthening. Ultimately, 14 organizations, shown in Table 24 below, were chosen as LTAPs and provided assistance to HealthGov LGU counterparts.

At the close of the project, HealthGov LTAPs were asked to assess their management and technical development as a result of working with HealthGov. On general management capacities, LTAPs scored themselves high (average of 8.5 to 9 from a total score of 10) in terms of: (a) adequacy of technical consultants, resource persons, facilitators, module writers, documenters and event organizers; (b) capacity to engage and mobilize local consultants and local organizations as partners in the provision of technical assistance; (c) previous experience in working with a USAID project, particularly one that relates to local health sector reforms, and preferably involving LGU capacity building, community health service provision and health advocacy; and current strength of networking with other local NGOs

On the other hand, they rated themselves low (average of 5 from total score of 10) in terms of their (a) ability to mobilize adequate resources (e.g. for a six-month period) to provide TA support to government partners (CHDs, LGUs); and (b) willingness to adjust the current daily rates of technical staff and consultants to current government rates or other financial limitations.

With respect to their technical capacities, competence, experience, and human resource development, LTAPs gave themselves high scores, indicating their confidence with respect to meeting LGU TA needs. To further build capacity and transfer of technology, LTAPs suggested that future USAID projects:

1. Build LTAP capacities on resource generation strategies to ensure financial sustainability
2. Facilitate links to other consulting firms/institutions
3. Provide on-line coaching/mentoring
4. Build LTAP direct contracting skills

Table 24. HealthGov LTAPs

Name of LTAP	Region / Province	Activity
Mahintana Foundation, Inc. (MFI)	Southern Mindanao / South Cotabato	LTAP for SDIR South Cotabato
Institute of Primary Health Care-Davao Medical School Foundation (IPHC-DMSF)	Southern Mindanao / Compostella Valley	LTAP for SDIR Compostela Valley
Negros Economic Development Foundation (NEDF)	Visayas / Negros Occidental	LTAP for CSR Policy Advocacy, Negros Occidental
Participatory Research, Organization of Communities and Education towards Struggle for Self-reliance (PROCESS) – Bohol, Inc.	Visayas / Bohol	LTAP for CSR Policy Advocacy, Bohol
PROCESS Foundation - Panay,	Visayas / Aklan	LTAP for CSR Policy Advocacy,

Inc.		Aklan
Northern Luzon Mother and Child Care Inc. (NLMCCI)	Luzon / Pangasinan	LTAP for SDIR Pangasinan
Philippine Partnership for the Development of Human Resources in Rural Areas (PhilDHRRA) Visayas	Visayas / Negros Oriental	LTAP for CSR Policy Advocacy Negros Oriental
Capiz NGO/PO Network for Enterprise Development, Inc. (CapizNED)	Visayas / Capiz	LTAP for CSR Policy Advocacy, Capiz
H.O.P.E. Volunteers Foundation, Inc.	Visayas / Bacolod	Implementing Priority and selected STI/HIV/AIDS surveillance, prevention and control activities in Bacolod City
Institute of Primary Health Care-Davao medical School Foundation (IPHC-DMSF)	Southern Mindanao / Compostella Valley	TA in Compostela Valley to update and enhance the CSR+ Plan and Policy and support implementation of selected key activities
Tool Box Creative Designs, Inc.	National	Layout & format editing of the revised 2009 FPCBT Manual and Trainers Guide
LEAD & Co.	Southern Mindanao / Saranggani	LTAP for MIPH in Saranggani
Technology Outreach and Community Help (TOUCH) Foundation, Inc.	North Western Mindanao / Bukidnon	CSR Assessment and Planning Bukidnon
TOUCH Foundation, Inc.	North Western Mindanao / Misamis Occidental	CSR Assessment and Planning Misamis Occidental
TOUCH Foundation, Inc.	North Western Mindanao / Misamis Oriental	CSR Assessment and Planning Misamis Oriental
TOUCH Foundation, Inc.	North Western Mindanao / Misamis	SDIR AOP/HSP Misamis Occidental
Muslim-Christian Agency for Advocacy, Relief and Development, Inc. (MuCAARD)	North Western Mindanao / Zamboanga del Norte	CSR LPD Zamboanga del Norte
MuCAARD	North Western Mindanao / Zamboanga del Sur	CSR LPD for Zamboanga del Sur
MuCAARD	North Western Mindanao / Zamboanga del Norte	SDIR AOP/HSP Zamboanga del Norte
BIDLISIW Foundation, Inc.	Visayas / Metro Cebu	HIV/AIDS Monitoring for Metro Cebu

Continual Knowledge Dissemination

The HealthGov project was a prodigious generator and disseminator of knowledge through technical tool development and documentation, training manuals and materials, orientation and training events, pilot studies and initiatives, stakeholder dissemination forums, inter-CA and inter-donor sharing and collaboration, and cross-departmental (DILG, DSWD) discussion. Key HealthGov tools and systems have been institutionalized into the DOH (AO, DO or MO) and LGU toolkits are being scaled up (through EOs or ordinances).

Quarterly reports, work plans, and special subject reports generated by HealthGov may be found on USAID's Development Experience Clearinghouse.

IV. Recommendations

HealthGov's first quarter progress report for Year 7 (October-December 2012) contains a detailed overview of the status of family health programs in each of the 25 provinces, as well as a listing of major challenges cited by health officials in accelerating KP implementation and reduction of unmet FP/MNCHN needs (Annex B). There was a fair degree of consistency expressed across provinces about leading concerns, which follow-on donor TA projects can help to address using many of HealthGov's tools and approaches.

1. CHT partner preparedness, deployment, and performance. While the pace of CHT recruitment, training, and deployment varies among provinces (with some fast-tracking implementation of training, and others delayed by logistical and financial constraints), all are concerned with monitoring CHT performance against their KP objectives. HealthGov assisted Isabela province with an initial CHT assessment, and found that while partners did well with some functions (household profiles, assessing health risks, delivering health messages, and developing Health Use Plans [HUPs]) they had trouble with monitoring HUP adherence and reporting health information summaries. Some lacked referral information from the MHO. Based on this information, the PHO was able to target coaching and mentoring in needed areas, and can follow up on the baseline conducted with HealthGov's *Guide to Assessing CHT Operations*.

HealthGov also assisted the CHD in Region 11 to assess CHT operations in several municipalities, which involved both collecting extensive data on CHT deployment and performance and focus group discussions with CHTs, clients, supervisors and municipal managers. Strengths and weaknesses were documented (see Year 7 Quarter 1 report), and CHD 11 and PHOs were able to begin action-planning to bridge current gaps and to make sure that gains can be sustained—such as by ensuring that increased demand for FP/MNCHN services can be met—and scaling up successful approaches to CHT retention, such as providing them with travel allowances to visit upland barangays. These two assessment experiences argue for making regular CHT performance appraisals part of routine monitoring and supervision.

2. Diagnose the causes of training delays, and resolve scheduling logjams. Virtually every province remarked on the relatively low rates of achievement for full RHM and PHN training in FPCBT 1 and 2 and supportive supervision. While CHDs, PHOs, and MHOs/CHOs had agreed on a training schedule when the new curricula were rolled out, targets are not being met. Anecdotally, this is for several reasons, including the strain on municipalities and staff from being away for training; a shortage of qualified trainers; lack of funds to hire qualified trainers and training venues; and distraction caused by elections or other political activities. Whatever the causes, work-arounds must be designed, as the DOH's service scale-up plans depend on an adequate number of properly trained providers. HealthGov has encouraged coordination with PRISM to increase training for LAPM providers; another option is to revive and strengthen the deployment of itinerant teams from hospitals and ILHZs to both perform services and conduct on-site training.

3. **Continue to research FP/MNCHN clients to better understand their choices and behaviors relative to high-impact services**. For example, in Cagayan Valley, Isabela, and other provinces, there is a mismatch between the coverage of SBA providers and the percentage of women delivering in facilities: why do women continue to prefer giving birth at home? CHD 2 plans a regional study of the factors that influence maternal care-seeking that could be very impactful in terms of shaping CHT messages. The design of other studies to

understand attitudes and practices limiting health-seeking can likewise be extremely helpful to health planners and managers.

4. Explore CHD organizational re-structuring to align with KP objectives. The Regional Director of CHD 3 in Central Luzon has "KP-nized" the office, so that staff and missions line up according to the three KP strategic thrusts: (1) Financial risk protection through expansion in enrollment and benefit delivery of the NHIP; 2) Improved access to quality hospitals and health care facilities; and 3) Attainment of health-related MDGs). The next job is to build the capacities of CHD regional and field staff to help LGUs achieve performance indicators under each major KP output, which include: policy development, regulatory oversight, and health service quality assurance. HealthGov has pioneered, with its many counterparts, the required tools for planning and policy development (MNCHN/CSR Policy and Plan Formulation Guide, MDG Breakthrough Strategy Planning Guide); service delivery (FPCBT 1 and 2, PHN Supportive Supervision Manual, FP/ANC-EPI Service Integration Guide, SDExH); and system tools (DQC for FP/MNCHN Indicators Training Guide, SMRS for LGU Training Handbook, and Guide to Assessing GHT operations). These can be used and enhanced over time as systems continue to evolve and policies continue to change, such as declaration of a constitutional right to access FP commodities and services.

4. **Continue strengthening FHSIS by creating inter-operability with SMRS, DQC, CHLSS, and other data collection platforms.** The Philippines is a dynamic and creative environment for electronic data management platforms. At present the e- and m-public health scenario is somewhat chaotic, but there are initiatives to bring innovators, users, and managers together in a cohesive effort toward inter-operability. Provinces should invest more time and seek private sector partners to help fund accelerated progress toward inter-operable electronic platforms that generate locally useful data on health and well-being.

6. Fast-track PhilHealth facility accreditations. CHDs and PHOs have the lead in fast-tracking accreditation, yet some LGUs have reported to HealthGov that they are not particularly motivated to achieve full accreditation. The reasons mostly have to do with negative perceptions of PhilHealth reimbursement practices, which PhilHealth has acknowledged. Evidence-based advocacy—such as was conducted by PNGOC members under HealthGov—can be very effective in overcoming such attitudes at local level, and speeding progress on facility quality.

7. Expand service delivery to include adolescent reproductive health (ARH) services. This is largely a matter of coordinating with POPCOM on scaling up appropriate ARH services within ILHZs. CHD 6 is currently coordinating with technical staff from the PHO in Capiz and POPCOM on including ARH in service networks.