PDACA-879

# LPP-Matching Grant Program
# Performance and Evaluation Report
# Digos, Davao del Sur
# Philippines

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## SUMMARY

The Department of Health, w th support from USAID and technical assistance from Management Sciences for Health (MSH), implemented the Matching Grant Program (MGP) as a component of the Local Government Performance Program (LPP) in February 1999. The goal of the program is to achieve greater impact and expand service delivery capacity of municipalities and component cities, particularly in four areas, namely: fully immunized children (FIC), vitamin A coverage (VAC), tetanus toxoid two plus (TT2+) for women, and, modern contraception (CPR). The FRONTIERS Manila carried out two phases of the LPP-Matching Grant Program Evaluation Study, the program performance and impact evaluation.

The program performance evaluation of the MGP activities in Digos, Davao del Sur was carried out from June 1999 to March 2000. The objectives were: to evaluate the relative effectiveness of various interventions funded by the MGP for reaching under-served and high-risk population with needed services, and to provide immediate feedback to improve program implementation. Adopting the "input-process-output-outcome" framework, the study utilized program-based data and careful monitoring of MGP activities and outputs.

A review of the 1998 performance indicators for RHUs I and II reveals that of the four MGP indicators, TT2+ ranks lowest, with a combined 52.5 percent coverage for the whole of Digos. This is followed by contraceptive prevalence rate (modern methods), which was 67.7 percent in 1998 (RHUs I and II combined). The FIC and Vit.A indicators were much better (82.7 percent. and 92.3 percent, respectively).

To achieve the MGP goals on the four health parameters, Digos proposed five interventions, namely: the Community-Based Managed and Owned information system (CBMO), health and nutrition posts, tetanus toxoid integration into pre-marriage counseling (PMC), BTL referrals, and, outreach to women in small and medium enterprises. These activities featured innovative and participatory processes of information gathering, focused on remote and inaccessible *barangays*, and aimed to

minimize missed opportunities. Except for outreach to small and medium enterprises, which was not implemented at the time of the study, community actions have shown that these programs can promise important impact in terms of generating the sense of ownership needed for true sustainability.

Data of May 2000 reveal that the coverage rates of the four program indicators increased in comparison to that of May 1999. FHIS and CBMO data show that from 83%, the rate of FIC increased to 93%, TT2+ from 32% to 75%, VAC from 75% to 96%, and CPR from 72% to 73%. These findings demonstrate that the implemented MGP activities may have been effective in expanding health service delivery, especially on these four areas of health performance

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## ABBREVIATIONS

| | |
|---|---|
| BCG | - Bacille Calmette Gourain |
| BHW | - Barangay Health Worker |
| BHS | - Barangay Health Station |
| BTL | - Bilateral Tubal Ligation |
| CBMO | - Community Based Managed and Owned (Information System) |
| CHO | - City Health Office |
| CPR | - Contraceptive Prevalence Rate |
| DHRFO | - Department of Health Regional Field Office |
| DPT | - Diphtheria, Pertussis Tetanus |
| DOH | - Department of Health |
| FHSIS | - Field Health Services Information System |
| FIC | - Fully Immunized Child |
| FP | - Family Planning |
| LGU | - Local Government Unit |
| LPP | - LGU Performance Program |
| MGP | - Matching Grant program |
| MOA | - Memorandum of Agreement |
| MOE | - Maintenance and Operation Expenses |
| MSH | - Management Sciences for Health |
| MWRA | - Married Women of Reproductive Age |
| NFP | - Natural Family Planning |
| NGO | - Non-government Organization |
| OPV | - Oral Polio Vaccine |
| PHO | - Provincial Health Office |
| PMC | - Pre-Marriage Counseling |
| RHU | - Rural Health Unit |
| SME | - Small and Medium Enterprises |
| TT | - Tetanus Toxoid |
| TT2+ | - Tetanus Toxoid Two Plus |
| USAID | - United States Agency for International Development |
| VAC | - Vitamin A Coverage |
| WRA | - Women of Reproductive Age |

## ACKNOWLEDGMENTS

The Population Council appreciates the support of USAID/Manila - Office of Population, Health and Nutrition (OPHN) for providing financial assistance in the conduct of the program performance evaluation of the Matching Grant Program.

Appreciation is also due to the field coordinators of the Management Sciences for Health (MSH) for their technical assistance and cooperation during fieldwork and consultations.

The field evaluators of Population Council also wish to commend the Local Government of Digos and the Department of Health XI Regional Office for helping in mobilizing designated point persons during information gathering done by the field evaluators of Population Council. The rural health physicians, nurses, midwives and *barangay* health workers of the RHUs 1 and 2, as well as the local offices and non-government organizations in the municipality, have also been very supportive and patient in assisting the field evaluators through data retrieval and in-depth interviews.

The hospitality and cooperation of community leaders, program managers and local officials during the entire program evaluation are likewise gratefully acknowledged.

Lastly, Population Council sincerely expresses gratitude to the numerous men and women, who in more ways than one, had been helpful in the various phases of the Matching Grant Program.

## I. BACKGROUND

The LGU Performance Program (LPP) is a five-year (1995-2000) USAID-assisted project with the objective of improving the "health of mothers and children by increasing the utilization of Family Planning (FP), Maternal Child Health (MCH), and nutrition services". The LPP strives to increase the capacity of local government units (LGUs) to manage health programs by providing both financial and technical assistance. Provinces and highly urbanized component cities have been enrolled into the program through a memorandum of agreement (MOA) "to implement a comprehensive plan on population, family planning and child survival program". LPP Grants are therefore designed to serve as incentives, encouraging LGUs to adopt best practices in the distribution of commodities, the training of staff, the equipping of service delivery sites, the provision of voluntary sterilization services, and the use of Information, Extension and Communication or IEC.[1]

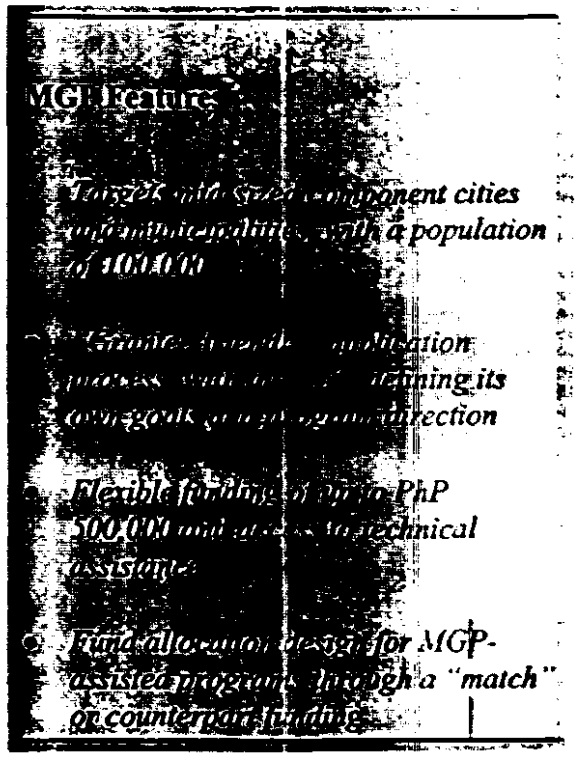
Data from the 1998 NDS and the Midterm Assessment in June 1998 raised the issue of whether the LPP has had any direct impact on delivery of RH/FP (Reproductive Health/Family Planning) services. The assessment report, after weighing the evidence, concludes that while the LPP is "an effective vehicle for developing LGU management and service delivery capability", it may not be the most appropriate means for achieving impact on health objectives. The report recommended a "follow-on initiative" that can put greater emphasis on impact, building on the strengths of the LPP, while overcoming its limitations.

### The Matching Grant Program: The "Follow-Up Initiative" of LPP

The above recommendation became the basis for the development of the Matching Grant Program (MGP). The Matching Grant Program is thus designed to stimulate the LGUs to focus directly on strengthening service delivery giving the local

government units more latitude in determining their local programs. Consequently, the MGP was developed with following well-defined features:[2]

- Targets mid-sized component cities and municipalities, initially those with a population of 100,000 and above, where actual primary health care services are provided
- Employs a "grantee-friendly" application process, with the Local Government Unit (LGU) defining its own goals and program direction
- Provides flexible funding of up to 500,000 pesos and access to technical assistance
- Encourages LGUs to increase fund allocation and expenditure for MGP-assisted programs through a "match" or counterpart funding




**MGP Objectives.** The MGP aims to improve the capability of municipalities and component cities to expand service delivery, and to achieve significant and measurable impact on the following four Department of Health (DOH) program areas:

1. Fully immunized children (FIC)
2. Vitamin A supplementation coverage (VAC)
3. Tetanus toxoid two plus (TT2+) coverage for women
4. Use of modern contraception (CPR) to reduce unmet need for family planning.

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[1] Jack Reynolds, et al, 1998 "Midterm Assessment of Intermediate Result 1 of Strategic Objectives 3 "Increased Public Provision of Family Planning and Maternal and Child Services". POPTECH Report No. 97-127-067.

[2] MSH, 2000. "Matching Grant Program (MGP): An Innovative and Responsive Program for Expanding 3 MSH, 2000 Service Delivery and Enhancing Quality of Care," pp. 1-2.

## OBJECTIVES OF MGP EALUATION STUDY

USAID Manila has called upon the FRONTIERS in Reproductive Health to work closely with the Management Sciences for Health (MSH) to conduct an evaluation of the MGP during 1999-2000. The objectives of the evaluation study are:

1. To evaluate the relative effectiveness of various interventions funded by the MGP for reaching underserved and high-risk populations with needed services, and

2. To evaluate evidence of direct impact in selected LGUs, as measured by the contraceptive prevalence rate (CPR), childhood immunizations (FIC), tetanus toxoid vaccination among pregnant and married women of reproductive age (TT2+), and vitamin A use (VAC) among children between the ages of 12-59 months.

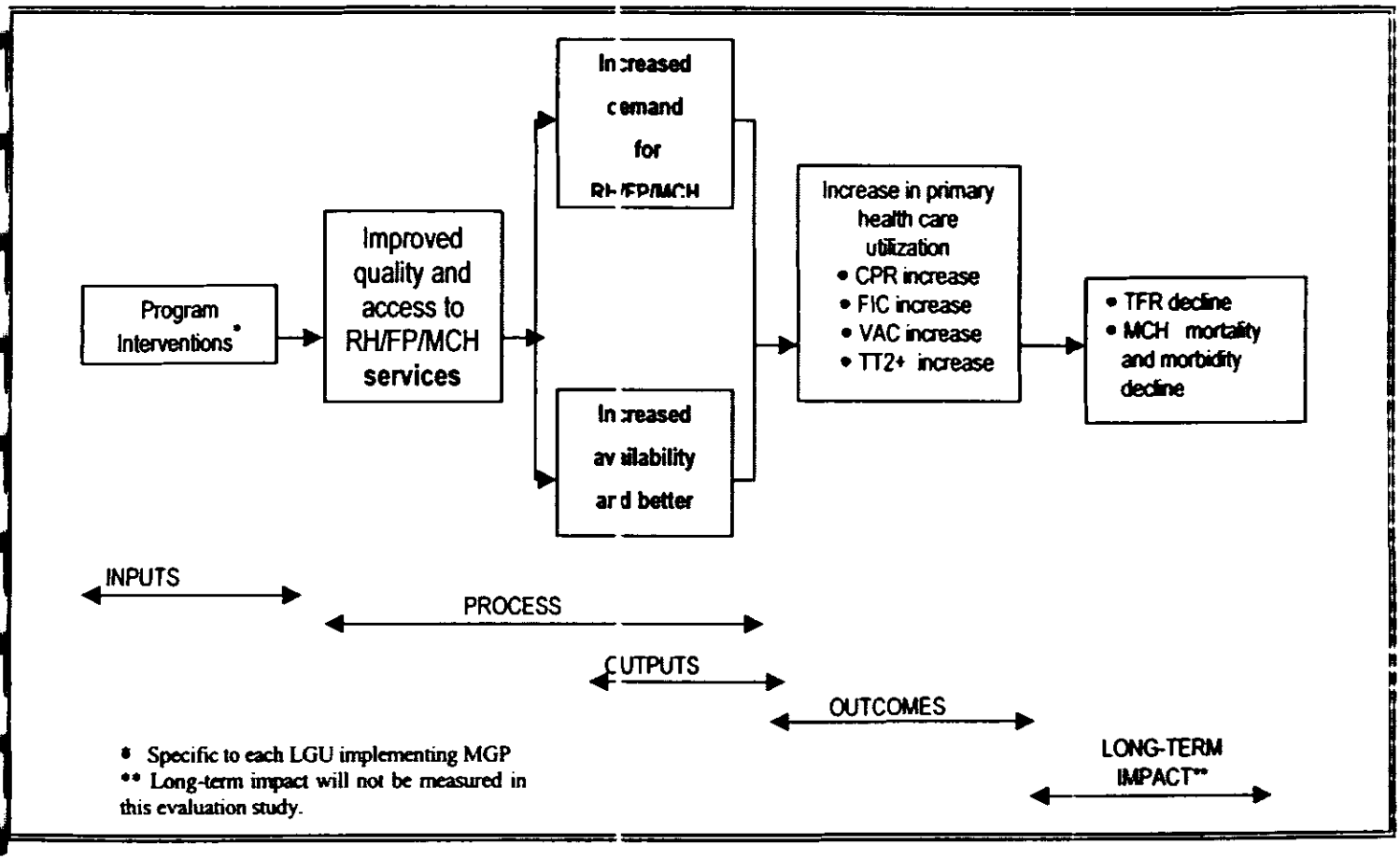
These objectives are directly related to the FRONTIERS Program's Intermediate Result 1: Testing innovative solutions to reproductive health and family planning service delivery. The MGP evaluation study will provide detailed information on its operations and impact leading directly to improving program performance and refining the design of subsequent MGP programs in the Philippines. The study results will be used by DOH and local government officials to develop policy and improve program management.

## RESEARCH DESIGN

Due to the rapid implementation and timetable of the MGP, the evaluation proceeded in two phases. Phase One is the process or monitoring evaluation This phase is limited to providing as much information about process and outputs (performance) among the first set of MGP participants. Phase Two consists of process and impact evaluation. This consists of assessing both program performance and outcomes. The primary objective is to determine whether different interventions (or mixes) will lead to significant increases in the four-targeted indicators (e.g., contraceptive prevalence rates).

The time frame for observing changes was six months. The Evaluation used the "input-process-output-outcome" framework as shown in Figure 1.

***Figure 1. Conceptual Framework Showing Links of the Program Components to the Outcome Indicators and the Different Categories of Evaluation Indicators***




## 1. Process and Monitoring Evaluation of Four MGP Sites

Phase I employed qualitative methods whereby MGP inputs, processes, and outputs are documented in the field through observation, in depth interviews of key informants and analysis of program-based data. [3]

[3] While every effort was made to ensure complete documentation of the MGP, there were key activities that were not observed by the field evaluator. For example, the planning stage for one of the MGP areas was not observed because this occurred before the evaluation study team was organized. To address this gap, key informant interviews were conducted to elicit information on what exactly happened during the planning activities.

Sites were observed on a regular, ongoing basis to ascertain whether program activities were being implemented according to plan, and assessed on how well these program activities were performed and utilized

**Site Selection.** The selection of a municipality or city into the MGP program was based on meeting a number of established criteria. These included:

- Clearly defined match, activities and budget
- Activities that will increase utilization of services among target clientele
- Activities should directly result in increasing coverage
- Discrete activities with reasonable chance of obtaining measurable impact within 12 months or less

The following LGUs were selected for Phase 1 of the evaluation study:

**Process and Monitoring Evaluation Sites**

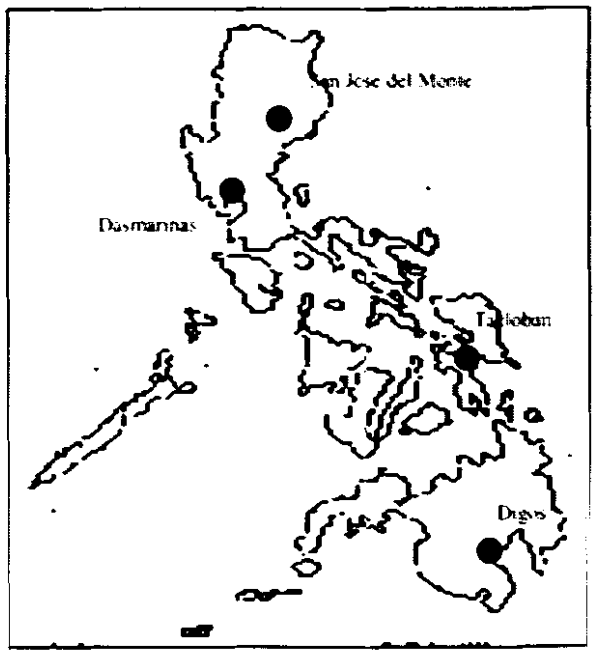
1. San Jose Del Monte, Bulacan-----Cluster A
2. Dasmarinas, Cavite----------Cluster B
3. Tacloban, Leyte----------Cluster C
4. Digos, Davao del Sur----------Cluster D

## 2. Impact Evaluation of MGP Sites

Strictly speaking, Phase 2 is an outcome evaluation (refer to Figure 1). It measures the immediate effects of the MGP interventions on specific program indicators, utilizing a quasi-experimental design the pretest-posttest nonequivalent groups design. The MGP program outcomes are evaluated using data from population surveys and situation analyses. Inferences about impact are based on the empirical analysis of outcomes (i.e., the direct and immediate result of program process and outputs.)

**Site Selection**. The original plan for selecting the impact sites was to use random selection from the second batch of MGP recruits[4]. However, because MGP was implemented on a "first come, first served" basis, it was not possible to randomize the selection procedure. In the end, the intervention LGUs were selected mainly because of the availability of a suitable control LGU within their province. All the selected LGUs are first-class cities and municipalities (i.e., they are all in the highest income category classification of the Department of Finance). The three sites chosen were Taytay in Luzon, San Carlos in the Visayas, and Tagum in Mindanao. These sites should not have initiated MGP activities before baseline assessment can be made.

Program and control LGUs were matched on the following criteria: 1) both come from the same province to control for administrative and other forms of support provided at province level, 2) similar population sizes, 3) same income class, and 4) similar performance indicators on the four outcomes of interest for the MGP (FIC, TT2, VAC and FP). Because of considerable differences in the state of economic development, impact pairs were selected for each of Luzon, Visayas and Mindanao – the three major geographic divisions of the country. Taytay-Binangonan, San Carlos-Cadiz, and Tagum-Panabo are the three pairs of impact and control sites that were chosen.




Because of delays in the implementation of the program interventions in Tagum, the third set of impact sites comparison (Tagum-Panabo) was dropped

[4] The selection of the three intervention LGUs was further limited by two additional factors: 1) the rate at which MGP is being implemented (LGUs who had not yet been oriented and did not have a work plan on which the baseline assessment could be made could not be part of the pool for selection of sites for the impact evaluation), and 2) since the intervention LGU had to have a control LGU from the same province, this precludes the selection of LGUs where all MGP-qualified units of the province have been recruited at the same time leaving no possible control

from the final impact evaluation. In he end, only two sets of comparison sites, Taytay-Binagonan and San Carlos-Cadiz, we e included in Phase 2 of the study.

This report will present the p ocess and monitoring evaluation resu lts for Digos, which covers Phase 1 of the MGP eva luation study.

A separate report will focus o1 the impact evaluation component of t1e evaluation study. In the next section of this pa1ticular report, the major findings are described in each of the four study areas organized as follows: (a) a brief description of th.e study area, (b) planning of the MGP interventio1s, with attention to the LGU analysis of problem areas and choice of interventions, (c) the findings with respect to the implementation of the MGP interventions are discussed focusing on such aspects of implemer tation as the application of new health informatio1 technology, the Community-based Management and Information System (CBMIS); mobilization of new resources for health and expansion in health services; and inn )vations in health service delivery, and finally (d) data on outputs, and in some instances service coverage of the four key services.

## II. THE MGP APPLICATION PROCESS

The FRONTIERS Manila staf carried out a program performance evaluation of the MGP in Digos, Davao del Sur (Region XI, Southern Mindanao). Digos is the provincial capital and is one of the four sites in the first batch of MGP recipients throughout the Philippines representing the Mindanao cluster. It is the first MGP recipient in the area. Its plan include1 an innovative, participatory process of obtaining information on clients in need of he alth services, and a focus on difficult to reach *barangays*. Digos also planned to mi1imize missed opportunities by providing tetanus toxoid immunization during pre-marr age counseling and in industrial establishments employing women workers.

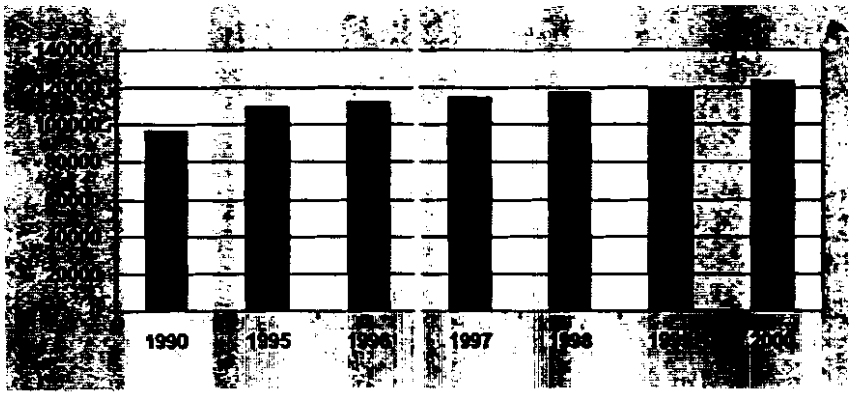
Digos also had one of the shor est application periods in terms of expediency of fund release. In February 1999, the MSH Field Coordinator and the DOH Regional Field Office (DHRFO) introduced the prog1am to the LGU. The Office of the City Mayor

received the letter of invitation from the DHRFO on March 22, 1999, and the Letter of Intent (LOI) was submitted back to the DHRFO, passing through the Sangguniang Bayan on March 29, 1999. Dr. Salud Dela Cruz, RHU I physician, was designated by the Mayor as the MGP Coordinator.

Sometime in April 1999, the representatives from the two rural health units of Digos drafted the MGP Plan. The activity was facilitated by Dr. Angel Libre, the Management Sciences for Health Regional Technical Advisor (MSH-RTA). Several weeks later, the DHRFO received and approved the MGP Plan on May 20, 1999. On that same day, the MGP Memorandum of Agreement between DHRFO and the LGU of Digos was approved and signed. Finally, the MGP fund was released to the municipality on May 24, 1999.

## III. MUNICIPAL BACKGROUND

As of 1995, Digos reached up to a total of 109,828, and in the last three decades, it showed an annual average growth rate of 5.26% between 1960-1970, 4.65% between 1970-1980 and 3.83% between 1980-1990 (see Figure 3). In 1998, Digos[5] had a projected population of 117, 846 with an annual growth rate of 3.83% (NSO and OMPDC). It is a relatively young population, with 91. 8% in the 49-years-old-and-below bracket.




Source: NSO and OMPDC, 1990

***Figure 2. Projected Population, Municipality of Digos***

Of the 26 barangays in Digos, eight are classified urban; the other 18 barangays are classified rural. In 1980, the urban-rural population distribution was 57.1% - 42.9% ratio, while in 1995, the distribution increased in favor of the urban population at 63:37. The average gross population density was 35 persons per hectare in the urban areas, and 2 persons per hectare in the rural areas. The upward trend of urban population indicates preferences for areas with greater availability of schools, markets and housing.

**Health Infrastructure**

Like many LGUs in the country, Digos lacks the health service infrastructure, manpower and resources to serve its growing population. Table 1 shows the health facilities available in Digos as of June 1999. Digos has two Rural Health Units (RHUs). The Davao del Sur Provincial Hospital is a government hospital in RHU 1 and the only government facility that provides permanent sterilization services in the entire province of Davao del Sur. Three of Digos' 26 barangays have no Barangay Health Station (BHS). Even if there are a number of private health facilities in each of the RHUs, they remain unaffordable to most of the low-income residents.

***Table 1 Health Facilities of Digos, as of June 1999 (Pre-MGP)***

| Health Facilities | RHU I | RHU II | TOTAL |
|---|---|---|---|
| Municipal Health Centers (MHCs) | 1 | 1 | 2 |
| Barangay Health Stations (BHSs) | 12 | 11 | 23 |
| Health and Nutrition Post | 0 | 0 | 0 |
| Government Hospital | 1 | 0 | 1 |
| Private Hospitals | 2 | 3 | 5 |
| Private Clinics | 10 | 5 | 15 |

Source: Digos MGP proposal/application, 1999.

[5] Digos Municipal Records, 1998

In terms of manpower for public health facilities, the following table shows that Digos is in need of physicians, nurses, med-techs, dentists and dental aides, and even *barangay* health workers (BHWs). Given the population and rapid population growth in Digos, health service providers are forced to cover more people than the normal ratio.

***Table 2. Health Manpower of Digos, 1998***

| Health manpower | RHU I | RHU II | Manpower-Population Ratio |
|---|---|---|---|
| Municipal Health Officer (MHO) / Rural Health Physician (RHP) | 1 | 1 | 1 : 56,377 |
| Public Health Nurses (PHNs) | 3 | 2 | 1 : 22,551 |
| Rural Health Midwives (RHMs) | 10 | 11 | 1 : 5,370 |
| Medical Technologist | 1 | 0 | 1 : 112,754 |
| Dentist | 1 | 1 | 1 : 56,377 |
| Barangay Health Workers (BHWs) | 199 | 234 | 1 : 51 households |
| Rural Sanitary Inspector (RSIs) | 2 | 2 | 1 : 28,189 |
| Dental Aide | 1 | 1 | 1 : 56,377 |
| **TOTAL** | **218** | **252** | **1 : 240** |

Source: RHU I & II Records, 1998, Digos, Davao del Sur

Health programs do not appear to receive the highest priority at the LGU level as reflected in the health budget allocation (see Figure 5). In addition, the local health board is not functional.

Figure 4 illustrates Digos' health budget from 1996 - 2000. Like many LGUs, the bulk (about 90% for Digos) of the health budget goes to personnel services. Because the Local Government Code stipulates that no personnel be laid off as a result of devolution, LGUs are forced to support the personnel they inherited from the national government. They are therefore constrained to allocate a substantial portion of their health budgets for personnel at the sacrifice of operations money. Such is the case of Digos, where 15% of its LGU budget goes to health (see Figure 5), but insufficient to cover drugs, equipment, repairs, and travel allowances to visit remote *barangays*. This has consequences for the

kinds of health services available particularly for community members from disadvantaged socioeconomic groups.

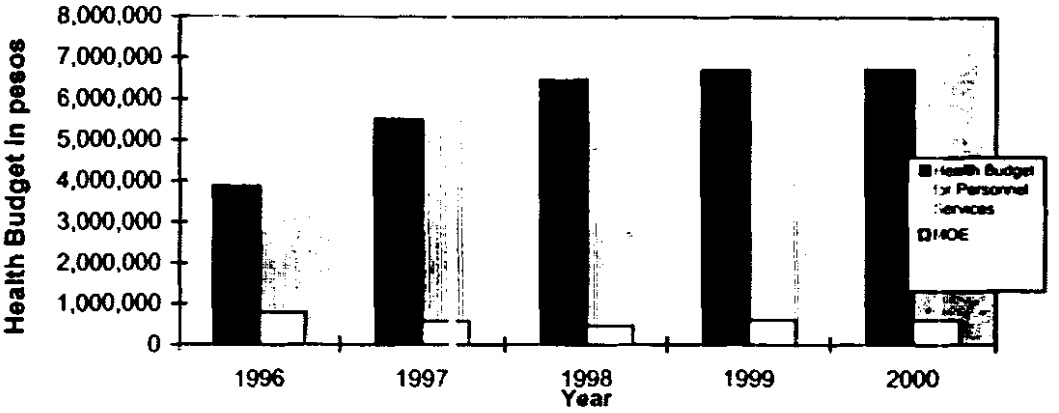



*Figure 3. Digos Health Budget, 1996-2000*

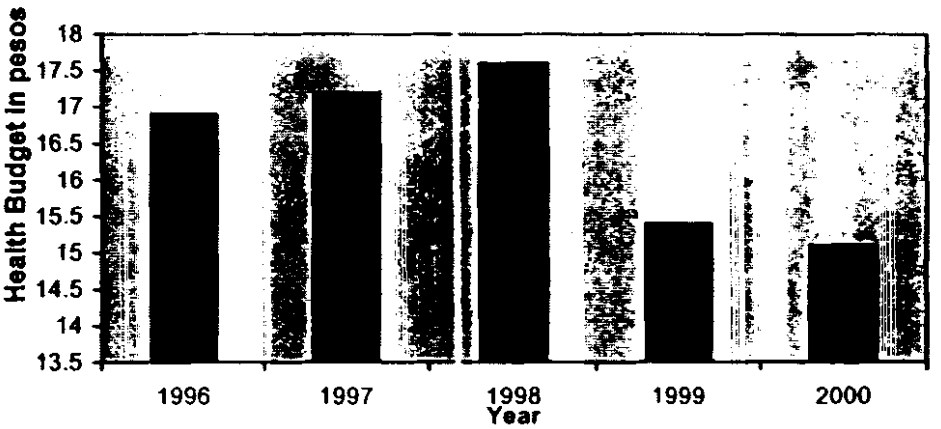



*Figure 4 Health Budget as % of LGU Budget*

## Health and Program Indicators

A review of the 1998 performance indicators for both RHUs I and II (see Figures 6 & 7, below) shows that among the four MGP indicators[6], TT2+ ranks among the lowest, with a combined 52.5% coverage for the whole of Digos. This is followed by the

[6] See APPENDIX for definition of terms.

contraceptive prevalence rate, which in 1998 was 67.7% (RHU I & II combined), and by FIC, 82.7%. Vitamin A supplementation had the best program performance at 92.3%.

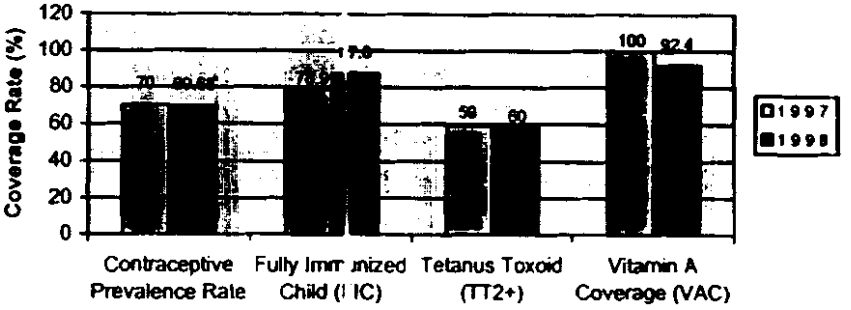



***Figure 5. Health Performance Indicators, RHU I***

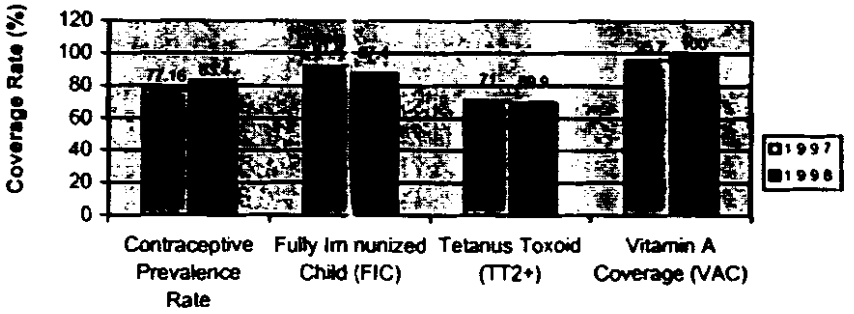



***Figure 6. Health Performance Indicators, RHU II***

## IV. THE MGP PROGRAM

There were four major strategies to be employed under the Matching Grant Program in Digos, Davao Del Sur in order to increase coverage and performance on the four MGP health indicators. These are 1) the reactivation of the *Bayanihan* Outreach activities, 2) integration of TT immunization to the pre marital counseling (PMC), 3) adoption of a community-based managed and owned information system (CBMO), and 4) establishing an inter agency IEC and service delivery system for female workers in small and medium enterprises (SMEs).

**1) Reactivation of the *Bayanihan* Outreach activities**

To increase coverage and p:rformance on the four MGP health indicators, the municipality of Digos identified the reactivation of its *Bayanihan* Outreach program as a major strategy to be done in all its 26 *barangays*.

As proposed in the MGP pla n, activities for this strategy including an orientation and planning meeting with the Association of Barangay Captains, an inventory of available supplies and procurement of additional supplies, linkaging and networking for additional service providers, actual conduct of Bayanihan Outreach, provision of support for FP clients and service providers, and food support for the conduct of Bayanihan outreach.

**2) Integration of TT Immunization to Pre-Marriage Counseling (PMC)**

To address the low turnout of TT recipients, Digos proposed to integrate TT immunization during pre-marriage counseling (PMC). PMC is an activity done twice a month in Digos. It is done as one group for both RHUs at the Women's Center, usually participated in by approximately 50 couples per session or 100 couples a month. As part of the MGP strategy, an information campaign on the TT immunization program was incorporated into the PMC, which highlights a screening procedure of TT status of the women. It intends to immunize on the spot and provide TT cards to women who have no or insufficient TT doses, and refers those who require additional doses to the midwives of their community.

For MGP's purpose, this strategy consisted in the following steps: a) passage of municipal ordinance, b) provision of TT cards, c) making IEC materials on TT available to the general public, d) inventory and procurement of needed medical supplies, and, e) linking and networking with influential groups, including religious groups.

### 3) Adoption of the Community Based Managed and Owned Information System

The third strategy under the MGP in Digos is the adoption of the CBMO as a health information system. The purpose of the CBMO is to generate information of good quality that could be used in addressing health service related concerns. As commonly practiced, health information is gathered by public health workers and volunteer workers alone. With the CBMO, the whole community becomes involved in the health information gathering, from the assessment of the community's health statistics, to data gathering, utilization of information gathered, direct service delivery, up to the management and sustainability of the health services.

Activities for this approach include a) the training of Rural Health Physicians, b) Public Health Nurses, and Rural Health Midwives on participatory CBMO, c) actual conduct of the CBMO, and d) quarterly community monitoring update meetings.

### 4) The Outreach to Small and Medium Enterprises (SMEs)

Another MGP strategy unique to Digos is the establishment of an inter-agency IEC and service delivery system for female workers in small and medium enterprises. The purpose of this strategy is to reach women who often work from early morning to early evening and do not have a chance to avail of public health services, particularly, FP services.

As required by law, these women are supposedly provided with health services by the establishments for whom they work. In reality, however, most establishments are unable to comply with this legal labor provision. While there are various government agencies catering to these workers in various ways, many aspects of public health remain unavailable to them, hence the importance of reaching out to these workers either through an IEC campaign or actual service delivery, and developing an action team that will ensure compliance to these labor provisions.

As proposed in the MGP plan, this strategy involves: a) orientation of the *Sanggunian* members on the SME outreach, b) development of directory of establishments, c) creation of an Interagency Action Team, d) conduct of planning workshop with SME managers/owners, e) implementation, and f) monitoring of the project.

## V. IMPLEMENTATION

The following discussion describes how the four major MGP strategies were implemented. Important offshoots of these four strategies are also discussed.

### 1) Reactivation of the Bayanihan Outreach activities[7]

The LGU appropriated P239, 000 or 60% of its total MGP funds for this strategy. The first Bayanihan outreach was done in Kapatagan, Digos, Davao Del Sur on June 18, 1999. This was the first major activity conducted under the MGP in Digos. In preparation for this activity, the MGP was introduced to Kapatagan community through a series of meetings and coordination with the BHWs as well as with the barangay council.

The Bayanihan Outreach was conceptualized to address community members needing medical and other related services, such as BTL, IUD insertion, provision of condom and pills, DMPA injection, circumcision, FP counseling, dental services, and medical consultation.

Though Kapatagan, where the Bayanihan Outreach took place, is under the jurisdiction of RHU 2, both RHUs agreed to jointly make all the necessary arrangements for the activity. They sought the assistance of the Provincial Health Office to form the medical team composed of medical doctors, medical technologists, OB team, and civic organizations such as the REACT, Lion's Club and Rotary Club. Invited also to the Bayanihan Outreach was the municipal mayor. The entire preparation for the first activity was notably impressive, welcoming the USAID delegates with streamers hung in the poblacion and in Kapatagan proper.

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[7] See APPENDIX for easy to read index-process-output table for this intervention.

On the day of the Outreach the medical team arrived on time. Hundreds of community members gathered and queued in the designated stations of the medical team. Although the expected visitors from USAID did not arrive, the activities went on. The medical team had to stay for three days to complete their work, running out of medicines, vaccines, and other supplies, and incredibly serving more than 700 clients in various services.

In their assessment of the first *Bayanihan* Outreach, the two rural health physicians realized that such strategy was difficult to sustain. As Dr. Dela Cruz, the RHU I physician, put it, "When one conducts a Bayanihan Outreach, the community thinks that it is a medical mission, and everybody in the community suddenly gets sick." Both RHUs were faced with problems. First, they could not regularly mobilize a big medical team. Second, there are no enough medicines, supplies and vaccines in their respective RHUs. Third, they were not able to prioritize those clients who were really in need since the BHWs failed to make a list of the clients in need of health services.

For the succeeding outreach activities, the two RHU physicians decided to conduct *Bayanihan* outreach separately. The health officers of each RHU initially agreed on devoting Wednesdays as Bayanihan Outreach day through the medical team that they each independently created composed of a rural health physician, a dentist, a sanitary inspector, the nurse in charge for the area, and two or three midwives, including the midwife in-charge of the target community.

Later Dr. Tajon, physician of RHU 1, decided to defer the *Bayanihan* outreach until the CBMO is conducted in the community. By doing so, the RHU can then prioritize clients in need of the health services, and maximize the limited vaccines and other medicines available. Two months later, this approach was replicated in RHU 2.

**Output**

The succeeding table summar zes their accomplishment.

***Table 3. Clients Served during the Bayanihan Outreach***

| Services Offered | No. of Client served |
|---|---|
| BTL | 11 |
| IUD | 2 |
| FP | 42 |
| Circumcision | 77 |
| FP Consultation | 10 |
| Dental | 88 |
| Medical Consultation | 686 |

Source: RHU 2, Digos Davao del Sur

**2. Tetanus Toxoid Integration into PMC[8]**

With the MGP, Tetanus Toxoid immunization was integrated in pre-marriage counseling (PMC), through a municipal ordinance endorsing such inclusion during the MGP. This ordinance, though not mandated, strongly encouraged women to receive Tetanus Toxoid immunization as a normal part of PMC.

During the initial conduct of TT integration to PMC, women wishing to be immunized had to go to the RHU 1 (which is about 100 meters away from the Women's Center, the PMC venue) for immunization. The first Fridays of the month were handled by RHU 1, and third Fridays, by RHU 2. By January 2000, TT immunizations were done at the Women's Center. Midwife representatives from both RHUs took turns in providing health-related lectures covering family planning, breastfeeding, and woman and child immunization. TT cards were likewise provided to women for easy tracking of

[8] See APPENDIX for easy to read index-process-output table for this intervention.

their TT status. Health providers from each of the RHUs were present to assist the designated speaker in giving immunization to interested women.

While information and lectures on tetanus toxoid immunization had already been available during pre-marriage counseling prior to the MGP, the enrichment of the educational component of PMC in several respects, and the availability of the actual immunizations in that setting represented a new model for service delivery. This is an effective way of capturing women who may have been missed opportunities.

The following tables summarize the TT accomplishments during PMC of the two RHUs for first, December 1999 and second, March 2000. It is worth noting that the total number of women given TT increased dramatically from 158 in December to 328 only three months later.

***Table 4. Women given TT during PMC as of December 1999***

| | | | |
|---|---|---|---|
| TT1 | 83 | 58 | 141 |
| TT2 | 16 | 0 | 16 |
| TT3 | 0 | 9 | 9 |
| TT4 | 0 | 0 | 0 |
| TT5 | 0 | 1 | 1 |
| TOTAL | 99 | 68 | 158 |

Source: RHUs 1 & 2, Digos, Davao del Sur

*Table 5. Women given TT during PMC as of March 2000*

| Tetanus Toxoid | RHU1 | RHU2 | TOTAL |
|---|---|---|---|
| TT1 | 166 | 123 | 289 |
| TT2 | 19 | 1 | 20 |
| TT3 | 3 | 12 | 15 |
| TT4 | 1 | 1 | 2 |
| TT5 | 1 | 2 | 3 |
| TOTAL | 190 | 138 | 328 |

Source: RHUs 1 & 2, Digos, Davao del Sur

In the table below, TT integration to PMC done from September to December 1999 accounts for 4.7% of the total LGU accomplishment. The table likewise shows that the most clients reached during PMC availing of TT1 is roughly 13.7% of the TT1 acceptors for that period.

*Table 6. TT Integration to PMC, September-December 1999*

| Tetanus Toxoid | PMC (RHU 1&2) | TOT (RHU 1&2) | Percentage |
|---|---|---|---|
| TT1 | 141 | 1029 | 13.7 |
| TT2 | 16 | 898 | 1.78 |
| TT3 | 9 | 581 | 1.5 |
| TT4 | 0 | 293 | 0 |
| TT5 | 1 | 580 | 0.17 |
| TOTAL | 158 | 3381 | 4.7 |

Source: RHUs 1 & 2, Digos, Davao del Sur

## 3. Adoption of the Community-Based Managed and Owned Information System (CBMO)[9]

Digos allocated PhP121, 00C of its MGP money for establishing a community-based information system (CBMO) o which PhP 75, 000 went to the conduct of training.

The re-conceptualized CBMO was intended to modify the people's self-limiting mindset that health service concerns are to be addressed solely by health service providers and volunteers. The CBMO aims to change this mindset by actively involving the community as a whole in health issues

In the creation of the CBMO, the RHUs had sought technical assistance from a local NGO. The initial activity was a three-day facilitators training conducted on 26-28 August 1999, held in Sulup, Digos, to assess the CBMO method and plan for its use during the MGP in Digos.

This training was facilitated by Mr. Eric Libre of Softskills Dev Consultancy and was participated in by all the nurses, midwives and the two rural health physicians of Digos. There were essentially three major parts of the training: discussion of the existing monitoring system, an overview of the CBMO concept, and the "installation" workshop/exposure where the participants, pretending to be mothers from a *purok* (household cluster within a barangay), were walked through the spot mapping, masterlisting and family planning modules.

After the training, health providers went back to their respective RHUs and began conducting the CBMO. In preparation for the activity, barangay officials and barangay health workers (BHWs) were informed of the schedule of the CBMO in their area and the processes to be done under the CBMO. They were asked to help gather people for this activity and to select one representative from each household.

[9] See APPENDIX for easy to read index-process-output table for this intervention.

A five-person facilitating team was selected from the participants to demonstrate the family planning module in one purok. Forty-three mothers, out of the estimated 80 households of the purok, came to the community assembly, which was held in an improvised tent 80 km away from the highway. The assembly was organized by the Center for People's Integrated Development and Services, Inc, a development NGO based in Digos, together with a municipal social worker.

During the scheduled day for the CBMO, the trained facilitator set the tone for an informal group discussion. Each household representative was asked to indicate whether there were women and children eligible for the MGP services and the current status of their immunization and/ or family planning use. The women were asked what method they were using and whether they were happy with their current method. Non-users were asked why they do not use family planning. The output was given to the *Barangay* midwife who would then schedule those with unmet needs for service delivery, either during the *Bayanihan* outreach or through the routine clinics.

Feedback from the participants were:

1. Appreciation on the participatory nature that allows mothers to contribute to the monitoring process
2. Appreciation on the group setting being able to provide opportunity for information provision on FP/child health issues
3. Expression of concerns on the CBMO operationalization, e.g., time, incentives, participation of BHWs and barangay officials, and expenses

Suggestions to improve the process were:

1. Identify portions in the module which can be integrated to save time and effort
2. Existing resources or information in the community can be utilized
3. Mothers can be grouped according to method use status

4. Mothers could be given copy of the form containing the information needed and they could check the appropriate responses guided by a facilitator who has a bigger cop of the form in front
5. The BHWs could be tapped to assist the mothers and ensure that they are filling the forms correctly

Though the CBMO, the community members participated in all phases of the program including collecting community health statistics, using that information, and facilitating direct service delivery. These activities contributed to a sense of ownership among community members in health concerns and ultimately to the promise of sustainability of health services. Since it is the community that manages the system, service providers are deloaded of the additional workload of information generation. At its best, the health service information system is no longer limited to the service providers of the community but also to the entire community, and system of this kind can contribute substantially to a sustainable model of service delivery in poor, isolated, and under funded locales.

**Output**

As of March 2000, the CBMO had been underway in the two RHUs, with one barangay out of 12 in RHU 1 while one out of 14 barangays in RHU 2. In RHU 1, the computed average of household surveyed is 2% out of the total 13,412 households while in RHU 2, the computed average of households surveyed is 8.8% of the total 10,691 households. A total of 1,211 households have already been surveyed or roughly 5% of total households in both RHU 1 and 2. The table below shows a summary of their CBMO accomplishment.

*Table 7. CBMO Accomplishment as of March 2000*

| Rural Health Unit | Total Households Surveyed | Estimated No. of Coop. Households | Percentage accomplishment |
|---|---|---|---|
| RHU 1 | 269 | 13412 | 2 |
| RHU 2 | 942 | 10691 | 8.8 |
| TOTAL | 1211 | 24103 | 5 |

Source: RHUs1 & 2, Digos, Davao del Sur

**4) Establishing an Inter-agency IEC and Service Delivery System for Female Workers in SME**

This strategy was allotted PhP 19, 999 from the MGP funds, scheduled from August 1999 to June 2000. Activities for this strategy supposedly include the following:

1) Orientation on SME outreach to Sanggunian members, which will cover the importance of SME outreach as an integral part in addressing this specific public health area of concern and seek concrete support of the LGU in the conduct of SME outreach.

2) Production of directory of establishments, which will involve human resources for the printing of the final copy directory of establishments.

3) Creation of an inter-agency action team, which will involve orientation, discussions, consultations and participation on different lines of work among SME managers/owners and inter-agencies working with various government agencies, such as DOLE, DTI, DSWD and Pop Com in the actual conduct of SME outreach.

4) Conduct of planning worksh op with SME managers/owners, which will involve meetings, orientation, consult ations and participation of SME managers/owners in the actual conduct of SME ou reach.

5) Project implementation and monitoring, which will involve development of mechanisms for monitoring and updating, and concrete monitoring mechanisms and system for SME.

**However, among the MGP strategies, the SME outreach is the only activity that has hitherto been unfulfilled. So far, RHU I has only *targeted* 4 SMEs and RHU II, 18.** Discussion on the implementation process of this particular strategy within the Population Council documentation period (June 1999-March 2000) could not be provided.

***Offshoots of the MGP***

**The Health and Nutrition Post**

The Health and Nutrition Pos was initially not an MGP strategy but an offshoot of the implementation of the CBMO. A concern arising from the CBMO as an information system was identifying a place where health information and services can be accessible to the whole community. This concern stemmed from the realization of the two RHU physicians that some barangays, especially the far-flung ones, do not have BHSs, or if ever there is one in their barangay, it is too far from peripheral villages. The RHU physicians thought that build ng a "Health and Nutrition Post" where health services and information are deliver d could make service delivery acces ible even in remote barangays.

The RHU I physician then sought support from barangay captains to promote the concept. The concept encouraged barangay officials, particularly in the areas covered by RHU I, to strengthen the program and construct several health posts in the *barangay*. *Barangay* officials, with volunteers from the community, donated materials to build

health posts in each of the *puroks* or household clusters. The community shouldered the physical construction of the health and nutrition posts so that "not a single centavo came from the Local Government Unit." The BHWs, the community members and the civic organizations such as the Lions Club, Rotary Club and REACT pooled resources in putting up posters and other paraphernalia. Districts 1, 2 and 3 of Barangay Dulangan, particularly, have examination rooms, curtains, and creatively designed receiving areas, vegetable gardens, bamboo fences, kitchens, comfort rooms and furnaces.

Community members showed interest in the Health and Nutrition post because many barangays do not have a BHS. By establishing a Health and Nutrition post in their area, basic services usually found in BHSs are now accessible to them.

These posts serve as outreach venues as well as mini-health station for the volunteer health workers (BHWs) and the designated health coordinators of each of the families. In each of these posts, information on community health and nutrition status are hung or posted, and basic health services are delivered. Examples of community health and nutrition information are electricity, water and sanitation, shelter, basic education and literacy, family care and livelihood. For MGP's purpose, community status information on family planning, child immunization, vitamin A and tetanus toxoid were also included. Herbal gardens are also found in the vicinity of the health and nutrition posts to complement the limited western medicines in these health service outlets.

In February 2000, Barangay Sinawilan of RHU2 completed four Health and Nutrition Posts in puroks Mangga, Narra, Bayabas and Rosas. Puroks Balisong and Tuwal were still under construction.

**BTL Referrals**

Like the Health and Nutrition Post, BTL referral is originally not an MGP strategy but an offshoot of the implementation of the CBMO. During CBMO, many patients were identified having unmet need in BTL, recounting the fact that they always had to be rescheduled for this particular service since government doctors could not accommodate

them during regular clinic hours. During the first 6 months of the MGP, bilateral tubal ligations (BTL) were done on an irregular basis at the Provincial Hospital. Sometimes as many as 25 patients were accommodated for operation in one day, exhausting the few doctors trained to do BTLs.

To address this problem, a schedule was adopted with a limit of 10 patients per month as an MGP approach. In order to accommodate the demand for BTLs a referral system was set up which allowed for those unable to avail of services on a particular day to be rescheduled. Hence, if more than 10 patients queue up on a given day, they would be re-scheduled. The BTL is conducted free of charge. Anesthetic and manpower are provided by the PHO while post operation medicines and transportation are provided by the MHOs.

During the launching of MGP in Kapatagan, 11 BTLs were performed. This BTL accomplishment echoed the assessment of the health providers in Digos that there are a good number of clients wanting permanent sterilization. Besides, permanent and semi-permanent methods tend to stabilize their CPR compared to temporary methods also being offered by the two RHUs. By providing them the opportunity, more clients were likely to avail of BTL.

## Output

***Table 8. BTL clients served under MGP as of March 2000***

| [illegible] | [illegible] |
|---|---|
| RHU 1 | 38 |
| RHU 2 | 56 |
| TOTAL | 94 |

## VI. CONCLUSION AND RECOMMENDATIONS

The accomplishment of the MGP in Digos can be summarized in the following figure, which illustrates the four indicators before and after the program.

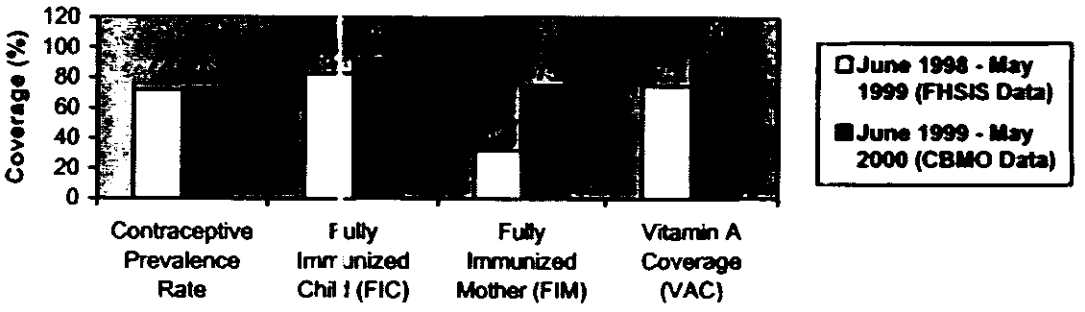


***Figure 7. MGP Indicators Before and After the Program***

The MGP activities in Digos highlighted a participatory process for obtaining information on clients needing services; it consistently focused on remote, inaccessible *barangays*. With the apparent increase in CPR, FIC, FIM and Vitamin A coverage rates shown above, it might be correct to infer that these MGP interventions have been effective in reaching out to underserved and inaccessible communities, in decreasing missed opportunities, and, in increasing availability of health services to clients.

Integration of tetanus toxoid immunization into pre-marriage counseling is able to capture "target"/missed clients in this fitting occasion. This intervention needs to be sustained, but requires service providers to maintain a recording system that will enable them to monitor their clients closely.

Since outreach to women in small and medium enterprises is the only proposed MGP program that has not yet been implemented, efforts to begin this activity should

already be undertaken. The two RHU physicians should already be able to identify target establishments and send out letters to SME owners and managers.

The two RHUs should promote the health and nutrition posts in districts other than the pilot areas through more outreach activities. To encourage *bayanihan* spirit in the *puroks*, it may be necessary to grant district awards such as "Best Health Post." Initiatives like this will motivate community members to participate and appreciate the value of the program in their locality. Civic groups such as the Rotary Club need to help *barangays* in carrying out their projects.

Coordination between municipal LGU volunteers and NGO doctors is necessary in sustaining regular schedules for ligation in different communities. Networking and participation among indigenous leaders and agencies are equally important in mobilizing trained community health workers to assist in the surgical services.

Aside from *barangay* health workers, community volunteers are key partners in reaching out to individuals who may have unmet needs and in making service delivery more efficient. It will be necessary to equip these partners with skills and information needed in service delivery.

Lastly, program implementation is dependent on the energy and initiative of the program implementers, and most often, program implementers can only be pushed to demonstrate efficiency when they are monitored and evaluated on. Therefore, monitoring and feed backing should always be a component in improving program implementation. There is also a need to assign more provincial or regional point persons to help monitor the development of the program.

***Appendix 1. Definition of Terms***

1. Contraceptive Prevalence Rate (CPR): This rate is measured as the proportion of women 15-49 years of age reporting current use of any contraceptive method at the time of assessment. The denominator consists of all women 15-49 years of age (WRA). However, in some DOH service statistics, the denominator is defined as currently married women 15-49 years of age (MWRA). Whenever possible and if the information is available, a delineation between these two measurements will be made.
2. Fully Immunized Child (FIC): This is the percent of living children 12-23 months of age who have been vaccinated before their first birthday with three doses of Oral Polio Vaccine (OPV), three doses of Diphtheria-Pertussis-Tetanus (DPT) vaccine, one dose of Bacillus Calmette-Guerin (BCG) vaccine and one dose of measles vaccine
3. Vitamin A Coverage (VAC): This refers to the percent of children 12-59 months of age who received a Vitamin A supplement in the last six months
4. Tetanus Toxoid two plus (TT2+): This is the percent of pregnant women and mothers of reproductive age (15-49 years) with children under 5 years of age who have received at least 2 doses of tetanus toxoid.
5. Unmet need for family planning (FP): This refers to the percent of currently married women of reproductive age (MWRA) who want to limit or space their next child but are not using any family planning method and those using a method but are not satisfied with their current method. The denominator consists of all married women of reproductive age 15-49 years of age.

### *Appendix 2. DOH and MGP Program Goals*

DOH and MGP program goals for the four key indicators, as well as findings from the 1998 National Demographic and Health Survey (NDHS) are shown in Table 3.

***Table 9. Program Goals vis-à-vis 1998 NDS***

| [illegible] | 1998 NDS | DOH Goal | MGP Goal |
|---|---|---|---|
| Contraceptive Prevalence Rate (CPR). modern methods | 27 | 35 | 36 |
| Fully immunized children (FIC) | 65 | 90 | 80 |
| Tetanus toxoid 2 plus (TT2+) | 38 | 80 | 80 |
| Vitamin A coverage (VAC) | 71 | 90 | 85 |

***Appendix 3. Early MGP Activities in Digos***

| [redacted] | [redacted] |
|---|---|
| MGP as a Program First Introduced<br>c/o Dr. Angel Libre and Mrs. Vida Acosta | February 1999 |
| Letter of Invitation Received from the Department of Health Regional Field Office (DOH-RFO) c/o Mayor Arsenio Latasa | Mach 22, 1999 |
| Letter of Intent Sent<br>c/o Sanggunian Bayan | May 29, 1999 |
| MOA Received by DHRFO | May 20, 1999 |
| MGP Money Released | May 24, 1999 |
| First Activity -Kapatagan Outreach | June 16, 1999 |
| 17 Tubal Ligation Clients | June 18, 1999 |
| Resolution on TT2 into PMC | August 4, 1999 |
| Barangay Visitation and Outreach-one a week | July 1999-Ongoing |
| Pre Marital Counseling Seminar with IT integration | September 1999-Ongoing |
| Special Tubal Ligation - 43 clients | November 23, 1999 |

***Appendix 4. Tables of Input Proces s-Output of MGP Interventions***

1) Bayanihan Outreach

| Input | Process | Output |
|---|---|---|
| From LGU<br>Staff time<br>From *Barangay* officials<br>Venue, physical arrangements<br>From community<br>Food for health providers<br>From private sector<br>Medicine donations<br>From MGP<br>P 239,000 for transportation & Supplies<br>From DHRFO/ PHO<br>Vaccines, family planning & Vitamin A supplies,<br>Manpower & supplies for BTL | • *Barangays* with most urgent health needs and difficult to reach prioritized<br>• Initially included all gov't services aside from health; assessed as too difficult to sustain<br>• Subsequently focused on offering health services: consultation & check-up, Immunization, Vit. Supplementation, FP re-supply, BTL, & circumcision | • All barangays visited at least once between June & Dec. 1999<br>• Generated community interest and awareness of health programs leading to construction of health & nutrition posts<br>• Utilization of services, as seen in the increase in FIC and TT2 rates |

**2) CBMO**

| | | |
|---|---|---|
| From LGU<br>Staff time<br><br>From Barangay officials<br>Venue, community mobilization<br><br>From community<br>Participation in community assembly<br><br>From private sector<br>NGO contracted to provide training<br><br>From MGP<br>P 121,000 for training & community assemblies<br><br>From MSH<br>Worked w/ NGO in conceptualizing CBMO process | • Hiring of NGO contr oversial from MSH & PHO perspective<br>• Generated interest & awar ness | • Operational in 2 pilot *barangays*, Dulangan for RHU I & Sinawilan for RHU 2<br>• 1211 households covered; 729 in Dulangan and 942 in Sinawilan<br>• Utilization of services, as seen in the increase in FIC and TT2 rates (see Fig. 4) |

### 3) Health and Nutrition Posts

| Input | Process | Output |
|---|---|---|
| From LGU<br>Staff time<br>From Barangay officials<br>BHWs provided posters & materials for CBMO data display<br>From community<br>Land & materials | • Mobilized community for health activities | • 7 H & N posts constructed in Dulangan; 4 posts in Sinawilan |

### 4) TT

| Input | Process | Output |
|---|---|---|
| From LGU<br>Staff time<br>From DHRFO/ PHO<br>Vaccines & supplies | • Required municipal ordinance delaying implementation by 2 months<br>• Built upon existing lectures given by health staff | • Had not been implemented at the time of the study |

**5) BTL**

| | | |
|---|---|---|
| From LGU<br>Staff time<br><br>From MGP<br>Post-op medicines & transportation<br><br>From DHRFO/ PHO<br>Manpower & operation needs | • Required linkage w/ Provincial Hospital to have a schedule that suited everyone's needs<br>• Lack of trained manpower initially a problem at the hospital | • 38 clients from RHU I and 56 from RHU II have had BTL from June 99 – March 2000 |