MGP TECHNICAL CONFERENCE FOR LUZON

Theme: Improving Access to Family Planning Services

HIGHLIGHTS OF PROCEEDINGS

March 3 – 4, 2003
EDSA Shangri-La Hotel
Mandaluyong City

Management Sciences for Health
Philippines Program Management Technical Assistance Team Services (PMTAT)
USAID Contract Number: 492-0480-C-00-5093-00

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Plenary: March 3, 2003

Opening Ceremonies

Welcome Remarks
Hon. Milagros Fernandez
Undersecretary, DOH

This third conference is a sharing of innovative approaches in the Family Planning, Maternal-Child Health, and Nutrition programs of the Department of Health. The MGP has strengthened partnerships between the DOH and LGUs. It is a show window of opportunities for cooperation at the primary health care level. I am confident that the innovative strategies and approaches discussed here will be replicated by other health managers throughout the country.

Message
Mr. Jed Meline
Deputy Chief, OPHN-USAID

The United States Agency for International Development has supported devolution in terms of making available technical support needed in the key program areas of family planning, MCH, and nutrition. The US government has been a major donor of up to 80 percent of FP commodities in the country since the 70s. In 1999, RP embarked on a self-reliance program to build technical and financial capability among program implementors. The framework for contraceptive independence initiative was conceived in 2001. It drew strength from the fact that 30 to 35 percent of patients served have the means to pay for services. It is important for government resources to be targeted to the poorest population. Technical assistance and support will be given to LGUs to target

resources for the support of the needy. USAID will provide Php3M for the FP program in 2003-2004, directing the 35 percent of the served population to the private medical sector. The MGP has resulted in incredible successes wherein the learnings should be taken home and replicated.

Keynote Address
Hon. J. R. Nereus O. Acosta
Representative, 1st District of Bukidnon

As the Board Secretary of the Philippine Legislative Committee on Population and Development, we are on the fore of issues affecting FP services. What afflicts the country is the lack of a sense of urgency on the part of leadership. The overriding theme to engender is the next generation. We should stand for the harder controversial decisions and craft policy to implement them. As the co-author of HB4110, we are receptive of broader views and perceptions on FP and Reproductive Health, women and children's rights, and other health concerns. Democracy invites debates, but it is unfair and uncharitable to make deductions that destroy family and society. We cannot argue against dogma and religious beliefs but we are here to shape policy respecting all beliefs and all sects. It is our duty to tackle the five "Fs" in population and development.

These are one, Facts – information and indicators pointing to the dire economic situation. Two – Freedom, from which broad understanding flows. Three – Financing, not only in terms of donor or government appropriations but in terms of capability to manage programs through optimal use of resources. Four – Framework, identifying needs and challenges through local health planning, governance, and prioritization. In negotiation, it is important to understand the frame of issues, recognizing the rights of women, children, and couples. Social policy is about understanding frameworks that are practical and achievable, because they are based on facts that can be extrapolated and dialogued. It is unfair to be called anti-life when you have uppermost the quality of the life of our citizens. Five – Fortitude, to believe in the work being done for the next generation. Development is like photography, for to develop, we must deal with the negatives involved in planning our families, our communities, and our nation.

Discussions

The future of HB 4110. Bills on population and reproductive health are presently at tension point. Rights discourse and public health issues are at loggerheads with forces that wish to keep to more traditional hierarchies and frameworks. In this context, we do not raise high hopes for their passage. We should attend to

advocacies to challenge parties. Senders of negative messages should be brought to a forum and dissuaded from labeling. In our talks with the President, we were able to discuss the bills, showing that common sense can prevail. Our leaders intuitively know their urgency and should snap out of the denial stage, the Philippines being past due its neighbors in the Far East.

Presentations

1. The DOH One Script Plan

Dr. Lilibeth David
Health Policy Development Bureau, DOH

The DOH One Script Plan hopes to strengthen the connectedness among parts of the organization. It defines five broad thrusts, six priority programs, systems improvement, and reforms. It aims to ensure that strategic direction and targets are pursued in 2003-2004, and adequately documented in the face of limited resources for health. Desired outcomes are supportive of the government's program of health service affordability, accessibility, promotion, and public protection.

Affordability involves the lowering of prices of medicines through GMA-50; protecting Filipinos from fake, substandard products and services through BFAD restructuring; preventing epidemics and diseases, including the management of infectious diseases and the promotion of women and child health through FP; making primary care services more accessible though the NHIP and hospital development services; and enabling Filipinos to live healthier lifestyles.

The strategic framework covers the formulation of organizational and operational strategies. The implementing mechanisms will be provided by zonal monitors, deputy zonal monitors, and members. Schedules and benchmarks have been set for the One Script Program in 2003. This will be supported by visits to monitor implementation and performance.

Discussions

DILG role in the One Script Program. LCEs will be informed thru the CHDs. LCEs get their directives from the DILG so, parallel information will be required at the agency level.

Thrusts and priorities in disease prevention. Programs that impact on population and development can utilize funds from the public health sector. This covers expanded immunization and infectious diseases.

Local involvement in the One Script Planning Process. Regional Directors and Chiefs of Hospitals are in constant touch with PHOs and MHOs in all planning stages. It was so named to tie up all the priorities from the local to central levels. This will not inhibit the activities of the regional offices and LGUs in other health areas, depending on the needs of each province, municipality or barangays.

Support for GMA 50 by the Health Secretary. The parallel drug importation program now involves the hospitals and the Bureau of Food and Drugs (BFAD) that provides quality seals for drugs. It also allows drugstores to participate to enable the public to purchase cheaper drugs of high quality. The DOH will re-launch the Botica sa Barangay, utilizing GMA-50 drugs, in Pampanga and Pangasinan. This will later branch out to other regions before the end of 2003.

Drug sources and BFAD seal as a requirement. Drug sources include India and local generics companies. Only the BFAD registration should be required of drugs procured through bidding.

2. Highlights of the 2003 FP/MCH Survey

Dr. Socorro Abejo
Chief, Demographic and Social Statistics Division, NSO

The 2003 FP/MCH Survey is a nationwide survey of female family members 15 to 49 years of age. It is the 7th in a series of surveys conducted since 1995. 19,843 households were visited, sampling a total of 31,792 women. Of this number, 29,760 persons were interviewed, resulting in a response rate of 93.6 percent.

According to the survey, 63.4 percent of the women were below 35 years, and 36.6 percent were 35 years and older. A total of 56.5 percent were married. The Contraceptive Prevalence Rate (CPR) decreased to 48.8 percent from 49.5 percent in 2001. From 1988 to 2002, CPR was shown to have consistently improved. The Pill continued to be the leading contraceptive method. Female sterilization ranked second with 11 percent. Pills are used to the greatest extent by women from 25 to 29 years of age, followed by women from 30 to 34 years. The calendar method was found to peak by the time women reach 39 to 44 years.

Cagayan Valley and Region 12 posted the highest CPR while ARMM registered the lowest. The Pill stood as the most popular method among poor and non-poor

alike. The public sector provided modern contraceptive supplies of up to 70.1 percent while the private sector accounted for just 26.1 percent.

Discussions

Need for a presentation on the effectiveness of the methods in the interest of clients and providers. Variables that measure effectiveness are not easy to operationalize and were not included in the surveys. The rate of effectiveness can be perceived through the DOH Health Standards. Dr. Catibog explained that in terms of method effectiveness, modern methods rank highest. Effectiveness depends on how well instructions were complied with by the user and the quality of counseling received.

Religion as a point to consider. In the section on "why women do not use any FP method," only 4 percent failed to cite reasons. Only in ARMM did women cite religious prohibition as a reason for not accepting contraceptives.

Record of sources of supplies of contraceptives. 70 percent of the surveyed women get their modern contraceptive supplies from the public sector, namely, government hospitals, RHUs, and BHS, while 30 percent get their modern contraceptive supplies from the private sector, namely, pharmacies and private hospitals performing sterilizations. Main reasons for non-acceptance were wanting a child, health restrictions, and fear of side effects. The high reliance on the public sector may be due to the public perception that contraceptives should be given for free.

Inasmuch as only two percent get supplies from BSPOs and BHWs, this points to the need for more personnel. Mr. Ephraim Despabiladeras of USAID pointed out that only qualified medical personnel should be the dispensers. The DOH should craft a policy authorizing BHWs and BSPOs to dispense these resources. BSPOs and BHWs are LGU personnel whose roles have shifted from dispensing contraceptives to referrals. It is the RHUs that provide the pills, resulting in a survey showing services of BSPOs to be low. They now function as health workers.

3. The New Family Planning Policy

Dr. Honorata Catibog
Center for Family Health, DOH

The new FP policy aims to provide universal access to FP guided by respect for life, informed choice and responsible parenthood. The Philippine population now

stands at 80 million, 40 percent of whom live in poverty. It is the 14th largest in the world, with a growth rate of 2.36 percent. The population is expected to double in 29 years.

Of this number, about 1.1 million want to stop giving birth and 900,000 want to space pregnancies, one out of 6 pregnancies end up in abortion. Abortion is rising from 320,000 to 400,000 annually. Teenage pregnancies account for 30 percent of all births. Four basic strategies were formulated to address the situation and these are the creation of FP itinerant teams, programs for the urban poor, mainstreaming Natural Family Planning methods, and strengthening FP in regions with the lowest CPR, namely, CAR and Regions V, VIII, and ARMM. The move is to expand the Community-Based Monitoring and Information System or CBMIS to non-MGP areas; frontline participation of hospitals, FP for urban and rural poor, and expanded role of voluntary health workers (VHWs).

Administrative Order 125 s. 2002 embodies the National NFP Strategic Plan 2002 to 2006, aiming to realize fertility awareness of at least 75 percent of young women and men. Opportunities to be actively explored are active case findings, delivery of services at the first point of contact, and zeroing FP drop outs by the hospital and community. To respond to unmet needs, targets will be set for backlog reduction at the LGU level. Focus will be given to the reduction of abortion complications, men's reproductive health, and adolescent reproductive health. The cost of FP commodity supplies that will be needed has been estimated at Php938 million.

The Contraceptive Independence Initiative Action Agenda will be pursued using a market segmentation policy that includes Philhealth coverage, LGU financing, private sector commodity provision, and national subsidy.

The Responsible Parenthood Program will be launched in March 2003. President Arroyo identified four principles under the program, namely, one, responsible parenthood as a shared responsibility between men and women considering financial and health status; two, responsible parenthood that encompasses the provision of food, clothing, shelter, and education to children; three, respect for life as a fundamental article of the Constitution, forwarding the view that FP rejects abortion, and four, fertility awareness.

Discussions

Method mix is not being promoted in FP program yet evaluation is done in terms of modern method mix. Back in 1994, traditional methods were no longer included. Per DOH directive, NFP and Modern Contraceptive Methods do not include the calendar and withdrawal methods.

In the quest for Huwarang Pamilya wherein families with more children were made to qualify for the award, the reverse should have been made the criteria. This points to the need to intensify IEC to promote smaller families.

Contraceptive supply beyond 2004 requires knowledge of market segmentation and potential acceptors. USAID is gradually withdrawing support for the pill, condoms, and IUDs. The President has informed that there will be no provision of funds for contraceptive commodities. The solution is to segment the market, seek alternative funding donors like the UNFPA in late 2003 to 2004, LGU subsidies, and re-direction of pay patients to the private sector.

4. Sentrong Sigla Certification Updates

Hon. Milagros Fernandez
Undersecretary, DOH

Sentrong Sigla standards and indicators were developed with multisectoral involvement. The standards are comprehensive and indicative of total quality, input, process, and outcomes. Their use is limited to public health facilities and not hospitals which are measured in terms of PHIC standards. The main focus areas are core public health services, facility, environment and systems, regulatory services, and basic curative care services. Improved processes and procedures involve the participation of stakeholders, extension of purposive technical assistance, improved supervision at the facility level, and enhanced monitoring.

There are three levels of certification, namely, Basic Certification, Specialty Certification, and Certification of Excellence. New incentive schemes are granted for each level of certification, inclusive of matching grant for performance. The DOH is now finalizing the new SS standards and instruments, organizing the regional technical assistance and assessments teams, orientation of these teams, and training of regional assessors.

Concurrent Sessions: March 3, 2003

CONCURRENT SESSION I
IMPROVING QUALITY OF HEALTH SERVICES

Highlights of Presentations

In the past, government health facilities have become, among others, synonymous with poor service quality. With its very limited resources, both financial and technical, government health facilities have had difficulties improving services. The shift from a highly centralized government health care system to a relatively more democratic system, coupled with the advent of new ideas to improve health care delivery, have offered new opportunities for health officials to look at their role from an entirely different perspective. The new challenge for local health officials is to reformat its organizations from mere curative facilities to service facilities with style and substance.

Without doubt, technical assistance from the *Sentrong Sigla* (SS) and the Matching Grant Program (MGP) served as impetus for local health officials to re-assess their role and take active part in reforming health care delivery systems within their communities.

1. Achieving Client Satisfaction: The Karangalan Health Center Experience
Dr. Alford Ortiz
Cainta, Rizal

The Karangalan Health Center in Cainta, Rizal has been in existence since 1982, it was only after its enrollment to the MGP and acceptance as a SS-certified facility in December 2000 did the community recognize its services. Prior to that year, the health center's contributions were considered insignificant due to its poor infrastructure and inadequate equipment, supplies, and drugs. The previous political administration also transferred most of the health center staff to the municipal hospital and the move severely affected the center's capabilities to provide services. With its very few and unsatisfied clients, staff morale was naturally low.

The turnaround occurred when the MGP assistance was granted sometime in 1999. Apart from the financial support from the DOH, the grant necessitated parallel commitments from the LGU. The combined resources from the DOH and

the LGU allowed local health officials to resurrect the nearly idle health center. Among the improvements instituted were the upgrading of the facility, provision of equipment, drugs, manpower, and supplies. Additional enhancements were also made in the systems and procedures of the health center, such as patient records, patient flow, and clinic schedule.

2. SS Certification and PhilHealth Accreditation: Toward Increasing Health Services Utilization in Ligao, Albay and Angat, Bulacan
Dr. Lea Remonte (Ligao City, Albay)
Dr. Guillerma Agustin (Bartolome, Angat, Bulacan)

The experiences of the City Health Office (CHO) of Ligao, Albay and the Rural Health Unit (RHU) of Angat, Bulacan were also presented to show that all levels of health facilities could reap benefits from *Sentrong Sigla,* PhilHealth, and the MGP. These facilities both went through an assessment of their deficiencies and carried out improvements to correct such inadequacies. After instituting reforms, positive developments began to occur in the CHO of Ligao and the RHU of Angat. Foremost of these were the significant increases in patients utilizing their services. The Ligao City Health Office, for example, cited a jump from its 21,967 patients in 2001 to 25,529 in 2002.

Securing their respective PhilHealth accreditations also enabled the two health facilities to provide OPD services to PhilHealth-enrolled indigents. With the growing number of indigents being enrolled by their local government units into the government's social health insurance program, the two health facilities were able to attract these beneficiaries to avail of their OPD services and, thus, gained a share of PhilHealth's capitation fund. Officials of the two health facilities hope to funnel back proceeds of the capitation fund to finance their operational requirements.

3. Modeling the Implementation of 5S at the Regional Office
Dr. Gerardo Bayugo
CHD for Bicol

Positive developments at the local level have challenged some regional health offices to keep pace. As implementers of Sentrong Sigla, the Center for Health Development (CHD) in Bicol felt that its role is incomplete if it does not serve as a model facility to its constituents. The CHD decided to adopt the 5S approach to quality improvement as a guide in instituting gradual quality enhancement activities in its offices. Originally conceptualized by a Japanese to enhance the

services of manufacturing companies, the 5S stands for *Seiri* (sort), *Seiton* (systematize), *Seiso* (sweep), *Seiketsu* (standardize), and *Shitsuke* (self-discipline).

CHD officials and staff initially used the 5S as a "housekeeping" tool to sort the important materials from those to be disposed. The success from the first phase prodded the CHD to continue to the next level, which is to arrange things. Eventually, since the 5S is being practiced daily, CHD staff began to apply the concept as well to the other office affairs. Systems were reviewed and functions were streamlined, all directed towards improving the workplace.

The outcome of reforms in the four different levels of health facilities has been remarkable. It brought health care in public facilities to a higher level or standard. Moreover, the changes have been beneficial not only to the patients but to the staff as well.

Issues and Concerns

Fund inadequacy need not hamper quality improvement programs. It has been observed that many agencies avoid embarking on quality improvement activities unless sufficient budgetary support has been guaranteed. However, it was stressed that fund availability can only help facilitate quality enhancement activities but it does not ensure success and sustainability. The experience of CHD Bicol underlines the fact that improvements can be started without the need for huge capital outlays. Simple housekeeping measures, for example, especially if done daily, can produce significant effects in the workplace and in the attitude of clients and personnel. Moreover, creative ways of addressing resource inadequacy may be devised. Volunteerism may be tapped to address shortages in human resources and inter-agency cooperation may be used to secure various forms of assistance.

Political support is needed to propel reforms at the local level. The support of local officials is an imperative in any reform initiative. The MGP in Ligao City, Cainta, and Angat underscored the need for local governments to participate in the program through a fund support scheme. The support was a crucial factor in jumpstarting the various reforms. However, LGU support does not end with the provision of financial resources. Local officials must constantly be updated of the developments in the health sector so other forms of assistance may be continually solicited from them. Advocacy and policy changes are some of the areas wherein political officials can also extend support.

Need to conduct parallel monitoring of public health programs. Apprehensions and caution were raised to the local health officials to closely monitor the provision of public health services. Although much of the reforms, particularly in

the district and rural health services, have resulted in increases in the number of patients, there may be a need to look at the vital health indices (e.g. infant mortality rate) to ensure that increases in patient load is due to renewed trust extended by the community and not because of the failure of public health programs.

Need for additional studies. Smaller studies are also proposed to gain a definitive conclusion that facility and service improvements are the real reasons for the increase in patient volumes. Suggestions include monitoring patient utilization of private facilities and classifying patients based on socio-economic status. The increase in the number of patients may be due to increase in the number of people wishing to avail of the free government services. If such is the case, there is a possibility that even those who can afford may be unduly benefiting from the scheme and may, in the long run, lead to a drain in LGU resources.

Clients must be considered partners. It was observed that health facilities have been limited to looking at clients as mere patients. There is a need to actively involve patients as partners in improving the health facility and ensuring project sustainability. Most of the reported reforms were government-initiated activities, with a large part coming in as increased funding for health services. Future plans must also contain strategies on how to tap community participation in ensuring the sustainability of these programs.

CONCURRENT SESSION II
IMPROVING SYSTEMS AND PROCESSES (1)

Highlights of Presentations

1. **Self-Assessment as a Strategy in Maintaining *Sentrong Sigla* Certification**
   Dr. Rowena Galpo
   Baguio City

Baguio, the summer capital of the Philippines, is a highly urbanized city located in the Cordillera Administrative Region (CAR). It has a total population of over 258,000. In 1999, 15 of the 16 health facilities have achieved Sentrong Sigla (SS)-certified status, with an upbeat readiness to provide basic health care. The Baguio Health Department Assessment Team (now known as the Quality Coordinating Team) was established in 1996. It monitors the adherence of local health facilities to SS standards and provides them with needed assistance. The team encourages the facilities to closely adhere to the standards by consistently pinpointing areas for their continued improvement.

The activities of the team members currently revolve around the facilities' self-assessment, assessment by the Baguio Assessment Team (BAT), joint identification of program deficiencies, and action planning. Assessment Summary Reports are made the bases for critical action and follow-ups. Assessment visits are done yearly; the follow-ups, depending on the summary results.

Self-assessment proved highly beneficial. Some of the advantages were the early detection of deficiencies, the prompt institution of corrective measures, prevention of backslides, retention of certification, and continued delivery of quality health services. The self-assessment also served to complement the evaluations done by the CHD. In the future, the tools may be utilized for resource tapping. There are plans as well to continually revisit the tools with the aim of raising previously achieved levels of standards.

Issues and Concerns

Composition of the Assessment Teams and extent of coverage vis-a-vis financial support. There are two teams that are composed of division chiefs, doctors, midwives, nurses, and educators. They undertake the assessments from a period

of two weeks to 1 month, in the course of which they are provided with transport, food, and material support.

Estimate of compensation and possibilities of replication in a low-finance scenario. The teams do not avail of extra compensation since the duties are part of their regular technical functions. In the case of the 420 health centers in the National Capital Region, the assessments are made by division chiefs, specialists, and the DOH Representatives. Assessments may also be done by the administrative staff. Other agencies may also take part in the assessments.

LCE involvement. Minor deficiencies surfaced by the assessments can be addressed at the facility level. LGUs can allocate a certain amount for bigger program support, facilities improvement, and infrastructure.

2. Quality Improvement Initiatives Toward a Healthy City

Dr. Evelyn Crisostomo
Marikina City

Marikina City is the country's new rave in terms of strides covered in the area of local governance and banner legislation. It has a population of 450,000 with 14 barangays and 16 health centers. Former Mayor Bayani Fernando spearheaded the city's quality improvement initiatives that have passed local, national, and international standards in the areas of physical reconstruction of facilities and roads, social values, and the promotion of excellence, discipline, and good taste.

Marikina City observed a 10-year Strategic Roadmap designed to make the city an industry-and government-friendly community. City health centers were SS certified, undergoing yearly physical infrastructure and quality service delivery improvement. The city found the need to constantly improve beyond SS certification. Among the health initiatives undertaken were the synchronized procurement of drugs through a single quarterly bidding. The quantification of drugs and supplies were done at the city level. A Drug Inventory Board was established to assure the availability of vital drugs and supplies. Receipts were issued to control their movement.

The Philippine Quality Awards and Total Quality Management are Marikina's own landmark initiatives that were cited by the World Health Organization and the DOH. These are participated in by pharmaceutical industries. Under the concept are programs that include the Save the Marikina River, Squatter-Free Marikina, the 5-Minute Quick Response Time, Garbage Transfer Stations, *Disiplina sa Bangketa*, and *Puno Kahit Saan*. A foremost lesson learned was that a leader with the political will and vision to institute quality improvement needs community support and partnership with GOs and NGOs.

Issues and Concerns

Management styles adopted for efficient garbage collection. Pre-segregation by the homeowners are required before the garbage is collected twice a week. Dump trucks are assigned for the pick-up of biodegradable and non-biodegradable wastes that are brought to the garbage transfer stations where another pool of trucks take them to the dumpsite. The city operates its own dumpsite. Timing is therefore made efficient. Chemicals are used to treat the wastes.

Types of IEC needed to make people comply with segregation. Slogan campaigns utilizing posters in high-visibility areas were employed, enjoining the public to adhere to the color-coding system in garbage disposal. The public need not buy expensive bags, but merely tie their containers with colored ribbons. Specific dates of the week were set for each of the barangays. A No Segregate-No Collection Policy was adopted.

Possibilities for replication by poorer LGUs. Political will, firmness, and resolve of leadership are vital. Constituents will eventually realize the value of the programs.

3. Increasing Appropriations Using CBMIS Data

Dr. Hazel Palmes
Gigmoto, Catanduanes

Gigmoto, a 6th class municipality in the windblown province of Catanduanes, enrolled under the MGP in October 2001. Many of its communities are located in extremely rural mountainous regions that are traversed by rough roads. The total population of 7,562 are served by three Barangay Health Stations. These stations are staffed by six health personnel and 70 BHWs.

In order to increase the quality of health care provided to the people, a program was conceived to increase LGU investments in health, with the aid of the CBMIS. The program was meant to identify gaps in health needs and services, facilitate an inventory of resources, enjoin the cooperation of municipal and barangay officials, and strengthen partnerships between the LGU and health providers.

Initially, four of the staff and all the BHWs were trained in CBMIS. The survey was then conducted, the data analyzed and fed back to the LCE for action. The LCE and barangay officials were involved in the trainings and in all program aspects. Members of the barangay council became active partners in the survey. Call cards were issued to the target clients with unmet needs, to facilitate follow-

up treatments and modalities. The health units networked with NGOs and lobbied with LGU officials to secure commitment and support.

The Mayor, barangay officials, and members of the Sanggunian, in turn, responded to the call by increasing the yearly budgetary allocation for health services. This was aided by their own perception of facts and prevailing conditions in the community borne by statistics in the CBMIS. The municipality extended a budget of Php1.29 million in 2000, Php1.56 million in 2001, Php1.62 million in 2002, and Php1.71 million in 2003. Meanwhile, funding support was extended to the BHWs by the municipality and the barangays in the form of monthly honoraria given steadily over the same period.

The program exhibited positive outcomes. There was an improved coverage in immunization, Vitamin A program supplementation, tetanus toxoid vaccination, and family planning. Mortality and malnutrition rates were consequently reduced. Lasting partnerships were formed between the health staff and the LCE. An upward trend was experienced in the public demand for health services and the regular allocation of supplies based on priorities. The CBMIS, coupled with feedback from the field, could be used to encourage support from the LCE. Moreover, the call cards prodded the clients to give attention to their health. In the future, the Gigmoto RHU intends to continually improve on approaches and responses to the CBMIS to enhance service delivery.

Issues and Concerns

If a 6th class municipality could succeed in increasing yearly allocations for health, there is no reason for richer municipalities not to do the same; did the call card play a role? Health workers were instrumental in pushing for allocations beyond Personnel Services to expand health programs. The call cards were merely issued to pinpoint unmet needs in FP and other services.

Whether success was due to CBMIS or persistent lobby work. The CBMIS functioned as the factual basis for justifying support. Powers of persuasion played a role in the negotiation for funds.

BHW profiles, incentives, and strategies in the survey. The ages of BHWs varied from young to very old. They undergo regular training and barangay governments provide them with monthly honoraria. BHW performance is monitored and evaluated.

PS increases beyond the maximum allowed ceiling. The Magna Carta for Public Health Workers is a mandatory law, but honoraria for BHWs remain a local prerogative. Excesses beyond the PS ceiling may be subjected to scrutiny.

Inclusion of menopausal women in the CBMIS. The sector is not applicable to any of the coverage areas.

Use of MGP funds for BHW training/transport. MGP funds may be used for these purposes, if set forth in the plan/agreement.

4. Integrating the Prevention of Abortion and Management of Post-Abortion Complications Program in District Hospitals

Dr. Josefina Francisco
Lingayen, Pangasinan

The province of Pangasinan, noting the trend in post-abortion cases in the past, decided to come up with a program that would provide better treatment protocols in the management of such cases to prevent abortion, manage complications arising from it, and prevent recurrence. The program was eventually replicated in western and eastern Pangasinan district hospitals.

The technical assistance for the program was provided by the USAID. The program has many innovative features and interventions. These include clinical management training for the medical staff and pre-and post-treatment counseling for the patients. Within the hospital premises, a flow chart was installed that guides the hospital staff in the management of emergency cases. The Hospital Management Support Services was established as a core support group. The protocol called for the adoption of the Manual Vacuum Aspiration technique in lieu of the traditional Dilatation and & Curretage (D&C). Under the same program, the delivery room of the hospital was expanded and a Post-Abortion Management Clinic was created as an integral unit of the hospital services.

The program pointed to the need for local advocates, local program management support, adoption of simpler procedures, and open lines of communication among supporters, providers, and clients. Future plans include the strengthening of family planning counseling services for post-abortive women to widen opportunities for FP acceptance and eradicate the need for abortion. The implementers have also stressed the importance of including MVA equipment in hospital procurement plans and of modifying the standards of practice in MVA.

It bears emphasizing that abortion is not an FP method and the MVA is not an abortion tool. The health provider must first render the accurate diagnosis of threatened or incomplete abortion before assessing the need for the MVA. EngenderHealth has trained a number of health personnel on MVA. MVA requires specific devices and instruments as well as training.

Issues and Concerns

Number of hospitals with Post-Abortion Management programs. Four hospitals in Eastern and Western Pangasinan have adopted and are currently implementing the program.

House Bill 4110 has provisions for counseling that are preventive in nature. The experience of Pangasinan hospitals should be disseminated in support of its passage. Pangasinan, for one, has never sanctioned the use of the D&C. The exchange of trust and confidence and the counseling that takes place during the actual treatment combine to function as an effective anesthetic. The risk to face is the fact that the patient who undergoes the MVA procedure by an unskilled provider can act as a witness to a malpractice suit. Another problem is the absence of local suppliers of the MVA device. This is a delicate subject that can be used as an anti-life tool.

On the prevention of abortion on the part of first-timers and promotion of FP in repeat cases. The low level of FP acceptance is due to lack of sufficient follow-up, which brings one to the level of education. This underscores the need for Mothers' Classes and Family Counseling.

Effectiveness of counseling in preventing abortions. Health providers in the province are presently evaluating data on patients so far counseled in order to find out how many of them are first and second to multiple timers. It is important to know what benefits it has given the constituency.

Reasons for abortion and negative ads vs. MVA. We are still in the process of educating and re-educating the clients. So far, the hospitals have not received any negative message countering the program because patients that were so far admitted were mostly emergency cases of massive bleeding. They have resorted to abortion for the single purpose of getting rid of their pregnancies.

Age incidence. Most of the cases involved women of reproductive age and multi-gravid patients.

On the issue of Marie Stopes, doctors are aware that abortion can be performed with the use of the suction machine. Is this the same as menstrual regulation? The instrument is different. The MVA is a manual or hand-held instrument that makes use of a modified septo-syringe. We are planning to train MHOs in the craft.

Conditions/requisites to the procedure. Patient history, pregnancy test, and ultrasonography are the basic requirements. The issue of malpractice was highly discussed in Pangasinan. The ultimate consensus was that abortion is not an FP

method. Psychotech is also not an FP Method. MVA is a blind procedure that can leave fragments behind, and should only be limited to incomplete induced abortion.

5. Mobilizing LGU Support for Health through CBMIS
Ms. Rose Rillo
Naga City

It should be noted that Naga City is located in the heart of Bicolandia where the resistance to FP is highly pronounced on account of the Catholic Church's campaign against the program. In spite of stiff opposition, the local governments rallied behind the program.

The conduct of the CBMIS survey from 2000 to 2002 has revealed the true state of unmet needs of the people in the three program categories of EPI, Tetanus Toxoid immunization, and FP. In a sweep, unmet needs for EPI stood at 992 in 2000, 189 in 2001 and 262 in 2002; unmet needs for TT was 709 in 2000, 238 in 2001 and 246 in 2002. Demand appeared to be highest in FP, amounting to 5,214 in 2000, 4,537 in 2002, and 4,364 in 2002. The survey also revealed that among the current users of FP methods, modern methods were preferred over traditional methods. The pill enjoyed the highest popularity, posting a prevalence of 26 in 2000, 32 in 2001 and 39 in 2002. This was followed by BTL and Natural Family Planning methods.

The city of Naga manifested its strong support for the CBMIS program. Nurses, Rural Health Midwives, and BHWs were trained in data gathering and other aspects of the program. Officials backed the allowances of these workers amounting to Php600/month with appropriate local legislation. This was padded up with barangay honoraria, uniforms, and IEC materials. With assistance from the LGU and partner networks, the Barangay Health Councils were organized and made fully functional.

Positive gains were realized. Unmet needs for EPI registered a sharp decline over the three-year period, from a high of 381 in 2000 to 174 in 2002. In FP, unmet needs dropped from 5,214 in 2000 to 4,364 in 2002. From a perspective, the program may be seen to have profited a lot from the support of the councils and the Local Health Board. The councils met quarterly to plan immunization schedules, organize the teams, and monitor progress. The LHB, after thorough program reviews, worked for intensified logistics and technical support. In summary, the initialized systems and processes led to the improvement of health services in Naga City.

(No discussions)

CONCURRENT SESSION III
STRENGTHENING COLLABORATION AND NETWORKING

Highlights of Presentations

1. LGU-LGU Networking in Capability-Building for No-Scalpel Vasectomy

Dr. Raul de Vera
San Fernando City, La Union

San Fernando City, the capital city of the province of La Union, was one of the recipients of the Matching Grant Program that started in May 2000. In September 2000, the City Health Office was certified as a Sentrong Sigla facility.

According to the baseline survey, among the FP methods that were in use, IUD and vasectomy registered the lowest percentage of acceptance. After more than two years of implementation, a visible increase in acceptance was perceived in two methods, namely the pill and vasectomy. However, in vasectomy, intensified activities started only in October 2000. From a low baseline of ten (10) vasectomized clients, the number of acceptors rose to a high of 40 by January 2003. This stride quickly won adherents and supporters for the program, both from the community, the health sector, and local governance.

However, a drop-out was experienced in the area of Natural Family Planning (NFP) because of slight errors in baseline data. Upon validation, traditional methods such as rhythm and the calendar method were misreported as NFP.

Issues and Concerns

Generation of clients. This proved to be an area of interest for the City Health Office. Barangay Health Workers (BHWs) were utilized for information dissemination on the benefits of family planning. A physician from the City Health Office was trained by EngenderHealth at Bacnotan District Hospital.

CHO-LGU cooperation/collaboration. The CHO assisted other LGUs in setting up vasectomy sites. First, the training facilitator served as resource person during the regular conduct of BHW training. Second, one vasectomized patient and his spouse agreed to visit Ilocos Norte to give their personal testimony during a Couples Class on Family Planning. Third, the CHO surgeon trained other MHOs and District Chiefs in Ilocos and La Union on the basics of vasectomy procedures.

Steps to follow in networking. The first step is to make FP work in the community. Exposures on field can convince other municipalities that there is truly a demand for vasectomy as a preferred FP method. The second step is to persuade LCEs into thinking that vasectomy is a desirable option for couples. They could provide transport services for clients in far-flung areas and assistance needed by other LGUs even if it means allowing physicians to go there on official time. A third step is to persuade LGUs to invest in new activities and skills acquisition.

2. Establishing Partnerships for Sustaining the Sentrong Sigla Movement

Dr. Napoleon Arevalo
Sorsogon

Since the start of the Sentrong Sigla Movement from 1999 to 2000, 11 of the 16 Rural Health Units in the province of Sorsogon were providing quality basic health services.

Based on the Bi-Annual Evaluation of the DOH-Center for Health Development-Bicol, some Sentrong Sigla-certified facilities were unable to uphold the standards. Thus, the RHUs and the Provincial Health Office (PHO) of Sorsogon examined ways of ensuring the sustainability of quality health services of SS-certified facilities. They also discussed possible actions that could be taken to upgrade the health delivery system of non-certified RHUs.

With these concerns in mind, the PHT initiated a series of dialogues and a workshop with the Provincial Health Office of Sorsogon on quality assurance systems and the structure that could be best equipped to operationalize the system. Since the prime movers of Sentrong Sigla in Bicol are the DOH Representatives, it was agreed upon that the DOH Reps would serve as the point persons for Sentrong Sigla. They would be designated as team leaders, with two other municipal DOH Reps as members.

The Continuous Quality Assurance Team for Sentrong Sigla - Sorsogon or CQATS sought to maintain the certification of RHUs and facilitate the certification of other health facilities including barangay health stations. A system was established covering a number of work areas. One, observation and inspection of the amenities of the health facility to guarantee that the equipment, supplies, and client records are functional, efficient and adequate; two, reviewing records to ascertain that services for preventive and curative care are available; three, check whether target client lists and monitoring charts are properly accomplished and updated; and four, interviewing RHU staff to validate records, carry out innovations, and appraise capacities based on trainings undergone and

other criteria. As a partnership between the PHT and the PHO, the CQUATS system will soon expand to involve other existing structures at the provincial, municipal, and barangay levels and not limited solely to Sentrong Sigla facilities.

Clarification

Sustainability of CQATS. It is a developing project. It may not be a perfect mechanism, but it should be made adaptable. It can serve as a blueprint for improved health care and services.

3. Ligation Via Pooling of Resources: A Challenge

Dr. Lourdes Sajonas
Ilagan City, Isabela

Historically, Ilagan, Isabela was one of the first enrollees of the Department of Health Matching Grant Program. It made use of the CBMIS, a tool in identifying and prioritizing women and children with unmet needs for family planning and maternal and child health services.

The program is being implemented in 37 target barangays covering 41 percent of the total number of barangays. Four of these are located in Metro Ilagan and the rest, in the rural areas. The CBMIS revealed that many couples are using temporary FP methods but are willing to shift to permanent FP methods, specifically bilateral tubal ligation (BTL).

However, several challenges were noted. For one thing, the distance traveled by the client to reach the VSS site is lengthy. This is compounded by the fact that public utility vehicles plying the areas are scarce due to poor road conditions and expensive fares. Other points to consider were expenses such as food and accommodation of the client and the watcher. The hospital fees charged by the Isabela Provincial Hospital ranging from Php1,000 to Php1,500 per client also posed as another challenge. Also, there are no regular schedules in the hospital for BTL since it is an elective procedure.

In order to address these challenges, partners were identified, in the person of hospitals and service providers. The hospitals that were cited were Isabela Provincial Hospital, Tumauini District Hosptial, San Antonio Hospital, and Cagayan Valley Medical Center. The service providers were EngenderHealth, Marie Stopes Foundation, the Center for Health Development, and its partner itinerant teams.

Issues and Concerns

Innovative strategies adopted by the LGU. Travel expenses of both the clients and BHWs were shouldered by the LGU by way of providing vehicles (ambulances and elf vehicles) to transport clients and BHWs to and from their barangays. The LGU also provided minimal meal allowances for BHWs. The problem of distance was bridged by identifying strategically-located hospitals, and by instituting a referral system with the nearest hospitals to minimize travel costs. Additionally, medicines and supplies needed in the BTL procedure were taken from LGU funds. Professional services were provided by EngenderHealth, CHD itinerant teams, and the government hospitals.

Positive outcomes. As a result of these innovations, in 2000, there were three hospitals providing BTL services with a total of 72 clients. In 2001, the number of clients served totaled 133.

4. Linking with the Private Sector for Voluntary Surgical Sterilization Services: The Antipolo Experience

Dr. Ma. Grace Alcantara
Antipolo City

The launching of the No-Scalpel Vasectomy program in Antipolo City was highly successful mainly due to the support of the Local Chief Executive and the well-organized conduct of preparatory activities. The activities consisted of the training of Barangay Health Workers in Competency-Based Family Planning, community assemblies, and dialogues with LGU officials. The program enjoyed the support of organizations and individuals such as Friendly Care, Congressman Sumulong, and Management Sciences for Health. The activities were capped by the drafting of the Memorandum of Agreement and an intensive IEC campaign.

The program's centerpiece activity was called *Usapang Lalaki* (a sort of *For Guys Only* dialogue). It was officially launched on February 14, 2003 at the Antipolo City Auditorium. The audience consisted of tricycle drivers, employees, barangay *Tanods* and other members of the male population. They listened to the testimonials of persons who have successfully undergone NSV and were happy about it. It served as an encouragement to other men to become acceptors themselves.

A novelty was introduced in the Antipolo campaign. Incentives, in the form of button pins marked by the slogan *"Tigasin ako"* (*I'm a toughie*) are given away to the potential client, along with food and travel allowances. T-shirts are also provided to each of the clients with a similar slogan on print. The biggest push,

however, was given by Congressman Sumulong, who gave a generous donation of Php200,000 as a further boost to Antipolo's family planning services.

The city also has a lot of other plans in store. One of these is a possible future tie-up with other private service providers. Other plans involve the training of the remainder of BHWs who failed to join previous trainings, fund generation, training of other LGU practitioners in BTL and NSV, intensifed IEC campaigns, and the expansion of CBMIS to all of the 16 barangays.

5. Bustos 3k: Sustaining Public-Private Partnerships

Ms. Estelita Mariano
Bustos, Bulacan

The municipality of Bustos, before the launching of the Primary Health Care (PHC) program, was like any other town in Bulacan. People were not as health conscious as they are today, so much so that their response to different life situations and the quality of the lives they led left much to be desired.

At the health centers, there used to be only one nurse, one doctor, and one or two midwives safeguarding the health of the entire population. People mostly consulted traditional herbalists and even quack doctors for various health problems. Roads were dusty, only a few barangays had sanitary toilets, malnutrition was high, fires and burning cases were frequent, maternal mortality rate was high, and only a few transport vehicles plied the roads.

In 1981, Primary Health Care (PHC) was introduced, but it took three more years for the people to develop a broader social outlook that was needed for its growth. Town leaders thought of using culture-based activities to awaken the interest, participation, and maintain the enthusiasm of the people in health care. These took the form of chorale group competitions, as well as singing and dancing contests. The local broadcast facility was utilized. PHC went on the air weekly on Saturdays. The program drew inspiration from the felt needs of community, with family health as guide. It was broken down into segments such as the information segment, a sharing segment highlighted by the participation of an important personality, and a short skit on the subject of the day.

As a result of these efforts, people became increasingly health conscious as shown by the heightened utilization of the services of health centers, including FP and maternal and child care.

CONCURRENT SESSION IV
INCREASING AWARENESS AND ACCESS TO STERILIZATION SERVICES

1. *Magiging Ok Pa Kaya Si Manoy?* Responding to Male Fears of Non-Scalpel Vasectomy: The Virac Experience

Dr. Lilian Olfindo
Virac, Catanduanes

"Baka hindi na ako tayuan…" "Baka hindi na ako makapagtrabaho gaya ng dati…" These are the common perceptions of potential clients of Non-Scalpel Vasectomy (NSV) in the province of Virac, Catanduanes. According to local statistics, since the 1970s, 0% was recorded for FP. Today, NSV has been introduced in Virac as a new health initiative. It all started when competency-based training (CBT) in family planning was offered to Barangay Health Workers (BHWs) in the area.

To test their skills after training, the BHWs were told to seek out male volunteers for vasectomy. They made daily rounds of one-on-one and small group counseling sessions in their barangays. They also attended to out-patient consultations at the clinic. Clients who volunteered to undergo vasectomy were given transportation allowances and subsidized meals, antibiotics, and analgesics.

Sixteen clients, mostly laborers, agreed to undergo the procedure at the RHU. They offered various reasons for accepting and these were mainly economic reasons (their earning capacities were inadequate), health conditions (either one of the couples had health problems), and that they already had one children too many (having exceeded their ideal family size). No complications were observed after the procedure. In fact, healthier, more confident sexual relationships were experienced and two clients from Virac even professed to have enjoyed prolonged erections. Thus, *"naging mas lalong okey si manoy!!!"*

2. *Kami Naman:* Male Group Support System

Ms. Helen Gianan
Pandan, Catanduanes

Pandan is a 5th class municipality in the province of Catanduanes with a population growth of 2.65%. According to the CBMIS survey conducted in October 2002, the male group category shows the least participation when it comes to family planning, recording only 8.2% of the highly-populated area that

resorted to vasectomy. This limitation was due mainly to factors such as unavailable facilities and services to lack or absence of permanent family planning methods. To make matters worse, advocacy campaigns were weak when it came to NSV.

To improve on the situation, BHWs were mobilized and given comprehensive training on family planning to recruit NSV clients. Informal meetings with eligible married couples were organized in collaboration with NGOs. Regular meetings were also held to monitor the progress.

Barangay officials also attended orientation workshops on NSV. This enabled them to promote the benefits and advantages of vasectomy among their constituents. The LCEs actively showed their support for the program by passing Resolution No. 2003-010 declaring every Friday of the week as "Male Clinic Day". By March 2003, 17 male clients have voluntarily lined up to undergo NSV.

3. Bringing Sterilization Services Closer to Clients in Taytay, Rizal

Dr. Ariel I. Valencia
Taytay, Rizal

When Taytay embarked on the MGP program in 1999-2000, the CBMIS was set up in all the five barangays of the municipality. After thorough evaluation, it was agreed that efforts would be focused in the area of Lupang Arenda. The site would function as the pilot area for a program designed to address the unmet health needs of the urban poor.

Aside from identifying the common health problems of the residents, the provision of VSS services to the clients became the focus. As it were, problems of scheduling and supplies commonly encountered at the District Hospital stood in the way of potential FP acceptors.

To achieve the MGP goal, the Taytay government financed the construction of a municipal hospital and equipped it by complementing the LGU budget with donations of equipment from the private sector. Two of the resident physicians availed of training on BTL using local anesthesia (mini-lap). The training was conducted by EngenderHealth in November 2002.

Health personnel and BHWs were also trained to recruit clients for BTL. As of today, BTL procedures average about three to four clients per month, all free of charge. The program will eventually include NSV as part of the range of services. This will be offered as soon as the training of BHWs and initial recruitment of clients for NSV are completed.

4. Experiences of a Model Training Center for Minilap under Local Anesthesia

Dr. Teresita Reyes
Cagayan Valley Medical Center

The Cagayan Valley Medical Center, a rural health facility, is the largest FP clinic in the region. The Center conducts advocacy and IEC campaigns on FP, especially VSS to increase prevailing client load. Being an accredited training institution, it offers skills training on Minilap Under Local Anesthesia, a two-week course based on a DOH-approved curriculum. The course aims to expand the availability and improve the quality of internally-managed VSS services.

The trainees consisted mainly of doctors, nurses, and midwives involved in FP. All of the trainees showed a positive attitude towards FP and commitment in providing VSS beforehand. The evaluation tools for this training consisted of the pre-test, mid-course and post-test questionnaires; skills assessment checklist; checklist for minilaparotomy clinical skills for surgeons, circulating nurses and nurse assistants; and training evaluation.

After meeting the course requirements, the participants were required do observe follow-up regimens after three months and submit their corresponding performance reports. The VSS Department of the CVMC offers free services and medicines and is open from Monday to Friday. It also created an itinerant team for BTL that performs the procedure and monitors the logistical requirements of the service in the hospital. The positive outcome of the project is the assurance of topnotch skills in VSS procedures for the ready availment of clients, even in one of the country's northernmost regions.

Issues and Concerns

Reservations re NSV. The most common concern of clients of NSV is whether they could still perform normal biological functions. The benefits of NSV should be stressed, particularly its efficacy and 100% safety during client orientation classes/sessions. This requires patience from health care providers.

Creation of a Local Itinerant Team for Vasectomy. This is a major factor in sustaining NSV aside from the allocation of funds from the LGU, personnel training, advocacy and IEC. In Catanduanes, coordination is being intensified to involve more doctors and nurses, enjoining them to establish their own itinerant teams, utilizing satisfied male acceptors as advocates and recruiters.

Training of doctors in NSV. This is a step-by-step process wherein doctors are called for didactics prior to competency-based training. In Virac, a plastic model is used before direct hands-on training. Although the operation is performed in a health center, care is taken that it is done within the confines of an OR.

AV Modules. DOH should come up with a VCD/VHS on NSV procedure perfected by local doctors and clients in order to support the advocacy campaign.

Physical examinations, prognosis, and recovery. Thorough physical examinations are required in order to gauge a client's health and fitness. Age is a primary factor. If the client is young, of reproductive age, and with no health complications, he is advised to discuss the matter with his family because of its permanence and irreversibility. After surgery, the client could resume normal tasks provided that he does not feel any pain or discomfort. A two to three-day respite is enough though this depends on the locality and the nature of the clients' work. Observation period is three months, during which the client should have a minimum of 20 ejaculations. He is also bound to practice FP until fully zeroed for sperm count.

NSV service fees. BTL procedures in Taytay are free of charge. The health office plans to charge a user's fee when the clientele expands. This mandates the centers to work for accreditation with Philhealth. Factories in Taytay that provide their employees with family welfare benefits are similarly guided. The centers are also looking forward to formalizing the accreditation of their staff as duly-accredited VSS providers.

Plenary: March 4, 2003

Highlights of Presentations

1. Initiating A Social Health Insurance Program

Mayor Valente Yap
Bindoy, Negros Oriental

Bindoy is a coastal municipality located 70 kms. north of Dumaguete City. It has 22 barangays and a population of 34,773 comprising 6,682 households. Approximately 70% of the people are poor.

The main RHU obtained SS certification in June 2000. The municipality has ten Barangay Health Stations. The RHU is presently staffed by an old municipal doctor. A capitation fund of Php1.2 million is available for social health insurance. In addition, a municipal budget of Php3.8 is given to the RHU that represents quite a big share of the municipal IRA (about 10%).

The social health insurance concept was first introduced locally as *Medicare Para sa Masa.* In August 2001, a Technical Working Group was created to oversee the indigency program and work for the accreditation of the main health center. An action plan was prepared outlining the various health programs. The facility was upgraded to conform with standards for accreditation. Finally, a Memorandum of Agreement was signed with Philhealth and in December, barangay captains, BHWs, and day care workers met for the orientation, after which they served as enumerators of the CBIS-MBN.

The *Sangguniang Bayan* of Bindoy committed Php100 thousand in premium subsidy. In February 2002, the Philhealth Indigency Program and ID Distritution was launched. Determined to strengthen the program further, the municipality sought the assistance of the Negros Oriental Provincial Government in the amount of Php200 thousand as provincial counterpart. This request was approved in 2002. In May, the initial capitation fund was received for the first batch of enrollees, counting 1,683 households. The household premium collected to date is Php34,230.

Bindoy found the program immensely beneficial to the people. Bindoy hopes to sustain the program thru a proposed sharing scheme. Bindoy hopes to sustain the program through a proposed sharing scheme. Household shares increase because health has become a primary concern. Therefore, in year one, household share stood at 118.80 but in year three, this increased to Php237.60. Eventually, household share in the total fund will be seen to increase because of the bigger

LGU share. From the actual enrollment of 3,883, a coverage of 58.11 percent in total households was achieved. The municipality is targeting 4,200 households from the present number.

The program owes its success to IEC strategy, enabling policies and benefits, and LCE participation. Moreover, the insurance program was highly visible in that the PhilHealth Service Office is located right across the main health center.

Issues and Concerns

Proliferation of political indigents. No patient is chosen above another. Social workers screen the poorest of the poor and bracket them. We cannot satisfy everybody at the same time but the people work hard to enlist in the program. Some of the enrollees are active advocates of the program.

Amount of barangay IRA contribution. A huge chunk of the IRA, say Php220 Million is spent for personnel services, but the barangay captains were persuaded to see the benefit of this program, otherwise, they will have a hard time addressing the needs of the poor. The poor seldom go to the hospital unless in serious condition. With the program's OPD package, the number of hospital patients can be reduced.

Effects of political turnovers on premium collection. People choose their leaders. Bad propaganda has been leveled against the program in the past, but cardholders now realize the advantages of the social health insurance, especially in surgical cases and caesarian deliveries. Indigents cannot be covered extensively by the program, hence the design of food for work and similar programs.

Breakdown of capitation fund for the cost of OPD and hospital services. The capitation fund was Php482,083,60 and the amount utilized, Php398,892.85. The share of doctors was not yet given because doctors receiving the Magna Carta benefits receive salaries that are higher than the LCE's. We implement salaries according to law but we demand the right services for our people.

Reasons behind the low household share of 39%. The families have indicated that the bigger the amount they shell out, the greater the risk. Hence, we have invited the participation of NGOs. It should be noted that the Php300 capitation fund is returned to LGU and not utilized for indigents. Incentives for the professionals who serve the indigents can be paid out of this fund. Outpatient consultation services are not paid out of this.

Percentage of the capitation fund as incentive for health workers. The grant of such incentives is being awaited from the mayors inasmuch as the project might

set a precedent. Ten percent of the amount is earmarked for the doctor and the other 10 percent for the health workers. The PHIC guidelines are unclear. At this point, the PHIC representative explained that 30 percent of the Php300 capitation may be earmarked for professional fees. But Philhealth will not pre-empt LGUs in the management of the fund since most of them realize the worth of their workers.

How clients are encouraged to progress from free service in the first year to fee for service in the second year. The job of re-enrolling the members is the role of the midwife who puts the IEC strategy to work. The mayors also encourage people to frequent the RHUs for guidelines. On Mondays after flag raising, an Open Forum is held by the Mayor with RHU personnel and municipal employees to discuss issues of the day.

Mode of household collection. All payments to PHIC are not paid directly to PHIC but to the LGUs. The BHW Federation collects the premiums.

2. Making CBMIS Work Through BHWs

Mayor Florencio Flores, Jr.
Malaybalay City, Bukidnon

Malaybalay is the only mountain city in Northern Mindanao. It has 46 barangays with a population of 128,547. The city has 687 BHWs with a ratio of one BHW per 159 households. Under the MGP, the LGU implemented the CBMIS that has become the basis for health planning and service delivery.

The city has invested heavily for the training, education and career enrichment programs of old and new BHWs. They were furnished with kits for all the programs. The city health office works for their accreditation, entitling them to incentives provided for by the city and barangay governments. A civil service eligibility is granted to any BHW who completes five years of continuous service. They are all enrolled in the Indigent Program of PhilHealth. We also organize an annual BHW Congress and Program Review for them. Additionally, the barangay or district gives them uniforms, and even retirement benefits. These investments started in 2001, when the city put up a counterpart fund of Php1.5 million to the MGP fund. This amount has since increased.

The city has realized a plow-back in its investments as could be seen from the decrease in unmet needs for immunization, TTV, Vitamin A supplementation, and family planning. Wide coverage was attained in the areas of fully immunized children (90%), TTV (93%), Vitamin A (99%), and modern CPR (59%). We tried to keep the momentum by dealing with issues. We keep on recruiting and training BHWs. We keep old and new barangay officials oriented and updated. We intensify FP efforts to generate clients. And we have constructed a mini-OR

at the city health office to give clients more access to VSS. We have also planned the construction of a mini-district hospital to serve eight barangays so VSS can be made available in remote areas.

3. Establishing Inter-Local Health Systems

Governor Daisy Avance-Fuentes
South Cotabato

South Cotabato, the Bread Basket of the South, has ten municipalities and one component city, Koronadal. There are 119 barangays and the population stands at 700,000, growing at a rate of 2.3 percent. The drive to excel is strong in the delivery of basic health services, that has been cited as a priority development agenda. The goal is to improve the poor's access to preventive and basic curative health care.

In pushing for this goal, the province closed ranks with communities and NGOs in upgrading health facilities and setting up effective referral services. The emphasis on the latter led to the development of an integrated health system. It was felt that this was the answer to gripping problems that used to riddle the health sector. These included severed links between public health and hospital services, poorly defined roles and responsibilities, duplications and gaps, lack of community awareness, inactive health boards, insufficient financing, and inefficient use of resources. Most of all, decision was based on politics rather than common good.

A baseline study was made, resulting in recommendations for bottom-up planning. The province had to widen access to health services, define the roles of the key actors, access resources, and train providers. The policy and conceptual framework was designed for the creation of the inter-local area development zones policy framework. Wide-based consultations were made, culminating in a MOA between the province and the municipalities.

Five area health zones were created each with a core hospital. A minimum package of primary health services was designed, along with health referral protocols. Strong linkages were established with the private hospital sector. The good practices in the piloted area of LHADZ were replicated in other LHADZ through sharing sessions. A landmark achievement was the establishment of the Health Management Information System, the integrated health planning, and a monitoring and evaluation system. The gains were tremendous. Ninety-one percent of RHUs became SS-certified. The health care facilities, aside from physical improvement, became functional referral points. All these gave way to higher performance in priority health programs. To sustain the LHADZ gains, the province is bent on institutionalizing and interlinking the whole system into a province-wide referral network.

Issues and Concerns

Extent of sharing. The program has been shared with the mayors and selected governors in Mindanao. Advocacy work on the LHADZ has been shared with the League of Provinces of the Philippines.

Duration of the set-up of the CBMIS. From the point that the CBMIS was established, activities were conducted on a massive scale, in schools and other venues.

BHW appointment and tenure. Appointments of BHWs pass through Barangay Health Councils and their accreditation, through the Local Health Boards. People in all the *puroks* and *sitios* participate in the screening of the BHWs. The province maintains a roster of BHWs and the only ground for their relief should be truly valid. BHWs receive honoraria from the province, municipalities, and barangays. Problems are solved at the level of the barangays.

Civil Service Eligibility of BHWs. The qualification set is a minimum of fve years of continuous services, which is submitted to the Civil Service Commission.
The BHW process is handled objectively, guided by development, not party. The best kind of leadership is to set people in one direction without partisanship.

Municipal cost-sharing in the LHADZ. Municipalities allocate a minimal amount but problems are shared. Unless cost is shared, patients will not be able to avail of core hospital services. The plan was central to the province – no counterpart funds were taken from the CHDs. The test is how to sustain when grants run out.

Concurrent Sessions: March 4, 2003

CONCURRENT SESSION I
SUSTAINING THE QUALITY OF HEALTH SERVICES

Highlights of Presentations

1. Sustaining Quality Health Services in a 5th Class Municipality

Dr. Arnel Binalla
Malilipot, Albay

Considering that the Sentrong Sigla Movement is a nationwide certification process with one set of standards to fit all RHUs from Batanes to Sulu, what may be easy for large cities and upper-class municipalities may prove difficult for a low-class municipality like Malilipot, Albay. Being a 5th class municipality in terms of Internal Revenue Allotment and local production, public health workers were greatly challenged to achieve SS certification for their facilities to get services going for the most number of low-income clients.

After assessing their respective facilities, they were able to identify some deficiencies and areas for improvement. Because of their determination to achieve SS status, the LGU and LCE supported plans to renovate the old RHU and allocate a budget for the purchase of medicines and supplies.

In 2001, the Malilipot RHU was certified as SS for Level 1 by the Center for Health and Development. The challenge facing the municipality is the continued delivery of quality health services, given its limited resources. The LCE and health staff conceived of an OPD package, an out-patient program funded from a capitation fund, as a strategy to ensure the sustainability of quality health services.

Malilipot's PHIC accreditation was approved in March 2002. Through the SS facility, constituents can avail of the PHIC-assisted OPD package of health services at any given time. Moreover, providers and their clients can rest easy that those services can be sustained.

2. Good Governance: Bringing Better Quality of Health Services Closer to the People

Dr. Eduardo Posadas
San Fernando City, La Union

San Fernando City, the capital of La Union province, has traditionally prioritized health in its development agenda, regardless of political transitions. The initial planning process of the City Development Strategy (CDS) took off from a baseline analysis of the city itself, its people, resources, and environment, in which a series of intensive workshops was conducted.

From the CDS, health planners were able to identify specific goals and objectives. These are Economic Development, Environmental Management, Developmental Administration, and Social Development. As far as the city health program is concerned, the primary goal is to bring quality health services closer to the people – by putting up Barangay Health Stations with lying-in clinic capabilities.

This initiative led to the establishment of the Bangbangolan Lying-in Clinic. Based in the city, the facility was made to comply with the basic standards of a BHS, the DOH criteria, and accreditation standards of the PHIC's Low-Risk Maternity Care Package.

The creation of this facility and the availability of the services it offers gained public trust and acceptance. In due time, it garnered SS certification from the DOH. This accomplishment is a by-product of good governance which, in turn, took off from the effective and efficient management of its leaders.

3. What's Life Like After Sentrong Sigla?

Dr. Ofelia Rivera
Mangaldan, Pangasinan

In November 2002, Mangaldan was declared a first class municipality. The Municipal Health Program offered an array of health services to its constituents. This was made possible by the determination of the local health staff to obtain Sentrong Sigla certification.

Preparations began in earnest with lobby work. The need to upgrade services and facilities for the benefit of the constituents was laid before the LCEs. It did not take long for them to extend the support that was needed. The municipal government provided funds for the improvement of the center facilities and the purchase of certain equipment and vital instruments.

Other funding resources came from the LPP Subgrant and other NGOs' programs. This led to the launching of special projects and activities like the Hospitalization Aid Program and the *"Alay sa Nakatatanda Program"*, a program for senior citizens. Ordinances and resolutions have also been passed by the *Sanggunian Bayan* members. These include the Non-Smoking Ordinance, Anti- Rabies Ordinance, Environmental Sanitation, and others.

Due to these initiatives, Mangaldan was awarded the SS certification in December 2000. The LGU became more supportive and the personnel, inspired by the positive results of their work. An increase in the yearly budget for health services was legislated by the municipal government to enable the main health facility to sustain its level of quality care. At present, the health providers continue to relate with the LCE and the *Sangguniang Bayan* members for sustained support for the maintenance of the SS. The facility has obtained PhilHealth accreditation as well. Another welcome development was a partnership that was forged between the local church and the municipality for the advocacy of the Natural Family Planning method.

4. Motivating SS-Certified Facilities to Further Improve the Quality Of FP and Related Services

Dr. Felicidad Ganga
Baguio City

The Baguio Health Department (BHD) maintains a number of health facilities counting one Main Health Center, 16 District and Sub-District HC, eight Satellite Clinics, and one City Hall Employees Clinic. Because of the high quality of health services, 15 out of the 16 health centers were certified for SS Level 1.

In 1986, the BHD and the Baguio City Youth Association (BCYA) entered into a collaborative undertaking designed to further improve health services in the city. BCYA is a non-stock, non-profit organization that was established to deliver innovative approaches by reaching out to the youth.

One of the strategies that was adopted was a merit and recognition program entitled "Search for the Highest Performing Health Center for FP and Related Services." This program was conceived to motivate SS-certified facilities to go beyond Level 1 certification and continuously strive for improvement by taking part in fair and healthy competitions. Criteria were based on the availability of services and program performance.

After thorough study of the entries, the winner handpicked for the coveted award was the Pinsao Sub-District HC. It was singled out as the Highest Performing Health Center for FP in Baguio City for CY2002.

The awards, a unique way of motivating health workers, was first attempted in 1996 but the criteria that were set then were somewhat subjective. It was only in 2002 that available data were utilized to formulate a more objective set of standards. The awards caught the attention of and generated support from the LGU officials and other NGOs. The strategies adopted also served to raise the morale of Baguio health workers and to heighten their awareness of the need to consistently improve upon their record as caregivers of their communities.

Issues and Concerns

Difficulty of obtaining LGU support. MHOs often find it extremely difficult to rally LCE support for Sentrong Sigla accreditation. Mayors and *Sanggunian* members must be strongly persuaded to believe that the additional budget sought would redound to the goodness and well-being of their constituents. It is necessary to convince them that investment in health is good politics. Experience on field bears that LGUs who have supported SS undertakings became more supportive of health programs.

Popular feedback. With the accreditation of more Sentrong Sigla centers, people develop trust and confidence in the health services provided, as borne by the increased number of referrals, generous donations from philanthropists, and willingness of clients to pay user fees. The latest survey in Baguio City after the SS accreditation revealed a high level of satisfaction hence, a tool to measure client satisfaction should be developed.

LGU-NGO-Church Partnerships. In Mangaldan, a partnership with the province gave rise to a sub-grant of P150,000 for the initial year and P125,000 for the succeeding years from the provincial government. The church and the LGU support common advocacies for NFP. The World Bank partnered with San Fernando City for the development of a sanitary landfill. With this move, barangays were compelled to cooperate by observing waste segregation and soiling up the dumpsite to prevent air pollution. They planted ilang-ilang trees around the landfill to detoxify the premises.

Drug overpricing. Drugs sold to LGUs are sometimes overpriced in spite of the bulk nature of the orders. MHOs could not counter this since transactions are approved by the mayor. In Baguio City, their mayor delegated the job to the Chief of Medical Services, enabling him to exercise prudence in transacting. In this way, the prices of drugs and equipment can be closely monitored.

CONCURRENT SESSION II
IMPROVING SYSTEMS AND PROCESSES (2)

Highlights of Presentations

1. Improving the Efficiency of Hospital Services: The Pangasinan Provincial Hospital Experience

Dr. Nemesia Y. Mejia
Pangasinan

The Pangasinan Provincial Hospital is now markedly different from the facility that it was before. Several landmark changes and innovations were introduced to turn it into the efficient and effective health delivery machinery that it is at present.

A patient satisfactory survey was first carried out, and made into a routine activity to constantly measure patient satisfaction. Secondly, the hospital made monthly evaluations of the cleanliness and orderliness of individual wards and departments, making sure that the five "S" of the standards are observed. Thirdly, the hospital adopted a scheme wherein an "Officer of the Day (OD)" among the patient watchers was tasked to assist in ward cleaning. The OD also took charge of observing patient movement and reporting uncleared and unauthorized discharges that could lead to unnecessary complications and mismanagement. Suggestion boxes were installed in the wards and departments to solicit comments and recommendations for improved hospital services.

Another innovation was the launching of a program called *Kabalikat sa Barangay,* a patients' assistance unit. Additionally, Health Education Materials in the form of VHS tapes on preventive and promotive health were made available for client use.

Human and equipment traffic throughout the hospital was improved with the installation of a Hospital Locator Chart. Out-Patient and In-Parient flow charts were also displayed to facilitate a better understanding of admission and treatment procedures.

The hospital thought it best to regulate visits. Visiting hours were set at 10:00 a.m. to 1:00 p.m. and from 5:00 p.m. to 8:00 p.m. This lessened potential friction among the visitors, watchers, and security personnel.

As a final cap to its upgrading process, the hospital took stock of the number of beds and rooms. Finally, the most important innovation made was the full

implementation of the color-coding of the Patient's Watchers Pass, wards, and uniforms of the medical staff.

With the institution of these changes and systems, the hospital is better equipped to serve its clients. The patient survey responses are closely attended to, in order to keep the satisfaction level and the quality of the program constantly on the rise.

2. Cabanatuan City Disease Surveillance System

Mr. Edwin S. Manabat
Cabanatuan City

Before the Cabanatuan Disease Surveillance System or CDSS was instituted in Cabanatuan City, Nueva Ecija, the reporting and recording system on the newsweekly entitled *Notifiable Diseases* provided limited information on disease occurrence. Hence, disease outbreaks reached professional attention only when cases have piled up on a large scale.

In order to fill in the information gaps, the CDSS was established as a vital tool for planning appropriate health interventions. It was felt that the City Health Office had to be pro-active in responding to the health needs of its community.

First, the CHO took a long quizzical look at existing reporting and recording systems, especially on infectious diseases. The system should be able to detect any significant increase in the number or clustering of cases at the earliest possible time. This will enable practitioners to act immediately and appropriately to address the incidence.

In establishing the CDSS, the CHO at first organized a surveillance team composed of one doctor, two nurses, one midwife, and one sanitary inspector. In March 2001, the team underwent training on basic epidemiology at the Trader's Hotel in Manila. During the workshop, 14 priority diseases were identified for monitoring. These included polio, acute gastroenteritis, animal bites, cholera, dengue, etc. The CDSS workflow was also designed and the persons responsible for each task, identified.

Back home, attendees to the workshop conducted a training session for the staff and Voluntary Health Workers in the district offices. Trainees were oriented on the features of the surveillance system, the technical definitions, the systems flow, and their designated duties.

The CHO availed of a brand new computer and supplies. Consequently, reporting forms were reproduced and made available. A separate workroom was also equipped with an air-conditioning unit, filing cabinet, and other furnishings.

In April 2001, after a month of thorough preparation and information blitzes, the CDSS was launched, initially piloting 19 barangays under the District IV field office. The local chief executive was duly informed and enjoined to support the program. A couple of weeks after start-up, 89 barangays were covered. The City Epidemiology and Surveillance Unit was finally put in place as an integral part of health services.

Meanwhile, the Integrated Disease Surveillance System (IDSS) was adopted by the hospital and RHUs in 2002. Outbreaks that were investigated were dengue cases in Barangay Patalac in July 2001 and measles cases in Barangay ACCFA in August 2001. In discerning the trends for the duration of the outbreaks, the clinicians undertook active surveillance, weekly entries and analysis of data, investigation and environmental surveys, information drives, immunization and the preparation of update reports for the LCE.

The program was able to accomplish the establishment of the hospital-based surveillance system, making the reports an integral part of the Mayor's State of the City Address and weekly Mancom meetings. Moreover, the reports could be accessed from the Internet. In the future, the CHO intends to upgrade the data collection system, monitor additional diseases, orient new personnel, and source out additional budget.

Issues and Concerns

The process sequence in the set-up of the CDSS. Health personnel from the various stations first gather data on diseases prevalent in the community. They perform an initial analysis of the health problems, providing action when necessary such as prescribing Oresol in the case of diarrhea. Data is then forwarded to the RHU for consolidation. RHU doctors and nurses render their analysis and interpretation, prescribing action such as obtaining water samples for analysis. Reports are forwarded to the CESU for data encoding on Thursdays. The team examines the data analysis and interpretation. When significant changes are noted for the week, a final report is generated for distribution to the LCE on Mondays, together with periodic monthly updates.

Disease outbreak protocols. The team mobilizes all concerned health staff. Several steps follow like house to house surveys, environmental assessments, case referrals, and submission of specimens to accredited laboratories. Other appropriate interventions to control further spread of the disease are undertaken. The final report will be released to all concerned agencies including LCE, barangay officials, the Center for Health Development in Luzon, and others.

3. The Pangasinan Pooled Procurement System

Dr. Nemesia Mejia
Pangasinan

The Pooled Procurement System is a unique approach adopted by the province of Pangasinan for the delivery of better health services. Prior to its adoption, the province experienced a number of management problems that arose from individual hospital purchases, delayed or non-delivery of drugs and medicines resulting in stock outs, a glut of emergency purchases, high prices of medicines, and long-winded payment processes. There were hospital therapeutic committees, but these were not functional.

The province devised a pooled type of procurement system. Under the system, the hospital prepares an annual procurement plan that is based on a value analysis of vital, essential, and non-essential drugs under an A-B-C categorization. The hospital then submits the annual procurement plan.

The General Services Office administers the bidding process. The GS Officer consolidates APPs of 14 Hospitals. The hospitals then prepare and submit purchase requests. Approval will depend on the integrity of submitted APPs, inventory management spreadsheets, and availability of funds. Purchase Requests are submitted to the GSO on the last Monday of every quarter. The GSO consolidates the purchase requests and prepares the hospitals' respective purchase orders. Suppliers will pick up the purchase order. They are duty-bound to deliver the supplies within seven working days.

When the supplies are delivered, the products are closely inspected by the hospitals. Upon finding them acceptable, these are officially received. As a last step, the LGU processes the payments to suppliers.

The outcomes of the system were positive. The quality of drugs turned out to be better on account of the shortened timetable. It served to reduce the prices of the medicines, and shortened the duration of procurement. Moreover, a one month buffer stock was always assured. The hospitals no longer had to undergo tedious procurement processes nor concern themselves with the job of blacklisting unscrupulous suppliers.

Issues and Concerns

Success factors. The biggest factor behind the success of the system was political will, particularly on the part of the governor. The Provincial Health Officer regularly met with the Chief of Hospitals.

Budget support. The province provided a 10% seed fund to jumpstart the process. The staff was oriented on fast track and analytical measures such as the VEN and ABC analysis.

Structural oversight. The Provincial Therapeutic Committee was created to set procurement policies. The Provincial Health Officer and General Services Officer monitor purchases down the line.

4. Harnessing Untapped Resources: The Role of DOH Representatives in MGP Expansion in Southern Tagalog

Ms. Lorenza Serafica
CHD-Southern Tagalog

When the Matching Grant Program was launched in the Southern Tagalog Region in 1999, a total of seven LGUs, three cities and four municipalities were initially enrolled. The program was expanded in 2001 and sustained through 2002. The MGP implementation involved teaching LGU teams the techniques of using the CBMIS tools, holding of the household survey, and planning activities based on the results of the survey. At first, the province studied ways of rolling these out to the enrolled LGUs in a rapid but systematic fashion.

A regional staff training was held as a component of the MGP technical assistance package. The trainors consisted of staff from the Local Health Assistance Division. This was followed by a Training of Trainers assisted by Management Sciences for Health. Due to the usual turnovers at the regional office, there was only one full time trainor and one part-time trainor for the MGP-TAP. To address this shortage, DOH representatives were recruited into the program as trainors.

Provincial DOH team members were identified. They had to undergo the two-phased workshop under the MGP technical assistance package along with the personnel of LGUs enrolled under the MGP.

The DOH Reps rose up to expectations. In subsequent workshops, they functioned as facilitators, some of them even traveling to remote island provinces where the fielded DOH Reps have not yet undergone the required training. The training pool was also tapped to assist the Cordillera Administrative Region in the conduct of the MGP-TAP in December 2002.

CONCURRENT SESSION III
EXPANDING PROGRAM COVERAGE

Highlights of Presentations

1. Urban Poor FP Initiative in Taguig

Dr. Isaias Ramos
Taguig, Metro Manila

Taguig, Metro Manila has 18 barangays with a population of 546,494 as of 2003. It is one of the 17 LGUs comprising Metro Manila. There are currently 20 health centers, three Barangay Health Stations, one District Hospital, two lying-in clinics, 40 private hospitals, and 30 private medical clinics.

Taguig's Urban Poor Initiative in FP is a strategy designed to bring services right where the clients are, based on a Minimum Basic Needs survey. On the average, the Contraceptive Prevalence Rate is high in the overall National Capital Region but low in select urban poor communities. Western Bicutan, the 2nd most populous barangay in Taguig, is an example and was designated the pilot area. A family is usually composed of five members. It is within the Fort Bonifacio Military Reservation.

The program was introduced in May 2002, aimed at improving the quality of life through increased access to family planning, particularly VSS through the services of an itinerant team. As a first step, voluntary health workers (VHWs) were chosen and trained in FP and CBMIS. A pool of 147 VHWs who were trained conducted house to house campaigns and barangay assemblies. Each of them was assigned 200 families.

The LGU led by Mayor Sigfrido Tinga, lent valuable support. A network of NGOs, GOs, and cooperating agencies like the USAID, JHU, MSH and EngenderHealth, and the DOH partnered with the LGU. Training was followed by promotional activities to recruit clients. To project the beneficial effects of the program on family well-being, satisfied users were asked to share personal experiences. Potential VSS clients were listed and scheduled for the operation in coordination with hospitals.

The program resulted in the expansion of service coverage, from 2002 to February 2003. A total of 189 underwent Bilateral Tubal Ligation and three for vasectomy. Out of 70 couples who attended the assemblies, the municipality was able to generate potential clients. The program capitalized highly on LCE support and the dedication and knowledgeability of the VHWs who succeeded in widely

disseminating the pluses of the program. Taguig's health centers guaranteed the availability of regular services.

VSS procedures are currently scheduled on 2nd Wednesdays of the month. Taguig plans to expand these activities to neighboring barangays and to coordinate with business establishments in the promotion of VSS to their workers. It also intends to intensify coordination with the district hospital for BTL operations, provide non-scalpel vasectomy, lobby for continued LGU support beyond the end of the project in June 2003, and institutionalize the VHW network.

Issues and Concerns

Higher training costs: VHWs or BHWs. VHWs are community volunteers recruited by members of the community of Western Bicutan and were trained exclusively for FP for greater focus. The VHWs may eventually become BHWs.

Political interference in VHW hiring/firing. Taguig maintains a complete registry of VHWs. Once recognized by the Local Health Board, they become part of the regular health personnel of Taguig. In Catanduanes, MHOs were asked to tap trained VHWs and were reminded that these persons are volunteers and not subject to termination. The Department of Interior and Local Government (DILG) formulated the Implementing Rules and Regulations governing VHWs.

RA 7853 prescribing the VHW Incentive Act. VHW accreditation and registration is a function of the LHBs hence, their termination is illegal. VHWs cannot be summarily dismissed without reason. Years of uninterrupted service could entitle them to incentives. They are recognized by the very LGUs that have invested in their training. Barangays can choose to add to their numbers but not reduce. If they are displaced, this will be inconsistent with the law and they have the right to contest the act. They could access the Public Attorney's Office for legal services. The VHW Performance Checklist can also be consulted. VHW federations are also governed by their respective by-laws.

2. Improving FP Coverage through IEC and Networking

Ms. Blesilda Enriquez
Marikina City

Marikina City is a staunch supporter of the Family Planning Program. The CBMIS surveys in selected urban poor areas showed that 35.4 percent of the MWRAs were not using any FP method while 71 .7 percent were not interested in FP at all. Twenty percent of the methods used were the withdrawal and calendar

methods. The city came up with recommendations on widening the gains of the FP program. The thrust taken by the Mayor was Population Management, wherein people should be made to understand the value of the right family size to suit their income capacities and responsible parenthood.

The city adopted several strategies to increase awareness, intensify service delivery and expand coverage by increasing the availability and the number of service providers. On August 1, 2002, the National FP Day was launched on the Riverbanks. Various sectors contributed to the campaign with the assistance of the DOH, John Snow Inc., Friendly Care Foundation, Johns Hopkins University, EngenderHealth, MSH, DKT International, and pharmaceutical companies. POs and NGOs also participated. Partner agencies distributed information materials, set up exhibit booths, and provided FP counseling services with help from multi-media.

As a front act, the city began social mobilization activities such as on-site counseling, special screening of potential clients for BTL and VSS, and coordination with service providers. This was followed by the launching of campaign activities like motorcades and exhibits. On NFP Day, 186 clients were counseled, 145 of whom were successfully referred to the service outlets. A total of 91 persons underwent BTL and 8, vasectomy.

The program gained public support. Services were made available on a regular basis at the Amang Rodriguez Medical Center and the privately-run Sto. Niño Health Center. A dramatic increase in acceptance was posted from the previous 3,983 in recent years to 16,212 in 2003 for all FP methods. Marikina City is strengthening the volunteer network with the holding of intensified training in CBMIS, conmpetency-based training in FP, training on pill dispensing by VHWs, and organizing community volunteers for FP. The city also plans to strengthen its networking activities with service providers at the Amang Rodriguez and the Friendly Care Foundation for an industrial FP project.

Clarifications

Distinction of BHWs from family health workers. There are two types of health workers in Marikina, the BHW institutionalized workers who implement DOH programs and who get incentives from the city government in the amount of Php500 in addition to barangay incentives; and the FP Workers who were former BSPOs and do not get incentives from the city government. Some of them were recruited into the BHW network. They will be given incentives in the future out of increases alloted to BHWs. Their roles were expanded from being mere suppliers of contraceptives to marriage counselors. They directly report to the Population Management Office whereas BHWs report to the health centers. The

FP Workers get their supplies directly from the city and focus solely on FP. BHWs obtain their supplies from the health centers and focus on the broad range of public health programs.

Sustainability of the program beyond 2003. The city will sustain service delivery even after DOH support has stopped. The Marikina Population Office has its own budget of Php1.3 million in 2003, with a portion dedicated to the purchase of drugs and medicines for FP services.

VHW incentives. VHWs are provided financial incentives in the form of transportation allowance. The spirit of volunteerism is strong among the former BSPOs but the city recognizes their efforts. Eventually, they will become part of the regular BHW network.

Monitoring CBMIS protocols in pill dispensing. Research has shown that there are problems on the field when it comes to dispensing, especially during weekends. A checklist is provided along with the service record. Patients are referred to the health center staff according to the CBMIS protocol.

3. Premyo Mula sa Basura: A Strategy for Garantisadong Pambata

Mayor Shalimar Tumaru, M.D.
Aparri, Cagayan

Aparri, Cagayan is known as "the place at the edge of heaven." It has 42 barangays and a population of 56,576 with an average growth rate of 1.0%. It is a 2nd class municipality with a budgeted IRA of Php53 million. Previously, majority of the people were not aware that food products were fortified with Vitamin A. The LGU embarked on a program to increase awareness of fortified food products entitled *Premyo sa Basura.* The concept was presented to the Municipal Nutrition Council. Under the program, product wrappers with the *Sangkap Pinoy Seal* (SPS) otherwise thrown as garbage were raffled off for prizes.

The project started with masterlisting zero to 59-month-old children. This was followed by an intensive information campaign. Social mobilization activities consisted of Donors Meetings by civic organizations and women's clubs, pledges and solicitations, and support for the waste management program by the LGUs.

At the outset, problems were encountered pertaining to geographical difficulties and low donor interest. Eventually, the program got underway and gained wide popularity. Mothers were made aware of the fact that micro-nutrients in the food products could ensure child survival and adequate nutrition. Costs were minimal because the program enjoyed the participation of stakeholders. Prizes were

donated by private benefactors, NGOs, and businessmen. Drop boxes for the wrappers were installed in strategic junctions. Raffle draws were scheduled on a monthly basis. Given away as prizes were fortified food products. As a side event, the *Operation Timbang* was simultaneously held to assess the nutritional status of children.

As a result of the program, Vitamin A coverage increased from 97.92 percent in 2000 to 110.35 percent in 2002. The program owes its success to LGU and NGO support. Aparri plans to pursue its initiative to increase the awareness of parents and caregivers on the benefits of Vitamin A. *Premyo sa Basura* turned out to be an effective way not only of addressing the nutritional problems of children but lowering the incidence of childhood diseases. The program can be sustained even with political turnovers in local leadership because of its no-cost nature and ease of management.

Clarifications

Rate of distribution. This was established with the tally of recipients.

International Reference Standards (IRS) for Operation Timbang as index of malnutrition. The IRS is not adopted because of the absence of training. It will be implemented in 2004 after the conduct of training this year. Operation Timbang will be closely monitored through the teamwork of the barangay health workers and the Barangay Nutrition Committee. Old standards currently aply.

Making consumers aware of what they buy; recycling of wrappers. Wrappers were redistributed to barangays as stuffing for throw pillows and other handicrafts.

Relation between good nutritional status and FP. Couples who practice FP have less number of children and will be able to provide them with their needs. There is a big correlation between FP and nutrition.

4. Improving Access to IUD Services: The Tanza Experience

Dr. Ruth Punzalan
Tanza, Cavite

Tanza, Cavite is a lowland municipality with a population of 127,147. It has 41 barangays. There is one main health center and 26 Barangay Health Stations. In the pre-intervention phase, nine of the health staff trained in Comprehensive FP, seven of them trained to provide IUD services. Only the main health center was

equipped to provide the IUD services. Four of the stations were designated as satellite FP clinics and outfitted with the appropriate equipment.

Clients were next identified for IUD insertion, aided by the issuance of call cards to MWRAs with unmet needs. Most of the women preferred pills and BTL. IUD preference accounted for only 12 percent. The MWRAs were given one-on-one counseling and the mobile IUD clinics were organized. Mothers who expressed the need for IUD services were served. Soon, the municipality was able to set up two functional FP satellite clinics, leading to the increase in the number of IUD clients.

Some of the issues encountered were that only nine percent of the staff were trained in comprehensive FP. IUD kits were few and certain mobility problems were encountered. There are plans to set up additional satellite clinics, train other midwives and nurses, and proceed with ongoing mobile clinic activities. Additional kits will be needed, with assistance from the MGP.

5. Expanding Service Coverage: The Culion Story

Dr. Emmanuel Gaudiels
Culion, Palawan

Culion is an island municipality in the province of Palawan with a population of 15,500. It is a 5th class municipality with 14 barangays. It has one RHU. The Culiun Sanitarium and General Hospital, founded in 1906, is located here. It is classified as a secondary hospital.

The CBMIS baseline data were found below the benchmarks set by DOH. In the area of FP, pills and BTL were the most popular methods. CPR stood at 53 percent due to efforts of the Culion municipal government that funded the initial provision of drugs and initiated the organization of frontline health workers, and the Culion Sanitarium that provided the operating venues and technical crew for VSS. These efforts were assisted by the Culion Foundation Inc.-Path that conducted community trainings on FP, furnished commodities, and the LPP-MGP that provided financial assistance for BTL and technical support for CBMIS and monitoring/evaluation.

The BTL Program involved networking among agencies, training of health frontline workers, recruitment of clients by BHWs, client referrals to rural health midwives and coordinators for screening, and organization of surgical teams. Procedures were performed when supplies were available.

Some of the issues that confronted the program were the extension of capability building down to the barangay level, the adoption of a referral system, and

extension of insurance benefits to the cases via the local BCCL District Health Insurance and Philhealth. Culion eventually hopes to implement CBMIS municipal-wide, focus on other areas with high unmet needs, and increase access to the program by other LGUs.

Clarifications

Amount of Culion grant; and outcomes after MGP implementation. The grant amounted to Php125T. The CBMIS must first be fully implemented within the next few weeks focusing on municipality-wide unmet needs before impact could be assessed. The limitations of Culion were given because of the expense of sea travel. It is premature to gauge impact because it is a new program that needs time for assessment of Fully Immunized Children and Vitamin A coverage.

Issues and Concerns

Difficulties of reaching benchmarks for EPI, TTV. Shortages in vaccine due to spoilage were encountered.

MCPR in excess of benchmark. The CPR should not be expected to increase because of the full implementation of the MCPR. Demand for vaccination will eventually decrease because of the slowdown in births. The target is computed on the basis of population. The implementation of one program should not take away resources intended for another program. Experience of targeting 3.5 percent will result in problems.

Program targets unnecessary in CBMIS. In CBMIS, there is no such thing as target since it is an actual population-based survey. Counting is based on the number of actual family members. Some of the programs pertain to the adequacy of supplies. Thus, all systems should be in place. It is wrong to think that if CPR rises, supplies for VAC and FIC should rise alongside.

Capability of VHWs to dispense drugs/commodities. There is an ongoing initiative to tap non-health staff for the distribution of FP commodities to generate more clients, enhance services, and raise CPR. An Operations Research is ongoing in Lucena (intervention) and Sariaya (control). VHWs were formerly eyed as sources of pill re-supply but are now targeted as dispensers for first users as well. DOH policy will sanction the move on the basis of the operations research. The resulting checklist will be accomplished by the VHW for recording purposes. Based on the survey, women will be advised to consult health centers.

The study will end in July for presentation to DOH in aid of policy. The activity will be preceded by training.

Adequate distribution must be assured. The CBMIS protocol governs distribution. VHWs are based in the centers from which they draw their supplies and maintain client service records. These clients are regulated by the BHWs and are asked to report to the centers for validation. In the case of Marikina City, majority of the VHWs are health-oriented hence, no criteria for VHW selection exists. Some of the VHWs are also midwives while others are best mobilized for counseling.

Physical examinations as a better protocol. The advantages and disadvantages of the VHW approach should be weighed. In a competency-based training, the checklist was observed to be "too general." VHWs should be held accountable to the nurse or doctor for correct medical assessments. An alternative would be for the physical examination to precede the checklist, for purposes of avoiding complications that could occur on weekends which may not be managed by the MHO.

Clarifications

Allowing BHWs to dispense pills. BHWs are trained in pill dispensing. The checklist serves the purpose of assessing patient condition. Irregular cases are referred to the HCs. This is helpful to women with no access to commodities other than VHWs.

The global trend is for VHWs to dispense pills as safely as any other provider – a practice that has been ongoing for ten years now. The Philippines is lagging behind countries like Finland, Indonesia, Bangladesh, and Africa. A future study can be made to assess impact. The bottomline is access to services. The closer services are to communities, the better for patients unable to visit the HCs where doctors are available for a limited time. There are risks involved. It is less risky to dispense pills under a controlled condition than allow potential acceptors to get pregnant.

Medical oversight on commodity dispensing. Dispensing is a medical function and VHWs should be tapped only in remote areas. It would be far more dangerous for mothers to buy pills from pharmacies without the benefit of medical oversight.

MGP fund utilization for the purchase of IUD kits. MGP funds direct service delivery and outreach activities, not commodities which may be funded by other sources. The MGP shoulders expenses that LGU can't otherwise absorb.

CONCURRENT SESSION IV
ENHANCING PROGRAM SUSTAINABILITY

Highlights of Presentations

In recent years, health facilities have increasingly been aware of the need to ensure program sustainability. Whereas before sustainability was limited to financial stability, health officials and staff have now recognized the importance of developing a multi-faceted approach towards long-term viability, not only of programs, but of the whole organization, as well.

1. Institutionalization of the Matching Grant Program in Local Governance: The Experience in the Pangasinan Municipalities of Mangaldan and Asingan

Engr. Aureo Philip Fabia
Mangaldan, Pangasinan

One of the first LGU beneficiaries of the Matching Grant Program was the province of Pangasinan. Although financial and technical assistance has been earmarked to support local health activities, provincial officials felt that merely bestowing the program without establishing a mechanism to strengthen coordination, participation, monitoring, and linkages would only limit the program's life span. A process was formulated to ensure that the assistance would be spent prudently and contribute to the improvement of health services.

The process started with an orientation of local officials and stakeholders. It was followed with an assessment of issues and problems besetting health, with special focus on family planning and child survival. After the discussion of issues and problems, benchmarks were established and the roles and responsibilities of the different offices were identified. Commitments were then translated into a memorandum of agreement before the grants were released to the municipalities.

By undergoing the process, the municipalities of Mangaldan and Asingan became more involved in the development of their specific program objectives and targets. As program partners, their participation in the process would ensure a clearer grasp of objectives, the activities are tailor-fitted to the needs of their communities, and parallel commitments are necessary to attain and sustain the targets.

Engineer Fabia proudly announced that the municipalities were able to come up with local initiatives to support the program. Among these initiatives were the

Church-LGU partnership on natural family planning, counseling activities at the community level, provision of honorarium for population personnel at the village level, and the establishment of the community-based monitoring and information system (CBMIS).

2. Institutionalizing Voluntary Sterilization Services in Pangasinan's District Hospitals

Ms. Luzviminda Muego
Pangasinan

For the Pangasinan Provincial Population Office, the devolution of health services offered more opportunities than threats for the effective delivery of family planning programs. Devolution enabled the Provincial Population Office to have a more active participation and control in planning and institutionalizing FP programs at the local level. Through this set-up, the PPO was able to strengthen its voluntary surgical sterilization services.

The institutionalization process for VSS required four major action points: improving hospital facilities, improving hospital staff capability, counseling services, and mobilizing community support. Improving hospital facilities meant the identification of strategically located public hospitals, which became the hubs of VSS activities, and enhancing their infrastructure and equipment. Staff capability focused on ensuring that VSS hospital personnel are properly trained on the procedure.

Counseling services, meanwhile, were geared toward training health personnel on the proper protocols to guide patients in making an informed choice. Lastly, but an equally important aspect, was mobilizing the community to provide the necessary support base for the VSS. Local officials and community volunteers were organized and oriented on the program.

By going through the four-part process, the Provincial Population Office and the Provincial Health Office were able to elicit participation from practically all major sectors involved in the program. It resulted in well-defined objectives, roles, and expectations. The continuing increase in BTL cases served by public hospitals in the province for the past nine years clearly indicates that health personnel have internalized the process and the province, with the active support from communities, has started to reap rewards in this particular area of family planning.

3. Networking: An Option for Sustainability of Contraceptive Supplies for LGUs (CHD for Cordillera)
Dir. Teresita Bonoan
CHD-CAR

For the CHD in the Cordillera Administrative Region (CAR), the issue of program sustainability came in the form of enhancing its dwindling contraceptive supply. In 2001, the region was faced with a very low contraceptive prevalence rate (46.8%) and high unmet family planning needs (26.9%). The announcement of the US government that it will no longer provide contraceptives all the more raised concern on the future of addressing FP requirements in the region, which has depended heavily on donations from the USAID.

The CHD saw the need to tap private groups to assist in the FP programs. The Center was able to facilitate an agreement between the provincial government of Abra and DKT Philippines, a non-governmental organization actively involved in the sale of FP commodities, particularly condoms now carried by pharmaceutical outlets.

Under the agreement, Abra received a Php200,000 worth of contraceptives as "starter consignment" under DKT's commodity revolving program. The program is primarily intended to fill-in the contraceptive requirements of the LGU in the face of the impending withdrawal of assistance from the USAID. Aside from the FP commodities, DKT has also committed to assist the LGU in producing its information materials and in training its personnel on the various concepts of FP marketing.

4. Health Financing Schemes: Fee for Service and Health Insurance
Dr. Francisca Cuevas
Pateros, Metro Manila

One of the most challenging post-devolution tasks of local health officials is ensuring the continuity of health services in the face of budgetary constraints. In Pateros, the smallest of the 17 cities and municipalities in Metro Manila, the health officer had to identify alternative financing schemes to ensure sustained delivery of health services to its community.

The first strategy was to introduce service fees. In a period of eight months (May to December 2002), the five health centers in Pateros were able to post modest earnings of P453,926. The collected fees were used to augment whatever financial support the municipal health centers were receiving from the municipal government. From its income, the health centers were able to hire additional

health personnel, procure additional drugs and medical supplies, and upgrade its facilities and services.

The second strategy employed was the enrollment of indigent families in PhilHealth. The scheme, a modification of PhilHealth "Greater Medicare Access" program, was designed to ensure indigent families continued access to basic health services in spite of the introduction of service fees at the health centers.

It is worth noting that the two efforts are sufficiently supported by municipal ordinances to provide it with the legal basis and to guarantee program stability.

Surprisingly, the introduction of service fees did not affect the demand for service at the health centers. In fact, patient load has increased by 6%. Moreover, with the complete package of health services and rare occurrences of supply shortages, the staff became more inspired, accommodating, and friendlier.

Issues and Concerns

Effects of LGU-religious sector partnership in sustaining the FP program. The MOA between the Pangasinan provincial government and the Catholic Church yielded closer cooperation between the two influential organizations. The two groups recognized the need for family planning. The local government offered assistance to the Catholic sector in promoting natural family planning (NFP), which led to a higher NFP utilization in the province. The Catholic Church in Pangasinan, on the other hand, reportedly respects government's mandate to deliver contraceptives and other methods of family planning. However, it was suggested that contraceptive prevalence rates must also be examined to determine if the government-religious sector partnership in Pangasinan have contributed positively to the promotion of family planning in the province.

Changes in political administration as threat to program sustainability. It is unavoidable for most government programs to be associated with its political benefactors such that changes in political landscape are viewed as serious threats to the continued existence of the program. Program officials must, therefore, incorporate safeguards to ensure program sustainability long after the leadership has changed. Municipal ordinances, resolutions, and memoranda of agreement can, for example, provide legal strength / basis for programs. Incoming local officials would normally respect agreements entered into by previous administrations.

Convincing local officials and securing support are necessary. The support of the local political leadership is extremely important, particularly in programs requiring public resources. There is a perception that local officials are reluctant

to lend support to undertakings that would possibly alienate their voting constituents. However, the case of the Pateros Municipal Hospital in introducing service fees proved that local officials are rational decision-makers. Convincing LCEs is not really difficult if a well-prepared plan is presented to them. Dr. Cuevas shared her experiences in selling the idea of fee-for-service and health insurance to local government officials. She oriented them on the financial difficulties faced by the local health sector and offered alternatives to address the situation. She also assured the LGU that fees would be tempered and made reasonable so as not to antagonize the public.

GO-PO Collaboration for greater understanding. Mayor Fetalvio also supported the idea that if the government provides something, it is also allowed to ask for something in return. Most LCEs are open to ideas that are sound and that are beneficial to the government and to the public. It must also be remembered that the leadership, commitment, and support of health (particularly hospital) officials and their staff are extremely important to the success and long-term sustainability of a program. The officials and staff must understand all aspects of the program and mechanisms must be incorporated wherein their active participation will be encouraged.

Need to include drug procurement system for VSS. An important factor in the success of the VSS is the inclusion of its drug requirements in the regular procurement plan of the hospitals. This underlines the principle that even the support mechanisms of the program(s) must be considered and are necessary to ensure its continued viability.