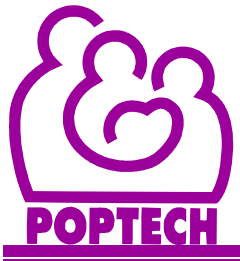

EVALUATION

OF THE

ENRICH PROJECT

IN THE

AUTONOMOUS REGION OF MUSLIM MINDANAO (ARMM)

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ACRONYMS

AED	Academy for Educational Development
ARMM	Autonomous Region of Muslim Mindanao
BCC	Behavior change communication
CA	Cooperating agency
CCF	Christian Children's Fund
CDLMIS	Contraceptive delivery logistics management information system
CHD	City Health Department
DOH	Department of Health
DOTS	Directly observed therapy, short course (for tuberculosis)
EnRICH	Enhanced and Rapid Improvement of Community Health
FHSIS	Field health services information system
FP	Family planning
HFC	Healthy Family Coalition
HKI	Helen Keller International
IEC	Information, education, and communication
KAP	Knowledge, attitudes, and practices
LEAD	Local Enhancement and Development for Health project
LGU	Local government unit
NDHS	National Demographic and Health Survey
NGO	Nongovernmental organization
NTP	National Tuberculosis Program
PVO	Private voluntary organization
SCF	Save the Children Federation, Inc.
SO	Strategic Objective
TBA	Traditional birth attendant
TSAP	The Social Acceptance Project
USAID	United States Agency for International Development

CONTENTS

Page

APPENDICES

EXECUTIVE SUMMARY

The Autonomous Region of Muslim Mindanao (ARMM), a poverty-stricken region of the Philippines, represents only 13 percent of the total Philippine population but registers the country's lowest family planning and health statistics, well below national averages. It is not yet clear if the high growth rate of 3.86 percent (National Demographic Health Survey [NDHS] 2003) can be averted when only 11 percent of couples accept and use modern contraceptives, and government efforts are severely limited and compromised with continuing unrest, political instability, and the sheer difficulty in reaching many remote populations.

Health indicators in the ARMM are alarmingly low. For example, vitamin A deficiency is most severe, with vitamin A supplementation coverage of 50.5 percent (6–59 months); the national average is 76 percent. Full immunization coverage is 44 percent (12–23 months); the national average is 70 percent. Only 50 percent of mothers are receiving health professional–assisted antenatal care, against a national average of 88 percent (National Demographic and Health Survey [NDHS] 2003). It is felt that unless continuous, concerted, and highly focused assistance is provided, the region will continue to deteriorate.

Many claim that the promise for improved governance through ARMM's autonomous status has yet to be realized. There are many who believed that conditions were better off under the previous arrangement, in which the provinces reported to the Department of Health (DOH) regional offices. The current leadership in the region is not trusted because of perceived apathy and lukewarm responsiveness to the health needs of the people. In addition, the national government's ability to respond is reduced in respect for the ARMM's autonomous status.

The regional office indicated that a complex administrative structure is part of the problem. There are five provinces in the ARMM (Maguindanao, Lanao de Sur, Sulu, Tawi-Tawi, and Basilan) and one city (Marawi). Isabela City is in the island province of Basilan but is not included in the ARMM. Cotabato City is outside of the geography of the ARMM but is the seat of the ARMM regional government. This creates confusion in terms of budgeting, resource allocation, and priority setting, and further reduces the jurisdiction and effective governance of the regional office. Furthermore, there are other legitimate issues to consider. The limited budgetary allocation (ARMM has no maintenance, operating, and other expenses budget, unlike other regions) and the unclear roles and responsibilities of regional, provincial, and local governments further weaken the administrative capacity of the region. Unifying the ARMM population, which is already divided not only geographically but by tribal affiliation, adds to the challenge.

The United States Agency for International Development (USAID), recognizing the situation in the ARMM, has provided technical and funding assistance to alleviate the population's general health status. In September 2002, USAID launched the Enhanced and Rapid Improvement of Community Health (EnRICH) project. Four U.S. private voluntary organizations (PVOs), with $2.8 million in funding assistance, were engaged to form and mobilize community organizations, develop strong multisectoral linkages,

improve the clinical skills of health workers, and expand the delivery of health services in selected municipalities of four of the five ARMM provinces (except Maguindanao).

Much has been accomplished over a short period of 18 months. For example, as of March 2004, a total of 17,207 new family planning acceptors for modern methods have been achieved in the four provinces of the ARMM (Lanao del Sur: 6,775; Basilan: 1,256; Sulu: 1,248; and Tawi-Tawi: 7,928). A total of 647 tuberculosis smear positives were detected and treatment was started in the three provinces (Basilan: 110; Sulu: 286, and Tawi-Tawi: 251). Helen Keller International (HKI) has reported a dramatic increase in vitamin A coverage of children under 5 from 78.8 percent in 2002 to 86.2 percent in 2003.[1] A similar trend was also visible for immunization coverage.

Before EnRICH, family planning (FP) and tuberculosis program coverage were virtually nonexistent due to DOH budgetary limitations. The ARMM budget covered only salaries, and there was no allocation for family planning and health program expenses. For grantees to achieve this level—considering major program limitations—is remarkable. In fact, the project may have been able to show additional results if the ARMM had reliable baseline information.

One of the most remarkable achievements is the success in forging truly multisectoral community organizations, with the active participation of the provincial government, Muslim religious leaders, key barangay leaders, and volunteer health workers working collaboratively to provide for the health needs of the community members. The fact that the motivations of the members are not based on monetary considerations presents a strong argument for sustainability. Civic duty and a sense of ownership appear to be the driving forces for cooperation. Strong community organizations not only complement the government's efforts in strengthening service delivery points (rural health units and barangay health stations), but are essential for ensuring sustainable development. Now, the burden of providing health coverage becomes a shared responsibility of the community and government.

The grantees have developed many variations in the formation of community groups. HKI formed barangay health teams in Lanao del Sur, Christian Children's Fund (CCF) organized community health committees, ACDI/VOCA composed healthy family coalitions, while the Save the Children Federation, Inc. (SCF) formed barangay health teams and barangay health committees. CCF and ACDI/VOCA, recognizing the strength of community organizations, formed and registered them with the Securities and Exchange Commission as a way of protecting their interests and using their legal personality as a way to access additional support from other government entities and donor groups. HKI and SCF are currently working on a similar registration process. There is a need to document best practices to facilitate replication and expansion of strategies in other municipalities of the ARMM.

Another outstanding achievement of the grantees is their advocacy efforts among Muslim religious leaders. Many key religious leaders (imams and ustadz), who earlier posed major resistance to family planning, have not only become converts but were also transformed into active spokespersons for family planning using the fatwa. Currently,

[1] Grantees derived their data from cluster surveys conducted in early 2003 and may vary from such national indicators as the NDHS.

family planning topics are increasingly included during Friday sermons in the mosque. The use of observation study tours for Muslim religious leaders has proven to be effective in changing attitudes and behavior. Continuing this effort and expanding it across other segments of the ARMM population will strengthen advocacy.

While the improvements in the delivery of health services are visible in the communities covered by the grantees, not all were able to benefit from it. EnRICH covers 340 of 1,897 barangays (18 percent) in the four provinces of the ARMM (except Maguindanao) due to resource limitation, geographic inaccessibility of many municipalities, and the prevailing peace and order situation in many areas posing serious security risks to project staff and community workers.

Project accomplishments, while substantial, are still insufficient to create a positive impact on the regional or national health indicators. The limited timeframe (two years) further reduced by implementation problems was not sufficient to enable grantees to complete the intervention. Many grantees are still in the midst of implementation, and time has expired.

The effective monitoring of project performance presented a major difficulty, not only for the grantees but also for the region, given the absence of reliable baseline data and the corresponding reliable and uniform health information systems maintained at the regional level. NDHS data, while limited in representing the geographic differences among the provinces, remains the most reliable source of information. Some provinces that maintain field health services information systems (FHSIS) and contraceptive delivery logistics management information systems (CDLMIS) may be able to provide a more accurate profile, but not all provinces are doing so. Furthermore, the mobile population of the ARMM and the number of tribal and remote populations there has rendered data collection extremely difficult. Additional efforts are needed to develop a uniform information and monitoring system that truly represents the geographic differences of the region.

Other outstanding strategies implemented by grantees in the ARMM include the

- use of radio for distance learning, effective for reaching a wide audience with health messages and improving the general knowledge and clinical skills of health workers;

- use of a floating clinic as a way to reach remote populations not accessible by land transportation;

- provision of contraceptives and other essential drugs (such as tuberculosis treatments) when commodities became unavailable;

- construction of service delivery points (barangay health stations) in areas where they are most needed, particularly when government resources and political will are limited;

- implementation of numerous skills training sessions to upgrade the skills of health workers;

- provision of small operating expenses to facilitate area coverage;

- implementation of observation study tours for Muslim religious leaders to strengthen advocacy;

- lobbying for provincial health office support for drugs when commodities are limited; and,

- ability to be flexible (grantees and donors) and quickly respond to changing needs, despite the restrictions imposed under the current cooperative agreements.

RECOMMENDATIONS

Continue the EnRICH project and expand it geographically. Two years is too short to realize a meaningful impact in family planning acceptance and the effectiveness of health interventions. The continuing disruptions caused by the peace and order situation, geographic distance and inaccessibility of many areas, and the difficulty in fielding project staff have further reduced the productive implementation time of the project. Most grantees are only in the midst of implementation, and time has expired. New start-up efforts will affect the momentum and continuity of implementation. It is strongly suggested that a timeframe similar to other project funding cycles (five years) be provided to the follow-on EnRICH project. The current 24 percent project coverage of selected municipalities in the ARMM is limited in achieving a significant impact on both regional and national indicators. While it is understood that there are still many municipalities where coverage is virtually impossible and risky, grantees have already identified some where conditions are conducive. The provisional health offices have identified these municipalities and the local chief executives have expressed a readiness to implement the project.

Expand project components. The improvement of health conditions in the community requires an integrated approach. While current strategies are based on greater need given the resource limitations, the overall effectiveness of the strategy is weakened when certain needs of the population are not addressed. The implementation of four additional project components is recommended.

- **Adolescent reproductive health:** While data are limited, adolescent reproductive health is recognized as one of the unmet needs in family planning. There are currently no services available to adolescents. Studies show that adolescent needs for FP are equally important and need to be addressed. SCF has recognized this as a gap in its program, and has included it in its future plans.

- **Functional literacy program:** This program is specifically intended for females. Where female literacy is low, the ability of the program to reach women with FP and health messages will be limited. Awareness will continue to be low, and empowering women will be an arduous task.

- **Disaster relief and preparedness of the community:** Grantees believe that the state of readiness is low, as are the response capabilities of communities to impending disaster. In the event of a regional or national disaster, the less-prepared communities would suffer and have the hardest time coping.

- **Livelihood projects:** Achieving sustainability will be difficult unless communities achieve economic self-reliance. A majority of ARMM communities are poverty stricken. Opportunities and resources are severely limited. The cycle of poverty, despondency, and dependence is difficult to break when communities do not have an economically viable livelihood. There is a need for assistance on income-generation projects, particularly for communities that have already organized themselves into community enterprises. To enable these communities to continue their path to self-reliance, technical assistance and an enabling environment have to be provided. Activities under this component may include livelihood skills development, marketing assistance for local products, and entrepreneurial training. The needed technical expertise may be drawn from some of the grantees that are already providing this kind of assistance in their current program.

Expand implementation of advocacy to Muslim religious leaders using the fatwa. Grantees have demonstrated their effectiveness in reducing religious resistance to family planning through their advocacy efforts focused on key Muslim religious leaders. However, their advocacy efforts have only been implemented in a few selected municipalities covered under the project. Religious resistance in many nonproject sites is still strong and will remain strong unless Muslim religious leader advocacy efforts are expanded to these areas and are uniformly implemented across the ARMM. The grantees should expand the promotion of the fatwa to other nonproject sites. Intensified efforts should be made with conservative Muslim religious leaders to gain their acceptance and endorsement of FP. Grantees should uniformly promote the use of Muslim religious leaders as advocates or spokespersons for FP. Grantees should also explore the use of highly placed religious leaders (grand mufti) to conduct advocacy among conservative Muslim religious leaders.

Use observation study tours for Muslim religious leaders. The project should continue the implementation of regional observation study tours for Muslim religious leaders to facilitate the sharing of information, strengthen support for advocacy, and unify all Muslim religious leaders towards the promotion of family planning.

Organize a Muslim religious leader advocacy group. Grantees should organize Muslim religious leaders into an active advocacy body to promote adherence to the fatwa among members, hold regular discussions, and develop uniform health and family planning messages, particularly during Friday sermons in the mosque.

Negotiate a discussion between the ARMM, provincial governments, and local government units (LGUs). It is apparent that the level of communication between the ARMM, provincial government, and LGUs is low. Regional work plans will be limited and less effective if participation of other key government leaders is nonexistent. It is particularly important that the process and venue for regular discussions are provided,

especially when the resources from the province and LGU are critical for supporting the delivery of services.

Develop a physical distribution system for commodity and essential drugs. FP will not prosper without commodity support. The frequent stock outages will constrain acceptance. A mechanism should be developed where commodities are shipped directly by the supplier to the destination province. This will reduce the transportation cost and at the same time expedite the shipment. Transportation costs should also be equally shared by the region, province, and LGU to widen the resource base.

Implement a health facility assessment and regional health information system. The project should engage an independent body to implement a health facility assessment for the ARMM. The health facility assessment should include the establishment of baseline data for basic health indicators and the development of a reliable health information monitoring system for the region. Measurements of performance should be done by the independent body at regular intervals.

Concentrate in key expertise areas. While grantees have performed well with all components under their charge, their achievements in their areas of expertise are outstanding. This comparative advantage needs to be optimized, and will require their concentration in their competency areas. However, a mechanism needs to be established wherein expertise is provided to grantees in areas where it is lacking, particularly during the formation of strategies. Grantees should also access available expertise within their organization (or elsewhere) to ensure a high level of competence.

FUTURE PROGRAM FOCUS AND NEXT STEPS

The follow-on project should focus on maintaining that which has been achieved. Best practices should be replicated and implemented in the ARMM's other geographic areas. Additional efforts should be made to create a mechanism that will foster a regular discussion among the key government leaders of the region, province, and LGU. The long-term solution to the problem lies in the strong collaboration of these bodies in the programming and sharing of resources in developing the ARMM and the eventual adoption of the project by the LGUs.

The development of baseline indicators should begin early in the next phase of EnRICH implementation. The strategy and components of the follow-on project should also be designed early, building on the project's prior accomplishments to ensure seamless project implementation.

CONCLUSION

The EnRICH project has set the stage and framework for the follow-on project. Grantees have successfully formed and empowered strong community organizations. There is evidence that these community organizations, operating under the power of volunteerism, will stay for the long term and be the best instruments for sustained development. Grantees have also demonstrated their tenacity for performing under the most difficult circumstances and security risks. Best practices have been identified from the multiple strategies implemented to achieve the desired health outcome. Political and

administrative challenges have also been identified, and solutions have been developed to address them. The winning strategies will now provide the foundation upon which to build. However, grantees still need additional time to complete what they have begun. The time provided was too short to enable the achievement of meaningful results. ARMM needs the EnRICH project to complete its development. The project needs to continue and expand to other ARMM geographic areas not yet reached. The lives saved and the health of mothers and children improved are more than commensurate returns on investment.

I. BACKGROUND

The Autonomous Region of Muslim Mindanao (ARMM) is one of the six administrative regions of Mindanao representing 13 percent (2.8 million) of the total Philippine population. The ARMM was created by law in 1989 and includes the provinces of Maguindanao, Lanao Del Sur, Sulu, Tawi-Tawi, and Basilan as well as the city of Marawi. The ARMM is predominantly Muslim (98 percent) with a high percentage of tribal and cultural minority populations. While Pilipino is commonly understood, in each island a distinct regional dialect is spoken (e.g., Tausugs, Yakan, Samaa, Maguindanao, and Maranao).

The five provinces of the ARMM are among the most depressed in the Philippines, with a 71.3 percent poverty incidence (National Statistics Office 2002) and with a population growth rate of 3.86 percent (when the national rate is 2.36 percent). ARMM health indicators are well below the national averages. Women using modern family planning (FP) methods account for only 11.6 percent, while the national average is 33.4 percent. Fully immunized child coverage, at 44 percent, is 29 percent lower than the national average, while the infant mortality rate, at 55 percent, is 20 percent higher than the national average of 35 percent (National Demographic and Health Survey [NDHS] 2003).

Political conflicts, weak leadership, frequent armed conflicts, and the geographic inaccessibility of many areas have made the delivery of health services extremely difficult and unstable. There are currently no perceptible improvements in the health indicators over the years.

In response, in September 2002, the United States Agency for International Development (USAID) launched the Enhanced and Rapid Improvement of Community Health (EnRICH) project to provide resources toward the improvement of health outcomes in support of USAID Strategic Objective (SO) 3 (the achievement of the desired family size and sustainability of FP programs). Specifically, the objectives were to

- install community health systems,
- strengthen government services,
- energize the regional government leadership,
- improve the delivery of health services, and
- increase the health-seeking behavior of families.

A total of $2.8 million was awarded to four U.S. private voluntary organizations (PVOs): Helen Keller International (HKI), the Christian Children's Fund (CCF), ACDI/VOCA, and the Save the Children Federation, Inc. (SCF).

Because most of these agencies were already working in the ARMM, they were able to quickly and effectively form and mobilize community organizations, develop strong linkages with government and local organizations, and implement skills training to improve the knowledge and capacity of health workers.

Over a short span of 18 months (October 2002–March 2004), the grantees have indicated many accomplishments. For example, HKI has vastly improved vitamin A

supplementation coverage in the entire ARMM, CCF procured and repackaged tuberculosis drugs for their service areas in Basilan, ACDI/VOCA is assisting the integrated provisional health office with refurbishing its floating clinic in Tawi-Tawi, and SCF is the catalyst for the construction of barangay health stations in some municipalities in Sulu.

In June 2004, USAID engaged an evaluation team to review project accomplishments, examine the strategies used, evaluate project relevance, identify best practices, and provide recommendations for future directions in the ARMM.

The team visited the ARMM regional office in Cotabato City and the project sites of Marawi, Basilan, Tawi-Tawi, and Sulu, and had extensive discussions with the staff of the four PVO project implementers, key religious and community leaders, provincial and municipal health officers, and community health workers.

II. KEY FINDINGS AND RECOMMENDATIONS

PROGRAM CONSTRAINTS

Project implementation has been beset by numerous constraints, including the five that follow.

Political and Administrative Constraints

The political situation in the ARMM is complex. There are five provinces in the ARMM (Maguindanao, Lanao de Sur, Sulu, Tawi-Tawi, and Basilan) and one city (Marawi). Isabela City is in the island province of Basilan but is not included in the ARMM. Cotabato City is outside of the geography of the ARMM but is the seat of the ARMM regional government. This situation creates confusion in terms of budgeting, resource allocation, and setting priorities, and reduces the jurisdiction and effective governance of the ARMM regional office.

The national government has continued the provision of drugs and vaccines for the ARMM, and while this is legitimate in view of the limited capacity of the region, it has further weakened the region's capacity for autonomy.

The administrative interface between the regional, provincial, and local government unit (LGU) levels is also not clearly defined. Roles and responsibilities are still confused, and regular discussions among key government leaders appear to be nonexistent.

The ARMM regional office claims that the region's internal revenue allotment is limited and does not include essential budgets for maintenance, operating, and other expenses, unlike other regions (see appendix C, table 2). Also, LGUs do not participate in health expenditures. Many claim, however, that the ARMM internal revenue allotment, while sufficient, does not have health as a priority.

A general feeling exists among the provisional health offices that the leadership in the regional office of the ARMM needs to be energized, as it has become less nimble and is often unresponsive to the needs of the provincial health programs.

The regional officers' infrequent visits to the areas, an absence of regular discussions, a lack of feedback mechanisms, and irregular reporting are among the possible reasons why the problems are not well understood.

Frequent drug stockouts in the provinces of Lanao del Sur and Basilan, for example, while an indication of this problem, are also perceived as a function of poor management planning and may be attributed to ineffective communication between provisional health offices and the regional office. Many claim that a reliable, physical drug distribution system is not in place because funds needed to transport the drugs are limited. Drug transportation costs in the ARMM provinces are substantial in view of the distances between the provinces and the regional office, particularly when the physical delivery of the drugs is centralized in the regional office.

Recommendations

The cities and municipalities within the geographic scope of the ARMM should be transferred to the jurisdiction of the ARMM regional government. This applies to the province of Basilan and the city of Marawi. The administrative control of the ARMM is weakened when these areas report elsewhere.

Because communication is lacking among the government bodies in the region, a third party has to act as an intermediary and negotiate a discussion among the regional, provincial, and LGU leaders. The current grantees may be best poised to undertake this function, considering their nonpolitical affiliations, their understanding of the problem, their networking skills, and their presence providing technical assistance in the area. The grantees can act as intermediaries between leaders, providing the venue and agenda for a regular discussion.

Measures should be initiated to transfer the responsibility for drug procurement to the regional office. However, before a transfer is put into effect, a careful examination of regional capacity should be conducted to ensure that the process of drug procurement is efficient and transparent.

Roles and responsibilities should be clearly defined among the regional office, the province, and the LGUs. Responsibility for the delivery of health services, including its funding, should be equitably shared. Strong linkages between the regional office and LGUs should particularly involve the planning, monitoring, and implementation of regional work plans.

The ARMM internal revenue allocation budget should adequately provide the funds needed for the transportation of contraceptives, vaccines, and essential drugs. Transportation costs, while the responsibility of the regional office, should be equitably shared by the province and the LGU. Mechanisms to transport commodities directly from the supplier to the provisional health offices on a regular basis should be developed. This will reduce the transportation time and cost and will ensure the timely delivery of commodities directly to the place of need.

Budget support for operations (maintenance, operating, and other expenses) should be provided to the ARMM. Currently there are no allocations for these expenditures, unlike other regions (see appendix C, table 2).

Policy Constraints

Appropriate policies can provide the enabling environment to support and enhance the effectiveness of interventions. There are many policy issues still to address, including the following items.

There should be a policy to include a budget in the ARMM internal revenue allotment for maintenance, operating, and other expenses, similar to other regions in Mindanao. This is essential to enable the region to support operating costs involved in the delivery or improvement of health services. Regional leadership should exert additional effort to

ensure the creation and adoption of policies that will compel the Department of Budget and Management to provide adequate allocation for health expenditures.

A policy is needed that defines the participation level of an LGU and province in the provision and funding of health services. Currently, the beneficiaries of the services are included in the jurisdiction of the region, province, and LGU, but the provision and costs of services are not shared.

A policy is needed that defines the responsibilities for procurement and distribution of drugs. Drug procurement responsibilities should be transferred to the ARMM regional office. Central procurement for the ARMM should be de-emphasized, including the implementation of contraceptive self-reliance programs. While regional procurement is recommended as a policy, physical distribution should be provided directly to the provisional health office, with the office sharing the cost of physical transportation. Because the geographic span of coverage involves higher transportation costs, responsibilities should be shared by the regional office, the integrated provisional health office, and the LGU concerned.

There should be a policy wherein the advocacy of Muslim religious leaders using the fatwa is uniformly implemented across the ARMM provinces and not left to the discretion of the implementers. Advocacy of Muslim religious leaders has been proven effective and has reduced religious resistance to FP, yet there is no uniform policy for its implementation. The enactment of the policy can unify and coordinate leaders' advocacy efforts for maximum effectiveness and wider coverage. The advocacy of Muslim religious leaders should not be the sole responsibility or prerogative of the grantee. Advocacy of Muslim religious leaders should be uniformly implemented in all the provinces of the ARMM, including cultural minority areas and nonproject sites. Expenses should also be equitably shared. The grantee should access outside expertise in the development of communication strategies from either The Social Acceptance Project (TSAP) or other technical experts.

A policy to engage an independent body to implement a health facility assessment is needed to assist in the development of baseline indicators and the measurement of performance at regular intervals.

There should be a policy on effective performance monitoring and evaluation at the regional office. The maintenance of a uniform health information system should be enforced across all ARMM provinces to facilitate the accurate assessment of impact and health outcomes.

Security Constraints

Peace and order problems have largely destabilized the region and are the major causes of disruptions in service delivery. The ability and effectiveness of grantees have been greatly reduced by their inability to access remote populations due to security concerns. Many ARMM provinces are still not accessible, and grantees constantly fear for the safety of their staff and other community health workers.

It is essential that separate strategies be developed for remote, geographically inaccessible, and high security risk areas of the region. The project might consider the expansion or replication of the floating clinic operated in Tawi-Tawi as one of the strategies appropriate in serving isolated and hard-to-reach areas.

The strong community partnerships developed by the grantees with community organizations have been effective and have often provided them the needed protection in their coverage of high-risk areas.

The practice of hiring local residents to implement project activities is also recognized to be relevant and effective in making grantees quickly acceptable within the community.

Military protection, while essential for safety, is not yet widely accepted in all provinces of the region. Many communities still view military personnel as adversaries, and a military presence can sometimes create negative repercussions and unnecessary tension. But there are resources within the military that can facilitate the work of the grantees. The military, aside from the transportation facilities they can provide to health workers, has a Civic Management Office that can implement outreach medical missions, and an engineering corps that can assist in building or upgrading health facilities. Grantees should access these resources when appropriate to help improve the military image and make them more acceptable in the community.

Recommendations

Grantees should continue their roles as negotiators of peace in the community. Their unique position and image as facilitators to improve health coverage should be optimized.

Grantees should continue to expand their practice of using local residents and local nongovernmental organizations (NGOs) with proven experience in the implementation of project activities. This strategy can further enhance their acceptance in the community and improve their image as true partners for development.

The grantees should exercise careful judgment in their associations with the military because close links with the military can sometimes affect favorable community support. Grantees should be discriminating in the use of military support, particularly in areas sympathetic to opposing forces. However, they should use the military in areas where community acceptance has already been developed through involvement in medical outreach missions, upgrading of essential infrastructure, and other civic action undertakings. In these areas, the partnerships should be maintained and expanded. Grantees should continue to identify appropriate resources within the military that can be optimized in the delivery of services. They should also continue their efforts to improve the military's image and bring them closer to the communities.

Religious Constraints

Grantees have demonstrated their effectiveness in reducing religious resistance to family planning through advocacy efforts focused on key Muslim religious leaders. However, these efforts have been implemented in only a few selected municipalities covered under the project. Religious resistance in many nonproject sites is still strong and will remain

strong unless the Muslim religious leaders' advocacy efforts are expanded to these areas and are uniformly implemented across the ARMM.

There are wide variations among Muslim religious leaders; while the progressives will be easier to convert, the conservatives will require intensive efforts. Using converted Muslim religious leaders as spokespersons for family planning using the fatwa has proven effective and should be used more often.

Grantees with varying levels of expertise are using multiple approaches and resources in the development of information, education, and communication (IEC) strategies and material. Some were able to access technical assistance from other in-country expert groups (e.g., TSAP), while others obtain headquarters expertise.

Recommendations

In-country technical assistance should be provided to grantees in the development of effective communication strategies, including IEC materials. Mechanisms should be established that would enable the grantees to readily access available technical expertise in the development of strategies and materials to promote the fatwa among Muslim religious leaders across the ARMM.

The grantees should expand the promotion of the fatwa to other nonproject sites. Intensified efforts should be spent on conservative Muslim religious leaders to gain their acceptance and endorsement of family planning. Grantees should uniformly promote the use of Muslim religious leaders as advocates or spokespersons for FP. Grantees should expand the geographic coverage of advocacy efforts to other segments of the population within project sites.

Grantees should explore the use of highly placed religious leaders (grand mufti) as advisers to facilitate advocacy among conservative Muslim religious leaders.

Grantees should organize Muslim religious leaders into an active advocacy body to promote adherence to the fatwa among their members, hold regular discussions, and develop uniform health and family planning messages, particularly during Friday sermons in the mosque.

The project should engage an independent body to monitor and evaluate the effectiveness of communication strategies. To ensure objectivity, this responsibility should not be undertaken by the implementing grantees.

The project should continue the implementation of regional observation study tours for Muslim religious leaders to facilitate sharing information, strengthen support for advocacy, and unify all Muslim religious leaders towards the promotion of family planning.

Knowledge, Attitudes, and Practices (KAP) Constraints

Knowledge

Fear of side effects is still considered the leading cause of resistance toward the use of modern contraceptives (oral and injectable contraceptives) at project sites of the ARMM. Currently, only 11 percent of women of reproductive age are using modern contraceptives in the ARMM, while the national average is 33 percent. There are strong misconceptions about the safety of oral and injectable contraceptives. The limited knowledge about FP methods and their safety is largely a function of poor counseling.

There are still major segments of the ARMM population that believe that FP is haram (bad), particularly the use of artificial methods, and that the Quran prohibits its use. For this group, natural methods are the only ones acceptable.

Family planning injectable contraceptives are still believed by many to be abortifacients. While injectable contraceptives are the preferred method of most working women, many feel that, aside from the common belief that Depo-Provera or tugsok is an abortifacient, it also causes amenorrhea and can interfere with their praying duties.

Attitudes

The lukewarm attitude of most women in the ARMM towards family planning is largely a function of their attitude that wives should be submissive to their husbands. Most of them are not empowered to refuse their husbands, even if the liaison will likely result in conception. Women also feel that, generally, husbands do not approve of family planning and would likely resent their wives practicing it.

While the Quran is explicit about the need for birthspacing to protect the health of the mother, there is still a prevailing general attitude that children are blessings from Allah and therefore should not be controlled.

Many women in the ARMM also believe that fertility is a desirable female attribute, and the earlier the woman can demonstrate it, the more acceptable she becomes.

There is a political dimension to the general attitude toward family planning. A common perception is that the promotion of birth control in the ARMM is the government's way of reducing the Muslim population. It is likely that such interpretations came from Muslim political leaders.

However, there is a strong, positive attitude toward birthspacing. Many believe that the spacing of birth is indicated in the Quran as a way to protect the health of mothers, and is one of the ways to ensure the quality of children.

Practices

The practice of birth control among the uninformed population is highly influenced by folkloric beliefs (e.g., jumping up and down after intercourse to prevent implantation; use

of herbs, liquor, or paracetamol to prevent conception). These practices are believed to be more pervasive among rural populations.

It is obvious that current practices are highly influenced by inadequate knowledge, particularly that the safety of artificial methods remains poorly understood (e.g., condoms can become dislodged in the uterus, pills can cause tumors and make the user fat, bilateral tubal ligation can make users oversexed, injections cause amenorrhea and interfere with praying duties).

Recommendations

While there are indications that KAP on FP is poor, it is not possible to validate findings in the absence of an independent evaluation on KAP in the entire ARMM. Current findings, obtained from discussions with health workers, are still considered anecdotal. Because of this, it is recommended that a KAP evaluation be included in the planned health facility assessment for the ARMM.

Expanded and intensified implementation of effective counseling is required in order to address the major misconceptions and misinformation on the effectiveness and safety of modern FP methods.

Because the husband's role is critical in the woman's decision, IEC and counseling efforts should be focused on the couple as a unit in order to increase male involvement in the decision.

The project should implement creative strategies to unify all sectors in support of FP (e.g., adoption of regional best practices).

RELEVANCE OF STRATEGIES

Community Mobilization

The development of strong community organizations was the most outstanding strategy used by grantees to improve the delivery of health services and the mobilization of resources. Their success in forging truly multisectoral community organizations with the active participation of the provincial government, Muslim religious leaders, key municipal and barangay leaders, and volunteer health workers, working collaboratively to provide for the health needs of the community members, is commendable. The fact that the motivation of members is not based on monetary considerations presents a strong argument for the likelihood of sustainability; civic duty and the sense of ownership appear to be the driving force for cooperation.

The strategy of forming strong community organizations complements the government's efforts in strengthening service delivery points (rural health units and barangay health stations). Combining these strategies strengthens the delivery of health services.

Similarly, the resulting strong community participation of members is essential for ensuring sustainable development. The burden of providing health coverage then becomes a shared responsibility of the community and government.

The grantees have developed many variations in the formation of community groups. HKI formed barangay health teams in Lanao del Sur, CCF organized community health committees, ACDI/VOCA composed healthy family coalitions, and SCF formed barangay health teams and committees.

While the rationale for development is similar, each strategy was customized to the need of the community. These multivaried approaches will provide the project with a rich collection of best practices that will be valuable for replication and/or expansion.

CCF and ACDI/VOCA, recognizing the strength of the community organizations, formed and registered their associations with the Securities and Exchange Commission as a way to protect their interests and use their legal personality as a means to access additional support from other government entities or donor groups. HKI and SCF are currently working on a similar registration process. There is a need to document best practices in order to facilitate the replication and expansion of strategies in other municipalities of the ARMM.

The strong participation of LGU leaders, particularly chairmen on the Committee on Health in the Sanggunian, and barangay captains in these community organizations make the unit even stronger, and further enable the association to be integral to the LGU health delivery system.

Other outstanding strategies implemented by grantees and community organizations in the ARMM include the

- use of radio for distance learning (in Tawi-Tawi, an ACDI/VOCA–sponsored distance-learning program was attended by 310 community health volunteer workers and over 50 barangay health workers, which proved to be an effective vehicle not only for reaching a wide audience with health messages but also for improving the general knowledge of health workers);

- use of a floating clinic as a way to reach remote populations not accessible by land transportation;

- provision of contraceptives and other essential drugs (such as those for tuberculosis treatment) when commodities are unavailable;

- construction of service delivery points (barangay health stations) in areas where they are most needed, particularly when government resources and political will are limited;

- implementation of numerous skills training programs to upgrade the skills of health workers;

- provision of small operating expenses to facilitate area coverage;

- implementation of observation study tours for Muslim religious leaders to strengthen their advocacy;

- lobbying for provisional health office support for drugs when commodities are limited; and,

- ability to be flexible (both grantees and donors) in order to quickly respond to changing needs despite the restrictions imposed under the current cooperative agreements.

Recommendations

The strategy of forming strong community organizations should be continued and expanded to other geographic areas of the ARMM.

Registration of the organizations with the Securities and Exchange Commission provides an additional advantage and should be pursued by all grantees as a way to protect the interests of the group.

The participation of LGU leaders in community organizations is strongly encouraged. This strengthens the organizations and improves their relevance in the LGU delivery system.

Additional incentives, such as training support for starting livelihood activities, should be provided to the community organizations to strengthen motivation and further develop self-reliance. This will enhance the motivation of members to maintain their active participation in community organizations.

Capacity Building

The implementation of numerous skills development training programs for government and barangay health volunteers has contributed to improved capacity. Trained health workers will raise levels of competence and help improve the quality of services.

The use of innovative approaches to training (such as distance learning used by ACDI/VOCA in Sulu, enrolling health workers to complete a basic health course) has provided convenience and has attracted active participation among barangay health workers. Aside from the knowledge and skills of direct participants, the entire radio audience benefited from the airing of essential health messages.

The training provided to traditional birth attendants (pandays) was valuable in upgrading their knowledge and skills, particularly regarding common aseptic practices to reduce infection during delivery and promoting birthspacing among mothers. Many believed that pandays have contributed largely to unsafe delivery practices and are partly responsible for the high maternal mortality rate. However, in the ARMM, pandays are integral to the delivery of health services and are there to stay. Training them is a worthwhile investment that will improve healthy practices. Sustained behavior change communication (BCC) efforts are essential to developing these traditional health practitioners into integral and active deliverers of healthy practices in the community. The operators of Well Family Midwife Clinics are starting to look into the use and

employment of pandays as regular birth attendants in their clinics as an approach to upgrade their skills and institutionalize their profession.

Recommendations

Grantees should continue to expand skills training as part of their capacity building strategies, especially among barangay health workers and specifically among pandays, who otherwise will not have the opportunity to upgrade their knowledge and skills. Training should be extended to other nonproject sites until a critical mass of trained health workers is achieved. In addition, volunteers should also be trained in management, simple financial management, and skills to identify potential sources of funds in order to support the delivery of services.

Panday training should continue and be expanded until a minimum level of knowledge and clinical skills are acquired. Grantees should also continue providing pandays with delivery kits to both emphasize hygienic practices and to minimize the use of hard-to-sterilize traditional instruments. The project should undertake a study to discover the extent to which traditional birth attendants contribute to maternal morbidity and mortality.

Multisectoral Collaboration

The approach in developing multisectoral participation in community organization has proven to be effective not only in expanding the resource base of the organizations but also in reducing resistance to various community programs. It has unified the otherwise fragmented community to work collaboratively toward a common cause.

The grantees' ability to harness multisectoral support, recognizing and accepting the strengths and weaknesses of each sector and promoting collaborative relationships, is commendable. Their success in gaining the strong involvement of the integrated provisional health office in support of service delivery is one of the major strengths of the project.

Their success in obtaining the full cooperation of the Muslim religious leaders is an outstanding achievement. The partnership arrangements with the integrated provisional health office, Muslim religious leaders, barangay key leaders, academics, and community laypersons, all sharing the responsibility for health, are viewed as more sustainable approaches to development.

Recommendation

The multisectoral approach to community development has strengthened and expanded community participation, widened the resource base, reduced resistance, and facilitated the effective delivery of services. This approach should be continued and adopted by all entities working in the area.

ADVOCACY

Advocacy is a critical component of the EnRICH strategy. Grantees worked with three major groups to obtain broad acceptance and to develop strong advocates for the program. These include the political leadership, the community, and the Muslim religious leaders. The roles and influence of each group are equally important in the acceptance and promotion of family planning and maternal and child health as priority areas for development.

Initially, the resistance of Muslim religious leaders towards FP was strong, but the solid advocacy program implemented by grantees changed this resistance to strong support. This was largely a result of the carefully crafted advocacy strategy that included observation study tours for Muslim religious leaders, involvement of these leaders in community organizations, a public relations campaign with Muslim religious leaders, the use of the grand mufti's prestige in support of the fatwa, and the development and dissemination of provincial versions of the fatwa.

Advocacy efforts directed at provincial government leaders were also partly responsible for their strong support of community programs. Most provisional health offices are supportive of the programs and have provided provincial resources to facilitate implementation.

Community advocacy efforts were also effective in bringing the community together to support the delivery of services.

Recommendations

Grantees should continue their strategy of maintaining strong advocacy and partnerships with the integrated provisional health office. Participation of provisional health offices should be integral to the implementation of activities.

Grantees should strengthen advocacy with the regional ARMM office and provincial and municipal local chief executives, enjoining their support for the delivery of services. Regular feedback should be provided to the regional, provincial, and municipal chief executives, not only on the implementation of activities but also on the achievements of the project.

Grantees should continue their practice of routinely inviting local chief executives to all community functions, particularly work planning meetings. This would add to the LGU's sense of ownership of projects.

Grantees should use the mussawarahs of Muslim religious leaders as forums for the discussion of FP and health issues. Observation study tours for Muslim religious leaders within the region should be continued and expanded as part of the advocacy strategy.

GEOGRAPHIC COVERAGE AND TIMEFRAME

The grantees of the EnRICH project currently provide support to the following municipalities of the ARMM provinces:

- HKI covers 6 out of municipalities in Lanao del Sur, plus one city;
- SCF covers 3 out of 18 municipalities in Sulu;
- ACDI/VOCA covers 5 out of 10 municipalities of Tawi-Tawi; and,
- CCF covers all 6 municipalities of Basilan.

EnRICH covers a total of 340 (out of 1,897) barangays in the four provinces of the ARMM (except for Maguindanao). While substantial as an initial strategy, project impact is largely limited to the selected project sites, and will not be sufficient to demonstrate regional impact. It is not possible to cover all areas of the ARMM, since many areas are not accessible. However, there are a number of municipalities where conditions are conducive for success. These municipalities have been identified by the provisional health offices and have indicated a willingness to implement the project.

The two-year timeframe for project implementation is considered too short to achieve meaningful results, especially when implementation time is further reduced by the peace and order situation.

Recommendation

To increase its impact, it is strongly suggested that the project be expanded to other geographic areas of the ARMM. For example, in Sulu, three additional barangays in Indanan and three in Patikul and Panguntaran Island have been identified as ideal expansion areas. These are the areas where FP and health statistics are very low; however, conditions are conducive to success with the strong support of the local chief executives. The selection of the expansion site should be jointly done by the provisional health offices, the grantees, and the local chief executives to facilitate ownership and the sharing of resources.

PROJECT ACCOMPLISHMENTS

Much has been accomplished over a short period of 18 months. For example, as of March 2004, a total of 17,207 new FP acceptors for modern methods were achieved in the four provinces of the ARMM (Lanao del Sur: 6,775; Basilan: 1,256; Sulu: 1,248; and Tawi-Tawi: 7,928). A total of 647 tuberculosis smear positives have been detected and treatment was started in three provinces (Basilan: 110; Sulu: 286; and Tawi-Tawi: 251). HKI reported a dramatic increase in vitamin A coverage for children under 5, from 78.8 percent in 2002 to 86.2 percent in 2003.[2] A similar trend was also visible for immunization coverage.

Before EnRICH, FP and tuberculosis program coverage was virtually nonexistent, due to DOH budgetary limitations. The ARMM budget covered only salaries, with no allocation for FP and health program expenses. For grantees to achieve this level is remarkable, considering the major program limitations. In fact, the project may have been able to show additional results if the ARMM had reliable baseline information.

[2] Grantees derived their data from cluster surveys conducted in early 2003, which may vary from such national indicators as the NDHS.

However, one of the most remarkable achievements is the success in forging truly multisectoral community organizations, with the active participation of the provincial government, Muslim religious leaders, key barangay leaders, and volunteer health workers, working collaboratively to provide for the health needs of community members. The motivations of members are not based on monetary considerations, which presents a strong argument for sustainability. Civic duty and a sense of ownership appear to be the driving forces for cooperation. Strong community organizations not only complement the government's efforts in strengthening service delivery points (rural health units and barangay health stations), but are essential for ensuring sustainable development. Now, the burden of providing health coverage becomes a shared responsibility of the community and government.

Grantees have developed many variations in the formation of community groups. HKI formed barangay health teams in Lanao del Sur, CCF organized community health committees, ACDI/VOCA composed healthy family coalitions, and SCF formed barangay health teams and barangay health committees. CCF and ACDI/VOCA, recognizing the strength of the community organizations, formed and registered them with the Securities and Exchange Commission as a way to protect their interests and use their legal status as means to access additional support from other government entities or donor groups. HKI and SCF are currently working on a similar registration process. There is a need to document best practices in order to facilitate the replication and expansion of strategies in other municipalities of the ARMM.

MANAGEMENT OF THE PROJECT

In general, the management of the project by grantees is appropriate. Essential project staff members were assigned to the project site to work with stakeholders and oversee project implementation activities. Most of the local staff hired locally are residents of the community. This practice was largely instrumental in achieving community acceptance and cooperation.

Management decisions were mostly made at the project site level, which also adds expediency and responsiveness to the decision-making process.

Allocation of resources is not rigid and is often responsive to the needs of the program. For example, CCF allocated funds for drug procurement, and SCF appropriated funds for the construction and upgrading of barangay health stations and health facilities and provided small operating expenses for barangay workers.

Recommendations

The practice of hiring local residents to implement the project should be observed by all grantees as standard policy. This will enable the project to be easily accepted and assimilated into the community. Local staff members are not only familiar with specific cultural and program constraints but also understand security impediments, which is valuable to the project. It is suggested that project staff reside in their respective areas of assignment to make them closer to and to become integral members of the community. It will also enable them to respond quickly and to effectively implement and monitor project activities.

Grantees should access expertise from other cooperating agencies (CAs) or elsewhere to assist in the development of strategies and implementation plans, particularly for activities outside their areas of expertise.

Project performance evaluations should be undertaken by an independent body to maintain objectivity and should be based on relevant and mutually acceptable indicators.

Allocation of resources should be flexible enough to maintain the maximum responsiveness to need. The approval of the donor agency to flexible spending is an asset that enabled the project to be responsive to the needs of the community. This practice should continue, particularly in cases where the appropriate support systems from other sectors of the government are not yet in place. Grantees should also have the facility to provide their own funds to support other critical expenses when needed.

SUSTAINABILITY

The development of strong community organizations provides a strong argument for sustainability, particularly when there are no monetary considerations to motivate members. These community organizations, motivated by a strong sense of civic duty, will likely stay for the long term. It is apparent that the community leaders who serve as strong advocates for the community organizations have already internalized the need and have a full appreciation of the organizations' benefits to the community.

Registering the newly formed community associations with the Securities and Exchange Commission, as in the cases of Isabela and Indanan, are also strong indications of forward planning and that the leaders view the organizations as viable units that will stay for the long term.

For example, the Healthy Family Coalition (HFC) formed in Tawi-Tawi has multisectoral membership with the strong endorsement of the provisional health offices and barangay leadership. It is likely that these political leaders will not only protect the interests of the coalition but will also empower it to implement local programs in the community. There are no other organizations in the community with a stature similar to the HFC. FP and health services for its members have become a strong unifying force for involvement. The strong sense of ownership among members will be instrumental in propelling the organization to achieve more in terms of its objectives.

The traditional system, in which LGUs reach out to communities to support government-formulated programs, has not been as effective, as the need was not identified from within the community and member appreciation is not as strong. In contrast, organizations formed by the community in response to need are not only stronger but will likely be protected and supported by members; participation is stronger with community organizations developed out of need. It is to the advantage of the LGUs to have numerous strong community organizations within their jurisdictions, as these politically independent units are likely to remain viable. Strong community organizations are long lasting and perhaps an ideal approach to sustainability.

While it is too early to determine whether these units will be subsumed and supported under the administration of the LGUs, there are already some indications that the barangay leaders have recognized the potent power of the coalitions through their active participation in the organizations.

Recommendations

A transition plan should be developed early in the implementation of community organizations. Community leaders should prepare soon for integration into an LGU's administrative control so that the LGU can start providing funding support for its activities.

Grantees should endeavor to register all community organizations that have been formed with the Securities and Exchange Commission. In this way, the interest of the individual organization is protected and the association functions as an official body that can receive development projects or other sources of outside funds.

The development of working relationships with other government agencies and reporting and information systems should continue until an appropriate process and reporting system is installed.

Members of the association should receive additional training on the basic skills of financial management, resource identification, and mobilization. An advisory body at the municipal or provincial level should be formed to provide guidance to the barangay association. Reporting and feedback systems for local chief executives should also be developed to facilitate their participation in the development of the association.

Technical assistance for the development of livelihood projects should be provided to complement the strong desire of these community organizations to develop their income-generating capabilities to provide for their future needs. Donor assistance, however, should be on a timetable to ensure self-reliance within a reasonable period.

GOVERNMENT SUPPORT

The unique administrative structure of the ARMM has created some difficulty for the national government to respond to its needs. Only a limited range of services can be provided without violating the region's autonomous status. It is the responsibility of the leadership of the region to request assistance from the proper government body. For example, the regional office can lobby the Department of Budget and Management for an additional maintenance, operating, and other expenses allocation as part of its internal revenue allotment.

Recommendation

As discussed earlier, grantees should facilitate and serve as negotiators to enable the regular discussion of provincial health needs. LGU participation should be clarified, particularly its contribution to the delivery of services.

Grantees should continue to hold observation study tours for community leaders where regional best practices are shared. Two examples are the mayor of Concepcion, Iloilo, who was able to mobilize outside resources despite a limited internal revenue allotment, or a town in Guimaras, Iloilo, where the internal revenue allotment was small but the town was still able to construct barangay health stations in areas where they were needed.

PROGRAM CONCENTRATION

Grantees are involved in providing technical assistance through a broad range of services. Some services required some level of expertise, particularly if strategies have to be developed to address them. For example, SCF is responsible for implementing activities to improve tuberculosis case detection and treatment, and HKI works in FP. While there are some complementarities to the assistance provided, subject matter expertise is essential for strategy formation.

Recommendations

While grantees have performed well with all components under their charge, their achievements in their areas of expertise are outstanding. This comparative advantage needs to be optimized and will require concentration in their competency areas. A mechanism needs to be established where subject matter expertise is provided to grantees, particularly during the formation of strategies in areas outside their expertise. Grantees should also access available expertise within their organization or elsewhere to ensure a high level of competence.

III. FUTURE PROGRAM FOCUS AND NEXT STEPS

The follow-on project should focus on maintaining that which has been achieved. Best practices should be enhanced and implemented in other areas of the ARMM. Additional efforts should be made to create a mechanism that will foster regular discussions among key government leaders of the region, provinces, and LGUs. The long-term solution to the problem lies in the strong collaboration of these bodies in the programming and sharing of resources in the development of the ARMM.

Baseline data should be developed quickly to guide implementation. The strategy and components of the follow-on project should also be developed quickly to ensure continuity and a seamless project implementation.

There is strong logic for the current LGU's Local Enhancement and Development (LEAD) for Health Project to access the support of the current EnRICH grantees for the implementation of LGU activities in the ARMM. While this optimizes the resources and expertise already developed, there is also the potential for reducing the effectiveness of the grantees, particularly if their resources are not expanded or are divided to cover both project activities. In the event that the grantees will also implement LEAD for Health, their resources should be clearly defined to support the objectives of both projects and to ensure that their attentions are not divided and that they do not lose their effectiveness.

EnRICH established community organizations that brought together stakeholders from many sectors. This early and increasing awareness has been very evident, and there are trends toward increasing use of services.

At the same time, EnRICH is addressing the issue of upgrading health facilities and improving skills of providers through training in anticipation of increased demand. Along with these, certain basic skills are also provided to community volunteers, especially in the remote areas.

The formalization of community organizations through registration with the Securities and Exchange Commission is expected to ensure sustainability, but perhaps only insofar as the existence of the group is concerned. It is recognized that the groups, together with their capacitated and trained members and the systems developed, have to become a part of the LGU. Otherwise, as happens to most community groups, they will always be considered outsiders to the LGU and may be accepted as partners only if the LGU so desires, and only with proper accreditation.

At the same time, these groups, once registered with the Securities and Exchange Commission, may become the first locally originated NGOs in the area.

Members of the community groups may become barangay health workers of the LGU and may then receive regular allowances. The groups themselves may also become part of the LGU by representation on the health board or other committees.

It is to be expected that the arrangement may give groups or their members some political identification and therefore may subject them to the consequences of changing political

leaders. However, this can be minimized if the groups have very significant numbers or are inherently influential, as with an advocacy group of Muslim religious leaders. Also, in areas where trained members of community groups have demonstrated their capacity to provide assistance at either the individual or community level, the residents would not allow their separation from service. For example, trained members who have assisted patients with diarrhea using oral rehydration, or who provided emergency care and preparation for the transportation for injured patients, will be held in high regard by the community. This is also true for those who provide leadership, guidance, and intervention during disasters and calamities.

It is strongly recommended that the EnRICH project initiate interactions with the LGUs in their areas of operation as soon as possible. The LGUs need to be informed of the project and its goals, and the grantees need to demonstrate that their established groups and systems fall within the menu of services, systems, and duties of the LGUs. The members of groups and teams have already been trained and some facilities have been upgraded. This will greatly increase the LGUs' capability to meet increased demand, widen the reach of services, and improve quality.

ADDITIONAL RECOMMENDATIONS

Continue and geographically expand the EnRICH project. Two years is too short to realize a meaningful impact of family planning acceptance and the effectiveness of health interventions. The continuing disruptions caused by the peace and order situation, geographic distance and inaccessibility of many areas, and the difficulty in fielding project staff have further reduced the productive implementation time of the project. Most of the grantees are in the midst of implementation and time has expired. New start-up efforts will affect momentum and continuity of implementation. A timeframe similar to other project funding cycles (five years) should be provided to the follow-on EnRICH project. The current 24 percent project coverage of selected ARMM municipalities is limited in achieving a significant impact on both regional and national indicators. While there are still many municipalities in which coverage is risky or virtually impossible, grantees have already identified some where conditions are conducive. The provisional health offices have identified these municipalities and the local chief executives have expressed their readiness to implement the project.

Expand project components. The improvement of health conditions in the community requires an integrated approach. While current strategies are based on greater need given the resource limitations, the overall effectiveness of the strategy is weakened when certain needs of the population are not addressed. The implementation of four additional project components is recommended.

- **Adolescent reproductive health (RH)**: While data are limited, adolescent RH is recognized as one of the unmet needs in FP. There are currently no services available to adolescents. Studies show that adolescent needs for FP are as important as adult needs and need to be addressed. SCF has recognized this as a gap in its program and has included it in future plans.

- **Functional literacy program**: This program is specifically intended for female populations. Where female literacy is low, the ability of the program to

reach women and girls with FP and health messages will be limited. Awareness will continue to be low, and empowering women will be an arduous task.

- **Disaster relief and preparedness of the community**: Grantees believe that the state of readiness and response capabilities of communities to impending disasters is low. In the event of a regional or national disaster, communities that are less prepared would suffer the most and have the hardest time coping.

- **Livelihood projects**: Achieving sustainability will be difficult unless communities achieve economic self-reliance. A majority of the communities in the ARMM are poverty stricken, and opportunities and resources are severely limited. The cycle of poverty, despondency, and dependence is difficult to break when communities do not have an economically viable livelihood. There is a need for assistance with income-generation projects, particularly for communities that have already organized themselves into community enterprises. To enable these communities to continue their path to self-reliance, technical assistance and an enabling environment have to be provided. Activities under this component may include livelihood skills development, marketing assistance for local products, and entrepreneurial training. The needed technical expertise may be drawn from some of the grantees that are already providing this kind of assistance in their current program.

IV. CONCLUSION

The EnRICH project has set the stage and the framework for the follow-on project. Grantees have successfully formed and empowered strong community organizations. There is evidence that these community organizations, operating under the power of volunteerism, will stay for the long term and will be the best instrument for sustained development. Grantees have also demonstrated their tenacity, performing under the most difficult circumstances and security risks. Best practices have been identified from the multiple strategies implemented to achieve the desired health outcome. Political and administrative challenges have also been identified, and solutions have been developed to address them. The winning strategies will now provide the foundation upon which to build. However, grantees still need time to complete what they have started; the time provided to date was too short to enable the achievement of meaningful results. The ARMM needs the EnRICH project to complete its development, and the project needs to continue and be expanded to other areas of the ARMM. The lives saved and the health of mothers and children improved are more than commensurate returns on investment.

APPENDICES

A. SCOPE OF WORK

B. PERSONS CONTACTED

C. AUTONOMOUS REGION OF MUSLIM MINDANAO TABLES

D. DATA FROM THE ENRICH PROJECT GRANTEES

APPENDIX A

SCOPE OF WORK
(from USAID)

STATEMENT OF WORK
FOR THE ASSESSMENT
OF THE
ENHANCED AND RAPID IMPROVEMENT OF COMMUNITY HEALTH
(EnRICH) Mindanao Project

I. Background

Health indicators in the Autonomous Region of Muslim Mindanao (ARMM) are way below national averages. Vitamin A deficiency is most severe in this conflict-torn area at 44.5% compared to the national average of 85.6% (2002 Maternal and Child Health Survey, Philippine National Statistics Office). The region also has the lowest immunization coverage (24% vs. 65.2% national) and the highest infant mortality rate at 55 infant deaths per 1,000 live births.

What makes the low health indicators doubly alarming is that ARMM is also faced with the highest poverty rate in the country. Its 2.4 million populace is growing by 3.86% with most families having an average household size of 6.13 – again, the highest nationwide. Family planning use is very low at 8.1%.

These extreme health, poverty and population growth figures are complicated by decades-long political conflicts making ARMM a major challenge for USAID health and nutrition efforts.

As a response from USAID, EnRICH was launched on September 2002. Considered to be the most significant innovation in improving health services in ARMM, it aims to revive community health systems to improve health outcomes and strengthen confidence in government services. Four grants, ranging from $500,000 to $1 million have been awarded to four US PVOs for a total of $2.8 million.

Areas of intervention include management and clinical skills training for health providers and local partners, linkages with local organizations to facilitate implementation and ensure sustainability, upgrading of primary health facilities, behavior change campaigns to improve health seeking behavior regarding family planning and TB, and installation of information systems.

Project period is from October 2002 to September 2004.

The grantees and areas of work are as follows:

1. Christian Children's Fund (CCF) - Basilan Province

Major Interventions: Family Planning
Tuberculosis treatment and control

Maternal and Child Health (MCH)

Implementing Partners:

- Isabela foundation
- Parents' Associations
- Provincial Health Office, Basilan

2. Helen Keller International (HKI) - Lanao del Sur Province

Major Interventions: Family Planning
Integrated Management of Childhood Illnesses (IMCI)
Vitamin A Supplementation
Tuberculosis Control and Treatment

Implementing Partners:

- DOH-ARMM
- Provincial Health Office, Lanao del Sur

3. Save the Children (SCF) - Sulu Province

Major Interventions: Family Planning
Maternal and Child Health

Implementing Partner:

- Provincial Health Office, Sulu

4. ACDI/VOCA – Tawi - tawi

Major Interventions: Family Planning
Maternal and Child Health

Implementing partners:

- Provincial Health Office of Tawi-tawi
- Neighbors Population and Development Services and
- Mindanao State University.

II. Rationale for the EnRICH Program Review

The primary objective of the assessment is to evaluate the implementation and progress of EnRICH and to provide recommendations for future directions/actions in ARMM

III. Statement of Work

A three-person team of consultants will be responsible for conducting a comprehensive review of the EnRICH program implementation. The team shall formulate recommendations to provide guidance to the mission on the possible next steps for the ARMM.

In particular, the team shall conduct an assessment of the following:

A. Assessment of Management Structure and Processes
- Assess the design and implementation process
- Were the strategies and activities appropriate to meet project objectives? What strategies and approaches work or did not work? Why or why not?
- What were the effects of external and unanticipated actions and/or events on the project, if any?
- How did the DOH-ARMM manage the implementation of the project and how effective was this management process?
- How did the LGU manage the implementation of the project and how effective was this management process?
- How did the PVO manage the implementation of the project and how effective was this management process?
- How did USAID manage the process from its end? Was it effective? Why or why not?

B. Assessment of Sustainability
- Examine post-EnRICH sustainability (DOH/ARMM, PVO)
- What are the plans of the LGU/PHO for sustaining systems and measures developed under the project upon termination of USAID assistance?
- Assess if present approach is worthy of emulation – how can effectiveness and efficiency of this approach be further improved?
- For activities that involved the participation of LGUs/local communities, what were the processes found effective and ineffective in terms of: 1) obtaining and sustaining community participation 2) getting an outside entity/organization (like the PVO and its consultants) to be accepted

C. Assessment of Project Outcome/Impact
- Measure extent to which project achieved its purpose level objectives.
- Extent to which project affected efforts to reduce infant and maternal mortality, increase FP coverage and demand for FP services, etc.
- Suggest ways in which project might achieve greater impact.

IV. Scope of the Review

The program review will cover the period from the signing of the EnRICH cooperative agreement (September 2002) until the time of review. Activities in selected municipalities at the following project sites will be examined:

A. Lanao del Sur
B. Basilan
C. Sulu
D. Tawi-tawi

V. Methodology

Review of project documents and reports; interviews with key USAID personnel and program managers, staff of EnRICH grantees and their partners, DOH – ARMM, municipal mayors, ARMM provincial and municipal health officers, health workers and clients: field trip to project sites.

Project documents to be reviewed include the following:

A. EnRICH Request for Applications (RFA)
B. EnRICH workplans
C. EnRICH quarterly/annual reports
D. Other relevant documents

Background documents will be provided to the members of the program review team at least a week before the review process. Additional background materials may be provided at the beginning of the activity.

Key individuals to be interviewed shall include, but are not limited to the following: USAID, other CAs, DOH/Mindanao Health Development Office (MHDO), DOH-ARMM, ARMM Provincial Health Offices and selected municipal mayors. Travel to the region will be limited to Cotabato City, Zamboanga and other ARMM provinces subject to security considerations.

Prior to deployment in-country, team members shall be given two days to review key project documents and reference materials. At the beginning of the work period, the members of the team shall spend one day for team building, briefing with USAID and further studying the basic reference documents. During this period, the team must reach an agreement among themselves on the specifics of the tasks and how to proceed and each member's roles and responsibilities.

The members of the team will report to the team leader. The team leader will report to the EnRICH CTO. Schedule of meetings with the abovementioned key individuals shall be coordinated through the Office of Population, Health and Nutrition (OPHN).

VI. Team Composition and Desired Qualifications

A. (2) Project Evaluation Specialists, with significant experience in family planning, tuberculosis and maternal & child health; extensive experience evaluating health programs and operations.
B. (1) Muslim Health Governance Expert, to provide inputs related to the assessment of health and governance matters relating to the ARMM regional government, provincial health offices, health providers and clients of health services; provide recommendations for future improvement of health interventions in the Muslim context.

VII. Work Requirements

POPTECH will be responsible for the following:

1. Development of assessment design and instruments
2. Fieldwork and data collection and analysis
3. Preparation and production of reports
4. Results dissemination

VIII. Reporting Requirements

1. Assessment Design
2. Draft Assessment Report
3. Draft recommendation for USAID comments
4. Final report containing the following:
   a. Executive Summary (stating findings, conclusions, recommendations)
   b. Table of Contents
   c. Body of Report (including brief program description, the environment in which the project operates, a statement of methodology used, major findings and recommendations)
   d. Annexes (including the SOW, list of persons/consultants interviewed, background supplemental materials useful for a better understanding of the report, annotated bibliography of pertinent documents used or consulted, and a list of acronyms)

IX. Timeframe

The activity should be completed in 6 weeks:

Briefing with USAID, Review of pertinent documents first 3 days
Review and approval of assessment design

Meetings with EnRICH grantees (Manila) 1 week

Assessment activities / Travel to ARMM 4 weeks

(meetings/interviews with DOH-ARMM
PHOs, clients, EnRICH field offices)

Draft report development, presentation to USAID last week

Final Report last week

X. Logistics

Contractor is responsible for arranging travel, office space, secretarial/logistical support and communications. In addition, the team leader is responsible for the draft and final report development as well as other eligible expenses associated with the completion of the program review.

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

MINDANAO, PHILIPPINES

Cotabato City
Dr. Lampa Pandi, Assistant Secretary of Health, Autonomous Region of Muslim Mindanao (ARMM)
Dr. James Maminte, Chief, Technical Services Division, Department of Health, ARMM

Christian Childrens' Fund, Basilan
Dr. Mitzi-Ann Casinillo-Erosido, Health Officer
Ms. Elisa del Puerto, Project Coordinator
Mr. Romy Perez, Behavior Change Communication Officer
Ms. Expectacion Cuevas, Community Development Officer
Ms. Teresita Illahi, Community Development Officer
Ms. Lorna Sahirin, Community Development Officer
Ms. Philma Tahalang, Community Development Officer
Ms. Hapira Alasa, Community Development Office
Mr. Harrybert Hajala, Officer-in-Charge, Integrated Provincial Health Office
Dr. Remus Dayrit, Director, Basilan General Hospital
Ms. Joy Puno, Family Planning Coordinator, Isabela City
Dr. Ana Tarabin, Health Officer, Lantawan

Integrated Provisional Health Office, Lanao del Sur
Dr. Linang L. Adiong, Provincial Health Officer I
Eli Santos, Jr., Administrative Officer III
Ms. Adelfa Manabilang, Reproductive Health/Family Planning Coordinator
Ms. Anacorita Evangelista, EPI Coordinator
Ms. Nelia Sarap, Nutrition Coordinator
Ms. Edna Rosa, National Tuberculosis Program Coordinator
Ms. Marilyn Santos, Malaria/Dengue Coordinator
Ms. Baimona Guiling, Nurse, Tamparan District Hospital
Dr. Aida Abaton, Municipal Health Officer, Balindong
Dr. Amer Saber, Director, Amaypakpak Hospital

Saguiaran, Lanao del Sur
Dr. Amoran Sampal, Municipal Health Officer
Ms. Magdaline Anticamara, Public Health Nurse
Ms. Omaira Macadub, Public Health Midwife
Ms. Bolawan Bayanan, Public Health Midwife
Ms. Sandor Panandigan, Public Health Midwife
Ms. Rocaira Botawan, Public Health Midwife
Ms. Mila Mapandi, Public Health Midwife
Ms. Sandor Balang, Public Health Midwife
Ms. Marian Bato, Public Health Midwife

Tawi-Tawi
Dr. Sukarno Asri, Provincial Health Officer
Ustadz Alih Bud, Dean, Center for Islamic Studies, Mindanao State University
George Malbun, Administrative Officer III, Integrated Provincial Health Office
Haja Jocelyn Bulante, Provincial Health Nurse, Bongao Rural Health Unit
Haja Ganda Jaani, Councilor, Municipality of Bongao
Ustadz Hairol Jamad, Healthy Families Coalition, Bongao
Ms. Edwina Jumsali, President, Barangay Health Workers Federation, Bongao
Mr. Felix Rosario, President, Neighbors Population and Development Services (NPDS), Zamboanga City
Dr. Moh. Shan J. Abdulwahid, Public Health Specialist, ACDI/VOCA
Ms. Karen Joy Lipio, Barangay Health Workers Distance Education Coordinator
Altreeke Dayan, Municipal Coordinator, Bongao
Fauzuddin Sarani, Municipal Coordinator, Tandubas
Sitti Rahma Jalmaani, Municipal Coordinator

Jolo, Sulu
Mercilyn Abdulhusin, Barangay Health Team, Mauboh, Patikul
Nancy Sadjail, Barangay Health Team, Bankol, Patikul
Ahmed Amilhemja, President, Barangay Health Team, Asturias, Jolo

Integrated Provisional Health Office, Jolo
Dr. Fahra Tan-Omar, Provincial Health Officer
Yussah Baddong, Project Manager, Save the Children Fund

MANILA, PHILIPPINES

U.S. Agency for International Development
Carina Stover, Chief, Office of Population, Health and Nutrition
John Wesley Dulawan, Project Development Specialist/Cognizant Technical Officer, EnRICH Project
Maria Paz G. de Sagun, Project Management Specialist, Office of Population, Health and Nutrition

John Snow, Inc.
Easter Dasmarinas, Resident Advisor
Nitz Bonsubre, Technical Officer

Management Sciences for Health, LEAD for Health Project
Jose Rodriguez, Director, Family Planning and Health System Unit
Ed Dorotan, Director, Local Government Unit
Mario Taguiwalo, Consultant
Bill Goldman, Chief of Party

Helen Keller International
Ellen Villate, Country Director
Eva Puertollano, EnRICH Project Manager
Limpa Pandi, EnRICH Coordinator

Christian Children's Fund
Ma. Saturnina L. Hamili, National Director
Vilma P. Albano, Finance and Administration Manager
Loide dela Cruz, Sponsor Relations Manager
Fatima Portugal, Executive Assistant/Grant Coordinator
Raymundo Gonzaga, Technical Coordinator
Reybert Calubayan, Program Officer
Ludy Dehit, Behavior Change Communication Officer

Save the Children Fund
Mel Capistrano, Country Director

ACDI/VOCA
George Dalire, Country Director
Jennifer Bernardo, Associate Director

The Social Acceptance Project (TSAP), Academy for Educational Development
Nora de Guzman, Chief of Party

APPENDIX C

AUTONOMOUS REGION OF MUSLIM MINDANAO TABLES

Table 1
Autonomous Region of Muslim Mindanao (ARMM)
Regional Profile

Indicator	National	ARMM
Population	76,498,735	2,951,888
Population Growth Rate	2.36%	3.86%
Life Expectancy at Birth	67.2 years	57.1 years
Maternal Mortality Ratio	180/100,000 live births	320/100,000 live births
Infant Mortality Rate	35.3/1,000 live births	55.1/1,000 live births
Household Size	5.0	6.13
Contraceptive Prevalence	48.8%	16.2%
Unmet Need for FP	20.5%t	35%
Crude Birth Rate	26.78/1,000	27.36/1,000
Crude Death Rate	5.89/1,000	9.51/1,000
Poverty Incidence	31.8%	71.3%
Literacy Rate	83.3%	61.2%
Total Fertility Rate	3.73	4.61

Table 2
Comparison of Budget Lines of Maintenance, Operating, and Other Expenses
by Region (2002)

	CHD* IX	CHD X	CHD XI	CHD XII	CARAGA	ARMM
1. **General Administrative Support**	7,041	2,487	9,509	9,019	4,113	
Regional Office						9,698
IPHO/Hospitals						74,632
2. **Support to Operations**	4,766	3,194	4,421	2,525	343	None
3. **Operations**						
Enforcement and Implementation of Regulations, Standards and Licensing of Health Facilities	2,287	6,924	3,703	6,139	2,089	None
Health Operations, Including Tuberculosis Control, Disease Prevention and Control, Health Promotion, and Other Health Operations	3,350	22,655	34,586	16,965	20,347	None
Local Health Assistance, Including Local Health System Development, Provision of Logistic Support to Local Health Programs, and Assistance Fund to Support Quality Assurance in LGUs	7,342	21,069	22,693	15,599	14,219	None
Support to Social Health Insurance and Other Community Health Care Financing	720	3,590	1,300	775	736	None
Health Facilities Direct Service Delivery	103,716	108,752	10,632	67,692	43,397	None
TOTAL	**129, 222**	**168,671**	**86,844**	**118,714**	**85,244**	**84,330**

*City Health Department

POPULATION TECHNICAL ASSISTANCE PROJECT

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APPENDIX D

DATA FROM THE ENRICH PROGRAM GRANTEES

The information included in this appendix was obtained from the four grantees of the EnRICH project, which was provided to the USAID Mission as part of their self-evaluation process. Numbers and data come from the individual grantees' own cluster surveys, quarterly performance reviews submitted to the Mission, and at times from the Field Health Services Information System. Because there was no common baseline, validating the numbers was not possible for the evaluation team. In a few cases, data are unavailable or incomplete.

The objectives included in the Objectives section correspond to those set forth in the respective cooperative agreements with USAID.

D–I. CHRISTIAN CHILDREN'S FUND (CCF) PERFORMANCE INDICATORS

Family Planning

Project Objectives (Based on USAID Cooperative Agreement)	**Baseline Data**		**Current Data**		**Comments**
	As of Nov. 2003	Source	As of May 2004	Source	
1. Increase modern contraceptives use by 10%	10.9%	Technical proposal (page 14)	1,134 acceptors coming from the 24 barangays: bilateral tubal ligation, 191; oral contraceptives, 726; condoms, 27; Depo-Provera, 190	Project's quarterly report for March 2004	Data for collection: total number of women of reproductive age in 24 barangays/municipalities
2. Increase natural family planning (FP) use by 10%	4.2%	Baseline survey	20 couples are using natural FP	Project's quarterly report for March 2004	
3. Increase knowledge of FP by 20%	93%	Baseline survey	1,016 mothers and 379 fathers participated in Ulama sessions in the community 12,849 mothers and 3,706 fathers attended FP sessions with para-teachers	Project data as of May 2004	
4. Increase by 20% the number of couples who spoke to spouses about FP	68% for Muslims, 79% for Christians	Baseline survey	Needs to have survey for the data	NA	

Tuberculosis

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Nov. 2003	Source	As of May 2004	Source	
1. To establish public/private mix to increase case detection, referral, and treatment					
1.1 Number of public/private mixes established	No public/private mixes existed before the project started	Rural health unit (RHU)	24 community health teams formed, composed of health workers, RHU staff, para-teachers, Ulama, and others	Project quarterly report for March 2004	
1.2 Increase in case detection	To be submitted during the evaluators' visit in Basilan		2,119 tuberculosis-symptomatic patients were examined and yielded 275 tuberculosis positives. All 275 tuberculosis patients submitted three sputum specimens.	Project list of tuberculosis-symptomatic patients as of March 2004	
1.3 Percentage increase in referrals	To be submitted during the evaluators' visit in Basilan		7% referral	Project list of patients transferred out	
1.4 Percentage increase in completion of treatment	To be submitted during the evaluators' visit in Basilan		70% completion rate	Project quarterly report for March 2004	
2. Train 70% of government health workers and community volunteers in DOTS*	To be submitted during the evaluators' visit in Basilan		30 RHU representatives and 410 community health team members were trained in DOTS	Project quarterly reports and records available from project	
3. Implementation of DOTS in four barangays, where 50% of infected patients will complete treatment	DOTS not operational in the RHU	RHU	DOTS is operational in 24 barangays and has treated 70% of 179 total evaluated tuberculosis patients	Project quarterly report	

*Directly observed therapy, short course

Other Process Indicators

Title or Type of Training	Inclusive Dates of Training	Total Number of Participants	Coverage Areas
1. Customized community organizing	September 30–October 2, 2002	12 staff members	Project level
2. Project approaches and strategies	November 11–13, 2002	12 staff members	Project level
3. Community development	December 10–11, 2002 December 12–14, 2002	48 community leaders 48 community leaders	Lantawan, Sumilip, Maluso Tipo-Tipo, Lamitan, and Isabela
4. Reproductive health care training and DOTS	January 2–3, 2003 January 13–14, 2003	12 staff members 42 RHU personnel	Project level 24 areas that EnRICH covers
5. Competency-based training for volunteer health workers for home delivery of FP services	February 12–14, 2003	13 staff members	Project level
6. Competency-based training on FP/tuberculosis and facilitation skills	November 11–13, 2003 November 18–20, 2003 October 11–13, 2003 October 14–16, 2003 November 9–11, 2003 November 13–15, 2003 November 26–28, 2003 November 25–27, 2003 November 4–6, 2003	398	Sumagdang, Lumbang, Tumahubong, Cabcaban town site, Taberlongan, Pamucalin, Pipil and Bohe Lebbung Abunbata, Maligue, Upper Benembengan, Lower Portholland, Tubigan, Atong-Atong, Lagayas, and Bohe Baca Baungos Ulame Maloong San Jose Santa Clara Manggal Tairan Lower Banas
7. National Tuberculosis Program microscopy, reporting, and recording	April 22–23, 2004 April 27–28, 2004 March 30–31, 2004 April 1–2, 2004 April 20–21, 2004 April 23 and 26, 2004 April 14–15, 2004 April 20–21, 2004 April 22–23, 2004 April 28–29, 2004 April 6–7, 2004	410	Sumagdang, Lumbang, Kabunbata, Maligue, Upper Benembengan, Baungos, and Atong-Atong Ulame, Tairan Santa Clara town site Maloong San Jose Manggal Tumahubong Cabcaban, Taberlongan, Pumacalin Lower Portholland Tubigan
8. Tuberculosis case finding and case holding	January 3, 2004	13 staff members	Project level
9. ARMM* community planning	November 11–14, 2003	Two staff members	Project level
10. Parenting, human life congress (Billings method)	October 23–24, 2004	Six staff members	Project level

Title or Type of Training	Inclusive Dates of Training	Total Number of Participants	Coverage Areas
11. Leadership success seminar	February 16–18, 2004	16 staff members	Project level
12. Natural family planning methods	March 29, 2004 December 16, 2003 December 18, 2003 February 10, 2004 February 11, 2004 February 12, 2004 February 13, 2004 April 6, 2004 April 7, 2004 March 22, 2004 March 11, 2004 March 12, 2004 March 19, 2004 March 23, 2004 March 31, 2004 March 26, 2004	28 staff members/RHU personnel 374 community health team members	Project level Cabunbata Maligue Sumagdang Lumbang Baungos Ulame Santa Clara Maloong San Jose Manggal Tumahubong town site Lower Portholland Tubigan Atong-Atong Pamucalin Lower Bañas
13. Standard days method	March 10, 2004 March 5, 2004 March 17, 2004 January 13, 2004 January 27, 2004 March 16, 2004 March 19, 2004 March 18, 2004 March 17, 2004 March 12, 2004 March 11, 2004	28 440 community health team members	Project level Sumagdang, Lumbang Cabunbata, Maligue, Tubigan Ulame Baungos Maloong San Jose, Tuberlongan, Pipil Santa Clara, Lower Portholland, Pamucalin Bohe Lebbung, Cabcaban town site, Bohe Baca Upper Banembengan, Lower Bañas, Lagayas Tairan Atong-Atong
14. Communication planning workshop	December 15–17, 2004	Two staff members	Project level
15. Materials development workshop	March 31–April 2, 2004	One staff member	Project level
16. Pap smear orientation	May 7, 2004	13	Project level

*Autonomous Region of Muslim Mindanao

D–II. SAVE THE CHILDREN FUND (SCF) PERFORMANCE INDICATORS

1. Increased use of modern FP methods in three municipalities (State number of clients as unit of measure)

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of	Source	As of May 2004	Source	The increase in number of new acceptors may be due to heightened campaign of Muslim religious leaders and other FP champion members of the barangay health teams on Islamic perspective on FP
Indanan	4	FHSIS*	45	FHSIS	
Jolo	94	FHSIS	133	FHSIS	
Patikul	4	FHSIS	181	FHSIS	
TOTAL	**102**		**359**		

*Field Health Services Information System

2. Increased use of FP services

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of	Source	As of May 2004	Source	
Indanan	4	FHSIS	45	FHSIS	
Jolo	94	FHSIS	133	FHSIS	
Patikul	4	FHSIS	181	FHSIS	
TOTAL	**102**		**359**		

3. Increased utilization of maternal and child health (MCH) services

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
Pregnant women with three or more prenatal visits	As of	Source	As of May 2004	Source	
Indanan	167	FHSIS	53	FHSIS	
Jolo	619	FHSIS	991	FHSIS	
Patikul	102	FHSIS	168	FHSIS	
TOTAL	**888**		**1,212**		
Pregnant women given tetanus toxoid 2 plus					
Indanan	160	FHSIS	80	FHSIS	
Jolo	382	FHSIS	405	FHSIS	
Patikul	52	FHSIS	224	FHSIS	
TOTAL	**594**		**709**		
Women with at least one postpartum visit					
Indanan	159	FHSIS	97	FHSIS	
Jolo	442	FHSIS	385	FHSIS	
Patikul	91	FHSIS	181	FHSIS	
TOTAL	**692**		**663**		
Postpartum women who initiated breastfeeding					
Indanan	151	FHSIS	94	FHSIS	
Jolo	425	FHSIS	352	FHSIS	The increase of figures attributed to project interventions such as training of barangay health team members in 3-in-1 course on integrated MCH, FP, and tuberculosis control. The reduction of figures in Indanan may be affected by the variable security situation.
Patikul	91	FHSIS	183	FHSIS	
TOTAL	**667**		**629**		
Pregnant women with complete iron dosage					
Indanan	156	FHSIS	73	FHSIS	
Jolo	619	FHSIS	873	FHSIS	
Patikul	20	FHSIS	146	FHSIS	
TOTAL	**795**		**1,092**		
Postpartum mothers given complete iron dosage					
Indanan	159	FHSIS	97	FHSIS	
Jolo	378	FHSIS	355	FHSIS	
Patikul	13	FHSIS	125	FHSIS	
TOTAL	**550**		**577**		
Breastfeeding mothers given vitamin A					
Indanan	152	FHSIS	94	FHSIS	
Jolo	524	FHSIS	510	FHSIS	
Patikul	10	FHSIS	126	FHSIS	
TOTAL	**686**		**730**		
Pregnant women given vitamin A					
Indanan	137	FHSIS	40	FHSIS	
Jolo	0	FHSIS	No data	FHSIS	
Patikul	53	FHSIS	No data	FHSIS	
TOTAL	**190**				
Women 15–49 given iodized oil capsules					
Indanan	120	FHSIS	No supply	FHSIS	
Jolo	463	FHSIS	No supply	FHSIS	
Patikul	3	FHSIS	No supply	FHSIS	
TOTAL	**586**				
Fully immunized children (9–11 months)					
Indanan	170	FHSIS	133	FHSIS	
Jolo	463	FHSIS	683	FHSIS	
Patikul	159	FHSIS	257	FHSIS	
TOTAL	**792**		**1,073**		
Infants exclusively breastfed up to 4 months					
Indanan	152	FHSIS	172	FHSIS	
Jolo	162	FHSIS	397	FHSIS	
Patikul	80	FHSIS	191	FHSIS	
TOTAL	**394**		**760**		

4. Increased use of tuberculosis services

Project Objectives (Based on USAID Cooperative Agreement)	Baseline		Current Data		Comments
Tuberculosis cases	As of	Source	As of May 2004	Source	The reduction in the current figure indicates an improvement in the number of tuberculosis cases, while tuberculosis symptomatic and x ray initiated treatment cases increase were due to the active involvement of the tuberculosis champions of the barangay health teams.
Indanan	19	FHSIS	22	FHSIS	
Jolo	332	FHSIS	182	FHSIS	
Patikul	0	FHSIS	4	FHSIS	
TOTAL	**351**		**208**		
Tuberculosis symptomatic patients with sputum exams					
Indanan	55	FHSIS	41	FHSIS	
Jolo	214	FHSIS	444	FHSIS	
Patikul	23	FHSIS	62	FHSIS	
TOTAL	**292**		**547**		
New sputum-positive cases with treatment initiated					
Indanan	3	FHSIS	6	FHSIS	
Jolo	201	FHSIS	12	FHSIS	
Patikul	0	FHSIS	1	FHSIS	
TOTAL	**204**		**19**		
Retreatment					
Indanan	8	FHSIS	6	FHSIS	
Jolo	19	FHSIS	11	FHSIS	
Patikul	0	FHSIS	0	FHSIS	
TOTAL	**27**		**17**		
X ray initiated treatment					
Indanan	8	FHSIS	30	FHSIS	
Jolo	112	FHSIS	159	FHSIS	
Patikul	0	FHSIS	3	FHSIS	
TOTAL	**120**		**192**		

5. Increased accessibility of FP/MCH/tuberculosis services

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
Number of consultations per barangay health station	As of	Source	As of May 2004	Source	Increases in the number of those accessing FP, MCH, and tuberculosis control services may be due to the opening of newly constructed and renovated barangay health stations, staffed by barangay health teams. Jolo data were drawn from individual reports of rural health midwives assigned in specific barangays as their catchment areas, even if there was no barangay health station in the specific barangay.
Indanan	No data	RHU	486	RHU	
Jolo	3,910	RHU	6,341	RHU	
Patikul	0	RHU	739	RHU	
TOTAL			**7,566**		

6. Increased quality of FP/MCH/tuberculosis services

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of	Source	As of	Source	
Indanan	NA		NA		
Jolo	NA		NA		
Patikul	NA		NA		
TOTAL	NA		NA		

7. Number of barangay health stations (BHS) and barangay health teams providing FP/MCH/tuberculosis services in the following areas: Indanan, Jolo and Patikul (18 barangays)

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Dec. 2002	Source	As of May 2004	Source	
Indanan					
Kajatian	1 BHS	IPHO*	1 renovated	Project data	
Kuppung	0	IPHO	1 BHS constructed	Project data	
Langpas	0	IPHO	1 BHS constructed	Project data	
Manggis	0	IPHO	1 BHS constructed	Project data	
Pasil	0	IPHO	1 BHS constructed	Project data	
Jolo	1 RHU	IPHO	1 renovated	Project data	In Asturias, no BHS was constructed per IPHO advice since the area is being served by the OP departments of the two hospitals in the barangay. Bus-Bus, Chinese Pier, and Takut-takut: no site/lot, or lack of barangay funds for site purchase. Takut-takut is acquiring a site to build a BHS. Bus-Bus and Chinese Pier are adjacent to the RHU.
Alat	1 BHS	IPHO	1 renovated	Project data	
Asturias	0	IPHO	0	Project data	
Bus-bus	0	IPHO	0	Project data	
Chinese Pier	0	IPHO	0	Project data	
San Raymundo	1 BHS	IPHO	1 renovated	Project data	
Takut-takut	0	IPHO	0	Project data	
Tulay	1 BHS	IPHO	1 renovated	Project data	
Walled City	0	IPHO	1 BHS constructed	Project data	
Patikul					
Anuling	0	IPHO	In progress		
Bangkal	0	IPHO	1 BHS constructed		
Maubon	0	IPHO	1 BHS constructed		
Umangay	0	IPHO	1 BHS constructed		
Gandasuli	0	IPHO	1 BHS constructed		
Additional					
Tagbak	1 BHS	IPHO	1	Project data	
Batobato	0	IPHO	In progress	Project data	
Buansa	0	IPHO	In progress	Project data	

*Integrated provisional health office

8. Other Process Indicators

Number of barangay health teams providing FP/MCH/tuberculosis control

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Dec. 2002	Source	As of May 2004	Source	As reported last quarter, there were 424 barangay health team members. Note: There were 10 trainees who missed a day of training and were not considered as graduates. Another 38 trainees were being considered for Jolo at the request of the barangay health committees, in order to fully cover the designated clusters.
Indanan	8	IPHO	82	Project data	
Jolo	26	IPHO	206	Project data	
Patikul	7	IPHO	123	Project data	
Additional three barangays: Tagbak, Batobato, and Buansa	7	IPHO	13	Project data	
TOTAL	**48**		**424**		

Number of barangay health committees

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Dec. 2002	Source	As of May 2004	Source	Before the project started, there was no barangay health committee in Jolo. In the 18 barangays covered by the project, only Asturias had a Barangay Kagawad for Health. Though not covered by the project, barangay health committees were organized in three additional barangays. Residents seek consultation in the project barangay health centers, since no health facilities exist in their areas.
Indanan	0		35	Project data	
Jolo	0		56	Project data	
Patikul	0		35	Project data	
Additional three barangays: Tagbak, Batobato, and Buansa	0		21	Project data	
TOTAL	**0**		**147**		

Note: The barangay health committee is composed of a chairperson (from the Barangay Kagawad for Health), a vice chairperson (the rural health midwife assigned to the barangay health station), five trained members from the barangay health teams (preferably the respective cluster leader), and seven members of the barangay health committees. The Barangay Kagawad on Health and the rural health midwife are both ex-officio positions. The five representatives from the barangay health teams are drawn from the average number of cluster per barangay, in which one cluster is headed by a leader who represents their concerns to the health committee.

Workshops, Meetings, and Conferences

Workshop, Meeting, or Conference	Inclusive Dates	Total Participants from EnRiCH Sulu	Coverage Areas
1. Project Orientation/Planning Workshop, and Orientation on Security Principles and Procedures	October 27–November 1, 2002	7 staff members	Jolo
2. Convergence Meeting of USAID Grantees in Mindanao	November 18–20, 2003	3 staff members	Mindanao-wide
3. Project Plan Review and Pretraining Workshop	December 12–15, 2002	9 staff members	Zamboanga City
4. Training Workshop on Project Approaches and Strategies	January 3–12, 2003	9 staff members	Sulu
6. 3-in-1 Integrated Modules	May 19–24, 2003	7 staff members	Sulu
7. Training of Municipal Pool of Trainers on the 3-in-1 Integrated Modules	March 9–13, 2004	18 staff members	Sulu
8. Behavior Change Communication (BCC) Training Workshop	July 20–23, 2003	2 staff members	Manila, Visayas and Sulu project areas

Other Training

Training	Inclusive Dates of Training	Total Number of Participants	Coverage Areas
1. Training workshop on project appropriates and strategies	January 2003	8 project staff members	EnRICH Sulu
2. On-the-job training on the financial system of SAVE	January 23 to February 10, 2003	1 project staff member (AFO)	EnRICH Sulu
3. Training workshop on situational analysis and political and institutional mapping	February 28 to March 2, 2003	7 project staff member	EnRICH Sulu
4. Training workshop on BBC	July 20–23, 2003	2 POs	All SAVE projects
5. Training on positive deviance inquiry	June 2003	1 PO	All SAVE projects
6. Training of trainers on 3-in-1 integrated course on MCH, FP and tuberculosis control	March 9–12, 2004	9 rural health midwives, 1 rural sanitary inspector, and 3 EnRICH PCs Total: 14	Jolo, Patikul, and Indanan project areas
7. Training workshop on developing advocacy and strategies for health	May 13–16, 2004	7 project staff members	EnRICH Sulu
8. Project orientation for: Partners Covered barangays IPHO project partners	 January 6, 2003 January 7–21, 2003 June 10, 2003	 IPHO, provincial and municipal local government units (LGUs), Ulama, DSWD, Red Cross Community members from 18 barangays 1 provincial health officer (PHO), 3 IPHO supervisors, 3 municipal health officers (MHOs), and 6 RHU staff	 Sulu (provincial partners) Indanan, Jolo and Patikul Jolo, covered barangays of Patikul and Indanan Jolo, Indanan, and Patikul
9. Training workshop for barangay health teams on appreciative community mobilization	July 10 to August 30, 2003	Community members of 18 covered barangays	Jolo, covered barangays of Patikul and Indanan
10. Consultative meeting with ulama on BCC strategies	February 28, 2003	Three ulama, five project staff members	Jolo, covered barangays of Patikul and Indanan
11. Pretest of 3-in-1 integrated module on FP, MCH, and tuberculosis		20 barangay health team members (barangay health workers, pandays, imams, Kagawad) of barangay Sanraymundo	Sanraymundo, Jolo
12. Training workshop on knowledge, attitude and practice (KAP) survey on MCH, FP, and tuberculosis control	August 1–15, 2003	25 enumerators/surveyors, editors, and field supervisors	Jolo, covered barangays of Patikul and Indanan
13. Study tour (Lakbay aral) for 18 barangay captains, 3 MHOs and 3 MPDCs	December 2–20, 2003 (two groups)	18 barangay captains, 3 MHOs and 3 MPDCs, 1 PPDO, 1 provincial administrator	Jolo, covered barangays of Patikul and Indanan
14. Training/refresher of "Ligtas Tigdas" volunteers on measles immunization	January 31, 2003	40 volunteer nurses, midwives and barangay health teams	Jolo, covered barangays of Patikul and Indanan
15. Symposium on "Bridging Health and Islam; Islamic Perspective on MCH, FP, and Tuberculosis"	March 31, 2003	2 ulama,169 community religious leaders	Jolo, covered barangays of Patikul and Indanan
16. Muslim religious leaders assembly and orientation on *Da'wats* organization	March 4, 2004	2 ulama, 80 community religious leaders, and 15 *Da'wats*	Jolo, covered barangays of Patikul and Indanan
17. Focus group discussion on project approaches and strategies	November 7–9, 2003	108 barangay health team members	Jolo, covered barangays of Patikul and Indanan

D–III. HELEN KELLER INTERNATIONAL (HKI) PERFORMANCE INDICATORS

General

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data*		Current Data			Comments
	As of Jan. 2003	Source	As of May 2004		Source	
1. Reduce number of underweight infants (under 2 years) by 6%	35.2%	2003 EnRICH baseline survey	No data			
2. Improve vitamin A status	No data	No data	No data		No data	
3. Improve contraceptive prevalence by 20%	25.7%	2003 family planning baseline survey for the EnRICH Project in Lanao del Sur, ARMM	Month and year	Modern contraceptive prevalence	Total contraceptive prevalence	
			April 2004	32.85%	32.96%	

*All baseline indicators to be compared with an end-of-project assessment/survey following the same protocol used at the baseline survey.

Specific

1. Infant feeding

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Jan. 2003	Source	As of May 2004	Source	
1. Increase breastfeeding of infants from birth to 6 months by 15%	No data		No data		Data from baseline still need to be analyzed
2. Increase number of children (6–11 months) with a frequent feeding of 3–5 times	No data		No data		

2. Increase immunization coverage

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Jan. 2003	Source	As of May 2004	Source	
1. Increase the number of fully immunized children (from 12 to 23 months) by 8.7%	62%	EnRICH baseline survey 2003	No data		

3. Improve home management of childhood illnesses

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Jan. 2003	Source	As of May 2004	Source	
1. Increase number of mothers visiting barangay health stations for prenatal care by 11%	70%	EnRICH Project baseline survey	No data		
2. Increase the number of mothers/caregivers who practice home management of childhood illnesses by 10%	60%		No data		
3. Increase the number of mothers who bring their children to barangay health stations when sick by 10%	29.1%		No data		
4. Increase the number of mothers/caregivers who continue feeding their sick children.	92.1%		No data		

4. Improvement of antenatal care/prenatal care

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Jan. 2003	Source	As of May 2004	Source	
1. Increase the number of pregnant women visiting barangay health stations for antenatal care by 12%	74.4%	EnRICH baseline survey	No data		
2. Increase the number of pregnant women who receive two doses of tetanus toxoid 2 by 18%.	62%		No data		

5. Improvement of micronutrient supplementation

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Nov. 2002	Source	As of Nov. 2003	Source	
1. Increase the number of pregnant women given iron supplements by 7%	70%	2002 Garantisadon Pambata cluster survey	No data		
2. Increase the number of children (6–23 months) who receive iron drops by 7%	No data				
3. Increase the number of households consuming iodized salt by 13%	25.5%	2002 Garantisadon Pambata cluster survey	48.5%	2002 Garantisadon Pambata cluster survey	
4. Increase the number of households consuming fortified food by 10%	No data		No data		Data will have to be analyzed

6. Increase vitamin A capsule coverage in all ARMM areas

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
Increase Objectives	As of Nov. 2002	Source	As of Nov. 2003	Source	
1. Infants (6–11) receiving vitamin A by 10%	52.9%	2002 Garantisadon Pambata cluster survey	87.1%	2003 Garantisadon Pambata cluster survey	
2. Children (12–59 months) receiving vitamin A by 6%	70.6%		86.2%		
3. High-risk children receiving vitamin A by 10%	23.5%				
4. Pregnant women receiving vitamin A by 10%	15.7%				
5. Postpartum mothers receiving vitamin A by 20%.	26.5%				

Other Process Indicators

Vitamin A

- Conducted consultative/planning workshops in the five provinces and one city: 96 regional/provincial/city/municipal action plans were developed
- Conducted advocacy training attended by nine integrated provisional health office technical staff, 6 municipal health officers (MHOs), 6 public health nurses (PHNs), and 18 rural health midwives (RHMs)
- Conducted advocacy forums: one provincial forum attended by leaders/stakeholders of the province; six municipal forums attended by local leaders and barangay chairpersons
- Developed and produced information, education, and communication (IEC) materials (Garantisadon Pambata flyers and streamers)
- Aired Garantisadon Pambata messages over the local radio and cable stations
- Conducted technical updates with 1,132 health workers from the five provinces and one city
- Monitored the distribution of vitamin A capsules by frontline health workers: for Garantisadon Pambata 2002, 350,000 preschoolers received capsules; for Garantisadon Pambata 2003, 420,000 preschoolers received capsules
- Conducted Garantisadon Pambata cluster survey in December 2003

Family Planning

- Conducted baseline survey
- Fifteen health workers trained as trainers on FP counseling
- Fifty-six health workers trained on FP counseling

- Malabang chief of hospital and three hospital staff trained on bilateral tubal ligation and nonscalpel vasectomy (22 bilateral tubal ligation cases and 2 nonscalpel vasectomy cases performed)

- Conducted orientation with 68 participants on nonscalpel vasectomy at Wao District Hospital, with ten men undergoing nonscalpel vasectomy the following day (joint activity of the integrated provincial health office in Lanao del Sur and Wao District Hospital through Matching Grant Program [MGP] and HKI)

Strengthen Health Workers' Skills in Managing Childhood Illness Through Integrated Management of Childhood Illness (IMCI) Strategy

- Conducted baseline survey

- Trained 28 health workers as trainers/facilitators of the IMCI 11–day course (18 trained as IMCI supervisors/facilitators, 2 as course directors, and 3 as clinical instructors)

- 242 frontline health workers were trained in the 11–day IMCI course:

    - 206 in Lanao del Sur (19 MHOs, 18 PHNs, 9 hospital nurses, and 80 RHMs)
    - 18 in Basilan (1 MHO, 6 PHNs, and 11 RHMs)
    - 11 in Tawi-Tawi (2 MHOs 2, 7 PHNs, and 2 RHMs)
    - 7 in Marawi City (1 asstistant CHO, 2 PHNs, and 4 RHMs)

- 131 district hospital chiefs and staff in Lanao del Sur oriented on the IMCI strategy

- 30 health workers trained as trainers in community IMCI

- 24 IMCI facilitators attended the facilitators workshop to review the seven IMCI modules, chart booklet, and facilitators manual to improve the conduct of the IMCI 11–day course

- Conducted monitoring activities quarterly

- Conducted facilitators' follow-up course with eight newly trained facilitators

- Conducted follow-up visits with trained health workers on the 11–day course

Please indicate other meaningful achievements in the performance of the project, (e.g., the number of staff trained, barangay health teams of barangay health station volunteers formed, council meetings held, IEC/behavior change communication (BCC) materials produced and implemented, and the number of clients counseled and referred, etc.).

- The capacity of the provincial technical staff of Lanao del Sur and the six pilot municipalities were strengthened in the area of FP, IMCI training, supervision, and advocacy, which further strengthened teamwork.

Training Sessions

Title or Type of Training	Inclusive Dates of Training	Total Number of Participants	Coverage Areas
Family Planning			
1. Training of Trainers on Family Planning Counseling	February 3–13, 2003	15	Regional technical staff IPHO technical staff, Lanao del Sur Health workers from six municipalities Helen Keller International staff
2. Training of Family Planning Counseling			
First Group	March 10–14, 2003	13	Health workers from Balabagan, Wao, Saguiaran, Calanogas, Balindong, Tamparan, and Lanao del Sur
Second Group	May 5–9, 2003	18	Health workers from Balabagan, Wao, Saguiaran, Calanogas, Balindong, Tamparan, and Lanao del Sur
Third Group	July 7–11, 2003	11	Health workers from Balabagan, Wao, Saguiaran, Calanogas, Balindong, Tamparan, and Lanao del Sur
Fourth Group	September 8–12, 2003	18	Health workers from Balabagan, Wao, Saguiaran, Calanogas, Balindong, Tamparan, and Lanao del Sur
3. Mussawarah dialogue with Ulama and Alima (religious leaders) of Lanao del Sur	July 15–16, 2003	22	Religious leaders, integrated provincial health office (IPHO) technical staff, Lanao del Sur
4. Nonscalpel Vasectomy (NSV) Orientation	October 20–21, 2003	68	Wao, Lanao del Sur
5. Training Course on Bilateral Tubal Ligation (BTL) Using the Minilaparotomy under Local Anesthesia (MLLA) Technique and NSV	October 27–29, 2003	4	District chief and nurses, Malabang District Hospital, Lanao del Sur
Follow-up visit	February18–19, 2003	6	Chief of hospital, nurse, Malabang, Lanao del Sur
Integrated Management of Childhood Illness (IMCI)			
1. Training of Trainers of the IMCI 11–Day Basic Course (in coordination with UNICEF)	October 11–22, 2002	17	IPHO, Lanao del Sur City health department, ARMM
11–Day Basic Course, first group	January 20–31, 2003	14	Health workers from Balabagan, Wao, Saguiaran, Calanogas, Balindong, and Tamparan
Second group	February 17–28, 2003	19	Health workers from Balabagan, Wao, Saguiaran, Calanogas, Balindong, and Tamparan
Third group	May 19–30, 2003	18	Health workers from Balabagan, Wao, Saguiaran, Calanogas, Balindong, and Tamparan
Follow-up visit with IMCI–trained health workers	August 4–8, 2003	8 per municipality	Health workers from Balabagan, Wao, Saguiaran, Calanogas, Balindong, and Tamparan

Title or Type of Training	Inclusive Dates of Training	Total Number of Participants	Coverage Areas
2. Facilitators Training, IMCI	November 25–29, 2002	15	IPHO Lanao del Sur City health department, ARMM
IMCI Facilitators Training	April 12–16, 2004	14	DOH ARMM (1), Tandubas-Tawi-Tawi (2), Tamparan-Lanao del Sur (2), Tuburan-Basilan (6), HKI (3)
IMCI Follow-up Training Course	March 26–28, 2003	7	Provincial health office technical staff, regional staff
IMCI Follow-up Visit	April 21–23, 2003	8	IPHO technical staff, Lanao del Sur, regional office
Training of Trainers on Community IMCI	September 15–19, 2003	35	MHO, PHN, PNS, IPHO technical staff, Lanao del Sur
Training of Trainers /IMCI 11–Day Basic Course, for prospective trainers	March 1–12, 2004	14	Basilan (6), Tawi-Tawi (2), Pinan (1), Christian Children's Fund (1), HKI (2)
Training of Trainers on Community IMCI	March 22–26, 2004	23	IPHO Lanao del Sur, Saguiaran, Tamparan, Balindong, Wao, Calanugas, Balabagan, and city health department, ARMM
3. 1–Day District Hospital Orientation on IMCI in Wao, Lanao del Sur	April 25, 2003	30	Hospital staff in Wao, regional staff, IPHO technical staff
1–Day District Hospital Orientation in Balindong	August 11, 2003		Hospital personnel
1–Day District Hospital Orientation in Unayan	August 13, 2003		Hospital personnel
1–Day District Hospital Orientation in Malabang	August 14, 2003		Hospital personnel
1–Day District Hospital Orientation in Tamparan	August 15, 2003		Hospital personnel

4. IMCI 11–Day Basic Course (Japanese International Cooperation Agency [JICA] and HKI/USAID)	January 5–16, 2004	20	Lanao del Sur
IMCI 11–Day Basic Course (JICA and HKI/USAID)	January 19–30, 2004	20	Lanao del Sur
IMCI 1–Day Basic Course (JICA and HKI/USAID)	February 2–13, 2004	20	Lanao del Sur
11–Day Basic Course (group one) Expansion in Basilan and Tawi-Tawi	April 19–30, 2004	20	Maluso, Sumisip, Lamitan, Tuburan, Lantawan, Basilan and Tawi-Tawi
11–Day Basic Course (group two) Expansion in Basilan and Tawi-Tawi	May 31–June 11, 2004	18	Tawi-Tawi: Bongao, Tandubas, Sitangkai, Panglima Sugala, Mapun, Sout Ubian, Laun, and Tabawan Basilan: Tuburan, Lamitan, Lantawan, and Sumisip
11–Day Basic Course (group four) expansion in Lanao del Sur and Marawi City	April 26–May 7, 2004	18	Maguing, Buadiposa Buntong, Bayang, Piñan, Kapantaran, Tugaya, Ganassi, Masim, Marawi, Marantao, Madalam, Dumalondong, and Lanao del Sur
11–Day Basic Course (group five) expansion in Lanao del Sur and Marawi City	May 24–June 4, 2004	20	Maguing, Buadiposa Buntong, Bayang, Piñan, Kapantaran, Tugaya, Ganassi, Masim, Marawi, Marantao, Madalam, and Dumalondong
Facilitators' workshop	May 17–21, 2004	25	IPHO Lanao del Sur, DOH ARMM, RHU Bumbarang, IPHO Tawi-Tawi, IPHO Jolo-Sulu, PHO Basilan, RHU Tandubas
Follow-up course	May 24–28, 2004	11	Basilan (4), ARMM (4), Tawi-Tawi (1), staff (2)
5. Training of Frontline Health Workers on Community IMCI, Tamparan and Balindong	June 8–12, 2004 (two groups)		Lanao del Sur
Training of Frontline Health Workers on Community IMCI, Wao and Calanogas	June 14–18, 2004 (two groups)		Lanao del Sur
Training of Frontline Health Workers on Community IMCI, Balabagan and Saguiaran	June 21–25, 2004 (two groups)		Lanao del Sur

Vitamin A 1. Orientation of data collectors for the vitamin A cluster survey, Lanao del Sur	December 9–14, 2002	38	City health department ARMM, IPHO Lanao del Sur, Balabaga, Wao, Saguiaran, Calanogas, Balindong, Tamparan, and Lanao del Sur
Feedback meeting on the vitamin A cluster survey in the ARMM (Zamboanga)	March 27–28, 2003	19	Regional staff, PHOs from five provinces
Feedback meeting on the vitamin A cluster survey (Iligan City)	April 7–8, 2003	20	Regional office, IPHO technical staff, MHO, and district chiefs, Lanao del Sur
Vitamin A consultative/planning workshop (Tawi-Tawi)	July 7-8, 2003	30	IPHO, Tawi-Tawi MHO and PHNs
Vitamin A feedback and consultative workshop with the health workers in Marawi City	August 25-26, 2003	13	Marawi City Health Office

Other Training Sessions

Title or Type of Training	Inclusive Dates of Training	Total Number of Participants	Coverage Areas
1. Feedback conference on the results of the EnRICH baseline survey	June 2–3, 2003	46	Regional health office staff, IPHO technical staff, Lanao del Sur; municipal mayors, SB members, district chiefs, MHOs, and RHMs from six municipalities
2. Workshop on the development of the Lanao del Sur EnRICH Project behavior change communication plan on FP, vitamin A, and IMCI	June 16–20, 2003	25	IPHO technical staff, Lanao del Sur; midwives, barangay health workers, public health nurses from six municipalities, regional technical staff
3. Workshop on the strengthened community-based health and nutrition action plan for the province of Basilan	June 30–July 4, 2003	22	City health department ARMM, Maluso, Lantawan, Tuburan, Sumisip, Lamitan, and CCF/USAID EnRICH Project, Basilan
4. Supervisory and monitoring workshop for the EnRICH Project in Lanao del Sur	August 18–20, 2003	30	MHO, district chiefs, PHNs, PHO staff, and supervising RHMs, Lanao del Sur
5. Technical updates on micronutrient supplementation in Lanao del Sur (two groups)	September 22, 2003 September 23, 2003	39 37	Lanao del Sur
6. Advocacy workshop for the six municipalities in Lanao del Sur	September 30–October 2, 203	35	PHO technical staff, district chiefs, MHO, PHN, and supervising midwives, Lanao del Sur
7. Program implementation review (first group)	March 29–30, 2004	34	MHO, PHN, RHM, district chiefs, IPHO technical staff, Lanao del Sur
Program implementation review (second group)	June 1–2, 2004	24	MHO, PHN, RHM, district chiefs, IPHO technical staff, Basilan and Tawi-Tawi
8. Retraining of frontline health workers of Basilan on micronutrient supplementation and food fortification, growth monitoring, and promotion and immunization	May 31–June 1, 2004 June 2–3, 2004 June 14–15, 2004	25 29	MHO, PHNs, RHMs, and IPHO technical staff of Basilan

D–IV. ACDI/VOCA

Performance Indicators

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Dec. 2002	Source	As of Dec. 2003	Source	
1. Increase contraceptive prevalence of modern contraceptives in Tawi-Tawi to near national levels	26.61% 17% 16.2%	FHSIS 2002 EnRICH baseline study FPS–MCHS 2002	28%	FHSIS 2003	Includes all municipalities (10) in Tawi-Tawi Includes all municipalities (10) in Tawi-Tawi; data for ARMM
2. Improve tuberculosis diagnosis and treatment among women of reproductive age (15–45) and children below 5 years Case detection rate Cure rate	35% 50%	FPS–MCHS 2002	42% 52%	FHSIS 2003	Includes all municipalities (10) in Tawi-Tawi
3. Improve maternal and child health indicators Infant mortality rate Maternal mortality ratio	18.5 1.9	FHSIS 2002	13.7 1.1	FHSIS 2003	Includes all municipalities (10) in Tawi-Tawi

Specific Indicators

Project Objectives (Based on USAID Cooperative Agreement)	Baseline Data		Current Data		Comments
	As of Dec. 2002	Source	As of Dec. 2003	Source	
1. Family Planning Program indicators: New acceptors in Tawi-Tawi	7,928	FHSIS 2002	8,803	FHSIS 2003	Includes all municipalities (10) in Tawi-Tawi
2. National Tuberculosis Program DOTS indicators: Tuberculosis symptomatic patients			255	FHSIS in EnRICH areas, 2003	

Other Process Indicators

Events/Activities	Inclusive Dates	Total Number of Participants	Coverage Areas
1. Launching of BHW distance education	December 7, 2003	88 persons	Five municipalities
2. First EnRICH health forum 2003	July 11, 2003	160	Five municipalities
3. Fatwa on family planning	December 6–7, 2003	122	Five municipalities
4. Press conference on fatwa	December 10, 2003	33	Manila
5. EnRICH community assemblies:			
First EnRICH community assembly	July 20, 2003	112	Barangay Pag-asa, Bongao
	June 27, 2003	117	Barangay Bakung, Simunul
	June 23, 2003	94	Barangay Darussalam, Languyan
	June 21, 2003	80	Barangay Silantup, Tandubas
	July 15, 2003	105	Sitangkai
Coalition, Muslim religious leaders, and BHWs assembly	January 20, 2004	28	RHU Barangay Pag-asa, Bongao
	December 29, 2003	35	RHU Tubig, Indangan
	NA	25	RHU Barangay Silantup
	December 22, 2003	34	RHU Barangay Darussalam
	December 23, 2003	29	Sitangkai
Peer talks on ARH/FP	December 16, 2003	68	Bongao
Bongao Community Assembly	June 16, 2004	60	Barangay Simandagit
6. ARMM activity			
ARMM assessment, first group	August 18–20, 2003	No data	In Zamboanga City
second group	August 25–27, 2003	No data	In Iligan City
third group	NA	No data	In Maguindanao (Cotabato)
ARMM assessment and validation	June 10–11, 2004	No data	In Davao City
7. IEC materials			
EnRICH brochures	December 1, 2003		5,000 copies
Fatwa brochures	December 1, 2003		5,000 copies

Training Matrix

Title of Training/Workshops	Inclusive Dates	Total Number of Participants	Coverage Areas
1. FP/MCH orientation workshop for IPHO staff	October 16, 2002	16	IPHO health personnel in five municipalities
2. Baseline study survey team workshop	December 18–19, 2003	40	Five municipalities
3. Resource mobilization workshop			
Group one	March 17–19, 2003	30	Bongao, Simunul
Group two	March 20–22, 2003	22	Languyan, Tandubas
Group three	April 22–24, 2003	15	Sibutu, Sitangkai
4. EnRICH strategic planning and baseline results presentation	April 1–3	41	Five municipalities
5. Basic microscopy workshop	June 9–11, 2003	20	Five municipalities
6. BHW training of trainers	August 28–30 and		
Group one	September 1–4, 2003	34	Bongao, Simunul
Group two	September 4–10, 2003	31	Sibutu, Tandubas, and Languyan
7. Distance education for BHWs	February-August 2004	300	Five municipalities
8. Mussawarah on family planning	August 16–17, 2004	64	Five municipalities
9. EnRICH municipal orientation workshops:			
Bongao	February 10, 2003	27	Bongao
Simunul	February 23, 2003	48	Simunul
Languyan	February 24, 2003	55	Languyan
Tandubas	February 25, 2003	32	Tandubas
Sibutu-Sitangkai	March 24, 2003	61	Sibutu-Sitangkai