PD-ACA-878

LPP-Matching Grant Program Performance and Evaluation Report San Jose Del Monte, Bulacan Philippines

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LPP-Matching Grant Program Performance and Evaluation Report, April 2001. This study was funded by the **United States for International Development (USAID)** under the terms of Cooperative Agreement number HRN-A-00-98-00012-00 and Subproject number 5801-13017.455.

SUMMARY

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

The Frontiers Manila staff carried out a program performance evaluation of the MGP activities in San Jose del Monte, Bulacan from June 1999 to March 2000. Representing Region III, San Jose was selected on the basis of its plan to prioritize underserved and marginalized groups, and to focus on family planning.

To achieve the MGP goals on the four health parameters, San Jose del Monte proposed five interventions, namely: the Community-Based Monitoring and Information System (CBMIS), community service outreach, the call slip system, revival of IUD insertion at the main health center, and networking with a district hospital for voluntary surgical sterilization.

The accomplishments of RHUs 1 and 2 during MGP activities show that they both surpassed the goals they set for themselves. FIC, VAC, and TT2+ coverage have been maintained at their previously high levels, and CPR has doubled compared with that of the baseline. The program activities, grounded in the CBMIS, have had subsequent service delivery strategies designed and redesigned in response to emerging information obtained from the information system. These components enriched the program, contributed to the positive outcomes observed, and showed that the applied use of data from CBMIS provided concrete evidence of research utilization for service delivery.

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ABBREVIATIONS

BCG	-	Bacille Calmett Gourain
BHW	-	Barangay Health Worker
BHS	-	Barangay Health Station
BTL	-	Bilateral Tubal Ligation
CBMIS	-	Community Based Monitoring and Information System
CHO	-	City Health Office
CPR	-	Contraceptive Prevalence Rate
DHRFO	-	Department of Health Regional Field Office
DPT	-	Diphtheria, Pertussis Tetanus
DOH	-	Department of Health
FHSIS	-	Field Health Services Information System
FIC	-	Fully Immunized Child
FP	-	Family Planning
GMC	-	Growth Monitoring Chart
IUD	-	Intra-Uterine Device
LGU	-	Local Government Unit
LPP	-	LGU Performance Program
MGP	-	Matching Grant program
MOA	-	Memorandum of Agreement
MOE	-	Maintenance and Operation Expenses
MSH	-	Management Sciences for Health
MWRA	-	Married Women of Reproductive Age
NFP	-	Natural Family Planning
NDS	-	National Demographic Survey
NGO	-	Non-government Organization
NSO	-	National Statistics Office
OPV	-	Oral Polio Vaccine
PHO	-	Provincial Health Office
PMC	-	Pre-Marriage Counseling
RHM	-	Rural Health Midwife
RHU	-	Rural Health Unit
SJDM	-	San Jose del Monte
SMDH	-	Sta. Maria District Hospital
SPDH	-	Sapang Palay District Hospital
TT	-	Tetanus Toxoid
TT2+	-	Tetanus Toxoid Two Plus
USAID	-	United States Agency for International Development
VAC	-	Vitamin A Coverage
WRA	-	Women of Reproductive Age

ACKNOWLEDGMENTS

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

The technical assistance, inputs and cooperation of the field coordinators of Management Sciences for Health (MSH) during fieldwork and consultations are gratefully acknowledged.

The Local Government of San Jose del Monte, Bulacan and the Department of Health III Regional Office helped in mobilizing designated point persons during information gathering done by the field evaluator of Population Council. The rural health physicians, nurses, midwives and *barangay* health workers of the RHUs 1 and 2, as well as the local offices and non-government organizations in the municipality, have also been very supportive and patient in assisting the field evaluator through data retrieval and in-depth interviews.

Population Council also expresses appreciation to the local officials, program managers and community leaders who extended their hospitality and cooperation in the entire evaluation period of the program.

Lastly, the numerous men and women, who in many ways had been helpful in the process evaluation of the Matching Grant Program, are duly recognized.

I. BACKGROUND

After the implementation of the Local Government Code of 1991 which involved the devolution of national functions to local governments units (LGUs) in the Philippines, weaknesses in the local health situation surfaced posing a challenge to policy makers and program implementers advocating for improved primary health care services. In response to this challenge, a five-year initiative (1995-2000) called the Local Government Performance Program (LPP) was designed and implemented by the Department of Health with technical assistance from the Management of Sciences for Health (MSH). The program document describes LPP as intending "to improve the health of mothers and children through increased utilization of family planning and child health (MCH) and nutrition services". [1] LPP Grants were "intended to serve as an incentive, encouraging LGUs to adopt best practices in the distribution of commodities, the training of staff, the equipping of service delivery sites, the provision of voluntary sterilization services, and the use of IEC".[2]

After an assessment review of the LPP undertaken in June 1998, several recommendations were advanced to improve its implementation. The assessment report noted that while the LPP is an effective vehicle for developing LGU management and service delivery capability, it also has its share of weaknesses and limitations. It described LPP as "highly centralized", "not performance-based" and "not sustainable". Hence, LPP, the report concludes, is not the most appropriate means for achieving impact on health objectives. The report recommended a "follow-on initiative that puts greater emphasis on impact, building on the strengths of the LPP, while overcoming its limitations".

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[1] Find the source of this quotation.

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

The Matching Grant Program: The "Follow-On Initiative" of LPP

The above recommendations became the basis for the development by the Management Sciences for Health of the Matching Grant Program (MGP). In contrast to the more general and more directive approach of the LPP to strengthen LGU health programs, the MGP is particularly designed to stimulate the LGUs to focus directly on strengthening service delivery giving the local government units more latitude in determining their local programs. Consequently, the MGP was designed with the following features:[3]

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

In particular, the MGP aims to achieve impact and expand service delivery in four target areas:

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

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

TT was determined by the MSH in consultation with the USAID Mission, that it is important to build an evaluation component into the MGP to serve two purposes: (1) to document the program implementation and highlight the processes and best practices that will help to guide and refine early MGP implementation, and (2) to assess MGP's impacts in improving the critical reproductive health programs of local governments. Hence, upon the request of the USAID Mission, FRONTIERS Philippines conducted an evaluation study of the newly launched Matching Grant Program in February 1999.

Objectives of the MGP Evaluation Study

The overall goal of the study is to inform policy with regard to the Matching Grant Program, particularly in terms of its effectiveness as a mechanism for strengthening local government health programs, especially in the areas of

- Reproductive health and family planning
- Maternal and child immunization
- Micro-nutrient deficiency prevention

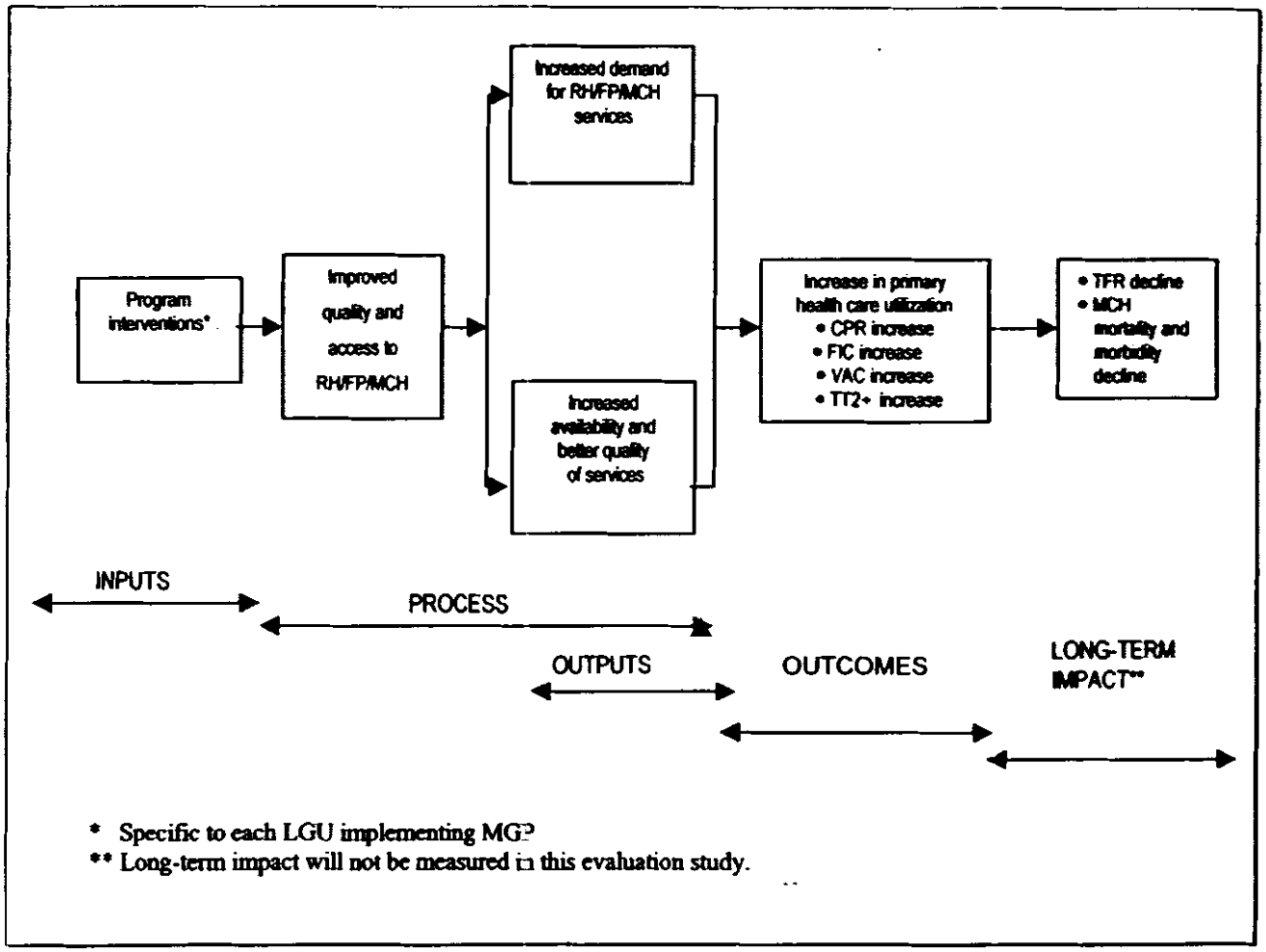
The specific objectives of the study are the following:

- To evaluate the different strategies of MGP for reaching under-served and high-risk population with specific service needs, and
- To evaluate evidence of direct impacts in selected LGUs, as measured by the level of performance relative to critical program areas such as: FP use, immunization (FIC and TT2) and Vitamin A supplementation.

Research Design

The conceptual framework used for evaluating the MGP's performance followed the "input-process-output-outcome" model as represented in Figure 1.

Figure 1. Conceptual framework showing links of the program components to the outcome indicators, and the different categories of evaluation indicators



Phase 1 of the MGP evaluation was planned to provide inputs to the development of the MGP itself. As a new approach of providing resources and technical assistance to LGUs, it is important to provide detailed feedback on the processes and mechanisms that evolve early in the project life. Hence Phase 1 constitutes basically a monitoring and evaluation activity.

Phase One: Process and Performance Evaluation

The Study Sites. Four LGUs sites from the first batch of twelve MGP recruits were selected for evaluation in June 1999. However, because two of the first twelve were not ready by June to be part of the process documentation, the site selection was really made only from ten initial MGP recruits. The bases for selecting the first four are as follows: 1) one LGU would be selected for each of the operating clusters[4] set up by MSH, 2) the work plans of the selected LGUs must contain a suitable mix of activities/ interventions that are expected to contribute to the four outcomes of interest, and 3) consideration was given to LGUs whose work plan contains innovations or unique approaches that could contribute to the MGP.

With these considerations, the following LGUs were selected for evaluation under Phase 1:

PROCESS/PERFORMANCE EVALUATION SITES

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

Research Methodology. MGP activities in these four selected sites were observed, measured on a regular, ongoing basis whether program activities were being implemented according to plan, and assessed on how well these program activities were performed and utilized. Field observations, informal interviews with stakeholders, and analysis of local statistics are sources of information for this phase of the study. While every effort was

[4] The clusters are arbitrary operational divisions of the country set up by MSH, the implementing agency of the DOH for the MGP. Cluster A consists of Regions 1, 2, 3 and CAR; Cluster B has Regions 4, 5 and

made to ensure complete documentation of the MGP, there were key activities that were not observed by the field evaluator[5]. In order to address this gap, key informant interviews were conducted to elicit information on what exactly happened during the planning activities.

Phase Two: Impact Evaluation

Strictly speaking this phase is an outcome evaluation (Refer to Figure 1). It uses a non-equivalent pretest-posttest control group design for evaluating the more immediate effects (or outcomes) of MGP program.

Ideally, the selection of the intervention LGUs would have been at randomly from the second batch of MGP recruits. However, because MSH and the DOH were implementing a "first come, first served" policy for recruiting LGUs, it was not possible to randomize the selection process. The selection of the three intervention LGUs was further limited by two additional factors: 1) the rate at which MGP is being implemented (LGUs who had not yet been oriented, and did not have a work plan on which the baseline assessment could be made could not be part of the selection process for the impact evaluation), and 2) since the intervention LGU had to have a control LGU from the same province, this precludes the selection of LGUs where all MGP-qualified units of the province have been recruited at the same time leaving no possible control. In effect, the intervention LGUs was selected mainly because of the availability of a suitable control LGU within their province. All the selected LGUs are first-class cities and municipalities, i.e., they are all in the highest income category classification of the Department of Finance. The three sites chosen were Taytay in Luzon, San Carlos in Visayas and Tagum in Mindanao.

NCR; Cluster C includes Regions 6, 7, 8 and 9; Cluster D is composed of Regions 10, 11 ,12, Caraga and ARMM.

Intervention and control LGUs were matched on the following criteria: 1) both come from the same province to control for administrative and other forms of support provided at province level, 2) similar population sizes, 3) same income class, and 4) similar performance indicators on the four outcomes of interest for the MGP (FIC, TT2, VAC and Family Planning). The intervention LGU should not have initiated MGP community activities before the baseline assessment can be made. Because of considerable differences in state of economic development, impact pairs were selected for each of Luzon, Visayas and Mindanao – the three major geographic divisions of the country. In view of these considerations, the following were the final sites selected for the impact evaluation:

MGP Area		CONTROL	
Taytay	(Luzon)	Binangonan	(Luzon)
San Carlos	(Visayas)	Cadiz	(Visayas)
Tagum	(Mindanao)	Panabo	(Mindanao)

It must be noted that the third set of impact sites (Tagum-Panabo) was eventually dropped due to some implementation delays. Only two sets, Taytay-Binagonan and San Carlos-Cadiz were included in Phase 2 of the study. Population surveys and a modified (shortened)[6] version of situation analyses were conducted before and after the implementation of the MGP in two sites.

The FRONTIERS Manila staff carried out a program performance evaluation of the MGP in San Jose del Monte (SJDM), Province of Bulacan (Region III, Central Luzon) from June 1999 to March 2000. San Jose, the largest municipality in Bulacan in terms of population, is one of four sites in the first batch of MGP recipients selected to

[5] For example, the planning stage for some of the MGP areas was not observed because this occurred before the evaluation study team was organized.
[6] The client-provider interaction instrument was not used in this study.

provide information on operations and performance that would be helpful in refining and improving the program's implementation. San Jose was selected based on its plan to prioritize underserved and marginalized groups and focus on family planning.

II. MGP APPPLICATION

The process of applying for the MGP requires close planning and coordination between key local government officials, local health workers, the DOH's Regional Office and the technical advisor from the Management Sciences for Health. For the San Jose MGP, the application process went through the following steps.

Selection. Region III, to which San Jose belongs, had a very different procedure from other regions in recruiting LGUs for the MGP. While the other regions sent invitations to apply for the MGP to all eligible LGUs, DOH Region III prioritized LGUs that could be issued an invitation based on the Region's (DOH) perception of the LGU's commitment. If the first LGU declines then the second in line is sent an invitation. San Jose was a second choice of the Region (DOH) for the MGP.

Orientation. The processing of the MGP application of San Jose Del Monte, Bulacan only started on May 11, 1999 when an MGP orientation was conducted by the Management Sciences for Health Regional Technical Advisor (MSH-RTA) in the municipality. At the time of the orientation the formal letter of invitation had not yet been received by San Jose's LGU. The letter required revision. The formal letter was finally received by the LGU which subsequently responded to with a LOI a few days shortly after the orientation.

Initial Planning. During the planning, given the large size of the municipality and the rapidly changing population size, it was decided that the MGP focus on an area that has a fairly stable population and is within the size prescribed by the grant. After the

selection of the catchment areas of RHUs I and II in San Jose, the MGP plan was developed.

First Draft of the MGP Plan. By June 2, 1999 less than a month after the MGP orientation in May, the first draft of the MGP Action Plan was finalized after a day's discussion. The discussion was facilitated by the MSH-RTA and attended by the RHU II physician, some selected nurses, midwives and BHWs from the two RHUs. The RHU 2 physician was chosen to be the MGP point person because the rural health physician of RHUI was about to retire.

Mayor's Approval of the First Draft of the MGP Plan. Immediately the next day, on June 3, 1999, the draft of the MGP Plan was discussed with the mayor and other concerned department heads of the LGU. The mayor then approved and signed the proposed *MGP Plan along with concerned department heads.*

MGP Plan Submitted to the DOH Regional Office. On June 5, 1999, two days after its approval by the Mayor and concerned department heads, the proposed MGP Plan was submitted to the DOH Regional Health Office in San Nicolas, San Fernando, and Pampanga. A DOH representative furnished a copy of the proposal to the Provincial Health Office (PHO).

DOH Regional Office On-Site Review of MGP Plan. Over a month after its submission to the DOH Regional Office, on July 14, 1999 a representative from the Regional Technical Advisor Team (RTAT) at the DOH visited San Jose Del Monte for the on-site review of the proposed Plan. A technical staff member accompanied her from the Provincial Health Office (PHO). She noted that 75% of the proposed plan was to be spent on transportation costs. The assigned MGP point person for San Jose explained that since MGP money cannot be used to purchase supplies and equipment, or fund skills training and salaries the budget could only be used for transportation. Meanwhile, the

MSH-RTA suggested the purchase of items such as umbrellas, bags, t-shirts, paper and pens for BHWs as incentives for volunteers (as had been done in other MGP areas). Both the regional and provincial representatives agreed with that suggestion and thus items on the proposed plan were changed. Other items reconciled were the merging of items on monitoring and updating with the follow-up and home visits of the BHWs clients.

Revised MGP Plan Submitted to the DOH Regional Office for Finalization. The RTAT representative and the MGP point person submitted the revised plan to the region 5 days after the on-site review on July 19, 1999. The DOH Regional Office then approved of the final plan.

Memorandum of Agreement Signed. Over a month later, on August 24, 1999 both the DOH Regional Office and the LGU signed a Memorandum of Agreement. The region waited for a separate trust fund account to be opened by the LGU in order for them to transfer the funds.

MGP Money Released. There were delays in the release of money because of a contract provision requiring the LGU to open a separate trust account for its MGP funds. This required a municipal board resolution authorizing the mayor to open an account. The funds were finally released in September.

It took San Jose a total of 104 working days to complete its application process, that is, until the MGP fund was received by the LGU. However, the implementation went ahead of time. With only 61 working days from the MGP orientation, the first key activity, the CBMIS orientation, was held among health providers (see discussion of CBMIS under the "Implementation" Section below).

For the most part the application process for the MGP, as designed, was a smooth process for San Jose Del Monte. First of all, the plan that was developed was focused

significantly on the needs of the city as perceived by local health professionals. Second, it appears that LGUs play a key role in facilitating the speedy processing of the MGP application. In reviewing the time spent by local and regional representatives in various stages of the application process, for instance, we see that the turn around time was fastest on the part of the LGUs. The only delay on the part of the LGU, towards the end of the application process, was in the release of funds which required several steps including a municipal board resolution before the mayor's being able to open a separate trust fund account. Finally, it appears clear that a well-organized team at the local level is key in facilitating not only the process of applying for funding but to initiating the actual implementation of the program. The work of Mr. the MGP point person and the MSH-RTA representative appear to be central here.

III. SOCIO-DEMOGRAPHIC AND HEALTH PROFILE OF SAN JOSE DEL MONTE, BULACAN

Demographic Characteristics

San Jose is the largest municipality in Bulacan in terms of population. Located adjacent to Metro Manila, San Jose is characterized by abnormal population growth due to massive squatter relocation and the increasing number of low-cost housing projects. The town's local government is hard put to meet the demands of this large, very mobile population since they receive little assistance from the national government to support these migrants. The town's 1999 population is estimated to be 269, 087[7] with 53,817 households.

Figure 2 demonstrates the abnormal growth that characterizes San Jose's population growth.

[7] San Jose del Monte Office of the Mayor

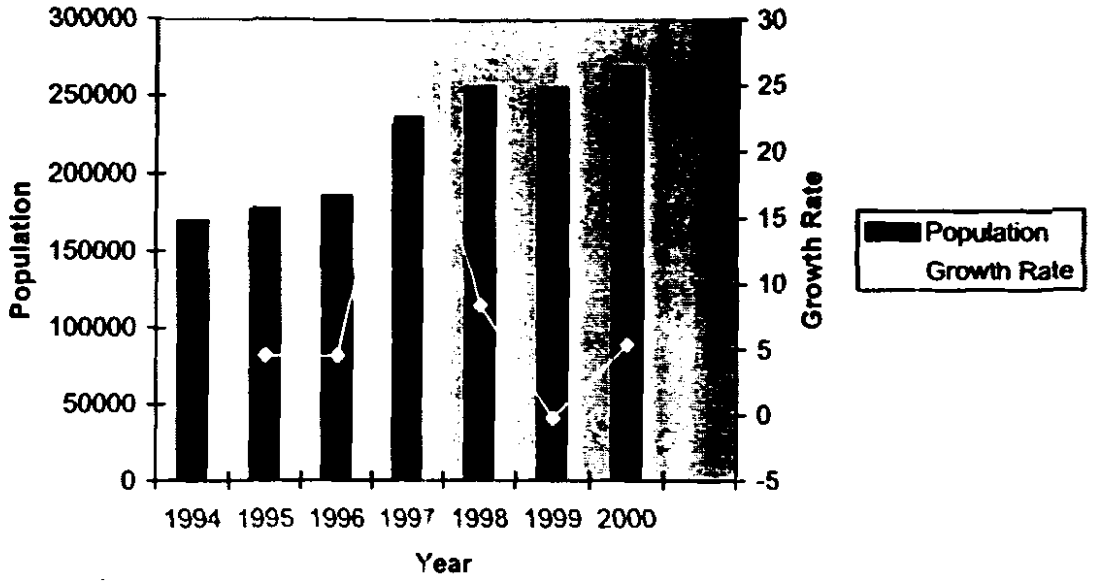


Figure 2. Population Curve of San Jose Del Monte

The Health Care Delivery System

San Jose is categorized into two informal divisions the *area*, referring to the urban resettlement area, and the *non-area* (i.e. those outside of the resettlement area). Two Rural Health Units (RHU I in Poblacion and RHU II in Tungkong Mangga) serve the *non-area* and three RHUs are in the *area* barangays of Minuyan, Bagong Buhay and Sta. Cruz. The Sapang Palay District Hospital (SPDH), run by the Provincial Health Office (PHO), is in Bagong Buhay.

Tables 1 and 2 in the Appendix show the health manpower and facilities of San Jose's RHU I and II (*non-area*) which together comprise the catchment area for its

MGP[8]. The two RHUs combined cover a population of 120,718, which is comparable to a medium-sized town and is about the population size stipulated by the MGP. The manpower to population ratio in the RHUs is quite low even by Philippine standards. Eleven Barangay Health Stations (BHSs) and 25 sub-stations serve 24 barangays ("villages"). For instance, the Physician to Population Ratio is 1:60,359 while for Barangay Health Workers the Manpower: Population Ratio is 1:244 households. There are many private clinics, but the largely urban-poor population cannot avail of their services on a regular basis.

Health Budget

Figures 3 and 4 illustrate San Jose's health budget from 1994 to 1999. While the health budget appears to be consistently about 3 – 4 % of the total LGU budget, most of the money goes to pay personnel salaries and benefits. For 1998 and 1999, only 20% of health money was spent for operations. This is quite typical of the post-devolution situation where LGUs find themselves forced to support the personnel they inherited from the national government (according to the terms of the Local Government Code). They are therefore constrained to place the bulk of their money into personnel sacrificing money for drugs, supplies, equipment, repairs and travel allowances to visit remote villages.

[8] While San Jose Del Monte is a recipient of the MGP under the Department of Health, only two of its five Rural Health Units (RHUs) have been covered because of limited funds. See more detailed discussed in "MGP Program" Section.

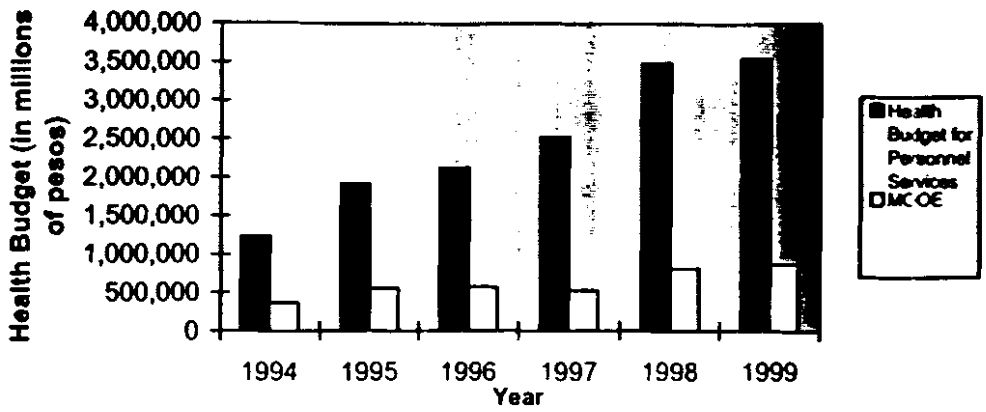


Figure 3. San Jose del Monte's Health Budget, 1994 – 1999

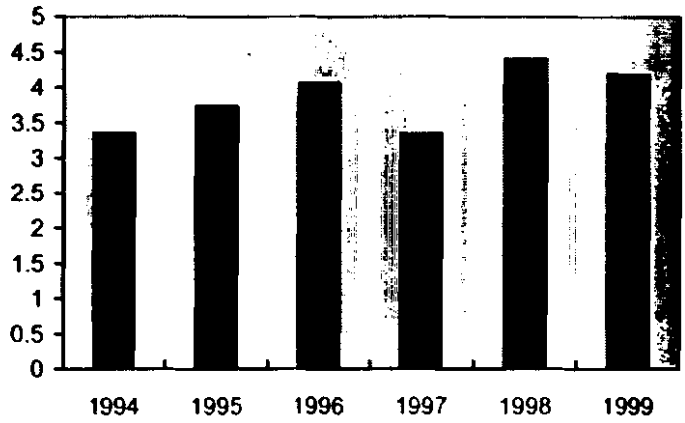


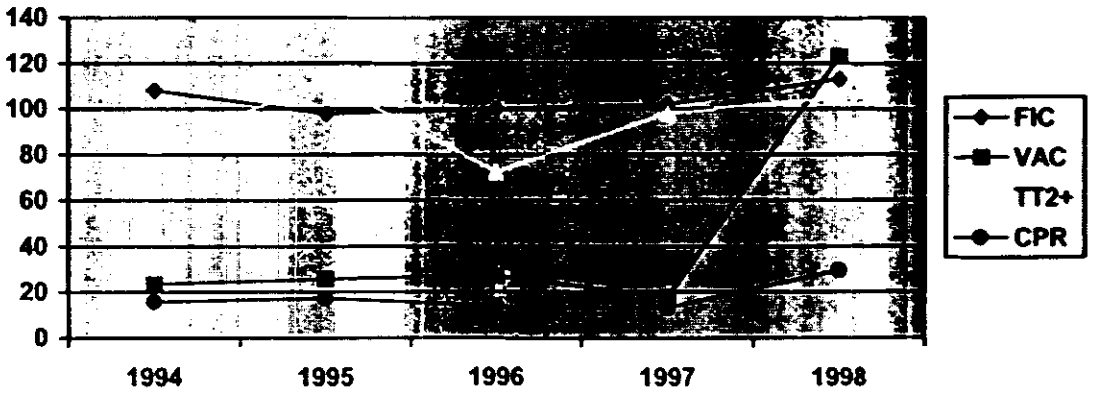
Figure 4. Health Budget as Percentage of LGU Budget

IV. MGP PROGRAM

While San Jose Del Monte is a recipient of the MGP under the Department of Health, only two of its five Rural Health Units (RHUs) can be covered by the MGP due

to limited funds. These two RHUs. RHUI and 2 of San Jose Del Monte Proper, cover 24 barangays serving a combined population of 120,718 in an estimated 20,120 households.[9]

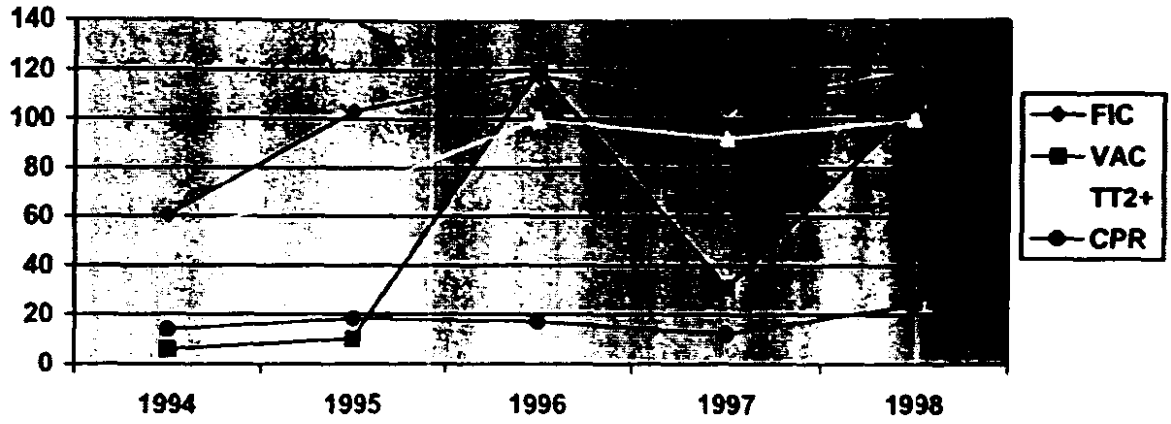
Pre-MGP Program Performance for FIC, VAC, TT2+ and CPR suggest that San Jose's RHUs I and II for 1998 have been doing quite well with its FIC, VAC and TT2+ (see Figures 5 and 6). The previously low VAC performance had been attributed to a lack of Vitamin A capsule, but with adequate supplies in 1998 performance went beyond 100%.



Source: SJDM FHSIS

Figure 5. Program Performance of RHU 1, 1994 - 1998

[9] Based on the 1999 Projected Populations



Source: SJDM FHSIS

Figure 6. Program Performance of RHU 2, 1994 -1998

These values, however, are misleading. The figures exceeding 100% are due to the use of population and target group estimates as denominators, a practice handed down from the Field Health Statistics and Information Service (FHSIS) of the Department of Health. While numerators are actual service counts, the Municipal Health Office (MHO) uses a population estimate given by the National Statistics Office (NSO) which is based on the last census (in this case, 1995). This estimate is then multiplied by a factor, representing the estimated proportion of the target group for that particular program: 3% for infants (FIC), 3.5% for pregnant women (TT2+), 11.5% for children 12-59 months of age (VAC), and 14.5% for married women of reproductive age (FP)[10]. The products of these estimates become the denominators for program performance. These formulae have been resorted to because of inadequate community-based information on which to base actual program targets. In a town like San Jose, which is growing much faster than the national average, this leads to an underestimate of the actual population and to performance indicators beyond 100%.

[10] FHSIS, DOH

Despite the inflation of the TT2+, FIC and Vitamin A Figures, it became clear to local authorities that Family Planning needed the most attention, with very low family planning acceptors in both RHUI and RHUII. Not surprisingly, the team decided to focus on family planning and set as its goal a modest increase of 10% in CPR from 1998 levels. The low CPRs can be attributed, according to the municipality, to:

- irregular IUD insertion at the MHCs;
- limited manpower trained in IUD insertion;
- inadequate equipment and facilities for IUD insertions at the MHCs and BHSs;
- high population to worker ratio resulting in poor coverage;
- low transport support for workers and volunteers hampering services to difficult to reach barangays; and
- a very mobile population due to high in-migration, thus requiring regular case-finding and masterlisting of target groups per program.

The problems identified in the inaccuracies of program figures and the factors contributing to low family planning use shaped the kind of MGP Plan that was implemented in San Jose del Monte. The first major intervention was the introduction of a Community Based Monitoring and Information System or CBMIS which provided more accurate information on the actual program indicators. The CBMIS then gave rise to subsequent programs including Community Service Outreach Activities, the development of a "Call-Slip" system, and the administration of vaccinations. In addition to these activities were those specifically targeting increased family planning (i.e. IUD and bilateral tubal ligations).

Through the MGP, San Jose Del Monte hopes to achieve the following specifically in the four program areas:

1) an increase in family planning acceptors by 10%
2) maintain the 100% TT+2 coverage
3) maintain the 100% FIC coverage
4) maintain the 100% Vitamin A coverage.

V. THE MGP IMPLEMENTATION AND OUTPUTS

The CBMIS[11]

The MGP point person in the town together with the regional technical adviser from MSH initiated a community-based monitoring and information system (CBMIS) as a way of identifying women with unmet need for family planning. Since the other LGUs in the first batch of MGP participants were also planning a similar system at that time, it was decided that the process be standardized across the MGP areas. San Jose served as a pilot area during the development of the standard CBMIS.

The CBMIS combines information gathering and service delivery during the house-to-house visits done by the Barangay Health Workers (BHWs). Aside from the four MGP indicators, SJDM also incorporated questions on other health programs such as the use of the growth monitoring chart (GMCs), promotion of iodized salt, and monitoring of environmental sanitation. Services such as the provision of Vitamin A capsules, FP counseling and re-supply (currently limited to condoms) are done on the spot. Those in need of follow-up are given call slips for referral to the next community service outreach or to a routine clinic, depending on the most proximate schedule time.

CBIMS Planning—First Draft of the CBMIS. The CBMIS tool for San Jose del Monte was developed during a workshop attended by the rural health physicians, selected Public Health Nurses (PHN), Rural Health Midwives (RHMs), and BHWs from both RHUs. Representatives from Department of Health Regional Field Office (DHRFO) and provincial health offices (PHO) also participated, with the MSH-RTA facilitating. The workshop took place approximately July 1999 (before fund release close to two months later in September).

In the workshop MGP performance indicators were stressed as the focus of the tool in order to get information on not only those who have been served in the target areas, but also those who have not been served. By identifying those who were not served, different service delivery strategies can be laid down depending on the circumstances, facilities, supplies, and manpower capabilities. Beyond the MGP target areas, however, the RHU health workers deemed it important that other kinds of information also be gathered (such as salt iodization and environmental sanitation).

In terms of the service delivery component of the CBMIS, much brainstorming and discussion was done as to the feasibility of providing certain services. For instance, the MSH - RTA had suggested that BHWs conducting the CBMIS should provide Pill users with a resupply on the spot. The MGP point person disagreed. Because Pill users require routine check-ups a discussions with a midwife on the possible side effects of Pill use which cannot be provided by BHWs (who are not adequately trained), the only FP that can be supplied are condoms on the spot. Later it was learned that in fact, the PHO of Bulacan also upholds that BHWs cannot resupply the Pill.

Pre-Testing of CBMIS. Having achieved a tool that was generated through the active participation and concern of local health workers, coupled with technical input from the MSH-RTA, the CBMIS was ready to be subjected to a pre-test. (Note: These activities took place prior to the release of funds).

A Masterlisting and Casefinding Team was created by the MGP point person which focused on assisting BHWs in training and other CBMIS-related needs.

Selected RHU I and II staff and all BHWs of San Isidro were oriented to the newly created CBMIS after which all of the BHWs of the barangay were assigned to

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[11] An easy to read table outlining the "inputs-processes-outputs for this aspect of the intervention can be found in the Appendix.

conduct house-to-house surveys. Each of the BHWs was assigned to survey 5 households as part of the pre-test.

The surveys were then reviewed by RHU workers along with the BHWs who had administered the pre-test surveys. Each of the items was discussed separately in order to understand which items BHWs had trouble with in order to detect flaws in the tool and to perform any necessary modifications. The result of this review activity became the final copy of the tool.

A subsequent, more general orientation of the masterlist followed the finalization of the tool. In addition, one-on-one training was done by the Masterlisting and Casefinding Team per barangay.

Subsequent Implementation of CBMIS.

Survey

The BHWs then conducted house to house surveys again but only in selected barangays due to a lack of funds (because MGP funds had still not yet been released at this point) in printing the tool. In the case of San Isidro, the initial surveys were only updated as most of the information was already gathered in the pre-test. In an exceptional case of Barangay Captain of Graceville, the Barangay Captain temporarily shouldered the printing cost of 1,500 copies of the tool so that the activities could be pursued while waiting for the MGP funds to arrive. Later, the Barangay Captain was reimbursed.

When MGP funds became available they were used for the printing of survey forms, meals and snacks for the CBMIS orientations, transportation allowances for BHWs, and BHW kits (as incentives for their volunteer work).

In Gumaok East, Graceville and San Isidro where surveys were almost complete, the results were then processed thro ıgh summary forms which includes information on the following: children and married wo nen of reproductive age (MWRA) with incomplete or no immunization at all; MWRA ne ɔding FP services; and eligible children who failed to have Vitamin A drops last April 1'99. The summary also includes household members having diseases, households needin; sanitary toilets, those lacking access to potable water and etc. Finally, the CBMIS becam: an opportunity for health workers to administer some services including the provision o: condoms, VAC, and children's Growth Monitoring Charts (GMC).

Service Provision

The completed household s ırveys are then consolidated and summarized by the BHWs, with the supervision of RH Ms. The information generated was then fed back to the respective rural health physicia ns for appropriate action. Further, the results of the CBMIS served as the basis for t ıe conduct of the community outreach. Areas with substantial "unmet needs" are priori ized and clients given call slips during the CBMIS are seen first. This system has made th outreach services more efficient and effective. Those who are unable to avail of these se vices (at the community outreach programs) are given referrals, with referrals to the RHU s ystem prioritized.

Additional Incentives for BHWs

A major concern in the CBM IS is its sustainability considering its intensive need for manpower. SJDM decided to provi le additional incentives (aside from the BHW Kits) by allowing BHWs to sell iodized salt during their house-to-house visits (note: based on initial findings of the CBMIS, the levels of iodized salt consumption was generally low). The BHWs make P3 per bag of salt s ld. There are reports that they earn up to P 1000 per month from these sales.

The implementation of the CBMIS and the significant additional programs that it eventually gave rise to (see below) demonstrate the importance of involving local health workers (both professional and volunteer) in all phases of a project. It was because the local RHUs insisted on including non-program indicators in the CBMIS survey that health workers were able to identify additional health issues being faced by the community. Meanwhile, the introduction of incentives was an important component of the CBMIS giving rise to an increase in the number of BHWs, who are volunteers.

As of March 2000, the CBMIS has been completed in eight barangays with three barangays out of 10 in RHUI and five out of 14 in RHUII. In RHU I, the computed average of households surveys is 73.56% out of the total households while in RHU II, the computed average of households surveyed is pegged at 81.27% of the total households. A total of 19,249 households have already been surveyed or roughly 77.56 of total households in both RHU I and RHU II. Table 1 shows a summary of the CBMIS accomplishment in San Jose Del Monte:

Outputs

Table 1. CBMIS Rate of Accomplishment

RHU	[illegible] HOUSEHOLDS	[illegible]
I	8516	73.56%
II	10633	81.57%
TOTAL	19149	77.56%

Though the evaluation study ended in March 2000, the plan for the CBMIS was to continue administering the survey until July 2000. The high rate of accomplishment at this stage of the implementation can perhaps be attributed to several factors. The first factor is the enthusiasm and initiative of local health workers in implementing this

particular intervention. While MGP were not released until September 1999, the CBMIS planning, CBMIS activities were already taking place from around July 1999 with the MGP point person shouldering the initial costs of the CBMIS in some areas, and in one barangay, the barangay captain shouldering costs in his particular locality. The second factor that may explain the high rate of accomplishment may be the incentives being offered to volunteers (i.e. Barangay Health Workers-BHW). From the MGP's inception (i.e. in the planning of budgetary allocations), incentives for volunteers have guided the implementation of the MGP programs. The result is that the number of BHWs has doubled, though the current ratio at 1: 122 households is still far from ideal The number of BHWs doubled from 99 to 200 during the course of the intervention. The innovative sale of salt becomes not only an incentive for more volunteers but provided a necessary service for community members. With four more months to implement the CBMIS in San Jose Del Monte and a total rate of accomplishment at 77%, we have reason to believe that they will meet their goal of 100% coverage.

The Call Slip System[12]

Clients whose service needs could not be provided on the spot during the CBMIS house-to-house visits are given call slips by the BHWs (i.e. those with unmet needs of "defaulters"). The call slips, developed with technical assistance from the MSH-RTA and printed with funds from the LGU, indicates the name of the client, the service needed and the next opportune visit either at a community service outreach (a specific MGP program discussed below) or routine clinic (with prioritization of RHUs). These are referrals for services that are beyond the capability of the BHWs such as provision of more detailed family planning counseling and of other contraceptives (aside from the condom), mother and child immunization, and other clinic services. The call slips also help in the systematic conduct of the community service outreach programs. Women and children

[12] An easy to read table outlining the "inputs-processes-outputs for this aspect of the intervention can be found in the Appendix.

with call slips are seen first and, if time and supplies allow, those without call slips are also attended to in the afternoon. This helps minimize overburdening the health workers with an unlimited number of clients, without antagonizing those who come for services.

Outputs

As of March 2000, a total of 1,434 call slips were given in RHU I while a total of 4,4449 call slips were given in RHU II. Out of these, a total of 1,181 clients responded to call clips given in RHU I (or 83.78%) and 2,810 in RHU II (60.82%).

Table 2. Call Slips Response Rate, as of March 2000

RHU I	1434	1181	83.78
RHU II	4449	2810	60.82
Total	**5883**	**3890**	**72.83**

Table 2 shows the distribution of call slips and client response per RHU. The differences in response rate between RHU 1 and 2 can be misleading unless the actual figures are taken into account. For instance, RHU 2 distributed almost three times as many call slips as RHU 1, and in the response rate, the RHU 2 garnered more than double the actual numbers of RHU 1, but the response rate of RHU 1 demonstrates that it performed better than RHU 2. Bearing in mind that RHU 2 has already covered 81.57 % of its total population as opposed to 73.56 % of RHU 1, it is possible that RHU 1 has yet to uncover more defaulters in its remaining unsurveyed barangays.

Clients, in general, were very responsive to the call slips. At a total response rate of 72%, the call slip program appears to have been successful. This perhaps can be attributed to the fact that the CBMIS which necessarily requires one-on-one, house-to-house contact

between health workers and community members is not only an information-gathering tool, but also a means of directly addressing community health needs.

The Community Service Outreach[13]

The community service outreach program was conducted following the summarized information gathered from the CBMIS forms. Together with the Call-Slip System, it aims to provide services to clients who have been identified as having "unmet needs" based on the CBMIS. It also serves as an "awareness and demand creation strategy" in the community as it draws attention to the importance of public health services, particularly preventive care. The community service outreach activities commenced in late August 1999—a few weeks after the implementation of the CBMIS and a month before the actual MGP fund release.

Prior to the conduct of the community service outreach, several activities were undertaken. First, there was the organization of a health team headed by the MGP point person. The team is responsible for going to the different *barangays* for the community service outreach. With a lack of manpower, the "team approach" was adopted bringing volunteer medical workers from other areas (i.e. outside of the MGP catchment areas) help out in the target community on the outreach day. Through this, more manpower is available for the big crowd that usually comes for services. Second, proper coordination with respective barangay officials is arranged including securing their support for the provision of snacks and lunches for the health team, and preparation of the venue. The PHO, meanwhile, provided for additional vaccines.

There were three types of outreach conducted in SJDM which provides

- immunization for mothers and children
- family planning counseling and resupply

[13] An easy to read table outlining the "inputs-processes-outputs for this aspect of the intervention can be found in the Appendix.

- Vitamin A supplementation.

1) Center-based outreach

On the morning of an outreach day, health center staff caters to the needs of clients who were given call slips during their CBMIS. The activity is held at the barangay hall or health station. During this outreach, mothers not using any family planning method were advised/supplied to practice FP and were likewise, injected with Tetanus Toxoid. Children were too, immunized. FP resupplies and follow-up immunizations were scheduled.

2) House-to-house outreach

In the afternoon of that day, clients who did not show up during the morning session are visited in their homes and served (i.e. mothers and children provided with TT2, mothers provided with family planning advice). Follow-up schedules are provided to those in need of subsequent doses.

3) Remote area outreach

For remote settlements such as the Dumagat[14] community of Sitio Karahumi Barangay San Isidro (an area about two kilometers from the nearest BHS that can be reached only on foot), a temporary center is set up on the designated outreach day. An information campaign is carried out prior to the visit through the barangay officials. In addition to the MGP services (TT2 immunization and family planning, and in this particular outreach—EPI or Expanded Program for Immunization was emphasized), chlorination of water supply and provision of toilet bowls was also done.

During the first months of the community service outreach, curative services were provided, usually in the afternoons. However, it was observed that these services took time and resources away from the preventive services and attracted too many clients who did not have call slips. Learning from this, subsequent outreach activities focused only on MGP services while those consulting for medical problems were referred to the routine clinics.

[14] The Dumagats are an indigenous people related to the Aetas, one of the first inhabitants of the Philippine islands. They are among the marginalized segments of our population.

Community outreach activities took place at least once in all 24 *barangays* in the MGP catchment areas. These outreach activities gained attention from the community but required substantial time, effort and resources to mount. While SJDM was able to mobilize volunteers for their health teams, they were only able to do because of the displacement of medical workers from the local Lying Center that had burned down. Without additional support, these activities may be difficult to sustain. The call slip system, together with the community outreach programs, can at least allow for those with unmet need to be serviced, even if it means that they only get referred to institutions that can better address their concerns.

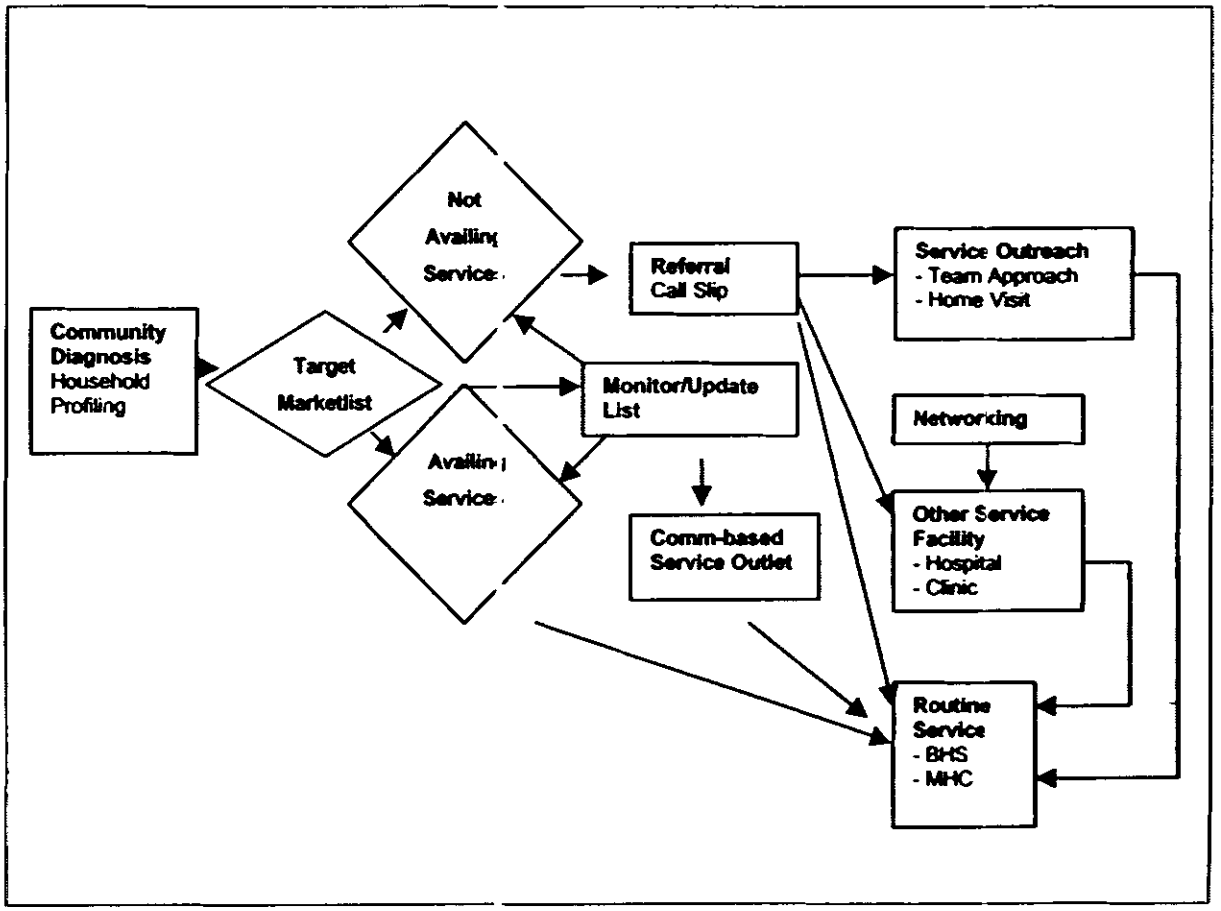


Figure 7. Operational Framework for the MGP Activities in San Jose del Monte

Figure 7 above shows the operational framework for the MGP activities in San Jose del Monte. This illustrates the integrated way in which the different MGP components are linked and focused on enhancing service delivery.

Revival of IUD Insertion at MHC

The IUD has never been a popular method in SJDM. Records from RHU I, where the service is available, show that from 1994 to 1998, an average of 15 insertions per year are done, accounting for <1% of total contraceptive use. At RHU II, the last records are from 1994, but clients from here are referred to the district hospital (SPDH) which thereby gets the credit for its FP program accomplishment. With the retirement of the only trained person at RHU I, there is no longer a trained person for IUD insertion. In addition to a lack of training in IUD in RHU II, its existing supplies were ransacked by theft in 1998.

The MSH-RTA consulted with the PHO on the matter in November 1999 since training is not within the scope of he MGP. The PHO replied that they are very much willing to hold a training for IUD insertion only that they have to do it when there are a good number of participants already interested in the service so as not to overspend for repeated training. For the meantime, the PHO suggested to coordinate with the chief of Sapang Palay District Hospital (SPDH) for a temporary referral system. In addition to the training, however, the PHO did provide an IUD kit, a stove, an examining table, and assorted forceps. MSH was able to coordinate with he SPDH hospital chief to accommodate clients from RHU I and II for IUD insertion in the interim period as staff were being trained. Referrals began at approximately November 1999.

In an interview with the Family Planning midwife of the Sapang Palay District Hospital (SPDH), it was learned that clients from RHU I and II were indeed coming to her for IUD insertion. She stressed, however, that once a client comes to her for IUD insertion, automatically, she becomes SPDH FP client and that recording will be reflected in her accomplishment and not with the sending RHU.

Outputs

Because the IUD interven ion was a referral program, the outputs from this intervention are not actually outpu s from the RHU I and II but can be attributed to the MGP intervention. Table 3 shows t ne number of IUDs inserted by year in SPDH.

Table 3. IUD inserted by year in SPL H

(Figures are gathered from interviews on / pril 13, 2000)

[illegible]	[illegible]	[illegible]	[illegible]
1998	0	0	0
1999	5	6	10
2000	1	2	3

Though the RHUs were u able to insert IUDs themselves, it appears that the intervention did have an effect on inc reasing the number of women getting IUDs (this is true specifically for RHU I as evidenced in the table below). For instance, for the year prior to MGP, no IUDs were being perform d at SPDH. It was only during the time of the MGP that IUDs were provided with a tot l of 10 for 1999 (note: the IUD referral system didn't start until November 1999) and 3 f r the first few months of the year 2000. A year-end report of IUD insertions may import nt to examine in order to understand the impact of the MGP in IUD use.

Networking with District Hospital for Bilateral Tubal Ligations

Like IUDs, permanent meth ds are available only at the district hospital (SPDH). The district hospital however only provides post-partums BTLs, unable provide regular BTLs. Clients need to go to the to vn of Sta. Maria. This severely limits access to this method. Hence, MGP implementer s needed to also network with the Sta. Maria District Hospital to set up a referral system w th them as well. This was done at about the same time

discussions were taking place with the Sapang Palay District for the IUD insertions, in November 1999.

The arrangement not only included a referral service to both SPDH and SMDH, it also placed the responsibility of the expense for the operation, particularly those executed in Santa Maria on the shoulders of the PHO (including service fees, medicine, and supplies). The RHU, on the other hand, would provide for post-operation medicine.

The MGP also provides escort services, covering transportation costs of clients and the accompanying health provider to either hospital. BTL

Outputs

As in the case of IUDs, the BTL intervention was a referral program. Table 4 shows the number of Post-Partum BTLs conducted by the Sapang Palay District Hospital.

Table 4. BTLs Performed by SPDH[15]

[illegible]	[illegible]	[illegible]	[illegible]
1998	2	1	3
1999	2	1	3
2000	3	1	4
TOTAL	**7**	**3**	**10**

As in the case of IUD insertions, we need to bear in mind that the referral system was not put into place until the later part of the year in 1999. Additionally, the evaluation study was concluded in March 2000 so the figures for 2000 are not quite complete. A year-end report may indicate some kind of impact on the part of the MGP in this area.

[15] BTLs for Santa Maria District Hospital were not available.

Additional Activities/ Offshoots of the MGP

Information garnered from the CBMIS become useful for identifying community health issues beyond those targeted specifically by the MGP. San Jose Del Monte was able to creatively address these problems by integrating them into the MGP program.

1. Vaccine Shortage

After the masterlisting was done in some barangays it was noted that many of the children beyond the set target range of the DOH have no or incomplete immunization. Their allocation of vaccines was only for 1-12 months old hence limiting the kinds of vaccinations available at the RHUs. To meet the need for vaccines, the MGP point person approached the Provisional Health Office specifically the DOH Representative, to seek additional vaccines to be covered by the various outreach activities of the MGP in San Jose Del Monte. Her request was granted and these vaccines were used beginning in August 1999 with the first set of community outreach programs.

After the successive comprehensive outreach activities were done in five barangays (Gumaok East, Gumaok Central, San Isidro, Paradise III, and Graceville) The RHU II ran out of vaccines. This was particularly true for the last barangay covered in October 1999 where many children came late and no vaccines were available. The vaccine allowances for the months of September and October 1999 as well as the additional vaccine supplied by the PHO had been used up.

Though not initially a key component of the MGP Plan, what is important to note with this particular program is the importance of the CBMIS in addressed community health needs directly. The MGP point person, for instance, firmly believed that children falling outside of the mandated age range of the DOH was necessary in order to protect them in the case of an epidemic. Further, children under the age of 5 are particularly

vulnerable to epidemic diseases She planned to make yet another request for vaccinations from the PHO.

The RTA attempted unsuccessfully to get vaccinations from the central office of the DOH. He was instead directed to the Region III DOH office that provided them with additional vaccines for their succeeding barangay outreach activities.

2. Universal Salt Iodization

Through the CBMIS, it was found that a majority of households were not using iodized salt. Further, additional surveys reveals that very few stores have an iodized salt supply. Health providers, however, were skeptical fearing that no amount of campaigning and law enforcement would work if iodized salt at affordable prices were not available in the market. Thus, a series of meetings were organized and undertaken by the MGP point person with local dealers and big suppliers/producers of salt to flood the market with cheaper supplies of iodized salt through the "Takal-Takal" system, as well as expanding iodized salt outlets in all barangays through BHWs. She decided to utilize the CBMIS and the BHWs to reach more households, and at the same time, provide the volunteers with incentives by allowing BHWs to sell iodized salt as they implement the CBMIS (note the above discussion). The selling of salt by BHWs started in July 1999.

To address this issue at the level of the LGU, in October 1999, SJDM's mayor issued an executive order reiterating the enforcement of the ASIN Law (RA 8172) and its implementing guidelines in the town.

3. Mother-Baby Watch

The baseline CBMIS and the BHWs' observations revealed that some mothers were not interested in availing of health services, despite their knowledge of the latter. The MGP point person decided to create the Mother-Baby Watch, an incentive-driven program focusing on health-seeking behavior. A mother and/ or her baby faithfully availing of health services gets points. Each service has corresponding points which are recorded on a watch

card. A total of 25 points entitles the mother to a pack of fortified foods which she can claim at the health center. A mother pack consisting of fortified noodles, iodized salt and maternal supplements, is given if she is pregnant or if her child cannot yet eat solid foods. A baby pack of cereals and other fortified goods is given if the child is of weaning age.

Points are categorized into 3 levels:

a) MUST: for routine services such as prenatal check-ups, TT or child immunization
b) EXTRA: for use of iodized salt, keeping of HBMR (Home-Based Maternal Record), and practicing FP after delivery
c) STAR: for baby FIC at 9 months, mother receives TT5, child is breastfed until 2 years

Private benefactors are tapped for the incentives. Each benefactor is asked to give P 25.00 per month for 33 months (or about P 825.00) to support a mother-child pair throughout the pregnancy, lactation and weaning period.

4. Solid Waste Segregation Program

The CBMIS also uncovered an alarming number of households that do not segregate their solid waste. The figures were then presented to the municipal council who tackled the issue by passing forming an ad hoc waste segregation group. Second, a municipal ordinance was passed to implement town-wide solid waste segregation. Once approved, a Solid Waste Segregation Program will be implemented municipality-wide. Further, consultations with barangay officials and NGOs are currently being conducted. The barangays are asked to send representatives for training in recycling at the ECO-Asia Research Institute, and encouraged to sell recycled materials as a form of income-generation.

5. Data Health Board

Included in one of the catch nent areas for the MGP is San Isidro which is home to a Dumagat settlement of about 8 5 families. The Dumagats are a group of indigenous people living near the borders of Ri:al and Bulacan. Like many other indigenous groups, many of the Dumagats are illiterate. In an attempt to make the health information system accessible to this particular commuuity, the RHU II introduced the Data Health Board to translate the CBMIS information or their use. Health programs are represented by figures, and household status, by cc lors. Data are arranged in a way that each household knows its "health status". Red mark: show incomplete coverage.

IV. CONCLUSION

Overall, the MGP in San Jo:e del Monte was implemented as originally planned (refer again to the outline of the MGP plan included in the above section on "MGP Program"). Program implementer:, however, were flexible enough to implement the program is alternative ways if nece:sary. Further, the indicators in the four targets areas are highlighted in order to demo nstrate how the MGP may have impacted service provisions in those areas.

The following summarizes t ie lessons learned from San Jose Del Monte from the evaluation of program performance which may help to inform the MGPs implementation in other areas.

At the local (municipal/city) level:

- In the case of San Jose del Monte, the MGP point person played an active role in all aspects of the program's implementation from the application stage until the program implementation stage. She participated in all aspects of the planning, implementation, and evaluation of each program of the MGP Plan for SJDM. She was able to mobilize local and regional resources (human,

monetary and in-kind) from both public and private sources above and beyond those provided by the MGP in order to enhance MGP-related programs.

- Support from local officials, particularly at the barangay level, appears to have been important in the program's implementation.
- Greater community participation in health activities begins with mobilizing and organizing the volunteer health workers. An incentive system, for instance in SJDM, helped to attract volunteers for manpower intensive activities like the CBMIS. Since the CBMIS involves house-to-house surveying, the more volunteers there are, more community members are brought into the survey and hence, more community members become likely to get more involved in different kinds of health activities. The community's participation in community outreach activities provides an example of this.

At the regional level:

- Coordination between the local MGP point person and the MSH-RTA appears to be critical in the implementation of the MGP. In the case of SJDM, for instance, it appears that the MGP point person and the MSH-RTA closely coordinated with one another during the entire process of the MGP's implementation. They are present at all critical meetings and appear to take the lead on critical issues.
- Support from the Provincial Health Office, particularly in-kind contributions, proved to be helpful in enhancing both MGP and MGP offshoot activities in SJDM.

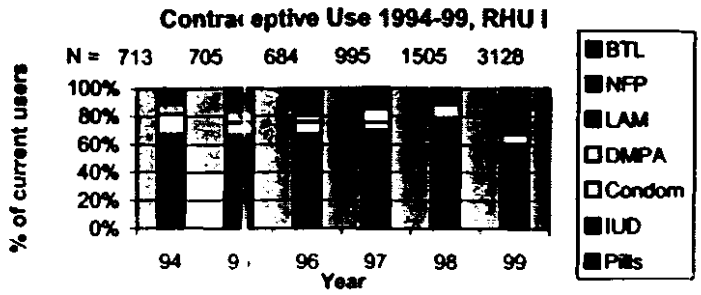
Program Concerns:

- While community outreach programs are an innovative strategy for expanding services in the target areas they may be difficult to sustain. Unlike the CBMIS which can operate on volunteer labor from the local community, community

outreach programs require properly trained staff to provide services to community members in the MGP's target areas. In the case of San Jose Del Monte, outreach activities involved three different strategies which are time and labor intensive. Further, because SJDM did not have enough trained staff locally to participate in the community outreach, it was required to recruit trained volunteers from other areas.

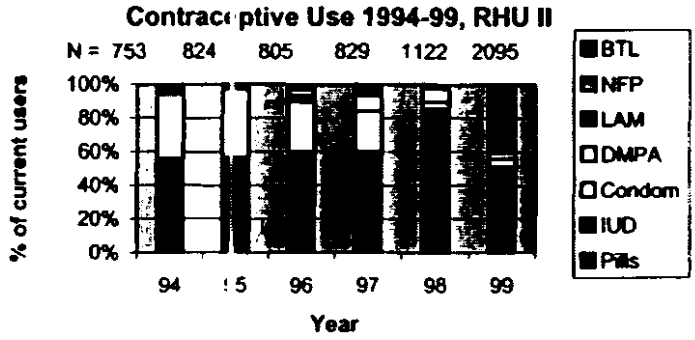
- Alternative methods of increasing family planning methods may need to be introduced. Introducing methods such as IUD insertions and BTL where there are few resources and trained personnel can be problematic. MGP family planning programs may need to focus on the existing skills and resources of a city. Programs such as the call-slip system and the community outreach programs may be better suited for dealing with family planning needs, yet they too (as discussed above) have some limitations.
- The MGP experience in San Jose del Monte is unique in that its activities are integrated, focusing on its CBMIS and relating subsequent service delivery (community outreach, call slips, IUD & VSS support, mother-baby watch and data health board) to the information generated.
- The MGP has served as a catalyst for other health programs such as Universal Salt Iodization, Mother and Baby Watch, Solid Waste Segregation Program and the Data Health Board.

San Jose del Monte has achieved the goals it has set for its MGP. It would be important to see, as it plans to expand implementation to the three other RHU catchment areas of the town, whether these gains are sustainable.



Source: SJDM, FHSIS

Figure 8 Contraceptive Use in RHU I, 1994 –1999



Source: SJDM, FHSIS

Figure 9. Contraceptive Use in RHU II, 1994 –1999

The accomplishments of RHUs 1 and 2 for their MGP show that they have both surpassed the goals they set out for themselves. FIC, VAC and TT2+ coverage have been maintained at their previously high levels and CPR has doubled compared to baseline. We have already discussed the issue of family planning and contraceptive use above, however, it is important to note the contribution of the intervention in maintaining FIC figures in the city. As noted in the 'Implementation" section above, the Vaccine program came as a result of initial findings from the CBMIS. Identifying a clear need in the community, the MGP point person took the initiative to secure more vaccinations for children despite the fact that they were outside the target range set by the DOH. Her

work resulted in the PHO's donation of vaccines which were used in the MGP community outreach activities.

Figures 10 and 11 illustrate the achievements in all four program areas. The data are based on San Jose del Monte's FHSIS reports. It would be interesting to compare this with the results of their CBMIS once completed.

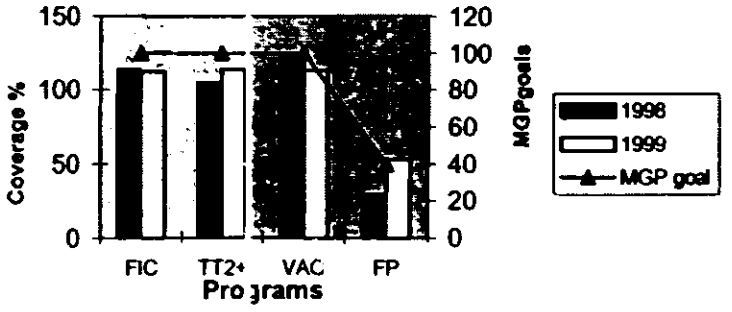


Figure 10. Program Indicators and MGP Goals, SJDM RHU1

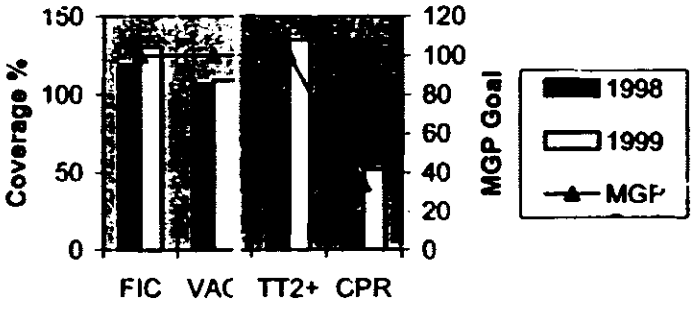


Figure 11. Program Indicators and MGP Goals, SJDM RHU2

Results of Additional MGP Prog ·ams

Vaccinations

The CBMIS was importar t in helping to identify children who were not fully immunized. The MGP program im plementers then secured vaccines from the PHO.

Universal Salt Iodization

The implementation of the "Takal-Takal" system and the incentive offered to BHWs in selling iodized salt has resulted i 1 first, out of the 200 BHWs in both RHUs, 166 selling iodized salt through their regular house to house visits/follow-ups. Also, from 15.2% of households using iodized salt, the pi ogram resulted in an increase in iodized salt coverage to 68% of households.

Mother and Baby Watch

As of this writing, there a e 81 pregnant mothers identified, screened, and now enrolled in the program. Mother an 1 Baby Watch booklets have already been distributed to them. There are also 50 benefactc rs who have committed to support one or more of the mother-beneficiaries. The MGP pc int person expects that come April 28, 2000, there will be more than one hundred benefactc rs.

Data Health Boards

The initial reports are very encouraging. Based on several informal interviews conducted among Dumagats, the DHB challenges the community members to take interest in their "status" and are finding ways to improve their color codes. The data

health boards are to be updated nonthly by the BHWs in coordination with their midwife.

APPENDIX

Table 5. Manpower Resources of RHU I and II, San Jose del Monte, as of 1999

[illegible]	[illegible]	[illegible]	[illegible]
Physicians	1	1	1 : 60,359
Nurses	1	2	1 : 40,239
Midwives	7	6	1 : 9,286
Med. Technologist	1	0	1 : 120,718
Dentist	1	0	1 : 120,718
Barangay Health Workers (BHWs)	23	76	1 : 244 households
Sanitary Inspector	1	1	1 : 60,359
Lab-aide	0	1	1 : 120,718

Source: SJDM MGP Proposal, 1999

Table 6. Health Facilities of RHU I and II, San Jose del Monte, as of 1999

[illegible]	[illegible]	[illegible]
Main health center (MHC)	1	1
Barangay Health Service (BHS)	7	4
Satellite BHS	10	15
Private hospital	1	0
Private clinics	15	13

San Jose Del Monte's MGP Plan

I. MONETARY AND HUMAN RESOURCES

- ✓ 400,000 pesos for the one year duration of the project [FROM WHOM]
- ✓ LGU counterpart of 105,800 pesos as counterpart
- ✓ LPP province to provide 116,000 worth of supplies, equipment and training costs
- ✓ technical assistance through the Regional Technical Advisor
- ✓ additional 100,000 pesos if the project is seen to be running smoothly but to be dispersed only after the submission of a second proposal. [BY WHOM]

II. PRE-IMPLEMENTATION ACTIVITIES

A) Recruitment of Additional Barangay Health Workers

- ✓ consulting with barangay officials and purok leaders regarding the need to recruit more BHWs
- ✓ shortlisting of probable candidates and subsequently interviewing them
- ✓ finalizing selection and formal designation of BHWs by barangay officials

B) Development and Production of Masterlisting (CBMIS) Tools

- ✓ meetings and workshops regarding the need to develop a masterlisting tool and discussing information it needs to incorporate
- ✓ pre-testing of the masterlisting tool
- ✓ assessment, validation and revision of the masterlisting tool
- ✓ final pre-test of the masterlisting tool in one barangay to be done by BHWs
- ✓ canvassing of the cost for the printing of the tools
- ✓ final printing of the masterlisting tools

C) Orientation of BHWs, Rural Health Midwives (RHMs) and Public Health Nurses (PHNs) on the tools and procedures for masterlisting

D) Orientation of Barangay Officials and Purok Leaders Regarding the Masterlisting to be Done Under MGP in Their Respective Areas of Jurisdiction

E) Increasing Frequency of RHMs visits to catchment barangays (at least once a week)

- ✓ preparation of monthly RHM schedule of barangay visits
- ✓ posting of weekly schedules
- ✓ announcement and follow-up of clients by BHWs

F) Establishment and Operation of Community Based FP Re-Supply Outlets

- ✓ identification/orientation of outlets
- ✓ posting of billboards per outlet
- ✓ distribution of contraceptives to outlets.

III. IMPLEMENTATION

A) Actual Conduct of Masterlisting in the MGP-covered Barangays

B) Initial Analysis of the Data Gathered Through the Masterlisting

C) Actual Conduct of Barangay Outreach, Specifically on Four Program Indicators Based on the Initial Information Gathered Through the Masterlisting

- ✓ health center
- ✓ house to house
- ✓ purok approach

D) Doing Home Visits for Data Collection, Provisions of Services, and/or Follow-ups

- ✓ weekly identification of non-availing clients
- ✓ referrals/provisions of call-slips

E) Comprehensive Processing and Presentation of Findings to Barangay and Municipal Officials for Appropriate Actions

F) Conduct of Quarterly Mopping-Up in Low Performing Barangays (Team Approach)

- ✓ monthly identification of low performing barangays
- ✓ scheduling and sending of notice to barangay officials and community

G) Updating of Masterlist and Continuing Case Finding

H) Daily Insertion of IUD at the RHC (Revival of IUD Insertion)

- ✓ identification of clients
- ✓ conducting IUD insertions by BHWs

- ✓ retraining of MHOs, PHNs and RHMs

I) Networking with Hospital for VSS

- ✓ coordination with hospitals
- ✓ identification of clients
- ✓ conducting VSS for clients
- ✓ Provision of Certificates to FIC as Incentive

Table 7. CBMIS Inputs-Process-Outputs Table

[illegible]	[illegible]	[illegible]
From LGU Staff time From Barangay officials BHW time From MGP a) PhP 50,000.00 for the printing of forms b) PhP 21,928.00 for the meals and snacks during the CBMIS orientation c) PhP 71,999.95 as Transport Allowance for BHWs d) PhP 102,250.00 for BHW Kits and T-shirts From DIRFO/ PHO Additional Vitamin A From MSH Technical assistance in development and conduct of the CBMIS	• Participatory approach to dev't of tool generated enthusiasm but took time • Required substantial manpower & time • Additional BHWs recruited & given incentives thru iodized salt sales • Information on other health services such as salt iodization and environmental sanitation obtained at the same time • Together with call slips gave RHU system for prioritization in service provision	• Number of BHWs doubled (from 99 to 200) • Underserved populations were identified and subsequently reached through community service outreaches held • 78% of households covered in 8 barangays (as of March 2000) • 5883 clients referred (based on number of call slips)

Table 8. The Call Slip System Inputs-Process-Outputs

Inputs	Process	Outputs
From LGU Printing of call slip forms From Barangay officials BHW time From MSH Technical assistance in developing the call slip system	• Took advantage of the CBMS visit to identify clients in need of services • Required sufficient motivation & initiative on the part of clients • BHWs played important role in distribution and motivating clients to respond	• 84% of clients in RHU I & 61% in RHU II responded to the call slips for an average of 73%

Table 9. The Community Outreach Inputs-Process-Outputs Table

Inputs	Process	Outputs
From LGU Staff time From Barangay officials Venue Food for health team From community Information & mobilization campaign From MGP PhP 12,500.00 for printing GMCs From DIRFO/ PHO Additional vaccines From MSH Technical assistance in identifying alternative ways of reaching target clients in optimal time and labor	• Curative services took time and resources away from preventive services • Barangay participation essential to carry out this activity • Demand creation strategy for health services	• All 24 barangays of RHUs I & II covered by March 2000 • Development of the call slip system • Many clients went back to routine services, esp. defaulters

Table 10. IUD Revival Inputs-Process Output Table

Inputs	Process	Output
From DIRFO/ PHO IUD kit (one copper T unit) 1 stove 1 examining table Assorted forceps Training of staffs on FP, esp. IUD insertion From MSH Lobbying with the PHO re: additional equipment and training for the SJDM health providers	• Access to IUD services is hampered by lack of trained staff & equipment • Training is not within the scope of the MGP	• Based on reports from the SPDH show that: from no referrals in 1998, RHU I and II referred 5 clients each in 1999; RHU I – 1 & RHU II – 2, for 2000 for a total of 13 during MGP period

Table 11. Networking with SMDH for BTL Inputs-Process-Outputs Table

Inputs	Process	Output
From LGU Post-op medications Accompanying staff From MGP Transportation costs From DIRFO/ PHO Cost of operation (supplies & medicines) Helped in fostering a network system appropriate for SJDM's status From MSH Technical assistance in fostering a network system through lobbying with the PHO	• Only post-partum BTL is available at the district hospital where clients are referred • Training on interval BTL would increase access to this method	• RHU I & II referred 3 clients for BTL to the SPDH in 1998, 3 in 1999 and 4 for 2000 (as of April 2000)