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LPP-Matching Grant Program
Performance and Evaluation Report
Tacloban, Leyte
Philippines

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SUMMARY

The Department of Health, with the support of the United States Agency for International Development (USAID) and technical assistance from the Management Sciences for Health (MSH) implemented the LPP-Matching Grant Program (MGP).[1] FRONTIERS Manila staff carried out two phases of the LPP-Matching Grant Program Evaluation Study, the program performance and impact evaluation. The program performance evaluation was conducted in four Local Governmen Units (LGUs)[2] from June 1999 to March 2000, of which Dasmariñas is part. The objectives are twofold: Firstly, to evaluate the relative effectiveness of various interventions funded by the MGP for reaching under-served and high-risk population with needed services; and secondly, to provide immediate feedback to improve program implementation. Greater impact and expansion of service delivery is expected in four areas: (1) increased coverage for fully immunized children (FIC), (2) vitamin A supplementation (VAC), (3) tetanus toxoid two plus (TT2+) for women, (4) and increased use of modern contraception (CPR) and reducing unmet need for family planning. Adopting the "input-process-output-outcome" framework, the study used program-based data through careful monitoring of activities, focusing on the inputs, processes and outputs. Evaluation activities in Tacloban covered the period from June 1999-2000.

Tacloban is the hub of development in Eastern Visayas. Migration from relatively less developed nearby areas (particularly Northern and Western Samar), account largely for its annual growth rate of 3.8%[5] (compared to the national growth rate of 2.5%[6]). Needless to say, this influx of migrant population exerts increasing pressure on the city's limited health care delivery and other social services.

A review of FHSIS 1999 indicators for the MGP's four target areas revealed that Tacloban has attained high performance in EPI and VAC, while TT2+ and CPR indicate low performance coverage. To achieve improvements in the areas identified as weak, Tacloban implemented 4 interventions including; the Community Based Masterlisting and Information System or CBMIS, Family Health Days/Mopping Up Operations, the integration of FP and TT services during the Social Hygiene Clinic and the Pre-Marriage Counseling Seminar, and finally, expanded health services through networking with NGOs. While the FHSIS identified specific areas of program weakness, Tacloban ultimately implemented a program

to address all four of the MGP's target areas. Further, the implementation of the CBMIS helped to remedy inaccuracies in the existing health information system.

Outputs from these interventions have resulted in the successful masterlisting of community members and the identification of clients with unmet needs through the CBMIS. Further, the CBMIS was also an opportunity for immediate service provision either through on-site services or referrals (considered a service in itself). Survey results from the CBMIS later helped in the implementation of the Family Health Days in all of the MGP *s*. Target clients were listed at the Family Health Days and provided services, those who were unable to get services during the activity were then followed up through "mopping up operations". 326 clients were provided with FIC services, 139 TT2+ and finally, 606 MWRA with unmet need for family planning were provided with services. In terms of clients being provided TT2+ and FP services, 47 (7.2%) of all (649) social hygiene clinic clients availed tetanus toxoid immunization, of which 22 clients received their first TT dose. 94 social hygiene clinic clients were supplied with condoms and pills while all were given lectures on FP and TT during bench conferences. 271 (91.7%) of 279 WRA attending pre-marriage counseling received TT immunization; of which 248 (89%) had their first dose, 5.4% received TT2, and 1.1% were given TT3.

Finally, in terms of the utilization of services from NGOs, 51 clients from Tacoma City ligated by Marie Stopes Foundation are subsidized by the MGP. Meanwhile, the Well-Family Midwife Clinic (WFMC) has performed 17 IUD insertions within the MGP period but only 8 are subsidized by the program because the rest as paying clients. Meanwhile, WFMC has served 25 DMPA clients

LIST OF TABLES AND FIGURES

ABBREVIATION

BCG	- Bacille Calmett Gourain
BHW	- Barangay Health Worker
BHS	- Barangay Health Station
BTL	- Bilateral Tuba 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

ACKNOWLEDGMENT

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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 Tacloban, and the Department of Health 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 health workers of the Anibong catchment area, as well as the local offices and non-government organizations in the municipality, have also been 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

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

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

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

The above recommendation became the basis for the development of the Matching Grant Program (MGP). The Matching Grant Program is thus designed to stimulate the LGUs to focus directly on strengthening service delivery giving the local government units more latitude in determining their local programs. Consequently, the MGP was developed with following well-defined features:[2]

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

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

- Targets mid-sized component cities and municipalities, initially those with a population of 100,000 and above, where actual primary health care services are provided

- Employs a "grantee-friendly" application process, with the Local Government Unit (LGU) defining its own goals and program direction

- Provides flexible funding of up to 500,000 pesos and access to technical assistance

- Encourages LGUs to increase fund allocation and expenditure for MGP-assisted programs through a "match" or counterpart funding

MGP Features

- *Targets mid-sized component cities and municipalities, with a population of 100,000*
- *"Grantee-friendly" application process, with the LGU defining its own goals and program direction*
- *Flexible funding of up to PhP 500,000 and access to technical assistance*
- *Fund allocation design for MGP-assisted programs through a "match" or counterpart funding*

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

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

Objectives of the MGP Evaluation Study

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

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

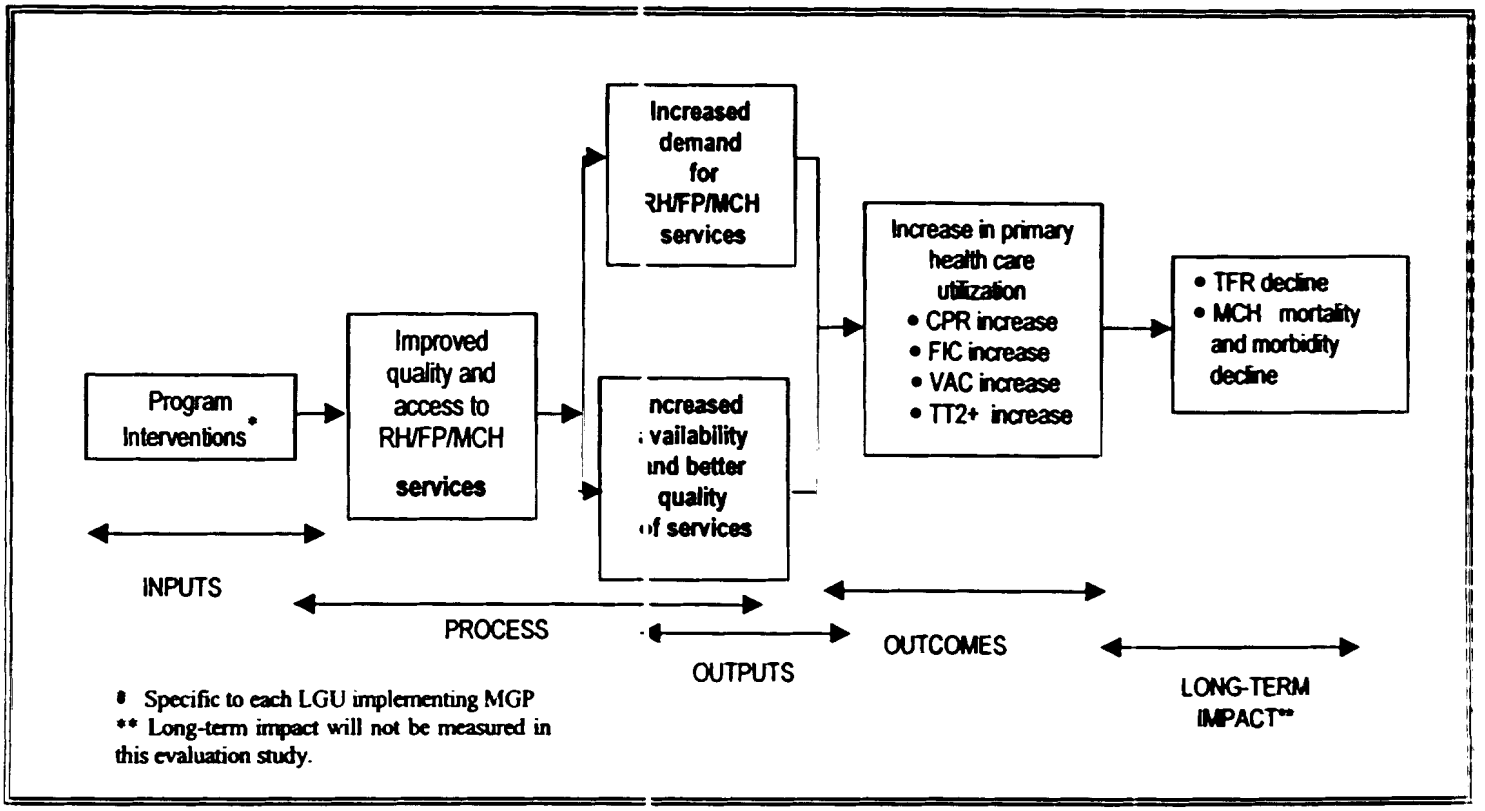
2. To evaluate evidence of direct impact in selected LGUs, as measured by the contraceptive prevalence rate (CPR), childhood immunizations (FIC), tetanus toxoid vaccination among pregnant and married women of reproductive age (TT2+), and vitamin A use (VAC) among children between the ages of 12-59 months.

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

Research Design

Due to the rapid implementation and timetable of the MGP, the evaluation proceeded in two phases. Phase One is the process or monitoring evaluation. This phase is limited to providing as much information about process and outputs (performance) among the first set of MGP participants. Phase Two consists of process and impact evaluation. This consists of assessing both program performance and outcomes. The primary objective is to determine whether different interventions (or mixes) will lead to significant increases in the four-targeted indicators (e.g., contraceptive prevalence rates). The time frame for observing changes was six months. The Evaluation used the "input-process-output-outcome" framework as shown in Figure 1.

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



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

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

- Clearly defined match, activities and budget
- Activities that will increase utilization of services among target clientele
- Activities should directly result in increasing coverage

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

- Discrete activities with reasonable chance of obtaining measurable impact within 12 months or less

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

Process and Monitoring Evaluation Sites

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

1. Impact Evaluation of MGP Sites

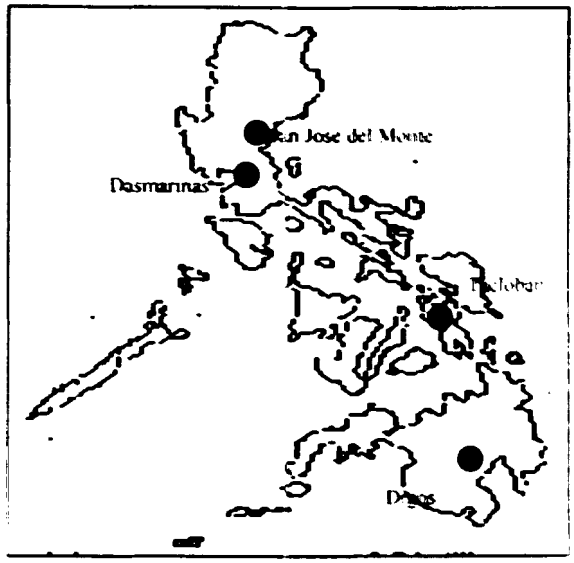
Strictly speaking, Phase 2 is an outcome evaluation (refer to Figure 1). It measures the immediate effects of the MGP interventions on specific program indicators, utilizing a quasi-experimental design: the pretest-posttest nonequivalent groups design. The MGP program outcomes are evaluated using data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

Site Selection. The original plan for selecting the impact sites was to use random selection from the second batch of MGP recruits[4]. However, because MGP was implemented on a "first come, first served" basis, it was not possible to randomize the selection procedure. In the end, the intervention LGUs 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 the Visayas, and Tagum in Mindanao These sites should not have initiated MGP activities before baseline assessment can be made.

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

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

Figure 2. The MGP Process and Monitoring



Because of delays in the implementation of the program interventions in Tagum, the third set of impact sites comparison (Tagum-Panabo) was dropped from the final impact evaluation. In the end, only two sets of comparison sites, Taytay-Binagonan and San Carlos-Cadiz, were included in Phase 2 of the study.

This report will present the process and monitoring evaluation results for Tacloban, which covers Phase 1 of the MGP evaluation study.

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

II. THE MGP PLANNING AND AP'LICATION PROCESS

The focus of this section is to c escribe and assess the MGP planning and application process in Tacloban City.

The MGP planning started wi h an invitation sent out on April 26, 1999 by the Regional DOH office to all qualified LGUs in the Region 8(with a population of at least 100,000) to participate in the MGP. Three LGUs in Region 8 fulfilled this requirement, namely: Tacloban City, Ormoc City and Catbalogan in Samar. Tacloban City Mayor Alfredo T. Romualdez was the first to respond o the invitation, sending out his letter of intent to the regional office of DOH on May 3, 1999

The MSH field coordinator vis ted the city a month later to orient the stakeholders about the process and requirements for participating in the MGP including the CHO, the DOH regional officials, representatives of NGOs, Marie Stops, and the Elite Family Development Organization (LEFADO) with its Well Family Midwife network, and local executives (mainly from the city popul:ation office and POPCOM). The orientation provided clarification of essential requirements of the MGP and facilitated planning for the development of the MGP proposal.

The CHO who was the prime implementer, as assigned by the mayor, of the MGP in Tacloban designated a member of his staff, the Family Planning coordinator, to be the MGP point person. The latter became responsible for the MGP proposal development with assistance from the MSH Field Coordi ator. The first draft of the proposal was sent to the DOH regional office and the MSH Field Coordinator. The draft proposal (with the comments) was then sent back to the CHO with recommendations for minor revisions.

It took the CHO three weeks to act on the requested revisions. On his visit to Tacloban City on June 28, 1999, the MSH Field Coordinator called the attention of the City Administrator and the Mayor to solicit his assistance in hastening the process. A meeting was then set up with the participation of the DOH Region VIII Regional Technical Advisory Team (RTAT) representative, POPCOM, and the City Health Office (namely, the City Health Officer, the Asst. CHO, and the Family Planning Coordinator as the MGP Point Person). The proposal underwent revisions during the said meeting, and was finally approved in July 7, 1999

The Memorandum of Agreement (MOA) spelled out the conditions for partnership between the DOH and the LGU under the MGP. This, however, had to be deliberated upon by local legislative body (the *Sanggunian Panlungsod*). A resolution was passed to authorize the City Mayor to enter into agreement with the DOH for and on behalf of the LGU. After the MOA was signed by the City Mayor on July 9, it was submitted to the DOH Regional Office for the Director's signature. It was finally signed by the Regional Director on July 13, 1999.

The required application documents had to be brought personally by the MGP Point Person to the DOH Regional Office. These documents were (1) the MGP proposal, (2) the MOA, (3) the SP resolution No. 99-141, and (3) a separate MGP trust fund bank account number. The MGP Point Person monitored and followed-up their application with the regional office in order to avoid any unnecessary delays. This personal follow-up paid off because on July 22, exactly 7 working days from the time the DOH director signed the MOA, the MGP check was released. It took a total of 68 days (slightly over two months) for the entire application & planning process to be completed.

Nine steps are thus identified as critical in the planning for the implementation of the MGP:

1) Invitation from DOH sent to Tacloban
2) Tacloban Mayor submitted letter of interest to the DOH regional Office
3) MGP Orientation to LGU Stakeholders
4) Preparation of MGP Draft Proposal
5) Review of MGP Proposal
6) Approval of MGP Proposal within the LGU
7) Signing of Memorandum of Agreement
8) Submission to the DOH of all application documents
9) LGU received MGP fund

As noted above, the MHS field coordinator had to intervene at one point to keep the application process moving. This instance emphasized the need for someone locally to ensure

that the MGP process is not stalled unnecessarily. The role of the Mayor is clearly essential, not only because he is the main signatory of the MOA but also because he is able to mobilize local stakeholders to act expeditiously in order to fast track the implementation of the MGP. Further, the personal follow-up of the MGP application materials to the DOH Regional Office ultimately facilitated the release of MGP funds.

In summary, the process from application to final MGP fund disbursement proceeded relatively smoothly and without much delay. The procedure of applying for the MGP was quite participatory and facilitative with the stakeholders at the LGU working in collaboratively with the management and advisory team (MSH-PMAT) and regional technical advisory team (DOH-RTAT).

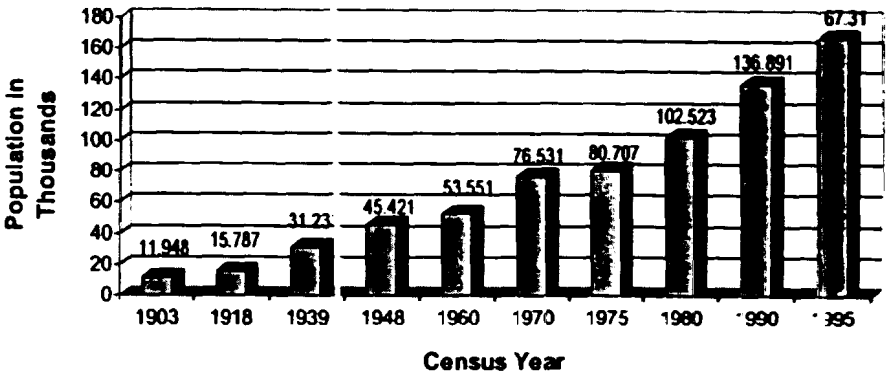
III. SOCIO-DEMOGRAPHIC AND HEALTH PROFILE OF TACLOBAN

Tacloban City, formerly named *Kankabatok*, is a first class component city of Leyte province located in Region VIII and created as such under R.A. No. 760 on June 20, 1952. Located in the northeastern portion of the island of Leyte, the city's land area totals to 10,090 hectares. It has 138 barangays, and only 14 are classified as rural barangays. Figure 2 shows the map of Tacloban City.

Demographic Characteristics.

Like many cities in the country the demographic experience of Tacloban is characterized by continued growth since 1903, accelerating more rapidly beginning in 1980 (Figure 2). The 1995 census shows a total population of 167,310 living in Tacloban City.

Figure 1. Population Growth in Tacloban 1903-1995



The city's population density is 1,658 persons/km^2 compared to the national population density of 229 persons/km^2. The city's population is relatively young, with 80% of its population below 40 years of age. The distribution of its people is concentrated in the urban areas, which comprises over 90% of its population.

Tacloban is the hub of development in Eastern Visayas. Migration from relatively less developed nearby areas (particularly Northern and Western Samar), account largely for its annual growth rate of 3.8%[5] (compared to the national growth rate of 2.5%[6]). Needless to say, this influx of migrant population exerts increasing pressure on the city's limited health care delivery and other social services. These new migrants tended to reside in specific barrages of the city. The City has a high literacy rate of 96.5%. Over 90% of Tacloban residents speak the local Leyte-Samarnon dialect, and the rest speak either Cebuano or Tagalog. Roman Catholic is the dominant religious affiliation of over 95% of the population.

The City Planning and Development Office reported that 66.4% of the labor force constitutes the economically productive population in 1998. Employment rate is 89%, but a majority of the urban poor fall under the category of unskilled labor.

Health Infrastructure

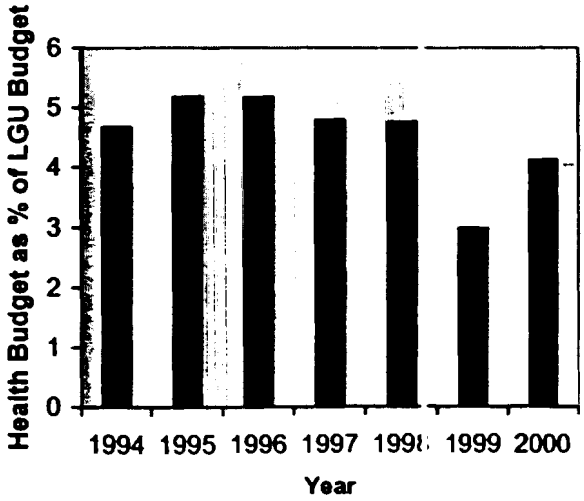
A closer look at Tacloban's health data shows that the health infrastructure has not kept pace with the rapid population growth of the city. First of all, Tacloban lacks adequate services and manpower. Overall the health services network in Tacloban includes, 4 hospitals

(2 public hospitals, Tacloban City Hospital, Eastern Visayas Regional Hospital, plus 2 private hospitals; namely Bethany Hospital and St. Paul's Hospital). The City Health Office (CHO) has only one health center, located at Kanhuraw Hill, capable of providing FP services for the entire city's 201,997 population. It is a multi-service clinic offering the following services: general medical consultation, family planning, MCH services, laboratory services, dental sanitation, TB, and leprosy services. Meanwhile, here are only 13 health stations (BHSs) serving 138 *s*.

NGO clinics providing maternal and child health care services are Marie Stopes Clinic and 4 Well-Family Midwife Clinics of LEFADO. There are, in addition to the two private hospitals cited above, 22 private clinics.

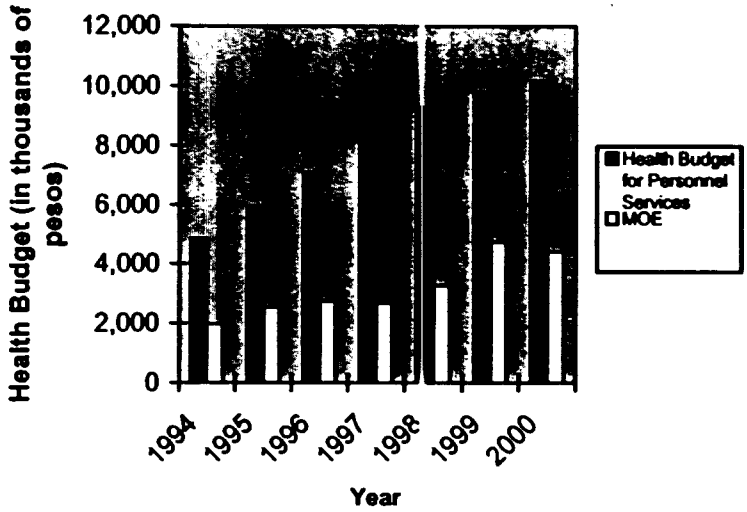
At the community level, there are 225 Health Workers (BHWs[8]) who are supervised by the City Health Office, and 133 Supply Point Officers (BSPOs[9], who are under the City Population Office). One midwife serves, on the average, eight barangays (about 100-150 households). Most of these community based workers do not receive any compensation or monetary incentives for their services.

Figure 2. Health Budget Compared to Total LGU Budget



While its total budget for health has been increasing over the years, the proportion of the health budget to the total LGU budget has, in fact, been decreasing from 5.2% in 1995 to 3.0% in 1999.

Figure 3. Health Budget Allocations 1994-2000



Of the total health budget, three quarters (1997) to two thirds (1999) go to personnel services, while funds for maintenance and operations (MOE) range from about 25% (1997) to 33% (1999) of the city's health budget in the past five years. This situation translates in decreased resources for supplies (drugs, medicines, etc.), equipment, transportation allowances for providers to serve remote areas, training and staff development, replacement and repair of facilities and equipment, and other similar expenses.

Health and Program Indicators

Figure 4. Tacloban Program Performance Levels

[illegible]	[illegible]	[illegible]
CPR	8%	46%
TT2+	56%	55%
VAC	100%	94%
FIC	100%	96%

Like all other LGUs, Tacloban has adopted the DOH Field Health Services and Information System (FHSIS) reporting system for estimating the level of their program performance. This means that program performance rates are computed using as denominators *estimates* of population groups that are targeted for particular services. To cite an example, in order to get the city's fully immunized children (FIC) coverage rates, the denominator is obtained by multiplying the *estimated* proportion of infants (which is set at the national level of 3.5%) with the city's *projected* population for the year (again computed based on the national growth rate which is below that of Tacloban). This computing approach explains why Tacloban, was reporting program performance rates beyond 100%. This practice is resorted to because there is a lack of reliable health information system at the community level, a situation that pervades throughout the country.

A clear implication of this is the need for a community-based reporting system, providing *actual* counts of specific population groups (such as women and children) from which more accurate denominators can be derived. This community based information system would be more useful and realistic in assessing program performance, and at the same time to be used as a tool for identifying target clients in need of particular health services. Despite the inaccuracies of the FSHIS data, it is worth noting that Tacloban has attained high performance in EPI and VAC, while TT2+ and CPR indicate low performance coverage.

IV. THE MATCHING GRANT PROGRAM OF TACLOBAN CITY

Anibong was chosen as the site of MGP activities in Tacloban. Health Officials chose to focus the MGP program towards *increasing the coverage of tetanus toxoid plus (TT2+) and FP services.* On the basis of the merit of proposed MGP activities, Tacloban received an MGP allocation of PhP 400,000 (equivalent to US$10,000). As a "meaningful counterpart" to the MGP grant, the LGU re-aligned PhP130,830 from the city's existing budget and allocated PhP 150,000 from its year 2000 budget for the MGP. The grant was to run from July 1999 through July 2000.

The infusion of these resources and technical assistance enabled the LGU to direct the MGP interventions on service delivery in 24 under-served urban barangays of Anibong.

Community Based Monitoring and Information System (CBMIS)

Like other LGUs in the country, Tacloban used the Field Health Services and Information System (FHSIS) for reporting and estimating the level of their program performance which has lead to, as discussed above, the reporting of program performance rates beyond 100%Realizing this, Tacloban decided to implement the Community Based Masterlisting Information System (CBMIS) as a basic activity to be undertaken under the MGP.

This scheme involves the master listing of all MWRAs and children in the MGP areas. Trained volunteer outreach workers, supervised by midwives and nurses, survey all families living in their particular areas, identifying those who have unmet health care needs. Individuals who are identified during the masterlisting as having a particular "unmet need" are given the necessary information and are referred to a fixed facility.

Family Health Day (FHD) /Health Mop-up Operations

The Family Health Day, although widely practiced in many parts of the country, is an MGP initiative in Tacloban. It consisted of extensive medical outreach activities, with multi-sectoral collaboration. It brings a wide array of basic health services to the community like Family Planning, EPI, Tetanus Toxoid Vitamin A supplementation, medical consultation

particularly for diarrhea (which is highly endemic in the area), dispensing of Oresol, dental services, provision of medicines, and advocacy through counseling and puppet show. The Health Mop-Up operations, on the other hand, involved house to house visits by service providers to deliver such services as immunization and family planning, to those who have missed out on the immunization, nutrition and family planning services in the fixed clinics and the Family Health Day activities

Active Provision of FP and TT Services in Social Hygiene Clinic and Pre-Marriage Counseling

This is a new service integration strategy tailored to addressing missed service opportunities to clients who cannot or have not availed of FP and TT services during routine schedules in the regular health clinics. Clients coming for social hygiene check-ups and pre-marriage counseling, with the MGP, have the opportunity to be given the first dose of TT2+ and provided with counseling on family planning. They can also be resupplied with contraceptives through the Social Hygiene Clinic.

Expanding Services Through Partnership with NGOs

This activity involves establishing partnerships with non-government organizations like LEFADO with its Well-Family Midwife Clinic for IUD insertion and DMPA, and Marie Stopes Foundation for bilateral tubal ligation (BTL).

V. MGP IMPLEMENTATION IN TACLOBAN CITY

1. The Implementation and Outputs of the CBMIS[5]

Development of the CBMIS Questionnaire

To begin the CBMIS the MGP Point Person in Tacloban developed an interview schedule, collecting data for each target program indicators with inputs from different program coordinators at the CHO and the MSH Field Coordinator. The draft of the questionnaire was finalized on July 5, 1999.

[5] See Appendix for an easy to read Input-Process-Output table.

Orientation

Having finalized the draft, the CHO conducted two batches of orientations for outreach workers on July 22 and 26, 1999. Prior to the actual conduct of household survey or masterlisting, it was decided that the CHO should orient the constituents of Anibong including the Barangay Chairmen, the Barangay Councilors/Kagawad, BHWs, and BSPOs about the MGP Program. This was held on July 29, 1999 at the Kanhuraw Convention Center Lobby. Highlights of the orientation focused on the introduction of the MGP by the MSH Field Coordinator, and the presentation of the MGP Plan.

On the subject of the CBMIS, the participants in the orientation meeting agreed to adopt the team approach for masterlisting based on clusters since only 1 BHW/BSPO/BNS is assigned per barangay. Teams or clusters were formed with the understanding that those unfinished or unsurveyed barangay/s will be covered by the other team/s who have completed masterlisting their areas. It was emphasized during the orientation that incentives will be given to BHWs/BSPOs/BNSs and members of the CHO Itinerant Team (responsible for overseeing the implementation of CBMIS) for conducting the masterlisting activity. The MGP allocated P28,000.00 for this purpose. Each field interviewer would receive P500 at P50/day for 10 days.

Organization and Composition of Working Teams

CBMIS field interviewers were identified and selected after the orientation was conducted. Only committed volunteers with higher educational background and some experience in conducting surveys were tapped. A total of 46 women (BHWs/BSPOs/BNSs), 7 of whom were BSPOs, conducted the CBMIS in the 24 barangays of the Anibong area. They were supervised by the CHO Itinerant Team composed of 9 members (nurses and midwives assigned in the area).

Three teams were organized to conduct masterlisting, namely:

Team	Composition	No. of Bgys. Covered
Sea Wall-Quarry Team	15 BHWs/BSPOs 4 CHO Itinerant Team	12 barangays
Anibong Team	15 BHWs/BSPOs 4 CHO Itinerant Team	7 barangays
Naga-Naga-Nulatula	10 BHWs + 2 Midwives 1 CHO Itinerant Team	5 barangays

Actual Conduct of Masterlisting

The household survey started on the 4th of August, 1999 by the Sea Wall-Quarry Team. The 2 other teams started 5 days later. However, after covering 12 barangays, the CBMIS was stopped as there were logistical problems that came up in the actual conduct of masterlisting. There were a lot of misconceptions and unclear expectations about the utility of the master list. Some of these problems include confusion about recording and tallying identified potential clients, areas of responsibilities (who collects and who tabulates data, who keeps the list, etc.) and how the CBMIS could be linked with services in the fixed clinic. Given these problems, it became clear that further pretesting of the tool was needed, as well clarification of the roles of field interviews, the midwives and nurses involved in both the masterlisting and service delivery functions of the CBMIS.

A meeting was later held by DOH, POPCOM, and NGOs to settle these issues. A version of a CBMIS tool used in another LGU (Legaspi) was studied by the MGP Itinerant Team for consideration in Tacloban. Since data consolidation was one of the issues raised by the service providers, the Legaspi form was revised in a way that would simplify recording and consolidation of the interviews data. It was decided that both the BHWs/BSPOs (field interviewers) and the nurses and midwives (members of the Itinerant Team) should keep a copy of the masterlist as a basis for identifying target clients, and services needed by target clients. It was decided that midwives and nurses become more involved in the actual masterlisting activity (as opposed to playing only a supervisory role).

The household survey was resumed and the remaining 12 barangays were surveyed using the new and revised form. This form still had some problems, but the teams managed to complete the master listing procedure on August 30,1999.

Data Processing and Consolidation

Accomplished interview schedules were submitted to the members of the CHO Itinerant Team for data processing and consolidation. The midwife or the nurse assigned to a particular barangay did the checking of field interviewers' survey outputs, consolidated and summarized the data in a survey report showing the total number of households surveyed, child and mother data (based on the 4 target areas), and unmet needs. The MSH Field Coordinator provided guidance on data analysis.

Service Provision

The actual conduct of masterlisting for the CBMIS was not only geared towards data generation, but also included service provision by BHWs/BSPOs/BNS. Service provision integrated into the masterlisting included: counseling/information-giving on-site and referrals of clients to service providers both to the City Health Office and NGOs for DMPA, pills, IUD, female and male sterilization, immunization for mothers and children, Vitamin A supplementation, and re-supply of condom and oresol.

Outputs

Table 5 shows the results of the masterlisting activity as of August 1999. The results gave the MGP team a picture of the target clientele in the community. Presented in this manner, the data in the table show the level of coverage on the first three indicators: Percent of fully immunized Children (FIC), Vitamin A coverage (VAC), and Percent of Women given TT2+. The data for these indicators are 46%, 99%, and 62%.

Table 5. Masterlisting/CBMIS Summary Results 1999

Indicator	Population
▪ Children 0 – 11 months old	1,219
1. > 9 months w/ incomplete or no immunization	175
2. < 9 months w/ incomplete or no immunization; recommended schedule not followed	208
3. < 9 months w/ incomplete immunization; recommended schedule followed	273
▪ Number of Fully Immunized Child (FIC)	563 (46%)
▪ Children 12 – 59 months (1 – 4 years old)	4,908
1. w/ incomplete immunization	167
2. not given Vitamin A in the last 6 months	27
▪ Vitamin A Coverage (VAC)	4,881(99%)
▪ Number of Women of Reproductive Age (WRA)	4,249
1. Pregnant women w/ incomplete or no TT	112
2. Non-pregnant MWRA w/ incomplete or no TT	2,027
3. Number of pregnant women	292
▪ Number of pregnant women given TT2+ (TT2+ Coverage)	180 (61.6%)
▪ Number of Married Women of Reproductive Age (MWRA)	3,825
1. No. of MWRA practicing FP method but not satisfied	84
2. No. of MWRA not wanting to have a child or wants to space but not practicing FP	1,676
3. No. of MWRA who wants a child soon	
▪ Number of MWRA w/ unmet need for FP	421
	1,760

* CHO Report as of August 1999

The CBMIS allowed for the identification of specific groups (unsatisfied FP users, pregnant women with incomplete TT, incomplete immunization, etc.) that are programmatically relevant to the health system. The health providers particularly appreciate this aspect of the CBMIS. The City Health Office has found the CBMIS to be a useful tool, not just for obtaining information about their clients, but for facilitating service delivery as well.

2. Implementation and Outputs of Family Health Day and Mop Up Operations[6]

The Family Health Day (FHD) and its "Mop-Up Operations" involved extensive medical outreach activities to make health services more accessible to the community and to particularly serve the identified target population specified by the results from the CBMIS. A Family Health Day per was scheduled within the Anibong catchment area. Each council

[6] See Appendix for an easy to read Input-Process-Output table.

and the CBMIS teams planned how to reach clients, ensure they receive services and are followed-up through "mop-up" operations.

NGOs like LEFADO, Marie Stopes, R.T.Romualdez Medical School, Leyte Institute of Technology, Glaxo Drug company participated in these activities. Medical clerks from RTR Medical School assisted in delivering health services while the Leyte Institute of Technology sponsored puppet shows to deliver relevant health messages during the Family Health Days. BTL services were handled by Marie Stopes.
From September 2, 1999-December 3, 1999, twenty-eight Family Health Days were scheduled.

Preparatory Activities

The MGP Point Person called a meeting to discuss matters concerning the medical outreach through Family Health Day in the each of the barangays where FHDs were to be held convening local leaders and BHWs/BSPOs/BNSs during their 1st regular monthly meeting on August 30, 1999 held at the Anibong Chapel. The MGP Point Person prepared the proposed schedule for FHD and consolidated survey results of the first three barangays where the first outreach was conducted. Highlights of the discussion were focused on the following agenda: status of masterlisting, incentive of field interviewers, FHD schedule, and barangay counterpart. The schedule of the first round of FHD was determined to be held the Tuesday and Thursday of each week.

Survey results were to be used during FHD. The CBMIS results would help identify target clients in the 4 target area and hence the specific services needed. The City Health Office thru the midwife or nurse informed their partners in the barangay (BHW/BSPO) on the survey result in order to plan particular FHDs. Survey results were to be posted on the wall of a facility which would list target clients for ease in cross-checking and identifying those who failed to come to the FHD and hence needed to be follow-up with a "mop-up" operation. For instance, a list of target clients was drawn up and checked as they came for services on the FHD itself. Those who failed to come by were followed up in their homes ("mop-up operation") in the afternoon, and were provided the services (if they gave their

consent) or told to go to the clinic for the desired services that cannot be given during the home visit. In the case of those who are not located during "mop-up", the NGO service provider of the Well-Family Midwife Clinic would complement the CHO midwife in revisiting and providing service to those clients during the weekend.

At the local community level, the barangay council had their share in the preparations and actual conduct of Family Health Day. They convened meetings with the BHWs/BSPOs on the necessary preparations (e.g. social mobilization, physical arrangement of the venue, provision of food, and other facilitative concerns). The council together with the BHW/BSPO were responsible in informing and mobilizing their constituents and target clients for their Family Health Day. It took 3 days of preparation prior to the conduct of Family Health Day.

Actual Service Delivery

Though IEC/advocacy is not a prime concern of the Matching Grant Program, the City Health Office still felt the need for its integration into the implementation of the MGP. Linking with the Leyte Institute of Technology (LIT), it made arrangements for the LIT's Community Extension Services Department to sponsor a puppet show which provided awareness and information on the 4 focus programs of the MGP. However, the involvement of LIT depended only on their availability during specific barangay FHDs.

FHD took place in two rounds with the first round of Family Health Day schedule ending last October 21. After the October 22 assessment meeting, the MGP Itinerant Team decided to expand service provision to another five barangays. 5 barangays (Bgy. 44, 44-A, 45, 72 and 73) from the first batch, were excluded however, because they already have high performance coverage, and can be sustained in the regular schedule.

The criteria for selecting the additional five barangays for expansion were based on the population (densely populated) and low performance indicators on the 4-program targets. The new five barangays included in the second round of Family Health Day were Bgys. 49, 50-A, 91, 94, and 94-A. The same preparations and activities were undertaken prior to actual service delivery provision during this second round of Family Health Day.

Utilization of the LPP-MGP Vehicle

The purchase of a vehicle was intended for mobility support for MGP activities, especially in community outreach activities like FHD and "mop-up" operations. The CHO requested the LGU for the local procurement of the vehicle on August 23, 1999. The vehicle was received by the CHO on the 25th of October, two months after it was requested. The MGP vehicle is a multi-cab, locally made by Four-A surplus assembler shop. The actual cost of the vehicle is P133,000.00, exceeding three thousand from the budget allocation. From its receipt, the vehicle was used for a short time for FHD and "mop-up" but was on hold due to some bureaucratic procedures for government vehicle registration and insurance. Charging for the vehicle insurance would have been an issue before MGP because the LGU has no budget for it. Fortunately, insurance fees and the exceeding amount of the vehicle were charged from the MGP fund.

Re-utilization of vehicle started last 3rd week of January when it was released by the local shop after the LGU had paid for the P133,000.00. In times when the vehicle is not used in community outreach activities like FHDs and mobile clinics every morning, the vehicle is stationed at the CHO for other errands. It is also utilized in servicing the clients from the community to particular health facility (i.e. transporting FP clients for ligation from the community to a facility and vice versa).

Outputs

The following table demonstrates the numbers of target population served (as generated from the CBMIS) as a result of FHD and related activities.

[illegible]	[illegible]	[illegible]
FIC	**838**	**326**
TT2+	**304**	**139**
MWRA with Unmet Need for FP	**1760**	**606**

3. Implementation and Output Integration of FP and TT services during social hygiene clinic & pre-marital counseling (PMC)[7]

Integration of family planning services and tetanus toxoid immunization in social hygiene clinic and pre-marriage counseling is a new strategy of the City Health Office under the MGP. The intervention is tailored to capture the missed clients who cannot avail of the services during regular schedule in health facilities.

Social Hygiene Clinic

The social hygiene clinic serves the city's commercial sex workers, who are all women of reproductive age and among those usually marginalized by routine service delivery. Every afternoon, midwife conducts a "bench conference" while clients are waiting their turn to be examined. Family planning, tetanus toxoid immunization and other health education topics are discussed, and leaflets are distributed. Clients may then opt to avail of FP and TT immunization services right then and there, and are scheduled for follow-up on subsequent social hygiene clinic days.

It was observed that, at first there was some sort of resistance from the clients because of their fear on TT immunization. Nonetheless, the resistance had reverted after the lecture and motivation of the service provider; thus, availing the tetanus toxoid immunization.

[7] See Appendix for an easy to read Input-Process-Output table.

Pre-marriage Counseling

Couples who register for marriage license are required to attend a pre-marital counseling (PMC) session where FP is discussed. With the MGP, the CHO began offering FP services on the spot, as well as TT immunization. This idea came about with the observation that some of the women who come for PMC are already pregnant. The PMC session, provided every Wednesday and Thursday, also provides the opportunity to address misconceptions regarding tetanus toxoid, particularly the fear that it would cause sterility. A system for follow-up to complete subsequent doses during the routine clinic was also established. There are at least 5 couples in every PMC session to a maximum of 12 couple-participants.

Negative reaction of participants is very negligible. In fact, only 2 clients refused the service because of fear of injection and negative notions of TT immunization. Common reactions of clients on TT immunization during the discussion of the topic were: a) young women's fear of injection and its pain and swelling, and b) fears of sterility However, those potential clients who had some initial fears were convinced and received the tetanus toxoid after a thorough explanation and advocacy on the part of service providers.

Outputs

- 47 (7.2%) of all (649) social hygiene clinic clients availed tetanus toxoid immunization, of which 22 clients received their first TT dose.
- 94 social hygiene clinic clients were supplied with condoms and pills.
- All social hygiene clients were given lectures on FP and TT during bench conferences.
- 271 (91.7%) of 279 WRA attending pre-marriage counseling received TT immunization; of which 248 (89%) had their first dose, 5.4% received TT2, and 1.1% were given TT3.

4. Expanding Services Through Utilization of NGO Clinics in the Area[8]

The City Health Office found it very important to work and collaborate with NGO clinics in order to expand service delivery coverage. Considering their limited manpower

[8] See Appendix for an easy to read Input-Process-Output table.

resources, they needed the services of NGO clinics to complement them on tubal ligation, IUD insertion, and DMPA. The MGP allocated a certain budget for the professional fee of NGOs who offered a big discount for those 3 services to indigent clients.

Service Delivery

The LGU required a Sangguniang Panlalawigan (SP) resolution to support the subsidy allocation for the services provided by the NGOs under the MGP collaboration. The same resolution was made and approved by the SP as per request of the City Health Office, being the proponent of the MGP. The partnership of the CHO and the NGOs started on July 1999.

Under the MGP collaboration, Marie Stopes Foundation provided the BTL, and the Well-Family Midwife Clinic of LEFADO provided IUD insertion and DMPA. The schedule of Marie Stopes Clinic for ligation was posted in the clinic.

Additionally, the community was being informed by the service providers and the BHWs. During the CBMIS, BHWs informed and motivated them. They secured referral slip from the BHW, certified by the CHO and the Barangay Chairman. The clients were accompanied by their BHW to the clinic during the ligation.

The Well-Family Midwife Clinic provides different services, available anytime of the day in the clinic except when the midwife joins with the Itinerant Team during Family Health Days. Maternal and child health care services are accessible to the community because the clinic is located in the Serin-Quarry area of the Anibong catchment area. FP clients for IUD insertion and DMPA who could no longer be accommodated by the CHO service providers are being served in the clinic by the resident midwife. IUD and DMPA indigent clients are subsidized by the MGP.

Aside from the involvement of the midwife of LEFADO during FHDs/mop-up operations, she also complements the CHO service providers in the Serin-Quarry BHS during the regular EPI schedule. This partnership with the CHO service provider in Serrin-Quarry was established even before the MGP. The partnership has been enhanced through MGP collaboration. Market segmentation is an important component of the collaboration. Indigent

clients who want permanent FP method can be served by the regional hospital (EVRMC) and Marie Stopes Foundation. The City Health Office, EVRMC, City Hospital, and LEFADO (Well-Family Midwife Clinic) provide services for non-permanent methods for indigent clients. The working or middle-income group is classified to be serviced by Bethany hospital for permanent method. LEFADO and Marie Stopes Foundation are identified as service providers of the working or middle and upper income class for the non-permanent method. Although the different stakeholders of the MGP had convened and made initial moves in classifying the population, it still requires a long process and concerted efforts for the institutionalization of market segmentation. The Provincial Population Office has also extended technical assistance for market segmentation, and until now it is still evolving.

Outputs/Outcomes

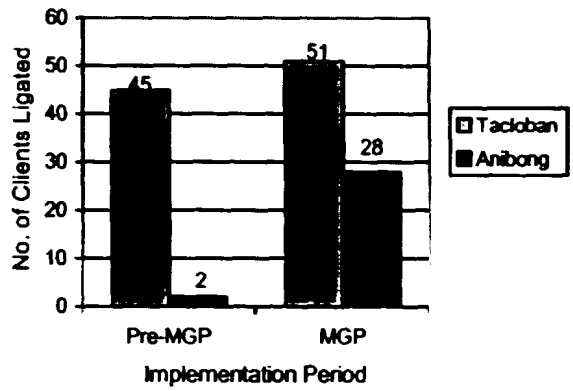


Figure 2. Comparative Data on number of clients ligated by Marie Stopes Clinic, Tacloban and MGP area (Anibog), Pre- and MGP Period

As demonstrated by Table 6, 28 clients from Anibong as compared with 51 clients from Tacloban City ligated by Marie Stopes Foundation are subsidized by the MGP.

Table 7 indicates that Well-Family Midwife Clinic has performed 17 IUD insertions within the MGP period but only 8 are subsidized by the program because the rest as paying clients. Meanwhile, WFMC has served 25 DMPA clients[9].

[9] See Appendix for more detailed break-down of services provided at each of the clinics.

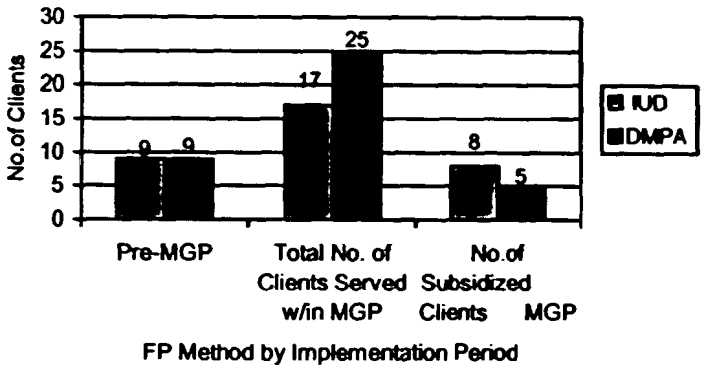


Figure 3 Comparative data on number of Anibong clients served by WFMC during Pre- abd MGP Period

Clients were satisfied with the service provided by the Marie Stopes Foundation. They were checked by the doctor before the operation was conducted. The operation was very fast. They were provided with free medicines by the clinic, and were instructed to return if there were complications. So far, clients have not felt any post operation complications, and were fine with the operation. They only returned to the clinic for the removal of the sutures. Further, clients were happy because the MGP has provided them the opportunity for a free ligation in Marie Stopes Clinic.

5. Other MGP activities

Coordination meetings have been conducted from time to time to assess program implementation. Members of the MGP Itinerant Team meets every month or as the need arises with the BHWs, BSPOs, partner NGOs and government organizations to monitor the progress of program implementation, provide feedback and to strategize about immediate solutions to problems and issues in the implementation. Re-direction of activities was also undertaken.

Table 6 summarizes the interventions implemented through the MGP in Tacloban. It shows the comparison of activities and service delivery of the CHO in the pre- and - MGP period.

Table 6. Comparative CHO service delivery in the Pre – and – MGP

Activities	Schedule Pre-MGP	MGP
• Routine / Regular		
- Family Planning Services		
Main Health Center (CHO)	Every afternoon	Every afternoon
Anibong BHS	Every Friday	Every Friday
Serin-Quarry BHS	Every Friday	Every Friday
Nula-Tula BHS	* Any day	* Any day
- EPI		
Main Health Center (CHO)	Every Wednesday	Every Wednesday
Anibong BHS	Every Wednesday	Every Wednesday
Serin-Quarry BHS	Once a month	Once a month
Nula-Tula BHS	Once a month	Once a month
- Pre-natal Care and Tetanus Toxoid Immunization		
Main Health Center (CHO)	Twice a week	Twice a week
Anibong BHS	Twice a week	Twice a week
Serin-Quarry BHS	Once a month	Once a month
Nula-Tula BHS	Once a month	Once a month
• Medical Outreach		
- Mobile Clinic for medical consultation	Twice a week	Daily
- Family Health Day		Once a month
• Dental Consultation (CHO)	Daily	Daily - integrated in the first round of FHDs
• Masterlisting / Community-Based Monitoring and Information System (CBMIS)	-	Started August for Anibong & March for Sagkahan Updating is done monthly
• Mop-up operation	-	Right after FHDs-home visit/follow-up target clients who failed to come on schedule
• Social Hygiene Clinic - Active provision of FP and TT services	Every afternoon	Every afternoon
• Pre-Marriage Counseling - Integration of TT immunization	Weekly (Wed.-Thurs.)	Weekly (Wed.-Thurs.)
• Deworming	Twice a year in all health facilities	Twice a year in all health facilities

Source : City Health Office

VI. CONCLUSION AND RECOMMENDATIONS

- The MGP has stimulated the City Health Office of Tacloban to focus efforts on the four program areas, through
  a) Integrating FP & TT services into existing programs like the social hygiene clinic and PMC sessions.
  b) Tapping NGOs and other community providers to augment limited public sector resources.
  c) Revitalizing outreach services such as the Family Health Day which has, additionally, increased utilization of routine services.
- The CBMIS experience from Tacloban emphasized a few lessons regarding the importance of preparatory activities before launching the masterlisting activity. These preparations should include the following:
  - Development and pre-testing of the survey instrument to elicit data from household members related to critical program indicators. This will be the basis for identifying persons needing particular services.
  - Development of necessary forms (1) to be used in collecting raw data and (2) for collating data on individuals with specific unmet needs.
  - A thorough training of all personnel involved or affected by the CBMIS. At the minimum, these include the data collectors (outreach workers) supervisors (midwives and nurses), doctors, and other clinic personnel. This training should involve (1) understanding the uses of the CBMIS, (2) understanding the role and responsibilities of all personnel in relation to the data collection and utilization of information derived from the CBMIS, (3) developing the skills needed to elicit information (such as the familiarity with the flow of the algorithm), filling out the forms, etc. (4) knowing how to deliver appropriate service based on the responses of the respondents to the questions and (5) agreements about referrals, updating of masterlists, and who keeps what type of records.
  - Incentives to data collectors (who may be volunteers) and the frequency of updating the masterlist.

- The CBMIS has been helpful in identifying clients in need of services, facilitates service delivery, and it is a useful tool in clarifying the denominators for program indicators. Sustainability of this intervention anchors on the capability of community health workers and service providers. At this point in time, it is very important that the MSH and DOH should provide technical assistance to these people on data processing, analysis, and utilization. Provision of non-monetary incentive/s (LGU's prerogative) to community health workers and service providers could be an added strategy for a sustainable CBMIS.

➢ Previous informal referral mechanisms became more formal arrangements under the MGP, establishing a referral system from the community to health facilities. This system should be continuously adopted by the local health system involving other stakeholders.

➢ Family Health Day activities contributed to increases in performance coverage, making primary health care services available and more accessible to the people in the community.

➢ Utilizing NGOs and other government organizations can fill a big gap in service provision in the community. Hence, the City Health Office should continue to forge efforts to sustain linkages with NGOs, treating them as active partners in providing primary health care services. Their participation and input during the planning process at the City Health Office before each calendar year of implementation may be necessary to improve and sustain active partnership.

➢ Integration of family planning and tetanus toxoid services in existing health programs like the social hygiene clinic and pre-marriage counseling is able to capture "target/missed clients" in regular schedule.

➢ LGUs like Tacloban have the capability to increase resources for health as well as tap the private sector in expanding service delivery. It is interesting to note that the health budget's proportion for 2000 has increased by almost a third. It is tempting to attribute this increase to a stimulating effect of the MGP on city decision-makers. However, MOOE's share of the health budget continues to languish at 30%, which is still inadequate for the city's health resource requirement. Apparently it is not enough

for the large and transient population of Tacloban, as it is reflected on the very limited number of BHSs (13) serving 138 barangays.

- Local officials and community health workers can be critical partners in reaching individuals with specific unmet needs for services making delivery more efficient.
- LGU's capability in program management may need to be strengthened. The LGUs, especially service providers can be given capability building seminars and workshops on effective program management.
- Evaluation is can be important in programs such as the MGP. Monitoring and feed backing can be effective in improving program implementation. Hence, this should be continued and carried out by program implementers.

APPENDIX

Table 7 CBMIS Input-Process-Output Matrix

Inputs[13]	Process	Output
From the MGP Fund: • Procurement of supplies & materials for survey forms • Snacks during orientation of CBMIS teams • Incentives of CBMIS teams From the LGU Fund: • Itinerant team's staff time • Mimeographing services for form reproduction	Form Development • Form went through several revisions as both MSH & LGU learned on-the-job • LGU developed 1st draft incorporating its own perceived data needs • MSH & PC contributed learnings from other LGUs Formation of CBMIS Team • Initially involved BHWs, BSPOs & CHO staff • 3 teams organized (MGP itinerant team, BHWs/BSPOs/BNSs) to conduct the CBMIS • Data obtained by BHWs & BSPOs needed revalidation, hence subsequent CBMIS done only by CHO staff • Commitment of volunteers led to concerns about sustainability Conduct of CBMIS • Identifying unmet need & delivering appropriate action were considered most difficult • Responsibility for processing & consolidation unclear • CHO midwives and nurses consolidated the data • Service provision includes counseling on MGP services, referrals, and re-supply of condoms and ORS packets for diarrhea • Monthly follow-up & updating • Time and manpower constraints • CBMIS result is a basic requirement for Family Health Day intervention	Summary of CBMIS data[14] • Children 0-11 mos. = 1219 * >9 mos, inc immunzn = 175 * < 9 mos, inc immunzn = 481 * FIC = 563 • Children 12-59mos = 4908 * w/ inc. immunz'n = 167 * w/o Vit A past 6 mos = 27 * Vit A coverage = 99% • Women of Rep. Age = 4249 * Pregnant = 292 * Pregnant, inc TT = 112 * non-pregnant, inc TT = 2027 * TT2+ coverage(pregnt)= 62% • MWRA = 3825 * non-user wanting to space/ limit children = 1676 * user, unsatisfied w/ FP = 84 * wants child soon = 421 * unmet need for FP = 46%

[13] actual items and costs are detailed in Appendix ___

[14] baseline CBMIS data, as of August 1999

Table 8 Family Health Day Input-Process-Output Matrix

Input	Process	Output
From MGP Funds : • Procurement of equipment & materials for upgrade of Anibong BHS • Purchase of vehicle • Purchase of 5 pap smear kits • Procurement of dental anesthesia • Incentives for Itinerant team • Unutilized budget for streamers From LGU Funds : • Staff time • Drugs, medicines • Fuel & lubricants • Logbook, pens, record cards From DOH/ PHO : • Contraceptive supplies • Antigens for immunization • Synringes, needles, and disposable gloves From Barangays : • Snacks & meals • Venue & physical arrangements • Certificates • Staff time for preparations and cleaning up From other stakeholders : • Staff time of NGOs • Service providers from Medical School & pharmaceutical company • Staff of academe for puppet show	Preparatory activities : • Carried out only after CBMIS identifies clients in need of services (listing of clients per barangay by program/service need) • Scheduling of activities and staffing • Meeting with local officials and service providers • Involved the community, local officials and CHO • Mobilized other stakeholders (NGOs, other GOs, academe, companies) and resources w/c MGP could not provide Actual conduct of Family Health Day : • Felt need for an IEC activity • Provision of FP, EPI, TT, VAC, medical consultation, dental health care services, medicines and re-supply,counseling / advocacy, and IEC-puppet show • House visits in pm to mop up clients who failed to come to Family Health Day • Medical & dental consultations removed from 2nd round & shifted to routine clinic • Decline in FP coverage after exclusion of medical/dental consultations from FHD • Gradual shift of clients from this outreach activity to routine services • Mobility support through the utilization of CHO/MGP vehicle	• 326 fully immunized children (38.9% FIC) of 838 target population • 139 pregnant women received TT2+ (45.7%) of 304 target population • 606 MWRA with unmet need for FP were served (34.4%) of 1,760 target population • VAC is at the level to be sustained at 100% • Many clients (has not retrieved the exact data) in consultation and dental services, as wel as recipients of re-supply and medicines provided

Table 9 FP and TT Services in Social Hygiene Clinic and Pre-Marriage Counseling Input-Process-Output Matrix

Inputs	Process	Outputs
From LGU resources : • Staff time • Logbook, TT cards, cotton & alcohol From DOH/ PHO : • Vaccines, syringes, needles No MGP inputs required	• No change in social hygiene clinic or pre-marital counseling session schedules, though some additional staff time was necessary • Bench conference on health education, FP, and TT immunization for social hygiene clinic clients • Utilization of extra doses of TT from routine and family health day schedules • Provision of TT immunization and FP contraceptives (condoms and pills) to clients • Required some mechanism for follow-up w/c was facilitated by the TT cards • Clients observed to return for subsequent services	Social hygiene clinic : • 47 (7.2% of all clinic clients) availed of TT services • 94 clients supplied w/ condoms and 4 w/ pills Pre-marital counseling : • 248 (89% of PMC women) received TT1, 5.4% received TT2 and 1.1% TT

Table 10. Utilization of NGO Clinics Input-Process-Output Matrix

Inputs	Process	Output
From MGP Funds : • Payment of services • Vehicle use • Provision of some supplies to the NGOs From other stakeholders : • Staff time • Certification process from CHO and	Preparatory Activities : • Required a City Council resolution for payment of services as MGP subsidy for BTL, IUD, and DMPA services for indigent clients • Service providers' advocacy and motivation of potential FP clients for permanent method • Established a referral system from the community to the facility. Previous informal referrals facilitated more formal arrangements under MGP • Logistic support from the DOH through the CDLMIS Actual Conduct : • Tapped Marie Stopes Foundation for BTL, and Well-Family Midwife Clinic for IUD and DMPA services • Payment of services has not been made because of administrative problems • Concern re: client niche particularly for WFMC • Market segmentation process still evolving	Marie Stopes : • 28 BTLs supported by MGP compared to 2 pre-MGP WFMC of LEFADO : • Pre-MGP (7 month period) served 9 IUD and 9 DMPA clients • During MGP served 17 IUD and 25 DMPA clients • Increase in child (from 56 to 98) & TT (from 12 to 37) immunization during MGP, even w/o subsidy from the program

Table 11 Comparative distribution of clients ligated monthly by Marie Stopes, Tacloban vs. Anibong, Pre- and MGP Period

Monthly Schedule	No. of Clients Ligated Tacloban City	No. of Clients Ligated Anibong Catchment
Pre – MGP		
July 1998	3	-
August	2	-
September	1	-
October	0	-
November	2	-
December	1	-
January 1999	2	-
February	2	-
March	11	1
April	3	-
May	7	-
June	11	1
Total	**45**	**2**
MGP		
July	14	8
August	4	1
September	6	6
October	5	4
November	6	4
December	3	-
January 2000	8	3
February	5	2
Total	**51**	**28**

Source : Marie Stopes Clinic

• intervention/activity started July 1999

Table 12 Comparative distribution of Anibong clients served by WFMC by method and service, Pre- and MGP- Period

Month							
Pre-MGP							
Dec 1998	3	-	18	8	-	-	-
Jan 1999	2	1	28	7	-	3	1
Feb	-	-	46	9	-	9	1
Mar	3	1	34	5	-	11	-
Apr	-	2	27	6	-	15	-
May	1	2	40	8	1	6	5
Jun	-	3	13	8	-	12	5
Total	**9**	**9**	**206**	**51**	**1**	**56**	**12**
MGP							
Jul 1999	1	6	39	5	-	14	2
Aug	-	-	16	4	-	3	2
Sept	*2	3	23	4	1	23	-
Oct	*4	*4	20	9	2	7	-
Nov	2 (*1)	-	16	7	-	14	4
Dec	1	5	14	4	-	7	8
Jan 2000	1	2	25	7	-	15	5
Feb	5	3	28	5	1	7	3
Mar	*1	2 (*1)	22	6	1	8	10
Total	**17 (*8)**	**25 (*5)**	**203**	**51**	**5**	**98 (FIC=3)**	**37**

Source : Well-Family Midwife Clinic, Anibong

* intervention/activity started July 1999