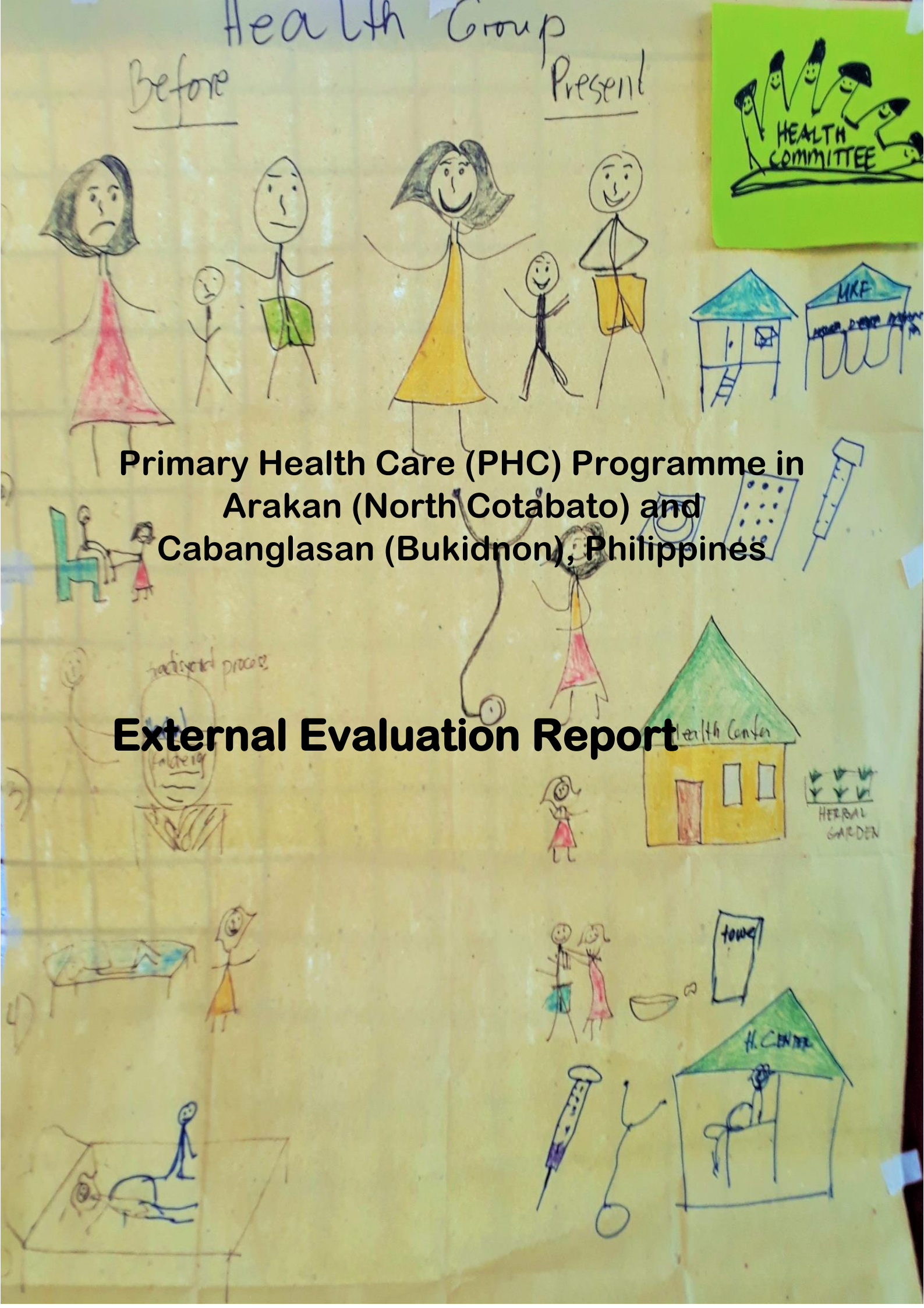

Primary Health Care (PHC) Programme in Arakan (North Cotabato) and Cabanglasan (Bukidnon), Philippines

External Evaluation Report

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Executive Summary

The Primary Health Care (PHC) Project in Arakan (Province of North Cotabato) and Cabanglasan (Province of Bukidnon), Philippines was implemented from 01 June 2015 to 30 June 2019, the last year being a no-cost extension phase. The project was implemented through German Doctors and a local partner organization. It was financially supported by the BMZ (German Federal Ministry for Economic Cooperation and Development). It aimed to improve the living conditions of vulnerable people, specifically regarding health, through access to health care, possession of health-related knowledge, health insurance coverage, access to affordable medication and hospital care. At the end of the project, the communities were expected to be in a position to maintain basic health care services for their citizens under their own power and independently.

The project originally targeted 28 villages (Barangays or Sitios) in Mindanao, but reduced to 17 villages in the 2nd year of implementation. These are located in the rural areas of Arakan (Province of North Cotabato) and Cabanglasan (Province of Bukidnon). The villages are remote and inaccessible, with rarely any public transportation. The distance to a hospital ranges between 20 and 80 kilometres. An established, reliable referral system doesn't exist.

The project adopted several key approaches and strategies namely: 1) Community Organising (CO); 2) training of BHWs and Purok Leaders; 3) provision of basic health services including enrolment of families into Philippine Health Insurance System of the Government; 4) equipping health centres and establishing village pharmacies; and 5) forging formal partnership with Local Government Units (LGUs) both at Municipal and Barangay levels.

I. Overall findings:

Outputs:

The five output indicators were achieved to varying levels of 68% – 111%. The establishment of village pharmacies was not achieved at all.

Outcomes:

The ***quantitative outcome indicators*** were achieved to varying levels. Three of the 6 outcome targets were fully achieved while the other three were only partially achieved.

The achievements against the ***qualitative outcome indicators*** are very encouraging. Significant changes were described by residents of communities, BHWs, RHU and LGU officials, project staff and PHC teams. The following are key outcomes that can be directly attributed to the project:

1. There is a *functioning health care delivery system at the community level.* Community-based basic health care services are being provided by newly trained BHWs alongside the RHMs/RHNs from the Rural Health Units in both municipalities of Arakan and Cabanglasan. Many of these services however, are still health centre-based, and are not easily accessible to families from more remote areas.
2. The *referral system* from community to RHU or secondary hospitals works moderately effective although this still needs further enhancement. The steps in the referral process is well defined and complied with by BHWs. Referral points beyond the RHU level are clearly identified.
3. Several *preventative and promotive health care practices* are now regularly observed by many families such as: a) personal hygiene; b) use of toilets; c) including vegetables in their diet; d)

mothers & their families are not afraid anymore to give birth at the hospital; e) children now receive more care or attention from parents especially on health, f) maintaining backyard vegetable and herbal gardening at health centres, and community levels; g) improvement in home and community environmental sanitation, and h) improved care and management of pets and dogs, household piggeries, etc..

4. There is a very *strong and solid co-ordination at BLGU/MLGU/RHU levels*. However, co-operation/co-ordination with other non-health related agencies/departments or CSOs or among other health NGOs such as Save the Children and World Vision (WV) at municipal level is weak and underdeveloped. BHWs have gained some influence at the level of RHU, Barangay Councils and Health Committees especially in representing priority needs of communities for inclusion in health plans and securing budget support for these. There are however areas of concerns that were identified that will need to be addressed.
5. *Health seeking behaviour and practices of families* have considerably changed especially in promotive and preventative aspects of health care.

The various ***approaches and strategies*** *adopted by the project all demonstrated advantages and limitations:*

1. The *Community Organising* approach was particularly effective in preparing the communities for their participation in the PHC Programme i.e. conduct of baseline survey/situational analysis, briefing on the objectives of the Programme. It also facilitated and mobilised communities in selecting their own BHWs, a significant factor in securing their trust and acceptance of BHWs. However, there seems to be no shared understanding of the CO concept/framework among PHC teams and CO functions seemed to have diminished after the first 6 months in the implementation stage. Co-ordination, networking and advocacy work did not seem to be pursued and sustained over time.
2. The *BHW training* modules addressed basic health concerns identified by the baseline survey. Training levels 1 & 2 produced BHWs competent enough to manage their own basic health problems and make referrals as needed. Training Level 3 was designed for specialised subjects (e.g. DOTS, cancer prevention, gender sensitivity) for more advanced BHWs, but project was only able to conduct training on Directly Observed Treatment-Short term (DOTS) for PTB. As a result, BHWs were not prepared in addressing issues around gender sensitivity, cancer prevention and community mental health. Participatory methods and tools were used during training which have likely facilitated better learning by the participants. The total attrition rate of 22% (13% during training and 9% inactive BHWs after completing training) over time is high. The training design and the approach in implementation seem not to have encouraged 'outside the box' thinking. Further, while the overall intention of the project is to empower BHWs to manage their own health care, the training did not include essential elements of programme/project management, resource mobilisation and organisational management.
3. The plan to *upgrade Health Centres and establish village pharmacies* did not happen. Since the Health Centres were all in good condition, the project provided medical and other health equipment instead which was more relevant to the operations of the centres. Village pharmacies were never set up because the project failed to recruit a licensed Pharmacist which is required by the DOH to run the pharmacy. There were no serious options explored that could have approximated the purpose of the village pharmacies e.g. wider scale production and sale of herbal medicines; linking with privately practicing pharmacists to provide legal cover and oversight; or

connecting to generic pharmacies/networks (i.e. TGP, Generica, etc.) that can extend outlets to remote areas.

4. The *provision of basic health services* (including campaigning for enrolment into PhilHealth Insurance) at community/HH levels by BHWs in collaboration with RHMs/RHNs proved to be very relevant, appropriate and effective not only in addressing simple and common illnesses, but also as a mechanism to replace the dole out approach of the Rolling Clinics. This approach has made RHU services more accessible and regular at health centre level and more likely to be sustainable. However, other health and health related issues such as sexual abuse, child abuse, bullying, depression, suicide and gender discrimination were not adequately addressed. Further, some services e.g. immunisation, pre-natal check-ups have remained health centre-based and therefore, access to households in far-flung areas is still limited.

5. The approach of *partnering with the LGUs* in the implementation of the PHC Programme was an effective way of institutionalising the results of the project. This practice can be considered innovative as it is seldom adopted by CSOs that tend to implement community-based projects in parallel with the mainstream health care delivery system. In addition, instituting joint MOAs with Municipal and Barangay LGUs is good practice. It should promote mutual accountability in ensuring the project gets implemented effectively and efficiently and most likely to be sustainable. It was not clear, however whether the concept of partnership was clearly defined and commonly understood by the staff. In a genuine partnership, partner-LGUs should have been involved in the development of the project. While MOAs exist, these were not regularly reviewed and assessed by both parties to reinforce mutual learning and accountability. Networking and alliance-building with other health and health related sectors were likewise not strongly established.

Few significant ***positive unintended outputs and outcomes*** *were identified:*

1) some Barangay Nutrition Scholars (BNS) were trained with 9 of them graduating and now actively functioning, 2) several of the newly trained BHWs have been granted honoraria from either the Provincial, Municipal or Barangay councils, 3) the project contributed to more effective compliance to national laws at the barangay level and also in the formulation of ordinances towards sustaining project results e.g. proper waste segregation and disposal, establishment of the Material Recycling Facility (MRF), and 4) the project has also strengthened capacities and compliance of Conditional Cash Transfer (CCT) -4Ps[1] covered households with the Barangay-wide promotion and support for health and sanitation, vegetable and herbal gardens, regular check-up of children and older people to the HC, etc.

Project management

The process carried out by the Project Team in developing and managing the project determined in many ways, the extent to which the project has achieved the results described in the above section. Participatory approach and other methodologies that promoted empowerment, self-sufficiency and ownership were applied to varying degrees during the entire process of the project cycle but mostly during implementation stage. There was minimal involvement of key partners and communities throughout planning, monitoring, and learning processes. However, some good practices that are worth replicating include the 1) conduct of baseline and end line studies; 2) forging partnerships with the LGUs

[1] The Pantawid Pamilyang Pilipino Program (4Ps) is a human development measure of the national government that provides conditional cash grants to the poorest of the poor, to improve the health, nutrition, and the education of children aged 0-18. It is patterned after the conditional cash transfer (CCT) schemes in Latin American and African countries, which have lifted millions of people around the world from poverty. The Department of Social Welfare and Development (DSWD) is the lead government agency of the 4Ps.

in the implementation of project activities including signing of formal MOAs; 3) participatory selection of BHW trainees; 4) participatory problem analysis at the start of training for BHWs and Purok Leaders; and 5) strong and effective team work among staff.

Several issues and concerns related to outcome indicators, targeting, risk analysis, monitoring/ learning/reporting and accountability were identified that should be considered seriously in order to enhance effectiveness and efficiency in achieving project objectives.

II. Analysis

Relevance:

The project responds and is relevant to the identified basic needs of the target communities as demonstrated by the results of the baseline survey with pre-defined questions and the problem analysis done during SALT training and at the start of training of BHWs. It is also consistent with municipal development goals, programme directions and priorities, national DOH programmes, Sustainable Development Goals (SDGs) in health, maternal health, poverty, environment.

Similarly, the project is aligned with the overall vison, mission and strategic goals of the local partner. However, it appears that the decision to implement this project was more based on the opportunity opened up by GD in their need for a local partner in implementing the project. Although there seems to be little strategic thinking done in considering the project, apart from its alignment with their strategic goals, the policies, systems and procedures of the local partner addressed the needs and the situation of the partners The strategy of focusing on enhancing the capabilities of Barangay PHC Workers, including adopting the CO approach and partnership with LGUs were most appropriate in the local and national context.

Effectiveness:

Approximately 80-85% level of achievement of both expected outputs and outcomes based on pre-defined indicators. Significant changes have been achieved at the outcome level as described in the section on overall findings above. While considerations for management expertise were reflected in recruiting full complement of a project management team, team members who were contracted part time performed less time during the actual project implementation. Other team members were most involved in taking over responsibility for the implementation of the project with the partner as the main liaison to GD. Having no expertise in PHC projects, the partner was limited to ensuring sound financial management and employing people with long term experience in implementing PHC projects which filled in the gap. However, the management of the project was not necessarily most effective (see project management section) which, if it was, the project could have achieved more.

The target areas of the project were based on the areas where the rolling clinics were operational and is considered appropriate particularly with the intention to develop the capacity of communities in order to become independent of the rolling clinics. Initially, the rolling clinics served as training ground for the BHWs who observed some of the clinic-based operations during their visits to the communities and the Doctors providing skills training and advice. However, these sets of skills acquired by BHWs were not included in the basic training modules for BHWs, therefore not necessarily relevant, effective or sustainable. Had this strategy been planned more systematically and built into the project design, it would have yielded greater benefits.

The CO process has resulted to several positive results including getting the Purok leaders to continue to meet regularly; low attrition rate of BHWs trainees; and formation of BHWs Associations that are now accredited or recognised by the Municipal Federation of BHWs. The process in preparing towards the BHWs training seem sufficient but efforts were not sustained at the same level of intensity to continue with other elements such as organisational strengthening, influencing/networking, exploring and implementing resource mobilisation initiatives; and BHW associations organisational and programme management (e.g. planning skills, monitoring, evaluation, financial management).

Efficiency

Three of the six output targets were underachieved. Due to problems, such as the Marawi siege and failed recruitment of required staff, the project activities have not been implemented on time as planned. While alternative plans such as transferring to another municipality and a no-cost-extension were initiated, these were not sufficient to compensate for the lost time caused by the problems that cropped up.

Specifically, on training of BHWs, the total cost of training including health kits was P7,776.37 per graduate, which is 166% higher than the budgeted cost of training of Euro 58.54 or P2,927. Considering that only 36 days (levels 1&2) of the 48 days (includes level 3) planned for training were used up, it appears that resources were not fully maximised. Further, the 76% training performance rate shows a significant level of cost-inefficiency on this particular component of the project. Additional cost was incurred for 9 Barangay Nutrition Scholars (BNS) who were trained but were not part of the target of the project. Fortunately, all 9 BNS graduates are active up to the present time. The target of 1 BHW serving 15 HH has not been adequately achieved. Total accomplishment of the project is 19.8 or 20 HH per BHW or 32% short of its target 15 HH serve by 1 BHW.

The overall cost of operation shows a seemingly mismatched operations cost and staff cost. Staff cost is 97% higher than cost of operations. Considering the 76% performance level in training, scaling down of targets (e.g. HC repair to provision of basic equipment, from 28 Barangays targeted to 17 actually reached), and to some extent discontinuation of targeted component (village pharmacies), the project is expensively implemented.

While there are several other primary health care projects in the Philippines that are similar to the approach adopted by this project, without a proper meta-analysis study, it is not possible to make a comparative analysis to determine cost efficiency.

Impact

The project has resulted directly in many significant changes at outcome level as described in the overall findings section. Most of these changes *reflect significant improvement in the health situation among families.* As the focus of the evaluation was on the outcome level, it did not deliberately seek evidence of impact apart from those that were described through the MSC stories at community level. Some expressions of impact include better relationships between neighbours due to improved management of the environment, particularly in backyard hog-raising which used to be a source of conflict, and with the new status of BHWs who have gained the trust and respect of their leaders and co-residents, claiming a strong sense of dignity, pride and self-esteem. While other indications of impact were not measured, the outcomes in themselves are certainly considered as significant contributions of the project to the potential impact of improving the lives of communities.

Sustainability

Although the project is seen and is always referred to as that of the German Doctors, the BHWs, RHUs, Municipal and Barangay Councils have taken ownership of the results and committed to continue, even scale up, the approach adopted by the project. The institutionalisation of results achieved so far is adequately guaranteed through the partnership with LGUs and other referral institutions. In addition, the recognition and credibility gained by BHWs from the Barangay Councils, RHUs and Municipal Councils; and the presence of BHWs Associations and stronger leadership of Purok leaders are potential factors for longer term sustainability. Although resource generation and mobilisation efforts, are still limited, there is potential in scaling up current initiatives and exploring others.

III. Conclusions

An overall achievement of 80-85% of both quantitative and qualitative output and outcome indicators is considered moderately successful considering the circumstances that arose during project implementation. Most notable is the political crisis that led to 7 months suspension of operations in Arakan and moving into new target areas in Cabanglasan. In addition, the total number of required staff was never completed throughout the project time line.

While many of the quantitative outcome indicators were not fully achieved (i.e. reduction in mortality of children below 6 years old; maternal mortality rate; immunisation rate and no. of family planning users), significant changes in the health care situation of communities were observed and can be directly attributed to the project interventions. Further, while the project delivered against most of its objectives, more would have been achieved given the resources made available if project management had been more effective. While upward accountability (i.e. towards the management of the partner organisation and the funding partner) was done through reporting, mutual accountability between partners particularly downwards (i.e. communities) was lacking.

The various approaches and methodologies adopted by the project were all relevant and appropriate but would need further refinement both conceptually and practically to be more effective and efficient.

Various factors were identified that facilitated or contributed to the achievement of results. Key challenges at different stages of the project cycle were described and lessons learnt and to be learnt were established.

Overall, the project is relevant, there are several indications that gains and results are likely to be sustainable; significant outcome have been achieved and indications of potential impact could be observed but it has not been fully effective and efficient.

IV. Recommendations

Evaluation events provide learning opportunities for all stakeholders, valuing what works and rethinking/changing what doesn't, improving practice and celebrating wins, big or small. This evaluation has provided all these. More specifically, it provided an opportunity to identify issues for consideration in the planning of the future project phase. The following points are recommended for consideration in the succeeding phase or any similar future initiatives.

Reflect and Rethink

1. Learning from this experience, the local partner and the Project Team need to reflect and establish clarity and a shared understanding of the various conceptual frameworks relating to many of the strategies adopted by the project. Of particular importance are the concepts of Community Organising, Participation, Partnership and Primary Health Care. This would provide coherence in the

approaches and structures set up for project management and clarity in the qualitative indicators to be used in measuring achievements in these areas.

2. The local partner should rethink its role as a 'conduit for funds' for specific projects to enhance the organisation's overall accountability towards partners and other key stakeholders and in providing strategic oversight of the projects.

Ensure Accountability:

3. Involve key implementing partners in the whole process of the project cycle and clearly define the areas/lines of accountability in ensuring that project objectives are fully and effectively achieved. Develop mechanisms that will strengthen horizontal and downwards accountability especially towards the trained BHWs and the communities they serve.
4. The local partner should consider carrying out due diligence checks with the key implementing partners, in this case the LGUs/RHUs, in order to clearly identify their capacity to deliver on their expected roles and responsibilities. Where gaps exist, the organisation could consider providing capacity development support in which case a capacity development plan should be designed and agreed for this purpose.
5. Build into the project design an exit strategy plan in order to ensure, to the furthest extent possible, the preparedness of key partners and communities to sustain the gains and benefits after phase out.
6. Both the local partner and Senior Project Management should exercise more strategic oversight function, and 'big picture thinking' ensuring effective and efficient achievement of outcomes and impact and these deliver against organisation strategic goals and mission.
7. In a context of genuine partnership, both the local partner and GD are accountable to each other in ensuring that partner communities or families are directly benefiting from committed resources for the project. It is in this spirit that the local partner and senior project management team, should feel free and able to take each other to account, requesting for regular feedback on their performance and participate in its learning process.

Change process in project development and management

Succeeding project development and management should seriously consider the following:

On planning:

8. Ensure a more meaningful and active participation of various stakeholders especially the communities, in project design/planning, clearly defining areas of accountability and responsibility
9. Improve targeting, make these more realistic and practical. If necessary, renegotiate, revise or adjust during the process of implementation
10. Develop measurable indicators both quantitative and qualitative at outcome and impact levels
11. Carry out a more rigorous risk analysis and plan for corresponding mitigating measures
12. Cross-cutting issues such as gender sensitivity, advocacy and rights-based approaches should be properly planned for and be integrated across all project components
13. In areas where other initiatives funded by similar funding partner, (in this case, the Rolling Clinics run by GD), an integrated plan should be developed to maximise expertise and resources available from these initiatives in order to achieve more sustainable results

On implementation:

14. Review allocation or appropriation of resources (both funds and staff time) on all the components or elements of the programme/project and ensure that commensurate resources are available for each component.
15. Adopt a more holistic and comprehensive rather than a piecemeal approach in managing issues arising during the process of implementation

On monitoring, evaluation and learning

16. Develop and put in place a comprehensive monitoring design from the start, incorporating more effective feedback mechanisms among various partners and ensure participatory/people-centred monitoring and assessment process.
17. Establish mechanisms to facilitate organisational learning and ensure that lessons and insights from experiences are documented, shared, and acted upon. Ensure that learning takes place not only within the organisation but among partners as well.
18. Financial reports should be used more often as a management tool to effectively address issues related to resource utilisation

On the entire project cycle

19. Gaps in competencies of project team in practising participatory planning, implementation, monitoring, evaluation and learning (PIMEL) should be thoroughly assessed and provide relevant capacity development support as needed

Focus of interventions in the next phase

While there are strong indications that the results gained from this project could be sustainable, these appear fragile and would still need further strengthening especially in areas where the project was not able to sufficiently focus on during implementation period. It is strongly recommended that both partners (local partner and GD) should seriously consider a follow up phase that will focus on the following:

- Supporting capacity development of LGU/RHU partners in providing effective support to the sustainability of the community health care system (BHWs, HC based services)
- Capacity strengthening of BHWs on organisational and programme/project management
- Further enhancement of the two-way referral system from BHWs to secondary/tertiary level health institutions. More specifically, GD should ensure that the BUDA agreement with BHWs in project areas be renewed with clearer referral protocols and arrangements when this is handed over to a new ownership and management
- Strengthening of capacity of BHWs to influence policy decision-makers in health at barangay, municipal and provincial levels
- Strengthening mechanisms of co-ordination, network, alliance building with other health and non-health organisations/agencies/departments
- Ensuring further development of resource mobilisation strategies at community level
- Documentation/further research studies on emerging models of good practice that will encourage or contribute to replicability, scaling up and widening of knowledge base (knowledge management).