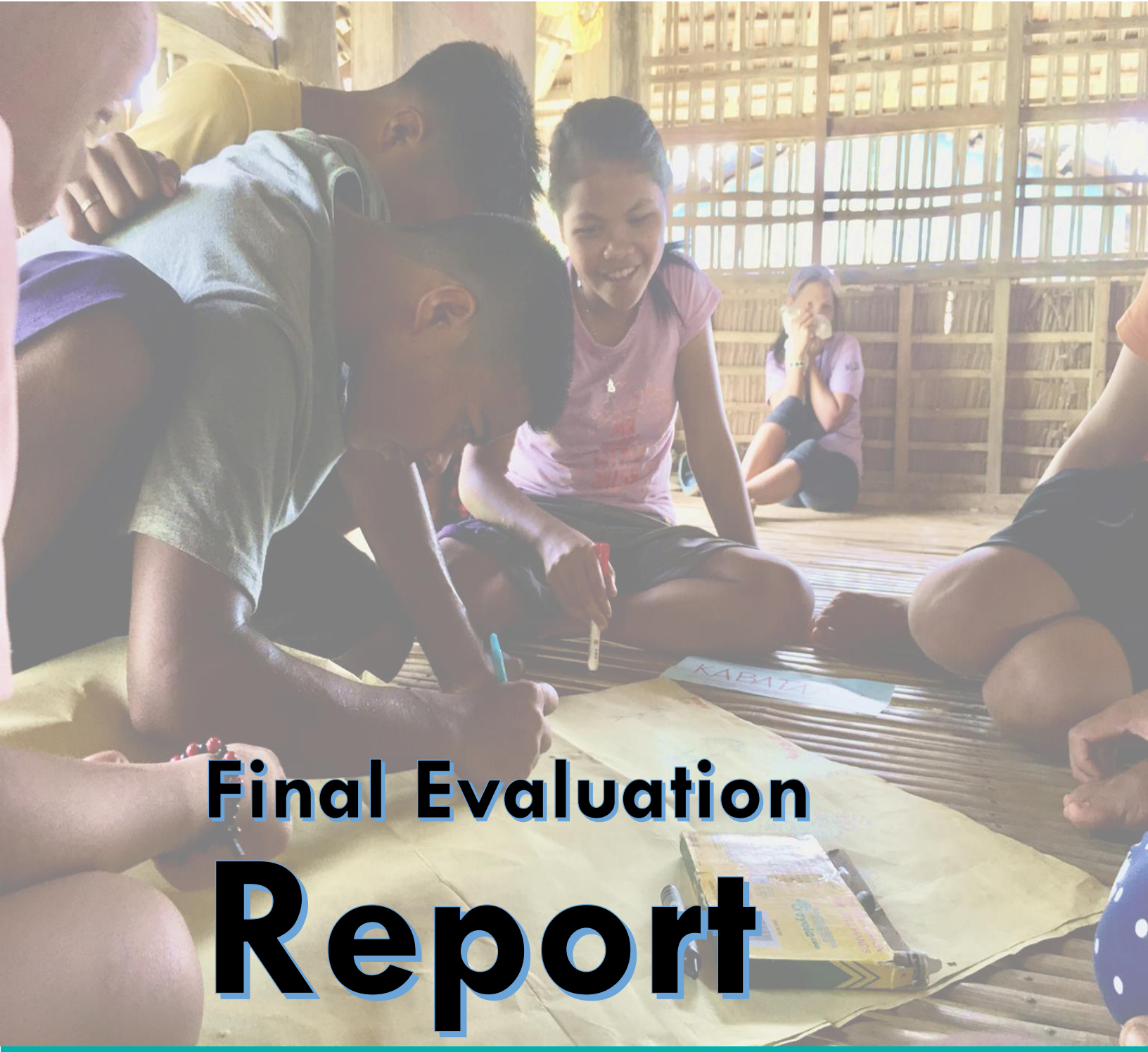

Final Evaluation Report

Rolling Clinics Committee of German Doctors for Developing Countries

Jane Bañez-Ockelford | Cristita S. Chanyee, January 2020

Acknowledgements

The Evaluation Team wishes to express sincere appreciation to the Committee of German Doctors for Developing Countries in the Philippines and German Doctors in Bonn for the opportunity to facilitate and learn from the process of this evaluation.

We sincerely thank the following for their participation, generous and diligent support during the whole process of the evaluation.

1. Ms. Joelyn Soldevilla Biag, the COO and the Rolling Clinics and Primary Health Care Teams for accompanying the whole process especially in organising and participating in all meetings, workshops, and community visits.

2. The participants of all FGDs, workshops and community meetings for engaging robustly with the discussions and exchange of insights and ideas and for being generous with their time

3. Ms. Rhoda Robenecia, the Finance / Admin Officer of CGDDC based in Manila for providing the team with the initial historical accounts of the CGDDC intervention in Oriental Mindoro.

4. Mr. Nestor Carbonera, chairperson of the BOD-CGDDC, Dr. Dayrit-BOD member for helping the evaluation team understand better the internal processes of CGDDC especially in the aspects of staff selection.

5. Those who have provided feedback to the draft report, all added value to the overall credibility of the final report.

The Evaluation Team:

Jane Bañez Ockelford	Team Leader
Cristeta Suelto-Chanyee	Co-Evaluator
Bona Dea L. Padron	Research and Documentation Associate

Executive Summary

The Rolling Clinic (RC) in Mindoro was established in 2001 and started in the North areas of Oriental Mindoro. The aim of the project is to provide basic health care to indigenous people, the Mangyans, who do not have access to health services at all. In 2002 the RC was expanded to the southern parts of Oriental Mindoro. Currently, the project serves people in need in 38 locations within 32 Barangays.

The German Doctor´s project is implemented by the local partner Committee of German Doctors for Developing Countries Inc. (CGDDC), a local registered humanitarian, non-stock, non-profit, non-governmental organization, incorporated in the Philippines in October 1991.

The evaluation was the first external evaluation conducted within 16 years that the Rolling Clinics have been operating in the Mangyan communities. It was carried out between October 2019 to January 2020, by a three-member team: Jane Bañez Ockelford, Cristita Suelto-Chanyee and Bona Dea Padron. The objectives of the evaluation were to:

a) assess changes at outcome level that can be related to the project activities of the Rolling Clinic in Mindoro.
b) generate recommendations to respond to the general assessment parameters of relevance, effectiveness, impact and sustainability.
c) Elaborate on the strengths and weaknesses of the project and identify best practice examples that could be derived and lessons to be learnt so that the gained knowledge can be used for further development of the Mindoro project and further project planning in other areas.

As agreed, the primary focus of the evaluation was on qualitative results that were mainly described and articulated by community groups, RC staff and RHU/LGU staff based on their own experiences and perceptions. Various participatory methods were adopted for collecting this information such as Most Significant Change (MSC) exercises, FGD, KII and validation workshops.

I. Overall findings:

One of the ***most significant contribution*** of the Rolling Clinics (RC) in Oriental Mindoro is reaching out to the far flung Mangyan communities which have not been adequately, if at all, served by the Rural Health Units (RHU) of the Government. Of the total of 426 barangays of Oriental Mindoro, there are 66 Barangays where the most neglected and isolated Mangyans are situated. Of the 66, the project has covered 32 (48%) barangays and established RCs in 38 sites attending to an average of 1,900 patients per month.

The RC as an initiative was seen as relevant in so far as addressing some pressing health concerns of communities such as common illnesses and few communicable diseases such as PTB, measles, chicken pox. It has not, however, sufficiently addressed preventative, promotive and rehabilitative aspects of health care. It is consistent and has delivered to the overall vison and mission of the GD and CGDDC (i.e. providing medical services to the poorest of the poor). Further, the services provided are aligned with national and municipal health programmes and priorities of the Government such as the TB, immunisation and growth monitoring programmes.

The Rolling Clinics effected several **major changes** in the health situation of individuals/families/ communities as identified by the communities and confirmed by GD RC staff, RHU personnel, and LGU health committees *(Please see Annex 2: Matrix of Outcomes)*. Most notable of these are less frequent incidence of common illnesses and 96% cure rate for TB cases that have resulted to improved family situations. These changes have been greatly attributed to the presence of RC clinics but also contributed to or in some cases, directly achieved by, other Government agencies/LGUs/RHUs or private organisations e.g. Mangyan Mission, civic organisations conducting medical missions in some areas.

The project adopted methodologies that have been useful and appropriate e.g. identifying community-based TB DOTS partners; health education sessions before health consultations start; and employment of health professionals as staff (RN, RM, Pharmacist) including those who are Mangyans themselves. Adequate resources were made available that ensured access to least served and provided proper treatment for selected diseases.
Some areas of coordination that have benefited the Mangyans between GD- RC and the formal health care delivery system (RHUs/Hospitals) and LGUs were observed. On TB treatment, the RC has followed the TB management protocols according to DOH standards and both have been sharing reports on TB cases, initially RC staff submit directly to the RHU but now to the Provincial Health Office (PHO) copying the RHU. Referrals are also made to RHU and Provincial Hospital and district hospitals with referral and return slips. However, there was no effective coordination to assess the results of joint efforts in describing/establishing improvements of the overall health status of the specific communities covered by the RC services.

The RCs were implemented as a 'medical service-provision' initiative and was not considered as a 'project' as defined in development work. Hence, not all the processes throughout the various stages of a project cycle i.e. planning, implementation, monitoring, evaluation and re-planning were effectively carried out.

The *overall approach* was not considered to be holistic. Since RC was mostly implemented as a medical service, there has been very limited preventative and promotive strategies undertaken. There were almost no initiatives in addressing non-health related causes of ill health such as poverty, livelihood, water and solid waste management. Further, there is no

certainty that most of the results, at least in the health situation, that have been achieved to date will be sustained in the event of withdrawal of RC services in the immediate future. Other *limitations and gaps* that were identified in the RC services in responding to health problems in the communities includes the lack or absence of adequate measures or mechanisms established in the following areas that would have ensured a more effective and sustainable services and results:

- addressing other health or health related issues or referring these to appropriate agencies/groups (malnutrition among adults and pregnant women apart from TB patients; environmental sanitation; solid waste management; livelihood)
- co-ordination with LGUs/RHUs (e.g. maximizing opportunities from existing monitoring activities of other key players i.e. DSWD, DOH-NDP, DepEd). At the community level there is minimal coordination between BHWs, TB DOTS partners, and parent leaders
- preventing malnutrition e.g. vegetable gardening for domestic consumption; health education in nutrition and follow up in supporting families in translating these into practice
- follow up on health awareness sessions in terms of practice
- referral system e.g. no formal agreements with public or private institutions
- monitoring mechanisms of qualitative changes/progress being achieved (no clear indicators, no formal assessments/reviews, not included in reporting)
- mechanisms to ensure the sustainability of results achieved by the Rolling Clinics such as:
    a. Formal co-ordination with LGUs/RHUs (all levels)
    b. Capacity development/strengthening of competencies community-based health workers (e.g. transfer skills to mainstream health service providers) towards empowering the people to claim their basic health rights and manage their own health care
    c. Setting of regular learning mechanisms drawing up insights and potential models of good practice
    d. Advocating for policy changes or more effective implementation of policies
    e. Strong networking/linkaging with non-health agencies/groups (e.g. agriculture, social development, water and sanitation)
    f. Sufficient efforts to generate local resources for continuing availability of health care services

II. Recommendations:

On the Overall Approach

1. It is strongly recommended that CGDDC consider integrating the RC services into it current PHC project. Since provision of basic health services is a one of the essential elements of PHC, it would be more effective that the planning and implementation of the RC services are considered as part of the whole rather than a stand-alone initiative.

This will also ensure a shift from a "dole-out" towards a more holistic and empowering approach to health care. Taking this perspective implies that the current concept and plan of the PHC project that was started early in 2019 be reviewed and assessed in order to make it more comprehensive, coherent and sustainable.

2. Taking on a PHC approach, it is essential to rethink the project's key strategies on partnership, capacity development/strengthening, empowerment and sustainability. A more holistic and developmental framework against which the project is contextualised and operationalised should be developed and shared across the organisation for a shared understanding and commitment.

3. The draft strategic plan developed in January 2019 should likewise be reviewed and finalise taking into consideration the results of this evaluation. Strategic goals and directions should be articulated more clearly with more defined indicators at strategic level.

4. Mechanisms that will ensure sustainability of basic health services or the results of the project should be adequately planned for and implemented. More efforts should be invested on resource mobilisation especially at community level.

5. When planning for the next phase of the project, it is strongly recommended that a phase - out or exit strategy be developed or planned for.

On Partnership/s and Co-ordination with mainstream HCD system and other key institutions/agencies

For a more effective, efficient and sustainable outcomes or results, it is strongly recommended that a partnership approach is adopted most importantly with the Local Government Units (LGUs) particularly with the Rural Health Units (RHUs) that has the mandate to deliver basic health services to its constituencies. Co-ordination and linkages should also be developed with other health and health related agencies or organisations (government, private or CSOs) that could support address the root causes of ill health.

1. To begin with, the CGDDC should develop its own partnership policy and guidelines that will provide the framework for the implementation of its partnership approach. It should cover all key partners at all levels from communities to districts and provinces; government, private or CSOs.

2. Memoranda of Agreements or Understanding (MOA/U) should be developed, agreed upon and signed with the relevant partner organisations to formalise the partnership. This should include Terms of Reference (TOR) defining the roles and responsibilities of each organisation/institution such as joint planning, monitoring/regular meetings/reporting. It should also consider provision or facilitation of capacity

development support to partners should gaps exist in their capacity to perform their expected roles and responsibilities.

3. Mechanisms for two-way referral systems must be established and formalised with institutions providing secondary and tertiary levels of health care particularly with district and provincial hospitals and specialised clinics. This should cover procedures and guidelines that define roles and responsibilities of both those individuals or groups referring patients and those accepting the referrals.

4. In cases where health policies need to be put in place or where existing policies need to be more effectively operationalised towards the protection and promotion of indigenous people's health rights, CGDDC should consider including policy advocacy in its programming.

On Project and Organisational Development and Management:

For more effective and efficient project management, more systematic and participatory processes for both strategic and programme/project planning, monitoring, evaluation and learning should be instituted. Specifically, these should include the:

1. Review and clarification of decision-making structures and processes between CGDDC in Philippines and GD in Bonn. The types of decisions to be made at various levels should be identified and agreed in order to have more realistic expectations and avoid confusion or unclear assumptions from both parties.

2. Establishment of adequate baseline data; more careful assessment of relevance and appropriateness of project methods, strategies and key activities; and development of monitoring, evaluation and learning plans.

3. Review of the current staffing structure, key roles and responsibilities vis-à-vis potential changes in overall programming approach and ways of doing things. Assessment of staff current competencies vis-à-vis their respective roles and responsibilities and where there are gaps, develop and support a capacity development plan to address these. The result of this assessment should also inform the organisation whether staff are fully maximised in their current positions or if they are appropriately placed in the right positions within the organisation and projects.

4. A simple performance management system should be put in place to serve as a management and learning tool for both management and rank-and-file staff.

On Accountability:

1. CGDDC Board and Management should develop and strengthen mechanisms to ensure accountability in all aspects: upward - to the Board of Trustees and funding partners; downward - towards the communities and people served; and horizontal - to partner organisations including relevant LGUs. These should include timely reviews, monitoring, feedbacking/reporting and learning lessons throughout the whole process of project cycle.

2. Involve staff and key implementing partners in the whole process of the project cycle and clearly define the areas/lines of accountability in ensuring project objectives are fully and effectively achieved. Provide support as appropriate to ensure full implementation of responsibilities.

3. There should be a conscious effort to identify emerging models of good practice, document these and share widely, both internally and externally to relevant stakeholders.