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## Formative Evaluation of the DOH's Complete Treatment Pack (Compack) Program

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Philippine Institute for Development Studies  
*Surian sa mga Pag-aaral Pangkaunlaran ng Pilipinas*

## Formative Evaluation of the DOH's Complete Treatment Pack (Compack) Program

*Dennis B. Batangan*

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# ***Philippine Institute for Development Studies***

## ***Final Report***

### **I. Project Title: *Formative Evaluation of the DOH's Complete Treatment Pack (Compack) Program***

#### **II. Abstract**

The complete treatment Pack (COMPACK) Program is a medicines access program designed to reach the poorest of the poor with complete treatment regimens for the top most common diseases in the country. The program aims to address the increasing morbidity and mortality due to these common diseases and high out-of-pocket spending in medicines and health services for majority of Filipinos. COMPACK also aims expands the choices and ensures access and availability of affordable quality generics to other segments of the population otherwise not included in the Pantawid Pamilyang Pilipino Program (4Ps) program of the national government. This study is a formative evaluation of the DOH COMPACK program which also aims to analyze its impact of the access to medicines program. The study utilized qualitative and quantitative research methods. The qualitative methods included Key Informant Interviews (KII), Focus Group Discussions (FGD), and records review. The quantitative method included a survey done to determine the knowledge and attitude of the beneficiaries on the COMPACK program. The results of the qualitative study showed that the introduction of the COMPACK program flowed from the DOH regional offices to the Local Government Units (LGUs) and that there were variable LGU processes for program adoption, integration to work programs and monitoring. The COMPACK medicines logistics management system however ensures that the medicines are delivered directly to the LGUs. The implementation of the COMPACK program depended a lot on the support of the LGU, capacity and efficiency of the RHU staff, management skills of the LGU and RHU in weaving the COMPACK program into the existing programs and their working relationship with the DOH. The DOH related factors in program implementation included: mismatch with the type and timing of medicines supply to the needs of the LGUs; inadequate consultation of the LGUs on their medicine requirements resulting to the oversupply of some medicines and undersupply of other items; perceived overload of requirements from the DOH and limited monitoring of the program beyond the submission of required reports. The survey on the knowledge and attitude to the COMPACK program showed the following results: 98.4% of the respondents indicated that they know something about the COMPACK program of the DOH; 91.5% of the respondents said that they were provided services by the program; 94.5% of the respondents said that the COMPACK program of the DOH had done some activities in their RHU; 73.6% of the respondents indicated that they do not see the LGU having problems in maintaining the COMPACK program; 96.1% of the respondents observed that more patients have been availing of the RHU services since the COMPACK program of the DOH was implemented; 94.6% of the survey respondents noted

that the RHU and LGU have become more active in health-related activities since the COMPACK program of the DOH was implemented; 97.7% of the respondents felt that the COMPACK program greatly helped in improving the health status of the communities and the health system. Recommendations include the following: **1.** Ensure the integration of the COMPACK Program into the LGU development plans. Include definite provisions on the prioritization of beneficiaries specifically 4Ps (Pantawid Familyang Pilipino Program) beneficiaries, PhilHealth members and non-PhilHealth members. Include civil society and private sector representatives in the conduct of national and local COMPACK program implementation reviews (PIRs) **2.** Address DOH related concerns including: Unstable and incorrect supply of medicines; uneven pacing of trainings and delays in the dissemination of program updates; program integration with other DOH programs like DTTB (Doctors to the Barrios Program), RNHEALS (Registered Nurses for Health Enhancement and Local Services), MAPS (Medical Access Programs) and PhilHealth Primary Care Benefit (PCB) package; and conduct of regular consultations and performance evaluation. **3.** Interphase with the National Online Stock Inventory Reporting System (NO SIRS), eHealth National Program on Electronic Medical Records (EMR) and electronic prescription systems, **4.** Further studies on the following: a. Comparison of COMPACK program impact between households who are Conditional Cash Transfer (CCT)-beneficiaries and non-CCT beneficiaries, b. Tracking the utilization of drugs and medicines access programs in selected sectors and beneficiaries to determine the convergence of benefits and/or redundancies in funding c. Supply chain management audit to determine the inefficiencies and barriers in distribution of drugs and medicines to intended beneficiaries, d. Conduct of cost-benefit or cost-effectiveness analysis of COMPACK medicines with respect to medical conditions that impose the heaviest burden in the National Health Accounts

*Keywords:* Medicine Access Program; Complete Treatment Pack Program; Access to Essential Medicines; Pharmaceutical Access and Management; Health benefits of Conditional Cash Transfer beneficiaries; Demand side health benefits

### **III. Background of the Project**

The Philippines has committed to achieving the United Nations' Millennium Development Goals (MDGs) when it signed the Millennium Declaration in 2000. The MDGs sets benchmarks for human development by 2015. One of the targets of the MDG No. 8 (Develop a Global Partnership for Development) is to increase access to affordable medicines in developing countries in cooperation with pharmaceutical companies. However, a study on the compliance to this MDG in the Philippines showed that the median availability of essential medicines is lower (highest value of 33%) than the reported 73% baseline figure in 2009.

The 2003 Philippine MDG report claimed that the "proportion of population with access to affordable medicines on a sustainable level" was **50-79 %** however independent studies show a much lower level of access. A survey conducted in 2005 by Institute of Philippine Culture, Ateneo De Manila University, Health Action International (HAI) and World Health Organization (WHO) showed that for the public sector facilities, the **median availability** of the medicines surveyed was **7.7% for innovator brand medicines and 15.4% for lowest priced generics**. In the private sector, the **median availability** of the surveyed medicines was **33.3 % for branded**

**medicines** and **26.5 % for lowest price generics** indicating a higher availability for the branded medicines. Even the highest figure of 33.3% median availability in the private sector is still way below the Philippine MDG report figure of 50-70%. Furthermore, the Median Price Ratio (MPR) for some of the medicines sold in the private retail pharmacies were shown to be as high as **184.09**, meaning that the prices of some medicines in the private retail pharmacies were 184.09 times over higher than the International Reference Price (IRP) used as reference for the said survey.

The 2009 WHO and DOH medicine survey with conducted in La Union, Palawan, Capiz and Misamis Oriental showed that for the public sector facilities, the **mean availability** of the medicines surveyed was **1.1% for innovator brand medicines** and **24.2% for lowest priced generics**. In the private sector facilities, the **mean availability** of the surveyed medicines was **22.8% for branded medicines** and **36.7% for lowest price generics** indicating a higher availability for the generic medicines in both the public and private sector facilities.<sup>i</sup>

As the current Administration gears toward the achievement of Universal Health Care (UHC) by 2016, it has to ensure additional resources for essential medicines, which is one the vital components of any functioning health system to enable it to deliver quality health services that will bring about better health outcomes for its people. However, health facility surveys conducted by the DOH and WHO consistently show poor availability of these medicines in the public sector<sup>ii</sup>. Several issues contribute to the problem such as the lack of national and local financing for medicines, inefficient pharmaceutical procurement practices, poor management and the lack of human resources to prescribe and dispense medicines at the point of service delivery.

This formative evaluation of Compack forms part of the KP evaluation studies specifically looking if the objective “to reach the poorest segments of the population with quality affordable medicines” was achieved. It also assessed if the program was able to “ensure availability of the DOH Complete Treatment Packs in the poorest localities in the country, particularly municipalities covered by the Conditional Cash Transfer Program of the Department of Social Welfare and Development (DSWD) otherwise known as the *Pantawid Family ang Pilipino Program (4Ps)* of the national government.”

#### **IV. Review of Related Literature**

In the past administration, the program of health reform was packaged as the 'FOURmula ONE for Health' designed to undertake critical reforms to improve the efficiency, effectiveness and equity of the Philippine health system. Vital reforms were organized into four major implementation components: (1) health financing, the general objective of which is to secure increased, better and sustained investments in health to provide equity and improve health outcomes, especially for the poor; (2) health regulation, which aims to assure access to quality and affordable health products, devices, facilities and services, especially those commonly used by the poor; (3) health service delivery, aiming at improving the accessibility and availability of social and essential health care for all, particularly the poor; and (4) good governance in health, aiming at improving health system performance at the national and local levels. Universal Health Care (UHC), also referred to as Kalusugan Pangkalahatan (KP), is the current articulation of the health sector reform agenda that had figured prominently in the past administrations. It emphasizes “provision to every Filipino of the highest possible quality of health care that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public”.

The present administration has pushed for the realization of the UHC to ensure the availability and accessibility of health services and necessities for all Filipinos<sup>1</sup>. This involves providing adequate resources – health human resources, health facilities, and health financing. The three strategic thrusts are to be pursued, namely: 1) Financial risk protection through expansion in enrolment and benefit delivery of the National Health Insurance Program (NHIP); 2) Improved access to quality hospitals and health care facilities; and 3) Attainment of health-related Millennium Development Goals (MDGs). The continuing low levels of integration, fragmentation and inequity in public financing<sup>2</sup> are coupled with the limitations in the implementation of universal social health insurance and in the use of health financing as a lever to drive health sector development.

The Philippine Development Plan for 2010-2016 focuses on achieving universal health care under the Aquino Health Agenda (AHA), which seeks to improve, streamline, and scale up reform interventions outlined in the Health Sector Reform Agenda (HSRA) and implemented under FOURmula One (F1) for health, with particular focus on the poor. This will ensure that as health reforms move forward, the poor are not neglected. The successful implementation of the AHA will restructure the health system, once its components are fully implemented:

- **Policy Priority 1:** Increase public financing (national government) on health within fiscal constraints and allocate for expanded PhilHealth<sup>3</sup> coverage for the population while holding PhilHealth accountable for results. In particular, additional public financing for health is allocated for expanding PhilHealth coverage for indigent families (Sponsored program) and for the near poor informal sector.
- **Policy Priority 2:** Undertake comprehensive reform of PhilHealth to make it an active and accountable purchaser in the health sector, setting the incentives and driving the process of service delivery transformations. This implies that PhilHealth becomes an active purchaser, able to use health financing to encourage public and private providers to ensure accessible, high quality health services.
- **Policy Priority 3:** Support DOH in strengthening its stewardship function vis-a-vis service delivery transformation; improved regulation of facilities (public and private), improved oversight for key health sector inputs such as human resources and pharmaceuticals, strengthened data for decision-making and sector monitoring and performance management.
- **Policy Priority 4:** Enhance the focus on public health including NCDs or MDG+ (possibly through DOH managed performance-based grants to LGUs).

The objective of UHC is to promote equity in health through the provision of full financial protection and improvement of access to priority public health programs and quality hospital care especially for the poor, reforming the health service delivery, currently a mixed system of government health facilities (DOH-owned, LGU-owned, and some hospitals having autonomy), private for-profit facilities (hospitals, physician clinics, and pharmacies), and a small number of non-profit private facilities run by NGOs and FBOs. The barangay (village) health station (BHS) is closest to the household. Rural health units (RHUs) and city health centers are located in each town/ city, with the larger towns/ cities having more than one RHU or health center. Private health clinics, diagnostic centers, and laboratories operate in larger

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<sup>1</sup> Universal Health Care (KalusuganPangkahalatan): Inequity in the Health System. <http://www.doh.gov.ph/Overview.html>

<sup>2</sup> In fact: i) the Government's revenue raising capacity is constrained, (ii) there is a large informal sector (almost 50% of the population) which means that mobilizing health sector resources from this group through enrollment into PhilHealth is a challenge, (iii) LGUs in underserved Regions face a fiscal constraint in financing health, and (iv) health financing is characterized by the co-existence of highly fragmented and sometimes overlapping streams of funding that run separately from and independently of each other (PhilHealth, DOH, LGUs).

<sup>3</sup> <http://www.philhealth.gov.ph/>: based on House Bill 14225 and Senate Bill 01738 which became The National Health Insurance Act of 1995 or Republic Act 7875, the Philippine Health Insurance Corporation (PhilHealth) was created and mandated to provide social health insurance coverage to all Filipinos in 15 years' time. PhilHealth assumed the responsibility of administering the former Medicare program for government and private sector employees from the Government Service Insurance System in October 1997, from the Social Security System in April 1998, and from the Overseas Workers Welfare Administration in March 2005.

- towns. Therefore, **UHC strategic thrusts** have been formulated as follows:
- **Protect the people especially the poor** from the financial burden of health care use by improving the benefit delivery ratio of the National Health Insurance Program (NHIP)
    - Redirect PhilHealth operations towards the improvement of the national and regional benefit delivery ratios
    - Attain and sustain universal coverage of NHIP (expansion of coverage to include the poor and the informal sector)
    - Promote availment of quality out-patient and in-patient services at accredited facilities through reformed capitation and no balance billing/zero co-payment arrangements for sponsored members; and
    - Increase the support value of health insurance for the poor through the use of information technology upgrades to accelerate PhilHealth claims processing
  - **Improve access to quality hospitals and health care facilities** by upgrading or expanding government-owned and -operated hospitals and health facilities and by providing quality services to help attain the MDGs, attend to traumatic injuries and other types of emergencies, and manage non-communicable diseases and their complications
    - Enhance targeted health facility program that shall leverage funds for improved facility preparedness for trauma and the most common causes of mortality and morbidity
    - Provide grant mechanisms drawing from public-private partnerships to support immediate repair and rehabilitation of selected priority facilities
    - Promote fiscal autonomy and income retention schemes for government hospitals and health facilities
    - Unify and streamline the process of DOH licensing and PhilHealth accreditation for hospitals and facilities
    - Cluster referral networks by region to address the fragmentation of services
  - **Attain the MDGs for health** by focusing public health programs on the following: maternal and child mortality, morbidity and mortality from TB, dengue and malaria, and the prevalence of HIV-AIDS, in addition to being prepared for emerging diseases, and prevention and control of non-communicable diseases particularly cardiovascular diseases, cancers, diabetes mellitus, and end-stage renal disease
    - Deploy Community Health Teams to actively assist families in assessing and acting on their health needs
    - Utilize the life-cycle approach when providing needed services, among which are family planning, antenatal care, delivery in health facilities, essential newborn care, immediate postpartum care, and Garantisadong Pambata package for children 0-14 years of age
    - Aggressively promote healthy lifestyle changes to prevent non-communicable diseases
    - Ensure adequate surveillance and preparedness for emerging diseases; and
    - Harness the strengths of inter-agency and inter-sectoral approaches to health.

To achieve the strategic thrusts, the following **instruments** are utilized:

- **Health Financing**, increasing resources for health to improve the financial risk protection of the poor and the vulnerable sectors<sup>4</sup>
- **Service Delivery**, addressing variations in health service utilization and health outcomes across socio-economic variables and across geographic boundaries<sup>5</sup>

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<sup>4</sup> Strategies and activities include: achieving universal health insurance coverage; increasing public investments for health; allocating health resources to appropriate financing agent; and securing fiscal autonomy of government health facilities and shifting to new provider payment mechanism

<sup>5</sup> Strategies and activities will be undertaken to ensure that appropriate health services are available at all levels of health care by transforming system into a service delivery network; enhancing the provided service packages to encompass the country's MDG commitments; eliminate endemic diseases; intensify disease prevention and control for both communicable and non-communicable diseases; and manage health emergencies and disasters; by investing in a health facility enhancement program; strengthening the gate-keeping function of lower level facilities; increasing the capacities of centres of excellence for specialty hospitals; enhancing quality assurance at all levels; ensuring that

- *Human Resources for Health*, assigning competent primary health care provider to each family, producing health professionals that are responsive to the current needs of the health sector, and addressing misdistribution of HRH by providing incentives for deployment in underserved areas
- *Policy, Standards and Regulation* implementation to revitalize and reorient the system<sup>6</sup>
- *Governance* aimed at promoting the system efficiency, transparency and accountability, preventing fraud within a Sector-wide Development Approach for Health (SDAH)
- *Health Information* capable to provide evidence for policy and program development and support the province-wide health system development<sup>7</sup>
- *Research and applied science* with tailored capacity building programs

The above policies aim at the achievement of results presented in the GOP Medium Term Development Plan, which affirms the government commitment to attain the MDGs (Table. 1).

**Table 1: Health, Nutrition and Population Targets<sup>8</sup>**

Indicators	Baseline	2011	2012	2013	2014	2015	2016
<b>MDG Indicators</b>							
Prevalence of underweight children under five years of age (%)	20.6 (2008)	17.6	16.6	15.6	14.6	13.7	12.7
Proportion of households with per capita intake below 100% dietary energy requirement (%)	66.9 (2008)	54.1	49.9	45.6	41.4	37.1	32.8
Under 5 mortality rate (per 1,000 live births)	34 (2008)	31.6	30.4	29.2	28	26.7	25.5
Infant mortality rate (per 1,000 live births)	25 (2008)	23	22	21	20	19.0	17
Maternal mortality ratio (per 100,000 live births)	95-163 (2010, NSCB)	97	84	70	61	52	50
Contraceptive Prevalence Rate (all methods)	51 (2008)	56.2	57.9	59.7	61.4	63	
Proportion of births attended by a health professional (%)	62 (2008)	69	72	75	80	85	90
Proportion of births delivered in health facilities (%)	44 (2008)	69	72	75	80	85	90
HIV Prevalence*	Less than 1% (2009)	<1%	<1%	<1%	<1%	<1%	<1%

hospitals are safe from disasters; use of incentives to promote public-private partnership (PPP) ranging from investments for tertiary care, all the way to involving private practice midwives in the delivery of primary services;

<sup>6</sup> Increasing and improving the availability and affordability of medicines, promoting generics and the rational use of drugs and technology services by strengthening the regulatory agencies of DOH such as the Food and Drug Administration (FDA), Bureau of Health Facilities and Services (BHFS), and by strengthening the post-marketing surveillance system as well as the regulatory functions of DOH agencies standards and processes for licensing/ certification/ accreditation of public and private health facilities (see Picazo, OF: Review of the Cheaper Medicines Program of the Philippines: Botika ng Barangay, Botika ng Bayan, P100 Treatment Pack, and the Role of PITC Pharma, Inc. in Government Drug Procurement, Philippine Institute for Development Studies: DISCUSSION PAPER SERIES NO. 2012-13: <http://dirp4.pids.gov.ph/ris/dps/pidsdps1213.pdf>, accessed December 2012

<sup>7</sup>To support the HIS, the Philippine National Health Research System (PNHRS) core agencies and partners collaborate in addressing the gaps in the access to essential medical products, vaccines and technology, and the HIS, focusing on diagnostics, vaccines, drugs, use of ICT in healthcare (telehealth), and traditional and alternative healthcare, developing new solutions to building information content and to providing access to relevant, current, and accurate health information.

<sup>8</sup> Sources: DOH, NNC, POPCOM and NSCB (For the specific annual targets, see the 5th AIDS Medium Term Plan (AMTP). The 5th AMTP goal states that by 2016, the country will maintain the prevalence of less than 66 HIV cases per 100,000 population.



<b>Indicators</b>	<b>Baseline</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Malaria morbidity rate per 100,000	22 (2009)	16.9	14.3	11.8	9.2	6.6	4
Malaria mortality rate	0.03 (2009)	<.03	<.03	<.03	<.03	<.03	<.03
TB prevalence rate per 100,000	486 (2008)	446	434	422	410	398	387
TB mortality rate per 100,000	41 (2007)	36	35	35	34	33	33
TB case detection rate	73 (2008)	79	81	83	84	85	85
TB cure rate	79 (2008)	82	83	83	84	85	85
Proportion of population with access to safe water (Households) (%)	82.3 (FHSIS 2008)	83	84	85	86	86.9	88
Proportion of population with access to sanitary toilet facilities (Households) (%)	76.8 (FHSIS 2008)	79	81	83	84	85.9	88
Population with access to affordable essential drugs (%)	73 (2009)	75	78	82	84	85	95
<b>Other Indicators</b>							
Population Growth Rate	2.04 (2000-2007)					1.48- 1.82	
Total Fertility Rate	3.3 (2008)					2.4- 2.96	
Percentage of out of pocket payment from total health care expenditure	54.3 (2007)			41			35
Benefit Delivery Rate (NHIP))	7.7 (2008)			15			30
National Health Insurance Program (NHIP) Coverage	53 (2008)	70	85	100	100	100	100
NHIP Enrolment rate	74 (2010)	85	90	100	100	100	100
Ratio of accredited health facilities to total number of licensed health facilities	90 (2010)	95	95	95	95	95	95
Mortality rate from lifestyle related and NCD (%)		-2%	-2%	-2%	-2%	-2%	-2%
Prevalence (%) of stunted under-five children	32.2 (2008)	28.0	26.6	25.2	23.8	22.3	20.9
Prevalence (%) of wasted under-five children	7.5 (2008)	6.5	6.2	5.9	5.6	5.2	<5
Prevalence (%) of thin children 6-10 years old	8.1 (2008)	6.9	6.5	6.1	5.7	5.3	<5
% of pregnant women who are nutritionally at risk	26.3 (2008)	24.8	24.3	23.9	23.4	22.9	22.4

### **COMPLETE TREATMENT PACK (COMPACK) Program**

The complete treatment Pack (Compack) Program is a medicines access program designed to reach the poorest of the poor with complete treatment regimens for the top most common diseases in the country. The program aims to address the increasing morbidity and mortality due to these common diseases and high out-of-pocket spending in medicines and health services for majority of Filipinos.

Compack also aims to expand the choices and ensure access and availability of affordable quality generics to other segments of the population otherwise not included in the Pantawid Pamilyang Pilipino Program (4Ps) program of the national government. This was done by making the DOH Complete Treatment Packs also available in public hospital pharmacies approved by the DOH for inclusion in the program. Their inclusion was based on parameters of regulatory compliance and adherence to rational drug use concepts and practices.

The Compack guidelines listed the following objectives:<sup>iii</sup>

- To increase patients' access to quality essential medicines, taking into consideration rational drug use and medicine availability up to the grassroots level.
- To improve primary health care in the poorest communities by addressing the needs of the population for essential medicines as part of primary and secondary prevention especially for chronic non-communicable diseases.
- To provide complete-treatment regimens to indigent patients as maybe identified by PhilHealth and other targeting systems.

The Compack Program is an expanded version of the Php 100 Treatment Pack Program of the DOH that was pilot-tested in Mindoro Oriental and other provinces. The Compack program as part of the access to cheaper medicines program was initiated in 2011 and needs to be evaluated if it warrants expansion, or if it should be folded over into the Primary Care Benefit of PhilHealth. This scope of the evaluation was intended as well to come up with recommendations on how the objectives of the Cheaper Medicines Program can be better achieved.<sup>iv</sup>

Compack is part of the DOH Medicine Access Programs or MAPs. MAPs are a set of programs that will support health care delivery through the provision of essential medicines to patients for all priority diseases in the country. This program is designated to be effective-focused and aims to result in:

- a. Decreased health care cost
- b. Improved primary health care in the poorest communities
- c. Sick indigent patients provided with complete treatment regimens
- d. Improved early detection for priority diseases
- e. Improved survival and incidence rates
- f. Cost-effective uniform treatment regimens in public health facilities

#### TYPES of MAPs

##### I. Maps for Out-patient Care:

- a. Botika ng Barangay (BnB)
- b. DOH Complete Treatment Pack (DOH ComPack)

##### II. MAPs for In-patient Care

- a. Regular In-patient Care
- b. Catastrophic Care
  1. Acute Lymphocytic Leukemia Medicines Access Program
  2. Breast Cancer Medicines Access Program
  3. Rare Disease Medicines Access Program

##### III. Other MAPs

- a. DOH Insulin Access Program
- b. Valsartan Access Program
- c. Geriatric Health Care Medicines Access Program
- d. Mental Health Care Medicines Access Program

The Botika ng Barangay (BnB) Program on the other hand was reintroduced in 2000 by the Department of Health (DOH) as part of the Cheaper Medicines Program and the proposed

Philippine Medicine Policy to address problems limited availability, irrational use, and high cost of drugs hampering access to essential medicines. It aimed to increase the access of the underserved and marginalized population to essential medicines through establishment of BnBs, which are community-based drug outlets. These outlets sell about 40 OTC essential medicines and 8 prescription drugs. The DOH initially aimed a 1:3 BnB to barangay ratio, later increasing it to 1:2 in most areas and 1:1 in the poorest barangays. In 2010, approximately 16,350 BnBs have been established nationwide. However, a number of BnBs discontinued operations due to several reasons. Problems in the implementation of the BnB program identified included inconstant supply of drugs, insufficient licensed pharmacists, inappropriate location chosen for BnB outlets, prohibitive costs of some medications, and apprehension of population on the use of generic medicines (Picazo, 2012). Establishing the association of these key factors for the success of the program is therefore crucial to enable the country to reach the MDG target by 2015.

### **The P100 Treatment Pack Program<sup>v</sup>**

The DOH initiated the P100 Treatment Pack<sup>9</sup> (P100 for short, and also known as the “Tipid” or ThriftPack) Program in December 2008 to widen people’s access to prepackaged generic drugs with an affordability limit of 100 pesos or lower. The intention is to encourage patients to take the full course of their drug treatment regimen (i.e., improve compliance), instead of patients buying them in individual tablets or capsules which end up being more expensive and often leads to discontinuance once the patient feels well enough. The drugs are packaged in a full set. Thus, the program meets two key pharmaceutical objectives at once: (a) improving the availability of quality-assured drugs at affordable prices, and (b) promoting the rational use of medicines.

The program was piloted in 72 DOH retained hospitals and 28 LGU hospitals. The program includes 24 drugs most commonly used, including antibiotics, antihypercholesterolemia, antiarthritis, antiasthma, antidiabetes, and Vitamin C. Of the 17 brands in the P100 list, five are in the Essential Drug List, the prices of which have gone down dramatically following the implementation of the Maximum Retail Price/Government Mediated Access Price (MRP/GMAP). In addition, 7 other drugs have since been included in the P100 list after the MRP/GMAP was implemented. In 2009, PhilHealth in its Circular No. 20, extended the coverage of the P100 program for its Sponsored Members (indigents) to include their drug consumption outside the hospital (take-home drugs) so that the patient can complete the full course of treatment

The P100 packs are currently dispensed at DOH retained and selected LGU hospitals, which are mostly patronized by the poor and lower middle class. This program was rebranded as the DOH Complete Treatment Pack Program, and beginning 2011, branched out into three sub-programs with different sets of beneficiaries. With its rebranding and re-launch as the DOH Complete Treatment Pack program, it is envisioned to be offered more widely to indigent Filipinos. Thus, medications for common acute infections and maintenance drugs for hypertension, diabetes, and high cholesterol will be provided for physician; (b) the patient has a DSWD ID number and/or PhilHealth number as being covered under the PHIC Sponsored Program; and (c) the patient adheres to the regimen prescribed by the RHU doctor and constantly does follow-up.

<b><u>V.</u>      <u>Objectives of the Project</u></b>
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**General Objective:** To conduct a formative evaluation of the DOH Compack program and analyze its impact of the access to medicines program.

**Specific Objectives:**

1. To understand the rationale, mechanics, and implementation of the Compack Program within the context of the overall strategy of reducing the cost and improving access to medicines, especially among poor households.
2. To analyze available data on program budgets, procurements, expenditures, supplies, inventories, drug destinations, and drug consumption patterns.
3. To identify and discuss specific strengths, weaknesses and bottlenecks, both at the policy and programmatic level, of the program and how these might be addressed.
4. To explore the prospects of strengthening the program, based on reasonable economic and other criteria.
5. To identify key lessons learned throughout the program duration and draw appropriate recommendations at the policy and programmatic levels

## **VI. Methodology**

### **1. Sources of Data**

This is a formative evaluation study describing several factors that may have affected the implementation of the COMPACK program.

A total of six LGUs were included in the study sites. The LGUs were selected to represent the major island groups of Luzon, Visayas and Mindanao.

### **Selection of Provinces and Municipalities**

The provinces and municipalities where the data were collected for the evaluation study were selected using a stratified two-stage sampling design. The provinces served as the primary sampling units while the municipalities are the secondary sampling units. At the primary stage of selection, provinces were categorized according to their geographic location and participation in the COMPACK Program.

All provinces nationwide were categorized and listed per major island group (Luzon, Visayas, Mindanao) according to the stratification variables described above. Within each stratum, provinces were selected per major island group. Random sampling was done in the selection of the two provinces each for Luzon, Visayas and Mindanao, and the subsequent selection of one municipality for each of the selected province.

In summary, the study population comprised of six municipalities from Luzon, Visayas and Mindanao which are listed in table 1 below.

**Table 2. Selected Sites Using Two-Stage Stratified Random Sampling**

Island	Province	Static Comparison Site
Luzon	Nueva Ecija	Talugtog
	Camarines Sur	Bombon
Visayas	Aklan	Tangalan

	Negros Oriental	Tayasan
Mindanao	Bukidnon	San Fernando
	Misamis Oriental	Balingasan

## **2. Research Methods**

The study utilized qualitative and quantitative research methods. The qualitative methods included Key Informant Interviews (KII), focus group discussions, and records review (RR). Primary data were drawn from the conduct of KII and focus group sessions, while secondary data were culled from available documents from previous assessments, evaluations and other project documents. These provided insights into the context and process of program development and implementation, and achievement of the desired targets. The quantitative method included a survey done to determine the knowledge and attitude of the beneficiaries on the COMPACK program.

### **Key Informant Interviews (KII)**

KII were conducted among the Compack program participants since the program started in 2011. A total of 22 KII were conducted in the six study sites. The respondents were selected from the provincial and municipal study sites. Program beneficiaries were also interviewed. The respondents with direct experience or interaction with the Compack program were selected. The responses of the interviewees were transcribed, coded and categorized.

### **Focus Group Discussions (FGD)**

FGDs were conducted among community members and patients seeking care at the health facilities. One FGD per LGU site were conducted. For the FGDs to be conducted the respondents were selected from among the health center beneficiaries and patients. Fifteen FGDs were conducted in the study sites. The FGD guide was pretested and revised prior to the actual data gathering. The responses from the discussions were transcribed, coded and categorized.

### **Survey Questionnaire**

A semi-structured questionnaire was developed to fulfill the research objectives. This was developed based on the results of the review of literature, documents on the COMPACK program, and the relevant parameters in the study framework. The whole questionnaire was written in Filipino and pre-tested, then translated into to ensure greater comprehensibility of the instrument. The respondents for the survey were selected around the Rural health Units in the study sites. Thirty household respondents were selected for each site. A spot map was used to identify the households in the site. All the four directions, i.e. North, East, West and South, with the health facility as the map's center was indicated in the spot map. For each direction, the field team selected as respondent every fifth household from the health facility until the required 30 households was accomplished.

## **Qualitative Studies on the Implementation of the COMPACK Program**

### **Initiating the COMPACK Program**

#### ***Introduction of new health programs in the LGU and community***

Any new program initiated by DOH normally passes through the regional office and then the provincial government for coordination and endorsement to the municipal LGUs. Prior to the implementation of the program in the municipality, the DOH representative conducts social marketing in the communities to determine the “fit” or suitability of the initiative. Once a fit or need is identified, he or she coordinates with the mayor for the program’s entry into the municipality.

The local health board (LHB) is convened to have the DOH representative introduce and discuss the program. The LHB is composed of the mayor as chair; the municipal health officer (MHO) as vice chair; and representatives from the rural health unit (RHU) chosen by the MHO, the private sector, and various LGU offices as members (e.g., social welfare and development office, planning and development office, budget office). Recommendations are then generated and forwarded to the Office of the Mayor for execution.

The Sangguniang Bayan (SB) on health creates the necessary ordinances, including those intended to inform the public about the program (such as the disadvantages if one is not a PhilHealth member) and those concerning budget allocation. Health programs are part of the development programs of the LGU. The development fund, which is 20 percent of the internal revenue allotment (IRA), is used to support these programs, including those in the barangays. If the program comes after the budget period, the mayor will order a budget realignment to support its immediate implementation.<sup>9</sup>

According to one of the mayors interviewed, the lowest amount he allots for the purchase of medicines from the developmental fund is Php 500,000 annually. Expenses on medicines can be taken from the MOOE (maintenance and other operating expenses), which is intended for office supplies and is separate from the personnel budget.

Part of the capitation received from PhilHealth is also used for medicines. The allocation usually includes a minimum of 40 percent for medicines, a maximum of 40 percent for the improvement of the facility, including equipment and capacity building, and a fixed 20 percent for the staff. The capitation is Php 500 per PhilHealth enrolled family in the municipality.

Non-PhilHealth members are generally not entitled to free health services, including laboratory tests. However, exceptions are made for some indigents as identified by the RHU staff and those who have letters from the mayor.

New or updated programs are introduced at the LGU level through the MHOs. After receiving orientation from DOH, the MHO, together with the program coordinator (each program has a coordinator), trains the trainers and disseminates information on the program through the health classes that midwives conduct whenever they go to the barangays during immunization day. The midwives are assisted by the barangay health workers (BHWs) and RN Heals during these sessions. The nurse disseminates the information about the new program while the BHWs are responsible for gathering the people. In some cases, especially when there are important issues that the communities should know about, the MHO and the nurse go with the midwives in doing the rounds of the barangays. There are also instances in which the DOH representatives meet with the community health team (CHT) members and BHWs to explain further any program updates.

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<sup>9</sup> During the annual budget preparation of the LGU, the mayor gathers all departmental budget proposals, including those of the RHU and barangays. These proposals are discussed and prioritized by the municipal development council before a budget is allocated.

In the Mindanao study sites, the introduction of new programs to the municipality level were first made to the RHU doctors. They, together with other health personnel, were called by DOH to workshops/seminars to the specific programs for implementation. The next steps depend on the strategies of the doctor. Since the MHO has access to the Mayor and the SB on Health, the MHO talks to them first about budgets and possible problems.

At the LGU level, the MHO prepares a presentation complete with a background on the DOH administrative order and the past ordinances of the municipality to justify the implementation of the program. As Vice Chair of the Local Health Board (LHB), the MHO requests the Chair, the Mayor, for a meeting. The MHO presents the program to the LHB as well as the draft of the needed ordinance. The editing and revision of the draft ordinance is also done by the MHO.

The MHO also has to lobby to the Mayor for the needed funds of the program. There are programs though that do not have budgetary requirements like the Expanded Program of Immunization (EPI) and Integrated Management of Childhood Illness (IMCI) hence the implementation is easier and faster.

To get the ordinances needed for the program's implementation, the MHO has to lobby and attend the committee hearings especially the first hearing. Otherwise, if the doctor is absent during the hearings, deliberation on the program will be deferred. The doctor need not attend the second and third hearings provided the councilors are already well oriented on the program.

At the RHU and Barangay levels, the programs are introduced to the RHU staff during the monthly staff meetings which is also convened as a training session. Then the midwives attend barangay meetings where they introduce the program and discuss the participation of the community. This is more direct and action is faster compared to doing it during Association of Barangay Captains (ABC) meetings where the barangay captains are seldom perfect in attendance. These are further reiterated in sitio visits, bench visits and during mothers' classes.

With the other bigger programs like Malaria, Maternal Newborn, Child Health and Nutrition (MNCHN), the MHO does the information dissemination in the barangays. Schedules are specially set for these events which can be funded by the LGU.

For new programs, a strong advocacy is needed to create an impact in the communities. This advocacy work needs financial support from the LGUs. In a community with around 60-70 percent Indigenous Peoples (IPs), it is very difficult to gather them for an activity unless there is food and giveaways. They prefer immediate food on their table rather than waiting for the long term benefits of an activity.

Further, the health personnel should be able to cover all their areas and all households in their assigned areas. Again this needs financial support for the transportation allowance of the personnel especially in areas where the land topography is really challenging. This was what happened to the malaria program with Global Fund and Shell as sponsors. They provided food during meetings and gave out mosquito nets and spray. The project also provided transportation allowance to the staff. The area has been malaria free for a few years now.

### **Introduction of the COMPACK program**

The COMPACK program underwent the LGU processes described above.

The interview informants knew about the COMPACK program from DOH orientation, describing it as intended for members of the Pantawid Pamilyang Pilipino Program (4Ps) and as including medical checkups and medicines for management of hypertension, diabetes, hypercholesterolemia, and the like. The DOH representative in one province in Luzon further understood the COMPACK program as an initiative to augment the supply of medicines for the National Household Targeting System (NHTS) beneficiaries of the 4Ps. The Department of Social Welfare and Development (DSWD) reportedly identified the beneficiaries based on their monthly income (quintile 1 and 2). COMPACK medicines include maintenance medicines for senior citizens. Beneficiaries are given medicines for one-month consumption and are advised to visit

the RHU for monitoring of their health condition. There are also essential medicines for children but only in small quantities.

In one province in Luzon, the MHO noted the lack of dialogue or consultation prior to the program to determine what medicines the community actually needed. While there was an oversupply of medicines for chronic illnesses, there was a minimal supply of medicines for common illness, such as colds, cough, and flu.

Since there was a significant number of non-moving medicines from the COMPACK program nearing their expiration date, the MHO decided to just distribute these to non-4Ps patients to avoid wastage. The recipients were just asked to sign on the inventory list. The MHO added, though, that these types of medicines kept on coming during the quarterly delivery. They had already informed DOH about the expired meds, asking DOH what they would do with these, but they had received no reply yet.

In a meeting that was called for the COMPACK program, the MHOs had already informed DOH about the issue of non-consultation prior to program implementation. They emphasized the importance of identifying first the actual needs of the RHU before delivering medicines. DOH replied that the program was in its observation phase and the medicines had already been paid for by DOH.

Recently, the DOH had asked them to list the priority medicines and so they are hopeful about receiving the supply in the first quarter of 2014.

In one province in Visayas, the MHO claimed that the number of patients going to the health center had increased after the program was implemented. According to the MHO, the residents seemed to want to take advantage of the benefits or incentives they could enjoy under the program.

In one province in Luzon, the public health nurse (PHN) also mentioned issues related to the medicines. She remarked that the MHO was not very keen on prescribing the COMPACK medicines and limited herself to one type of medicine, such as Metropolol, so patients were left with no choice even if they did not prefer this medicine. This resulted in stocks of unused medicines nearing expiration.

In response to the oversupply of some medicines, the PHN said that, per the advice of DOH, they distributed COMPACK medicines to non-PhilHealth members. Limited medicines, such as Sambong, Lagundi, and antibiotics, were still exclusively provided to the program intended beneficiaries. Despite this, however, the PHN related that the supply of "maintenance" medicines remained excessive compared to the demand.

Another issue cited by the PHN pertained to the distribution of anti-diabetes medicines to non-PhilHealth members who could not afford to pay for the glucose blood test, which is a requirement of the MHO. Based on the ordinance, non-PhilHealth members have to pay Php 100 for laboratory tests. Only PhilHealth members are entitled to free laboratory tests.

In Mindanao sites, the MHO is the main RHU staff involved in COMPACK since the MHO is the only one who can dispense medicines. The MHO also brings this program to the barangay during visits to the area. She makes it a point that she visits the barangay before or after the patient profiling and bring these medicines. But she tells the patients especially the older ones that they have to comply with the required clinic follow ups at the RHU for at least two months. They were told that their blood pressure (BP) and blood glucose must be under control before they can get their medicines from the midwives during the latter's visit to the barangay. Once they are under the care of the midwives, it is the responsibility of the midwives to update the MHO of their sugar or BP levels during monthly meetings. Transportation cost to and from the barangays can be very expensive (400-500 one way) hence this will help them minimize their expense.

The mayor's decision is crucial in determining the budget to be allotted to a program like COMPACK. The mayor also decides on where to source out the funds for the program budget. According to the Mayor in the Mindanao, not all programs/activities need to pass through the Mayor's office, there are some that are directed by the RHU. The COMPACK is one such program. Problems can also arise from the decisions of the MHO in the implementation of a program like COMPACK. An example is the distribution of medicines, if the doctor decides to give medicines even to those who are not qualified beneficiaries. What happens is that qualified beneficiaries are left with no medicines at the last quarter of the year.



## **Stakeholders, Partners, and Roles in Program Implementation**

### ***Program stakeholders***

The major stakeholders for the COMPACK program mentioned are DOH, LGU, RHU and the community. The DOH is the provider of assistance in training, equipment, medicines, and the like; the LGU is the implementer, with the RHU as its implementing arm on the ground; and the community is the beneficiary whose participation is the main indicator of the success of the program. In one province in Luzon, the DOH representative noted the collaborative effort among DOH, the municipal LGU, and the RHU in the management of health programs. DOH is generally happy with the support given by the municipal LGU.

The MHO in one Visayas municipality cited private entities and other government agencies as partners, such as Abante Aklan and Dios Mabalos, the Department of Education, Department of Social Welfare and Development, with its Kalahi-CIDSS, and the Department of Agriculture, with its livelihood projects. The MHO emphasized the importance of livelihood or income-generating initiatives, saying that promoting a healthy lifestyle also requires a sustainable source of income to ensure the households' subsistence.

The mayor in one Visayas municipality observes the lack of NGO involvement in health programs implementation. The mayor in another Visayas municipality also welcomes NGOs to assist on the program, citing the Rotary Club of Dumaguete as willing to help.

Other NGOs mentioned were World Vision and Abante Aklan, which provide educational support in private institutions.

In Mindanao, an MHO indicated that everybody, each and everyone is involved in the programs. These partners and stakeholders become part of their health program implementation including that for the COMPACK program They have specific health program stakeholders in their municipality though, specifically

- The German Doctors - they have been in the area since the 1990s. They also give health services but their focus is in the barrios, especially those remotely located. They go around the mountains in their vehicle full of medicines and medical supplies
- CSOs (Civil Society Organizations). These are actually the NGOs like the ones working on Solid Waste Management. They are actually accredited by the LGU. They are not all health groups but they get involved in all health programs.
- Armed Forces of the Philippines (AFP) The military doctors and dentists help during medical missions
- Provincial Government. They respond to the municipality's request of assistance by sending doctors and nurses during the former's annual medical mission.
- Office of the Congressman who donates medicines during the annual medical missions
- Global Fund initially and now Shell Foundation for the malaria program. The partner provides food for meeting participants, Transport Expense Voucher (TEV), mosquito nets and spray to the communities
- Mary's Troop - Supports the Family Planning program. Goes around the barangays to. Perform tubal ligation for free, papsmear for only P100 and gives out free Intra Uterine Devices (IUDs)

### ***Partners in implementation***

Note worthy is the support of private individuals for health-related projects including COMPACK. The mayor of Talugtug in Nueva Ecija recognized the support of Talugtug's Balikbayan Association and Masons. During the town fiesta, the *balikbayan* (Filipinos residing overseas who have returned to their hometown for a visit) would conduct a fundraising activity for specific causes. In 2010, they donated Php 400,000 for the renovation of their RHU. The mayor provided counterpart funds of the same amount while DOH gave Php 1 million.

The Masons, on the other hand, sponsors medical missions in Talugtug every year. They bring their doctor members as well as medicines. The LGU, aside from hosting the activity through the RHU, also provides medicines. The LGU has partnered with Paulino J. Garcia (PJG) Hospital in Cabanatuan City in order to borrow medical equipment, like ECG machine, during medical missions.

Other groups conducting medical missions are the Nueva Ecija Medical Society and another from Pampanga that performed cataract surgery in the RHU. Ophthalmologists came to Talugtug and brought with them the necessary instruments and supplies.

Talugtug likewise joined an Inter Local Health Zone (District 2), which tapped an NGO for a free ligation project in the municipality.

Being a member of a Unified Health Zone, Talugtug is one of five municipalities that contribute annually to a certain hospital that will accommodate their patient referrals. The original district hospital turned out to be very far from Talugtug so arrangements were made with Guimba District Hospital, which is nearer the municipality.

Other private individuals, including *balikbayans* and nuns, donated glucometer and strips. However, since there are no compatible strips available locally, the machine was good only until the strips lasted.

In the municipality of Bombon, the DOH representative said that the COMPACK program is implemented through coordination among 4Ps, the RHU (the municipal link), and the community health partners (CHPs), who act as a bridge to ensure the barangay has knowledge about the medicines and how these can be accessed.

Bombon has a partner in its mental health program. It is a private organization that conducts sessions and teleconferences, where they can monitor mentally ill patients (schizophrenic and psychotic).

The PhilHealth is also recognized as a health program partner in Bombon. From the capitation, the RHU is able to obtain funds for medicines and supplies and improve the facility.

In one municipality in the Visayas, the PHN identified DSWD, through the NHTS program, as their partner in implementing the COMPACK program. DSWD provided the list of the poorest of the poor in the barangays and, in partnership with PhilHealth, rendered medical assistance. She additionally cited the LGU as a partner responsible for the necessary logistics, aside from endorsing the program.

In another municipality in Mindanao, the following partners in health programs including the COMPACK were identified

- German Doctors

The group is involved in community health care for 25 years. All doctors are foreigners who come and go in the area. Usually they stay for two weeks. They have a mobile clinic and visit the remote areas of the municipality. They bring their own medicines but they get tetanus toxoid from the RHU. In return, they give accomplishment reports to the RHU. This arrangement allows the municipality to monitor the health service delivery including distribution of medicines of the other providers since there is a coordination between them and the RHU. They are also very much involved in the TB program, getting sputum samples from suspected TB patients and making referrals to the RHU. If they lose track some of their patients maybe due to transfer of residence, they inform the RHU to do the follow-up.

- Business Sector

The MHO managed to organize the market vendors, hog raisers, bakeshop owners, peddlers, and butchers and engage them in environmental and sanitation activities like protecting the water source, upholding the clean water act, and other tasks indicated in the sanitation code. The MHO also assigned the groups specific areas to clean in the municipality. They also join activities of the RHU during special health program celebrations.

- Religious Sector

Once in a while, they do participate in the activities of the Local Poverty Reduction Program, whose implementers are primarily a group of 10-15 NGOs.

- Auxiliary Teams (Barangay-based)

This include the Women's Health Team and the Brigada sa Kahimsug whose members are local citizens who can easily be tapped for emergency response like the provision of first aid before the patients are brought to the RHU, conduct of infection control activities, dissemination of health program activities like COMPACK and reporting of Violence Against Women (VAW) incidents.

### ***Roles in program implementation***

The interview respondents generally have common perceptions of the roles played by stakeholders in implementing the COMPACK program and other health programs.

#### Department of Health

- Provider role, including technical assistance to equip the RHU staff with the necessary knowledge and skills.
- Source of programs and equipment (DOH-Central). During the renovation of the Bombon RHU, DOH provided supplies and equipment for the birthing home and TB-DOTS center.
- Distributor of supplies. Based on the accomplishments and targets of the RHUs, the provincial health team (DOH-Province) allocates the supplies (e.g., vaccines, medicines) to the different municipalities. The case is the same with DOH-Region, which provides supplies to the provinces, depending on their accomplishments and targets.
- Source of medicine for outreach programs initiated by the RHUs.
- Central DOH provides the program logistics as well as financial assistance. It supplies the goods like medicines, vaccines needed by their programs. They also provide the modules of the programs.
- DOH regional offices provide the link of the central office to province. The DOH regional offices also provide technical assistance but usually courses them through the province.

#### Department of Social Welfare and Development

- Implementing partner, providing the NHTS list or list of 4Ps beneficiaries.

#### Local government unit/local chief executive

- Provider of logistical and funding support for facility improvement. In one municipality in Luzon, the LGU undertook the renovation of the facility because the RHU was no longer fit for its purpose, with leaks and holes all over it. In another municipality in Luzon (Bombon), the LGU, together with DOH, was instrumental in the renovation of the RHU, which included the construction of a birthing home and the TB-DOTS center. The mayor approved the request of the RHU staff to use the prize money that Bombon won in Good Housekeeping for the rehabilitation of the RHU. The LGU granted an additional Php 900,000 based on the project proposal submitted by the RHU. DOH then provided Php 1 million and the TB-DOTS program approved a fund of Php 200,000.<sup>10</sup>
- Source of financial support for the RHU staff training and outreach initiatives. For instance, in a Visayas municipality, the mayor's office provides allowance, security, and transportation during the RHU's medical outreach in geographically isolated areas.
- Source of project funding through the annual budget allocated to the health department, paving the way for the smooth implementation of projects.
- Adoption of mandates as part of the implementation of national health programs at the municipal level. The Local Health Board (LHB), in particular, discusses these programs.
- Discussion and assessment of problems or issues in implementation, and generation of recommendations for implementation by the mayor's office.
- Creation and passage of ordinances needed for the adoption of mandates through the SB on health.
- Source of medicines. The provincial government allocates a budget for medicines and vaccines. This means that not all medicines distributed by DOH-Province come purely from DOH. In a Luzon municipality, the mayor himself finds ways to secure more medicines for his constituents. He went to various offices to solicit funds for medicines, including the Philippine Charity Sweepstakes Office (PCSO), the Office of the Vice Mayor, regional office, senators, and some members of the private sector.
- Provincial Health Office provides as link of the DOH Regional Office to the Municipality. The PHO also acts as the technical working group for the municipalities and consolidates all plans of the RHUs before submitting them to the region
- Facilitator in implementing a new program in the municipality. This involves convening the LHB, setting up the budget, and ordering the creation of ordinances required for program implementation.
- Initiator of change. This includes introducing changes to existing practices that will make implementation of programs more patient-friendly.
- Barangay Captains facilitate the implementation of the program in their barangays.

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<sup>10</sup> It is important to acknowledge the RHU, however, because of its persistence in its goal of improving the facility and widening its services to the communities, which resulted in the creation of such project proposals.

#### DOH representative

- Coordination with the LGU/LCE, particularly on DOH programs to be implemented at the municipal level.
- Negotiation with the LHB for the passage of an ordinance for local adoption of national health programs in the community.
- Technical assistance to RHU staff in terms of capability building on different programs, such as family planning, expanded program on immunization (EPI), tuberculosis, environment and sanitation, nutrition, and mosquito-borne disease.
- Social marketing. The DOH representative sells the programs to the municipalities.
- Conduct of a situational analysis of the municipal health status of the community, for example causes of low rating/score (does the problem lie in DOH, or in reporting; or is it a cause of staff inefficiency?).

#### Municipal health officer

- Advocacy, including information dissemination about the programs
- Lobbying with the mayor and SBs for ordinances and other needs, and with the DOH representative for needs from DOH
- Implementation, including consultation with patients and home service to bedridden patients or those who have difficulty in coming to the health center.
- The doctor is the link between the DOH and the Mayor, and between the Mayor and the community. The MHO can influence the mayor's support to the program.
- The MHO is the main implementor of the program and has the main task of bringing down the projects to the communities/people.

#### Public health nurse

- Checking supplies, preparing requisitions, dispensing medicines with the assistance of the midwives, and preparing the required data or documents (e.g., reporting, monitoring).
- Information dissemination, which involves going around the barangays to inform the local people about the project.
- Supervision of the work of BHWs, who are the front-liners of the RHU in the community. The PHN in a Luzon municipality even spends his own money for the BHWs' fare if he has some amount to spare, in order to ensure they will be able to carry out their work.
- Proposal preparation. The PHN in a Luzon municipality, together with the MHO, develops proposals to request assistance from the LGU, NGOs, and even medical representatives, in addressing the hindrances to program implementation and carrying out their advocacy work.
- Coordination with the mayor in requesting staff to assist in program implementation and requesting the NHTS list.

#### Community or beneficiaries

- The community is expected to do its part as well to ensure the success and effectiveness of health programs. Parents, for instance, must see to it that the immunizations of their children

are complete and on time. High-risk pregnant women must take part in the family planning program and complete their prenatal checkups.

- The beneficiaries are not just the community but also groups and organizations like the schools, religious sector. They must be able to understand the program.

#### Others

- In a Visayas municipality, the PHN noted that a regional office personnel in charge of COMPACK and *Botika ng Barangay* (village pharmacy) comes to the RHU and collects the “utilization report” on dispensed medication. The LGU reportedly assists the RHU in information dissemination, providing the necessary logistics and budget.
- The RHU staff were described in Mindanao as reaching out or making the programs available to the remotest areas and to the most deprived members of the community. They also perform advocacy activities

#### **Good practices noted**

Worthy of note is the use of score cards by the RHU staff in a municipality in Luzon. The mayor is very particular about the RHU’s performance and monitors the LGU score card ratings. The LGU score card includes indicators on access to medicines. The RHU staff members are thus conscious of fulfilling their tasks and responsibilities effectively, knowing that the mayor is closely checking on them.

In a Luzon municipality, the mayor has made various initiatives that can provide good examples to other localities:

- Free use of the ambulance during emergencies
- 24/7 operations of the RHU
- Discounts on child deliveries for indigents
- Incentives to those who will deliver their babies in the RHU
- Incentives to “*hilots*” who will bring pregnant women to the RHU

The DOH representative of Bombon disclosed that her biggest accomplishment so far is being able to work with the people and promoting “teamwork” with the LGU, which can generate positive results on any health program. If there are issues and problems, she has learned to accept what can’t be done, and for what can be done, she has learned how to negotiate with the LGU.

#### **Related issues raised**

The mayor in one Luzon municipality raised the lack of support from the current regional director. He recalled that the former Regional Director was very different, as he was actively involved in health programs, even attending the inauguration of their renovated RHU. Whenever he sent the MHO to the region to request medicines, the MHO would normally return with about Php 20,000 worth of medicines. But with the current regional director, they receive nothing.

The mayor in one Visayas municipality, in turn, noted that the development councils should have a role in information dissemination. He revealed that he did not know about the COMPACK program. He was just informed that there were deliveries of medicines and he had to sign some documents. The mayor had no idea of the criteria for the selection of the municipality as site of implementation. He was just told to send representatives for training at DOH. There were no partner NGOs, as DOH directly implemented it.

Another challenge lay in the LGU's financial capability for sustaining the program. In one municipality in Luzon, the DOH representative said that although the mayor is already exerting efforts to respond to the requests of the RHU, the LGU still falls short of what is expected of it.

The issue of monitoring was also raised. The mayor in one Visayas municipality mentioned that he could still not gauge the effectiveness of the program due to the lack of updates. The RHU merely submitted reports for his signature.

Another mayor in a Visayas municipality is thinking of creating a monitoring team composed mostly of private sector representatives that will look into the implementation of programs and projects being implemented by the LGU including the COMPACK program. The mayor believes that involving the private sector in the planning process will help in making LGU initiatives successful.

In a Luzon municipality, the MHO emphasized the importance of ordinances. The MHO recalled that, in the absence of an ordinance, the mayor initiated the "No home deliveries" policy. He called the "*hilots*" (traditional birth attendants) to a meeting and informed them of the prohibition on home deliveries. He even offered the *hilots* a Php 500 incentive for every pregnant woman they could refer to the RHU for child delivery. However, when the mayor was suspended for several months, the incentives were stopped as well and so the practice of home births was revived.

In Bombon, the promising project of renovating the RHU was partially completed. Despite the Php 200,000 funding support from the TB-DOTS program, the LGU was unable to complete the construction of the structures required for the TB-DOTS center to be fully accredited with PhilHealth. The PHN said that perhaps the mayor had been besieged with many concerns that he failed to focus on the project. Moreover, the LGU was unable to come up with a bigger lot required by DOH due to financial constraints. Consequently, the RHU is still very crowded, especially now that more people are accessing its services due to the 4Ps.

An issue pertaining to the COMPACK program that is common across the municipalities covered is the lack of necessary consultation with the RHUs to identify the needs of the beneficiaries prior to program implementation. This resulted in the oversupply of medicines for chronic illnesses and the inadequate supply of medicines for common illnesses, which are prevalent in the communities.

Related to this, the PHN in one municipality in the Visayas raised the need for regular monitoring of the COMPACK program at the field level. She mentioned that DOH should deliver medication according to what is requested by the RHU to avoid wastage. The PHN noticed that DOH does not follow what is indicated in the RHU's request, rendering them unable to supply in-demand medicines, such as antibiotics. The PHN added that the PHO personnel in charge of COMPACK should be knowledgeable in the status of the program through the quarterly reports they submit (utilization report on dispensed medication and inventory report).

In Mindanao, the DOH management of programs was described as 'detached' with the PHO doing most of the work for DOH. Such that when they get to visit the RHU, they seem detached from the field situation.

The MHO in a Mindanao site said that she finds it funny that even between the offices of DOH, there could be an absence of communication. They just found out recently that the offices in-charge of the infrastructure and licensing are not coordinating with one another. They were surprised that their birthing home was not approved by the licensing team due to some structural deficiencies when in fact the structural plan came from the DOH itself. These offices might be in the same roof, just a few steps away from each other yet a major problem like this could happen. So they have to renovate in time for January 2014. Though they have no problem with the budget, the doctor has a hard time finding people to do the job.

### **Factors Facilitating Program Implementation**

#### ***Support of the local government unit/local chief executive***

The support of the LGU, especially the mayor, is crucial in the implementation of health programs like the COMPACK program. If the mayor's top priority is infrastructure, for example, then funds for health programs will be minimal. If the mayor gives importance to local health needs, approval and implementation of health and related initiatives is easier. In Bombon, the

mayor, together with DOH, approved the RHU proposal to renovate the facility, with the addition of a birthing home and TB-DOTS center. Moreover, the mayor allocated a budget of Php 900,000 for this project. And when the municipality won the Good Housekeeping seal, the mayor approved the use of the prize money of Php 400,000 for the renovation.

In a Luzon municipality, the mayor ordered the 24/7 operations of the RHU, indicating his serious intention of serving the health needs of his constituents. In a Visayas municipality, the MHO describes the mayor as very supportive and hands-on so the MHO has no complaints about program implementation.

Another area of support is in ensuring peace and order to guarantee the safety of medical practitioners and other RHU staff in carrying out their tasks in the communities, including the remote areas. In Talugtug, the mayor is very keen on fighting insurgency, especially since the municipality is surrounded by areas infiltrated by the New People's Army (NPA).

In a Visayas municipality, the mayor provides vehicle, LGU staff, and funds for food and snacks as needed for health projects or RHU activities. Sometimes, the mayor even joins the RHU staff in going around the barangays to promote and disseminate information on health programs.

Harmonization of the legislative and executive branches of the LGU has also been identified as a crucial factor in the easier implementation of health programs.

In Mindanao, political will to support and finance the implementation of the program was identified as essential. The mayor and the barangay captains are the implementing officers in their respective areas hence they can really make things happen for programs like COMPACK.

The mayor's function as the executive officer of the municipality greatly facilitated program implementation. His support is the most crucial. Even if he says yes but does not give full support to the activities, then the program will not be carried out successfully

#### ***Availability of LGU funds***

Aside from the annual budget allocation, LGUs obtain funds from their PhilHealth accreditation. The capitation and claims they get from the services they offer at the RHU enables them to support the continuous operation of the RHU and provide counterparts for other programs like COMPACK.

In a Visayas municipality, the mayor disclosed that they have not had any problems with the health budget because they source it from the PhilHealth capitation fund. The LGU is not limited in funding the RHU supplies and equipment, transportation allowance of health personnel, and the like, since they obtain a significant amount from PhilHealth claims and capitation. The mayor claimed that they were the first municipality to obtain PhilHealth accreditation.

A respondent in Mindanao indicated that as the executive officer, the mayor actually allocated the budget based on the priorities of the LGU and the RHU's different health activities. Hence, it is easier to manage the programs because the sources are already identified.

#### ***Capacity of the RHU to provide services***

Since the RHU is the health facility serving the communities, its capacity and resources must be adequate for the needs of the local people. In a Luzon municipality, at the initiative of the mayor, the RHU is already equipped to accept admissions. The availability of two ambulance vehicles also makes referrals easier.

Equally important is to have skilled and trained RHU staff to effectively implement health programs like COMPACK. In a Luzon municipality, the midwives have been trained in basic family planning and one nurse has been trained on IUD insertion. In order to motivate the health workers, however, and ensure their consistent dedication to their jobs, the LGU must work to provide them with their full benefits.

As in any team effort, cooperation among RHU staff members helps ensure the efficiency of their operations. A pleasant working environment makes for a happy and contented staff, which then positively affects their services, implementation of programs and treatment of patients.

In Mindanao sites, the dedication and commitment of the staff were identified as a factor influencing success of the program. Their concern to the constituents,



resourcefulness and hardworking attitude were valued attributes. . They can be sustained as such if they are well compensated, provided incentives, acknowledged for their accomplishments and contributions. The attitude and skill of the MHO as the prime mover of all the programs was very important

Similarly in the Mindanao sites, the competence of the RHU staff were identified. These are the Barangay Health Workers (BHWs), Midwives, Barangay Auxiliary Sanitary Inspector s who provide adequate and proper education to the community. Their perseverance despite the difficulty they undergo in going from one barangay to another is a big factor to the success of the program.

### ***Presence of BHWs in the communities***

The BHWs are the eyes and ears of the RHU in the barangays. They can track participants in various health programs (e.g., expanded program on immunization [EPI], family planning [FP], maternal care package [MCP], COMPACK and tuberculosis–directly observed treatment, short-course [TB-DOTS]) and maintain their records. They remind patients about the next activities and are the RHU’s treatment partners for TB-DOTS. In some cases, the BHWs even personally administer the medicines to TB patients just to make sure they are taking their medication correctly. They also bring suspected TB patients to the RHU.

In a Visayas municipality, the BHWs do the leg work in the communities, taking care of 20 households each. The MHO said that, since they only have five midwives and the areas they cover are geographically isolated, it would be difficult to reach their intended beneficiaries without the BHWs.

In Mindanao study site, it was noted that despite the very meager honorarium and transportation allowance, the Barangay Health Workers (BHWs), Community Health Teams (CHTs) and navigators continue to fulfill their duties and responsibilities. Likewise, the midwives despite the heavy workload still finds time to visit their barangays and walk miles if needed just to serve the people.

### ***Support from ordinances***

The SB on health creates the necessary ordinances and ensures the proper placement of the program in the community, complete with the operational guidelines. This works for health programs like COMPACK . The LHB, on the other hand, serves as the forum for discussing and assessing issues and problems and provides recommendations for implementation by the mayor’s office.

### ***Organization of training activities***

Carefully planned training is helpful to RHU staff members, since it will equip them with the knowledge and skills they need to carry out their duties without necessarily affecting the time they need to devote to providing services. In a Luzon municipality, the MHO recognized such importance of training from DOH. She pointed out, however, the need for ample time for the RHU staff to echo the training to the target beneficiaries.

### ***Dedication of the municipal health officer***

If the doctor is not keen on serving the people, the program will suffer. The MHO of Talugtug is hands-on and personally goes around the barangays. If RHU staff members need transportation, he allows them to use his service car.

The MHO in Bukidnon was described as ‘dedicated and committed’ . She has the ability to convince the mayor. Her passion to excel is also a stirring factor that can facilitate the implementation of new programs. As a department head and because she is related to the Mayor, she can also move people to do things.

True to her calling because she doesn’t choose who to serve; she together with her team rushes to the site of encounter and treat all those who need medical help regardless of affiliation, military or rebels- she treats them the same. It’s my profession, she would say.

### ***DOH assistance***

Aside from providing the health program, DOH partly subsidizes the expense that go with its implementation. In the MCP and TB-DOTS programs, DOH provides equipment, cash

assistance to improve the health facility, sustained supply of medicines (COMPACK), vaccines and other medical items needed in the implementation of the programs and treatment package for free, from which the RHU can make claims or receive capitation from PhilHealth. DOH also provides personnel/staff to monitor program implementation.

In fourth, fifth and sixth-class municipalities, all-out assistance from DOH will ensure program sustainability.

In Mindanao, DOH assistance in the form of financial assistance, program modules and training were seen as essential. The assistance through the Health Facility Enhancement Program (HFEP) and licensing were mentioned as important. The coordination and good relations between the DOH and LGU were seen as important factors in the success of programs.

#### ***Advocacy and information dissemination efforts***

Any health initiative will not be useful or successful without the cooperation of the intended beneficiaries. It is therefore important for the local people to be properly informed of the program and its benefits. The LGU and RHU must promote a positive health-seeking behavior among the communities so that they will use the health services available to them.

#### ***Cooperation of the community***

In the Mindanao study site, it was noted that though there are problems with some target beneficiaries due to cultural differences, the rest are cooperative. Their continuing participation in the programs give the staff a push to do good in their job to be able to serve them.

Community support can be through their participation in the programs. They however should be properly oriented about the program since if they don't understand it, they will not participate, and will stay away from the program. Such orientation for the COMPACK program was beneficial. An MHO said that if the community does not cooperate, there will be no purpose in the work of the RHU. To sustain their cooperation, the community must understand the program and be satisfied with the RHU's performance. That would even convince friends and relatives of patients served by the RHU to regularly visit the RHU

### **Factors Hindering Program Implementation**

#### ***Limited funds of the LGU***

. In Talugtug, the mayor admitted that it would be difficult for the municipality to increase its IRA share because among the three bases of IRA allocation, it is only population that is variable; the other two, land area and "equal sharing," are fixed. He looks forward to the alignment of the Priority Development Assistance Fund (PDAF) to national government agencies, including DOH.

New programs like COMPACK thus should take into consideration the limitations of the implementing municipalities and extend more assistance to fourth, fifth, and sixth class municipalities. Financial constraints affect the capacity of the LGU to hire adequate number of staff members and provide them with fair compensation. This then has implications for the performance of the RHU and the delivery of services to the intended beneficiaries.

*Logistics support for BHWs.* In Bombon, BHWs receive only around Php 300 to Php 500 a month as honorarium. They do not have transportation allowance even if their main task is to go around the barangay. Even though most of the barangays are relatively small and the BHWs only need to walk to reach their destination, attending meetings and doing coordination work at the RHU require them to shell out personal money for fare. Considering that they are the front-liners of the RHU in the field, they need to have the resources they need to carry out their tasks efficiently. The mayor claimed that he sometimes spends his own money to shoulder their fare.

Inadequate logistics support and lack of transportation allowance was also mentioned in Mindanao study site. According to the PHN, this is especially true if new projects arrive after the first or second quarter of the year. By this time, realignments are already very difficult to make because fundings are almost used up. Hence, launching of new projects are

sometimes postponed. If there is a new program launched, then the implementation will not be full blast.

*Low morale of health workers.* Like the BHWs, health workers at the RHU in Bombon have to fight for their hazard pay, which is very important for them, since they are exposed to various types of diseases. The LGU reportedly put on-hold this benefit for some time. When it eventually gave them their hazard pay, this comprised only 5 percent instead of 25 percent of their basic pay. This notwithstanding, their subsistence allowance was reduced to compensate for amount allocated for the hazard pay.

The health workers could not do anything about it, since the Magna Carta, which is intended to protect the rights of public health workers, is not mandatory to the LGU. Besides, they fear that their subsistence allowance will totally disappear if they continue to demand for the full payment of their hazard pay.

In a Luzon municipality, there is a lack of ordinances to support health programs and enforce the implementation of the health program and to provide guidelines for the processes. COMPACK program would have sustainability problems if there are no ordinances to support it at the LGU level

#### ***Lack of staff at the health office***

In a Visayas municipality, the mayor remarked that even with the presence of RN Heals nurses, the small number of staff at the RHU is insufficient for the vast number of health programs being implemented. This was increasingly felt when the 4Ps was launched. Added to this are the numerous DOH training and seminars the staff members are required to attend at least twice a month, which take away a significant amount of time intended for carrying out their RHU duties. The mayor further mentioned the frequent absences of the doctor for health reasons, which of course affected the delivery of RHU services. In other cases, the doctor is not available because he is attending training.

In Talugtog, the MHO admitted that she does not have enough time to conduct advocacy personally in the barangays because of the work demands at the RHU and the lack of staff. Since the RHU operates 24/7, the midwives have to do night duties so instead of staying in their assigned barangay health stations (BHS) for two days, they fit all of their tasks in one day. Sometimes, they go to the BHS only during the schedule of immunization. Some of their tasks are thus affected, resulting in a low rating in their score card.

RHU staff members often have to juggle multiple tasks, which then makes them less focused in performing their duties. The PHN in a Visayas municipality, for instance, experiences an overload of work. Aside from supervising midwives, implementing program activities, and preparing compliance accreditation activities and reports, the PHN attends to the paperwork of the rural health physician, who is often absent because of his health condition. As more and more health programs are initiated, the administrative tasks of the PHN become heavier, particularly in terms of reporting. Since there is only one PHN at the RHU, the magnitude of work is greater than the PHN's physical capacity to handle. There are instances in which the submission of reports is delayed because the PHN has to do fieldwork, such as when there was a high incidence of dengue in the municipality. The PHN had to go with the RHU staff from barangay to barangay to educate and remind the community how to avoid dengue and keep the family safe. There are some tasks, however, that the PHN delegates to other RHU staff. For instance, under the COMPACK program, the PHN assigned one of the RN Heals nurses to do the recording of medicines dispensed and to handle consultations.

The problem of staff shortage is generally attributed to the lack of LGU funds to augment the staff. The LGU of Bombon, a fifth-class municipality, could not replace the two midwives who had retired because of financial constraints. Instead, it hired a midwife on a contractual basis. However, since only permanent employees are allowed to attend DOH and other agency-sponsored training and seminars, contractual workers as well as volunteers lack the necessary capacity development.

The competence and work performance of the RHU staff affects the implementation of the program even if the health unit is managed well.

### ***DOH-related factors***

- Unstable and Incorrect supply of goods from the DOH

Though the supply in 2013 was reportedly sufficient and on time, an MHO in the Mindanao site said that it was in 2010- 2011 that they experienced no supply of vaccines from DOH. There was a timetable/schedule of immunization but without the vaccines, the program staff had nothing to do. With the COMPACK program, she said that they were asked to list down the medicines they needed since the start of the program but still the last delivery they received did not match their list. Hence, a lot of these medicines have already expired or nearing expiration.

- Uneven Pacing of the seminars/trainings from the DOH

Most the seminars/trainings from the DOH are given at the last quarter of the year. It affects their schedules and their performance since they have to work double time to catch up with the demands of the RHU after their long absence. The MHO has to strategize to comply with all the tasks, reports and expectations. This also affects the rolling out of the new DOH programs. In 2012, DOH announced that they will be planning their calls in 2013, but this was not realized. Hence the program roll outs were not conducted on time.

- Coordination and communication gaps between DOH offices

This can delay the implementation of the program and also results to a waste of time, energy and funds. Their efforts at the DOH should be coordinated. In the case of health facility enhancement projects, basic requirements like the structural plan and design of a building should have been discussed and approved by the participating agencies/departments before construction is started. Proper communication was also mentioned as essential. But the information to be communicated should be understood properly so that it can be relayed clearly.

- Delays in program updates

There are programs where staff are not updated or oriented since program updates are not regularly scheduled and the MHO has assigned them by turns in attending the seminars/trainings. The staff need to be updated so they can take over other health staff who maybe out on official business, absent or on leave.

- Synchronization of program schedules

DOH sometimes gives out programs for implementation without considering the workload of the health personnel at the RHU and the field, as well as the budget appropriation schedule of the municipalities

### ***Overload of training, seminars, and meetings***

In a Luzon municipality, there are times when the RHU staff members attend training and seminars one after the other, leaving them with no time to roll out what they have learned. They have already made a request through the Association of Municipal Health Officers (AMHOP) that training from DOH and NGOs be held done twice a month only.

According to the MHO, there have also been instances of overlapping training so the RHU distributes representatives among the training activities or chooses which training is worth attending. She recognizes the purpose and benefits of the training but stresses the need for ample time to share their learning with the communities.

Training activities likewise affect the availability of RHU staff, aggravating the problem of lack of staff in the health facility. For instance, the midwives assigned to the maternal care package (MCP) program cannot be found on certain days because they have to attend training.

One mayor in a Visayas municipality noted that because health personnel are called to attend DOH and related training, it seems like the RHU does not have a permanent doctor.

Program overload was noted in Mindanao that prevents full implementation of programs. This is because the staff attention to one program is shortened. New programs like COMPACK also generate additional workload since each program has different requirements in the reports

#### ***Lack of PhilHealth coverage for some residents***

Since the RHU prioritizes 4Ps and PhilHealth members, residents who are not covered by PhilHealth have limited access to health services. In a Luzon municipality, an ordinance was issued, stating that non-PhilHealth members shall pay for their laboratory tests. Even in the distribution of medicines, non-PhilHealth members are the last recipients. In 2013, the LGU allocated Php 300,000 (down from Php 500,000 in the previous year) for regular medicines intended for non-PhilHealth members. However, the medicines are good only until the supply lasts.

The LGU sponsorship for PhilHealth coverage has been steadily decreasing not only because of the presence of the National Household Targeting System (NHTS) and 4Ps coverage, but also because its premium is beyond the capability of a fifth-class municipality like Bombon. In fact, Bombon still has an outstanding account with PhilHealth.

The PHN of a Luzon municipality further revealed that while the number of NHTS and 4Ps enrollees was increasing, there was the issue of “wrong allocation of membership.” In particular, these programs left out many poor households and seemed to have included largely teachers and overseas Filipino workers. While this issue has been addressed, a significant number of very poor households have not been covered. This could be attributed to the people who made the listings, as they were not from Bombon. While the decision to assign people from outside Bombon to identify program participants was intended to avoid partiality, they lacked the necessary guidance and thus failed to identify the poorest of the poor.

#### ***Lack of necessary equipment in the RHUs***

In Talugtug, the RHU lacks BP apparatus and glucometers needed to dispense medicines for hypertension and diabetes to patients. Since the medicines are not moving, they are left with excessive supply, with some nearing their expiration date. Moreover, DOH has yet to deliver the delivery table for the birthing home.

The mayor is concerned about the increasing need for admission of simple cases. While the RHU already has a few beds, he believes they need ten more, in order to help more people. The beds are the least of his concern because he can get these from the provincial hospital. This means, however, that the RHU needs to hire more staff.

#### ***Unstable supply of vaccines and medicines***

In Talugtug, the supply of vaccines from DOH is irregular. When there is no vaccine available, the children will be unable to take their shots and will be recorded as defaulters. This will then bring down the performance rating of the RHU.

The MHO expressed, “*Sana po, all year-round ang supply ng meds*” (I hope the supply of medicines is all year-round). She observed that there are more patients going to the RHU when there are medicines available and that the visit become less and less as the supply dwindles.

#### ***Lack of medicines needed by the communities***

The PHN in a Visayas municipality remarked that DOH kept on supplying medicines that were low in demand or not needed by the people, resulting in wastage. DOH seems to not consider the RHU’s request for particular medicines as identified by the RHU based on the cases they handle at the facility. The RHU reportedly receives complaints from patients that the COMPACK program lacks the needed medicines.

In Bombon, the DOH representative said that in the coming years, the MHO will do a forecast of needed medicines under the COMPACK Program, including buffer stocks. This will help ensure that DOH will deliver only the requested medicines.

#### ***Distant location of community from the RHU***

Some residents are discouraged from going to the RHU because of the distance. This is especially true for those located in upland barangays. In a Mindanao site, the area of the municipality was described very big and some of its 24 barangays are widely separated from each other. Moreover, its terrain is mountainous and some of the roads are still rough. He said that there are still clusters of households which they were still not able to reach. There was no available vehicle that would be able to maneuver the difficult roads.

Due to the terrain of the place, and the area that one barangay covers, many of the BHWs, CHTs and navigators have complained about the difficulty in covering all the households in their areas since their transportation allowance is only 200 pesos a month. Each ride in a motorcycle ranges from 75 pesos and up. Moreover, if they are called to the RHU, their fares are not reimbursable. They cannot also get it from their honoraria because each of them gets only around 300 from the municipality and 100 from the barangay each month. In some of these barangays, there are also peace and order problems

### ***Community's attitude toward health care***

Some residents do not see the value of health care, especially preventive health care. They tend to evade the scheduled interventions from health programs.

In Bombon, the DOH representative noted the passive health-seeking behavior of mothers. Some want the midwives to go to their houses to have their children immunized while others have other children or tasks to attend to that they defer visits to the RHU. To address this problem, the RHU staff members go from house to house by teams to administer the vaccine.

In terms of the family planning program, the difference of opinion between husband and wife (i.e., traditional versus modern methods) affects the availment of FP services. This implies the need to intensify the advocacy on family planning in the communities.

In Talugtug, the MHO noted that there are a few programs where the participation of the community is problematic. In the maternal care package program, for instance, it is difficult to get women to undergo prenatal checkup especially during the first trimester of pregnancy. Some are hiding their pregnancy while others do not feel anything and thus do not see the need for consultation. As a result, they are not properly guided on how to manage their pregnancy and ensure their and their child's health.

The MHO further disclosed that home births still stand at 3 percent. The challenge here is how to prohibit the *hilot* in other municipalities from coming to Talugtug. The MHO has already coordinated with the officials of those municipalities about this issue but they are uncertain as to when they will be able to gather all their *hilot*.

The PHN in a Luzon municipality thinks there is a need for a new advocacy strategy to hold the interest of the people and make them understand the programs better. The PHN added that while the thrust of the health initiatives is preventive, the people's mindset is on the curative aspect of health. They no longer look at the function of the RHU as primary care benefit (PCB). They want medicines for every complaint they have and do not like the natural treatment methods (water, herbs) the RHU advises them to take. If there are no medicines at the RHU, they want prescriptions.

The PHN believes it will be helpful to spend a significant amount on information, education and communication (IEC) mediums that will appeal to the people, instead of conducting the usual lectures that the people have grown tired of. For instance, at the RHU, an LCD and monitor (or if these are too expensive, a portable DVD player, or a television) may be installed to show information on the health programs coming from DOH. This way, the people will have something to watch and learn while waiting for their turn. The PHN has already suggested this to the local health board but he has been told that no budget appropriation has been made yet for the purchase of an LCD and monitor.

### ***Community's dependence on the LGU***

In a Luzon municipality, the LGU distributed toilet bowls in the communities to address the sanitation problem, which is in turn the noted cause of diarrhea cases among the households. When the LGU personnel made their monitoring rounds in the communities, they noted that a lot of the toilet bowls were broken or used a hen's nest. While the LGU's approach was supposedly

participatory, expecting some counterpart from the beneficiaries, the local people believed that it was the obligation of the LGU to finance the installation of toilet bowls as well.

A mayor in the Mindanao site said that the community were cooperative with medical activities and medicine program of the RHU but were not as cooperative with the other health programs like the sanitation program. Community participation is dependent on the community's understanding of the health program as well as the prevailing practices and health beliefs of the community

## **Assessment and Monitoring Results**

### ***Program accomplishments and areas of improvement***

*Medicine supply.* The COMPACK program has been generally helpful to the communities, particularly 4Ps members. In order to optimize its benefits, however, DOH must identify the medicines actually needed by the people to ensure adequate supply of the appropriate drugs. The RHUs have noted the excessive supply of maintenance medicines as opposed to medicines for common illnesses, which are higher in demand. Since maintenance medicines are not fast-moving, they tend to remain unused until their expiration date, resulting in wastage. Medicines for common illnesses appear to have a higher demand and must therefore account for a considerable portion of the medicine supply from DOH.

Dispensing of medicines is also affected by the preferences of the attending physician. There is an MHO, for instance, who limits her prescription to one type of medicine for hypertension, leaving the other medicines untouched.

Even if the RHU attempts to make the medicines accessible to non-PhilHealth members to address the oversupply, patients cannot avail themselves of this benefit if they do not have money to pay for the blood sugar test, for example.

In a Visayas municipality, the PHN mentioned that the micronutrient supplement given to children is not popular among the children because of its taste. The RHU is suggesting that it might be better if it is in syrup form with better taste.

*RHU operations, personnel, and equipment.* The local people are generally grateful to the RHU and the assistance it provides. In Talugtug, the communities appreciate the 24/7 operations of the RHU which expanded the access to health programs and the availability of ambulance vehicles. The mayor wants to equip the facility with an ultrasound machine but is aware of the added cost of paying the associated personnel. He also sees the need for a sanitation inspector but the LGU has no funds to even support the full benefits of health workers, how much more the salary of additional personnel?

In Talugtug, DOH has yet to deliver the delivery table for the birthing home of the RHU even if the facility has been operating for a year already. The MHO said that they did not buy one because they were expecting the one to be given by DOH.

While the number of staff is technically enough for the municipal population (doctor, 1:20,000; nurse, 1:10,000; midwife, 1:5,000), this is still insufficient if one will consider the large number of health programs to be implemented and managed. For instance, Talugtug needs four more midwives, in addition to the six it currently has, in order to keep the barangay health station active as well as sustain the 24/7 operations of the RHU.

The MHO herself has been unable to do her advocacy work for health programs in the communities because of the demands in the RHU alone. The night duty is supposedly for the birthing home only, but patients still come for consultation at night, even for non-emergency cases, so there are instances in which the MHO is on duty 24 hours if there is a shortage of staff.

In the Mindanao sites, the convergence of COMPACK with the Registered Nurses for Health Enhancement and Local Services ( RNHeals) and the Rural Health Midwife Placement Program (RHMPP) are a big help to the municipality especially that the area coverage is wide, the terrain is rolling and the population is big. With the presence of these two deployment programs, the distribution of medicines to the the barrios has been made possible.

It's a big help to the people because they will not anymore spend for the fare or go through the difficulty in travelling on a motorcycle just to get medicines from the RHU.

The following improvements in the management of the program were recommended:

- Computerization of the Health Programs. Program data and data of beneficiaries would be easier to retrieve.
- Proper scheduling of the implementation of programs. Proper planning of activities will assure a more focused and funded programs.
- Consultation with the people from the field. He said that it is important that the field people should be consulted if there are new programs because the situations in the communities, though maybe similar in some aspects may also vary largely from one municipality to the other. Not only consult but these inputs from the field must be used/considered in the implementation.
- Full financial support to sustain the activities. This will address the concerns regarding the problem in community participation and the lack in transportation allowance for the healthworkers which are needed in sustaining the program thus achieving its objectives. The emphasis is on the word "full" so the effect of the program will also implemented be at its fullest.

*Information dissemination.* Usually, when there are forthcoming medical missions and other health program activities, the RHU conducts an information campaign to notify the communities a week before the scheduled date of the activity. Announcements are also made during the flag ceremonies for the barangay captains to hear.

In a Luzon municipality, the PHN was surprised to learn that the people did not know about COMPACK medicines when they were asked about this during a survey. As he is certain that the program was properly introduced, he is thinking that perhaps the BHWs introduced the medicines not as COMPACK but as medicines for 4Ps members.

In a Mindanao site, it was noted that unlike the other programs, COMPACK was not introduced as a program but a package where everything was introduced in the context only of its implementation. The focus were on the medicines, the forms to be used, the reports needed, the audits that will be conducted, etc. Moreover, most of the medicines that arrive in bulk are those that are least in demand.

### ***Monitoring and evaluation***

In a Luzon municipality, the MHO shared that they are still waiting for the regular monitoring and evaluation by the DOH regional and provincial offices, including data quality checks of RHU reports.

In a Visayas municipality, the provincial health officer (PHO) monitors the performance of the RHU based on reports submitted by the PHN on the sector programs of DOH. The midwife provides field data to the PHN for inclusion in the reports, and then the MHO reviews and approves them prior to submission to the PHO. This report also forms the basis of planning and assessment to improve the performance of the RHU.

In another Luzon municipality, the DOH representative revealed that, for the COMPACK program, they have a matrix to identify who among the beneficiaries are visiting the RHU regularly, how much medicines are released, and the diagnosis of the doctor. The rule is the patient will not be given medicines without the doctor's prescription.

As mentioned in an earlier section, the MHO will do a forecasting of medicines needed, including buffer stocks, and submit the list to DOH. The delivery of medicines from DOH will be based on this list.



In another Visayas municipality, the PHN monitors the implementation of programs on the ground through the midwives as well as through the community health team (CHT). The Field Health Service Information System (FHSIS) is the monitoring tool used, and the report is submitted quarterly. The PHN, however, admitted that because of the heavy workload and busy schedule, monitoring of programs is done only when problems arise.

In a Mindanao municipality, it was noted that few monitoring activities done. Locally, the Community Health Teams (CHTs), Barangay Health Workers (BHWs), midwives and barangay sanitary inspectors perform their respective monitoring rounds. They have their own forms and records to fill up. They also get the accomplishment report of the German Doctors so their reports include the services provided by other partners.

On the DOH level, it is the DOH rep who is their link in terms of monitoring in the municipality. Generally, the DOH-Rep visits the RHU to collect reports and relay communication from the DOH regional office. Although there are also communications done through email and the cellphone.

It was noted that it was very rare that people from the Region and Central office would visit them. In such case, they do not visit the communities; they stay only in the confines of the RHU. The last time that people from the higher offices came to visit them was 3 or 4 yrs ago, if she is not mistaken.

A nurse in Mindanao observed that the regional health office and the provincial health office have monitoring functions but they do not really go to the field. As per his observation, their role is limited to just gathering data through the reports submitted to them since there are monthly, quarterly and annual reports. They do visit the RHU but far in between but not solely for monitoring purposes.

At the LGU level, a mayor in Mindanao narrated that every Monday, they have meeting of department heads of where the doctor, being the head of the RHU, gives updates and reports on new programs and activities. On ordinary days, the doctor would also visit the mayor to discuss possible assistance the mayor's office can give to the RHU. LHB meetings are also called as needed and health issues and updates are discussed

The LGU keeps abreast of the Programs and the RHU's performance through the MHO who reports regularly during the department heads' meeting. At the RHU level, the midwives are the collectors of the data from the field. They visit their barangays regularly but they get more information from the BHWs and CHTs who are the frontliners in the field. From the forms and checklists filled up by her "fieldworkers", each midwife checks and consolidates the data and give a report to the PHN. The PHN then checks and consolidates the midwives' report and submit a summarized report to represent the RHU's final report.

### **Lessons Learned**

#### ***Too many activities, less focus of the staff***

Given the large number of health programs and activities, not to mention the administrative work that goes with these, the RHU staff members experience duty overload that they are unable to focus on new programs. This is an important issue to address because when workers are burned out, they will be unable to perform their jobs effectively. If workers are happy, they carry out their duties with ease and enthusiasm, which then facilitates the achievement of program goals.

The COMPACK program is supposed to be a big help but because of certain limitations, it has become a big waste. First, most of the medicines that are delivered to the RHUs are not what they need. The deliveries contain bulk of maintenance medicines for diabetes and hypertension, and only few bottles/boxes, in some deliveries there were none, of antibiotics and medicines for common sickness like cough and colds and fever.

Second, only the doctor can dispense the medicines. These maintenance meds need prior checkup with the doctor and some laboratory procedures to determine if they are really needed by the person. So the people have to visit the RHU. The RHU personnel can only give the medicines if they are already prescribed by the doctors. And even if the midwives, during

their barangay visits, are allowed to deliver these medicines to the people who have been already prescribed with it, it is limited because the patients have to perform regular consultation with the doctor. Otherwise, the midwives will not be able to give them their maintenance meds.

### ***Convergence of programs***

An MHO in Mindanao realized that when new programs like the COMPACK, Maternal and Child Program (MCP), Tuberculosis Directly Observed Treatment Short-Course (TB-DOTS), New Born Screening are introduced, they are actually not additional tasks or work to do at the RHU but opportunities for people to access health services that used to be available only in the urban areas. This 'levels up' the services provided by the RHU. The MHO realized that the recently introduced programs are not really new. They are actually interconnected with the previous programs as part of an evolving health system. Because of limited resources, improvements are incremental "Little by little, the health services are being improved" until eventually the RHUs can give the people better access to better programs.

The MHO also realized the need to learn to speak Lumad to be able to serve them better. They are the most disadvantaged group in the municipality hence the more they need these health programs to improve their lives. The MHO learned as well that attendance to annual Program Implementation Reviews (PIRs) is beneficial since you get some good practices from other municipalities. She also discovered that NGO support is useful. If the LGU is not very interested in your program, the presence alone of NGOs during meetings will put pressure on the officials.

### ***Importance of full LGU support***

The RHU is indeed the "answer" to the health needs of the people, but only if the LGU provides all-out support not only in the implementation but in the programs' sustainability. As noted in other sections of this report, the RHUs have insufficient supplies, rendering them unable to sustain the services they are offering to the people.

### ***Need for consultation between DOH and program implementers***

This is reflected especially in the COMPACK program, where the supplied medicines are generally not what is required in the communities. There is notably an oversupply of maintenance medicines and a scarce supply of medicines for common illnesses. These have resulted in the wastage of medicines as they remain unused until their expiration date and in the inadequacy of the RHU to respond to the priority medication needs in the communities.

It is important for DOH to validate the community's needs with the program implementers. Its initiatives must be need-based in order to really benefit the intended participants. In programs where DOH did not listen to their suggestions, the implementation is usually problematic. The PHN in Luzon said that DOH should consult them and act on their recommendations because they know the situations in the communities and their problems. Like in the COMPACK program, if they have given us what we requested, there would have been no wastage and more people would have been treated. He added that in cases like these, it is such a big advantage that your MHOs bear great influence on the Mayor otherwise, the program implementation would be a very big question mark.

### ***Need to Phase Trainings and Implementation activities***

While training is important to equip the RHU staff with the knowledge and skills necessary for them to carry out their duties, it is so numerous that it consumes a significant amount of time that the staff could have devoted to servicing the people. It is also a huge

expense for the LGU, especially if the training venue is in a faraway place. Registration fees are also considerably high.

The mayor in a Luzon municipality suggests that, where possible and equally effective, training material be produced instead (e.g., pamphlets, manuals). Since the RHU staff members are educated, they will not have a hard time understanding the directives. Local facilities may also be tapped as venues to lower the expenses, as well as contribute to the local economy

Invitations for meetings, trainings and seminars from the DOH usually come one after the other especially during the fourth quarter of the year. She said it does not give them time to roll out the program activities and it also keeps them away from their other tasks especially their clinic schedules. According to the doctor, DOH has the habit of talking to them rapidly, asking instant compliance for certain requirements. Rushing things for them at times resulted in returned documents because the requirements were not properly communicated and understood. There were a number of programs/activities that initially did not work out due to miscommunication with DOH. But because the LGU is devolved, the RHU has to find means to implement the program with minimal assistance. This situation can affect a program like COMPACK. Sometimes they call for participants the day before the activity. This becomes a problem if the person does not have money for fare or if in the case of the midwives, they are in their areas where there is no signal for cellphone

#### ***Use of reliable data in negotiations with the LGU***

When making a request to the mayor or the LHB, one must have factual, evidence-based data on which the mayor or the LHB can make their decisions. When the data sufficiently provide justification for the request, one is likely to generate a favorable response. In presenting the data, lay down the facts and describe the benefits or consequences if the request is granted or denied.

#### ***New advocacy strategy***

To encourage the participation of the people, the RHU must try new approaches in their advocacy work. The people seem to have grown tired of the lectures on preventive health care. Being knowledgeable in the needs and preferences of their communities, the RHU staff must seek to adapt the content and form of their advocacy to what they know will elicit the attention and participation of the people.

Showing of informative videos from DOH is one way. Installing a television at the RHU for this purpose may be an effective approach, since the intended audience – the patients – are already there. Given that watching videos is more interesting than listening to talks, this form of IEC will likely catch the attention of the people.

#### ***Community counterpart in development initiatives***

While the LGU recognizes that the communities need assistance in ensuring access to basic social services, it does not necessarily follow that the people will rely completely on the government to provide for their needs. The sense of dependency on government must be discouraged. In one municipality, for instance, the LGU distributed toilet bowls to the households to address the sanitation problem in the communities that is reportedly the source of diarrhea cases. However, as the households thought the LGU would shoulder the installation as well, many of the units distributed were left unused or broken.

It is important to instill in them the value of health and sanitation to their overall wellbeing. Once they appreciate its importance, they will consciously include health and sanitation expenses in their household budget or find ways to augment their income and be able to meet this need.

In Mindanao, the value of social mobilization was highlighted. Organizing groups into task force; educating them about their responsibilities to oneself, family, community and nature. The Barangay Auxiliary Sanitary Inspectors (BASI) was identified in a Mindanao site as an example. The BASIs are the guardians of the environment and sanitation program in the barangay level. They monitor construction and condemnation of CRs, proper waste

management, making of compost pits, protection of water supply, monitoring of rabies patients, dissemination of programs like COMPACK and other environmental and sanitary concerns.

**Established system at the RHU**

It is important to have an establish system, beginning with the identification of beneficiaries, consultation, up to the dispensing of medication. Patient then do not simply go to the RHU and ask for medicines. They follow a process. This helps ensure that the program reaches the intended beneficiaries.

Equally is important to have a system of recording to make sure reports are updated, as well as a staff who will be responsible for recordkeeping.

**Survey to Determine Knowledge and Attitudes on the COMPACK Program**

**A. Demographic Characteristics of Respondents**

A total of 180 respondents were surveyed with 13 males and 167 females from Luzon, Visayas and Mindanao comprised the sample. Of the 180 respondents, 10 (5.6%) were single, 134 (74.4%) were married, 3 (1.7%) were separated, 17 (9.4%) were widow/widower and 16 (8.9 %) were in a live-in arrangement.

**Table 3 . Sex of respondents by Island group**

	Island group			Total
	Luzon	Visayas	Mindanao	
Sex of respondent male	2	6	5	13
	3.3%	9.8%	8.5%	7.2%
female	58	55	54	167
	96.7%	90.2%	91.5%	92.8%
Total	60	61	59	180
	100.0%	100.0%	100.0%	100.0%

The educational attainment of the respondents are in Table 3 with most 74 (41.3%) being elementary graduates and 46 (25.7%) attaining elementary level education.

**Table 4. Highest grade completed by the respondent by Island group**

	Island group			Total
	Luzon	Visayas	Mindanao	
Highest grade completed none by the respondent	0	0	2	2
	.0%	.0%	3.4%	1.1%

elementary level	12 20.3%	22 36.1%	12 20.3%	46 25.7%
elementary graduate	23 39.0%	23 37.7%	28 47.5%	74 41.3%
high school level	7 11.9%	14 23.0%	9 15.3%	30 16.8%
high school graduate	14 23.7%	2 3.3%	6 10.2%	22 12.3%
college level	2 3.4%	0 .0%	0 .0%	2 1.1%
college graduate	1 1.7%	0 .0%	2 3.4%	3 1.7%
<b>Total</b>	<b>59 100.0%</b>	<b>61 100.0%</b>	<b>59 100.0%</b>	<b>179 100.0%</b>

In terms of occupation, most or 98 (54.7%) of the respondents were not formally employed, 34 (19%) were in informal or small business, 10 (5.6%) were farmers, and 9 (5.0%) were farm laborers.

**Table 5. Occupation of respondents by Island group**

		Island group			Total
		Luzon	Visayas	Mindanao	
Occupation of respondent	none/retired/housekeeper	38 63.3%	30 49.2%	30 51.7%	98 54.7%
	farmer	0 .0%	9 14.8%	1 1.7%	10 5.6%
	farm laborer	3 5.0%	3 4.9%	3 5.2%	9 5.0%
	informal business- vendor/small business	10 16.7%	8 13.1%	16 27.6%	34 19.0%
	formal business - market stall owner/store owner	0 .0%	0 .0%	1 1.7%	1 .6%
	service workers - employed	3 5.0%	1 1.6%	3 5.2%	7 3.9%

service workers - home-based	2 3.3%	0 .0%	2 3.4%	4 2.2%
office worker	1 1.7%	3 4.9%	2 3.4%	6 3.4%
professional	3 5.0%	6 9.8%	0 .0%	9 5.0%
special occupation (e.g. lottery collectors)	0 .0%	1 1.6%	0 .0%	1 .6%
Total	60 100.0%	61 100.0%	58 100.0%	179 100.0%

The five most common health problems were fever and flu – 141 (81%), cough and colds – 139 (79.9%), Hypertension – 45 (25.8%), Loose bowel movement (LBM) -15 (8.6%) and asthma - 12 (6.9%)

**Table 6. Most common health problems/diseases that affect your family by Island group (multiple response)**

		Island group			Total
		Luzon	Visayas	Mindanao	
Most common health problems/diseases that affect your family	Fever/flu	42 75.0%	53 88.3%	46 79.3%	141 81.0%
	Cough/colds	41 73.2%	47 78.3%	51 87.9%	139 79.9%
	LBM	7 12.5%	5 8.3%	3 5.2%	15 8.6%
	Skin diseases	0 .0%	2 3.3%	0 .0%	2 1.1%
	Asthma	6 10.7%	4 6.7%	2 3.4%	12 6.9%
	High blood pressure	20 35.7%	17 28.3%	8 13.8%	45 25.8%
	Diabetes	3 5.4%	1 1.7%	2 3.4%	6 3.4%
	Convulsion	0 .0%	0 .0%	1 1.7%	1 .6%
	Arthritis	0 .0%	0 .0%	1 1.7%	1 .6%
	Dengue	0 .0%	0 .0%	2 3.4%	2 1.1%
	Urinary tract infection	2 3.6%	0 .0%	1 1.7%	3 1.7%
	Allergy	0 .0%	0 .0%	2 3.4%	2 1.1%
	<b>Total</b>	<b>56</b>	<b>60</b>	<b>58</b>	<b>174</b>

\*Percentages and totals are based on respondents.

## B. Knowledge and Attitudes

The table below shows that out of the 128 responses, 126 or 98.4% indicated that they know something about the COMPACK program of the DOH.

**Table 7. "I know something about the COMPACK\_ program of the DOH" by Island group**

		Island group			Total
		Luzon	Visayas	Mindanao	
"I know something about the COMPACK program of the DOH"	yes	25 96.2%	48 98.0%	53 100.0%	126 98.4%
	no	0 .0%	1 2.0%	0 .0%	1 .8%
	don't know	1 3.8%	0 .0%	0 .0%	1 .8%
Total		26 100.0%	49 100.0%	53 100.0%	128 100.0%

When asked if they were provided services by the COMPACK program of the DOH, 118 (91.5%) of the 129 respondents said that they were provided services by the program.

**Table 8. "I was provided services by the \_COMPACK\_ program of the DOH" by Island group**

		Island group			Total
		Luzon	Visayas	Mindanao	
"I was provided services by the COMPACK program of the DOH"	yes	21 80.8%	44 88.0%	53 100.0%	118 91.5%
	no	3 11.5%	6 12.0%	0 .0%	9 7.0%
	don't know	2 7.7%	0 .0%	0 .0%	2 1.6%
Total		26 100.0%	50 100.0%	53 100.0%	129 100.0%



Exploring the related activities of the COMPACK program in the RHU, 121 (94.5%) of the respondents said that the COMPACK program of the DOH had done some activities in their RHU.

**Table 9. "The COMPACK program of the DOH had done some activities/programs in our RHU" by Island group**

		Island group			Total
		Luzon	Visayas	Mindanao	
"The COMPACK program of the DOH had done some activities/programs in our RHU"	yes	23 88.5%	46 93.9%	52 98.1%	121 94.5%
	no	0 .0%	2 4.1%	0 .0%	2 1.6%
	don't know	3 11.5%	1 2.0%	1 1.9%	5 3.9%
Total		26 100.0%	49 100.0%	53 100.0%	128 100.0%

Exploring further the sustainability of the COMPACK program through the LGU, 95 (73.6%) respondents indicated that they do not see the LGU having problems in maintaining the COMPACK program

**Table 10. "The LGU has some problems in maintaining the COMPACK program of the DOH" by Island group**

		Island group			Total
		Luzon	Visayas	Mindanao	
"The LGU has some problems in maintaining the COMPACK program of the DOH"	yes	5 19.2%	6 12.0%	0 .0%	11 8.5%
	no	14 53.8%	37 74.0%	44 83.0%	95 73.6%
	don't know	7 26.9%	7 14.0%	9 17.0%	23 17.8%
Total		26 100.0%	50 100.0%	53 100.0%	129 100.0%

In terms of availment of RHU services, 123 (96.1%) of the respondents observed that more patients have been availing of the RHU services since the COMPACK program of the DOH was implemented

**Table 11. "I observed that more patients have been availing of the RHU health services since the COMPACK program of the DOH was implemented" by Island group**

		Island group			Total
		Luzon	Visayas	Mindanao	
"I observed that more patients have been availing of the RHU health services since the COMPACK program of the DOH was implemented"	yes	22 84.6%	50 100.0%	51 98.1%	123 96.1%
	no	1 3.8%	0 .0%	1 1.9%	2 1.6%
	don't know	3 11.5%	0 .0%	0 .0%	3 2.3%
Total		26 100.0%	50 100.0%	52 100.0%	128 100.0%

In terms of the effect of the COMPACK program to the RHU and LGU, 122 (94.6%) noted that the RHU and LGU have become more active in health-related activities since the COMPACK program of the DOH was implemented

**Table 12. "The RHU and LGU have become more active in health-related activities since the COMPACK program of the DOH was implemented" by Island group**

	Island group			Total	
	Luzon	Visayas	Mindanao		
"The RHU and LGU have become more active in health-related activities since the COMPACK program of the DOH was implemented"	yes	24 92.3%	48 96.0%	50 94.3%	122 94.6%
	no	0 .0%	1 2.0%	0 .0%	1 .8%
	don't know	2 7.7%	1 2.0%	3 5.7%	6 4.7%
Total	26 100.0%	50 100.0%	53 100.0%	129 100.0%	

When asked on the effect of the COMPACK program to health situation, 126 (97.7%) of the respondents answered that the COMPACK program greatly helped in improving the health status of the communities and the health system.

**Table 13. "The implementation of the COMPACK program of the DOH greatly helped in improving our health status/system" by Island group**

	Island group			Total	
	Luzon	Visayas	Mindanao		
"The implementation of the COMPACK program of the DOH greatly helped in improving our health status/system"	yes	23 88.5%	50 100.0%	53 100.0%	126 97.7%
	don't know	3 11.5%	0 .0%	0 .0%	3 2.3%
Total	26 100.0%	50 100.0%	53 100.0%	129 100.0%	

#### **VIII. Discussion**

1. The Complete Treatment Pack (ComPack) is a medicines access program designed to reach the poorest of the poor with complete treatment regimens for the most common diseases in the country. The 2012 DOH Annual Procurement for Drugs and Medicines amounted to PhP 1,019,095,814.04 with allocation for all provinces of the country. Basic medicine packs for outpatient care were distributed quarterly to all 1,392 Rural Health Units nationwide since 2011. These include antihypertensives, antidiabetic, antibiotics, antiasthma, and other medicines for common infections.

The COMPACK program is currently the main government pharmaceutical procurement program as it was expanded to cater to the medicine requirements of the Conditional Cash Transfer (CCT) beneficiaries of the Pantawid Pamilyang Pilipino Program (4 Ps). There was an initial impression that the COMPACK medicines were exclusive for CCT beneficiaries but this was eventually addressed by the DOH in an Administrative Order (2011-0013). The DOH AO indicated that the COMPACK program "shall be implemented in priority areas identified b the DSWD as part of the CCT program. It may also be implemented in other LGUs as part of the Province-wide Investment Plan for Health (PIPH) of the DOH particularly those LGUs aiming to increase availability of essential medicines in their public facilities. The DOH COMPACK program medicines can be availed of by PhilHealth's eligible sponsored members and their qualified dependents in PHIC-accredited hospitals as take-home medications as per PHIC Board Resolution No. 1214. S. 2009"

The current policy on COMPACK medicines distribution includes PhilHealth and non-PhilHealth members but with priorities to the following sub-groups : a. Philhealth members, b) National Health Targetting Survey (NHTS) identified families c) Pantawid Pamilyang Pilipino Program (4Ps) beneficiaries d) Senior Citizens d) Persons With Disabilities (PWDs)

2. The results of the qualitative study showed that the introduction of the COMPACK program flowed as programmed from the DOH regional offices to the Local Government Units

(LGUs) and that there were variable LGU processes for program adoption, integration to work programs and monitoring. The COMPACK medicines logistics management system however ensures that the medicines are delivered directly to the LGUs. This shortens the delivery time as the commodities do not have to go through the Center for Health Development (CHDs) and Provincial Health Offices (PHO).

The implementation of the COMPACK program depended a lot on the support of the LGU, capacity and efficiency of the RHU staff, management skills of the LGU and RHU in weaving the COMPACK program into the existing programs and their working relationship with the DOH. The DOH related factors in program implementation included: mismatch with the type and timing of medicines supply to the needs of the LGUs; inadequate consultation of the LGUs on their medicine requirements resulting to the oversupply of some medicines and undersupply of other items; perceived overload of requirements and scheduled trainings from the DOH and limited monitoring of the program beyond the submission of required reports.

The DOH in response to these concerns initiated in 2012 a 'requisition' system such that the stock delivered to the LGUs are based on their needs. Prior to the said requisition system, the medicine requirements were estimated and subsequently procured based on forecasted requirements. This requisition system was initially implemented in 2012 and fully implemented in 2013. As such, DOH expects that by 2014, the stock deliveries to LGUs will be needs based and would avoid the problems in the mismatch and oversupply of COMPACK medicines. The problem of expiring medicines was addressed by DOH by an earlier issuance clarifying that COMPACK can be implemented as part of the Provincial Investment Plan for Health (PIPH) access to medicines program, and that medicines can be availed of by PhilHealth eligible members and as take home medicines for confined PhilHealth members. DOH also allowed the transfer of medicine stocks to nearby hospitals and other government health facilities such as the infirmaries and clinics being managed by other government agencies.

The convergence of COMPACK program with the other DOH programs was also noted. The inclusion of Lagundi and Sambong tablets in the medicine list facilitated the distribution of Philippine Institute for Traditional and Alternative Health Care (PITAH) Herbal Processing Plant products in the RHUs. The distribution of the said herbal medicines also enhanced their use as part of the Standard Treatment Guidelines (STGs) for common respiratory and urinary tract ailments. The Doctors to the Barrios (DTTB) Program, the Registered Nurses for Health Enhancement and Local Services (RNHeals) and the Rural Health Midwife Placement Program (RHMPP) were noted as complementary programs to the distribution of medicines in RHUs and their respective coverage areas. One respondent from Mindanao gave the following observation on the complementation of the human resource deployment program with the COMPACK program. "It's a big help to the people because they will not anymore spend for the fare or go through the difficulty in travelling on a motorcycle just to get medicines from the RHU."

3. The survey on the knowledge and attitude to the COMPACK program showed the following results: 98.4% of the respondents indicated that they know something about the COMPACK program of the DOH; 91.5% of the respondents said that they were provided services by the program; 94.5% of the respondents said that the COMPACK program of the DOH had done some activities in their RHU; 73.6% of the respondents indicated that they do not see the LGU having problems in maintaining the COMPACK program; 96.1% of the respondents observed that more patients have been availing of the RHU services since the COMPACK program of the DOH was implemented; 94.6% of the survey respondents noted that the RHU and LGU have become more active in health-related activities since the COMPACK program of the DOH was implemented; 97.7% of

the respondents felt that the that the COMPACK program greatly helped in improving the health status of the communities and the health system.

These results indicate that the COMPACK program was very visible and had a high utilization in the RHUs with 91.5 % responding that they were provided services by the program. The value of the program in the perceived improvement of services at the RHU level was also evident as 94.6% of the respondents noted that the RHU and LGU have become more active in health related activities since the COMPACK program was implemented. The response on the sustainability of the program was less enthusiastic as only 26.4% indicated that they anticipate LGUs having problems in maintaining the COMPACK program.

The sustainability of the program is one of the concerns from the LGU and community respondents considering that it is perceived as a beneficial health program. The DOH also announced that the COMPACK is a transition program which will eventually be integrated into the PhilHealth Primary Care Benefit Package. Part of the concern is that the medicines may not be made available to non-PhilHealth members and that the public health programs currently benefitting from the COMPACK inventory might be affected by the decline or even absence of medicines if the COMPACK program is phased out.

4. The COMPACK survey data when analyzed with the 2012 DSWD monitoring of the Pantawid Pamilyang Pilipino Program (4Ps) provides an indication of the contribution of the COMPACK program to the 4Ps. The September 2012 Monitoring Report of the DSWD<sup>vi</sup> on the Pantawid Pamilyang Pilipino Program (4Ps) indicated that 91.29% of the total monitored program beneficiaries in the municipalities visit health units to seek for health services, indicating a high level of access to the 4Ps related health programs including the COMPACK program. The DSWD monitoring result presents a similar trend in the COMPACK survey findings indicating that 91.5% of the respondents were provided services by the COMPACK program. The DSWD monitoring report had only CCT beneficiaries as respondents while the COMPACK survey did not stratify the CCT beneficiaries from the non-CCT beneficiaries.

A more systematic evaluation of the 4Ps from the 2012 Philippine Conditional Cash Transfer Impact Evaluation<sup>vii</sup> commissioned by the World Bank indicated that “although more children are visiting health centers to meet the program conditionality of regular growth monitoring, the study did not find an increase in childhood immunization coverage” The same study found that “more poor households in Pantawid barangays reported to be covered by the health insurance program under PhilHealth. Reported coverage of PhilHealth social health insurance in Pantawid barangays was 10.8 percentage points higher than the 67 percent reported coverage rate in the non-Pantawid barangays.”

The above data on the availability of medicines in relation to the COMPACK program shows a marked improvement in previous essential medicines survey. In 2009, the availability of 15 key essential medicines in public health facilities was found to be at only 53.3 % while warehouses that supply the public health system registered mean availability at 33% <sup>viii</sup>. Another study conducted by the European Commission (EC) in 2010 across 234 primary health care facilities and 65 hospital pharmacies in 10 Regions for an extended list of 44 essential medicines shows an even worse situation with mean availability at only 25%<sup>ix</sup>

5. A WHO medicine survey in 2009<sup>x</sup> reported that the mean four (4) week household medicine expenditures for 1071 households was PhP 441.00. Qualitative data from the study showed that COMPACK program beneficiaries reported a twenty- thirty (20-30) percent decrease in their monthly medicine expenditures associated with the introduction of the COMPACK program. This translates to an estimated PhP 88.20 to PhP 132.30

weekly savings on medicine expenditures per household associated with the COMPACK program.

The 2012 Philippine Conditional Cash Transfer Impact Evaluation commissioned by the World Bank found that that “poor households in *Pantawid* barangays spent 38 percent more on education per capita and 34 percent more on medical expenses per capita than those in non-*Pantawid* barangays.” These related findings indicate that households who are CCT-beneficiaries have additional resources available at the household level for education and medical expenses and a possible shift in spending patterns of CCT households in favor of education and medical expenses.

6. The study pointed to the discontinuity of the COMPACK as a medicine access program and the PhilHealth benefit packages requiring medicines. The availment of COMPACK medicines by PhilHealth and non-PhilHealth members was also the subject of numerous clarifications by the LGU providers as discussed above. The COMPACK medicines were provided free to CCT beneficiaries who are enrolled under the PhilHealth sponsored program and other RHU patients irregardless of whether they are PhilHealth members or not. For PhilHealth members however, the COMPACK medicines were treated as part of the benefit packages while for non-PhilHealth members, the COMPACK medicines were part of the LGU health services and access to medicines program. The RHUs who serve as LGU health care providers for sponsored PhilHealth members were facilitating the linking of the benefits as they are the designated and authorized health service providers of both the DOH and PhilHealth programs.

In subsequent developments, the PHIC proposed for the expansion of the the Primary Care Benefit Package and the integration of the medicine benefits to include ‘drug-related requirements’ for additional conditions such as the following:

- Asthma: Salbutamol inhaler and Prednisone
- Acute Gastroenteritis (AGE) with no or mild dehydration: ORS and zinc supplements (for children)
- Upper Respiratory Tract Infection (URTI): Paracetamol, Amoxicillin, Erythromycin
- Pneumonia (Minimal and low risk): Paracetamol (to include children), Amoxicillin, Salbutamol (for children), Erythromycin
- Urinary Tract Infection (UTI): Ofloxacin
- Diabetes Mellitus: Metformin, Glibenclamide
- Hypertension: Hydrochlorothiazide, Metoprolol, Enalapril, Amlodipine
- Dyslipidemia: Simvastatin
- Deworming: Mebendazole

Outstanding issues on the choice of medicines for certain conditions in the above still have to be sorted out by PhiHealth and DOH NCPAM, These include Mebendazole and Glibenclamide. Mebendazole procurement was discontinued in 2013 since this was already included in the Garantisadong Pambata program of the DOH. Mebendazole is the primary medicine used in the deworming component of Garantisadong Pambata program. . Glibenclamide on the other hand was removed from the COMPACK list in 2014 based on the recommendation of the WHO.

The said expanded Primary Care Benefit Package assumes that there are PhilHealth accredited drug outlets in the LGUs to supply the specified drugs and medicines. In areas where there may be no accredited drug outlets, the COMPACK program is expected to still be the main source of drugs and medicines to support the PhilHealth medicine related benefits.

7. Another difficulty in the COMPACK program implementation relates to the reporting system. The reporting system and forms used for reporting were found to be redundant and difficult to set up at the RHU level. The logbooks and forms to be accomplished by the RHU staff for COMPACK were additional tasks in their drugs and medicines utilization report. The separate reports for the various medicine access programs from the DOH, LGU, House of Representatives, private donors, and the PhilHealth PCB claims were repeatedly mentioned by the RHU staff as additional and overlapping tasks.

The overlapping medicine utilization reports include the drugs and medicines component of various health information systems such as the following: MNDRS (Maternal Neonatal Deaths Reporting System), iTIS (Integrated Tuberculosis Information System), NOSIRS (National Online Stock Inventory Reporting System), SPEED (Surveillance in Post Extreme Emergencies and Disasters), WOMB (Watching Over Mothers and Babies), iClinicSys, RxBox and GIS (Geographic Information Systems) Health Facility Mapping. The NOSIRS is a logistics management initiative with standard and formal reporting systems that can generate logistics information at all levels of the health care system. NOSIRS utilizes Supply Management Recording (SMR) as the recording tool to efficiently track the status of commodities at health facilities and hospitals nationwide. The integration of COMPACK reporting into NOSIRS was recommended and has been planned by DOH.

## **IX. Recommendations**

1. Ensure the integration of the COMPACK Program into the LGU development plans specifically the Provincial Investment Plan for Health (PIPH). This will help ensure the continuity of medicine access programs at the LGU level and provide support to the national programs with drugs and medicines component. The COMPACK program is a much needed and appreciated program which addresses gaps in access to medicines specially in geographically isolated and disadvantaged areas. Hence the recommendation to ensure its continuity by ensuring its integration in the LGU development plans. Commodities should also be procured according to the estimated needs of priority populations based on the preferred method mix per age group as determined by data on observed health seeking behaviors using the most recent demographic health survey or its equivalent.

A related policy recommendation is to clarify the provisions on the prioritization of beneficiaries specifically for the 4Ps (Pantawid Pamilyang Pilipino Program) beneficiaries, PhilHealth members and non-PhilHealth members. This will avoid the dilemma faced by the RHUs as to who among the qualified beneficiaries receive the medicines. The LGU respondents in the study also recommended the inclusion of civil society and private sector representatives in the conduct of national and local COMPACK program implementation reviews

2. Address DOH related concerns including: Unstable and incorrect supply of medicines; uneven pacing of trainings and delays in the dissemination of program updates; program integration with other DOH programs like DTTB (Doctors to the Barrios Program), RNHEALS (Registered Nurses for Health Enhancement and Local Services), MAPS (Medical Access Programs) and PhilHealth Primary Care Benefit (PCB) package.



The structured participation of LGUs and health service providers in the consultations, program implementation reviews and performance evaluation visits can help sort out the current program gaps. The needs-based approach through the requisition system initiated by the DOH can address the mismatch problems but may not be able to sort out the logistics issues inherent in the CHD operations. The directed convergence of COMPACK with other DOH programs in certain areas like the Doctors to the Barrios (DTTB) Program, Registered Nurses for Health Enhancement and Local Services (RNHeals) and the Rural Health Midwife Placement Program (RHMP) will enhance the efficiency and visibility of the participating programs in the areas where they are jointly implemented.

3. Interphase with Information and Communication Technology (ICT) solutions specifically the National Online Stock Inventory Reporting System (NOSIRS) and the electronic pharmacy component of the PhilHealth Primary Care Benefit (PCB) system to harmonize the implementation of related program components. This will promote efficiency in the distribution of quality commodities to targeted beneficiaries. The NOSIRS, for example, can map the medicine inventory coming from various sources and track commodity flows until these reach the beneficiaries. The electronic pharmacy component of the PhilHealth PCB system also ensures that the PhilHealth members receive the drugs and medicines component of the benefit packages.

Capacity building inputs to physicians in the health facilities to also include: Review of the Standard Treatment Guidelines (STGs); Rational Use of Medicines specifically the rational use of antimicrobials; supply chain and inventory management consistent with NOSIRS and to include proper disposal of expired or damaged medicines; good governance principles in the provision and distribution of health commodities;

4. Further studies are recommended on the following:
  - a. Comparison of COMPACK program impact between households who are CCT-beneficiaries and non-CCT beneficiaries
  - b. Tracking the utilization of drugs and medicines access programs in selected sectors and beneficiaries to determine the convergence of benefits and/or redundancies in funding
  - c. Supply chain management audit to determine the inefficiencies and barriers in distribution of drugs and medicines to intended beneficiaries
  - d. Conduct of cost-benefit or cost-effectiveness analysis of COMPACK medicines with respect to medical conditions that impose the heaviest burden in the National Health Account.

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<sup>i</sup> Batangan D and Juban N (2009). Philippines Pharmaceutical Situation: 2009 WHO Household Survey on Medicines. WHO, DFID, and MeTA Philippines

<sup>ii</sup> Ibid.

<sup>iii</sup> DOH Administrative Order 2011-0013 "Implementing Guidelines on the DOH Complete Treatment Pack to Ensure Sustainable Access to Essential Drugs and Medicines for the Marginalized Sectors"

<sup>iv</sup> Philippine Institute of Development Studies (PIDS) Terms of Reference for Study Number 20

<sup>v</sup> PIDS, Discussion Paper 2012-13

<sup>vi</sup> DSWD 2012 "Monitoring Report on the Pantawid Pamilyang Pilipino Program (4Ps)" September 2012

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<sup>vii</sup> The World Bank. Report Number 75533-PH “Philippines Conditional Cash Transfer Program Impact Evaluation 2012. January 22, 2013 (revised November 2013)”.

<sup>viii</sup> Batangan, D. B and Juban, N., “Philippines Pharmaceutical Situation 2009 WHO Household Survey on medicines”, 2008-2009, WHO Press, Geneva, 2009.

<sup>ix</sup> Dichosa, M.J and Sarol, J. et al., . Establishment of Baseline Performance Indicators of Health Sector Policy Support Programme Phase II. European Commission, 2010

<sup>x</sup> Batangan D and Juban N (2009). Philippines Pharmaceutical Situation: 2009 WHO Household Survey on Medicines. WHO, DFID, and MeTA Philippines