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Financing and Delivery of Health
and Sanitation Services through Effective
Resource Mobilization and Inter-governmental
Coordination: A Case Study of Cotabato City

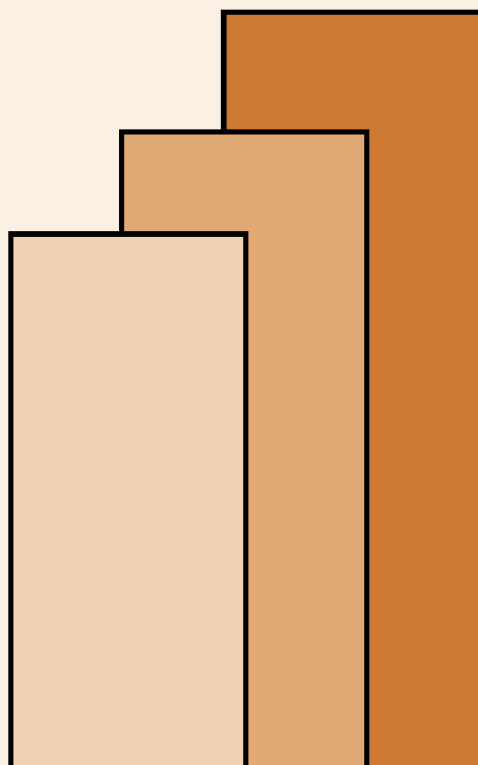
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PREFACE

This paper is one of the eight case studies in the health sector conducted under the project, “Population and Urbanization: Managing the Urbanization Process Under a Decentralized Governance Framework.” The project is jointly undertaken by the Philippine Institute for Development Studies (PIDS), the National Economic and Development Authority (NEDA) and the Development Academy of the Philippines (DAP). Among the components of the project are case studies of selected cities highlighting their innovations in health, housing, and environmental management.

The main objective of the case studies is to identify the strategies of model cities that can be replicated by other cities and local government units, particularly in the financing and delivery of basic services under devolution and increasing urbanization.

This case study focuses on Cotabato City which was recommended by NEDA-Region XII as a model city for health. The city aimed to bring health services to the barangay people but lacked funds to build additional health stations and hire additional manpower to man these facilities. To address this problem, it came up with the “Special Project on Health and Sanitation”, which won a Silver Award in the 1997 HAMIS (Health and Management Information System) Contest.

The paper is organized as follows. The first section gives a backgrounder on the city, its land area and population, health facilities and financing. This is followed by a discussion of the problems and constraints to the city’s efficient health service delivery. The next part presents the “Special Project on Health and Sanitation” which is the city’s response to overcome the constraints to health service delivery. The key elements for the success of the project are then identified in the succeeding portion. The fifth section focuses on the strategies that other cities and LGUs can replicate. Finally, the paper ends with some concluding remarks and recommendations.

**FINANCING AND DELIVERY OF HEALTH AND SANITATION SERVICES
THROUGH EFFECTIVE RESOURCE MOBILIZATION
AND INTER-GOVERNMENTAL COORDINATION:
A CASE STUDY OF COTABATO CITY**

Virginia S. Pineda and Ma. Lourdes Lim¹

I. CITY BACKGROUND

Brief History

The city of Cotabato was created under Republic Act No. 2364 on June 20, 1959. Under this charter, the city covered a total land area of 17,599 hectares and was politically subdivided into five barangays. At present, 32 more barangays have been created giving the city a total of 37 barangays.

Location

Cotabato City is located on the northwest portion of Maguindanao Province, in the region of Central Mindanao. It lies at 7 138'44 or north latitude and 124 14'32.06 east longitude. It is around 689.9 nautical miles southeast of Manila and is more or less 220 kilometers from Davao City. Cotabato City is bounded on the north by the municipality of Sultan Kudarat with the Rio Grande de Mindanao as the boundary; on the east by the municipality of Kabuntalan; on the south by the municipality of Dinaig (all are municipalities of Maguindanao Province); and by Illana Bay on the west. Presently, Cotabato City is the seat of two regional governments: Region XII and Autonomous Region in Muslim Mindanao (ARMM).

Land Area and Population

Cotabato City has a total land area of 176 square kilometer. Between 1990 and 1995, its population increased from 127,065 to 146,779 persons or by 16 percent. Likewise, population density per square kilometer rose from 722 in 1990 to 834 in 1995. Of its 37 barangays, 29 are urban and 8 are rural. The city has about 26,900 households.

Family Income

Currently, about 60 percent of the population live within the poverty level (with average gross family income of P6,000 and below per month). The middle income group with an average gross family income of P6,001 to P40,000 monthly constitutes 30 percent, while the high income group with over P40,000 monthly income makes up the remaining 10 percent.

¹ Research Associate, Philippine Institute for Development Studies, and Director, NEDA-Region XII, respectively. The authors would like to thank the officials and staff of the Cotabato City Office of Health Services for providing the data and information used in the case study.

Health Facilities

Presently, the city's health facilities consist of one (1) Main Health Center, 37 Barangay Health Stations (BHS) with seven (7) extensions, one (1) government hospital, and four (4) private hospitals. The Cotabato Regional and Medical Center (CRMC) has a capacity of 240 beds while the private hospitals have a combined capacity of 474 beds. As a regional hospital, the CRMC serves not only Cotabato City but also the provinces of Cotabato, Maguindanao, and Sultan Kudarat.

Health Expenditures/Budget

In 1991, before devolution, the city's health expenditures was P3.0 million, which was 7 percent of its total expenditures. Of this amount, 75 percent was for basic health services and the rest was for hospital expenditures. In 1994, after devolution, health expenditures rose to P8.5 million which was 5 percent of the city's total expenditures. About 98 percent of the amount was spent for basic health and nutrition while the rest is for other health expenditures including operation/maintenance of facilities.

In 1996, the budget for health services is P7.5 million. Of this amount, 90 percent was for primary health and 10 percent for curative services. City health budget constitutes 8 percent of the total budget. For 1997, the city health budget is 6.5 million which is about 4 percent of the total city budget.

II. PROBLEMS/CONSTRAINTS ON EFFECTIVE HEALTH SERVICE DELIVERY

The implementation of the 1991 Local Government Code (LGC) in 1992 provided the impetus for local government units to assume greater roles and responsibilities in bringing about socio-economic development for their respective constituents. This is in view of the devolution in the provision of basic services such as health, social welfare, socialized housing, agricultural extension, tourism development, among others, from the national to local governments.

The devolution of health services from the Department of Health (DOH) to local government units was in consonance with the national goals of "Health for All" by the year 2000 and "Health in the Hands of the People" by the year 2020. The national vision signals the initial step for local constituents to take active participation in the delivery of basic health services in their communities as well as an opportunity for local government units to manage their respective health services in the most effective and efficient manner. Considering these meritorious objectives to attain the national vision, the devolution process also posed problems for the DOH and the local government units, particularly on inadequate financial resources to undertake vigorous health service delivery programs.

In Cotabato City, the constraint of insufficient budgetary resources was only one of the problems faced by the LGU in the provision of effective and efficient health services to its constituents. Other problems encountered ranged from the geographic location of its barangays, economic status of its population, inadequate health manpower and facilities, and pre-LGC implementation situation.

Economic Status of the Population. People of various ethnic origins coming from as far as Aparri to Tawi-tawi populate the city of Cotabato. Majority of its population is composed of the Maguindanaoan tribe and people from the Visayan regions.

About 60 percent of the population is composed of marginal farmers and fisherfolks, seasonal job workers, unskilled laborers and jobless individuals. Those belonging to this group live within the poverty threshold level as they earn an average gross family income of P 6,000 and below per month. The remaining 40 percent accounts for the middle and high-income groups. This implies that majority of the city's population is poor and disadvantaged and, therefore, most wanting of health and other basic services from the government.

Accessibility and Transportation Constraints. The city's geographical feature makes delivery of health services a major challenge to the local government. Brooks, rivulets and creeks of various sizes criss-cross and traverse the city in all directions. Eight barangays can only be reached by water transportation. Three other barangays are not easily accessible by public transportation.

Before its special project on health and sanitation, the city has been providing health care at the Main Health Center and eleven satellite stations. However, people in remote areas cannot avail of these services because of transportation difficulties.

Inadequate Financial and Budgetary Resources. The Office of Health Services (OHS) had very limited financial resources. Its regular budget (P4.5 million in 1992) was just sufficient to cover personal services and maintenance and operating expenses.

Inadequate Health Manpower and Facilities. Due to financial constraint, the OHS could not put up additional health facilities and employ much needed additional health personnel. Prior to its special project on health and sanitation, the city has only 11 health stations regularly manned by midwives. In terms of manpower, the OHS had only 39 regular personnel. These consisted of 4 doctors, 6 nurses, 11 midwives, 1 dentist, 1 medical technologist, 8 sanitary inspectors, and 8 non-technical and administrative personnel. Such health facilities and manpower have been inadequate to cover all the households in the city.

Adverse Pre-implementation Health Situation. Until 1993, major health statistics and conditions indicate the need to give more focus in the delivery of basic preventive health services to the constituents of Cotabato City, particularly to the disadvantaged groups living in the remote barangays. Based on the National Statistical Coordination Board (NSCB) data for 1990, the city's infant mortality rate was 44.0 per 1,000 livebirths while maternal mortality rate was 182.8 per 100,000 livebirths.

III. THE SPECIAL PROJECT ON HEALTH AND SANITATION - A POSITIVE RESPONSE TO EFFECTIVE AND EFFICIENT HEALTH SERVICE DELIVERY

A. Overview of the Project

The Special Project on Health and Sanitation is a proposal that sought to address the inaccessibility of basic health services to people in the far-flung barangays of Cotabato City. It is basically founded on bringing these services to the people by installing a health station in each barangay. The project was conceived in 1992 during the conduct of the City Planning Workshop. The Office of Health Services (OHS) was its main proponent with the support of the private sector. The project was pushed through and became the initial response to the problem.

The Project has two components, namely: (1) the establishment of at least one health station for each of the 37 barangays of the city as well as the hiring of casual personnel to man the health stations all year round; and (2) provision of minimal but highly significant funding support for health-focused activities, such as advocacy to national and special locally-implemented programs and projects.

The main objective of the project is to improve and sustain the yearly delivery of basic health services to all the barangays in the city. The project amounted to P 3 million pesos which was financed from the 20 Percent Community Development Fund of the Cotabato City government.

B. Project Management and Organization

The Main Health Center under the City Health Office exercised the overall supervision of the Barangay Health Services Extension Component of the Project through the Area/Cluster Supervisors. At least one (1) barangay health station was established in the 37 barangays in the city. Seven (7) other extensions were set up for catchment areas in larger or heavily populated barangays.

For more effective supervision and monitoring, the barangay health stations are grouped into seven (7) clusters. These clusters are in accordance with the sub-city clusters or barangay groupings organized for facilitating administrative concerns of the city government. Each cluster is headed by a Cluster Coordinator who is a permanent nurse or midwife with extensive training and experience in city health programs.

All Barangay Health Midwives (BHM), now called Barangay Health Aides (BHAs), are directly under the supervision of the Cluster Coordinators. The Barangay Chairmen assist in the monitoring of the administrative performance of the respective BHAs.

C. Strategies Implemented to Address the Constraints to Effective Health Service Delivery

1. Provision of Barangay Health Station and Midwife for Each Barangay

To give the people ready access to basic health services and facilities, particularly among the poor and disadvantaged groups residing in the remote barangays of the city, the primary strategy of the city is to provide each barangay with its own health station and midwife. Affluent cities could easily do this but for those that lack financial resources, it was a formidable task. Cotabato City serves as model for cities that intend to provide a BHS and midwife for each barangay but lack sufficient funds.

Before the implementation of the special project on health and sanitation, the city has only 11 health stations regularly manned by midwives. In the city's experience, building cost for a concrete BHS is about P100,000. At most, the city could construct only three concrete BHS per year. The OHS managed to overcome the lack of permanent BHS structures and provide each of its 37 barangays with its own BHS by utilizing barangay halls, and rooms or spaces in private homes of concerned citizens (free-of-charge) as health stations.

Actually, the city even went beyond providing one BHS per barangay. Realizing the differences in barangay size and population, the OHS also set up seven (7) other stations for catchment areas in larger or heavily populated barangays. As of 1996, the city has 37 BHS and seven BHS extensions. Of these, 23 are permanent structures constructed by the city while the rest are temporarily located in barangay halls or private homes.

Another target of the OHS was to have one midwife stationed in every barangay. However, the regular budget for the OHS could not meet the salary requirements of the additional permanent midwives. To solve this problem, the strategy was to hire casual midwives and get their salary from the 20 Percent Community Development Fund.

2. Mobilization of Available Resources

Unable to hire health workers, the OHS identified the existing manpower resources that can be tapped for delivery of health services. It activated some 100 volunteer health workers, mostly trained hilots, to assist the midwives in the BHS. They provide maternal delivery services and promote other basic health care services to the purok levels. In appreciation of their volunteer services, the city gives them a cash gift of P500 during December of each year.

The city likewise mobilized health services-related educational institutions, non-government organizations, private companies, and civic minded citizens. These groups provide volunteers, medicines, refreshment, vehicles, and financial support during advocacy activities.

The OHS also obtained support from barangay officials. Funds for medicines come from the barangays. In case of problems, the midwives coordinate with the barangay officials and discuss with them any proposals or recommendations. Health concerns are among the topics for discussion during “pulong-pulong” or barangay meetings that are held about once a month. Barangay captains also help in advocacy programs by presiding over meetings to plan the activities and to mobilize the support and participation of local residents.

3. *Barangay Clustering*

For more effective supervision and monitoring, the OHS grouped the 37 barangays into seven (7) clusters. This is in accordance with the sub-city cluster system adopted by the city government for facilitating local administration and management. A Cluster Coordinator who supervises and monitors the activities of their respective BHSs and barangay midwives heads each cluster.

Dividing the work of supervision and monitoring of the 37 barangays among seven coordinators facilitated these tasks. Focusing on only a few barangays enabled the coordinators to immediately respond to the problems and needs of the barangays within their respective clusters.

D. Activities Under the Special Project on Health and Sanitation

Project activities fall under three categories: a) DOH regular programs implemented at the barangay level; b) locally initiated health activities; and c) advocacy activities for periodic national and global health programs.

1. *Implementation of regular and sanitation programs at the barangay level*

The midwives, assisted by volunteers, carry out the following regular DOH programs: pre-natal and post-natal care, breastfeeding, immunization, family planning, nutrition (food supplementation, iron and iodine, vitamin A); disease/epidemic surveillance and control (e.g., diarrhea, respiratory diseases, tuberculosis), environmental sanitation and health education. They also give first aid to emergency medical cases.

The midwives and volunteers conduct regular house-to-house visits to promote health awareness and distribute IEC (information, education, communication) materials. Together with the resource persons provided by the OHS, they hold mothers’ classes about twice a month.

The health stations serve as the mini-hospitals while the midwives can be considered as the little doctors in the barangays. A daily average of 20 patients seek medical assistance or at least immediate relief from certain ailments from the barangay health stations. Considering that there are 37 BHSs and seven extensions, the total patients served in the barangays may be approximated at around 880 patients per day. The Main Health Center cannot possibly serve all these patients. It can accommodate only about 50 medical consultation cases per day. In many instances, it

has to request unattended patients to come back after a few days. The presence of BHS in every barangay has helped alleviate overcrowding of patients in the Main Health Center and saved the people transportation costs.

2. *Implementation of locally-initiated health programs/activities*

The Project enabled the OHS to initiate the following programs and activities that cannot be funded under the regular budget:

a. Civic action activities in celebration of the Araw ng Cotabato (every June 20)

The OHS provides free medical and dental services to the poorest sectors of the city. This is done in collaboration with the Philippine Medical Society, drug companies, other government agencies and non-governmental organizations (NGOs).

b. Continuing education for medical and paramedical personnel

Technical capabilities of the OHS personnel are upgraded through special locally-initiated seminars and workshops. In the past years, many such opportunities were missed by the OHS personnel due to lack of funds.

c. Semi-annual and annual health review and evaluation workshops

The OHS conducts semi-annual and annual review of its programs, activities and performance. Through the workshops, the OHS staff and health workers learn of better ways of doing things as they listen to lectures, interact with each other, share their experiences, problems and solutions. The workshops, therefore, serve as effective monitoring and management tool.

d. Medical assistance to civilian volunteer organization (CVO) members

The project has provided a P50,000 medical assistance for the CVO members who get sick or injured while rendering volunteer services. CVO groups were organized by the city government in each barangay to assist in emergency situations caused by calamities and in safeguarding peace and order in their respective barangays.

e. Health and safety seminar for garbage collectors and street cleaners

The purpose of health and safety seminars is to provide health and safety tips to workers who are constantly exposed to health-hazardous conditions related to their jobs of solid waste collection and street cleaning.

3. *Advocacy of national and global health programs*

In the past, the OHS had to cram for preparations and solicit funds to meet the advocacy requirements of DOH programs. With funding from the project, Cotabato City even registered outstanding performance in two of these periodic national programs – immunization and nutrition.

For the annual DOH Immunization Program (February and March), the city was cited as the highest performer in Region XII and one of the top ten cities nationwide in the Oplan – Alis Disease Campaign in 1994 and 1995. It also excelled in the Knock-out Polio Campaign in 1996.

During the nutrition months (July and October), OHS activities included weighing of children and distribution of micro-nutrients over and above the regular program implementation; education on proper nutrition given through the OHS radio program and distribution of IEC materials; and holding of yearly healthy baby contest with the support of NGOs, drug companies and other government agencies. Cotabato City was also commended for its achievements during the nutrition months.

With funds from the project, the OHS was able to provide free dental services, toothpastes and toothbrushes during the National Dental Health Week (February), medical testing services during the Women’s Health Month (March) and STD-AIDS Awareness Month (December). It has also conducted information campaigns through slogan and poster-making contests, parade and symposium. All these advocacy activities were done in collaboration with NGOs and other government agencies such as the Cotabato Regional and Medical Center, Philippine National Red Cross, and City Social Welfare and Development Office.

E. Impact of the Project

Since the project’s implementation, no epidemic has occurred in the city. Previously, Cotabato City has been reported in 1992 as one of the areas in the country with the highest incidence of dengue – a total of 213 cases. Dengue incidence dropped significantly to 39 cases in 1996.

While the city’s adjacent municipalities and provinces suffered from measles epidemic in 1996, Cotabato City was able to control the spread of the disease. Its measles cases during the year were manageable at 214 cases.

The prevention of epidemics is attributed to the presence of a BHS midwife and volunteer workers in every barangay to conduct disease surveillance and information campaign on proper health care and sanitation. The project also enabled the OHS to intensify its environmental sanitation drive with the hiring of a utility personnel to handle fogging and spraying operations.

With the implementation of the project, health conditions in the city have improved as reflected in the reduction from 1990 to 1995 of infant mortality rate from 44 to 36 (per 1,000 livebirths), child mortality rate from 61 to 50 (per 1,000 children below age 5) and maternal mortality rate from 183 to 150 (per 100,000 livebirths). These were even lower than the average for the Philippines (Table 1).

Table 1. Comparative Mortality Rates, 1990 and 1995

Mortality rates	1990		1995	
	Cotabato City	Philippines	Cotabato City	Philippines
Infant	44.0	56.7	36.1	48.9
Child	60.9	79.6	50.0	66.8
Maternal	182.8	209.0	149.9	179.7

Infant mortality: infant deaths per 1,000 live births

Child mortality: number of deaths among children less than 5 years of age per 1,000 children of the same age range

Maternal mortality: number of maternal deaths per 100,000 live births

Sources: Herrin (1998) and National Statistical Coordination Board

IV. Key Elements Contributing to the Success of the Project

1. Intergovernmental Coordination and Collaboration

The city government, through the OHS, was successful in establishing strong coordinative and collaboration linkages with the executive and legislative branches of the local government through the City Development Council. It was manifested in the support provided by the barangay officials, non-government organizations and the private sector in the conceptualization, development and implementation stages of the project. The ability of the city government to provide these basic health services to the disadvantaged people in the far-flung areas harnessing the support of various development actors shows the extent of its coordination and collaboration efforts. One illustration of the success of this effort was the provision of a BHS in each barangay and additional seven BHS extensions due to the support accorded by the barangay officials and concerned private citizens by allowing the free use of barangay halls and private homes as health stations.

2. Mobilization of Local Financial Resources

The problem of inadequate financial resources faced by the city government in the implementation of health programs and projects has been addressed by its willingness to support the special project using the 20 Percent Community Development Fund. Had the OHS depended on the regular budgetary source and did not explore other sources of funds, the delivery of effective and efficient health services may not have been brought down to the barangay level. The ingenious approach to the health service delivery problem, particularly in its financing, afforded the implementation of a meaningful project attuned to the needs of the population.

3. Presence of Health Facilities and Personnel in the Barangays

Since there is a health station serving each barangay, people have a place to go for their immediate health needs. Health conditions improved because there are people who deliver health services. There are midwife and volunteers in every barangay who implement regular health and sanitation programs, advocacy activities for periodic health-focused programs, and locally-initiated health activities. Through

their house-to-house visits and community classes, they promoted health awareness, proper nutrition and sanitation. By doing disease surveillance, they prevented epidemics. The availability of a utility worker to handle spraying and fogging operations also helped reduce dengue cases.

4. Mobilization of People for Volunteer Work

The mobilization of approximately one hundred (100) volunteers to assist the thirty-seven (37) midwives facilitated the delivery of health services to more people at minimum cost. As a token of gratitude, the city gives each of them P 500 cash gift in December. The city also recognizes the outstanding performance of barangay health workers through annual awards. These volunteer workers are one of the key factors that contributed to the remarkable performance of the city in the implementation and advocacy of annual health programs of the government.

5. Barangay Clustering

The strategy of clustering the barangays into seven (7) sub-city areas facilitated the implementation and monitoring of the Project. Moreover, the designation of a Cluster Coordinator for each area provided focus to the supervision and monitoring of health activities in the barangays.

6. Clear goals/plans/programs

Primary health was one of the major priorities of the local administration in the provision and improvement of social services in the city. In line with this, the city leaders have set a specific goal - to provide a BHS and midwife in every barangay, and accordingly devised plans and financing scheme to achieve this goal. The OHS then prepared a project proposal which was discussed thoroughly in the Annual City Planning Workshop participated by government agencies and non-government organizations. With its concrete measures, the proposal was subsequently implemented as the Special Project on Health and Sanitation.

V. STRATEGIES THAT CAN BE REPLICATED BY OTHER CITIES

Given the experiences and lessons learned from the case of Cotabato City on the financing and delivery of health and sanitation services, the following strategies may be replicated by other cities in the development and implementation of similar activities in their respective areas:

1. Provision of Barangay Health Station in Every Barangay by Using Barangay Halls and Private Homes

Cotabato City's experience shows that there is really a need for a physical structure or facility to house a BHS so that the people will know where to go for their health needs. In addition, it presents possibilities of substitution or sharing in the use of facilities. A certain facility does not have to be utilized solely for BHS. It can serve as BHS on certain days of the week and have other uses during other days.

Another important lesson that can be derived from the Cotabato City experience is that the insufficient budgetary support for the establishment of barangay health facilities did not hamper the city to pursue the provision of a BHS for each barangay. Through effective coordination and collaboration with barangay officials and private citizens, the city government was able to set up the health stations using barangay halls and private homes for free. Since the barangay residents are directly benefited by the BHS, it is enough incentive for them to help the city government through free accommodations in their respective barangay halls or private homes. Another alternative is to offer rent payment for the use of these facilities.

2. Provision of Midwife For Each Barangay

Without the health personnel, the presence of health facilities in the barangays does not guarantee the delivery of health services to the community at any given time. This is the rationale for the provision of barangay health midwives in each BHS who were hired on a casual basis.

3. Intensive Planning and Coordination

The case of the Cotabato OHS imparts to other local government units that to be able to implement meaningful projects in the light of national goals and thrusts, thorough planning and extensive coordination work must be done. The key to the attainment of the LGU's objectives in the implementation of development projects lies in the ability of the planning staff to articulate these needs, identify viable measures to address the problems, coordinate with beneficiaries, local officials, and NGOs, and explore local financial resources that can be tapped for the project.

4. Mobilization of Local Resources

Following Cotabato City's example, other cities could activate trained hilots to assist the midwives in the health stations. The barangay officials and midwives may approach the identified trained hilots individually or organize a meeting with them to encourage their participation in health service delivery.

Other cities could also request the assistance of health service-related educational institutions, non-government organizations, private companies, and civic-minded citizens in conducting health-related activities for periodic advocacy programs and also during the celebration of the cities' respective foundation days. City officials or representatives may approach them directly or call a meeting with them to plan the activities and specify their participation or contribution (such as manpower, refreshments, and financial support).

5. Barangay Clustering

In Cotabato City, the clusters matched the delineation of the sub-cities identified by the city government for its administration. Other cities could also follow their own government's delineation as basis for the barangay grouping. They could also devise other schemes such as grouping the barangays based on their proximity with each other.

6. Annual Program Review and Evaluation

Other cities could also conduct an annual workshop or general meeting among its health workers, as being practiced by Cotabato City, to serve as a forum for assessment of performance, exchange of information and social interaction among them. In this activity, health workers learn to provide information on their respective projects, exchange ideas, and interact with one another, thereby promoting camaraderie and smooth working relationships.

VI. CONCLUSION AND RECOMMENDATIONS

Cotabato City is a good example for other cities to follow, having set a goal and searched for ways to attain it in the shortest possible time. If the OHS just relied on the construction of BHS funded by the regular budget, it would not yet have accomplished its objective of providing one BHS per barangay. At present, the city has only 23 concrete BHSs. Based on the construction rate of three (3) BHSs per year, it will take about five more years to build additional fourteen (14) concrete BHSs to complete its target of 37 BHSs or one BHS for each barangay. Likewise, if the OHS depended only on its regular budget, it would not have been able to provide a midwife for each barangay. Its resourcefulness and initiative in looking for funds and alternative set-ups for BHSs and hiring of midwives enabled the city to bring health services to each barangay starting in 1993.

The same arrangement may be explored to facilitate the immediate realization of another OHS goal - the establishment of seven (7) sub-city District Health Offices (DHO), each manned by one (1) doctor and one (1) nurse. This project is planned for implementation in 2003-2008.

The city government may also hire the DHO personnel on temporary basis. To reduce costs further, the doctors could work on a part-time basis. This is following the experience of Puerto Princesa City whereby the city government was able to provide doctors to satellite clinics on part-time arrangement. Puerto Princesa City has five strategic satellite clinics, each with a catchment area of four to eight barangays. The doctors (one for each clinic), who are hired on contractual basis, attend to the patients for two days a week and in the remaining days, engage in private practice. The city pays each doctor a monthly salary of P 10,000.

Similarly, Cotabato City could explore the arrangement made by Puerto Princesa City in the provision of doctors and other health personnel in the sub-city clusters. The city and barangay governments could share in the payment of salaries to these health personnel.

In the final analysis, the implementation of the 1991 Local Government Code provided the local government units the opportunity to examine the mandate given them as well as their human and physical resources to be able to deliver the basic services to their respective constituents. The decentralized local governance policy encouraged the LGUs to be resourceful and take initiative in planning, developing and implementing programs and projects in their localities. The Special Project on Health and Sanitation of Cotabato City has exemplified that with creativity, political

will and determination, and dedication to public welfare, the delivery of health services to the people can be ensured and sustained.