EXECUTIVE SUMMARY

Introduction:

Six years after, one project has come to end. This is the Community Based Health Program (CBHP) conceptualized and implemented by the Catholic Relief Services – Philippines in the Dioceses of Dumaguete, Jaro and Borongan. This is a clear shift from the usual paradigm of development practiced by the CRS over the years from food aid to community development. There are many stories to tell. The project has proven its high points, although given more chance, these long points could have been longer and the short points shorter. What started with two pilot barangays in 1997 expanded into three more areas two years after (1999). The Local Government Unit of Lambunao saw its potential and expanded into three more areas, by year 2000 using its own funds to fund most project activities. The LGU of Igbaras followed this example and expanded into three more areas. Todate by the end of the sixth year (2003), CBHP is operating in 14 hard to reach barangays.

The Evaluation Process:
Two simultaneous evaluations were conducted almost the same months. An external evaluation was conducted that run across all levels of the program, from the targeted areas of development (TADs), the communities, to the municipality, district, provincial and national level. An internal evaluation conducted by trained members of the communities themselves called the Local Research teams. This report is the consolidation of both evaluations. Having all stakeholders involved in the evaluation makes this evaluation highly participatory.

The Program:
The Community Based Health Program utilized four major strategies: Health Services delivery, Community Organizing, Partnership/Linkages and Capacity Building. These strategies have been evaluated and account for the success that this program had achieved these past six years.

Health delivery services improved greatly with the designation and appointment of a Rural Health Midwife in all the TADs; knowledge and practices of families in various aspects of health have improved through the efforts of the Community Based Health Volunteers (CBHVs) health education activities; the revival of the district health system of the Department of Health, a timely effort of the provincial health system that complemented the efforts at the barangay level.

Mobilization for health resulted from the community organizing strategy. This developed into People's Organizations, slowly gaining capacity and confidence in project management extending not only in the health domain but in issues that confront them, like addressing their lack of income, poor roads, their lack of access to over the counter medicines, and many more. Slowly the organized groups learn the value of working together for their health

concerns. Today, these groups are into the second phase of the lives of organizations = that is, strengthening the organizations.

The partnership with the Local Government Units, particularly with the Rural Health Units have surged this project forward. Local Government Executives allocated funds to pursue health activities. CBHP even transcended problems of politics in most areas. Partnership and linkages did not stop with the municipal level health system. Partnership reached up to the Provincial and National levels. Support came as technical, material and financial resources poured into the program.

Trainings have been conducted. As more leaders and health caregivers were trained, more confidence were gained as the participants used the new knowledge and skills to improve not only themselves, but their families, neighbors and community as well. The volunteer and highly committed CBHVs plodded on to serve their people. They are ready to be trained more on managing simple cases, so that the service continues even in the absence of the health professional.

Sustainability:
Although the program can gain more with 3-4 more years of strategic implementation, sustainability can be gleaned through the capacity and confidence the people themselves have. During these years, they have learned how to help themselves. The Local Government Officials and the Rural Health Units, having seen the result of working together, affirm to continue the support to the TADs through fund allocations for the next years. All stakeholders have developed enough trust and respect.

There are many more stories to tell. Let it be shared.

To CRS and the partners, my heartfelt congratulations for restoring dignity and equity of health to the most disadvantaged communities as the TADs.

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FINAL EVALUATION of the COMMUNITY BASED HEALTH PROGRAM

in TARGETED AREAS of DEVELOPMENT

Dioceses of Dumaguete, Jaro and Borongan

Catholic Relief Services

I. BACKGROUND: Ref: Scope of Work

Catholic Relief Services (CRS) is implementing the CBHP (Community-Based Health Program) in TADS (Targetted Areas of Development) in partnership with the dioceses of Jaro (Iloilo), Borongan (Eastern Samar), and Dumaguete (Negros Oriental). The program started in 1997 in two pilot barangays. After the mid-evaluation in 1999, two more barangays were covered. The expansion continued with four new barangays in 2000, two in 2001 and one in 2002. Inspired by the achievements of the program, one of the Municipal Mayors initiated the expansion of the program in three more barangays this year with his commitment to provide logistical support after CRS assistance. As of this date, the program coverage includes a total of 14 barangays (8 in Iloilo, 3 in Negros Oriental and 3 in Eastern Samar) with some 18,744 individual beneficiaries.

The Goal of the CBHP in TADS is to improve the health conditions of poor families in hard to reach and underserved areas.

Specifically, the program aims to:

1) *Enable at least 85% of community households in TADs to identify and prioritize their health needs, manage health related activities, mobilize and sustain resources.*
2) *Improve access, utilization and quality of health for at least 85% of families in TADs.*
3) *Enhance the capabilities of the counterparts on organizational and project management to ensure the sustainability of the health program at institutional level.*

Patterned after the Partnership for Community Health Development (PCHD), the CBHP in TADs utilized the following four strategies:

1) *partnership building*
2) *community organizing*
3) *upgrading of health services*
4) *capacity building*

Partnership building involved the establishment of a functional working relationship among the Diocese, Department of Health (DOH) and the Local Government Units (LGUs). The partnership arrangements at the provincial, municipal and barangay levels were designed to support community based efforts and initiatives of people's organizations.

The community organizing component aimed to mobilize people and develop their capability to respond to their needs through collective action. Except for the three newest project areas, all the barangays have organized People's Organizations (POs).

In terms of upgrading the health services, the program focused on the training of community health volunteers to augment the limited health manpower of the DOH and to improve access to health care delivery.

The institutional capacity building was provided as a support and integral part of the other strategies. The Diocese and the POs were provided ample opportunities to become effective project managers through training for skills development, exposure visits and regular program planning conferences,

OBJECTIVES of the EVALUATION:

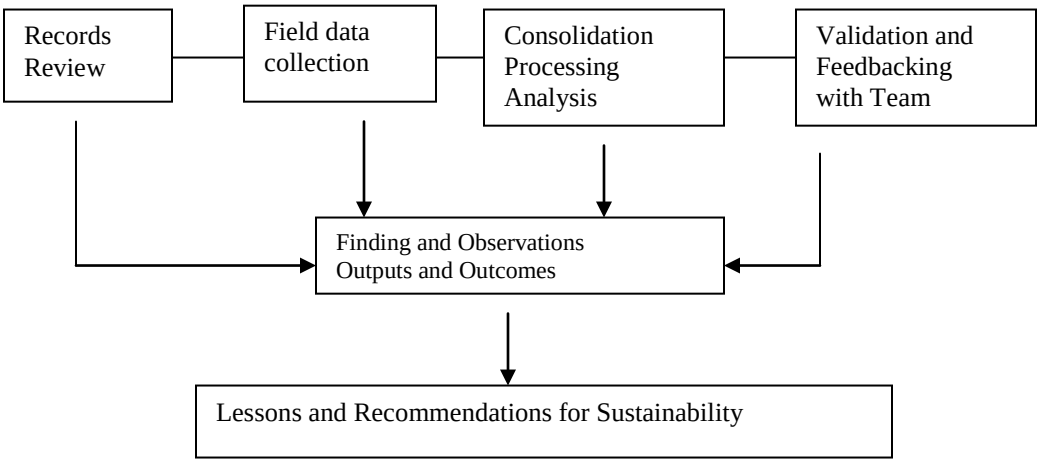
1. *Determine the changes accruing to the beneficiaries in terms of:*
   - *Participation in community health activities*
   - *Leadership and empowerment*
   - *Health and Nutrition knowledge and practices*
2. *Determine the effects of the program on the availability, quality and utilization of health services.*
3. *Determine the effectiveness of the program strategies in attaining the program objectives.*
4. *Determine the capability of the Dioceses and the People's Organizations in sustaining the program beyond 2003.*
5. *Distill the overarching lessons from the program*
6. *Come up with recommendations for the sustainability of the CBHP.*

II. SCOPE and METHODOLOGY:

This evaluation has two parts. Both parts of the evaluations were conducted almost simultaneously. Part A is the external evaluation. Findings are contained in this report. This is mainly qualitative. Its framework for the evaluation and the levels for the evaluation are presented. Part B is the internal evaluation aimed to get the impact of the CBHP through a KPC survey. This is mainly quantitative using the indicators agreed upon at the beginning of the project. Local Research Teams (LRTs) trained by the project collected the data. The table of results presenting the baseline and final evaluation according to the indicators are presented as part of the general findings with the comparative tables per diocese as **Appendix C.** A more detailed description of the scope and methodology follow below:

PART A – External Evaluation

This framework was followed in planning the activities of the evaluation:



Levels of the evaluation:

CRS Health Program Manager	DIOCESE of DUMAGUETE 1 Prog Coordinator 1 Community Organizer	DIOCESE of JARO 1 PC 3 CO	DIOCESE of BORONGAN 1 PC 2 CO
PROV	LGU - PHO	LGU - PHO	LGU - PHO
MUN Mayor SB Health MPDO MHO	LGU - RHU BASAY	LGU – RHU LAMBUNAO and IGBARAS	LGU – RHU CAN-AVID and ORAS
BRGYs to be visited	Cabalayongan Linantayan* Maglinao	Sibagwan Panuran* Calampitao	Can-Ilay Malogo Batang

PO-FAMILIES-CBHV PO-FMLS-CBHV PO-FMLS-CBHV

- Records review consisted of reviewing the project design, progress reports, evaluation reports, baseline assessment reports, implementation plans, proposals from the central office, diocese office and POs in the barangays. Files in the TADs and PO business records, patients records were also reviewed whenever available.

- The general schedule (**Appendix G**) for the evaluation was arranged and confirmed by the CRS Health Program Manager in consultation with the Diocese staff from the three sites. There were two external evaluators. The CRS Program Officer was with the evaluators in all activities. The Program Coordinators and the Community Organizers were also present during the field activities.

- The CRS/Diocese did the selection of the villages. One full week per diocese
  was allocated. A total of 8 villages was scheduled to be evaluated. The proposal to do Dumaguete first was to maximize the 4 working days before the All Saints Day, knowing this holiday is important to Filipinos. Iloilo was reserved on the second week. Borongan was set for five days on the third week.

- The original intent was to go back to the city every day. In Dumaguete, to save on
  travel time of two hours from the city to the municipality and two hours back, it was deemed necessary to sleep in a nearby city (Bayawan) 30 minutes from the TADs. This also facilitated the time to conduct the evaluation covering the three TADs in the diocese of Dumaguete in two full days.

- In Iloilo, the team had its base in Jaro since no appropriate lodging is available. We traveled to and from the municipality and TAD barangay every day. From Iloilo, SECDEP provided the vehicle to the municipality. From the municipality, a vehicle was assigned by the LGU. In Igbaras, the MPDC, MHO, RSI and RHM joined the field interview.

- In Borongan, since the municipalities, Can-Avid and Oras are 2 and 21/2 hours by road respectively and travel to each TAD took 2 hours by pumpboat, the team looked for lodging in Can-Avid to save on travel time.

- The field data collection was mainly done through key informant interview, focused group discussions, home visits and project visits. This was started at the level of Catholic Relief Services. A validation workshop was done with Project staff of CRS and the Diocese every after completion of the work in each site.

- An interview guide was used, but always expounded and answers probed. Later in the evening, the data were consolidated and trends were analyzed. Everyone agreed on the questions to be asked.
- Information given at community level or by key informants are immediately triangulated with those of the main partners and vice versa.

- An H-tool was used in general to ensure comparability of responses. The completed H-form consolidating the Key informants' responses are presented after each narrative along Health Services, People's Organizations, Partnership, Capacity Building and Sustainability. (**Appendix B for details per diocese**.)

- The H-Tool is a relatively easy participatory technique for generating data from participants in an FGD setting. The method makes use of an H-form, the term derived from the final illustration of the discussion results. The tool incorporates elements of ranking, consensus-building and evaluative approaches to a given issue.

- The appropriateness of this tool lies in its sequence and clear framework. The H-Tool:
    - enables individuals and/or groups to record their own views and ideas in a non-threatening and open, yet structured, way.
    - fosters individual expression as well as common understanding and consensus.
    - can be used in meetings, workshops, conferences and other group discussion activities.
    - keeps a discussion focused, specific, progressive and can easily lead to action points.
    - helps to facilitate and record semi-structured interviews without introducing facilitator bias.
    - enables people of all ages to participate in indicator identification, monitoring, evaluation and planning for improvement in many contexts.

- The impact indicators for the evaluation will come from the project indicators as stated in the proposal and matched with the partners' indicators. This was used mainly during the Internal Evaluation (see Part B)(Ref: logical framework of the project).

- A validation and feedbacking was conducted by the evaluators after every diocese
  with the Project Team (Program Officer, Program Coordinator and Community
  Organizers). This process was very helpful in presenting the findings without the

feelings of defensiveness among the team. The result is a learning and recognition of gaps within the program design.

- Keeping with the spirit of participation, a national workshop was conducted with partners for validation and feedbacking of results. The participants were mainly the CRS Health Program Manager, Program Officer, Program Coordinators and Community Organizers and the Municipal Health Officers from Dumaguete and Iloilo. The output is incorporated into the main report.

- During the final conference attended by the Bishops and ArchBishops, Mayors and MPDC partners, MHOs, Barangay Captains and PO Leaders, CBHVrepresentatives and the PC and COs, the results of the external evaluation were presented. Corrections to the data were received and included in this report.

PART B INTERNAL/SELF EVALUATION

Background:

- At the start of the program, CRS and its partners developed a Management Information System that would serve as a mechanism for monitoring and evaluating the program activities. The stakeholders – CRS, LGUs, Diocesan counterparts and the TADs actively participated in the process of developing the system. A set of indicators for each of the three major program objectives was agreed upon as basis for monitoring and evaluating the program in conjunction with the external evaluation that would be conducted.

- Local residents were trained at the start of the program to gather the needed data and information at baseline and at the end of the program. A refresher training course was also conducted for the local researchers prior to the conduct of the final evaluation.

Methodology:

- Key informant interview was the method used in gathering baseline date for indicators under objective no.1 while MIS reports provided the data for the final evaluation.

- Most of the indicators under objective no. 2 were measured or assessed through the KPC (Knowledge, Practices, Coverage Survey. Data on referral system, access to water and toilets, trained CBHVs/TBSs, GMP and home visits were gathered from the MIS reports/records.

- Assessment of indicators for objective no. 3 was based on reports/records.

- The KPC is a management tool used to collect beneficiary-level information related to maternal and child health and survival. It was originally developed

by the Child Survival Support Program of Johns Hopkins University, revised substantially by the Child Survival Technical Support Project (CSTS) and the Child Survival Collaborations and Resources (CORE) group. The KPC is designed to assess critical knowledge and practices that affect child health and survival; estimate CS intervention coverage and build local capacity to gather and use information for health decision making.

- The tool used for the KPC survey is a structured questionnaire that covers the following modules or topics: Breastfeeding/ Infant and Child Nutrition, Sanitation, Growth Monitoring, Diarrhea, ARI, Pre-Natal and Post Natal Care, AIDS and Health Contacts/ Sources of Information. The original questionnaire (in English) was adapted to suit the needs of the program and translated into the local dialect to facilitate the data collection.

- Data gathered from the baseline survey provided a profile of the population of intervention with regards to key indicators. Results served as rational basis for the identification of priorities and objectives; planning of community projects including the designing of health education sessions. At the end of the program, a final KPC was conducted to determine whether the project met its program objectives. Because of methodological constraints, the KPC survey is not expected to demonstrate the causal role of the interventions.

- Respondents included all mothers with 0 – 23 months old children at the time of the baseline and final surveys.

- Trained local researches processed the data gathered (baseline and final) using the manual method. Analysis was done using frequencies and percentages. Results of the survey were presented and validated with the other local stakeholders.

- Results of the selected KPC indicators are shown in the table (under objective no.2). A separate full report of the KPC survey (baseline and final) will be prepared by CRS. Tables are presented under **Appendix C**

Putting the Reports Together: This final report put together the results of the external and internal evaluation as much as it can.

III. LIMITATIONS of the EVALUATION:

PART A – External evaluation

- Going back to the levels of evaluation, except for the Diocese of Dumaguete (meeting and blessing from Archbishop John Du), the other bishops and parish priests for the locality were not met. They were on mission or retreat.

- Mayors of Igbaras, Can-Avid and Oras were interviewed. The Mayors of Basay and Lambunao were not available.

- The PHO in Dumaguete was not available, although the PHOs for Iloilo and Eastern Samar were interviewed.

- Time was always limited. Hence, focused group discussions were used a lot in the barangays. Home visits and project visits were done when either one of the evaluators have completed the FGD. In Dumaguete, the interview with TAD-2 was cut short because of the rain. Road will be unpassable if we stayed on. In Sibaguan TAD-4 in Iloilo, the project and home visit were not done because of the rain.

- Barangay FGDs were highly dependent on the people who came. These were mostly the PO officers, Barangay Council members and the CBHV/BHWs. Very few members came for the evaluation. They were mostly met during home visits and patient interview when the evaluation session coincided with a clinic.

- Although we are all Filipinos, there was still some language barrier between the Tagalog speakers and the Visayan. We tried to improve the understanding through the translation done by the local staff like the PO, CO who accompanied us.

PART B – Internal Evaluation

- The inherent nature of the KPC questionnaire (used for Objective No. 2) limits itself to quantitative type of questions, no probing is allowed to expound on the question

- Some respondents were shy to respond to the AIDs questions.

- Although the KPC questionnaire was translated into the local dialect, the local researchers may not have acquired mastery in interviewing.

Other limitations as encountered by the external evaluators:

- The analysis, lessons, conclusions and recommendations from the Internal Evaluation need to be done by the people who participated in the process. The external evaluator found it difficult to analyze the findings and make conclusions and recommendations specific to the internal evaluation, except for some analysis coming from the data itself.

COMPARATIVE TABLE of INTERNAL EVALUATION RESULTS ACROSS DIOCESES

OBJECTIVE 1:
Dumaguete: Enable at least 85% of Community Households in TADs to identify and prioritize health needs, manage related activities, mobilize and sustain resources.
Jaro: To enable communities to identify and prioritize health needs for planning, implementing, mobilizing, managing and sustaining resources.
Borongan: To increase the capacity of families to participate in the identification, prioritization of their health needs for planning, managing and sustaining resources.

	DUMAGUETE		JARO		
INDICATORS	BASELINE	FINAL	BASELINE	FINAL	BA
1. Presence of functional PO in each TAD	0	3	0	5	
2. 85% of families in TADs actively participating in health related community activities	0	83%	44%	70%	
3. POs recognized and supported by BDC, BC and GAs	0	3	0	5	
4. Number of functional leaders trained (Dum, Bor) Number of functional leaders (Jaro)	0	90	0	238	
5. % of active leaders (Dum) % of trained active leaders (Jar) % of active leaders trained (Bor)	0	97%	0	238	
6. Presence of functioning health related activities (Dum) Water project, toilet project, H&N post, data health board, healthy barangay project (Jar) BSB, water, supplementary feeding, 2-way referral system, herbal medicine processing, latrines (Bor) GMP, H&N post, CB-SHI, water system, sanitary latrines	0	5	0	6	
Presence and use of community based information system	0	3	0	5	

Comments to help CRS/ diocese strengthen the explanations in the remarks column of individual reports (Appendix C)

1. Please note the different ways of articulating the objective. Because of this there will be different indicators that will be necessary. If you use the objective of Dumaguete as written, then the number of households will be the main denominator to be used. The indicators # 1, 3, 6 and 7 will not be appropriate. The objective as written by Borongan will ask for what capacities are being increased and since " families" is the unit, then again the indicators will not be appropriate. The closest articulation is that of Jaro but it could be refined as "To <u>enable each TAD</u> to participate in identifying and prioritizing health needs for planning, implementing, mobilizing, managing and sustaining resources".

2. There is need to be more precise with the indicators. There is a problem of "meaning". For example, take Indicators #4 and #5.

. % of active leaders (Dum)
% of trained active leaders (Jar)
% of active leaders trained (Bor)
} these have different meanings

3. Listing of health related activities are not constant across the dioceses. Is this meant to be? Or the listing of the health activities depended on what was functioning at the time of the final evaluation? In the same listing, Dumaguete should not list data health board since this is part of indicator #7.

4. See baseline for indicator #2: What is 44% in Jaro considering there are 5 TADs which did not start CBHP at the same time. The same question is applicable for the 14% baseline from Borongan. These may be explained in the remarks column by each diocese.

5. What were the 3 functioning health related activities during the baseline of Indicator # 6 in Borongan? Does this mean there were ongoing projects in health in the beginning of the CBHP project, which accounts for the 45 functional leaders in indicator # 4 ? This could be explained in the remarks column.

OBJECTIVE 2:
Dumaguete: To improve access, utilization and quality of health services for at least 85% of families in targeted areas of development.
Jaro: To improve access, utilization and quality of basic health services.
Borongan: To improve access, utilization and quality of health services for at least 85% of families.

	DUMAGUETE		JARO		BORONGAN	
INDICATORS	BASELINE	FINAL	BASELINE	FINAL	BASELINE	FINAL
1. Increased percentage of pregnant mothers given 2 TT doses by delivery	58	81	47%	84%	25%	76%
2. % deliveries attended by TBAs (Dum) Increased % of deliveries attended by health personnel (Jaro) Increased % of deliveries attended by trained health personnel	41	100	63%	99%	32%	96%
3. (Dum) none Increased % of pregnant mothers who seek at least 3 PN visits (Jar/Bor)			75%	86%	41%	89%
3. % of pregnant mothers given 2 iron supplements (Jar/Bor) none	83	91				
4. %of newborn weighed by Trained Health Personnel	No baseline	92	0	69%	28%	85%

	DUMAGUETE		JARO		BORONGAN	
INDICATORS	BASELINE	FINAL	BASELINE	FINAL	BASELINE	FINAL
5. (Increased) % of FIC by 1 year of age	38	90	20%	84%	41%	93%
6. (Increased)% of mothers who initiate breastfeeding within1 hour after delivery	64	84	79%	79%	44%	91%
7. (increased) % of mothers who start giving supplementary feeding at six months	82	100	73%	93%	30%	91%
8. % in moderate malnutrition (Dum) % in moderate malnutrition (Jar) % decrease in moderate malnutrition (Bor)	38	7.6	14%	5%	**18%**	**30%**
9. % of severe malnutrition (Dum) % in severe malnutrition (Jar) % decrease in severe malnutrition (Bor)	20	4	60%	20%	**10%**	**37%**
10. % of mothers who continue to give - breastmilk - foods - fluids (during diarrhea)	54 54 0	100 83 83	75% 48% 52%	77% 80% 76%	0	NA

	DUMAGUETE		JARO		BORONGAN	
INDICATORS	BASELINE	FINAL	BASELINE	FINAL	BASELINE	FINAL
11. (Increased) % of mothers who seek treatment for ARI in an appropriate medical institution (facility)	62	100	43%	87%	0	50%
12. (Increased) % of mothers who seek treatment for diarrhea in an appropriate institution (health facility)/(medical facility)	51	83	64%	83%	0	NA
13. (Increased) % of families in AIDS education who can cite correctly: - 2 methods of transmission of AIDS - 2 methods of prevention of AIDS	0 0	83 83	0 0	59% 58%	6% 6%	90% 87%
14. Presence of 2-way health referral system	Not functional	Not functional	0	5	0	5
15. (Increased) % of families with access to potable water	41	76	24%	81%	41%	87%
16. (Increased) % of families with access to sanitary toilets	17.4	65	21%	63%	31%	44%
17. (Increased) % of families	21	79	23%	32%	12%	26%

	DUMAGUETE		JARO		BORONGAN	
INDICATORS	BASELINE	FINAL	BASELINE	FINAL	BASELINE	FINAL
who practice sanitary methods of garbage disposal						
18. % of trained BHWs/CBHVs (Dum) Number of trained CBHVs (Jar) % of trained BHWs/CBHVs (Bor) Number of trained BHWs/CBHVs	0	88	0	23	12	46% 26
19. % of TBAs trained (Dum) Number of trained TBAs (Jar) Number of trained birth attendants(Bor) % of trained birth attendants (Bor)	15	100	3	5	9	13 69%
20. Frequency of GMP sessions	quarterly	monthly	2-3 times a year	monthly	quarterly	monthly
21. % of children weighed at least once in the last quarter	No baseline	92	62%	95%		
22. % of severely malnourished visited	0	83	0	100%	0	100%
23. % of medical cases referred by CBHVs to appropriate institution (Bor only)					5%	100%
24. Number of					5	22

	DUMAGUETE		JARO		BORONGAN	
INDICATORS	BASELINE	FINAL	BASELINE	FINAL	BASELINE	FINAL
cases referred back by RHUs to CBHVs (Bor only)						

Comments for improvement:

1. On the objectives, Dumaguete has the most complete statement.
2. The numbers under Dumaguete are assumed to be in percentage. It is more specific for Jaro and Borongan.
3. A word in parenthesis ( ) under the indicators indicate it is missing in Dumaguete, unless specified.
4. There are many examples of different uses of indicators, whether in percentages or number or both, ex. #18 and 19
5. Just looking at numbers indicate a general improvement along a specific indicator across the dioceses.
6. However, there are indicators that are better presented as each TAD rather a composite. For example, access to water and toilets are better presented as each TAD since some TADs already achieved 100%. See external evaluation table across TADs
7. #8 and 9 are examples of confusing information: the % of moderate and severe malnutrition show INCREASES in malnutrition rather than a DECREASE. Need to recompute.
8. #10 shows a different handling of data by Borongan compared to Dunmaguete and Jaro. This data seems to evaluate the practice (and since there were no cases reported the previous 2 weeks before the survey then NA is given fro Borongan; but in Dumaguete and Iloilo, it seems the evaluation was on the knowledge level. Which is which?
9. Dumaguete reports a non-functional referral system. But this is contrary to what is reported during the external evaluation with the presence of the Sta Bayabas Interlocal Health Zone.
10. Borongan has two extra indicators #23 and 24 that were not used by Dumaguete and Jaro.

OBJECTIVE # 3:
Dumaguete: Enhance the capabilities of counterparts in the management of CBHP.
Jaro: Enhance the capabilities in organizational project management to ensure sustainability of health program at the institutional level.

Borongan: To enhance the capabilities of the counterpart in the management of CBHP

	DUMAGUETE		JARO		
INDICATOR	RATING	REMARK	RATING	REMARK	RATIN
1. Timely submission of complete and accurate report	Satisfactory		Excellent	MIS implementation Supervision	2
2. Strategic plan completed by the end of the program	Satisfactory		Fair	For polishing	3
3. Planned activities completed by the end of the program	Satisfactory		Satisfactory	Some of the activities were on the process of implementation	2
4. Diocese able to access funds from other agencies for CBHP	Satisfactory		Satisfactory	Project proposal for submission to targeted agencies; LGU appropriated some funds for the extension of TADs	2
5. Diocese able to access materials and technical support from other agencies	Satisfactory		Excellent	Able to access funds, manpower and material support for CBHP in the TADs aside from CRS	3
6. (Dum) Other agencies involved in the program Number of other agencies involved in the program (Jar)	Satisfactory		10 (DOH, BDC, LGU, DA, DSWD,	Strong partnership Credibility of the program	

	DUMAGUETE		**JARO**		
INDICATOR	RATING	REMARK	RATING	REMARK	RATIN
Number of agencies with which the Diocese has MOAs			DILG, RHU, MPDO, PNP, DECS		5 (actua numbe

Comments for improvement:

1. Another example of objectives written differently across dioceses.
2. # 6 indicator have different meanings and will require different indicators (for example, Borongan will require more formal involvements through MOAs, while the two other dioceses may just require involvement.
3. How can Dumaguete make satisfactory ratings without remarks? Suggest to fill in remarks column.
4. Likewise, I suggest for Borongan to explain the meanings of the numbers 2, 3

IV. MAJOR FINDINGS and OBSERVATIONS across TADS:

PART A: External Evaluation

The 4 major strategies of CBHP were evaluated.
*(Note: A comparative **consolidation of findings and observations** are also presented in **tables**, validated with the Diocesan teams and MHOs in the National Workshop held in Cebu, November 19, 2003)(**Attachment A)***

*The detailed presentation of findings and result of the focused group discussions are found in **Attachment B** presented by Diocese. Here you can find the strengths, challenges and recommendations of people themselves as they evaluated this program. It also presents the ratings people gave a particular strategy and the trends across respondents using the H-tool.*

A. HEALTH SERVICES (Table 1)

- **Availability of Health Personnel**: Across the TADS, due to the CBHP, a regular RHM had been assigned to conduct a regular clinic at least once a month either at the Barangay Health Station, the Health Post or the Barangay Hall which serves as a Multipurpose Hall. The most frequent and regular visits of the RHM are in Maglinao of Dumaguete diocese and Panuran of Jaro diocese. The rest has regular visits but these are minimum of once a week, once a month or irregular once a month.

- **BHWs and CBHVs**: Barangay Health Workers have been trained since the Alma Ata by the RHU. There are 37 in the TADs who are active and accredited by the RHU. With the coming of the CBHP, there were BHWs who retrained. New volunteers were named Community Based Health Volunteers (CBHVs). These volunteers, 58 CBHVc across the TADs are active and are still purely volunteers. Over time, some of the CBHVs were accredited as BHWs, therefore some of the said CBHVs maintain their name but they are already BHWs. BHWs are generally the ones who get some honorarium from the LGU and the Barangay.

- **Functions:** CBHVs and BHWs have the same functions of health education in their respective puroks; they advice on illnesses but weak on preventive measures; do home visits but regularity has not been established. They assist the RHMs but no clear task assignments. One CBHV in sitio Orchid of Cabalayongan, even emphasized her role as the "cleaner" of the Health Post. It is more the trend that the CBHVs do not open the BHS or HP when the RHM is not around. In Panuran, the CBHVs are active in HP even without the RHM. In Can-Ilay, the CBHVs are active in clinic when the RHM is present.

  Supervision: Across all TADs, there is no clear and systematic supervision from the RHM. Although when asked, the CBHVs all claim they report to the RHMs. In Dumaguete, CBHVs do not have access to medicines. It was explained though,

that before a kit is left with the CBHVs but the auditing of the medicines and supplies had been the problem. Lack of supervision had been evident because although these volunteers do not have access to medicines, one CBHV claimed she advises "cotrimoxazole" for cough. In Panuran and Sibaguan, the CBHVs have access to medicines.

- **Reports:** All BHWs give their monthly report to the RHM (RHU) and CO (CRS). But it was also raised that there are two reports. The one for CRS only counts children 0 – 59 months and the one for DOH counts those 0-60 months. This is a big question. Why should there be two different targets?

- **Water project:** Linantayan (Basay), Panuran and Calampitao (Lambunao) and Batang (Oras) are the TADs with 100% access to safe and potable water. In Lambunao and igbaras, there is chlorination reported. The two pilot areas (Linantayan and Panuran) are already improving their water system by adding more spring boxes to serve more homes; the other is enlarging its reservoir to make the water system into a Level 2. The original windmill in Linantayan is no longer functional. Can-Avid water system is still being completed; in Batang (Oras) there is a question about the agreed water project design. It is supposed to have 10 faucets but only 5 has been installed. People do not know the reason why.

- **Toilet Project:** The highest coverage of toilets among all TADs are Panuran (100%), Calampitao (90%) and Maglinao (75%). In Sibaguan 53 toilet bowls are waiting to be distributed; in Batang 18 toilets are uninstalled.

- **Botika sa Barangay:** In Basay, no BSB has been started although the SB Health has contributed seed money for purchase of medicines. In Can-Avid and Oras, there are also no BSBs. In Lambunao and Igbaras, BSB has started operating but the maintenance and recording of sales need improvement. The main problem of the BSB is the growing credit in TADs 1, 2, and 4.

- **Herbal training:** Herbal trainings have been conducted in the Dioceses of Dumaguete and Jaro, none in Borongan. Initially, cough syrups, ointments have been produced. Feedback is that they are very saleable. However, the PO/CBHVs have stopped producing the herbal medicines because of the rains. Jaro TADs plan to continue the herbal processing in the dry season. In Borongan, the herbal training had been delayed for a long time since request was done. An explanation given during the validation was "other training priorities and outstanding cash balances". Budget was apparently released September 29, 2003.

- **Data Boards (an output of the MIS):** All the data boards across the TADs are updated except Maglinao where the data board was destroyed by the last typhoon and only 1/3 has been replaced.

- **Barangay Health Stations and Health Posts:** BHSs are found in Linantayan and Maglinao in Dumaguete; Panuran in Lambunao. Health Posts were in

Calampitao and Cabalayongan. The newer TADs of Sibaguan, Can-Ilay, Malogo and Batang conduct health services in their respective Multipurpose Barangay Halls. Across the TADs, only Maglinao has the most organized BHS, with patients records filed in the clinic, with water and toilet, health education materials posted on the wall, basic equipments weighing scale, BP and stethoscope available for use. The other BHS with all these except that it lacks the Health education materials displayed for patients review is Panuran. All the rest have to put up more health materials. For other stations the BP is carried by the RHM. In Calampitao, only 4 of 10 BHWs know how to take the BP. In Borongan area, clinic equipment are carried by the Midwives when they come for service. Water and toilet facilities are lacking in the rest of the TADs.

- **Social Health Insurance:** In Dumaguete, the social health insurance is called PESO (People's Empowerment Saves One) for Health. This was initiated from the Basay District Hospital and was operating before CBHP came. One effect of partnership across LGUs was the rapport among the service providers; hence any project easily found its way into the TADs. This should be considered an added gain of the project. Although the membership is still low, it provides an opportunity to cover the indigents in the district with insurance coverage when ill. In Lambunao and Igbaras, the form of social insurance is known as Community Based Social Health Insurance (CB-SHI). The three pilot TADs for CB-SHI have undergone orientation, a flyer is ready in Calampitao and 2004 support had already been allocated by the LGU. In Can-Avid, this is being piloted at Malogo with a P20/member contribution since August 2003.

B. COMMUNITY ORGANIZING & PEOPLE's ORGANIZATIONS: (TABLE 2)

- **People's Organizations:** Across the TADs there is now an association or organization registered or in process of registration with DOLE. It is good to note that some of the TADs (Cabalayongan, Panuran, and Batang) have maintained a very local identity using their local dialect. This will contribute to feelings of ownership. Four others (Linantayan, Maglinao, Calampitao and Sibaguan) have identified themselves as People's Health Association and Movement for Improvement Association. Two others (Can-Ilay and Malogo) identifiy themselves as a Community Based Workers' Association. In Can-Ilay, a CBHV admitted that the organization was meant to be a CBHV/BHW organization and they really asked some households to sign up as members for registration purposes.

- **Membership:** If membership is gauged per household, the highest percentage of members is found in Maglinao with 75% and the lowest is in Can-Ilay with 14%. The pilot TADs of Linantayan is 24% and Panuran is 49%.

- **Major projects across TADs** are the Water and Toilet construction projects which have been identified as the major health needs of these hard to reach areas (see Health services for details).

- **Income Generating Activities:** An indicator of growth and progress of people's organizations is their engagement in other aspects of their needs which also affect health conditions and these are income generating activities. The most IGPs are found in Panuran; second are Maglinao and Calampitao. Linantayan and Malogo have started. The others are not yet engaged in them.

- **Organizational Structure:** Across the TADs we found that there is still no clear understanding of organizational structure and the relationships of the different functions, thus will have some problems later on accountability. Identifying who composes the general assembly was unclear in all TADs except Batang.

C. PARTNERSHIPS: TABLE 3

- The strongest among the four strategies is along partnership. Partnership is divided, in the presentation of tables, into Counterparts among partners and the Relationships and Linkages among partners.

- **Primary stakeholders:** At community level, the Barangay officials, PO, households in general, had shown a high level of commitment and volunteerism for CBHP. People have contributed labor, money, materials and manpower to keep the projects going/ The Barangay Council have allocated and paid for some honoraria for health workers; water project and the CB-SHI.

- **LGU:** The LGU has provided financial assistance to all TADS for infrastructure like contruction of health posts/BHS, water projects; contributions also were along social projects like the BSB, CB-SHI and livelihood activities. All the LGUs have also started to pay for salaries of Community Organizers assigned in the locality. The RHUs have assigned Midwife services to all the TADs albeit, in some areas are still minimal. Human technical resource is a given as LGU staff participate in the many trainings this project had provided.

- **IPHO:** Before 2001, the PHO had stronger support due to the PCHD program of the DOH. Today, majority of the counterparts are into toilet bowls and water and toilet facilities, and some honoraria for CBHVs. The technical and human resource is going on in all areas. All Provincial Health offices extend whatever support they can extend to all their areas. One PHO even considered the CBHP as a plus factor in improving the health services in the TADs.

- **Relationships and links with and among one another:** These aspect of partnership is ongoing across TADs although it is in Panuran where these partnerships have gone beyond health but rather in the overall aspect of the community life like roads, spillways. There is also strong links with other agencies outside this formal partnership.

- **Confidence of all TADs:** All TADs have declared that community leaders, PO leaders, CBHVs can approach LGUs anytime, they know who to approach in case of needs and assistance. They affirm the rapport they have to LGUs and because of the CBHP, Health has become a major project of LGUs.

- **Problem areas: T**wo TADs in Borongan cannot go full speed ahead of their activities because of rifts between the Barangay Captain and a Kagawad (Can-Ilay) and the Barangay Captain with the community in another (Batang). One municipality (Oras) has to transcend political differences as they affect personal and working relationships and non-participation in program activities

D. CAPACITY BUILDING in TADs (TABLE 4)

- **Organizational management:** All the TADs have surpassed the initial rigors of organizing and mobilizing for health. They have enough capacity to organize groups in the future. They are however, in the Strengthening phase of Organizations and this is where they are weak at. They have unclear structures, very few members engaged in activities, members are sometimes not even counted. There are very few general assemblies, many officers meetings. Membership development is needed. Some organizations need to have clearer articulation of the purpose of the organization.

- **Project Management and Internal Control Systems:** All TADs have more capacity along project implementation and monitoring. They are still weak in identification of other problems, planning and evaluation. There is also a general weakness in supervision and financial recording and reporting. There are bits and pieces of records, seldom updated (i.e. list of members); records of credits in the BSB, initial inventory, but no records of daily sales, summary of total assets. In Linantayan, the bankbook is dormant with last balance as of 2001.

- **Training Inputs:** a list of training inputs since the beginning of CBHP was found in Iloilo. If this is an indication of the training inputs across TADs, then there has been a lot. Most of the trainings had been conducted outside the barangay. Upon return, the COs follow up in the barangay using a supervisory checklist. The trainees who have been followed up were the MIS, CBHVs and the POs. Likewise, there were reported barangay level trainings like team building, gender, leadership, herbal training and growth monitoring.

- **Effects of trainings:** Many people, leaders, members, barangay officials, have been trained in all aspects of CBHP. The people acknowledge the effects on them personally, their usefulness in the household and effects had been observed in the general action of the communities. There are however, still lack of capacity to TRAIN others in the community since there is an assumption that people trained will echo the lessons to others. There are also no (minimal)local materials seen that are available for use by local trainors, leaders especially the BHWs and

CBHVsas they carry out Health education. Some communities even commented that HE is "boring" because they tend to be the same as the one conducted.

E. SUSTAINABILITY across TADs (TABLE 5)

- **Sentrong Sigla RHUs:** All RHUs (Basay, Lambunao, Igbaras and Oras) are Sentrong Sigla accredited health centers meaning these have enough capacity to provide services, there are good services and facilities as assessed y the Department of Health. RHU of Can-Avid is still working for its accreditation. Although this is not directly an output of the CBHP program, being a Sentrong Sigla will ensure more probability of continuous RHU support for RHMs, BHWs and CBHVs in the TADs.

- **The Interlocal Health Zones:** This strengthening of District Hospitals also will provide a facility for referrals for more serious diseases. The social health insurances will support the indigents for hospitalization.

- **CBHVs and BHWs and RHMs at community level:** Having these caregivers at the community level increases the possibilities of sustainability, increasing the access of people in hard to reach areas to health services. There is no question about the high level of commitment, volunteerism and hard work being done by these caregivers.

- **POs** have shown a good level of development across the TADs although the strongest sense of ownership and confidence had been verbalized in Panuran, Calampitao, Linantayan and Malogo.

- **Integration of Programs** social and economic have started in Panuran, starting in Linantayan, Calampitao and Malogo. Others still have to act and take advantage of opportunities emerging in the area like the Grameen and KALAHI.

- **Extension to other barangays and support by the LGUs** is one of the major indicators that CBHP will sustain in the present TADs.

PART B – Internal evaluation

- Project outputs defined from the logical framework of the project have been delivered (objectives 1 and 3) across the dioceses, i.e. presence of a PO, number of trained leaders, functioning health related activities, community based information systems (objective 1 indicators) and submission of reports, strategic plans, completion of planned activities, accessing funds from other agencies, involvement of other agencies and diocese accessing materials and technical support from other agencies (Objective 3 indicators) (**Appendix C per diocese results).**

- Since the baseline for Objective #1 were all zero, then whatever there is today is considered a gain.

- Project impact or results from the Objective # 2, just by comparing numbers also show a satisfactory achievement. But the question we raise is the comparison of results based on the population during baseline and during the final evaluation.

V. ANALYSIS of the FINDINGS and OBSERVATIONS:

- There has been an improvement in the health delivery services across TADs because of this project. CBHV as the trained caregivers have proven their strong commitment and volunteerism across time. It had not been easy but as they move on they learn a little bit more. Their potentials have not yet been maximized, to name a few:
  - existing "controls" that do not give opportunity to actualize their experiences along the curative health. Some RHUs still do not give them a simple kit that contains over the counter medicines; encourage rotation in BHS and HP even if the RHM is not around.
  - some BHWs do not know how to check blood pressures; some CBHVs do not know how to check temperatures;
  - lack of supervision so that their little knowledge will not be abused also, like one CBHV claimed she advises a patient with cough with "cotrimoxazole" without knowing what it is.
  - So far the CBHVs have not been trained to identify and manage simple illnesses;
  - because of these lack of opportunities, CBHVs have not developed full capacities as a caregiver, hence, credibility has not been established so some households do not consult them for illnesses, rather they go directly to the RHU or the district hospital.
  - a semi literate CBHV emphasizes her role as a cleaner of the Health Post rather than a caregiver.
  - there is no regular supervisory meetings from the midwives to increase these potentials.

- Improvement in health care practices is largely attributed to the efforts of the trained CBHVs in conducting health education sessions; from the support of the LGUs in providing material and technical resources (vaccines, toilet bowls, midwife assignments) that improved the delivery of health care services.

- The PHN has not been mentioned anywhere in the CBHP. But among the health profession, the nurses are the ones who are trained to supervise, to take care of clinics, to do patient care. This could be raised and reviewed in the next RHU meetings and stakeholders meetings.

- The data boards are a means of training communities to monitor their health indicators, which are tracked regularly anyway. The data boards have been beautifully done. They are situated on study boards along the street, near a clinic visible to everyone. Most of them are above six feet (so that children cannot reach them). CBHVs have to climb a ladder to update them. Can the design be more friendly so that it is reachable? More importantly, how are the monthly data being utilized by the CBHVs, BHWs, RHM, PO and the BC in identifying health problems, identify actions, monitor and evaluate these actions (health programming).

- Partnership is the strongest of the four strategies. Because of the extent that it has reached today, it could be rated a 10. But politics still can be the main hindrance in moving forward (Borongan case). What role should the Program Coordinator play in such cases? Keep quiet or facilitate discussions? The PC commented that "other than the personal competence of the Program Coordinator, it is also important whether the goals, objectives, plans are clear to all stakeholders as these are the unifying elements as far as the partnership is concerned".

- The partnership and linkages between and among communities and dioceses, LGU, RHU and other government agencies, evidenced by the technical, material and financial sharing have moved this project to the level it is in today.

- Stakeholders meeting is the mechanism identified by everyone for strengthening the partnership links vertically and horizontally. But this has been irregular lately. If this is happening now before the phase out, what more after phase out? Who will be designated the initiator for these meeting in the future?

- People's organizations represent the community. They are the primary stakeholders of CBHP. Why have they been excluded in some trainings and important meetings like strategic planning?

- Trainings had been a strong strategy for increasing knowledge, attitudes and practice of people in the community, leaders, officers and partners. For trainings that expect participants to "echo" to others, modules on how to do this are not found. There had been minimal local materials that can be used for community level trainings.

- Program supervision is lacking at all levels:
  - RHM to CBHVs (RHMs in charge, a casual, admitted she does not supervise BHWs; BHWs asked how they are supervised just say only during Health education)
  - MHO or PHN to RHMs (if there is quality supervision, then the BHS/HPs will be more equipped with health materials.
  - Diocese PC to COs (more in Dumaguete and Borongan especially in strategizing field work)
  - CRS PO to PC (too many diocese coverage will decrease program supervision)

- Due to the nature of CBHP, to reach depressed and hard to reach areas, prioritizing the installation of water facilities and sanitary toilets, was a very successful entry point and program strategy in the pilot TADs. The need now is to install systems of maintaining the facilities through maintenance fees, management monitoring, financial recording and reporting to the general assembly regularly.

- The Community Organizing strategy of CBHP has led to the organization of people's groups intended to be the mechanism for communities to identify and prioritize health needs, manage health related activities and mobilize and sustain

resources. The organization phase has been successful. The next hurdle is into the strengthening of the organizations.

- There is a mix-up of PO identities as portrayed by their names. Some have very limited reason for being like the Community Based Workers Organizations; some have an intention to be the health association.

- The membership to the People's organizations is still low, if the intention is to reach as much of the community households. But to this date there are household members and individual members. There is nothing wrong with a household membership as long as the implications are clear like: implications to counting participation, distribution of patronage refunds, membership fees, loan repayments and priority for benefits. On the other hand, there is an observation of benefits to PO members and non-members are the same. Therefore, what is the incentive for becoming members? People can even count membership as a disincentive because of the fees to be paid. Some POs when asked how many members there are in the organization, would count the number of leaders. This is because there had been more regular officers meetings and occasional general assemblies.

- The phasing out of the CO in Linantayan shows indications of a weakening PO. With a heavy capacity building agenda, 6 years of internvention is not enough. If CRS phases out by December, who and how will this be managed?

- As the evaluation was being carried out, unintentionally some organizational implications came up which could explain some of the weaknesses found in the field, like:
  - the coverage of three barangays by the Community Organizers is just too much considering the expectations and objectives of this program.
  - some logistic support of transportation is provided but should be reviewed for a CO who walks to three barangays, especially since these are hard to reach areas (Dumaguete). A motorcycle can be the type of support given to facilitate mobilization.
  - is the COs expected to do everything? In Borongan, because the PC is premised to "trouble shoot" to keep the project on track, and he is handling other diocesan projects as well, the CO does almost everything. Quality is therefore sacrificed. We suggest a delineation of responsibilities like the COs be primarily responsible for barangay level work and the POs in charge of the partnership activities, reorienting partners, new staff, reflection sessions and tactic sessions
  - One PO covering three diocese (although there were two POs covering the three dioceses before) is also too much. The tendency will be that the PO will spend more time in Program administration and Finance rather than Program Supervision.
  - The POQR is a better way of reporting the accomplishments rather than the CO accomplishment reports in matrix form. Training proposals done for every training may be too much, since the trainings are the same across TADs anyway.

COs reported they have less time for field work.

- **RATING** the strategies using the H-tool with a scale of 1-10 the consensus during the national validation workshop (and to some extent consistent with the People's own evaluation) are as follows:

- Health services	**- 8 RHMs, BHWs and CBHVs active presence**
- People's Organizations	**- 7 except Panuran which is 9**
- Partnership	**- 10 up to the extent it has reached today**
- Capacity building	**- 6 second level trainings, follow-up and supervision**
- Sustainability	**- 8 from present indicators**

VI. MAJOR LESSONS Learned:

(Note: More lessons expressed by workshop participants can be found in **APPENDIX F**)

- "The poor do not lack brains only opportunities". (Chinese scholar)**.** Educational attainment was not a hindrance in my work with communities. People have talents they are just waiting to be developed (CO)

- Success of the program lies in the hands of the people. Although limited in education, the communities have strong potentials of leadership, if given the right opportunities

- CBHP is a good entry entry point for other programs to come (MHO)

- CBHP awakened community, leaders, government officials and service providers to the importance of health and started to work together.

- Community organizing is long and tedious but a critical factor in mobilizing people to action. It must be continued (PC/MHO)

- Community organizers need to do a lot of critical thinking, analysis and probing (10 steps ahead) to be able to elicit the same awakening from all partners (CO)

- On partnership, barangay officials are very political but with CBHP they gave importance to health (CO)

- Partnership is an art – learn the interests and culture of your partners, be open-minded and transparent about the program and all issues.

- Engaging into genuine partnership needs a lot of coordinating and linking, sharing of resources, communication, information sharing to work. (MHO)

- There are four mutuals to partnership: Mutual knowledge, Mutual respect, mutual trust, mutual help" (Chinese scholar) This was reaffirmed in the partnership strategy. As people gained a common understanding of CBHP and what it wants to achieve(knowledge), all partners learned and acknowledged its own strengths and weaknesses (respect of each other), thus knowing this gave way to trusting each other towards the same objectives, thus partnership (mutual help).

- A program can be sustained if the people are involved in all phases of the program – problem identification, planning, implementing, monitoring and evaluation.

- It is important to recognize and acknowledge volunteerism through some monetary and non-monetary incentives.

- Behaviour change cannot be achieved overnight – development is a long term process.

- Action-reflection-action process is very helpful not only for the staff but for communities as well.

- The importance of having clear program vision, objectives, activities and indicators cannot be overstated.

- A development organization like CRS can change from food program to a development paradigm that recognizes people's participation and ownership, capacity building and empowerment. It needed a challenge and a persistence and a "heart" to work for people's equity in health and restoring their human dignity.

VII. CONCLUSIONS: Based on objectives 1 – 4 of the evaluation, we conclude:

- From the internal evaluation results, *participation of families in health* related activities has not reached the target of 85% yet (Dumaguete – 83%; Jaro – 70% and Borongan – 61%), it is significant to note the achievement compared to baseline data (Appendix C). using the findings from the external evaluation, judging from specific TADs and using specific indicators, some TADS have participated fully having reached 100% *access* to some projects, like the water project. Using another indicator of *organizing into a functional PO* with a purpose of managing health related projects, then all the TADs would have achieved the objective. If membership to the PO becomes an indicator of participation, then the TADs still rate very low. Hence, this indicator can be further improved by being more specific in the definition of "participation" from being a "beneficiary" or an "active participant" to a "decision maker" (See Arnstein 1969 ladder of participation).

- Some factors for an empowered community are in place in the TADs across the three dioceses like the presence of a functional PO, trained community leaders with some knowledge and skills in project management (planning, implementing, and monitoring their activities). Ability to sustain these projects and resources will be a test of the coming months.

- Many trainings have been conducted. Local leaders (POs, BCs, CBHVs, TBAs) have used these competencies across the years, gained confidence that drove them to develop their communities.

- Strong, committed and empowered leadership have emerged throughout the TADS with knowledge and skills in project management. Some TADs have gone beyond the management of health related projects but gone ahead in addressing other issues that confront them like lack of income, linkages with government and NGOs supporting them in road improvements, spillways. Some areas for development will be along organizational strengthening.

- Improvements in health care knowledge and practice among families are evident across TADs. These changes are largely attributed to the efforts of the trained CBHVs who conducted health education to motivate caregivers; the strong partnership with LGUs in providing material (vaccines, toilet bowls, etc.) and technical (midwives, trainors, etc) resources.

- Improvements in indicators have been gleaned from the reports although some of the improvements are not directly attributed to the program like the revival of the interlocal health zones; district level PESO. But because of the very good partnership with LGUs , membership and therefore coverage of community people for health insurance had been facilitated. The orientation and preparations for the Community Based Social Health Insurance (CB-SHI) directly emanating from the project is now piloted in Malogo and is picking up for implementation for other TADs in Jaro and Borongan.

- The CBHP had brought about the availability of Rural Health Midwife services in all TADs through the assignments of all RHUs of a Midwife to open and provide clinic services at the Rural Health Station or the Barangay Health Post or even in a Multipurpose Hall. This has been much appreciated by the hard to reach communities who claim " before CBHP, we were never visited by anybody. Even our LGUs may not know we existed".

- Availability of health caregivers had been largely improved through the training of and provision of health education to families by CBHVs, particularly the growth monitoring of malnourished children which were carried out monthly. The quality of services rendered by the Health professional (RHM) in some TADs can still be greatly improved. Likewise the quality of services that can be provided by the committed CBHVs can be further strengthened through improved training and supervision.

- Patients have utilized these health services at the BHS/BHP and at the RHU and interlocal health zones. A two-way referral system has been instituted, albeit it can still be systematized more. When CBHVs can also manage simple illnesses and recognize cases for referral, this system will greatly be improved.

- **RATING** the strategies using the H-tool with a scale of 1-10 the consensus during the national validation workshop (and to some extent consistent with the People's own evaluation) are as follows:

- Health services	- 8 RHMs, BHWs and CBHVs active presence
- People's Organizations	- 7 except Panuran which is 9
- Partnership	- 10 up to the extent it has reached today
- Capacity building	- 6 second level trainings, follow-up and supervision
- Sustainability	- 8 from present indicators

This rating shows the effectiveness of the program strategies in attaining the CBHP objectives.

- The strategic planning activity conducted in all dioceses, the implementing partners have identified ways to continue and sustain the program beyond CRS' assistance. Project proposals to funding agencies had been written and submitted. The LGUs have given their continuing support through fund allocations for health activities for the next year, 2004.

VIII. RECOMMENDATIONS

Health Services

- Health service delivery in the municipality and barangays has improved with CBHP. There are also some occurences not necessarily directly from this project but due to the continuing development of the formal health system, like
  - Sentrong Sigla for all TADs: being recognized by the DOH as Sentrong Sigla means the RHU has basic facilities and capable staff and improved indicators
  - Philhealth and CB-SHI; PESO for Health (safety net for indigents)
  - Interlocal Health Zones and referrals: for improved services, there is sharing of facilities, expertise and supplies among the referral centers
  - RHMs assigned to TADs and visiting regularly although minimal except Panuran
  - Increase in the number of recognized BHWs and CBHVs
  - Water systems and toilet construction had brought about a decrease in communicable diseases.
  - Health education had improved the general knowledge in health in all TADs.

- Primarily for MHOs:
  - MHOs and PHNs to review the tasks and functions of RHMs in strengthening the technical capacities of CBHVs as barangay health care givers.
  - PHNs to visit Health Posts and BHS to improve clinic HE materials and patient records.
  - PHN to support and improve RHM supervisory skills to BHWs/CBHVs
  - Strengthen the technical/clinical role of the CBHVs in TADs like:
    -- Rotation in health posts
    -- Learn basic skills in BP, ARI, diarrhea management, fever
    -- Dispensing OTC medicines
    -- Preventive and promotive care
  - Maximize the monthly clinics by RHMs in TADs to improve on-the-job training of BHWs/CBHVs
    -- Identifying major health concerns for the period;
    -- Planning health activities;
    -- Review of recording/reporting
    -- Identify cases for home follow-up especially those referred to district hospitals and RHUs
  - During RHM clinic days, let the BHWs perform the first check-up and advise to patients (initially closely supervised, later by themselves). This will build BHWs' credibility among households; therefore people will go to them when the midwives are not around and during referrals.
  - Ensure the back referrals and follow up at the household level

- Considering the far flung and hard to reach areas, lack of available medicines when needed, and presence of hilots/traditional healers. CBHP could strengthen traditional

modalities in health care. Herbal trainings lead to ability to prepare herbal medicines making them readily available. Ensure that BSB is operational in all areas.

- Before phase-out of CRS – plan with partners how the following trainings could still be conducted like:
  - CBHVs basic skills
  - Record keeping
  - Financial recording and reporting
  - Facilitation
  - Membership development for greater participation

People's Organization

PO's have varying degrees of functionality and clarity of purpose due to the development orientation and skills of COs. In Dumaguete, the CO is the third; in Can-Avid the present CO is the fourth assigned since the beginning. They came in without endorsements, without enough orientation given to them by PC and partners. In Iloilo, the same CO had facilitated the PO since the beginning.

- Criteria for selection should include a development background and/or work experience.
- Proper orientation and whenever possible a clear phase-over and overlap period of COs in the TADs.
- Conduct of regular reflection and tactic sessions among COs and PC as an implementing team.
- COs to link CBHVs with POs and BCs through defined reporting of cases and activities
- On strengthening:
  a) Review DOLE requirements and CBL
  b) Clarify organizational structure, roles and functions
  c) Membership development
  d) Discuss implications of HH membership vis-à-vis individual membership as to its effects on: fees, refunds, loan repayments, benefits, participation in projects and activities
  e) Improve internal control systems (simplified) along operational and financial, policies, recording, reporting, auditing and general supervision.

Partnerships

This is in general the strongest of the four strategies. Working with the formal system ensures sustainability of services.

- Vertical links are generally strong. The main breakdown is politics and personalities.
- It is the horizontal links that may need improving in terms of general linkages, reflections, monitoring and evaluation.

- Review the MOUs for "limiting rather than enhancing" clauses (as per PO – Borongan); include signatories and representation from the POs at this time as the primary stakeholders.

Counterparts will have to be more proactive in seeking new funds and new partners.

Capacity Building

There had been lots of formal training inputs predetermined from the CBHP proposal and action plans. Training needs assessments had been done through quarterly meetings. Training needs were focused for Diocesan staff. No assessments had been found as to its effects or results.

Before phase-out:

- One training/activity that has to be carried out is a strategic planning at TAD level with the Pos, BC, CBHVs and others.
- Another activity is a strategic planning among partners from Municipal to Diocese level with POs represented.
- Ideally, the first activity will be an input into the partners' strategic planning.
- Whatever comes first, i.e., Borongan had the second level, then this outputs could be shared during the TAD's own strategy plan.
- Conduct strategic planning activity in Dumaguete.

- Training materials for village use. Since there is an assumption of "echoing" training with other member of the community.
  - Conduct TOT with materials to be used;
  - Follow-up initial training done by the participants, i.e., for CBHVs HE; PO leaders' orientation to members.

- If CO is found to be critical in the mobilization of people in health and other activities, part of the strategy should be the training of indigenous community organizers as second liners, to be supported later by the LGU or the PO.

- Health in its broad definition from Alma Ata of 1978 defines it as not only the absence of disease, but also enabling a person to live a socially and economically productive life. Encourage integration of economic activities among the TAD communities. Encourage POs to link with government department who can support them like the DA. DSWD for training and financial support.

- Take advantage of the following opportunities:
  - Grameen project: on-going project being managed by SECDEP; integrate with social project like CBHP
  - Kalahi project: new project being launched that will provide economic support to people's projects.

- GTZ: potential partners who can be tapped for funding support
- Linkages with other NGOs in the project areas, i.e., PLAN Philippines sought the support of Oras LGE.
- Explore other self-help efforts done by communities, i.e., nutrition program for malnourished school children.
- POs themselves to explore other linkages for technical and financial support.

- The development paradigm under the CBHP concept (pro-people, participatory)
  - Has to be clear at onset;
  - Reiterated regularly in major for a and trainings
  - Repeated to orient "new staff and partner" and communities

- No question about the strength of partnership today. Commitment to sustain will become a reality when these are:
  - In barangay, municipal plans;
  - With annual appropriation;
  - Regular monitoring, evaluation, reflection

- Encourage and fund inter-Diocese study visits and reflections for sharing lessons and failures; challenging one another of what people can do by themselves.

Sustainability

- Document the experiences and lessons learned by the pilot TADs as case studies which could be used by LGUs, RHUs, POs, BCs for sharing; for partnership building and policy advocacy. CRS may even document its processes into a manual on CBHP for use by other LGUs and NGOs in Health.

- Mainstream the CBHVs as BHWs or whatever name the DOH uses, for its village health providers.

- To sustain future activities of a CBHP: whichever is feasible in every situation.
  a) The future integrator/facilitator could possibly be the LGU (MPDC and MHOs)
  b) Explore the more active participation of the parishes in the light of continuing Diocese's work initiatives.
  c) Transform the implementing team from the Diocese as a local NGO (like the experience of SECDEP).
  d) CRS can retest the models in a second phase of CBHP.

- There is also the need to continue the capacity building for community based leaders to include the CBHVs, PO officers and the local research teams

- Concept of community-based health program and possibly shift toward community-managed health program.

- Untimely to phase out at this time. For the stronger TADs, there could be more focus on areas for strengthening. For weaker TADs, it may be appropriate to support more at least 2 to 3 years. The program could expand its network so that the project costs can be shared by other agencies. Training costs can be cut down by conducting them at the barangay level.

TRAININGS CONDUCTED

(List taken from Iloilo files)

Trainings	Dates	Participants
CBHP in TADS	February-December 1997	1 Barangay (TAD)
LRT Training	August 4-8, 1997	14 Leaders
PRA2	October 1-4, 1997	14 Potential Leaders
Training of Community Health Volunteer	March 19-21, 1998	15 Volunteers
NIS Volunteer Training	March 23-26, 1998	14 Volunteers
Values Formation Team Building Workshop	March-April 2003	10 BDC 15 GKKKBA members
LRT Training (Phase 1)	May 19-21, 1999	10 Leaders
NHETT	June 14-16, 1999	15 CBHVs
GMP Counselling Training	November 8-10, 1999	30 CBHVs
MIS II and Supervision Workshop	October 28-31, 1998	13 MIS Leaders; 9 CBHVs; 9 Hilots, 3 old Leaders
TBA Training	August 27-29, 1998	Hilots
Gender Sensitivity Training	December 15-17, 1999	30 Community Leaders
Bookkeeping Training	April 24, 2000	10 Leaders
MIS Volunteer Training, Phase 1 and 2	June – Phase 1 August – Phase 2	14 Volunteers 1 LGU CO
PRA1 Training	June 13-16, 2000	9 Leaders
PRA2 Training	June 10-14, 2000	5 Leaders – T4 5 Pot – Alugme; 5 Leaders – Iniador 4 BDC on Health 1 CO – 4 GU
MIS Volunteer Training 1 and 2	June 27-29, 2000 – Phase 1 August 1-4, 2000 – Phase 2	MIS Volunteers
PDM Training	September 20-22, 2000	9 Leaders 7 Leaders

		9 Leaders 17 LGU
CBHV Training	November 27-29, 2000	Calampitao
CBHV Training	May 16-18, 2001	TAD 3,4,5
CBHV Phase 1	June 19-21, 2001	TAD 3,4,5
CBHV Phase 2	June 25-27, 2001	TAD 3,4,5
CBHV Phase 3	July 11-13, 2001	TAD 3,4,5
MIS Training	July 25-27, 2001 – Phase 1	MIS Volunteers
	August 15-17, 2001 – Phase 2	MIS Volunteers
KPC 2000 + Training	September 4-7, 2001 – Phase 1 Sept. 26-29, 2001 – Phase 2	MIS/LRT
Gender Sensitivity	June 18-21, 2002	TAD 3-5
Traditional Medicine Training Workshop	October 2-4, 2002	23 CBHVs (TAD2 - 7; TAD3 – 7; TAD4 – 4; TAD5 – 5)
CO, Project Management, Facilitation, Conflict Management and Team Building Training	December 10-14, 2000	35 Community Leader; 25 PO Officers; 8 BDG – TI – 5
Conflict Management and Team Building	December 10-12, 2002	35 Community Leader; 25 PO Officers; 10 BDC = TADS 1-5
CO Training for Second Liners	January 14-17, 2003	25 PO Officers = TADS 1-5
Health Nutrition Model	March 17-21, 2003	24 PO + Leaders = TAD2; 14 Volunteers; 10 CBHV
GOPP	October 27-29, 2003	Potential Leaders
PRA1 Training	May 19-23, 2003	18 potential Leaders
PRA2 Training	July 7-11, 2003	Potential Leaders
NHETT	October 28-30, 2003	27 CBHVs
Project Proposal Development	November 4-6, 2003	15 PO Laders; T2-5; 1 LGU – CO
PDM Training	August 26-28, 2003	LGUs
Basic Bookkeeping Training	April 24-26, 2003	TAD2 – 6; TAD 3 – 5; TAD4 – 6; TAD5 – 6
Refresher Course on Basic Bookkeeping and Financial Management	October 9-10, 2003	Auditors and Bookkeepers

Project Proposal Development	November 25-27, 2003	15 PO Leaders (TAD2 – 5); 1 CO-LGU
Final KPC Training	October 1-3, 2003	TAD2 – 7 LRTs; TAD3 – 6 LRTs; TAD4 – 5 LRTs; TAD5 – 6 LRTs
Strategic Planning Workshop	November 10-12, 2003	5 CBHP; 8 TAD Leaders; 12 LGU (MHO, MPDC, SBH, MW and Mayors); 2 CRS; 3 SECDEP Members of Board

LIST of ACRONYMS

BSB	*Botika sa Barangay*
BHW	*Barangay Health Worker*
CAMIA	*Calampitao Movement for improvement Association*
CBHP	*Community-Based Health Program*
CBHV	*Community-Based Health Volunteer*
CB-SHI	*Community-Based Social Health Insurance*
CO	*Community Organizing*
CanCOMBHWO	*Can-Ilay Community Based Health Workers' Organization*
GKKBA	*Gugma sa Kauswagan San Katawhan sa Barangay Association*
HPM	*Health Program Manager*
LGE	*Local Government Executive*
LGU	*Local Government Unit*
LinPHA	*Linantayan People's Health Association*
MACBWO	*Malogo Community-Based Workers Organization*
MagPHA	*Maglinao People's Health Association*
MAKASAKA	*Makugihon Katauhan sa Cabalayongan*
PHO	*Municipal Health Officer*
PDC	*Municipal Planning and Development Coordinator*
OTC	*Over-the-Counter*
PC	*Program Coordinator*
PHO	*Provincial Health Officer*
PHN	*Public Health Nurse*
PO	*Program Officer*
PO	*People's Organization*
RHM/MW	*Rural Health Midwife also Midwife*
RHU	*Rural Health Unit*
RSI	*Rural Sanitary Inspector*
SAPABA	*Samahang Pangkalusugan sa Batang*
SIPIA	*Sibaguan People's Empowerment Association*
TAD	*Targeted Area of Development*

INTERVIEW GUIDE FOR DIOCESE

Diocese:

_____

NAME of RESPONDENT(s):

_____

POSITION: Program Coordinator _____
Community Organizer _____

Determining the working relationship among the Diocese, LGUs (provincial, municipal and Barangay levels and the DOH):

A. What is the extent of support you have given the DOH (RHU) for this project?
   1)
   2)
   3)
   4)
   5)

B. Using a scale of 10, how will you rate this support? H tool

C. What type of support have been given?

D. Any focal person assigned to this project?
   (Name) _____

E. How would you rate the Health services: Use a scale of 1-10: H tool.

F. Do you think this partnership will sustain when CRS assistance ends?

   How?

G. Please rate in a scale of 1-10 the PO
   (Name: _____) as to its:
   Activity? _____
   Ability to mobilize people for its needs _____
   Capability to plan, implement, monitor and evaluate its actions _____

H. List three major PROBLEMS encountered during this partnership.

I. What LESSONS have you learned from this partnership?

J. If you are to do a similar project in the future, what RECOMMENDATIONS can you give to ensure the project can be sustained?

K. Other comments:

QUESTIONS for PEOPLE's ORGANIZATIONS

Name of PO: _____ **Barangay _____**
Municipality _____
Diocese _____

Respondents:

_____

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

1. When were you organized?
   _____
2. Who organized you?
   _____
3. Using a scale of 1-10, rate your PO?
   As to its being active _____. What indicators are you using?
   As to its ability to mobilize as to needs _____ . Example of this need?
   _____
   As to your capability to:
   - plan _____
   - implement _____
   - monitor _____
   - evaluate your actions _____
4. What kinds of training have you attended?
   List topics or modules:
   Which of these have been most useful?
   What other topics could be added?
5. What are the activities the PO have undertaken or still being busy with?
6. What are the major PROBLEMS have you encountered in the aspect of partnership with the DOH (RHU/BHS)?
   LGU?
   Diocese?
   CRS?
7. If CRS assistance ends, do you think you can sustain this PO to keep going? Explain.
8. What LESSONS have you learned as a PO?
9. If there is a similar project in the future, what RECOMMENDATIONS can you give?

INTERVIEW GUIDE for CBHVs

Barangay _____
Municipality _____
Diocese

_____

Name of Respondents:
1.
2.
3.
4.
5.

1. How many CHVs are there in this barangay? _____
   How many are active? _____
   How many are inactive? _____ Why?
   _____

2. How many were trained in the last 3 years?

3. What topics during the training had been most useful to you as CBHV?

4. What topics were not provided but you need more of? Why?

5. How many have you referred to the health service this month?
   What were these cases?

6. How many deaths were there in this village since last year?
   Maternal deaths? _____
   Infant deaths?
   _____
   Children below 6 years
   _____

7. What incentives do you get from the:
   PO
   _____
   RHU
   _____

8. What is the difference in you role from that of the BHW?

9. Who supervises you? _____
   Rate this supervision 1-10

10. How many years have you been CBHV?
    What keeps you going?

INTERVIEW GUIDE for LGUs

Province: _____
Municipality: _____
Barangays: _____
Positions:
- Mayor _____
- SB Health _____
- MPDO _____
- BC _____

Name of Respondent(s):
1.
2.
3.

A. What is the extent of support you have given the DOH for this project?

B. Using a scale of 1-10, how will you rate this support? H tool

C. What type of support have been given?
   1) Cash _____
   2) Technical Assistance _____
   3) In kind (specify) _____

D. Any focal person assigned to this project?
   Name:
   _____

E. How would you rate the health services? Use a scale of 1-10
   - As to its availability? _____
   - As to its quality of service? _____
   - As to its utilization by the communities? _____

F. PPDO plans reflecting CBHB? Yes [ ] No [ ]
   MPDO plans reflecting CBHP? Yes [ ] No [ ]

G. In what ways does the: Province [ ] Municipal [ ] Barangay [ ]
   Support people's initiatives in Health?

H. Do you think this partnership will sustain when CRS assistance ends? How?

I. Using a scale of 1-10, please rate the PO.
   (Name: _____) as to its:
   Activity? _____
   Ability to mobilize people for its needs _____
   Give example of needs addressed _____
   Capability to plan, implement, monitor and evaluate its actions _____

J. List 3 major PROBLEMS encountered during this partnership

K. What LESSONS were learned from this partnership?

L. If you are to do a similar project in the future, what RECOMMENDATIONS can you give to ensure the project can be sustained?

INTERVIEW GUIDE HOUSEHOLDS and COMMUNITY MEMBERS

Municipality: _____
Barangays: _____

NAME(s) OF RESPONDENTS: (continue at the back if additional space is needed)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

A. Are you a member of the PO? If no, why not?
   If Yes, go to B
   If No, go to D

B. If PO member, which community health activities have you participated in?

C. Please rate each of them using a scale of 1-10: H tool.

D. What treats/cures your children when they get sick?

E. Look for opinions about:
   - Outcomes and results
   - Provider-user relationship
   - Costs (consultations, transportation, medicine)
   - Waiting time
   - Physical aspects (privacy, cleanliness)
   - Availability of drugs, laboratory services
   - Access (distance, availability of transportation)
   - Follow up at home

F. Which health services have improved during the last 3 years which were not there before?

G. What services need improvement?

H. If we want to improve this project of improving the health conditions in this barangay, what RECOMMENDATIONS will you give?

INTERVIEW GUIDE for DOH

Province: _____
Municipality: _____
Barangays: _____
Positions:
- PHO _____
- MHO _____
- RHM _____

Name of Respondent(s):
1.
2.
3.

A. What is the extent of support you have given the **Diocese** for this project?

B. Rate this support using a scale of 1-10: H tool

C. What type of support have been given?

D. Any focal person assigned to this project?
Name: _____

E. What is the extent of support you have given the LGU for this project?

F. Rate this support using a scale of 1-10: H tool.

G. Any focal person assigned for this project?
Name: _____

H. How have you supported the People's Organizations?

I. How will you rate the PO?
(Name: _____) as to its:
Activeness _____
Ability to mobilize people as to its needs? (what was this need)
_____
Give example of needs addressed _____
Capability to plan, implement, monitor and evaluate its actions _____

J. List the health activities undertaken by the PO.

K. List 3 major PROBLEMS encountered in this partnership.

L. What LESSONS have you learned from this partnership?

M. If you are to do a similar project in the future, what RECOMMENDATIONS can you given to ensure the project can be sustained?

REFLECTION ON CBHP FROM PARTICIPANTS of the National Workshop:

Rachel (CO, Jaro)
- My engagement in CBHP developed me personally
- It improved my skills and knowledge about communities
- In my own Barangay I don't even know the number of households, the leaders and their attitudes but in the TADs I know everything

Justine (CO, Dumaguete)
- My most important learning – - one has to be strong to do development work
- CBHP have done many things – it improved talents, skills and attitudes of people including myself
- Based on the evaluation, our TADs may be rated low, but I will rate them high, since despite the difficult situation of the people and hardships that the leaders went through they were able to do and achieve a lot. They did not expect any thing in return; more importantly, they worked voluntarily
- Before the people in the TADs are not joining meetings and are not talking, but now since they are equipped with the necessary knowledge and skills, they are now calling and facilitating meetings, that's why sometimes they are mistaken as teachers—then they become proud
- People were able to feel their obligation to help other people not only on the aspect of health
- On partnership, barangay officials are very political, but with CBHP they gave importance and priority to health
- "Nakapaghihinayang", "sayang" if all these efforts started will not continue
- What will happen to CBHP if CRS is not around anymore? My commitment will continue, and I say now that for next year I will continue my volunteer work even without salary. There are many more things that can be done

Adele (PC, Dumaguete)
- I had been a community worker for a long time, and I can make a comparison - - before, partnership was given less important by some organizations, but here in CBHP partnership is very strong
- Other Barangys are now asking for help to adopt CBHP

Dr. Valencia (MHO, Basay))
- Participation in CBHP had enhanced my knowledge and skills in planning, implementation and even monitoring programs
- One important skills developed in me, was my coordinative skills, where I played a great role in coordinating or linking diocese staff with LGU officers
- CBHP is an entry point for other programs to come
- Community have improved their self-esteem – with meetings, visit of different partners in the community, etc - - without these, the community is invisible

- Thanks for the chance to travel around the Philippines – Davao, etc. - - without my participation in CBHP I could not have reached these places

Dr. Gallo (MHO, Igbaras)
- I realized that SECDEP is "pinakamabusisi and masinsin"
- CBHP awakened leaders, it brought close relationship among Barangay officials and LGUs
- CBHP is a model to other communities
- Thanks CRS for the opportunity to meet new friends and visit places

Marlie (CO, Borongan)
- I developed skills in decision making
- I have been deciding for the program alone, its good that my decisions have been right, though with some weaknesses
- Partners stayed with me despite difficult times that happened - - the communities have seen the sincerity of the Diocese to help so that they stayed with us
- Thanks to CRS - - the attendance to meetings, visits to places

Sim (CO, Jaro)
- I learned how to adjust to every individual, because of their uniqueness
- I'm happy with my work in the Barangays- - - leaders had improved, some vices of people were gone
- I learned to have critical thinking, we do a lot of critical analysis/probing
- Thanks to CRS, particularly my first time to ride the plane -- I had been to places, hotels and lots of trainings

Ferly (PO, CRS)
- I'm proud to say, that the Dioceses have done their best, though there are still some weaknesses
- Partnership was the greatest achievement that I see
- I realized that I should spend at least once every month to sitt down with the Diocese

Lucile (CO, Jaro)
- CBHP had been a big help in the community particularly on health education
- Access of people to basic health services had been achieved, particularly since they live in very hard and difficult to reach areas
- People's capacity had been developed
- I realized that educational attainment is not a hindrance, people have hidden talents - - they are just not given chance to be developed
- CBHP work is worthwhile
- Thanks CRS, I had grown with CBHP, particularly in dealing with communities, thanks for the chance to travel

Luz (PC, Jaro)

- Initially my apprehension was doing partnership; then I came to realize that partnership in CBHP is not hard to learn and not hard to work with government particularly the LGUs - - there are good results
- With the two big programs I am handling, GRAMEEN and CBHP – I am challenging myself - -will I be able to handle this well? I am very thankful my COs can be relied upon - - I focused on looking for donors, preparing proposal and encouraging partnership
- With the phase-out of CBHP – - - "naghihinayang" ako with my 3 COs, I will try my best to still find other means and continue supporting them
- This evaluation process I saw as a tool for further improving implementation

Dr. Alquiza (MHO, Lambunao)

- At first, I thought of CBHP as an additional workload when introduced by SECDEP to the municipal council
- My previous experience with other NGOs, when they leave, the project also ends; I thought this will happen again with CBHP
- Before Barangay Panuran is the most difficult area, and usually becomes isolated with bad weather; but after 3 years I have seen the fruits of the work in Panuran which will be continued by people
- Having a big coverage of 73 Barangays, when BHWs have been trained well, there was less work at RHU
- I learned to be aggressive in requesting funds from LGU
- I'm happy to CRS and SECDEP for making Panuran a showcase for even for international visitors
- Panuran is very far improved from the other Barangays
- Thanks for the travels to CRS, my personal development will stay even if CRS is not around

Mila (HPM, CRS)

- CRS took a long course shifting from the food program to CBHP. It was a big challenge for CRS to learn by doing CBHP
- There had been a high commitment and courage that I have seen during the implementation
- I'm happy that we have addressed the big/major issue on health by reaching the difficult and hard to reach areas
- Having heard from the evaluators the partnership is a success - - the proposal stated CRS as catalyst! - - then CRS have been successful
- The evaluators suggested loosening control on partners. I agree that this could be done since this is consistent with the participatory process that have been done
- I feel sad for the untimely phase-out of CRS support, since CARITAS have delisted the Philippines and have other priorities. But, this maybe an opportunity tor the Dioceses to start standing on their own and seek for their own donor.