The Sorsogon City Experience

Introduction

Sorsogon City was a prime site for the local gender budget initiative: a vibrant network of CSOs, a relatively new female politician at the helm, a supportive staff, and a rich history of GO-NGO partnerships in various fields, including women's and children's health. And yet some obstacles had to be overcome: internal dissension, incomprehension and turfing, among others, that threatened to undo the project before it could take off.

Fortunately, WAND-UNIFEM's clear mandate and guidelines and the steady support of the partner NGO, *Lingap Para sa Kalusugan ng Sambayanan* (Care for the Health of the People) or LIKAS, helped the Sorsogon team stay the course and in time, move from assessment and planning to training and mobilization.

Sorsogon City in the Bicol region, south of Metro Manila, was created by the merger of Sorsogon and Bacon municipalities in the year 2000. It has a total land area of 31,292 hectares occupied by 64 barangays. Its population of 149,900 (2005) constitutes 26,047 households. Population growth rate is 2.15%, slightly lower than the national average of 2.3%. Population density is a high 379.6 persons per square kilometer, with implications for the city's health programs, particularly family planning.

Some basic statistics

The city has two district health units, 64 barangay health stations, 91 personnel, one hospital-based outpatient facility and 335 barangay workers (BHWs). Eighteen percent of the population have no access to potable water and are vulnerable to water-borne diseases; while 21% have no access to sanitary toilets. Majority of the latter reportedly come from the coastal barangays. There were five infant deaths in 2003 rising to 39 in 2004. The five maternal deaths in 2003 increased to 12 in 2004. Forty-two percent of families live below the poverty threshold while over 43% of the population is of reproductive age.

The CSO-LGU tandem

At one end of the tandem, Mayor Sally Lee confesses to having been "just a housewife" for 16 years and engagement in church apostolate as her initial credentials for public office. This background accounted for program priorities that lean towards social services such as health, livelihood and the building of people's centers.

Mayor Lee decided to close down a city-run hospital whose 2002 income of P200, 000.00 was not commensurate with its P6 million budget. She also started the *Mauswag na*

Ciudad (A Prosperous City), a doctor-to-the-barangay approach cum ancillary services, which mobilized young doctors for grassroots service. The evaluation processes that the GBI set in motion eventually revealed the program to be undercutting, even undermining, basic health services. Mayor Lee supports ongoing efforts to integrate the bifurcated programs.

At the other end of the tandem is a vibrant CSO community: 87 registered cooperatives and people's organizations, many of which are LGU-accredited. Half of the active NGOs are in the health sector with LIKAS taking the lead.[1]

LIKAS was founded 27 years ago by a group of medical students and young health professionals who wanted to make their health skills and training relevant through community-based health programs. LIKAS began with organizing and training health workers in urban and rural poor areas, and mobilizing communities on health-related issues such as water and nutrition. Since its Sorsogon health workers were also farmers, LIKAS sought to address agrarian unrest in the 80s through peasant organizing and socio-economic enterprises. LIKAS follows a participatory integrated area development framework.

In the early 90s, LIKAS organized community-based women's groups at the barangay level. But its gender initiatives largely consisted of gender sensitivity training in schools, and among NGOs and LGUs. In 2001, it pilot-tested Gender Watch groups in several barangays in Irosin, Sorsogon to combat violence against women and children. Later, it helped organize the multi-sectoral provincial Sorsogon Women's Network for Development among NGOs, POs and LGUs, which developed a six-point women's development agenda.[2]

Gender mainstreaming in government received a boost when a women's advocate helped Mayor Sally Lee organize the city GAD council during her first term in office (2001) through training and other means.[3] The growing LGU-NGO interface in health and gender concerns would prove invaluable in shaping the local budget initiative project in Sorsogon City.

Orientation: National Inception Workshop in late 2004

At the National Inception Workshop, the Sorsogon team report tackled impact, outcome, and output indicators from an NGO perspective:

impacts	*Outcomes*	*Outputs*
♀ reduced maternal deaths	♀ reduced obstetric complications due to hemorrhage	increased number of mothers provided with prenatal care increased number of women provided with micro-nutrients increased access of indigent pregnant women to tetanus toxoid vaccine
	♀ enhanced awareness of couples on responsible parenthoood	increased number of recipients/acceptors of family planning methods and services
♀ reduced infant mortality	♀ reduced incidence of immunization-preventable diseases ♀ total eradication of polio and measles	increased number of EPI beneficiaries

Introducing GRRB to Sorsogon City stakeholders in late 2004

The Sorsogon GBI set off in earnest with a project partners' meeting and a GRRB orientation and planning seminar on local gender budgeting in December 2004. The project manager first shared the highlights of the GAD policy appraisal undertaken by NCRFW-UNIFEM including the split between agency and gender budgeting, and gender budgeting's failure to adapt to mainstream budgeting.

Citing the rise of children's malnutrition and maternal mortality rates,[4] she raised the following questions: How much is allocated for children and women's needs? Are the allocated funds spent as planned? What is their impact on women?

Project consultant Rosario Manasan shared the project implementation framework, methodologies, tools and indicators. She stressed that mainstreaming gender in planning starts with a local development agenda which should address a number of critical questions[5]. Manasan also discussed the promotion of women's empowerment and gender equality as goals that should guide the implementation of programs, projects and activities (PPAs). Another research consultant, Caroline Manguiat-Ubalde, presented the framework for Gender Analysis of the Sorsogon City Health Program. She also differentiated between outputs, outcomes and impacts.

Three levels of results and their indicators		
Level	**Nature**	**Indicators**
Immediate output	Products or services	Coverage, clients served (e.g. families with access to safe water)
Intermediate outcome	Benefits to clients	Reduction in morbidity, complications, unwanted pregnancies
Long-term impact	Changes in organization, community or system	Reduction in maternal and infant mortality rates

Phase 1: Assessment and planning begins with a gender analysis of Sorsogon City's PPAs

The Gender Analysis of the Health Programs, Projects and Activities of Sorsogon City (2001-2004) sought to determine how these PPAs promoted or disregarded gender equality. It also probed their impact on the women of Sorsogon City.[6] Research methodologies included data-gathering, interviews and focus group discussions (FGDs).[7] Among the study's key findings were:

The existence of two parallel health programs

In 2001, a new health service delivery system was introduced, *Mauswag na Ciudad* (A Prosperous City), which is community-based, accessible to all especially those in remote areas, with doctors-to-the-barangay. The existing health program consisted of devolved DOH programs and local city health programs which provided the communities with 31 services. Two district health units (DHUs) and 64 barangay health stations (BHSs) implemented the devolved DOH programs while the Amberg Hospital served as base for the Mauswag na Ciudad health initiatives.

Mauswag na Ciudad was supposed to complement the ongoing DOH and city health programs. Mauswag doctors were tasked to assist the DHUs in health care delivery to the communities, hopefully strengthening the preventive and promotive aspects of health care through the general accessibility of their services. Besides treating diseases, they also conducted health education and counseling in the barangays. However, complementation turned into competition with barangay folk turning to the mobile and more accessible Mauswag services (discussed at length in the vignette at the end of this chapter).

The annual procurement plan served as the city health plan

The annual procurement plan (APP) prepared by the city health officer served as the city's health plan. Sex-disaggregated data are maintained at the barangay health stations but the district health units lose the disaggregation when collated at the city health office and Amberg Hospital because the focus, according to the City Health Officer, is on monitoring and reducing morbidity and mortality rates of the general population. Only cardiovascular data remain sex-disaggregated.

There were two support structures on health and gender

These were the City Gender and Development (GAD) Council and the City Health Board. The former was constituted in response to rising cases of violence against women and children in the city, while the latter was formed in the 90s (in compliance with the Local Government Code) as consultative body on health concerns, which meets regularly.

Health care delivery was top-to-bottom

With regards to the role of men, women and the community in health services delivery, "health PPAs emanate from the top" with women, men and the community largely serving as mere recipients of health services. However, women play a more active role in the implementation of the maternal and child health care program.

In general, women more actively seek out health care services offered by the barangay health stations. Monitoring and evaluation rest largely with barangay health workers who monitor project implementation, conduct surveys and follow-up activities and submit monthly reports. (See Annex 11 for a fuller discussion on the gender and health support structures.)

Impact on women of Sorsogon City's health PPAs

The FGDs readily pointed to the following programs as most beneficial to women: maternal and child health care, extended immunization program, family planning and micronutrient supplementation. Specifically, they said women learned how to plan their families, had the opportunities to recover their health after pregnancy and delivery, could take care of themselves and help in livelihood activities, and illnesses were prevented and the number of sick children reduced. But when asked which programs contributed most in promoting gender equality, they had difficulty responding because no PPA was expressly designed to promote gender awareness and equality.

The existence of data gaps

The report noted that the framework for analysis of gender-responsive budgeting (GRB) should be able to differentiate between two kinds of expenditures: gender-specific or targeted, and general or non-targeted. The former includes maternal, reproductive and

child health programs, while the latter covers programs that control communicable diseases such as tuberculosis and malaria, and provision of curative care.

However, data gaps made it impossible to fully disaggregate data into two categories. At the same time, it was noted that bulk of the public health programs (operated by the district health units) pertained to maternal and child health services, and may therefore be considered gender-specific, while bulk of the Mauswag programs was related to general expenditures.

Higher expenditures do not necessarily translate into better results

In 2001, the infant mortality rate (IMR) was 5.8 (per 1,000 live births) compared with the national average of 15 for all cities; and the maternal mortality rate (MMR) was .57 (per 1,000 live births) compared with the national average of .63 for all cities. Sorsogon City had a health personnel complement of two doctors, eight nurses, 22 midwives and 277 BHWs. However, the allocations for health service slightly declined from 8.95% of total budget in 2001 to 8.65% in 2002, keeping the same percentage in 2003.

Notwithstanding the slight drop in the health budget, there was an increase of health personnel between 2001 and 2003: from 2 to 14 doctors, 22 to 67 midwives, and 277 to 335 BHWs. Morever, the doctor: population ratio was more focused from 1:69,000 in 2001 to 1:10,300 in 2003, double the World Health Organization standard of 1:20,000.

And yet the MMR rose from .57% (per 1,000 live births) in 2001 to .8% in 2002 and 1.47% in 2003; the IMR increased from 5.8% (per 1,000 live births) in 2001 to 6.4% in 2002; and the percentage of malnourished children (under 5) which slightly declined from 6.1% in 2002 to 5.3% in 2002 sharply increased to 8.8% in 2003. Noteworthy also is the fact that the incidence of tuberculosis increased from 24 in 2001 to 35 in 2002 and 61 in 2003.

Higher expenditures do not necessarily mean reduced IMR and MMR

The report drew two conclusions. First, higher (in absolute terms) health expenditures do not necessarily translate into reduced infant and maternal mortality and reduced malnutrition rates. Second, the higher MMR, IMR and malnutrition rates were linked to "leakages", caused by several factors: poor combination of programs, especially poor balance between preventive and curative care; poor balance between personnel services and maintenance, overhead and operating expenses (MOOE); and inefficiencies in procurement.

The report recommended better monitoring and participation on the part of civil society, and a deeper awareness of gender in health care delivery starting with sex-disaggregated data of beneficiaries. The report wryly remarked, "Sometimes gender-neutral may mean gender-blind."

Gender appraisal forum in early 2005

The Gender Appraisal Forum in February 2005 shared results of the foregoing study. It also sought to review the LGU's planning and budgeting process for a shift towards GRRB in health; to develop and deepen commitment among LGUs and CSOs to gender advocacy; and to draw up an action plan for future project activities in Sorsogon City.[8]

In the ensuing open forum, comments and questions included health issues; the bias in health service delivery caused by political affiliations; and the need for qualitative, not just quantitative, health indicators. The problem raised by two parallel health structures was articulated as: "There is seeming division in the medical services rendered by the city, resulting in confusion in terms of reporting".

Workshop planning for the next 11 months (February-December 2005)[9] called for the conduct of a strategic health assessment, analysis and planning; integration of the parallel Mauswag and devolved DOH programs; improved health service delivery; health reforms; capability building; functional local special bodies or councils (e.g. local health boards); resource mobilization; and institutionalization of a management information system (MIS). LIKAS was tasked to convene the core team members and the Project Steering Committee (PSC) of Sorsogon City, to oversee implementation of the action plan.

Top-level participation, high spirits and a firm commitment to integration marked an auspicious start to the planning process.

Project Steering Committee meeting in February 2005

Although PSC[10] members had joined earlier activities, this was the first meeting to focus on the action plan which had been reworked by LIKAS into six key result areas (KRAs) with corresponding objectives, key activities, target outputs, required inputs, timetable and persons-in-charge.[11]

The six KRAs under improved health service delivery are integration of the two parallel programs, health policy reforms, capacity building for health service providers, improving the functions of the local health board, resource mobilization and institutionalization of a management information system (MIS). After some discussions, the action plan was approved and one suggestion adopted, i.e. including training in gender mainstreaming and policy advocacy skills.

Strategic Assessment and Planning Workshop in April 2005

Stakeholders review the VMG, draw up a balance sheet for the city, and plan for organizational capacity building

GO and CSO stakeholders gathered for a strategic assessment and planning workshop to draw up a two-year gender responsive and results oriented strategic plan for the

Sorsogon City LGU. This entailed a review and reformulation of the city's vision, mission and goals; a critical assessment of the local situation vis a vis provincial, regional, national and global trends; and promoting camaraderie among various stakeholders. Inputs on governance preceded the workshops.

Tackling local governance from both ends (government and constituents), project manager Dorotan said it pertains to "how a government establishes, maintains and deepens its relationship with its constituents", and at the same time, "how civil society critically engages with LGUs to promote transparency and ensure people's participation".

Sorsogon City Mayor Sally Lee in the opening ritual of Sorsogon City Strategic Assessment and Planning Workshop

Thus, making a difference in local governance is all about excellence, innovation, motivation and creativity. It is also about advancing one's mission, achieving desired results (performance), serving the people well (commitment, effectiveness and efficiency) and creating social impact. Dorotan cited several factors that foster and enhance excellence in local governance: granting of local autonomy, devolution of basic services, participatory governance, increased financial resources and preferential option for the poor and marginalized.

CSOs as partners in local governance

Resource person Marilou Capucao discussed civil society organizations as partners in local governance and development. Defining civil society as a "web of autonomous associations independent of the state, bringing citizens together in pursuit of their common interests", Capucao surveyed the wide range of CSOs in Sorsogon City.[12]

Currently NGOs perform the following strategic roles: empowerment of people and capability building; delivery of social services; development innovation and model building; advocacy and monitoring of policy; and formation of networks and coalitions of NGOs. As well, NGOs have emerging roles: advocacy, electoral-related roles and participation in governance.

Resource person Carol Ubalde introduced the area balance sheet (ABS), a tool for area development and management.[13]

Another resource person, Joji Rayel-Orbase, presented a Situationer on Sorsogon City to help participants validate data, develop an understanding of the factors that perpetuate local poverty and underdevelopment, and identify opportunities for countryside development (see Annex 13 for a summary of the presentation).

Challenges of good governance

- **for LGUs**
  To strengthen partnership with CSOs through active participation of the latter in local bodies, which strengthen people's participation in service delivery.

- **for NGOs**
  To improve track record and maintain their identity; to deepen their understanding of LGU dynamics; and to continue to be innovative, creative and responsive.

Workshop participants decided to undertake VMG review and reformulation as a separate activity and focus instead on assessing the city programs and services that reflected the VMG. The next workshop sought to determine the city's strengths and weaknesses in addressing the needs of its constituencies, identify the opportunities and threats in the city's external environment, and pinpoint and prioritize the pressing needs of the city.[14]

Priority needs: City Health Office reorganization and consolidated city health plan

The following priority needs emerged:

- fast-tracking reorganization of the City Health Office
- drafting a consolidated city health plan (with corollary information system, capability building and program budget allocations)
- strengthening GO-NGO coordination to avoid duplication of services

An additional comment was on the lack of coordination between executive and legislative bodies manifested in the absence of an executive-legislative agenda.

The third workshop focused on organizational capacity development starting with goals and objectives that addressed the questions: where is the organization headed; and when is it going to get there?

Under the social services KRA, two health-related objectives were identified: improvement of the health information system and strengthening the GO-NGO network for better service delivery (see Part II, C.3).[15]

Phase 2: Training and Capability Building

Four capability building activities dealt on enhancing gender responsiveness in local governance; gender responsiveness and results orientation in budgeting; PIME (planning, implementation, monitoring and evaluation); resource mobilization; and people's participation in local governance.[16]

Seminar on enhancing gender responsiveness of local governance in May 2005

Sorsogon City LGU learns basic gender concepts and the importance of benchmarks and gender specific indicators

In the first training workshop, one participant remarked that GAD discussions in the barangay only elicit such patronizing comments as, "*Uh, gender... that can be discussed with the women*". One creative presentation concerned GAD programs of the executive and legislative departments which benefited women victims, prompting the budget officer to remark that GAD should also be the concern of other government agencies including the police, for instance, in relation to cases of trafficking. The city mayor reported that some establishments became girlie joints at night featuring a "show down" with women doing a slow striptease to music before a male audience. It was further observed that some female students turned to occasional prostitution for tuition money.[17]

The project manager stressed that gender analysis must be part and parcel of all LGU programs, otherwise how can the differential effects on men and women, and their participation, be anticipated and factored in?

Advocacy strategies

Resource person Remmy Rikken spoke on advocacy strategies that seek to influence policy and decision-making at various levels that include the use of media, lobbying, coalition building and organizing citizen events. Advocacy must also help to educate women, workers and the community so they can identify, analyze and solve their own problems. The challenge is to build organizations and social movements that help the marginalized, especially women, to press their demands through sustained participation and influence on decision-making.

In summary, project manager Dorotan said that advocacy was meant to develop and deepen gender sensitivity among LGU personnel, and to enhance their capacities in terms of knowledge, skills and orientation. The challenge, she stressed, is to adopt gender-specific indicators and benchmarks in the city's health programs and projects in order to measure the impact of interventions. For instance, she said, in line with MDG no. 3, interventions after a year should reduce maternal mortality rates.

She also noted that the city's annual investment and GAD plans focused on programs and activities, not results. There were no clear input and expected output indicators put forth. Consequently, there was no way of checking whether a ₱50, 000.00 allocation actually helped pregnant mothers and malnourished children. Dorotan concluded that the vision and mission for a gender-sensitive city can only be achieved with genuine GO-CSO partnership based on mutual trust and confidence that is built through constant dialogue, brainstorming, consensus building and healthy debate.

Training Workshop on Gender Responsive and Results Oriented Budgeting in May 2005

This joint training workshop sought to set the broad mandates and frameworks for gender and rights-based governance; for conducting a gender analysis of 2005 health and agriculture plans and budgets of Sorsogon and Hilongos, respectively; and for adopting enhanced health and agriculture sector plans.

Landmark women's documents and gender mainstreaming

Resource person Luz Lopez Rodriguez took off from women's invisibility in development planning in spite of the vital roles they play in the money and care economies, their political marginalization, their strategic and practical needs and the concepts of equity and equality. Rodriguez tackled two documents setting forth women's rights and a third that needed to be informed with a gender perspective, CEDAW, BPFA and MDG, respectively (see sidebar).

Three goals in the MDG expressly address women's concerns: promoting gender equality and empowerment, reducing child mortality, and improving maternal health (nos. 3, 4 and 5, respectively). Rodriguez stressed that all three processes must be viewed as complementary (see Part II, input A.2.1 for a full presentation).

CEDAW, BPFA and MDG: Landmarks in women's and human rights

- ♀ Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), a women's bill of rights with 30 articles
- ♀ Beijing Platform for Action (BPFA) sets forth 12 priority areas pertaining to women's rights and requiring state commitments
- ♀ Millennium Development Goals (MDG): concrete, time-bound and measurable goals, targets and indicators for poverty reduction

NCRFW Deputy Director Loren Umali next discussed the four phases of gender mainstreaming in government and its various entry points.[18]

Bacolod and Davao case studies

Two LGU case studies shared their experiences in mainstreaming gender. Among the findings in the Bacolod City case study were: gaps between policy and implementation; minimal compliance with "traditional" departments (health, social welfare) accounting for most of the GAD budget; politics undermining CSO participation in planning and budgeting; unclear basis for identifying GAD projects; and weak capability in GAD planning and budgeting. All this confirmed the need for a fresh approach to gender budgeting. (See Part II, input D.3 for a summary of the case study.)

The Davao City case study took note of innovative gender programs including Gender Watch to monitor implementation of a Women Development Code; a multi-sectoral male advocacy group in support of gender mainstreaming; an annual women's summit; and a program targeted to curb violence against women.

A series of workshops provided tools for analysis, evaluation and planning. In one workshop, the Sorsogon team presented a skit on maternal mortality: a husband's awakening to gender issues and consequent advocacy of condom use, and Catholic church strictures on family planning. In another workshop, both teams underwent self-assessment with the instrument "Gender-Responsive LGU Ka Ba?" (Are You A Gender-Responsive LGU or GeRL).[19]

> The GeRL Tool is a comprehensive tool whose two major sections are: basic LGU information and data that are sex-disaggregated; and LGU basic services rated on a continuum of 1 to 5 according to their gender- responsiveness (e.g. availability of day care centers). It includes health, safety and protection-related facilities and services within the LGU and in various women's centers; programs such as livelihood, anti-domestic violence and training such as gender training; local structures and mechanisms such as committee on decorum and investigation (related to the anti-sexual harassment law); GAD focal points; use of sex-disaggregated data; GAD budget allocation; and involvement of women in LGU programs.

Another workshop required participants to revise their 2005 LGU Plan and Budget using result indicators and monitoring and evaluation mechanisms. The Sorsogon City reformulated plan tackled three PPAs: capacity building of staff in gender; integration of the Mauswag health services with the devolved DOH programs; and maternal and child health care (MCHC). (See Part II, C.3)

Among the comments elicited on the Sorsogon City plan were the need to target not only BHWs but also families in the MCHC program; the use of the life-cycle approach to identify appropriate programs at each stage for men and women, including community-based activities in primary health care; more detailed budgeting; counterpart funding vis a vis donor funds to indicate the LGU's commitment; and listing final outcomes, not just activities (e.g. not just number of training workshops conducted but their impact on women and men).

Gender-responsive and results-oriented planning, implementation, monitoring, evaluation (PIME) and resource mobilization in mid-2005

Stakeholders learn planning, implementation, monitoring, evaluation and resource mobilization from a GRRB perspective

This joint training workshop for LGUs sought to enable participants to enhance their respective LGU health and agricultural sector plans; and to gain knowledge, and hone their skills in planning, monitoring, evaluation and resource mobilization.

The project manager provided a framework for linking reproductive health, population policy and sustainable development, and zeroing in on the Millennium Development Goals, including the reduction of extreme hunger and poverty and reduction of child and maternal mortality rates, which should provide an anchor for LGU plans and strategic goals.[20] Joji Orbase focused on the process of enhancing the LGU health and agriculture sector plans employing a comprehensive planning format and Gantt chart. Finally, the workshop sought to integrate the CEDAW and the United Nations MDGs in these plans.

Training-Workshop on Planning, Implementation, Monitoring and Evaluation (PIME) and Resource Mobilization – June 1-3, 2005

Integrating the CEDAW and MDG targets in LGU health and agriculture plans

- reducing by 50% the number of people living in extreme poverty by 2015
- reducing by 50% the number of underweight children under 5
- reducing children under 5 mortality rate by 67% by 2015
- reducing maternal mortality rate by 75% by 2015
- increasing access to reproductive health services to 60% by 2006, 80% by 2010 and 100% by 2015

To further guide the planning process, Carol Ubalde presented "What Is a Good Plan?" This, along with preceding inputs, primed participants for the succeeding workshop on planning.

The 2006 GAD Plan and Budget of the Sorsogon City Health Office targeted maternal mortality reduction and reproductive health services as its key programs. It highlighted such gender issues as non-participation of husbands during prenatal visits, gender insensitivity of health personnel, women's lack of access to reproductive health services, and conflicting church and state perspectives on reproductive health. The plan also included corresponding GAD objectives, activities, targets, performance indicators and budgets.

The next inputs focused on the cycle of planning, implementation, monitoring and evaluation (PIME): an overview on the phases and principles of PIME was followed by inputs on current LGU PIME practices and generating interventions for improvement by Joji Orbase and Carol Ubalde (see Part II, input B.1). The final presentation tackled resource

mobilization with insights on, and how to develop, resource mobilization.[22] (See Annex 14 for resource mobilization plans of two NGOs.) Working committees were constituted for both project sites to ensure that plans were finalized and implemented on time.

What is a good plan?

- a good plan is results-oriented and gender-responsive
- anchored in the LGU's vision, mission and goals
- has SMART[21] objectives, goals and targets
- requires policy support and resources
- should be participatory
- should build in mechanisms for monitoring and evaluation

Seminar Workshop on People's Participation in Local Governance (PPLG), June 28-30, 2005

Capacity building for CSOs

This was the first of two training activities geared towards strengthening and capacity building for CSOs as project partners. The seminar-workshop aimed to equip participants with competencies for meaningful participation and involvement in local governance, particularly in health and agriculture planning and budgeting.

Participants were expected to address the following concerns, among others: basic principles and concepts of local governance and of LGU dynamics, powers and attitudes; avenues for CSO participation in local governance and best practices of the same; the role of advocacy in local governance and the principles of social marketing and advocacy; and principles and concepts of resource mobilization and identification of needed resources. Each team was also expected to formulate re-entry and advocacy plans.

Resource person Jose Victor Garganera of PHILDHRRA National Secretariat started with an overview of people's participation in local governance and tackled best practices in local governance and avenues for meaningful CSO participation (see Part II, input A.2.4 for a summary).

Christine Reyes presented an overview of social marketing and policy advocacy and their role in CSO participation in local governance. She guided participants in developing an advocacy plan for meaningful CSO participation in local governance with pointers on environmental analysis, review of the policy-making process, and advocacy planning, strategies and tools. In developing a resource mobilization plan, Reyes addressed the

following concerns: reviewing the PPLG (people's participation in local governance) re-entry and advocacy plans; identifying activities that require resource mobilization; determining the costs and resources needed; and identifying potential fund sources (see Annex 15 for Sorsogon CSOs' re-entry plan).

Phase 3: Action component and piloting

This final phase takes off from plans formulated at the earlier strategic assessment and planning workshop. Supplementary to these are the following planning documents: City Health Office Integration Plan (March to July 2005), Sorsogon City Organizational Capability Development plan (May 2005 to June 2007), and Annual Health-focused Gender and Development plan and Budget FY 2006. The third document zeroes in on MDG no. 4, specifically reducing under-5 children mortality from 19.6% to 15% and MDG no. 5, specifically reducing maternal mortality rate from 3.2% to 1.66% by 2006.

Sorsogon Partners' Complementation Forum on Health, July 1, 2005

Pinpointing gaps and areas for complementation

A final activity was the Sorsogon Partners' Complementation Forum on Health co-sponsored by the Lead for Health Project of the United States Agency for International Development and the Management Sciences for Health (USAID-MSH) which sought to enhance health NGOs' participation in improving the health situation in Sorsogon City and Sorsogon province. After the health NGOs shared their respective programs, the City Health Office integration plan was presented focusing on improved health service delivery with the following components: integration of Mauswag with devolved DOH programs; health policy reforms; improved capacities of health personnel, LGUs and CSOs; improved functioning of the local health board; and institutionalization of the management information system (see Annex 16 for the CHO integration plan).[23]

Gaps and areas for complementation or partnering in terms of programs and projects were identified; thus, LIKAS and the provincial health office planned to undertake training for BHWs; World Vision said it would share its information and education materials on tuberculosis; and the DOH said it would provide the software for the health information system (HIS) which LEAD (Local Enhancement and Development for Health) project said it would help develop.

Oyen Dorotan giving an input at the Partners Complementation Forum on Health, July 1-3, 2005

The final open forum focused on consensus building and commitment sharing. The need to ensure health NGOs' participation in the local health board was underscored, and

concern was expressed on LGU hesitance to provide a budget for information materials on STI/HIV/AIDS. CSOs could play an advocacy role with mayors, especially in vulnerable port areas and not wait for an outbreak or increased incidence of these types of disease before acting on the problem. Working committees were constituted based on health issues identified and geographic spread, to ensure that plans are finalized and implemented on time.

Project outputs in Sorsogon City

Sorsogon City's outputs may be best described as aggregate outputs: database and analyses, plans, executive and legislative measures, and mechanisms established.

The first aggregate output included ***a socio-economic profile of the city, gender analysis and budget and expenditure analysis***, particularly of health programs, which constituted the base for succeeding stages.

A second aggregate output included the ***various plans formulated***: City Health Office integration plan, 2006 City Health plan, Organizational Capacity Development plan, Planning, Implementation, Monitoring and Implementation plan, Resource Mobilization plan, and Advocacy plan.

A third aggregate output were ***executive and legislative measures***, or policy support, ensuing from the aforementioned plans: memorandum circular of the City Budget Office requiring all department heads to submit gender-responsive budget proposals for 2006, and city ordinances adopting the 2006 City Health plan and the CHO Integration plan.

A fourth aggregate output were the ***mechanisms established to ensure project sustainability and institutionalization*** over the long term: a multi-sectoral health planning committee composed of seven LGU and four CSO representatives, and a network of CSO advocates.

Singular achievement

In her summary at the End-of-the-Project conference, Sorsogon City project team leader, Marian Ferreras cited the project's singular achievement as the integration of the parallel Mauswag na Ciudad and the devolved DOH vertical programs through the City Health Office Integration plan "for better service delivery".

She further noted that the various plans were not separate and distinct but complementary. For example, the health plans needed a capacity development plan for effective service delivery; a resource mobilization plan to ensure needed resources for implementation; and an advocacy plan to ensure needed resources for sustainability even in the face of leadership change.

The seven LGU representatives in the multi-sectoral core team include the city officers for planning, budget and health, three district health officers and the GAD focal point person. CSO representatives come from World Vision, Barangay Health Workers Federation, and a reproductive health NGO.

Key Result Areas

Moreover, the Sorsogon City core team has highlighted six key result areas:

- ***Capacity building*** which has developed increased awareness and competence for the tasks of planning, implementation and monitoring of rights- and results-based plans and budget

- ***Partnerships*** as exemplified in a multi-sectoral health planning committee composed of health managers and stakeholders

- ***Advocacy*** as manifested in executive and legislative support for a gender-responsive and results-oriented health plan and budget

- The ***budget process*** with gender-friendly players at each stage and allocations responsive to maternal health targets

- ***Sustainability*** with an oversight committee to track budget responsiveness to gender gaps and the establishment of a CSO network

- ***Knowledge*** with production and popularization of documentation reports, and exchange of experiences and materials through the steering committee and partners' meetings

Summary and Conclusion

The Aha! (or Eureka) moment for the Sorsogon team was the stark realization that the city had, in fact, two duplicate health delivery systems: the new Mauswag na Ciudad package of health projects and the devolved Department of Health programs. The former was termed "political", owned by the mayor's office and dispenser of easily accessible services including PhilHealth cards that offer an array of health benefits. The latter consisted of services provided in large part through the district health units (formerly rural health units of the two merged municipalities).

Competition (even contradiction) rather than coordination was the growing leitmotif of these parallel programs, evident in the fact that the two district health units became white elephants, with barangay folk increasingly drawn to the 24-hour highly mobile projects of Mauswag. But given the existence of a "walking" or mobile blood bank project under the Mauswag program, one did not know how to reconcile the reported death from severe blood loss of a pregnant woman. Indeed, there was a failure of communication and coordination.

What about the city health office? It was really non-existent before the GBI project, or barely so, an irony considering that the city's three districts had existing district health offices. There was no city health plan, only the poor substitute of an annual procurement plan.

Thus the Gender Budget Initiative project in Sorsogon City compelled its stakeholders to speak the truth about the state of the city's health delivery systems, spelled out in a gender analysis of the city's health PPAs revealing that:

- Men (and to a lesser extent women) were passive recipients of the health delivery system.

- Health PPAs were generally non-targeted in nature, i.e. very few were gender-specific (the maternal and child health care program being an exception).

- There were no clear mechanisms and tools for gender analysis, planning, monitoring and evaluation in community health.

- A poor output mix meant a lack of balance between preventive and curative services.

These findings and more provoked sharp but, ultimately, healthy debate during the gender appraisal forum in early 2005. The critique of existing health delivery programs was fleshed out with examples from the forum participants.

- Item one: many barangays lacked the services of midwives, notwithstanding the fact that additional midwives had been hired, but could not be deployed, for lack of a final training process because no nurses were available to train them. Asked one forum participant: "Why not let senior midwives do the training?"

- Item two: problems concerning nurses and midwives had become politicized, adversely affecting health service delivery. Only those belonging to or identified with the ruling party had access to medicines and health supplies.

- Item three: decisions of the city health board were not carried out; neither did the board pass programs and projects with legislative concurrence.

This forum and subsequent fora, highlighted the need for greater openness all around, most especially on the part of local officials and LGU staff, and the corresponding need for the training of health workers and personnel, many of whom were observed to be deficient in knowledge about health care.

At the same time, CSO representatives articulated the need for greater CSO participation – to maximize resources, to integrate health planning processes, and to clarify the budget on priority health problems.

Specifically, one CSO participant said that the seminars on local governance and the PIME cycle opened his eyes to the need for active CSO participation in planning and monitoring without which task forces function on the technical level but do not effectively intervene in the budgeting process. He thanked the GBI project for providing this opening.

Likewise, gender consciousness raising helped the participants draw the connections in their everyday lives. The city budget officer, for example, thought that the flexitime program for government employees was simply a whim on the part of women employees. He later realized that flexitime, in fact, enables working parents to bring their children to (and/or fetch them from) child care and grade school. As for office supplies, he now had a deeper appreciation of the importance of "toiletries" (including toilet paper) for female office employees.

Thus, a succession of training seminars (strategic assessment and planning, "genderizing" local governance, PIME, PPLG) gave shape and form to a number of plans, mentioned in the foregoing section (CHO integration, ten-month action plan, two-year organizational development and capacity building plan, resource mobilization, etc.).

Each training workshop built on the foundations laid by the last one, breaking down defenses, developing a sense of ownership, creating collective commitment and spurring innovative approaches and methods. For instance, the tight-lipped city health officer, several trainings later, spoke proudly of the TAKUSA project, an innovative "macho" approach that would teach fathers such skills as shared parenting. Twenty fathers trained per barangay would total, for 64 barangays, 1,280 TAKUSA fathers in one year!

Equally significant was the focus on the planning and budgeting process. The city planning and development officer said that in the past, budget proposals followed a format from the budget office and if funds were insufficient, cuts would be arbitrarily made. The city budget officer had discretionary powers and there was room for abuse. Now, he continued, there is a clear link between planning and budgeting.

The city health doctors echoed this view. In the past, they said, budgets were "dekahon" (boxed or inflexible), carried over from the past year, not specifying who does what. It was so difficult to ask for funds. Now, the process is reversed: rationale followed by proposed solution or program, part of which would be the budget allocation. Targets are more precise and projected.

Best of all, the concept of "tripartism" gained currency: the need for teamwork among the LGU, national government agencies, and the CSOs. With capability building, managerial skills of all three partners are optimized. Not only one or two have the power to implement a program, now a consensus among the three partners is needed to ensure that the program is going somewhere.

Perhaps, a fitting cap to the Sorsogon experience is an account of a women's health project in Barangay San Juan, barely a year old when the gender budget initiative project in Sorsogon City started. As Lilia Jaso, a barangay women's leader, tells it, the women's health organization with 40 members (albeit only half are active) is the project's backbone.

When a rapid appraisal study at project onset recommended rehabilitation of the water system whose plastic pipes suffered from many illegal connections, the women took the matter into their hands. Eschewing the bidding process, they searched on their own for suppliers, securing the necessary materials at a savings of ₱54,000.00 (from ₱200,000.00 in funds provided by the city government and the European Union).

Part of the savings paid for a women's center and part went to an emergency fund for qualified women members as an alternative to local usurers. The women's center is venue for meetings as well as a place for education and training sessions for mothers. It also serves as a feeding center.

Jaso speaks with pride about the *botika sa barangay* (community drugstore) funded through ₱25,000.00 capital from the European Union grant. In the past, barangay folk would buy from drugstores open only on Mondays through Fridays at certain hours, with 100% mark-up prices. Now, the botika sa barangay is open 24 hours with drugs at only 20% mark up.

Coming from the training workshop on Gender Responsive and Results Oriented Budgeting in Leyte, Jaso said that her deepest impression was that "People need to monitor where the barangay council spends the money. We need to learn to intervene for this is our money: for too long, budgeting has been a 'closed door' process."

Gender and governance is a clear link between planning and budgeting, advocacy and monitoring–by an empowered community and organized men and women. Slowly but surely, Sorsogon stakeholders are learning that this is what the gender budget initiative is all about.