How to support local government to integrate CVD and diabetes prevention and management into existing health systems - the Davao City experience, Philippines.
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Lessons Learned

How to support local government to integrate CVD and diabetes prevention and management into existing health systems - the Davao City experience, Philippines.

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Marion Sindezinge
Intern for the health department,
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List of abbreviations and acronyms

ACHO         Assistant City Health Officer
ADNEP       Association of Diabetes Nurse Educators of the Philippines
BHC            Barangay Health Centre
BHW           Barangay Health Worker
BLGU          Barangay Local Government Unit
CHO            City Health Office
CHW           Community Health Worker
COPD          Chronic Obstructive Pulmonary Disease
CVD            Cardiovascular Disease
CVRF          Cardiovascular risk factors
DHD            Diabetes and Heart Day
DJF             Davao Jubilee Foundation
DOH            Department of Health
DOH-CHD      Department of Health-Center for Health and Development
DSWD         Department of Social Welfare and Development
HCP            Health Care Professional
HI                Handicap International
IEC              Information - Education - Communication
INCDPCP    Integrated Community-Based Non-Communicable Diseases Prevention and Control Program
INGO           International Non-Governmental Organizations
LDSG          Local Diabetes Support group
LGU            Local government unit
M&E            Monitoring and Evaluation
NCD            Non-Communicable Disease
NCVDPCP     National Cardiovascular Diseases Prevention and Control Program
NGO            Non-Governmental Organization
PADE          Philippine Association of Diabetes Educators
PEN            Package of Essential Non-communicable
PHCP          Primary Health Care Professional
P&O            Prosthesis and Orthotics
SPMC          Southern Philippines Medical Centre
TOT             Training of Trainers
TWG            Technical Working Group
WHO           World Health Organization
Terminology guidelines

Here we explain the different terms used in this document that are specific to the Philippines, in order to provide a better understanding and encourage replication in other countries with comparable systems / structures.

CVD Program/Project:
- The CVD Program is the program implemented by the Davao City Health Office (CHO) at the city level in order to increase access to services by implementing the Diabetes and Heart Day (DHD) in every Barangay Health Centre. This program refers to the DOH’s National Cardiovascular Diseases Prevention and Control Program (NCVDPCCP)(31).
- The CVD project is the HI project, including the CVD Program, but focusing on capacity building of the CHO, DJF and Local Diabetes Support groups (LDSGs) and partnership building.

City Government:
- The City Health Office (CHO) is the public primary health care provider. The CHO is the local health authority of the city government and is in charge of the implementation of the public health programs sponsored by the DOH, as well as city hospitals.
- The Health Care Professionals (HCPs) working in the public primary and secondary health centers are both managed and paid by the CHO. In the same way, the Community Health Workers (CHWs), who are volunteers in the community, are managed and compensated by the CHO (unlike the Barangay Health Workers [BHWs] who are also volunteers in the community, but are managed and paid by the Barangay Local Government Unit [BLGU]). These public health workers administer the public health services in the communities.
- The Local Government Units (LGUs) make up the political subdivisions of the Philippines. Considering the extremely decentralized political system, they are guaranteed local autonomy and responsibility for their own health services. A Barangay (or village) is the smallest political unit. A Barangay Local Government Unit has also some political autonomy. The Barangay captain is the chief of the Barangay Local Government Unit - a city official.
- A Barangay health centre (BHC) is a local public primary health care centre (there is a BHC in every Barangay). A district is a geographical grouping of several Barangays.
- In Davao for example, the city is divided into 16 districts and 182 Barangays.
- The Local health Board (LHB) serves as an advisory body to the Sanggunian (local legislative council) on health-related matters. He’s chaired by the local chief executive (so the Mayor in a city) and is established in every province, city and municipality. The DOH is represented in all local health boards by the DOH representatives. Legislative power at local level is vested in the local legislative council.

Other partners:
- The regional Centers for Health and Development (CHDs) are the regional network of the DOH. They mediate between the national DOH and the LGUs.
- The Davao Jubilee Foundation (DJF) is a local rehabilitation service provider, including prostheses and orthotics provision.
- The Southern Philippines Medical Centre (SPMC) is a public tertiary level hospital and a referral institution for specialist care.
Executive Summary

This lesson learning publication focuses on Handicap International’s Cardiovascular Disease (CVD) project implemented in Davao City in the Philippines from 2010 to 2013.
The specific subject focus is the Davao City Health Office (CHO), the main implementing partner of the project. We are exploring the significant changes achieved by the CHO and the factors which made them possible. In the final section of the document we move forward from the looking at this very specific experience in Davao City to try to propose more general recommendations about how to work with similar local government health departments (in low and middle income country contexts) to develop effective diabetes and CVD prevention and management services.

The target audience for this publication is primarily Handicap International staff working on the issues of diabetes, cardiovascular disease and non-communicable diseases. However the lessons learned can be relevant for all interventions aimed at building effective partnerships with local government to implement sustainable services.

As well as an internal audience this publication will be shared with key external stakeholders within the Philippines, with a view towards raising awareness on diabetes and CVDs, but also to strengthen capacities to replicate aspects of the CVD project in other cities of the Philippines.

Please note: this publication has an accompanying CD-Rom which includes an electronic version of this document, but also a comprehensive practical toolkit developed by the project. The contents of this CD Rom are also available online at http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/index.htm
Philippines, 2011
Introduction

A. LESSON LEARNING RATIONALE

B. SPECIFIC FOCUS
Introduction

In 2007 Handicap International (HI) piloted a three-year project on Diabetes in Davao City, Philippines. At that time HI was a relatively unknown organization in the city, having worked only through a partnership with a local NGO – the Davao Jubilee Foundation’s (DJF) prosthesis workshop in the previous years. The Diabetes Project was implemented from 2007 to 2009 in only 10 Barangays (local communities) in the city and was considered part of the ‘special projects’ of the Davao City Health Office (CHO).

In 2009, at the end of the project, the different partners decided to extend the pilot project experience for an additional 4 years (from 2010 to 2013) and to **massively scale up the activities to cover all of Davao city** (182 Barangays). This scaled up project became ‘The CVD Project’ (cardiovascular disease project) which operationalized existing frameworks by the Philippines Department of Health and the World Health Organization (WHO) Non-Communicable Disease (NCD) and was the first of its kind in the Philippines in terms of increasing access to cardiovascular diseases (CVD) services in the primary health care centers or Barangay Health Centers.

The CVD project focuses on 4 key elements:

1. Building the capacities/ autonomy of Health Care service providers / City Health Office
2. Building the capacities / autonomy of local diabetes support groups
3. Building the capacities / autonomy of rehabilitation service providers
4. Building functional referral systems between health, P&O and rehabilitation service providers

Lesson learning rationale

Now in 2013, after three years of implementing the CVD Project, the HI Philippines Program, the Project Team and the Technical Adviser have identified this experience as something extremely important for HI to capture, analyze and share more widely.

The CVD Project, successfully scaled up from 10 Barangays to 182 over six years, is an important success story for HI. It represents (alongside projects in Nicaragua and East Africa) one of the organization’s first detailed experiences for developing a comprehensive CVD project. Indeed HI has had several opportunities now to share the CVD Project experience both with national and international audiences, through oral presentations and abstracts at conferences. The interest the project has generated at different levels has provided an opportunity for HI to promote its experience in implementing projects on NCDs and prevention of disabilities. **As such, the good practices, lessons learned and practical tools and resources captured from the CVD project will be used in different ways:**

- **At the global level:** For HI, the CVD Project in the Philippines provides a comprehensive point of reference for designing, implementing, monitoring, evaluating - and scaling up - a successful CVD project. Therefore this publication can be used as a resource to train HI staff to develop similar projects in other countries.
Within the Philippines: HI, as the only INGO working on CVDs in the country, can use the lessons learned from the project to increase awareness about diabetes and CVD generally, but more specifically, to help sustain existing CVD services within Davao City. Given that the project is now into its phase-out year these lessons learned will help facilitate the transition from an HI-led project to a local stakeholder-led endeavor. Furthermore, HI hopes to replicate the Davao experience in other cities of the Philippines. This lesson learning document will be used to inspire local and national government leaders / agencies as well as civil society groups to initiate projects in an autonomous way to address the implementation gaps in the prevention and management of CVDs. Governments need concrete examples that a program or system actually works, that a NCDs control intervention has had positive and tangible impact on people's lives before they implement the same in their localities. Their roles/contributions in such ventures need to also be clarified for them to be able to commit.

Specific focus

The CVD project in Davao City is a complex, multi-faceted experience which has occurred over six years. It is not possible for this lesson learning publication to capture and analyse every element of this experience. Therefore, it is necessary to make a specific focus. Overall, the key success of the project was the strengthening of the Davao City Health Office - the local government health authority - to be able to successfully integrate CVD and diabetes interventions into its existing health provisions. The CHO is really the implementing agency of the City government concerning the public health programs, and can be considered as the main partner of HI in the implementation of the CVD program. Therefore, this lesson learning publication looks at:
- The most significant changes achieved by the CHO and the role of HI and other actors in facilitating or supporting these changes
- Practical recommendations and tools for HI to be able to replicate these actions in other contexts.
Philippines, 2011
Principles and Benchmarks

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Principles and Benchmarks

A

Definition of diabetes, cardiovascular risk factors and non-communicable diseases

The World Health Organization (WHO) defines “non-communicable diseases” (NCDs) as non-infectious chronic diseases, as opposed to communicable (infectious) diseases. The main diseases in the category of non-communicable diseases are cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. These diseases share certain risk factors: tobacco consumption, poor diet, sedentary lifestyle, excessive alcohol consumption. This category has been built based on the possibility for implementing joint prevention interventions. Cardiovascular diseases are diseases affecting the heart and blood vessels. The main disabling cardiovascular diseases include:

- Stroke leading to paralysis of certain parts of the body
- Heart attacks leading to heart failure and therefore severe limitation in the daily activities due to breathlessness from minimal physical activity
- Arteritis of the lower limbs leading to difficulties with walking.

These diseases are more likely to develop in people subject to risk factors known as cardiovascular risk factors (CVRF), mainly diabetes, arterial hypertension, blood lipid disorders (dyslipidemia), smoking, alcohol abuse, high salt intake, sedentary lifestyle, excess weight and obesity, a family history of similar diseases.

Some risk factors for non-communicable diseases are modifiable (unhealthy diet, physical inactivity and tobacco use) while some are not modifiable (age, heredity, genetic factors).

Type 2 diabetes, or diabetes mellitus, which is one risk factor of cardiovascular diseases, is characterized by progressive organ resistance to insulin. While hereditary and genetic factors play an important role, this type of diabetes can also result from a lack of physical exercise, a diet high in fat and sugar, excess weight and obesity. It can remain asymptomatic for several years, after which symptoms are minimal for a long period of time. This is why, in developing country contexts, where access to health care is difficult; the disease is often not diagnosed until the onset of chronic complications (1).

Treatment may simply involve following recommendations for a healthy lifestyle, complemented if required by oral anti-diabetic drugs, or even once or twice daily injections of insulin in certain cases. This is by far the most common type of diabetes (which affects around 90% of people with diabetes around the world).

B

Epidemiology of cardiovascular diseases and diabetes

According to the World Health Organization, non-communicable diseases, mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world, representing 63% of all deaths in 2008 (2). Out of the 36 million people who died from chronic disease in 2008, nine million were under 60 and 90% of these premature deaths occurred in low- and middle-income countries. 80% of cases of premature cardiovascular diseases and stroke, 80% of
type 2 diabetes and 40% of cancers could be avoided through healthy diet, regular physical activity and avoidance of tobacco use (3).

The countries of south-east Asia suffer from a double disease burden, that of communicable diseases that remain an important public health problem, as well as NCDs that have emerged as the leading cause of death. The main underlying determinants of non-communicable diseases, notably diabetes, are globalization, urbanization and population ageing (3). The nutrition transition partly explains the increase in the incidence of non-communicable diseases (4).

With an estimated 285 million adults living with diabetes in 2010 and 439 million by 2030, diabetes is increasing across the world. Between 2010 and 2030, there will be a 69% increase in numbers of adults with diabetes in developing countries and a 20% increase in developed countries (5). Other estimates are even worse, since according to the International Diabetes Federation, “some 366 million people worldwide, or 8.3% of adults, are estimated to have diabetes” (6). The latest estimations state that 6.8% of all cause mortality is attributable to diabetes (7) and the WHO projects that diabetes will be the 7th leading cause of death in 2030 (2). Diabetes is therefore, without doubt, a serious public health problem.

Almost 80% of diabetes deaths occur in low and middle-income countries (8). Almost half of diabetes deaths occur in people under the age of 70 years; 55% of diabetes deaths are in women. The World Health Organization (WHO) projects that diabetes deaths will increase by more than 50% in the next 10 years without urgent action. Most notably, diabetes deaths are projected to increase by over 80% in upper-middle income countries between 2006 and 2015 (9).

### Diabetes, cardiovascular diseases and disability

If not correctly managed, diabetes and other cardiovascular diseases can have serious disabling impacts and potential long-term complications (1): blindness, hemiplegia, heart failure, renal failure, chronic ulcers, lower limb amputation, erectile dysfunction, vascular dementia... Moreover, living with a chronic disease often leads to psychological disorders (10). As reported by the International Diabetes Federation (IDF), every 30 seconds a lower limb is lost due to diabetes, whereas 85% of all diabetes-related amputations are preceded by foot ulcers and therefore can be prevented (11).

The aforementioned diabetes-related impairments can lead to long-term physical, sensorial, psychosocial, psychological and intellectual impairments which, in interaction with various environmental and social barriers may hinder the full and effective participation in society of persons living with diabetes and thus place them in disabling situations. According to the World Report on Disability (12), estimations show that non-communicable diseases are estimated to account for 66.5% of the years lived with a disability in low and middle-income countries (13).

Finally, people with disabilities can be more vulnerable to NCDs (primarily due to reasons of poverty and social exclusion) - and we must therefore ensure that projects on NCDs are accessible to people with disabilities (14).
Diabetes and HI’s mission and goals

Handicap International (HI) is an independent and impartial international aid organization working in situations of poverty and exclusion, conflict and disaster. Working alongside persons with disabilities and other vulnerable groups throughout the world, our action and testimony are focused on responding to their essential needs, improving their living conditions and promoting respect for their dignity and their fundamental rights.

With a network of eight national associations (USA, Belgium, Canada, France, Germany, Luxembourg, Switzerland, and United Kingdom), Handicap International, founded in 1982 and co-recipient of the Nobel Peace prize in 1997, has programs in 60 countries and acts in both emergency and development situations.

People living with disabling diseases constitute one of the categories of beneficiaries listed in Handicap International’s Scope of Activity: “Persons suffering from a usually chronic disease which affects the integrity and function of one or several organs and may lead to activity restriction. Without treatment or adequate care management the disease may at some point result in irreversible physical, sensorial or mental impairments.” (14)

Diabetes, a disabling disease, features in Handicap International’s reference documents, including the Scope of Activity and 2011-2015 Federal Strategy. Indeed diabetes, as well as other chronic diseases, is defined in the latter as one of the priority themes for achieving impact.

Handicap International is committed to diabetes and other cardiovascular risk factors control for several reasons:

- In our intervention zones, the needs, in terms of the diabetes and other cardiovascular risk factors epidemic, are immense
- Whilst there are low cost effective interventions which can be put into place, the health systems in developing countries are not always able to do so
- As disabling diseases, diabetes and other cardiovascular risk factors fall under the organization’s scope of activity
- The international mobilization against this epidemic is still emerging.

For detailed information about Handicap International’s position on diabetes and other cardiovascular risk factors, please refer to the full 2012 Policy Paper:


In 2006 HI reoriented its approach towards prevention of disabilities and launched its diabetes control campaign. In the first phase several projects were implemented in Thailand, Mali, India, Philippines, East Africa and Nicaragua. For HI, diabetes has been a starting point for working with people living with non-communicable diseases. Since 2009, instead of adopting a vertical, disease-based approach, HI decided to widen the scope of intervention, targeting cardiovascular diseases and diabetes in order to increase the cost efficacy of the
interventions. This approach has allowed us to support health and social systems in pilot countries through the changes required to manage these diseases, and subsequently to conduct synergistic actions on other cardiovascular risk factors (arterial hypertension, lipid disorders, excess weight, etc...) in a second time. Currently, it carries out diabetes and CVD prevention actions and provides, in collaboration with local partners, care and support for people with diabetes in the Philippines and Nicaragua.

Handicap International’s approach is focused on the following strategic axis:

- Support to local Health Systems in the integration of diabetes prevention, care and management in the continuum of care of the existing services;
- Provision of technical support to health professionals (nurses, doctors, etc.) through training in prevention, diagnostics, patient education and medical follow-up;
- Support to the creation/ strengthening of the local rehabilitation services with a special focus on the access to quality services;
- Strengthening the civil society for advocacy and lobbying purposes.

Diabetes: a major issue in the Philippines

In the Western Pacific Region (TGHE Philippines) 132 million adults have diabetes, the largest number of any region. This region contributes 4.7 million of the 17.3 million global cardiovascular disease deaths (6).

The Philippines are a group of islands in Southeast Asia with a projected population of more than 98 million in 2013 making it the 12th most populous country in the world (15). Wild et al in an article on the “Global Prevalence of Diabetes” published in Diabetes Care estimates that the Philippines will be one of 10 countries with the highest number of diabetes cases by 2030 (16). According to the estimations of Shaw et al. for 2010, diabetes prevalence in the Philippines is 6.7% and will increase to 7.8% by 2030. In other words, 3.4 million of people are currently affected by diabetes and this will increase to 6.2 million by 2030 (5). The 2005 Philippines Health Statistics states that diabetes mellitus is the 8th leading cause of mortality in the Philippines and accounted for 18,441 deaths. Heart diseases and vascular system diseases (diabetes is a major risk factor) are the first and second causes of mortality at the national level (17). NCDs have replaced the positions of infectious diseases particularly pneumonia and tuberculosis as top-most common causes of deaths.

A cross-sectional population-based study was conducted in 2002 among 7044 adults aged 20-65 years old residents of urban and rural areas in Luzon in the Philippines estimated the crude diabetes prevalence to 5.1% which represented a 54% increase over the figure (3.3%) in 1982. Only one in three diabetics reported that they had diabetes (18).

A cohort study conducted in 6 of the Philippines’ 13 regions in 2007 by Soria et al. stated that the 9-year incidence of type 2 diabetes mellitus (T2DM) was 16.3% among Filipinos and the prevalence of diabetes was 28.0% (19).

In Davao City, according to the City Health Office, over the period 2004-2008, diabetes was ranked the 7th all-age leading cause of mortality with 279 deaths on average annually or 20.6 per 100,000 inhabitants.
Philippines Health System and the role of City Governments and City Health Offices

In its current decentralized setting, the Philippine health system has the Department of Health (DOH) serving as the governing agency, with both local government units (LGUs) and the private sector providing services to communities and individuals (20). The DOH is mandated to provide national policy direction and develop national plans, technical standards and guidelines on health. The DOH was made the “servicer of servicers” by:

1) Developing health policies and programs
2) Enhancing partners’ capacity through technical assistance
3) Leveraging performance for priority health programs among these partners
4) Developing and enforcing regulatory policies and standards
5) Providing specific programs that affect large segments of the population
6) Providing specialized and tertiary level care.

Under the Local Government Code of 1991, LGUs were granted autonomy and responsibility for their own health services, but were to receive guidance on health matters from the DOH through its network of DOH representatives under the supervision of the regional Centers for Health and Development (CHDs). The LGUs make up the political subdivisions of the Philippines, LGUs are guaranteed local autonomy under the 1987 Constitution and the LGC of 1991. The Philippines is divided into 78 provinces headed by governors, 138 cities and 1496 municipalities headed by mayors, and 42 025 Barangays or villages headed by Barangay chairpersons (NSCB, 2010). Legislative power at local levels is vested in their respective ‘Sanggunian’ or local legislative councils. Administratively, these LGUs are grouped into 17 regions. The LGUs serve as stewards of the local health system and therefore they are required to formulate and enforce local policies and ordinances related to health, nutrition, sanitation and other health-related matters in accordance with national policies and standards. They are also in charge of creating an environment conducive for establishing partnerships with all sectors at the local level.

Public health in the Philippines consists of program packages for the prevention, management and control of diseases, as well as the promotion and protection of health. To ensure access, these health program packages have been adapted to the various levels of health care delivery (from community-based to tertiary level facilities), to various population groups (mothers and infants, children and adolescents, adults and older persons), and to specific diseases (tuberculosis, malaria, cardiovascular diseases, cancer) (DOH, 2005).

The prevention of cardiovascular diseases, diabetes mellitus, chronic obstructive pulmonary disease, breast and cervical cancers is advocated and promoted through the healthy lifestyle and management of health risks program of the DOH. The system is managed by the DOH and the local government units (LGUs). While direct delivery of public health services is no longer the DOH´s function, it provides the LGUs with technical assistance, capacity building and advisory services for disease prevention and control, and also supplies some medicines and vaccines. Public health workers such as doctors, dentists, nurses, midwives and volunteer...
barangay health workers (BHWs) administer the public health services in the communities. inequities are noted in the distribution of such health facilities and human resources for health, as most facilities are concentrated in the National Capital Region (NCR) and Luzon areas, while southern Mindanao has the least. The provincial governments, through their City Health Offices (CHO), are in charge of the public health programs as well as city hospitals. A local health board chaired by the local chief executive is established in every province, city and municipality. It serves as an advisory body to the Sanggunian (local legislative council) on health-related matters. The DOH is represented in all local health boards by the DOH representatives.

Figure 1: Philippines Health System
Brief overview of the project

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Brief overview of the project

A

Project background and rationale for intervention

HI started working in the Philippines in 1985, primarily in the rehabilitation sector. HI is now one of the key organizations addressing disability issues in the country. It has wide range of complementary projects which assist to enhance people with disabilities' access to services, to promote their active participation and social inclusion, to develop partnerships at all levels in line with national and international policies, and to reduce the impact of natural disasters and conflicts. Before the 2007 Diabetes Project, HI’s interventions in Davao City had focused on supporting a local partner’s prosthesis workshop: the Davao Jubilee Foundation.

Diabetes care is still not sufficiently integrated into the Philippines' public health system. The programs most strongly supported by nongovernmental organizations are mainly focused on the prevention and control of communicable diseases. In 1986, the national Non-Communicable Disease Prevention and Control Program started with programs on cancer, CVD and diabetes control. This evolved into the Integrated Non-Communicable Disease Prevention and Control (INCDPC) Program in 2003. The INCDPC framework focuses on primary prevention through promotion of healthy lifestyle and does not include adequate provision for the strengthening of diabetes care services.

Before 2007, services for the management of NCD risk factors like diabetes were provided by private clinics and tertiary care facilities the cost and location of which made services inaccessible to many. Care and rehabilitation of people living with diabetes were largely unavailable. One reason for this gap is the highly decentralized system of service delivery with the responsibility resting mostly on local government units (LGU). Availability of services is dependent on the current leadership’s priorities, local resources and capacity of local stakeholders to operationalize existing national programs. Therefore there was a considerable gap between the existing national NCD framework and the much needed services for NCD prevention and control.

Davao City, with an estimated population of 1.5 million in 2011, is one of three major cities in the Philippines. With a total land area of 244,000 hectares, its population is distributed in both rural and urban areas with many people located far from urban centers where most health services are available. The city is divided into 182 Barangays - the smallest political units. There are 198 Barangay health centers in Davao City distributed in 16 district health centers managed by the City Health Office.

The city of Davao was chosen to develop the project because:

- Since 1992, Handicap International has been working in partnership with the local NGO, Davao Jubilee Foundation. This partner wanted to develop a diabetes control project. HI should provide technical support and finally took the project in hand;
- According to the exploratory mission by HI in 2006, Diabetes was the sixth leading cause of death in this city (Statistical report 2005 for the city of Davao [City Health Office]) and the...
third reason for orthopaedic fitting in the rehabilitation centre that partners Handicap International (Davao Jubilee Foundation) (Statistics for 1996 - 2004 for the Davao Jubilee Foundation rehabilitation centre);

- The city is already equipped with public and private healthcare structures from primary through to tertiary level;
- The Davao City government and the City Health Office were really interested into participate to the project.

With a national framework and the presence of various local resources in Davao City, the main challenge was to capacitate stakeholders and bring them together to bridge this implementation gap in order to increase access to much needed services.

The Pilot phase 2007-9

HI took on this challenge through a three-year pilot Diabetes Project implemented in 10 pioneer Barangays in Davao City from 2007 to 2009, with funding support from the Ministry of Foreign Affairs of Luxembourg and Sanofi Aventis. HI assisted in decentralizing diabetes prevention, care and management. It was implemented with a local inclusive development approach focusing on the autonomy of and coordination between local stakeholders in order to achieve sustainability.

The pilot project’s aim was to increase access to multidisciplinary integrated diabetes management at the community-level by capacitating the City Health Office (CHO) - the public primary health care provider, Davao Jubilee Foundation (DJF) - a local rehabilitation service provider, Diabetes Support groups and Barangay local government units. Primary health care professionals (PHCPs) and community health workers (CHWs) of the CHO were trained on the basic care for people with diabetes. This project also established a local approach to diabetic foot care and management. The project trained DJF technicians to upgrade their skills in producing prosthesis and orthotics (P&O) appropriate for people with diabetes. General information, patient education and health service provision tools were developed and pilot tested. The emphasis on preventive foot care and rehabilitation made the Diabetes Project unique. Foot care was integrated in the trainings, education materials, health center services, referral and monitoring. Finally, advocacy work resulted in improved financial and geographical access to medicines and blood sugar testing.

The minimal recommendation for diabetes care delivery in resource limited countries is “to organize care around the person living with diabetes, using an appropriately trained healthcare professional to deliver the diverse aspects of that care” (21). In the Philippines, this recommendation has been applied in the pilot project for decentralizing care to public primary health care centers, through “Diabetes Day”.

“Diabetes Day” is a day dedicated to diabetes care, whereby health services are delivered through a multidisciplinary team, including diabetes consultation (doctor), diet counseling (nutritionist), diabetes education (nurse), basic foot care and monitoring (Barangay Health Workers). It is a first in the Philippine public health system, implemented on a weekly or monthly basis, and only in pilot health centers. It increases geographical access to diabetes care services, which were previously only available on the tertiary care level and from private institutions.

Support for local stakeholders in initiating Diabetes Day goes beyond looking at their
technical capacities or human resources. It requires the participation of a variety of community stakeholders (in the health care team, local government, civil society organizations) working together to address the various needs of people with diabetes that go beyond the remits of the healthcare team. Providing diabetes services in public primary health care centers is a culmination of various parallel efforts focused on the same goal.

Community level diabetes support groups were also organized. Support was provided in strategic planning and organizational development so that these organizations were able to advocate for access to services as well as find additional resources to support the cost of care of its members. In order to get support from LGUs, diabetes education sessions for policy makers were conducted.

The pilot phase of the project was highly successful and attracted significant interested from key health providers in Davao City. HI capitalised on this interest and worked with these actors to propose a massive scale up of the project.

The Second Phase - scaling up - 2010-13

Based on the 2007-9 pilot phase, the scale-up CVD Project was launched in 2010, in order to continue the decentralization of diabetes prevention, care and management to all of the 182 Barangays in Davao City. The CVD Project continued the multidisciplinary and integrated approach to care for people with CVD risk factors (including diabetes) that was used during the Diabetes Project.

A multi-stakeholder partnership was formed to implement a city-wide CVD Program with diabetes and hypertension as entry points. The CVD Program is the program implemented by the CHO at the city level in order to increase access to services by implementing the Diabetes and Heart Day (DHD) in every Barangay Health Centres. This program refers to the DOH’s National Cardiovascular Diseases Prevention and Control Program (NCVDPCH)(22). While the CVD project is the HI project, including the CVD Program, but focusing on capacity building of CHO, DJF and Local Diabetes Support groups (LDSGs) and partnership building.

Policies were created to support the program, a series of tools for health services delivery were elaborated and health services were put in place including medical nutrition therapy and basic laboratory. The Project covering all 182 Barangays aimed to replicate good health service delivery practices developed in the first phase and to operationalize the national Integrated Non Communicable Disease Prevention and Control (INCDPC) framework, through complementary primary, secondary and tertiary level interventions. Primary health care professionals and community health workers were trained on Project implementation in the first half of 2011. The setting up of basic health services for CVD risk management became the priority. An important component of the project was creating a referral system among health and rehabilitation service providers. Awareness raising activities targeting both general public and policy makers were organized to promote the health services already in place.

Aside from the capacity building of health service providers, the project also worked with one pre-existing diabetes club and six smaller local diabetes support groups organized during the first phase of the project so that they can implement and sustain their activities. Peer support/education is now piloted in all these organizations.
The City Government of Davao with the City Health Office (CHO) as its implementing arm accepted the responsibility of being the primary implementers of the CVD Program and required all its health care professionals and community health workers to be trained on its implementation. Relevant policies (regulations/ordinances) were put in place to mandate the implementation of the CVD Program. The city already passed two resolutions recognizing the celebration of World Heart Day on September 29 and World Diabetes Day on November 14. The City Tax Code was revised to accommodate laboratory tests important in the monitoring of diabetes.

Increasing access to health care services through the decentralization of care is a key concern for HI’s diabetes projects. This is especially challenging since the diabetes projects are piloted in various low resource settings.

Today, project ownership among stakeholders is strong and solid partnerships developed. This approach for supporting local stakeholders in the decentralization of diabetes care may be useful for other countries with similar health care systems.

### Table 1: Summary of HI’s pilot diabetes project (2007-9) and the scale-up CVD project (2010-13)

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<td>Davao Jubilee Foundation</td>
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Lesson Learning Process and Summary of Findings

A. LESSON LEARNING – SELECTING A FOCUS

B. METHODOLOGY

C. KEY LESSONS LEARNED – CHANGES OCCURRING IN FIVE MAIN AREAS

D. SUMMARY OF KEY LESSONS LEARNED
Lesson Learning Process and Summary of Findings

Tips: how to read this section of the document

In this part of the document we explain how and why we decided to focus on the Davao City Health Office for this lesson learning study. We then explain the methodology for capturing and analysing the lessons learned.

The lessons learned are organised according to a set of generic “competencies” that might apply to any local health authority coordinating diabetes prevention and management services. We use these competencies to present and analyse the most significant changes achieved by the CHO in Davao City.

Lesson learning – selecting a focus

What do we mean by learning lessons?
The objective of this process was not to make an evaluation of the whole project or to measure the results against specific criteria and indicators. Rather, we wanted to take a more subjective, qualitative look at specific aspects within the project to analyse the more indirect ways in which change had occurred - and to try to draw out generalisations which could be applicable in other contexts. HI’s standard methodology for lesson learning (23) requires selecting a specific subject focus. This should be:

- an important experience which has perhaps not occurred in other countries
- something which we can analyse in great depth
- something from which we can develop very specific, targeted and practical recommendations for HI staff working in other contexts

Overall the CVD project, scaled up from 10 Barangays to all 182 Barangays of Davao City, with significant strengthening of local service provision, can be considered to be highly successful. However, after six years of project implementation there are many different lessons to learn and it is impossible to capture and analyze all of them in detail. Our lesson learning process originally started with a Learning Paper in 2012, made by the CVD project team in the Philippines. A Learning Paper is a rapid lesson learning exercise to review the whole project experience from a macro, project management perspective. From this exercise we were able to see what had really worked well in the project and what had been more problematic.

Following the Learning Paper we then worked with the HI Philippines Program Technical Coordinator, the Project Team, the Technical Advisor and the Knowledge Management Unit to try to identify a specific focus for a more Detailed lesson Learned Review.

The major success from the project — which has not happened in other countries — was the significant strengthening of the City Health Office (CHO), which had taken the very general WHO Guidelines & National Policy and developed a specific Davao City Policy, helping to scale up the CVD project massively and providing the resources to implement quality services.

1. http://www.hiproweb.org/fr/accueil/secteurs-de-competence-/activites <*> /secteur-de-competence/sante-et-prevention/maladies-non-transmissibles/docs/liste.html?tx_hidrtdocs_pi1%5BuidDoc%5D=886&cHash=5351e6de69
The decision of focusing specifically on the CHO does not mean the rest of the project was less successful or important, but was made in order to provide a clear overview about a public health approach to chronic care integration in an existing health system in a low/middle income country, and to act as a guide about how it could be replicated in a different locations with a similar socioeconomic context.

**Lesson Learning Focus:** How to develop the capacities of local government to integrate CVD and diabetes prevention and management into existing health systems - based on the Davao experience

**Primary target audience:** HI staff working on the issues of diabetes, cardiovascular disease and non-communicable diseases in countries around the world. But also partners and key stakeholders in the Philippines who may wish to develop or replicate the Davao experience in other cities.

The approach is based on collectively identifying the most significant changes that occurred during the project. More specifically we wanted to identify how the CHO had changed since 2007. This does not mean changes in terms of statistics or numbers of patients for example. Rather, we were looking for the key milestones in the CHO's development, in terms of changes in behavior, technical competencies and activities. Once we had identified the key moments of change during the project, the most important were placed within a timeline and then each one was analyzed in detail, to break down the different factors which made the change possible.

Identifying and categorising these types of changes can be complex. We therefore developed a framework to organise our interviews and subsequent analysis.

We developed a set of universal competencies that might apply to any local health authority acting on CVD/Diabetes policy implementation. This is a generic list of competencies that could apply to any City Health Office in a low- and middle-income country with a decentralized health system. The standards were adapted from the WHO Stakeholder Analysis Guidelines (24) but also HI’s Access to Services Framework (25).

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The 16 ‘competencies’ (See Appendixes) are very much overlapping and inter-connected. But for each one, we tried to analyze with the HI team:

- The national policy framework
- The CHO’s role and competencies before the project in 2007, in terms of accessibility/organization/availability of care services, organization of the health system, etc.
- The CHO’s current role and competencies

We then identified on a timetable/schedule:

- The most significant changes or milestones that were achieved (26) by the project (a positive change as well as a big challenge or difficulty experienced) - the “key moments” in the project’s development
- The key factors for achieving those changes (i.e. the specific actions of HI and other actors) - the “success factors”
- The specific contextual factors for Davao (for example any political, environmental or economic brakes and levers)

Starting with our reference point of 16 generic competencies (which could apply to any local health authority) we analyzed the key moments of change for the CHO in Davao City. From this list of 16 we then narrowed down the 5 most important competencies which related specifically to the CHO of Davao City.

Therefore, in the lessons learned section of this document we refer only to 5 competencies or ‘areas of change’ - and not to all 16 from the original framework. That is not to say that the other 11 competencies are not important. It is just that these 5 were most relevant for the Davao CHO and correspond directly to a key moment in the development of the project. In another city or country context it could be different.

It is important to note that this report is not the result of applied academic research. It is a qualitative assessment that was undertaken to capture what worked well at field level according to the actors who implemented the project. Some of the limitations experienced during the research include the fact that it draws heavily on the project’s team and partners’ testimonies, the short timeframe and language barriers.

Key lessons learned – changes occurring in five main competency areas

Competency 1: The CHO is willing to take a lead role in pushing for health policy reform on CVD and Diabetes; and develops a robust policy which is specific and relevant to the context

The national policy framework:

According to the Manual of Operations 2009 of the DOH (27):

- The CHO recommends the adoption or formulation of their own Integrated NCD Prevention and Control Policy Program
- The CHO recommends the formulation of local policies and ordinances to provide a supportive policy environment for the implementation of NCD prevention and control programs
- The CHO lobbies for the LGU’s compliance to NCD-related national laws and policies
Situation before the project:

The National Cardiovascular Diseases Prevention and Control Program (NCVDPCP) was launched in 1992 by the DOH (22). In 2000, the framework for Integrated Community-Based Non-Communicable Diseases Prevention and Control Program (INCDPCP), based on the WHO global strategy for NCDs prevention and control, has lead to the National Healthy Lifestyle Program (2000-2006) (28). This program is mainly an awareness-raising campaign which aims to decrease morbidity, disability and premature deaths attributed to NCDs, through dissemination of information, education and communication materials targeting the common preventable, lifestyle-related risk factors (primarily tobacco use, unhealthy diet and physical inactivity). In addition to this campaign, the national government launched a Proclamation No.973 in 2003 which declared cardiovascular disease prevention and control a priority program of the government (28). All government agencies are required to collaborate with the Department of Health and the Department of Interior and Local Government and give full support to all the activities under the NCVDPCP (22). The first Manual of Operations on an INCDPCP (29), which puts in one document guidelines, policies and standards in the delivery of NCD prevention and control services, was written in 2007 by the DOH, in collaboration with the WHO. The second version was written in 2009 (27). But even if the DOH (national) has this program, it has not translated into concrete health services in Davao City.

The program was launched but it was not possible to continue the activities mainly due to:

1. Lack of operational policies at the local level
2. Lack of defined and clear-cut tools and protocols (for program implementation)
3. Lack of community involvement (approach is not multi-stakeholder)
4. Lack of financial resources/funds: priority was given to communicable diseases programs which are funded by the national government through the DOH.

The CHO, as an implementing agency and not a policy-formulating institution, pushes for policies via the Local Health Board. The Local Health Board (composed of representatives from various government offices including the CHO, representatives of the DOH...with the City Mayor as Chairman) is the one proposing policies at the city level. Composition of the local health board is not purely health care professionals (it also includes lawyers, city planners, accountants, etc). The City Council, composed of elected councillors, is the policy-formulating body of the city (the chairman of the City Council is the vice-mayor).

Process 1 of policy formulation (City Level only):

(1) Local Health Board ->(2) Councillor who will sponsor the policy ->(3) City Council who will debate, recommend, approve the policy ->(4) City Mayor for final approval

Process 2 of policy formulation (City Level only):

(1) Councillor who will sponsor the policy ->(2) City Council who will debate, recommend, approve the policy ->(3) City Mayor for final approval

These two processes are different only at the origin, because a policy can originate either from the (1) Local health board and/or (2) any city councillor. That means that a councillor can get policy ideas from local health board or from his or her own
(through constituent meeting, personal interests, etc).
The local health board cannot propose policies at the national level. Policy at the national level is through the House of Representatives (composed of elected congressmen all over the country) and the Philippine Senate (composed of 24 elected senators), via the DOH (for a health policy).

Current situation:

Operationalization of the national policy:

With a NCD policy already existing at the national level (27), the challenge for HI was to define clear-cut protocols to implement the national NCD Prevention and Control Program. The CVD program is thus a local adaptation and operationalization of the CVD Manual of Operations 2009 (27), with a focus on 2 out of the 5 NCDs.

From the beginning of the program development, the DOH recommended the coverage of all 5 NCDs. In the DOH integrated NCD risk factors management program (27), the scope of intervention includes:
- Malignant neoplasms or cancers
- Chronic Obstructive Pulmonary Diseases (COPDs) and related conditions
- Diseases of the heart
- Diseases of the vascular system leading to hypertension
- Diabetes mellitus.

The CVD Program, supported by HI, is an integrated NCD Risk-Factor Management Program, addressing the major risk factors of non-communicable diseases and focusing on two diseases – Diabetes mellitus and hypertension. The CHO and HI decided to limit the CVD Program coverage to diabetes and hypertension for the time being to be able to effectively concentrate on and provide quality concrete services for diabetes and hypertension control at the Barangay health centres while addressing other risk factors common to all NCDs such as smoking, obesity, physical inactivity, and hypercholesterolemia.

Policies at city level:

- City government level (approved and signed by the City Mayor):

After the adoption of their own Integrated NCD Prevention and Control Policy Program, the CHO had also to formulate local policies and ordinances to provide a supportive policy environment for the implementation of the CVD Program. For this, the Davao City Health Office has achieved the following:

- A CVD Program MOU, with City Ordinance granting authority to the City Mayor to sign/approve the MOU (2011). This mandates the formulation (including implementation, monitoring and evaluation) of an integrated NCD prevention, management and control program.

- The CHO, through the Local Health Board and through the office of the city councillor for health, has worked on the approval of various policies to support the CVD Program. It can be said that the CHO has gained some experience in lobbying for specific policies to support the implementation of the program and was instrumental in the passage of these policies. Examples of this include:

  - World Diabetes Day (WDD) Proclamation in Davao City (2008)
  - World Heart Day (WHD) Proclamation in Davao City (2011)
  - Revision of the City Tax Code to include the CVD Program Laboratory services (2012): the aim is to authorize the City Treasurer’s Office to collect fees for the testing of blood cholesterol, HbA1c and urine albumin; and to ensure the availability and sustainability of these affordable
laboratory services in the city's 16 health districts and the main City Health Office laboratory. Because of this revision, these services can also be availed through the city's indigency programs and the Philippine health insurance system.

- **CHO level:**

The CHO pushed for the Diabetes and Heart Day (DHD) resolution in the Local Health Board, making CVD Program a local policy and a regular program of the city (not a "special project" of the CHO any more). The CHO also released an office memo, for DHD to be held every Friday. As the Barangay health centres are under the governance of the CHO, they have to respect the resolution of the Local Health Board (*refer to change area 3*).

**Policies at Barangay level (approved by the Barangay captains):**

HI and the CHO have presented the CVD Program to the Barangay captains, in order to get their support through the formulation of Barangay level policies to ensure that the program is able to reach people in the communities. The Barangay governments are under the city government, so they have to respect the city government policies (like the WDD, the WHD and the revision of the City Tax Code) but as the system is very decentralized, they have to formulate their own policies to ensure the implementation of the services in the Barangay.

**Policies at internal level:**

Apart from lobbying for policies within the City Government, the CHO has also lobbied for policies inside its CVD Program partners. In 2011, the CHO through its City Health Officer sent a letter to the Chief of Hospital of Southern Philippines Medical Center (SPMC) – the public tertiary health care facility - requesting for out-patient consultations to be free of charge for patients referred via the CVD Program. This request was subsequently approved and is now a hospital policy.

Moreover, in the context of the CVD Program, the CHO together with other members of the Technical Working Group (TWG) develop practical guidelines for the implementation and the monitoring of the services.

Some manuals/guides in each institution are currently being developed:
- in SPMC and DJF: about the referral system
- in the CHO: about the referral system, health services, monitoring/reporting and training/orientation of new personnel

The manuals are technically written by HI, in collaboration with the partners, based on what is actually done and also based on the workshops with the partners. The manuals are a "how to" document, they do not contain indicators and targets. Policies will be developed in each institution in order to officially recognize the manual. The aim of the policies is to institutionalize and sustain the CVD program. The different manuals will be merged into one, to ensure the sustainability and replication of the project in other cities.

**External assessment of the CVD Program through policy research:**

Finally, the CHO also introduces the CVD program to policy researchers. An example would be that policy research on nutrition uses the CVD Program as its research subject. The researcher is a faculty of the University of the Philippines College of Public Health and a graduate school student from Chulalongkorn University in Thailand.
Some contextual factors specific to Davao made these changes possible:

- There is already a policy at the national level, so HI doesn’t need to work on the approval of a NCD policy by the DOH; and the CHO has to implement this policy.
- Davao City has always been very open to NGOs and it is very supportive to having national programs to be pilot-tested in the city.
- Davao City is already recognized as ahead among its peers when it comes to policies for NCD control because of its tobacco control policy. In 2002 the City Government of Davao passed the Comprehensive Anti-Smoking Ordinance ahead of the National Tobacco Regulations Act of 2003 which mandates the Department of Health to implement a National Smoking Cessation Program.
- There was a new election and a change of Mayor in 2010: the new Mayor Sara Duterte-Carpio is involved in the program and accessible.

The City Mayor at the start of project implementation (2010) is hands-on when it comes to health. The Mayor sat down in Local Health Board meetings; hence, decisions are easily accepted.

- Dr Al-ag is the Chairman of the Committee on Health of the City Council or Sanggunian: all policies about health pass through his office. HI did not have any direct professional link with him prior to the CVD Program which was started in 2010. Involvement of Dr. Al-ag in the program hastened the accomplishment of the policy requirements of the CVD Program, by sponsoring policies and providing very valuable advice on the city legislative process.

In the Philippines, it is very difficult to convince politicians to advance/advocate a specific cause or policy, but Dr Al-ag knew about Handicap International before the CVD project, because he was active with Davao Jubilee Foundation (DJF). During the course of project implementation, the relationship with Dr. Al-ag became stronger when he became Chairman of the Board of DJF.

The key moments in the CHO’s role on CVD policy development and the factors for their success:

- **Key moment 1:** In January 27, 2010: Local Health Board Meeting (CHO initiative). This included:
  - Naming of CVD Program coordinators: CVD Program coordinator (nurse: Chona Dazon) + CVD Program medical coordinator (Dr Agosta), introduced by the CHO - new functions
  - Next steps and necessary policies for the CVD program development at the city level identified

The success factors for achieving this change were:

- HI proved that it is possible to integrate services in the existing health centres, with the results of the pilot phase.
- HI asked to the partners what they wanted to do and how they wanted to achieve it.
- HI, through the Project Manager, was able to develop a good relationship with the City Health Officer (Dr Villafuerte) who was invited to a meeting about diabetes in Madagascar in 2009. By spending time with her and introducing the work of HI to her, we managed to develop not only a professional relationship but also a personal one. From that time, the City Health Officer was more interested and involved in the CVD Program and she was really helpful in the development of the CVD program at the city level. She also pushed for the creation of 2 new functions of CVD Program coordinators and initiated the meeting between HI and the Local Health Board.
The Local Health Board is the right place to discuss about the CVD program, because it is the one proposing policies for the extension of the CVD program at the city level.

The CHO had already an experience working with international NGOs (such as World Vision, on Tuberculosis program) that provide training to public health workers, service providers, tuberculosis support groups. The CHO knows that this kind of collaboration is possible; World Vision showed that it is possible to develop a program, and that this program can be replicable in other areas.

HI took some time (at least one year) to explain the project and the role of HI (capacity-building, support methodology and not providing some medicines...).

So the partners realized that even if HI leaves, the services can continue.

HI has been consistent with the CHO in delivering what has been promised. And therefore HI was recognised as a dependable actor for partners.

The first phase and the partners’ exposure to HI via international events showed them that they are dealing with organization like HI with high technical standards.

HI created a highly professional team, which could speak the same language as the partners and work directly with them. The HI team is technically competent: doctor, nurse, nutritionist, communication and management (the first project manager [during the first phase] knew how to coordinate the team and the different partners). The team has a complementary set of technical capacities, and management (good recruitment process: persons with complementary background). The team members stayed a long time, so there was a continuity of the approach. Flexibility and autonomy were given to the project manager to build his team: this is a success factor for all the project, for the first phase of the project, and the success of the first phase is a success factor for the local health board meeting.

“It is very easy to work with HI, because usually other NGOs demand so much... We have a really good working relationship with HI, because they tell us precisely what is our role on the non-communicable diseases, what we can do, what we cannot do... All was clear since the beginning. They explained clearly what is expected out: this is what we want.”

Dr Josephine Villafuerte, Davao City
health Officer

Key Moment 2: In March 2011: Dr Al-ag became CVD program’s champion (first interaction with the City Councillor for Health)

He worked on the MOU and he facilitated the approval of the following:

- the ordinance to authorize the mayor to sign the MOU
- the World Heart Day Proclamation
- the revision of the City Tax Code

The success factors for achieving this change were:

- The CHO engaged HI in orienting Dr Al-ag when he asked for an orientation from the CHO when the MOU was given to the Health Committee à we were thus able to engage the legislative component of the City; working hand to hand between the legislative and executive arms of the government.
- HI asked Dr Al-ag to participate with us in The World Diabetes Congress in Dubai in December 2011 (with Dr Villafuerte, Chona Dazon and Dr Yumang), in order to orient him on HI and expose him to
global approaches to NCDs à huge work was done on the revision of the city tax code afterwards.

HI found a balance between bottom-up and top-down approach

“After the congress in Dubai, I was really convinced that diabetes is one of the major diseases now, where the City should act. If you want to convince other cities of the Philippines to implement the program, you have first to present them the problem and to show them the effects of CVDs, because many don’t realize that CVDs are a problem. Moreover, the fact that it required a minimum investment from the City Government convinced me to support the CVD Program.”

Dr Bernard Al-ag, Davao City Councillor for Health

Competency 2: The CHO collaborates with all the key stakeholders on the policy and its implementation

The national policy framework:


- CHO coordinates with national, regional, provincial levels for technical assistance and submit documents and reports as needed
- The CHO establishes links with Barangays and communities for social mobilization and participation.

The situation before the project:

No collaboration regarding NCD Prevention and Control (usually top-down management; key stakeholders were not involved).

The current situation - changes achieved as a result of the project:

The CHO, during the development of the CVD Program has ensured that technical assistance was sought from DOH regional and national level, as well as local experts and partners. It ensured that the CVD program is aligned with the DOH NCD program.

The CHO, through the HCPs in the district and Barangay health centres, advocates for support from Barangay Local Government Units (BLGU) in their implementation of the CVD program. An example would be that HCPs ask the BLGU to support the implementation of the CVD Program in their Barangay through the following:

1. Community mobilization (information dissemination, awareness raising in the community on the presence of the services or DHDs in the Barangays and advocacy)
2. Venue for DHDs (Barangay halls, community gymnasium, etc.)
3. Snacks for HCPs and patients
4. Logistics – use of equipment like sound system, chairs, tables, etc
5. Provision of glucose test strips

Moreover, a technical working group (TWG) for the CVD Program was created in 2010 composed of key stakeholders (HI, SPMC, City Government of Davao through the CHO, DJF and DOH-CHD Davao Region). This TWG is mainly responsible in the development of CVD and Diabetes services including implementation tools, minimum standards, quality assurance, monitoring and evaluation procedures, etc.

The Local Inclusive Development approach is used in proposing decisions related to policy and implementation of the CVD program. Key Stakeholders like SPMC, DOH,
persons with diabetes, LDSGs are gathered and consulted regarding actions to be made. An example would be the formulation of the CVD program MOU initiated and facilitated by HI. This MOU ensured that the roles and responsibilities for all key partners were clearly outlined from the beginning.

Some contextual factors specific to Davao made these changes possible:

The Davao City Health Office already has good relationship/collaboration with other program partners (SPMC and DOH) even before the beginning of the CVD Program.

The key moment in the CHO’s development, in terms of ensuring collaboration and partnership with partners: February 29, 2010: Multi-stakeholder MOU Workshop

- Each stakeholder identified roles and responsibilities (SPMC, DJF, DOH, CHO, some Barangay captains and persons with diabetes)
- Participatory development of the MOU
  - Identification of focal persons (in terms of operationalization) in SPMC (Dr Suzette Alegarbes, the head of the Mindanao Diabetes Centre), DJF (Chona Serra, Rehabilitation coordinator) and DOH (Dr Annabelle Yumang, NCD Coordinator)

The success factors for achieving this change were:

- Participatory development of the program: HI was never prescriptive; each partner identified by themselves what they can do for the program. The role of HI was more facilitation, coordination, technical support.
- The logistics ensured good food, venue selection, distance from the office, right environment, in order to motivate the partners. This implies that HI puts a high value on the persons and the partnership.
- Working with the right persons: because HI had an experience with the partners and knew well the key actors, HI was able to choose the focal person for each partner.
- It is important to choose the partners according to the needs, to the logical framework and to the HI model for local inclusive development (30).
- HI defined clearly the objectives and methodology of the workshop. The content was researched before the workshop (the signing of the MOU was easy because the process before was very clear for all involved, with lots of meetings, legal reviews etc...)
- HI took a lot of time to define the process for developing the MOU. HI prepared all the minutes of what was said by each partner.

Competency 3: The CHO is willing to take a lead role in developing and supervising quality CVD and Diabetes services

The national policy framework:

Subject to the provisions of The Local Government Code of the Philippines (31)
- Local Government Units (LGUs) should deliver (via the Health Offices) health services which include programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services; access to secondary and tertiary health services; purchase of medicines, medical supplies, and equipment needed to carry out the services herein enumerated.


- The CHO provides packages of services or interventions at the Barangay level to
prevent and control NCDs

The CHO upgrades facilities, deploys staff and equips them to deliver quality NCD prevention and control services

The situation before the project:
The Davao CHO was interested in CVD and NCDs in general and they also recognized the existence of the national framework. However, resources were not placed by the local government to fully operationalize this framework and the CHO did not prioritize the development of a health program, given the limited resources available.

Moreover, CHO personnel had limited technical capacities in the prevention and control of diabetes and NCD in the primary health care setting. The knowledge and common practice of the CHO health care professionals (HCPs) on NCDs were limited to disease-specific interventions such as diabetes. The main CHO approach was clinical/medical with the doctor as the only health service provider involved in management. There were no management protocols common to all health service providers and diabetes/CVD management depended on the clinical background and experience of the district doctor. The HCPs of the CHO at that time were not able to implement a standard program for diabetes and CVD because no program was present at city level. Although there were several frameworks coming from the DOH, there has been NONE of any of these NCD Programs that were successfully integrated in the existing health services. For example, there were no diabetes patient registries, no hypertension patient registries in the health system, no concrete screening activities for diabetes and its complications, no health education....all of these issues were to become a priority for HI’s CVD project.

The current situation, as a result of the CVD Program:
The NCD-MOP (Manual of Operations), released by the DOH in 2009 (27), was adapted (diabetes and Hypertension only) by the CVD Program and integrated into existing health care services. The CVD risk management package by WHO (32) and the WHO Package of Essential Non-communicable (PEN) disease interventions for primary health care in low-resource settings (33) are integrated in the public primary health care system through the CVD Program.

The CHO fully implements the CVD Program package of services called the Diabetes and Heart Day (DHD) in the Barangay and district health centres levels. The CHO now has the commitment to provide health services specific to diabetes and CVDs, in a multidisciplinary manner and at the community level.

The CVD Project has facilitated the capacity-building (provision of program tools, Information-Education-Communication (IEC) tools, equipment and staff training) of the CHO so that quality NCD prevention and control services are offered. The CHO has now a total of 63 trainers or experts, 340 HCPs and 2,001 CHWs who are trained to implement the CVD Program. As a direct result of the trainings done with the CHO, standard services during Diabetes and Heart Days are being implemented in almost all the health centres. The services are provided by both community health workers and health professionals (nurse, midwife, nutritionist...), with their roles in the multidisciplinary team clearly defined, therefore health services continue even in the absence of the doctor.

Finally, the CHO Coordinator and the City Health Officer are also sent to national and international diabetes conventions to improve their technical competence (ex: CHO’s participation in the World Diabetes Congress in Dubai in 2011 and in national diabetes conventions: Foot and Wound Care...
by Diabetes Philippines in 2012, Philippine Association of Diabetes Educators and Association of Diabetes Nurse Educators of the Philippines Joint Annual Convention (2011 and 2012)).
The CHO also supports the CVD program trainers and other staff in the health centres who want to attend conventions and trainings (for update of technical competence) through facilitating financial subsidy from the local government.

Some contextual factors specific to the Philippines and to Davao:

- The CHO is largely dependent on external institutions (like the Department of Health [DOH] or NGOs) for the initial implementation of health programs. They are mainly implementers and do not develop health programs. In Davao for example, it is notable that the CHO implemented the anti-smoking program or the CVD Program ahead of other cities and municipalities. So in many ways, the CHO is dependent on DOH when it comes to health trusts and programs (including frameworks, policies, etc) and it is dependent on other institutions for the operationalization of the health programs (ex: Tuberculosis Program with World Vision, CVD Program with HI, etc).
- The Davao City Health Office has a city-wide presence through its 198 health centres (already existing even before the project). Implementation of the program is therefore not too resource-intensive since there are already existing structures (buildings), relationships (CHO to the Barangay LGUs and immediate communities), and manpower.

The key moments in the CHO’s technical development and the factors for its success:

- Key moment 1: In September 2011, Diabetes and Heart Day (DHD) Services started after the completion of health care professionals (HCPs) and Community Health Workers (CHWs) trainings.

The success factors for achieving this key moment were:
- Flyers were distributed before the DHD by the Community health workers.
- The HCPs and CHWs received all the required forms and the tools for the training.
- The HCPs had the responsibility to train the CHWs in the Barangay health centres. HI assured the logistics and technical support for each of the CHW’s training.
- Before the beginning of the services, CVD Program District coordinators were named. They are responsible in the overall coordination of the CVD program activities in district and Barangay levels, which include implementation, monitoring and evaluation.
- The services for the DHD are already defined and the steps (registration, screening, laboratory, consultation, patient education and recording) are very clear.
- The multidisciplinary approach: the role of each HCP and CHW in the health centre is clearly defined.
- The CHO provided free blood sugar test to attract the population.
- Orientation of Barangays captains during the World Heart Day celebration, to present them the CVD program and ask them to participate. The orientation focused on the services of the CVD Program and the ways in which local leaders can help strengthen it. The purpose is to promote the program and to allocate some budget. It was an opportunity for the CVD program to really involve the city government. Attended by almost 250 Barangay officials and other government leaders the event intended to get support from the city’s officials through the
formulation of Barangay level policies and the implementation of projects/activities to ensure that the program is able to reach people in the communities.

**Key moment 2:** In July 2012, the CHO releases an office memo, following a resolution from the Local Health Board, for DHD to be held every Friday: the start of the uniform day of implementing the DHD, which follows the same pattern as other public health programs. Indeed, all national health programs (like the immunisation program, the tuberculosis program, the maternal and child health program...) have their own dedicated day in the primary health care centres. Thereby, the CVD program became more a regular health program of the CHO. That’s also increase the frequency of the implementation from once a month to every week.

The **success factors** for achieving this change were:

- HI initiated a participatory program review based on data collected through the CVD Program monitoring and evaluation system, which consolidates data from barangay health centres and which enables us to present data to the CHO.
- The review was presented to the City Health Officer and the Assistant City Health Officer for Operations (Dr Culas).
- The Assistant City Health Officer for Operations (ACHO-Operations) is the right person to act on the problems of implementation, because her role is to ensure the implementation of the health programs in the primary health care centres. The ACHO-Operations was also the one who pushed for the DHD resolution in the Local Health Board making DHD a local policy.
- Acceptance of the memo by the health centres, because now the CVD program is no longer a “special project” of the CHO but a regular program of the city. The Barangay health centres are under the governance of the CHO, so they have to respect the resolution of the Local Health Board.
- The flexibility of the project team to support CHO on administrative work related to the CVD program, like communication, letters, memos... (HI team has time and willingness to do that).

**Competency 4: The CHO encourages and ensures effective referral mechanisms between different service providers**

**The national policy framework:**


- The CHO establishes and operates a referral scheme to ensure patients needing higher level of care and services to access them.

**Situation before the project:**

No referral mechanisms between primary health care centres and tertiary/specialist or rehabilitation care centres.

The referrals of the CHO are typically:

- Without a standard form/tool
- Without clear-cut indications on the referral
- Referrals are sent to other service providers without a written agreement between them and the CHO
- Referrals are not recorded or logged or tracked

**Current situation – changes achieved by the project:**

The CHO, through the CVD Program, is now
implementing a three-way referral system for its patients requiring specialist and rehabilitation care.

The definition for the conditions for referral in the CVD program was developed in 2010 with the Technical Working Group composed of HI, CHO, DJF, SPMC and DOH. The referral system of the CVD program links different levels of care (as this is a public health system, the referral system links service providers which are either DOH-funded like SPMC and/or a charitable institution/non-profit organization like DJF).

The SPMC is the referral institution for tertiary and specialist care. The DJF is for rehabilitation services, including prosthesis and orthotics. The CHO is for primary and secondary care.

The CVD Program referral system which was developed with the stakeholders of the program (CHO included) has:

- An MOU between service providers to accept referrals from partner institutions.
- Trained HCPs to make appropriate referrals
- System of monitoring and logging referrals and counter-referrals
- Clear-cut indications on making the referral in each concerned service provider
- A single referral form/tool to be used by all concerned

The CHO is leading the coordination with SPMC in setting up this referral system. Moreover, CVD Program patients referred to SPMC are not charged the consultation fees.

**Some contextual factors specific to Davao:**

- SPMC is the only public tertiary level hospital in Mindanao Island (1,500-bed hospital) controlled by the DOH and should receive all cases referred to them by any institution.
- It is not possible to institutionalize a referral system between SPMC and DJF because SPMC is a public hospital whereas DJF is a non-profit organization. Moreover, doctors of SPMC have their own already established informal contacts (who manufacture some prosthesis in private clinics), so HI cannot impose them to refer their patients to the DJF (however, DJF trained health care professionals from CHO to present them the activities of DJF: the goal was to increase the referral system between CHO and DJF).

**The key moment in the CHO’s development relating to referral mechanisms:**

September 2012: Meeting with SPMC on referral system – the appropriate steps were defined to institutionalize the referral system. The CHO formally called for the meeting with HI following-up the meeting, specifying that only decision makers of the hospital should attend.

- Dr Audan, member of the medical management committee and Chief of clinics (sent by Dr Vega the Chief of hospital) suggested to introduce the CVD program in the MEDMANCOM (Medical Management Committee of SPMC, which is composed of all the departments heads) starting the process of institutionalization of the referral system in SPMC

Therefore, HI had managed to get into their policy-making body

It was the first time HI could speak to a powerful person. This leads to acceptance, greater awareness and institutionalization inside the SPMC.

The **success factors** for achieving this change were:
The CVD coordinator and trainers are doing the regular field monitoring of the services focusing on (1) presence and (2) quality of DHD services. The trainers of the CHO also provide individualized and/or group coaching activities and post-monitoring training to each HCP and CHW in the health centres.

The CHO has a regulatory role in terms of visiting and checking the quality of services only in the context of the CVD Program:

- The CVD Program, through the CHO, is implementing a thorough recording of cases that documents vital information of cases. A patient registry is in place in all health centres which is the main source of quantitative data for the program. The patient registries also record patient’s actual values of the monitoring parameters (which can provide a good picture of the level of control of NCDs in the communities).

Aside from regular coordination meetings with the CHO (usually monthly), the CVD program conducts an annual program review which evaluates the efficiency and overall performance based on implemented activities on its annual plan. An example would be the Annual Program Implementation Review for 2011 and 2012.

The key moment in the CHO’s development in terms of providing a regulatory:

- HI developed a strong relationship with Dr Vega (the chief of hospital)
- Dr Audan was our source of information on the next steps
- HI insisted on asking SPMC to send key personnel/decision makers during the meeting (most of the previous meetings with SPMC were attended by middle managers and not decision makers of the entire hospital)
- The meeting was planned, objectives and agenda were clear, the history was traced and the MOU reviewed highlighting the role of SPMC in the referral system.

Competency 5: The CHO provides a regulatory role in terms of visiting and checking the quality of services (Monitoring and evaluation)

The national policy framework:


- The CHO establishes and implements functional surveillance systems for NCDs
- The CHO conducts regular monitoring and evaluation of program

The Situation before the project:

The CHO does not conduct regular monitoring and evaluation of the NCD program, as no services are being implemented.

The current situation - changes achieved as a result of the project:

The CHO, being the lead implementer of the CVD Program was actively involved in the development of the CVD Program:

- The CHO, through the trainers, developed the quality monitoring checklist (with Handicap International).

The CHO, through the CHO, is implementing a thorough recording of cases that documents vital information of cases. A patient registry is in place in all health centres which is the main source of quantitative data for the program. The patient registries also record patient’s actual values of the monitoring parameters (which can provide a good picture of the level of control of NCDs in the communities).
Monitoring procedure collectively defined by the TWG, monitoring activities started in October 2012 (CHO, together with HI)

The success factors for achieving this change were:
- Participatory development of the monitoring checklists by the CVD program trainers (work between CHO and HI).
- The process was defined more by the CHO (post-monitoring conference, etc...)
- The objectives of the monitoring were clearly defined by HI, with the CHO
- The monitoring is well accepted by the health centres, because it is an opportunity for them to express their difficulties and challenges, providing a channel for feedback (HI coached the CHO on how to do the feedback)
- It is an opportunity for the health service providers to be coached on how to deliver the services properly
- It gives them a sense of importance and responsibility to implement the services regularly and of quality
- The CHO provides resources for the monitoring process (vehicle, manpower...).

With growing national recognition about CVDs (Davao was the first city in the Philippines to implement the anti-smoking law), the Davao CHO was interested in CVD and NCDs in general and was also aware of the existence of the national framework but didn't have the full technical capacities to develop a city program based on this framework.

**Positive changes regarding policy formulation:**

The CHO, as an implementing agency and not a policy-formulating institution, pushes for policies via the Local Health Board.

Thus, HI strengthened the lead role of the CHO in pushing for health policy reform on CVD and Diabetes, by providing technical support to the CHO to adapt and to operationalize the existing national NCD- MOP (Manual of Operations) released by the DOH in 2009 (27), with a focus on 2 out of the 4 NCDs: diabetes mellitus and hypertension. Moreover, HI developed relationships with the Local Health Board (responsible for proposing policies at the city level) and with the City Councilor for health (who formulates the policies). In so doing, HI was able to engage the legislative component of the City; working hand to hand with the legislative and executive arms of the government.

Through these government offices, the CHO worked on the approval of various policies to support the CVD Program, like an MOU (with City Ordinance granting

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**Summary of the key lessons learned**

**Before 2007:**

Despite the existence of a national NCD policy based on the WHO frameworks, no NCD Program was successfully integrated in the existing Philippine health services at the beginning of the Diabetes Project’s pilot phase in 2007. The DOH program was mainly an awareness-raising campaign targeting the common preventable, lifestyle-related risk factors (primarily tobacco use, unhealthy diet and physical inactivity), without operational policies at the local level. There was also a lack of defined and clear-cut tools and protocols for program implementation, for community involvement and for financial resources, because priority was given to communicable diseases programs which are funded by the national government through the DOH.

Lesson learning process and summary of findings
authority to the City Mayor to sign/approve the MOU mandating the formulation of an integrated NCD prevention, management and control program, the World Diabetes Day and the World Heart Day Proclamations in Davao City and the revision of the City Tax Code to include the CVD Program Laboratory services. The CHO has gained some experience in lobbying for specific policies to support the implementation of the program and was instrumental in the passage of these policies, with the help of HI.

In order to ensure long-term sustainability, HI placed a strong emphasis on partnerships and participatory processes. In addition to the MOU which clearly outlined everyone’s different roles and responsibilities, HI facilitated the collaboration of the CHO with all the key stakeholders on the policy and its implementation, by creating a technical working group (composed of HI, CHO, DJF, SPMC and DOH) to oversee implementation of an integrated NCD prevention, management and control program.

Positive changes regarding service provision:

**HI strengthened the lead role of the CHO in developing and supervising quality CVD and diabetes services** (the Diabetes and Heart Day: DHD) in the Barangay and district health centres, by integrating the CVD risk management package by WHO (32) and the WHO Package of Essential Non-communicable (PEN) disease interventions for primary health care in low-resource settings (33) in the public primary health care system; and by facilitating the capacity-building of the CHO (provision of program tools, Information-Education-Communication (IEC) tools, equipment and staff training). Moreover, HI supported the CHO on administrative work related to the memo (office order) for DHD to be held every Friday. Thus, it was the start of the uniform day of implementing the DHD, which follows the same pattern as other public health programs and which is recognized as a regular health program of the CHO.

In the same way, **HI helped the CHO to encourage and ensure effective referral mechanisms between different service providers**, by developing the protocol for the referral system of the CVD program with the Technical Working Group (TWG). The CHO, through the CVD Program, is now implementing a three-way referral system for its patients requiring specialist and rehabilitation care and the referral system is institutionalized in SPMC.

Finally, **HI strengthened the regulatory role of the CHO in terms of visiting and checking the quality of services (Monitoring and evaluation)**, by entrusting the monitoring activities to the CHO. Monitoring procedure, practical guidelines and quality monitoring checklist were collectively defined by the TWG; and in order to report an evidence-based DHD’s implementation, HI established a joint monitoring activity with the CHO.

To conclude: since the beginning of the second phase of the project, we have witnessed a significant development in the role of the CHO, in terms of their interest and technical capacities but also in terms of their alliances/relationships and regulatory role. We have explored various success factors but an important element was the HI team itself, which was comprised only of local Philippine people who knew the partners and the health system well and had a high level of complementary technical skills.

The pilot phase offered an important
opportunity for HI to test and refine the process and to prove to the partners that functioning integrated services, which don’t require additional human or financial resources, can be implemented within the existing primary health care centers. Moreover, the HI team developed a very positive and productive relationship with the City Health Officer and has been consistent with the CHO in delivering what has been promised. Therefore HI was recognised as a dependable actor for partners.

Finally, the big changes were not only due to the actions of HI but mainly to the involvement and the motivation of the CHO, who really took the program in hand. HI preferred the participatory development of the program with a view towards long term sustainability - and thus HI’s role was mainly to provide coordination, facilitation and technical support - while the CHO took the lead.

Figure 2: Diagram to summarize the lessons learned

<table>
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<tr>
<th>Date</th>
<th>Actors involved</th>
<th>Reference in lessons learned section of this document</th>
<th>Major changes</th>
<th>Factors that led to the change</th>
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</thead>
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<tr>
<td>Since 1992</td>
<td>- HI&lt;br&gt;- CHO&lt;br&gt;- Local Health Board&lt;br&gt;- DOH</td>
<td>Competencies 1 (policy) and 2 (collaboration)</td>
<td>Existence of a national NCD policy (based on the WHO frameworks)</td>
<td>- The CVD Program is a local adaptation and operationalization of the national frame (27), with a focus on diabetes and hypertension</td>
</tr>
<tr>
<td>2007-2011</td>
<td>- HI&lt;br&gt;- CHO&lt;br&gt;- Local Health Board&lt;br&gt;- DOH</td>
<td>Competency 3 (services)</td>
<td>Local policies to support the CVD Program:&lt;br&gt;- MOU&lt;br&gt;- World Diabetes Day&lt;br&gt;- World Heart Day&lt;br&gt;- Revision of the City Tax Code</td>
<td>- Success of the pilot phase&lt;br&gt;- Implication of the City Councilor for Health (Dr Al-ag)</td>
</tr>
<tr>
<td>2011-2012</td>
<td>- HI&lt;br&gt;- CHO&lt;br&gt;- Local Health Board&lt;br&gt;- TWG</td>
<td>Competencies 4 (referral system) and 5 (M&amp;E)</td>
<td>City-wide CVD Program: Diabetes and Heart Day (DHD)</td>
<td>- Integration of the CVD risk management package by WHO (32) and the WHO Package of Essential Non-communicable (PEN) disease interventions for primary health care in low-resource settings (33) in the public primary health care system</td>
</tr>
<tr>
<td>Start in September 2011</td>
<td>M&amp;E:&lt;br&gt;- HI&lt;br&gt;- CHO (CVD coordinator)&lt;br&gt;- Technical Working Group (TWG)&lt;br&gt;- Referral: HI / TWG&lt;br&gt;- CHO&lt;br&gt;- SPMC&lt;br&gt;- DJF</td>
<td>Monitoring &amp; Evaluation</td>
<td>Referral System</td>
<td>- Creation of a TWG&lt;br&gt;- Resolution of the Local Health Board (DHD&gt;Local policy and regular program of the CHO) and Office memo for DHD to be held every Friday&lt;br&gt;- Barangay level policies&lt;br&gt;- Capacity-building of the CHO: trainings conducted by HI&lt;br&gt;- Tools produced and services’ organisation defined very clearly</td>
</tr>
<tr>
<td>2012-2013</td>
<td>- HI&lt;br&gt;- CHO (CVD coordinator)&lt;br&gt;- Technical Working Group (TWG)&lt;br&gt;- Referral: HI / TWG&lt;br&gt;- CHO&lt;br&gt;- SPMC&lt;br&gt;- DJF</td>
<td></td>
<td></td>
<td>- Process developed by the TWG&lt;br&gt;- Guides/manuals developed by HI and the TWG&lt;br&gt;- SPMC policy: out-patient consultations free for patients referred through the CVD program, institutionalization of the CVD Program in SPMC</td>
</tr>
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Practical Recommendations – towards replication or scaling up in other contexts

A. PLANNING AND START UP: RECOMMENDATIONS TO INCLUDE CVD/DIABETES PREVENTION AND MANAGEMENT IN THE PUBLIC PRIMARY HEALTH CARE SYSTEM

B. RECOMMENDATIONS FOR SERVICE IMPLEMENTATION

C. RECOMMENDATIONS FOR ACTIVITIES MONITORING AND EVALUATION
Tips on how to read this part of the document

In this section of the publication we are moving on from very specific lessons learned about Davao City and using this to make more **general recommendations** which could apply to any CVD/Diabetes project in a low- and middle-income country with a decentralized health system.

We are using our experience and specific activities which have been conducted in Davao, to think about how HI staff in other countries might approach a similar CVD project.

Please refer back to the terminology guide at the beginning of this publication to explain any specific terms used.

The recommendations are organised as follows:

- Recommendations for creating a favourable environment to involve a local health authority on NCD project implementation
- Recommendations for service implementation (again based on the core CHO ‘competencies’ outlined in the previous section of the document)
- Recommendations for activities monitoring and evaluation.

The recommendations are primarily for all HI teams working on CVD/Diabetes related projects – but can be widely shared with other HI colleagues and external partners.

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PLANNING AND START UP: Recommendations to include CVD/diabetes prevention and management in the public primary health care system

1. At national level:

- **Choosing the location and the appropriate context to develop the project:**
  The key requirements for deciding the location and the type of context which is well suited to develop this type of project are:
  - According to the WHO and to the Institute for Health Metrics and Evaluation (34), cardiovascular diseases and diabetes should be recognised as some of the main causes of disability and mortality in the country and in the city concerned;
  - A policy based on the WHO frameworks should already be written at national level by the Department of Health; the local government units have the mandate to take the problem into account and to implement services for the community.
  - The health system should be decentralized, so that the city has the autonomy to implement its own program;

- It would be helpful to further deepen the role of the Department of Health (DOH) to increase the possibility of a scaling up to the national level. A hands-on role for the DOH would be useful (eg. in planning, monitoring). This entails a deeper understanding of how the DOH works in the development of health programs considering the complexity of its different offices.
2. At city level:

- **Deciding the location and the appropriate context to develop the project:**
  Key aspects to take into account are:
  - There should be a well structured, well established local NGO which is already working on Diabetes and CVD or interested to do so - in order that services can be implemented requiring a minimum of additional resources.
  - The government leaders/city’s officials should agree to participate.

- **Stakeholders and partners:**
  When HI works to improve access to basic health services in the communities using a local inclusive development approach, it is important, in, to involve partner implementers who represent the main stakeholders:
  - the public primary health care provider (the city government through the CHO),
  - a referral institution for tertiary and specialist care (SPMC),
  - a local rehabilitation service provider including prosthetics and orthotics (the DJF),
  - the beneficiaries through Local Diabetes Support Groups and
  - the DOH.

  The challenge is to find ways to functionally link these stakeholders together (e.g. local diabetes support groups with health/rehabilitation service providers).

  For future interventions, the following stakeholders could be involved to increase access to services:
  - Professional and civil society organizations which are also implementing or facilitating access to services to the poorest populations (e.g.: Diabetes associations like the Association of Diabetes Nurse Educators of the Philippines [ADNEP]; and the Philippine Association of Diabetes Educators [PADE])
  - Private health service providers to expand the referral system, keeping in mind the need of the most vulnerable
  - Large employers / companies for inclusion of CVD health services into employee packages
  - Schools for early lifestyle related interventions, such as proper nutrition and physical activity
  - Other government institutions that can complement the health care services (e.g.: The Department of Education, Department of Social Welfare and Development, Ministry of Labour...).

3. Key planning or pre-project actions by HI:

a. **Exploratory mission and baseline study:**

   It is necessary to conduct exploratory missions and a baseline study prior to the full implementation of the CVD program as a way to verify the existence of the NCD problem. We would recommend that HI’s guide for INGOs: “Needs assessment to develop diabetes control and prevention projects in limited resources countries” (35) is used to conduct the exploratory mission; and that HI’s “Access to Services” (25) approach is used to investigate the current service provision / structures.

b. **Pilot phase:**

   A pilot phase is recommended in a country where HI is not known in the field of diabetes and CVD. This allows for the establishment of HI as a credible stakeholder in the field, the development of strong partnerships and the space for experimentation when it comes to implementation. It also gives some time for the project team and HI to understand what the project is all about and if the
interventions are really applicable in the field.

Moreover it could be a good way to first gain experience with one disease (diabetes), before to set-up a more integrated CVD approach.

As a result of a pilot phase, HI should able to prove that services can be implemented at very minimal cost and that these services function properly and don't require additional human resources.

Based on the Davao experience, a pilot phase is not necessary for a replication in another city of the Philippines because we know the objectives that need to be achieved and what it takes to achieve them. A direct scaling to the entire city is possible, because we have precise interventions and activities.

3 years for a pilot phase and 4 years for a second phase constitute a reasonable timescale. In a local inclusive development approach and in a purely capacity building project, time should be allowed for strong partnerships building (around 2 years), the development of the tools and the trainings. At the beginning of a project, it is important to take some time to really understand how the health system is built, who are the decision-makers, who are the most important partners and what is the best way to deliver communication.

The timescale should also take into account the contextual factors of the city (like elections...), which can be time consuming.

c. Budget:

The budget should include the baseline study, the external final evaluation and some capitalization/lesson learning of the project. The budget should also allow the team to explore innovative ideas, to get the technical support that the project needs and the flexibility to modify the team structure when needed.

Moreover, it has to take into consideration the costs of meetings (food, venue and travel), travels for international congresses, trainings, tools review and development.

d. Technical competencies:

It is necessary to ensure that technical assistance is sought from the Department of Health (DOH) at regional and national level. To do so, it’s essential that H.I. can present itself as a technical reference for the thematic, with an active network of scientific collaboration with universities. This will ensure that the project is aligned with existing CVD measures or programs.

The team’s competencies: Dealing with NCDs demands a complex and multidisciplinary set of competencies in order to help define the project strategies and approaches, to be more cost efficient and to have greater impact. It’s preferable to assure that the needed skills are well represented and that an appropriate budget is allocated. The project manager or a key team member should have a communication background, to deliver clear messages: this is a part of the partnership-building process. Moreover, having a project manager or a technical team member who is a local technical person is better, so that he perhaps already knows the partners. It is recommended to designate a person in the team who talks with policy-makers and another who talks to technical people. The roles of the team should be clear in terms of who is in relationship with each partner. However, before this phase, all the members have to discuss together the messages content such that they match and do not exhibit discrepancies.

The project participatory approach and the level of intervention, which is mostly at the institutional level, reduce the number
of needed members in the team to deliver what is expected.

- **The support from HI’s headquarters:** a constant link with the HI technical advisers for organizational development and peer support interventions will facilitate a better understanding and definition of the project’s approach in these domains. This should include links with HI’s Health and Prevention Unit.

**e. Advocacy by HI and partners:**

Due to the novelty of the thematic, it is necessary to convince the partners of the importance of NCDs before engaging in a project:

- **Clearness in the information delivered:** in order to convince the partners to participate in the project and to develop a good working relationship with them, HI has to be very clear on HI’s role, what HI can do, what HI can’t do, and what HI expects out of the relationship... All these points have to be clear from the beginning.

Moreover, HI has to be consistent in its messages. In order to be a dependable actor for partners, HI has to be consistent with the CHO in delivering what has been promised. Finally, it is important to take some time to explain the project and the role of HI (capacity-building, support methodology and not providing some medicines...) so that partners can realize that the project can continue even once HI leaves.

- HI should try to find a **focal person** (like a District Health Officer or a doctor with responsibilities at city level), to facilitate the contact with the public primary health care provider.

- The HI **Country Programme Director** should be invited for big events as well as when the project manager meets people for the first time. This will show to the partners that the project is important and that they are important.

- In order to convince the city government to implement the program, HI has to prove that it requires a **minimal investment** from them in terms of financial and human resources. The aim of HI is to strengthen what already exists, so it doesn't require a much additional work.

> “In order to convince other cities in the Philippines to implement the program, HI has to share the successful experience in Davao because Davao is recognized in the Philippines as a leader in the implementation of pilot projects.”

Dr Josephine Villafuerte, Davao City Health Officer

- Moreover, it is important to advocate early on for the implementation of a well structured, clearly **organized referral system:** in order to avoid delays in the setting up of a referral system, a clear definition of what a “functional referral system” should be is needed before the team can proceed with definite steps and concrete activities in this domain.

- **Finally,** it is also important to try to advocate with disability mainstreamed into NCD discussions and planning: the **mainstreaming of disability** should be included in the project’s logical framework or, if not possible, non-contractual indicators on disability should at least be defined. This is to ensure that strategies and activities are put in place correctly.

A practical example to **improve the CHO’s understanding on the concept of disability and its link to NCDs:** the CHO has to be trained on basic disability concepts which are discussed during CVD program trainings. The trainings must include definition of disability, models of disability, accessibility...
and inclusive health programs. To improve the link between inclusive health programs and the mainstreaming of disability:

- Diabetes and Heart Days (DHD) should be conducted in an accessible location (usually on the ground floor of health centres).
- Health care professionals (HCPs) have to explain to the patients the relationship between diabetes and CVD and disability (i.e. by preventing complications with CVDs to reduce disabilities - but also that people with existing disabilities may be more vulnerable to CVDs).
- HCPs have to be trained to regularly monitor (monthly) their patients to prevent complications and therefore to reduce/prevent disabilities; and to acknowledge the importance of foot risk assessment to prevent amputations.

**Recommendations for SERVICE IMPLEMENTATION**

**Tips on how to read this section of the document**

In this section, we propose four concrete recommendations for implementing HI's NCD projects. Each one corresponds to the competencies in the lessons learned section of this document and makes specific reference to the Davao experience to provide practical examples. Here we make many references and recommendations regarding the ‘CHO’ - but this refers to ANY local health authority co-ordinating NCD services, in ANY country context. Please refer to the terminology guide at the beginning of this document for help with any specific terms.

Again the recommendations are targeted towards HI staff working on NCDS / CVD projects - but can be widely shared with other colleagues and external partners.

“Project activities should be well documented to facilitate better lesson learning by ensuring that there is a paper trail of the activities being done (e.g. use of activity designs, activity documentation forms, project newsmagazine). The evolution of the order of activities should also be documented and activities should be revised, according to the circumstances like the demands of the community and opportunities that come along. Some flexibility should be allowed in the project, to give the team more room for trouble shooting and creativity in activities.”

Dr Ivy Boyose-Nolasco, CVD Project Manager

**Ensuring the lead role of the CHO in pushing for health policy reform on CVD and Diabetes**

In order to launch an integrated NCD prevention, management and control program (which includes implementation, monitoring and evaluation), we suggest the following steps:

- HI and the local health authority should adapt and operationalize the NCD policy already existing at the national level, defining clear-cut protocols and focusing on what is feasible in primary health care centres.
- In order to allow recognition of the program at the city level, HI should initiate and facilitate the formulation of a Memorandum of Understanding (MOU) or of a Memorandum of Agreement (MOA) between HI and the key stakeholders,
approved and signed by the City Mayor. This memorandum defines the respective roles and responsibilities of each stakeholder and ensures a participatory development of the program.

The MOU aims to:
- Formulate a City-level CVD Program composed as follows: prevention, control, monitoring and referral system using a multi-stakeholder approach involving all parties of this agreement.
- Identify and empower the actors/organizations that will spearhead the city-wide implementation of the CVD program.
- Compose a steering committee that will ensure the implementation of the provisions of the MOA and create and manage and/or supervise the Technical Working Group (TWG), which will be composed of representatives from each partner as well as representatives from other sectors or agencies when necessary.

Example of an MOU – outlining the roles of each partner, as taken from the existing Davao MOU [See CD Rom section ‘Partnership Building’. TOOL: «MOU 2011». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/PB-02.pdf]
- The City Government, through the City Health Office, is the primary implementing partner of the CVD Program. The City Government will formulate policies, resolutions and ordinances for the adoption and implementation of a CVD program at the city level. It will also ensure the sustainability of the program by mainstreaming it in development plans and providing human and financial resources.
- The tertiary level hospital will provide technical assistance to the capacity building of primary health care providers and receive referral of patients requiring tertiary and specialized care.
- DOH-CHD shall implement the Healthy Lifestyle Program in the city as well as provide technical assistance to the development of the CVD Program and the capacity building of primary health services providers.
- HI will serve as the coordinating body, will provide technical and logistics support according to the funds allotted by its donors. HI will also network with other actors both nationally and internationally and will serve as a link between the parties and other stakeholders.
- HI and the local health authority should engage the legislative component of the City (in the Davao example: the Local Health Board through the City Councillor for Health), in order to work hand to hand with both the legislative and executive arms of the government and to facilitate the formulation of policies, providing a supportive policy environment for the implementation of NCD prevention and control programs. To do this, HI has to make the City Councillor for Health aware of the CVD/diabetes problem, and to convince him/her that it is possible to implement services functioning at a minimal cost, via a pilot phase for example.

Ensuring collaboration between the CHO and all key stakeholders on the policy and its implementation

In order to improve the collaboration between the local health authority and other key stakeholders on the policy and its implementation, a technical working group (TWG) for the CVD Program should be created, composed of key stakeholders (in the Davao experience, the group was composed of: HI, SPMC, City Government...
of Davao through the CHO, DJF and DOH-CHD Davao Region). Using a participatory approach, this TWG should be mainly responsible for the development of CVD and Diabetes services including implementation tools, minimum standards, quality assurance, monitoring and evaluation procedures, etc.

Ensuring a local inclusive development approach, the stakeholders should be gathered and consulted regarding actions to be made.

Before designing interventions such as trainings and tools, it is recommended to make the city’s local government a partner through a MOU, in order to hasten policy development.

The project should also forge solid partnerships with service providers to encourage a high level partner ownership of the interventions. Ownership is also largely due to the participatory manner in which the interventions/activities are developed and to the availability of health services for CVD in the communities.

Ensuring a lead role of the CHO in developing and supervising quality CVD and Diabetes services

1. In order to improve the CHO’s technical knowledge and understanding about CVD and diabetes prevention and management:
   
   a. Exposure visits:
   
   The relevant persons of the City government and the DOH should be sent to national and international diabetes conventions, in order to increase their awareness of the NCD problem.

   Moreover, this helps to strengthen the relationships between these people and the members of the HI project team.

   b. Trainings:
   
   In order to build capacities of the health service providers, several trainings have to be conducted [See CD Rom section on ‘Health Services: Training’. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/chapitre_A2_en.htm#A.2.1]

   In the Davao experience, training for the CVD Program included the following:

   1. 4 days Basic Training on CVD for primary health care professionals of the city for the implementation of the CVD program (2011). This is a course covering both theoretical and operational frameworks of the CVD program using a mix of lectures, simulations and demonstrations. Experts coming from partner implementers such as the SPMC and the DOH-CHD-Davao Region served as lecturers, facilitators and moderators. All HCPs from the city’s 16 health districts were required to attend the training and to pass the post-training examination before a certification of course graduation is conferred. Despite high course completion requirements, the total training completion rate stood at an impressive 98%. The training aims to make health services for CVD available in the local barangay health centres of Davao City. In achieving this, the HCPs of the CHO need to be trained not only to provide health services for CVD but also to train the thousands of Community Health Workers (CHWs) across the health stations so that multidisciplinary health care is delivered.

   2. 2 days CHWs Trainings on the implementation of the CVD program (2011). The training covered the entire 16 health districts. Facilitators were District HCPs of the CHO who were earlier trained on the CVD program. Following a design validated by the program’s technical working group (TWG), the training utilized a mix of oral presentations and practical demonstrations, role playing and
Practical recommendations

practicum covering topics specific on case finding, monitoring and patient education. The training aims to capacitate CHWs in the prevention and monitoring of CVD and diabetes. Contents of the training include CVD and diabetes screening, foot risk assessment, health education, recording and reporting of gathered data.

“A positive change in the CVD and diabetes prevention and management is the capacity-building of the CHO, especially at the level of the Community Health Workers. They are important because they live in the community. Their work is better organized and functional now. The sense of voluntarism is more important now.”

Dr. Ely Buenaventura - District Health Officer

3. 14 days Training of Trainers (TOT) for diabetes education (2012 and 2013): for HCPs from the CHO, DJF and SPMC. The training was conducted by the Association of Diabetes Nurse Educators of the Philippines (ADNEP) and the Philippine Association of Diabetes Educators (PADE), with funding from HI. The Diabetes Education training aims to strengthen the competencies of primary HCPs in providing quality care to patients with diabetes mellitus and those at risk along with their families and the community. The training is a comprehensive program for licensed nurses, nutritionist-dieticians and other allied HCPs. It covers both the basic and advanced clinical knowledge on diabetes and its complications including its screening, diagnosis, pharmacological and non-pharmacological management. The course also includes the development of skills and attitudes necessary for effective delivery of diabetes education and care for persons with and those at risk for diabetes. The new Diabetes Educators are tasked to ensure that quality health services under the CVD program are put in place in the health centres. Moreover, these Diabetes Educators were officially inducted as regular members of PADE and ADNEP during their 10th Joint Annual Convention in Manila. The Diabetes Educators of the CVD program now constitute the newly-formed chapter of PADE and ADNEP in Davao City. This 14-day TOT plus a 2-day CVD Program operational training was the most cost-effective of the trainings which pushed the implementation of the CVD Program and increased the chances of sustainability of services.

4. 1 day Refresher Trainings (2012): for HCPs and CHWs, conducted by the Diabetes Educators, in the different health centres.

5. Other more specific trainings:

a. 1 day Advocacy Training for CVD Program trainers and health District Coordinators (2012): it is aimed at defining the CVD program for the Barangay Local Government Units (BLGU). The highlight of the event was a panel discussion on how different sectors can provide support in the implementation of the CVD Program and the approaches to advocate for support from local officials. The discussions revolved around ways of integrating the different services of government to support the implementation of the program such as providing vegetables seedlings from the City Agriculturists Office and regular physical activity time in government offices and public places.

b. 2 days Diet and Nutrition Counselling Workshop for City Nutritionists (2012): the training was facilitated by the trained Diabetes Educators of the CHO. The workshop aims to provide the nutritionists with necessary skills and
tools to conduct Medical Nutrition Therapy (MNT) in the health centres. MNT includes diet prescription, meal planning, diet-counselling and diabetes education.

**c. 1 day Laboratory Training for HbA1c and Lipid Profile for Medical Technologists (2011-2012): demonstration of the machine on the field.**

“Before the training, I didn’t have the steps on how to conduct the nutritional therapy, how to do it properly, step to step. Before, I wasn’t confident, because I wasn’t trained on diabetes. Now I have the confidence to give nutritional education to the patients, with a personal counseling, specific to CVD cases. Education is clearer because there are more steps to follow and more tools. The program doesn’t only give a knowledge (on how to manage and to deal with diabetes), but we are more enthusiastic and motivated. Before, the patients didn’t care a lot of their health. They are also more enthusiastic and more interested now, because they are more confident.”

Ms. Love Joy Binobo, Public Health Care Nutritionist and Diabetes Educator/CVD Program Trainer

**c. Ownership:**

In order to increase the sense of ownership of the project by the partners:

- Handicap International should provide logistics, technical and funding support. As its main counterpart, the local health authority should provide human resources as well as suitable training venues for the conduct of the trainings.
- It is important to give the responsibility to the HCPs to train the CHWs because it improves the sense of activities ownership.
- It is important that trainers are trained by a national diabetes association, because it gives them a national recognition. Moreover, the membership of the program’s stakeholders in these associations facilitates a functional link with the CVD program specifically in the exchange of technical expertise and sharing of resources in achieving common goals in the prevention and management of diabetes and CVD.

2. In order to improve the understanding of the CHO about how to integrate CVD and diabetes prevention and management into existing health services:

**a. Integration of the WHO frameworks:**

The CVD risk management package by WHO (32) and the WHO-PEN (Package of Essential Non-communicable disease interventions for primary health care in low-resource settings) (33) should be integrated in the public primary health care system.

**b. Competencies regarding decentralization:**

The current DHD model answers to 2 main problems:

- Only one doctor is available at district level
- The main CHO diabetes approach was medical with the doctor as the only health service provider involved in management, the other health care professionals had limited technical capacities in the prevention and control of diabetes and NCD in the primary health care setting and there were no management protocols common to all health service providers.

As explained in the DHD part, the health and non-health staff is now trained on the diabetes and CVD prevention and control. In order to assure sustainability and increase accessibility of the services, they were organized with a multi-competencies approach and with the role of each HCP and CHW in the health centre clearly defined. Therefore health services but medical consultation can be delivered even in the absence of the doctor.
c. Processes and tools:

Processes and tools have to be kept simple and adapted to the capacity of service providers. The feedback of the HCPs, CHWs and users should be integrated in the manufacturing process of the tools, resulting to tools and processes that are of quality and adapted to the needs of the community.

d. The package of services:

According to the Davao experience, the Diabetes and Heart Day (DHD) represents the most clear and concrete way to integrate services into existing primary health centres. To do this, concrete steps for the DHD’s services have to be defined and several tools have to be developed, with the partners:

- **Information sharing and communication:** Flyers have to be distributed before the services’ day by the Community health workers. They have to go into communities, house by house, to distribute a general information flyer on the services available in the health centres (in Bisaya) [See CD Rom section on ‘Information Campaign: CHO Health Services’. TOOL: «Do you have diabetes?». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/ICAR-22.zip] and to help people to complete the diabetes self-assessment questionnaire. This screening tool is available in Bisaya and English and required many tests and a significant collaboration work between HI, the HCPs and the CHWs, in order to create a tool which is easily understandable by the CHWs and applicable in the community. Moreover, at the beginning of the project implementation, services should be made more attractive to the population through the availability of free blood sugar tests.

The **different steps** of the services have to be very clear:


   The patient Registry contains basic and monitoring information on persons with diabetes and hypertension, who avail of health services in Barangay Health Centres. Patients are only registered in their residence Barangay; so if they consult in another Barangay, they are not recorded and they are referred to their residence Barangay for registration.

2. **Screening** (done by a nurse, a midwife or a CHW)
   
   a. Diabetes screening (review a diabetes self-assessment questionnaire with the patient and a blood sugar test with a glucometer is done if the risk of diabetes is high)
   
   
   c. Hypertension screening
   

   This screening tool is based on WHO tool and is available in English.

   e. Routine Foot risk assessment [See CD Rom section on ‘Health
3. **Basic laboratory tests**: Fasting Blood sugar (FBS), Random Blood Sugar, HbA1c, Lipid profile and Urine microalbumin [See CD Rom section on ‘Health Services: Laboratory Services’. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/chapitre_A2_en.htm#A.2.5] The laboratory request form contains instructions for blood testing in Bisaya at the back.

4. **Medical consultation** (always made by a doctor, so if the patient need to see a doctor, he’s referred to the district centre).

5. **Education** (made by all professionals: doctor, nurse, midwife, nutritionist and CHW) [See CD Rom section on ‘Information Campaign: Prevention & Control’. TOOL: « Diabetes questions and answers». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/Diabetes_QA_Brochure_English_2008.zip] The Medical Nutrition Therapy Kit is a tool for Nutritionist-Dieticians in the conduct of nutrition education and counselling for persons with diabetes and other cardiovascular disease risks such as hypertension and hypercholesterolemia. The models in this kit are of food common in the Philippines including the durian which is abundant in Davao. [See CD Rom section on ‘Health Services: Medical Nutrition Therapy. TOOL: «MNT Kit». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/HS-18.zip]

a. Smoking cessation counselling.

b. Diet/nutrition counselling (by a nutritionist). If the patient is diabetic, he receives the diabetes diary: it is an education and monitoring booklet with full-colour pages for patients and health care teams. The first version of this diary was released in 2008. It is available in Bisaya with English subtitles. [See CD Rom section on ‘Health Services: Medical Nutrition Therapy. TOOL: «My Diabetes Diary». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/HS-40.pdf]

c. **Basic foot care education and wound care.** The foot care kit is a tool used by both HCPs and CHWs in providing basic foot care for persons with diabetes. It contains monofilaments, foot risk assessment forms, samples of shoe insoles, hypoallergenic lotion, mirror and soap. It also comes with the basic foot care poster, written in Bisaya and in English and titled Prevent foot amputation, take care of your feet [See CD Rom section on “Health Services: Foot & Wound Care”, TOOL: ‘Foot Care Kit’; and section “Information Campaign: Prevention and Control”, TOOL: ‘Prevent foot amputation, take care of your feet’. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/HS-19.zip and http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/CVDProgram.pdf]
The Wound Care Kit is a set of basic wound care instruments and initial consumables which will be used by the health care teams in District Health centres to care for patients with acute and chronic wounds [See CD Rom section on “Health Services: Foot & Wound Care”, TOOL: ‘Wound Care Kit’. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/HS-20.zip]

Even if the patient has a low risk of CVD or diabetes, he receives an education (without steps 3 and 4, who are only made if patient has a high risk).

Then the patient is dismissed at home, or referred to a specialist or another health centre [See CD Rom section on ‘Health Services: Referral’. TOOL: «CVD Prog. Referral Form». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/HS-24.zip] and a next visit in the BHC is fixed.

6. Recording
   b. Patient record, where all the forms can be stored inside [See CD Rom section on ‘Health Services: Referral and Reporting’. TOOL: «Patient Record». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/HS-25.zip]

“The main challenge on CVD and diabetes prevention and management in Davao is the behavior change of the community, because the barriers are the cultural beliefs: some consult the traditional practitioner... Moreover, there is a lack of education in the population and a money problem for transport and healthy food.”

Dr. Annabelle Yumang, NCD Coordinator, DOH- CHD Davao Region

e. Sustainability of the services:

In order to ensure the sustainability of the services, services should start after the completion of the HCPs and CHWs trainings. Moreover it is essential to:

- Appoint officials:
  - The head of the health care teams (i.e. the doctors, who are also the District Health Officers in the Filipino case) should be properly oriented, trained on the CVD Program and involved in the decision making process to ensure the implementation of the program.
  - District coordinators have to be named, in order to ensure the overall coordination of the CVD program activities at local level, which include implementation, monitoring and evaluation.
  - The local health authority has to mobilize key stakeholders to deliver quality services and to provide all human resources for health service delivery [See CD Rom section on ‘Advocacy’. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/chapitre_A4_en.htm].

For the Davao CVD Program, 2 new positions have been created by the City
Health Officer: (1) CVD Coordinator and (2) Health Education and Promotion Officer. Their main task is to ensure that the CVD program is being implemented in the health centres.

**Formulate a policy:** the local health authority has to release an office order with the support of the legislative component, in order to increase the acceptance of the health centres for the implementation of the CVD program services and to implement the services at a uniform day. In that way, the CVD program can become a regular program of the city and not a “special project” for the local health authority.

**Allocate consistent budget:**
- To really involve the city government, the city’s officials have to be orientated on how to promote the program and to allocate some budget.
- The local health authority has to lobby for regular budget allocation for NCD prevention and control, in order to increase resources (human, financial, technological, political), by working on the inclusion of the budget for CVD/NCD in the City’s Local Investment Plan.
- In addition, the local health authority should provide budget for the CVD program in the form of the following:
  - Use of vehicles for CVD Program activities like trainings, caravans, field monitoring
  - Venue for trainings, meetings and other events
  - Printing of some CVD program tools
  - Budget counterpart for special activities (for the WHD, the CVD caravan project...)
  - Human Resources for CVD Program activities like trainers, HCPs doing coordination work for the CVD Program, etc.

3. In order to improve the efficiency of the CHO in addressing CVD and diabetes and its impact on their communities:

a. Link the CVD program with other existing programs:

The local health authority should link the CVD Program with other government programs.

An example of what HI did in Davao was to link the CVD Program with the 4P Program of the Department of Social Welfare and Development (DSWD).

Implemented in the beginning of 2012, this national government program is designed for the poorest of the poor and includes financing of basic medications including medications for hypertension (Metoprolol and Losartan Potassium only) and diabetes (Metformin only, no insulin). The DOH is solely responsible in the identification of the medicines. The CHO is not involved in the identification and verification of the beneficiaries of this program as it is a task done by the DSWD through the Barangay local government units (BLGUs). Patients of the CVD Program who are also 4P beneficiaries receive FREE medications for hypertension and diabetes, which is funded by the national government through DSWD through the 4P Program. The CHO may (or may not) augment the purchase of these medicines from their own budget (planned annual procurement) after the supplies from the national government are fully utilized. For patients of the CVD Program who are not 4P recipients, they can buy the combined hypertension and diabetes medications (good for 30 days) for only 100 pesos.

b. Make medicines available:

In order to ensure the availability of medicines, it is necessary to convince local partners to formulate local policies for the availability of medicines in pharmacies,
allocate budget and to offer medicines at subsidized price. But it is important to note: HI is not to enter into the logistical networks of drug distributions, nor to buy drugs stock to be distributed, and has to assure that the local health care provider is ready to practically implement this part.

In Davao, basic oral anti-diabetic agents and hypertension medications have been included in the Botikang Barangay (Pharmacy in the Barangays), which sells the medicines at a very cheap price. The Botikang Barangay is operated by the Barangay local government units (not all Barangays have this) and is usually attached to the health centres.

c. Link the CVD program with the national health insurance:

In order to make services accessible to the majority, the public primary health care provider should comply with the accreditation and licensing requirements of the National Health Insurance and DOH.

The Davao CHO has facilitated the accreditation of some of its district health centres to be primary health care centres accredited by Philippine Health Insurance Corporation (Philhealth) and of DOH’s Quality Assurance Program called the SentrongSigla.

By being a Philhealth-accredited centre, CHO’s services to its patients (laboratory services, consultation) are compensated by Philhealth which the CHO can use to upgrade its facilities. Accreditation with Philhealth is similar to a hospital accreditation which follows a strict and defined set of criteria defined by the Philhealth.

The SentrongSigla Quality Assurance accreditation is DOH’s seal of excellence for health centres that meet the minimum standards that it has defined in the delivery of quality services.

“The government is now looking into the needs. I’m negotiating with PhilHealth (the Philippine Insurance) to submit a proposal for a partnership between Philhealth and DJF. In that way, Philhealth will finance a part of the prosthesis.”
MS. Cheryl Cavan, Operations Manager, Davao Jubilee Foundation

d. Increase community awareness:

Finally, HI should be innovative in awareness-raising and information and the local health authority, through the CVD Program, should involve the city’s officials, primary health care centres and people in the communities (Local diabetes support groups) for information dissemination, awareness raising and advocacy.

Handurawan: (Cebuano and Hiligaynon word for “Vision”) is the Official Publication of the CVD Project in the city of Davao, which comes out every 6 months. The publication’s name reflects the project’s vision of bringing stakeholders together for a coordinated effort to improve the lives of people with diabetes and other CVD risks. The publication includes relevant news (milestones, accomplishments), technical updates of the CVD Project and CVD Program, feature articles, tips, human interest stories, interesting facts and photo-essay activities, as well as feature stories of stakeholders. It is printed in at least 2500 copies, distributed to the stakeholders and Barangay health centres and is also sent in an electronic version to a web-mailing list of partners [See CD Rom section on ‘Information Campaign: HI and CVD Projects’. TOOL: «Handurawan». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/Handurawan_1_2011.pdf]
World Heart Day (WHD): the City Mayor declared September 29, 2011 and every year thereafter as World Heart Day in Davao City via Proclamation No.19. The City Government of Davao and HI organized two consecutive events on September 29 to launch the WHD and announce the start of the city’s CVD Program. A fun run entitled One Run, One Heart was organized and was attended by almost 2000 participants from government institutions, private organizations, schools and universities and the general public.

World Diabetes Day (WDD): is the global awareness campaign of the diabetes community. In 2008, Davao City Mayor signed Proclamation No.15 declaring November 14 of each year as World Diabetes Day in Davao City, in support of UN Resolution 61/225.

CVD Program medical caravan: the CVD Project partners brought CVD Program services from Barangay health centres to a high-population venue to celebrate WHD 2012. Named the CVD Program Caravan, medical services such as screening, medical consultation, laboratory testing, diet and nutrition counselling and health education were brought to a local mall during 2 days to increase public awareness on the availability of quality and accessible CVD-related services in the health centres of Davao City. A video about the program was played throughout the activity while photos and stories about CVD Program beneficiaries were exhibited. A brief press conference and luncheon followed with members of the press and leaders of LDSGs. Health care providers from the Davao CHO and SPMC took turns manning health service stations. Nearby Barangays were invited to encourage their constituents to avail of the services. An estimated 1000 people were reached by the event with at least 200 walk-in patients benefitting from the free medical services offered in a 7-hour period for 2 days. The CVD Program Caravan was materialized through the sharing of human, financial and material resources amongst Davao CHO, SPMC, DOH-CHD Region XI and HI.

Photo-essay competition: Matters of the Heart was organized to raise awareness on CVD by putting forward the stories of persons with diabetes, hypertension and persons with disability due to CVD complications whose lives have changed for the better because of the CVD Project. The competition was organized by the CVD Project of HI. The entries were displayed from September 28-29, 2012 at the mall just in time for the WHD celebration and the CVD Program Caravan. The photo-essay entries were written and captured by students from different colleges in Davao City [See CD Rom section on ‘Information Campaign: CHO Health Services’. TOOL: «Matters of the Heart»]. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/[ICAR-30.zip] and the first prize was a brand new DSLR camera with accessories. The winners were judged by Philippine Daily Inquirer Visayas Correspondent, Award-winning Davao Photographers, Head of the Technical Coordination Unit of HI-Philippines Program and Information Officer from the Philippine Information Agency-Davao.

Community Theatre: 24 Peer Support Volunteers (PSVs) from several LDSGs were trained on Community participatory Theatre.
Production during a 3-day workshop in 2011, in partnership with a Davao-based youth theatre group whose Artistic Director is also the CVD Project Communication Officer. The workshop aimed to equip the participants with the basics on creative drama, dance and movement, songs, music and rhythm, creative writing, visual arts and production design. The short plays were written by the participants. The productions are presented during community events (like WDD) as one of the approaches for information, education and communication to draw the interest and participation of the community in diabetes education and prevention [See CD Rom section on ‘Information Campaign: CHO Health Services’. TOOL: «Diabetes - we can triumph over this». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/ICAR-28.zip ]

- Posters for the rehabilitation centre developed with the technical support of Hi in order to increase access to P&O and rehabilitation services [See CD Rom section on ‘Information Campaign: DJF Rehab Services’. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/chapitre_A1_en.htm#A1.4 ]

- In order to hasten the organizational development of local diabetes support groups (LDSGs), it is necessary to define the roles of LDSGs early on in the project before designing interventions. Peer support should have been one of the main interventions in the first phase and identified as the main role of LDSGs above advocacy and self-management.

In the first phase, volunteerism should have been encouraged through peer support which means that persons with diabetes volunteer their time to provide service for persons who experience the same situation.

Available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/PS-06.zip ]

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Dr Ivy Boyose-Nolasco, CVD Project Manager

Ensuring the CHO coordinates effective referral mechanisms between different service providers

**Example:** The CVD Program three-way referral system between the Davao City Health Office (CHO), Southern Philippines Medical Centre (SPMC) and Davao Jubilee Foundation (DJF) was designed to cater to the medical needs (primary, secondary, tertiary and rehabilitation care) of patients with diabetes and hypertension from primary to tertiary care including rehabilitation services.

![Diagram of the CVD Program Referral System](image)

In order to improve the implementation of a 3-way referral system for patients requiring specialist and rehab care, the CVD Program referral system should be developed with the stakeholders of the program and should have:

- Established definitions of a functional referral system before designing interventions
- An MOU between service providers to accept referrals from partner institutions and a policy on the referral system in the different health care centres
- Clear-cut indications on making the referral in each concerned service provider and trained HCPs to make appropriate referrals
- Processes and tools designed together with partners and a single referral form/tool to be used by all concerned
- Systems for monitoring and logging referrals and counter-referrals
- The CHO should lead the coordination with the tertiary hospital in setting up this referral system
- The protocol for the referral system should be developed by the Technical Working Group
- The referral for wound care and insulin management needs to be explored
- The CVD Program recommends that the tertiary hospital implements a referral system that:
  - Does not charge CVD Program patients with consultation fees
  - Records or logs all cases referred to them in the Emergency Room and Outpatient Departments
  - Records or logs all cases they counter-refer
- Manuals/guides on the referral system should be written in each institution by HI, in collaboration with the partners. The manuals are a “how to” document, they do not contain indicators and targets. Policies should be developed in each institution in...
order to officially recognize the manual. The aim of the policies is to institutionalize and sustain the CVD program.

“The patients requiring primary and secondary cares are already supported by the community centers (primary health care centers). Thanks to the conduction of the DHD, patients can already be consulted and controlled. The CVD program helps us a lot, because we just receive patients requiring tertiary cares.”
Ms. Elena Zapanta, CVD Coordinator, SPMC

Recommendations for MONITORING AND EVALUATION

Ensuring the CHO provides a regulatory role in terms of visiting and checking the quality of services (Monitoring and evaluation)

Baselines

Existing health systems are often not very effective in terms of collecting data on NCDs, and thus the monitoring of activities and the presentation of the project to the donors can be difficult unless some specific actions are put in place.

It is mandatory to have a diabetes baseline survey’s budget line: without this survey it can be almost impossible to gather significant information on key indicators for project monitoring and evaluation, and to show to the donors what has been changing.

If a baseline has not been planned, during the initial phase of a project it is better not to include indicators on the outcomes in the logical framework, but rather a special focus on the presence of the services, whereby performance indicators are preferred (14).

Participatory monitoring

In order to ensure ownership of the project interventions and to increase the chances of sustainability, monitoring and supervision of health services have to be led by the local health authority, with technical support and mentoring from Handicap International.

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Monitoring team

To ensure that the planned CVD Program Monitoring activities are pursued, a **monitoring team** should be created.

Based on the Davao example, it should be composed of the following personnel, structured as shown below:

Figure 4: Composition of the monitoring team

In this example, the monitoring team was tasked to perform the following **functions**:

**CHAIRMAN:** Assistant City Health Officer for Operations
The Chairman of the CVD Program Monitoring team is tasked to oversee implementation of the planned monitoring activities. Specifically, the chairman shall ensure the following:
- Field visits are coordinated, arranged and conducted as planned.
- Post-monitoring feedback to the City Health Officer.
- Application of post-monitoring interventions in the monitored centre.
- Coordination with other local government offices involved/concerned with the CVD Program.

**CO-CHAIR:** CVD Program Medical and Nurse Coordinators
The Co-chairmen shall act as the “eyes and ears” of the Chairman of the CVD Program Monitoring Team. They shall lead in the actual field monitoring following a pre-identified schedule. Specifically, the co-chairmen shall ensure the following:
- Identification of schedules of field monitoring visits.
- Conduct of the actual field monitoring using CVD Program monitoring checklist.
- Issuance of Post-monitoring reports to the following:
  a. District Health Officer
  b. Barangay Health Station In-Charge
  c. Chairman of the Monitoring Team

**MEMBERS:** All District Health Officers, CVD Program District Coordinators and Diabetes Educators
The members of the CVD Program Monitoring team shall assist the Co-Chairmen in the actual conduct of the field monitoring activities within their respective districts. Moreover, they are also specifically tasked to continue monitoring activities within their districts with or without the Co-chairmen.

The Monitoring Process

The Monitoring Process should be clearly defined:

- Scheduling and coordination with the Main City Health Office.
- Friday is the designated field monitoring for the Diabetes and Hearts Day at the Barangay Health Centres since DHDs are being performed every Friday at the health
centres. The CVD Coordinator is the one who makes the one month schedule for the health centres to be monitored and identifies the members of the monitoring team for each schedule.

- The areas and health stations to be visited are unannounced.
- The team is composed of CVD Coordinator from the CHO Main Office, the District CVD Coordinators and Diabetes Educators and the HI team.

**Monitoring Checklists:**

- Nine checklists are used in the monitoring process: one to monitor the presence of services and the remaining eight to monitor the quality of services. The checklists ensure the objectivity of the monitoring process and set the minimum standards in the delivery of the services to guide health care professionals involved in the DHD.

The checklists are: [See CD Rom section on ‘Health Services: Monitoring’. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/chapitre_A2_en.htm#A.2.8]

**PRESENCE:** Barangay Health Station Services Checklist

**QUALITY:**

- Anthropometric Measurements Quality Checklist
- Hypertension Screening / Blood Pressure Monitoring Quality Checklist
- Foot Risk Assessment Quality Checklist
- Foot Care Education Quality Checklist
- Diet and Nutrition Counseling Quality Checklist
- Tobacco Cessation Counseling Quality Checklist
- Laboratory Services Quality Checklist
- Recording Quality Checklist

- For each BHS visited, one set of the checklists must be filled out regardless if services are being performed or not.

**Actual Monitoring:**

- The monitoring team should arrive at the health centre at the time when services are being delivered.
- Each member of the monitoring team (can either be the CVD Program Coordinator and the Diabetes Educators) is given a random checklist. The monitoring team must:
  - Not interrupt the health station staff performing the services
  - Observe the services being delivered based on the checklist and appropriately fills up the checklist based on the observations
  - Rate the provider objectively using the rating guide in the checklist
  - Not provide coaching to the health care professional while doing the actual service
  - Take down notes including the strengths and weaknesses of the health service provider
  - Wait for all patients to leave before doing the post-monitoring conference.

**Post-monitoring conference:**

- After the DHD, members of the monitoring team will have the feedback with all the members of the health station – HCPs and CHWs.
- When speaking, the member giving the feedback should be very cautious with the tone and manner in which he/she delivers the feedback. For the CVD Program, members of the monitoring team should keep in mind the following when giving feedback:
  - Start by saying the POSITIVE things
  - Continue by saying the things that NEEDS IMPROVEMENT
  - End by saying HOW things can be improved
All members should speak about the checklist and disregard his/her opinion. The monitoring process should be as objective as possible in all cases.

The discussion must include the points, things or services that needs to be improved, a discussion of the omission and the errors committed during service delivery, suggestions, recommendations and the rating for the specific service.

If necessary, the members must show how the services should be performed through a skills demonstration, followed by a return demonstration to ensure that the services will be performed with an acceptable quality the next time.

If a service is undone (hence the checklist is unused), the member should probe the health station staff why the service is not being performed. This should be documented in the monitoring checklist and next steps should be arrived at using the participatory approach.

The leader of the monitoring team (usually the CVD Coordinator) will wrap up everything and will also give his/her comments and ratings. All checklists will be given to the Co-Chair of the Monitoring Team at the Main City Health Office for review, further analysis and consolidation.

After the field visit, the findings should be communicated to the health centre through its District Health Officer. This Office Order explains the conclusions of the monitoring team and gives information about the implementation of services.

Then, if the services are not implemented, the next field visit is randomized after they received the letter, so they don’t know when the next visit is.

The DHD has to be implemented. It's under the responsibility of the district health officer to implement the DHD, joint with the main CHO.

**Recording and Reporting**

Patients are recorded in various program-developed tools for monitoring purposes. This aspect of the program is also part of the monitoring activities and should be done on a monthly basis. [See CD Rom section on ‘Health Services: Recording & Reporting’. Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/chapitre_A2_en.htm#A.2.7 ]

HI contributed to the elaboration of the record tool, but the practical implementation is under the direct responsibility of the CVD District Coordinator and the CVD Program Coordinator, in order to increase the sustainability of the monitoring process. Various forms and reports are generated in different levels of the City Health Office as illustrated in the matrix below:
Table 2: Example of patient data flow of the CVD program within the City health Office

<table>
<thead>
<tr>
<th>Institution</th>
<th>What?</th>
<th>Tools / Forms Used</th>
<th>Person Responsible</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barangay Health Stations</td>
<td>Patients data (registry, monitoring, etc)</td>
<td>Patient Registry Patient Record Folder</td>
<td>Depends on the CVD District Coordinator</td>
<td>Updated every after a DHD is done</td>
</tr>
<tr>
<td></td>
<td>Monthly Statistics</td>
<td>Barangay Health Station Monthly Statistics</td>
<td>BHS - in - Charge</td>
<td>Prepared immediately at the end of the month</td>
</tr>
<tr>
<td>District Health Center Laboratories</td>
<td>Patients Laboratory Utilization of CVD Program-related services</td>
<td>CVD Program Laboratory Registry - Results Journal</td>
<td>Medical Technologist</td>
<td></td>
</tr>
<tr>
<td>District Health Offices</td>
<td>Patients data (registry, monitoring, etc)</td>
<td>Patient Registry Patient Record Folder</td>
<td>CVD District Coordinator</td>
<td>Updated every after a DHD is done</td>
</tr>
<tr>
<td></td>
<td>Monthly Statistics</td>
<td>Barangay Health Station Monthly Statistics</td>
<td>BHS - in - Charge / Nurse Supervisor / District Coordinator</td>
<td>Prepared immediately at the end of the month</td>
</tr>
<tr>
<td></td>
<td>Consolidated Monthly District Statistics</td>
<td>EXCEL: Monitoring Toolkit</td>
<td>CVD District Coordinator</td>
<td>BHS monthly statistics are gathered and consolidated in one report submitted to the Main CHO on or before the 10th of each month covering the preceding month</td>
</tr>
<tr>
<td>Main City Health Office</td>
<td>Consolidated CITY Monthly Statistics</td>
<td>EXCEL: Monitoring Toolkit</td>
<td>CVD Program Coordinator</td>
<td>All district monthly statistics are gathered on the 10th of each month and consolidated for review of the City Health Officer and other Program Managers</td>
</tr>
</tbody>
</table>
At the end of the process, the consolidated City monthly statistics are sent by the main CHO to HI and an annual report is made by HI [See CD Rom section on ‘Project Management: Human Resources’. TOOL: «CVD Project Beneficiaries Monitoring Toolkit». Also available online: http://www.hiproweb.org/fileadmin/cdroms/Capi_CVD_Philippines/files/PM121.xls]

Since the final report is a consolidation of various partial reports from other offices within the CHO, it is important to understand the flow of the reporting system. The failure of one office to submit the monthly report can result in:

1. Incomplete consolidated data
2. Inaccurate figures (usually under-reporting of cases handled)

- The CHO sends data to HI as soon as they receive the monthly district statistics. Data transmission could take several months, due to internal implementing timing. HI should work in collaboration with the CHO to find ways to reduce the delay of data transmission from Barangay and District Health centres.
- The HI team is receiving data from the CHO and from the DJF, but not from SPMC, as it is only constrained to send data to the DOH. In order to ensure that the different partners share their data, it should be specify in the MOU.

The figure below demonstrates the flow of the reports within the City Health Office, Davao City.

*Figure 5: Flow of reports of the CVD Program within the City Health Office*
Conclusion

Taking into account the importance of diabetes and CVD as public health problem in the Philippines and the successful experience of HI in NCD prevention and management during the last 7 years, it is relevant to share this local expertise in order to facilitate replication or scaling up in other contexts.

The target audience for this publication is primarily Handicap International staff working on diabetes, CVD and NCDs integration and management. However the lessons learned can be relevant for all interventions aimed at building effective partnerships with local government to implement sustainable services. This publication could also be shared with both the local audience in Davao and key external stakeholders in some other cities in the Philippines, with a view towards raising awareness on diabetes and CVDs, but also to strengthen capacities to replicate aspects of the CVD project in other cities of the Philippines.

This document is a result of collaborative qualitative research, made with the HI team and partners to identify key lessons learned and develop these into generic recommendations. The key success of the project was the strengthening of the Davao City Health Office - the local government health authority - to be able to successfully integrate CVD and diabetes interventions into its existing health provisions.

The main objective of the project was to assure, through partnership and technical capacity building, the development of a fully sustainable, competent and independent of HI CVD service provision.

We identified 5 major change areas in the competencies of CHO, which correspond to a key moment in the project development. For each of them, the HI Philippines team played a central role in providing facilitation, coordination, logistic and technical support:

- In terms of policies formulation, HI worked with the CHO on the adaptation and operationalization of the national existing policy, focusing on diabetes and hypertension. Moreover, by sending relevant city’s officials and partners to international seminars to convince them on the importance of CVD and diabetes, HI was able to engage the legislative component of the city to approve and sign policies supporting the CVD program.

- In terms of collaboration with all the stakeholders, HI encouraged the partnership approach and the participatory development of the program, with the creation of a MOU and a Technical Working Group.

- In terms of development of CVD and diabetes services, the success of the pilot phase gave the possibility to test and refine the approach and proved that it was possible to implement quality integrated services. HI was also able to get the political and financial support of the city’s officials for the implementation of the services in the primary health care centres. Moreover, HI strengthened capacities of the CHO with several trainings for HCPs and CHWs, defined the different steps for the package of services and developed several tools with the partners.

- Concerning the referral system, HI was able to implement a three-way referral system for patients requiring specialist and rehabilitation care. HI defined the process and the tools with the Technical Working Group and was able to institutionalize the referral system in SPMC, thanks to the strong relationship with the chief of hospital.

- Finally, concerning the monitoring and evaluation of the program, HI defined the processes and the tools with the Technical Working Group and set up a joint monitoring system with the CHO.
The next steps for HI concerning CVD in Philippines

The CVD Project team has been receiving requests from different stakeholders, mainly from civil society who would like to implement similar but smaller scale projects targeting the most vulnerable. The Local Government of Davao would also be more than willing to share this experience. A minimal technical team can provide this assistance with the following stakeholders:

- Department of Health: to facilitate regional, municipal or city-wide multi-stakeholder collaborations. This will also keep the DOH engaged and keep HI within their radar. It is the time to present concrete data that the interventions work to proper authorities such as the DOH so that they can take the lead together with the LGUs.
- Local Government Units along with their primary health service providers
- Smaller NGOs and other civil society organizations
- Schools
- Companies

HI will organize a CVD summit in Davao city in November 2013, in order to facilitate the sharing of experiences with other cities and municipalities on the implementation of the CVD Program by the City Health Office and to generate interest among local government units to implement their own CVD Program. The aim of the summit is to identify stakeholders from other provinces willing and capable to replicate the program with the support of the Davao City Health Office pool of trainers.

HI already submitted a project proposal to the World Diabetes Foundation, for a 2-year project (2014-2016). The goal is to increase access to quality, multidisciplinary diabetes and CVD risk factor management. The objectives are:

- Strengthening diabetic foot care services in Davao City’s public primary health care system as an integral component of the city’s Cardiovascular Disease (CVD) Program.
- Disseminating Davao City’s multidisciplinary approach to CVD Risk factor management with diabetes and hypertension as entry points, in 4 other cities/municipalities. Given that health service delivery is decentralized, HI will work directly with the Local Government Units (LGU). HI will be presenting the project to local government officials and will work with the Local Health Board to identify concrete steps in developing their own CVD Program including the identification of relevant policies. Partnership will be forged with the LGU through the City/Municipal Health Offices to implement the CVD Project. HI will push for the signing of Memorandum of Agreements between the City/Municipal Governments, DOH and HI to serve as the legal basis for implementing the CVD Program and later a City/Municipal Ordinance to formally recognize the CVD Program as part of the their regular health programs.

Next steps for HI on CVD / Non-communicable diseases globally

HI’s 2011-2015 strategic aims concerning CVDs and NCDs are:

- Strengthen/consolidate existing prevention and control projects targeting non-communicable diseases
- Develop new projects, especially in Asia, North Africa and Middle East America
- Develop rehabilitation cares for people living with diabetes and other cardiovascular diseases related disabilities
- Strengthen the link between the treatment of non-communicable
diseases, rehabilitation care and psychosocial support

- Ensure that interventions are more inclusive of vulnerable persons, in particular people with disabilities
- Develop Handicap International’s approach to primary prevention activities to move towards an integrated approach targeting several non-communicable diseases and a health promotion approach: promoting healthy lifestyle through multi-sectoral responses, combining different types of activities such as education and advocacy.

A project for a disability-inclusive public health program can be a natural transition for Handicap International in order to be known as a stakeholder on disability in Davao City.
Appendices

Fig 6. Project Poster Presentation

Learning Lessons from experience: How to support local government to integrate CVD and diabetes prevention and management into existing health systems -the Davao City experience, Philippines-

Important success story for HI: one of the organization’s first detailed experiences for developing a comprehensive CVD project.

Project partners:
• City Government of Davao with the City Health Office (CHO) as its implementing arm
• Southern Philippines Medical Center (SPMC), Davao public tertiary level hospital
• Department of Health (DOH) - Center for Health Development-Davao Region (Region XI)
• Davao Jubilee Foundation (DJF), local rehabilitation service provider, including prosthetics and orthotics provision.

Objective of the lesson learning: Share the HI experience in Davao in the development of the capacities of local government to integrate CVD and diabetes prevention and management into existing health systems.

Specific subject focus: the role of the Davao City Health Office (CHO), the main implementing partner of the project.

We are exploring the significant changes achieved by the CHO and the factors which made them possible, through workshops and individual interviews with the HI team and semi-structured interviews with external partners and beneficiaries of the project.

On a set of 16 competences, we identified 5 change areas, which correspond to a key moment in the development of the Davao CHO. For each one, we explain the role played by HI.

Some specific factors at national level, at city level and at HI level contributed to the successful implementation of the project:
• General national factors:
  ➢ Decentralized health system
  ➢ National NCD policy based on the WHO frameworks, mandating the city governments to implement the services
• Factors specific to Davao CHO:
  ➢ Team competencies: technical capacities and communication background
  ➢ Philosophy of partnership, coordination, logistic and technical support

<table>
<thead>
<tr>
<th>CHO changes</th>
<th>Role of HI</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CHO is willing to take a lead role in pushing for health policy reform on CVD and Diabetes</td>
<td>Adaptation and operationalization of the national policy, focusing on diabetes and hypertension</td>
</tr>
<tr>
<td>The CHO collaborates with all the key stakeholders on the policy and its implementation</td>
<td>Engagement of the City legislative component (the Local health Board); CVD Program recognized as a regular health program of the CHO</td>
</tr>
<tr>
<td>The CHO is willing to take a lead role in developing and supervising quality CVD and Diabetes services</td>
<td>Success of the pilot phase</td>
</tr>
<tr>
<td>The CHO encourages and ensures effective referral mechanisms between different service providers</td>
<td>Processes and tools defined with the TWG</td>
</tr>
<tr>
<td>The CHO provides a regulatory role in terms of visiting and checking the quality of services (Monitoring and evaluation)</td>
<td>Processes and checklists defined with the TWG</td>
</tr>
</tbody>
</table>

HI assured, through partnership and technical capacity building in 5 key change areas, the successful development of a fully sustainable, competent and independent CVD service provision.

This capitalization will be used:
1/ in the possible replication of the project within the Philippines and in other countries;
2/ in the possible scaling up as the next phase of the CVD Project;
3/ in developing and implementing similar projects within HI.

Authors: Marion Sindezingue, Davide Olchini, Michael Guy

Handicap International

Bibliography:
• World Health Organization. Guidelines for Identifying and Managing Chronic Disease in Primary Health Care. 2004
• World Health Organization. Frameworks and guidelines for the implementation of chronic care. 2004

Photo credits: © Corentin Fohlen
Generic competencies for a local health authority regarding diabetes prevention and management.

For the CHO of Davao City we decided to focus only on 5 competencies. The following table outlines the full list of 16 core competencies which could apply to any local health authority concerning the development and management of CVD services. In other contexts it is possible a different 5 competencies might be selected.

<table>
<thead>
<tr>
<th>Capacities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interest:</strong></td>
</tr>
<tr>
<td>The CHO has a genuine interest in addressing CVD and Diabetes and its impact on their communities</td>
</tr>
<tr>
<td>The CHO is willing to take a lead role in pushing for health policy reform on CVD and Diabetes</td>
</tr>
<tr>
<td>The CHO is willing to take a lead role in developing and supervising quality CVD and Diabetes services</td>
</tr>
<tr>
<td><strong>Technical Knowledge and Capacities:</strong></td>
</tr>
<tr>
<td>The CHO has technical knowledge and understanding about CVD and diabetes prevention and management</td>
</tr>
<tr>
<td>The CHO has an understanding about how to integrate CVD and diabetes prevention and management into existing health services</td>
</tr>
<tr>
<td>The CHO understands how diabetes and CVD links with disability and how this can be addressed in a comprehensive way</td>
</tr>
<tr>
<td>The CHO understands how CVD and Diabetes relates to other social or health sectors - like education, employment, housing etc</td>
</tr>
<tr>
<td><strong>Resources:</strong></td>
</tr>
<tr>
<td>The CHO has sufficient resources –human, financial, technological, political, and other– to mobilize key stakeholders to deliver quality services</td>
</tr>
<tr>
<td><strong>Concrete Actions:</strong></td>
</tr>
<tr>
<td><strong>Alliances/relationships:</strong></td>
</tr>
<tr>
<td>The CHO collaborates with all the key stakeholders on the policy and its implementation</td>
</tr>
<tr>
<td>The CHO works with other departments of local government (for example education, employment, housing) to develop a multi-sector approach to diabetes and CVD and a continuum of quality services.</td>
</tr>
<tr>
<td>The CHO works regularly consults with service users and responds to their needs</td>
</tr>
<tr>
<td>The CHO encourages and ensures effective referral mechanisms between different service providers</td>
</tr>
<tr>
<td>The CHO regularly consults with service providers and responds to their needs</td>
</tr>
<tr>
<td><strong>Regulatory role:</strong></td>
</tr>
<tr>
<td>The CHO develops a robust policy which is specific and relevant to the context</td>
</tr>
<tr>
<td>The CHO provides a regulatory role in terms of Practical Guidelines for implementing services</td>
</tr>
<tr>
<td>The CHO provides a regulatory role in terms of visiting and checking the quality of services (Monitoring and evaluation)</td>
</tr>
</tbody>
</table>
Bibliography


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How to support local government to integrate CVD and diabetes prevention and management into existing health systems - the Davao City experience, Philippines.

This lesson learning publication focuses on Handicap International’s Cardiovascular Disease (CVD) project implemented in Davao City in the Philippines from 2010 to 2013. The specific subject focus is the Davao City Health Office (CHO), the main implementing partner of the project. We are exploring the significant changes achieved by the CHO and the factors which made them possible. In the final section of the document we move forward from the looking at this very specific experience in Davao City to try to propose more general recommendations about how to work with similar local government health departments (in low and middle income country contexts) to develop effective diabetes and CVD prevention and management services.

The target audience for this publication is primarily Handicap International staff working on the issues of diabetes, cardiovascular disease and non-communicable diseases. However the lessons learned can be relevant for all interventions aimed at building effective partnerships with local government to implement sustainable services.

As well as an internal audience this publication will be shared with key external stakeholders within the Philippines, with a view towards raising awareness on diabetes and CVDs, but also to strengthen capacities to replicate aspects of the CVD project in other cities of the Philippines.

Please note: this publication has an accompanying CD-Rom which includes an electronic version of this document, but also a comprehensive practical toolkit developed by the project.

Handicap International Philippines