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Towards the Institutionalization of ABCSDP: Highlights of the Feasibility Assessment

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The Area-Based Child Survival and Development Program (ABCSDP) is a joint venture of the UNICEF and the Philippine Government aimed at uplifting the poor maternal and child health conditions of the country. Four major strategies are applied to pursue this objective, namely: convergence, focused targeting, social mobilization, and decentralization, which are basically incongruent with the sectoral and centralized approach to service delivery employed by the government. This article encapsulizes the significant findings of the case studies and the survey in the seven priority provinces. The various factors affecting the institutionalization and sustainability of the program are discussed with respect to the four aforementioned strategies. An important point on GO-NGO collaboration is raised towards a more effective service delivery.

Introduction

Background

In 1988, the United Nations Children's Fund (UNICEF) together with the National Economic and Development Authority (NEDA), other leading departments in the social service sector and nongovernmental organizations launched the Area-Based Child Survival and Development Program (ABCSDP). The ABCSDP is characterized by the application of a mix of strategies which serve as an alternative to the implementation of the traditional, sectoral approach in the delivery of services catering to the needs of mothers and children.

ABCSDP model applies four strategies: convergence, focused targeting, decentralization and social mobilization. The first strategy which is the application of *convergence* makes ABCSDP unique. This implies the collaborative efforts among national line departments, local government units and nongovernmental organizations in the different phases of the management cycle of planning, implementation, and monitoring and evaluation of services catering to the mothers and children.

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In addition, the intersectoral efforts of the different agencies are to converge on focused targets who are the depressed, deprived and underserved (DDU) mothers and children. The ABCSDP labels this second approach as *focused targeting.*

The third strategy encouraged is *decentralization.* This is actually differentiated from the current mode of implementing social services in the major line departments since the provincial leaders are extended financial responsibility and substantive involvement in designing the package of activities pertinent to child survival and development. These activities are devolved to the province through its provincial development council or any related apparatus convened for the purpose. Subnational coordinative bodies below the provincial level (such as the municipality and the barangay) are also encouraged to be convened in order to ensure an area based, convergent process in planning, implementation, monitoring and evaluation of services targeting the mothers and the children. Prior to the launching of the new Local Government Code, national line departments took charge of the financial allocation and substantive involvement in the different aspects of the management of their sectoral concerns.

Finally, the preceding strategies are to be internalized by interagency participants through the process of *social mobilization.* Capability-building exercises are encouraged by the ABCSDP to generate awareness and commitment among local agency representatives. Furthermore, mothers are also targeted in the social mobilization campaign to enable them to appreciate or develop the demand for health services. Mothers are assumed to have a peculiar responsibility in making decisions pertinent to health matters.

The package of services encouraged by the ABCSDP model does not depart from the major services delivered by most of the sectoral departments. However, the thrust of ABCSDP is to encourage the implementation of this mix of services to assure child survival and development (CSD) including the health and welfare of the mothers. For example, the key services encouraged are those emphasized by the Department of Health (DOH) such as maternal and child health. Thus, activities like immunization, growth monitoring, food supplementation and prenatal health are engaged in.

Another activity is food production and nutrition which is carried out by encouraging families to engage in bio-intensive gardening (BIG). This entails the planting of nutritious foods in the backyard and in communal lots in order to assure the continuous supply of nutritious food for the family. This is to be carried out in cooperation with the Department of Agriculture (DA) and the DOH.

Water supply and sanitation (WATSAN) are both encouraged by DOH. This aims to provide water through the construction of shallow and deep wells and the

exploration of other water sources. Sanitation, in turn, is primarily addressed by the construction of toilet facilities. Both concerns are considered basic in promotive and preventive health care.

Another feature of the program is education and early childhood development. This entails the adoption of small-school and multigrade technologies that are suitable to the sociocultural milieu of the target beneficiaries. It is consonant with the Department of Education, Culture and Sports' (DECS) objective of indigenous experimentation in education (NEDA 1990:209).

Relevant approaches to early childhood development is also encouraged. Strategies include day care centers for 3-6 year-olds and child-minding centers for 0-3 year-olds which are envisioned by the Department of Social Welfare and Development as appendages for substitute mothering (DSWD n.d.:2).

Income-generating projects (IGPs) are also encouraged by the program in order to enhance the economic self-sufficiency of the depressed families and therefore, enable them to procure necessary resources for their health.

It is argued that the implementation of the ABCSDP strategies will enhance the delivery of the mixed services on the assumption that agencies which converge their efforts to respond to the concerns of mothers and children in specific areas surpass the sectoral, nonconvergent efforts of line departments. Maximization of services will lead to improved availment of services and will thus redound to a reduction in mortality of children and mothers.

The priority areas initially selected to serve as test cases for the feasibility of the model are the seven worst-off provinces which were considered according to such indicators as infant mortality, malnutrition rate, enrollment rate, and family income. The seven provinces include Ifugao in Luzon, Negros Occidental in the Visayas, and Lanao del Sur, Maguindanao, Basilan, Sulu and Tawi-Tawi in Mindanao.

In 1987, the year prior to the implementation of the program, infant (less than 1 age group) mortality rate per 1000 livebirths was registered at 54 (UNICEF and GOP 1990:41). Child (age group of 1-4) mortality rate was 6.5 per 1000 population (see UNICEF and GOP 1990:40-42). The health status of the children in the seven pilot provinces was even worse-off. The two priority provinces with available data showed an IMR for Ifugao of 80.9/1000 in 1986; and Lanao del Sur at 106.4/1000 in 1986 (UNICEF and GOP 1990:72).

The Research Problem

As the Philippine Government prepares itself for the next programming cycle for children called CPC IV (Country Program for Children) in 1993, NEDA and UNICEF deemed the importance of determining the effectiveness of the ABCSDP model and some indicative directions for its institutionalization and sustainability. The ultimate objective is to ascertain the potential of institutionalizing ABCSDP nationwide within the context of the new Local Government Code.

Hence, the UPCPA Study Team primarily aimed to determine the feasibility of institutionalizing the Area-Based Child Survival and Development Program. The assessment of its feasibility was based on the actual experiences of implementing the program in six most depressed, deprived and underserved barangays of Ifugao, Negros Occidental, Lanao del Sur, Maguindanao, Sulu, Basilan and Tawi-Tawi.

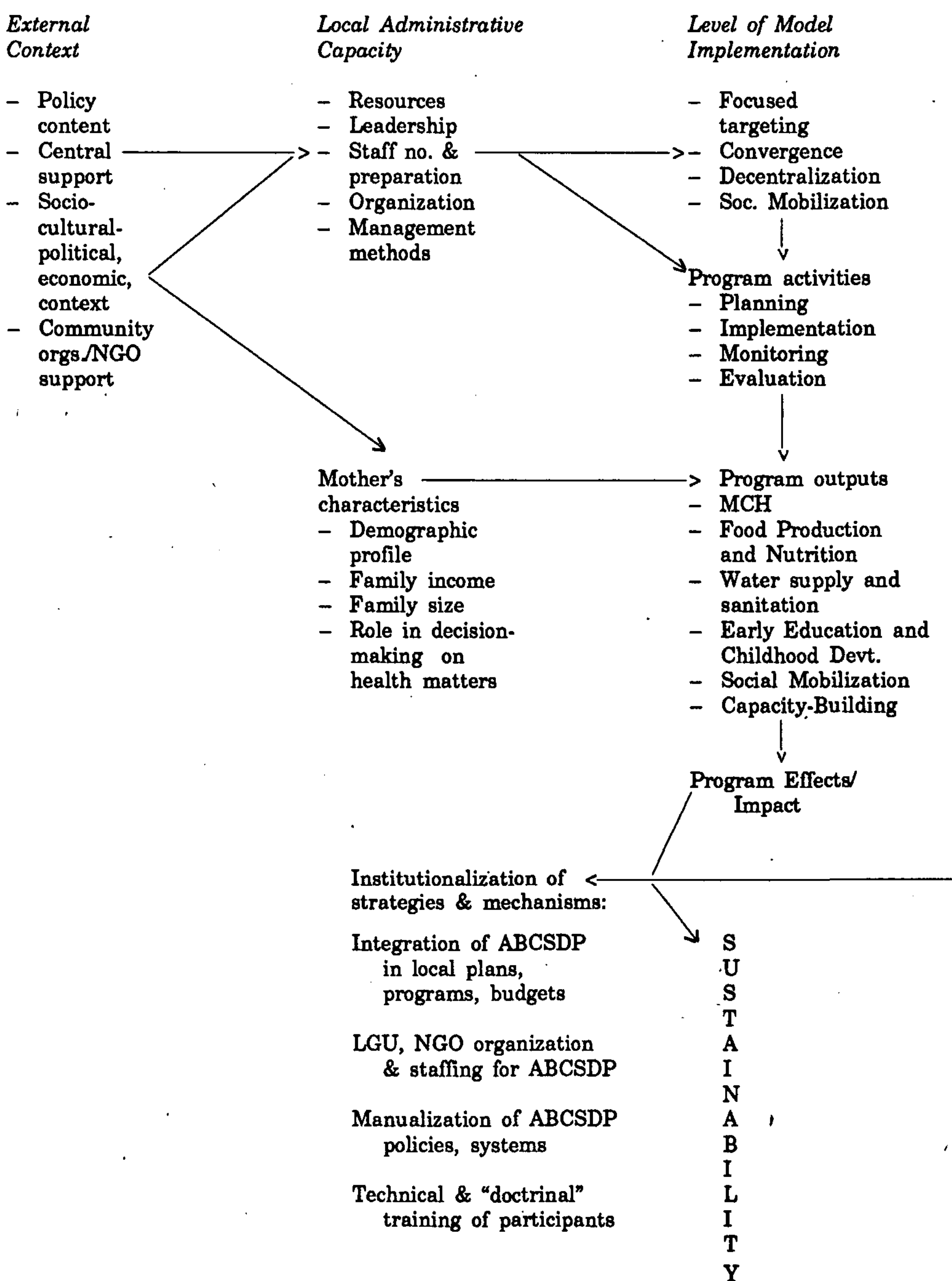
This study served as Phase I of a three-phased undertaking on the institutionalization of ABCSDP. Phase II aims at the determination of specific strategies for institutionalizing the program after drawing from the experiences in its implementation. It will be carried out in the third to fourth quarters of this year. Phase III will be the formulation of manuals to pave the way for the nationwide adoption of the approach within the context of the recently-adopted Local Government Code and the National Program of Action for Children. This is to be undertaken in the first two quarters of the year 1993.

In addition to compliance with the ABCSDP model, the study posits that program effectiveness is influenced by other factors. These include the administrative context of ABCSDP (i.e., the availability and adequacy of resources), the sociodemographic characteristics of the mothers and their spouses and the socio-cultural-political-economic milieu of the program.

Compliance with the ABCSDP model is envisioned to assure the maximization of services delivered by various sectoral departments in charge of four concerns. The concerns are maternal and child health, food production and nutrition, water and sanitation, and early childhood development. Said maximization of services contributes to the enhancement of availment by the target beneficiaries and ultimately, the improvement of the health status of the mothers and their children.

A summary of the arguments is presented in the framework adopted indicated in Figure 1.

Figure 1. Analytic Framework for Evaluating Program Performance and Institutionalization



Methodology

Two broad strategies were adopted in this research. One was the case study approach which was applied to understand the actual processes in implementing the strategies and services envisioned by the ABCSDP. The case study was consolidated using the results of the interviews of 374 key informants and program implementors. Documents and records were also analyzed to gain insights into the mechanics of program implementation and draw some patterns from its results and outcomes.

The dynamics of implementation of ABCSDP were drawn from the experiences of implementors of the seven provinces covered by the study. In each province, two municipalities were studied: one as experimental site and another as control site. The experimental municipalities are exposed to ABCSDP in 1988 or 1989. Their experiences were compared with non-ABCSDP municipalities (or municipalities introduced to ABCSDP only recently) called the control areas. In every municipality, three barangays were drawn. The exceptions were the municipalities of Negros Occidental and Sulu with two control barangays each. But in both provinces, one barangay was added as a component of the ABCSDP municipality. The additional barangay had an exposure to an NGO as an active ABCSDP implementor. Its inclusion enables the study to examine if NGOs spelled a difference in the implementation of ABCSDP. Thus, the data used in the case study were drawn from a total of 15 municipalities and 42 barangays. The distribution of barangays per municipality is shown in Table 1.

Table 1. Distribution of Barangays into Experimental and Control Categories

Experimental Areas	Control Areas	Total
1 priority municipality/ province + 1 in Negros Occidental = 8 municipalities	1 non-ABCSDP mun. or an ABCSDP mun. starting in 1991/1990 per province = 7 municipalities	15
3 ABCSDP priority barangays per municipality selected + 1 in Sulu + 1 in Negros Occidental both under NGO leadership = 22 barangays	3 non-ABCSDP barangays or 3 barangays most recently introduced to ABCSDP in the municipality selected, minus 1 each for Sulu and Negros Occ. = 20 barangays	42

Similar municipalities and component barangays served as sites of the survey conducted. Respondents were mothers of children whose ages are from 0 to 6 years old. The survey is used to gain insights into the services availed of by the family for their children and the mothers, and the morbidity and mortality patterns of children

and of other household members. The characteristics of the respondents such as their family income, educational attainment and participation in decisionmaking on health matters were also drawn. An interview schedule was formulated to draw responses for the aforementioned items.

To determine the effectiveness of the program, comparisons were made between sampled households in 22 experimental barangays or ExBs vis-a-vis 20 control barangays or CBs. They were compared in terms of the strategies in the implementation of services as envisioned by the program and the results and outcomes of the said services they have availed of.

Impact indicators primarily relied on the data provided in the household survey because of the lack of secondary data at the barangay level. A total of 1,992 mothers were interviewed and randomly selected on the basis of the total population per barangay using a formula recommended by Frank Lynch of the Philippine Social Science Council. Of the total 1,992 respondent mothers, 1,054 were from experimental barangays and 938 from the control barangays.

Impact indicators focused on child morbidity and mortality and general morbidity and mortality in the household. Maternal morbidity and cohort mortality of children born in 1988 were also considered as indicators. Children as a category referred to those with ages between 0-6 years. The time frame of the assessment of morbidity and mortality was the last six months preceding the study in relation to the total number of members in that age group in the surveyed households.

Data collection was undertaken for the period 1 August to 30 September 1991 for most of the provinces, except in Ifugao which extended up to 31 October 1991.

Summary of Findings and Analysis

Patterns in Implementation of ABCSDP Strategies

Among the strategies adopted by the program, most success has been achieved in convergence. This is indicated by the more conscious effort among the sectoral field personnel and those of local government units to meet together and coordinate with each other. Such situation has resulted in the improvement in the availability of services.

It is in the area of social mobilization where there is greatest room for improvement. Efforts along this particular strategy have to generate more explicit manifestations of support for program activities from provincial and municipal executives. Moreover, more time, attention and resources must be devoted to working out culturally sensitive processes of planning and monitoring and the modes of delivering social services and in active community organization efforts.

Focused targeting as a strategy requires accurate and reliable information. Through such information, high-risk families may be identified, their location established, and their needs assessed so that the physical and administrative arrangements through which regular means of providing them a package of basic social services, as priority recipients, may be ensured. Lack of reliable information in lower levels of local government which can ensure regular information leading to the identification and location of these families over time has led program planners to rely on key informants other than objective indicators. This is particularly true for highly inaccessible areas, where unfortunately, more of the high-risk families also tend to reside.

More coordinated service delivery processes between national agencies and local government units appear to be evident in the sectors of health and social welfare. The case of health may be partly explained by the decentralized decisionmaking processes in the Integrated Provincial Health Office even before the adoption of the ABCSD program.

Decentralization in terms of devolving more control, authority, responsibility and resources for social services to lower levels of government is indeed innovative. The program has for the first time contributed to the devolution of substantial powers to the prioritized provinces by extending financial assistance towards the realization of the ABCSDP strategies and activities. Other provinces operate within the framework of a top-down bureaucratic machinery. Within this framework, national programs for health and social services for mothers and children are defined by national departments and implemented through their respective field offices.

Decentralization has made a headstart at the provincial level in the seven ABCSDP provinces. The systematic sharing of power with municipalities and barangays in these provinces, however, has yet to be fully strengthened. There are exceptional cases though, as in the municipality of Ilog, which is considered an experimental area by program implementors to fully harness the decentralization efforts of the program at the municipal and barangay levels. While there are exceptional barangays, the cases have shown that the structure and processes of community governance at the barangay level in most of the seven provinces are yet to be more firmly established.

Factors that are frequently mentioned by implementors as crucial to program implementation and sustainability are: (1) interest and commitment of local government executives (governors, mayors and barangay captains); (2) active participation of barangay residents in project identification, mobilization, implementation and monitoring of the program; (3) commitment of line agency service delivery workers and their willingness to cooperate with local officials and employees; (4) cooperation between government and nongovernmental organizations; and (5) sustained funding and technical assistance.

The Implementors

An important component towards the realization of the strategies and programs for child survival and development is the implementors. Their contribution to the program is herein posited to be influenced by such factors as preparation, capability and commitment for undertaking relevant programs for child survival and development.

Socioeconomic Profile of the Implementors. Based on the socioeconomic profile of the implementors, more women (54%) than men (46%) are involved in the program. However, the men do not constitute the minority because they are mostly placed in positions for key decision areas. They are mostly found in regional and provincial offices or are serving as barangay officials while the women are mostly in the field serving as ABCSDP technical staff and frontliners for line agencies and NGOs. The frontliners are the barangay-based implementors who include the day care workers, parateachers and school teachers, midwives, barangay health workers, barangay midwives and agricultural technicians. Thus, the women although more in number are working under the men.

But whether a man or woman, the implementors are mostly mature with an average age of 40 years old. Such maturity may be considered an asset of the project because it indicates possession of wealth of experience and patience needed to sustain a project which is still trying to define itself. But 90% of them are married and have an average of four children. The size of their nuclear family indicates the domestic burden that the implementors have to assume in addition to implementing ABCSDP. Their household income of ₱45,116 per year means that the six members of the average implementor's household have to live within the budget of ₱627 a month each.

Preparation of the Implementors. Inspite of the heavy domestic burden shouldered by the implementors, they are adequately prepared for development work. Their average educational attainment is 3rd year college. But most of the college graduates are in the regional, provincial and municipal levels. Those in the barangay have less education. The frontliners have only an average educational attainment of 2nd year college while the barangay captains only attained 4th year high school. But both groups obtained less number of training opportunities than the line-agency and NGO-ABCSDP implementors. These patterns indicate that training programs have but little compensated the lack of education of some as these boosted the already high education of others.

Nonetheless, they are all experienced with 86% of them having worked before taking on their present job. Their work experience is likewise largely related to their present job being in the government. The experience is an asset to the program.

Capability of the Implementors. The capability of the implementors is measured through their knowledge about the project. It is clear that the lower one goes from the regional and provincial levels, the less percentage of implementors knows something about the project. All the key implementors know something about the project. However only 81% do so among the line agency ABCSDP implementors although there are more among the NGO implementors at 98% percent. Among the barangay-based implementors, only 72% of the frontliners are knowledgeable. But they are more knowledgeable than the barangay captains of whom only 53% know about ABCSDP. But their knowledge is selective. The most widely disseminated information is on ABCSDP sponsor agencies. On this aspect, 47% of the implementors gave correct and complete answer. On the other aspects (ABCSDP's rationale, objectives, components and strategies), less than 47% came up with complete and correct answers. This is despite the fact that the implementors have been doing their present work for six years.

The lack of knowledge of the implementors about the project may be partly explained by the scope of the responsibilities assigned to them for the project . The key implementors (who are key executives performing managerial functions) and the line-agency and NGO ABCSDP implementors (who are technical staff partly engaged in coordinative work) seem to be so preoccupied with supervision/coordination/ monitoring activities. The direct project implementation seems to be done mainly by the frontliners although close to half of the line agency ABCSDP technical staff are also doing it. But inspite of the greater immersion of the frontliners in implementation, they seem to be almost completely excluded from decisionmaking and planning. This compartmentalization of responsibilities among frontliners and technical staff does not strongly indicate a dynamic interaction among various implementors.

Commitment of the Implementors. One of the indicators of the commitment of the implementors is the time they spent on ABCSDP implementation. Based on their own estimate, the NGO implementors spent more time on the project than the government implementors. The NGO implementors spent an average of 85% of their working time on the project while the line-agency implementors spent only an average of 55%. However, this finding does not indicate less commitment from government workers but the greater number of demands they have to handle. The barangay officials have apparently the least time for the project with only 28% of their working time devoted to it since their main role is to manage the operation of the entire village.

But in the course of working on the project, the implementors faced certain problems. The most common are beyond their capability to intervene: peace and order and inadequacy of logistics. Some can be relieved at their levels but cannot be completely solved without outside assistance: fund-related problems and disinterest of superiors. In fact, 79% of them actually took some steps to solve these problems to move forward the project. Another 43% even went to the extent of augmenting

the resources of the project. This initiative indicates that the ABCSDP does not only have well-prepared, capable implementors but committed ones as well.

Results of the Survey

Profile of the Mothers and Fathers. The socioeconomic profile of mothers and fathers in the areas surveyed reveals that focused targeting as a strategy has indeed materialized. This is suggested by the fact that mothers and fathers in the experimental barangays rank lower in selected indicators than the mothers and fathers in the control barangays.

Table 2 shows that the respondent mothers in the experimental areas are worse off in educational attainment (mean grade level is 5.28 years) than those from the control areas (mean grade level is 6.56 years). They are also less literate with a total percentage of 35% who claimed not being able to read and write as against only about 25% among the mothers in the control barangays.

Table 2. Socioeconomic Profile of the Mothers and the Fathers in the Sampled Households, by ExBs and CBs

	ExBs	*CBs*			
Literacy of Mothers					
Literate	65.56	74.73			
Nonliterate	34.44	25.27			
	100.00	100.00			
Mean Age of Mothers	30.13	31.03			
(n)	1054	938			
Mean Years in school of mothers	5.28	6.56	t-test	=	-5.99
(n)	1053	938	alpha	=	.0001
Mean Income of Family	₱1877.56	₱2145.30	t-test	=	3.5582
(n)	1045	914	alpha	=	.0004
Mean years in school of father	5.45	6.67	t-test	=	-5.8
(n)	1031	914	alpha	=	.0001

The profile of the fathers in the surveyed areas further confirms the edge of the control areas over the ABCSDP areas. The fathers in the experimental areas manifest a lower educational attainment (5.45 years of schooling) as against the control areas with 6.67.

This educational standing has perhaps been responsible for limiting the economic opportunities of families in the ABCSDP areas. The mean income level of the families per month in these areas amount to ₱1,877.56 per month. Families in the sampled CBs had a mean of ₱2,145.30. This difference is statistically significant.

However, income levels in the two areas are considerably low since the poverty threshold is ₱4,997.00 per month in 1991 while the food threshold is ₱2,283.00 (Ibon Facts and Figures 1991:2).

Decisionmaking on Health Matters. An important finding in this research is the prominent role of the father in decisionmaking pertinent to health matters. Based on the data in Table 3, mothers are not the sole decisionmakers on health matters. Mothers as sole decisionmakers in each of the four decision areas only occur in 34.34% or less of the total number of respondents (1,992) in each decision area. Furthermore, there is a progressive decrease in the unitary role of the mother in decisionmaking when more complex decisionmaking is made. For example, mothers figure prominently as sole decisionmakers in 34.34% of the total respondents who rendered emergency treatment at home to a sick family member. However, the role of the mothers as sole decisionmakers diminish in some areas of responsibility. These areas include who to consult when a family member is ill and can no longer be managed at home (28.26%), how much money to spend on health matters (24.4%) and when to hospitalize a sick family member (21.59%).

Table 3. Decisionmaking on Health Matters (in Percentage)

Decisionmaker(s)	*Decision Areas*			
	Emergency Treatment	*Who to Consult*	*Amount to Spend*	*When to Hospitalize*
Respondent	34.34	28.26	24.40	21.59
Spouse	29.82	29.92	37.70	30.77
Both	29.57	32.93	31.78	39.26
Both and Others	2.61	3.93	2.61	4.22
Others Only	3.61	3.21	3.51	4.07
No Answer	.05	–	–	.10
Total	100.00	100.00	100.00	100.00
n	1992	1992	1992	1992

Chi square test = 149.84
d.f. =12 Alpha < .01

Joint decisionmaking figures prominently in making decisions on who to consult when a family member is ill (32.93%) and when to hospitalize a member of the family who is ill (39.26%).

The husband figures as the most prominent person in making a decision regarding how much to spend for health matters (37.7%) perhaps because he is the major breadwinner in the family.

There is a statistical difference between the persons involved in each decisionmaking area with a chi-square test (149.84, d.f.=12, alpha < .01).

The findings here coincide with the earlier ones on decisionmaking patterns in the family that a "thinking task" like determining who to consult when a family member is sick and when to hospitalize tends to be more shared than the "doing task" such as giving an emergency treatment at home (Contado 1991:159).

Differences in the involvement of males and females are noted by region. For such decisionmaking processes as providing emergency treatment at home and when to hospitalize a family member who is ill, the most equalitarian are the Ifugao families, with more than half of the families attributing to joint decisionmaking resolution of these two issues. The most patriarchal are the Muslim families who rely mostly on the husband for these two decision areas with more than 35% of the households in these areas relying on the father as decisionmaker. In the case of Negros, the mothers are relied upon more often when a family member becomes sick. The father is depended on more often when the decision to hospitalize a family member is the major concern. (See Table 4.) Thus, these findings imply that fathers are important decisionmakers on health matters with the mothers not having the sole prerogative to decide.

Table 4. Decisionmaking on Selected Health Matters by Household Members, by Regional Affiliation

Decision makers	*Decision Areas and Regional Affiliation*					
	Emergency			*When to Hospitalize*		
	Ifugao	*Negros*	*Mindanao*	*Ifugao*	*Negros*	*Mindanao*
Respondent	38.8	45.3	30.35	21.74	25.14	20.59
Spouse	2.68	23.48	37.64	4.35	37.02	35.01
Both	57.86	28.45	23.52	73.24	35.36	32.68
Both/Others	0	1.66	3.46	0.0	1.66	5.86
Others Only	.66	1.1	5.03	.67	.83	5.79
Total	100.0	100.00	100.0	100.0	100.0	100.0
n	299	362	1331	299	362	1331
Chi square test	205.49			241.34		
d.f.	8			8		
alpha level	5.5E-13			6.580E-12		

Influence of the Program on Knowledge of ABCSDP and Availment of Services for Children and Mothers. The influence of the program on the awareness of its existence is suggested by the high percentage of ExB mothers (59.4%) who know about ABCSDP in comparison to only 8.74% of the mothers in the CBs.

A more significant indication of the influence of the program on the target beneficiaries is the fact that the ExBs have a higher level of availment of the services for children and mothers. Furthermore, the application of selected health practices suggested by the ABCSDP package has been manifested in the ExBs more prominently.

(1) Availment of Services for Children

For the children, improvements have been noted in the ExBs vis-a-vis the CBs for such services as growth monitoring, nutritional supplementation and day care. However, for both the experimental and control areas, immunization coverage is high with a little more than 60% of the total number of children being immunized. This is higher than the mean percentage of children covered by immunization in 1987 which was 44.54% for the seven provinces (UNICEF and GOP 1990:73). The lack of difference between the experimental and control areas may be attributed to the fact that the program did not discriminate between ExBs and CBs in immunization. (See Table 5.)

Table 5. Number of Children who Utilized/Benefited from a Recommended Practice, by ExBs and CBs

Services	*ExBs*		*CBs*	
	f	%	f	%
Immunization	1346	61.69	1196	63.1
Growth monitoring	1223	56.05	911	48.1
Nutritional supplement	732	33.5	368	19.4
Day care	325	14.9	101	5.3
Total number of 0-6 children	2182		1895	

The extent to which the program has improved the experimental areas vis-a-vis the control areas was determined by the difference between the baseline condition or the year when ABCSDP was first introduced (1988) for half a year's

performance and the most recent period (January to June 1991) in the ExBs and the CBs. Thus:

First Observation	Areas	Second Observation	
1988	ExBs	1991	————> Diff.
1988	CBs	1991	————> Diff.

Furthermore, the difference of 1988 and 1991 percentage of coverage for the CBs is subtracted from the difference of 1988 and 1991 coverage in the ExBs in order to determine the net effect of the program. Thus:

Difference for ExBs in 1988 and 1991 percentage of utilization	-	Difference for CBs in 1988 and 1991 percentage of utilization	=	ABCSDP effect

Table 6 reveals that the services suggested under the ABCSDP package have higher percentage of availment among children in the ExBs as compared with the CBs. The services with the most number of utilizers between the two time periods are nutritional supplementation and day care services. The net percentage difference in nutritional supplementation is 8.29%. In day care services, it is 3.46%. The program had the least effect on growth monitoring with only a difference of 2.48 percentage points.

Table 6. Percentage of Children who Utilized/Benefited from a Recommended Practice, by ExBs and CBs and Comparing 1988 and 1991 (January-June)

Services	*ExBs*			*CBs*			*Difference of ExBs & CBs for '91 & '88*
	1991	*1988*	*Diff.*	*1991*	*1988*	*Diff.*	
Immunization			no data available				
Growth monitoring	18.95	1.37	17.58	15.6	.5	15.1	2.48
Nutritional supplement	15.7	2.06	13.64	6.2	.85	5.35	8.29
Day care	5.95	.87	5.08	1.9	.29	1.62	3.46
	n = 2182			n = 1895			

However, there are no data available for immunization because the mothers had difficulty recalling the various immunization shots received by their children.

A comparison of the overall availment of services for 0-6 children in the ExBs and CBs further validates the earlier argument that ABCSDP areas have indeed improved in the delivery of services in the targeted barangays. The ExBs obtained a mean level of service of 3.44 as against only 2.94 in the CBs. This difference is statistically significant with a t-test for difference of means (t=9.69, d.f. of 1978, alpha of .0001 for unequal variances). However, the fact that the mean for the ExBs is only 3.44 indicates that much can still be done to achieve the whole range of services available for children.

The significance of ABCSDP in influencing the utilization patterns of the sampled households for their respective children is once again borne out in the test comparing those who ever heard of ABCSDP (n=708) and those who are unfamiliar with the program (n=1280). A significant difference exists between the two groups with the respondent mothers who ever heard of ABCSDP having a higher level of availment with a mean of 3.68 as against only 2.96 among the unfamiliar mothers (t-test=12.63, d.f.=1254, alpha level for unequal variances=.0001).

Four selected characteristics of the household were examined to ascertain whether they influence the utilization patterns of the services for children. One pertains to the mean level of schooling of the mother. A positive relationship is argued on the assumption that mothers with higher educational attainment are more inclined to appreciate the value of availment. This is because of the implication of the service in the improvement of the health status of their children.

Another factor is the educational attainment of the fathers. A positive correlation is hypothesized and has the same rationale as the pattern posited for mothers' educational attainment and overall availment of services for children.

A positive correlation is hypothesized between overall availment and size of the family. The argument is that families with a bigger size tend to indicate a higher utilization pattern.

Finally, a negative correlation is posited between overall utilization and level of income since those with higher educational attainment will rely less on government and NGO services for children since they have the resources to pay private practitioners.

Table 7 summarizes the findings on tests of these relationships. Three factors, except family income, are related with overall utilization per household. Positive correlations were noted between utilization of services for children per household and

such characteristics as the educational attainment of mothers and fathers and the household size. The fact that income is not a significant factor for availment augurs well for the program because this indicates that the economically deprived are not discriminated by program implementors.

Table 7. Summary of Correlation Tests for Selected Sociodemographic Characteristics and Utilization of Health Services for Children

Factors Related with Availment of Services for children	*Correlation*	*Alpha Level*	*Result: Significant (S) or Not Significant (NS)*
Mother's education	.18	.0001	S
Father's education	.15	.0001	S
Household size	.05	.01	S
Family income	.01	.73	NS

(2) Availment of Services by Mothers

To cater to the mother's health maintenance, the program has augured well for prenatal services like injection of vitamin supplementation and injection with tetanus toxoid, receiving reading materials on health matters and receiving other health services or information. Experimental barangays benefited from these more than the control barangays.

However, there are certain services for mothers which can still be maximized. These are in such aspects as mother's classes and the conduct of training programs to encourage participation in community activities. Hence, the weakness of the program in these aspects led to a poor showing in actual participation of mothers in community activities. Table 8 summarizes the various services availed of by the mothers.

Table 8. Services Availed of by Mothers, by ExBs and CBs (in Percentage)

Services Utilized	*ExBs n=1054*	*CBs n=938*
Prenatal Services	53.23	45.31
Vitamins	45.9	37.5
Tetanus Toxoid	44.78	33.38
Physical Exam.	32.2	31.3
Other Prenatal Services	4.6	3.09
Other Personal Health Services	12.52	6.50
Mother's Classes	23.24	14.82
Training for Community Activities	15.56	9.06
Reading Materials Received	17.84	12.79
Other Services	7.02	2.56

Table 9 summarizes the overall effect of the program for each of the services. On the whole, it can be seen that the program has made a difference in terms of improving the utilization of various services among the mother respondents. The most effect is witnessed in prenatal services such as tetanus toxoid and physical examination, except for vitamin supplementation indicating less than one percentage point net effect. ABCSDP areas also maximized its services in the dissemination of reading materials pertinent to health and availment of other health services.

Minimal effects are noted in availment of mother's classes and in participation of training programs for community activities. There is less than one percentage difference between two time periods for the ExB and CB respondents. This could explain why a negative result is obtained in the actual involvement of the respondents in community activities from the experimental areas vis-a-vis the control areas. This finding indicates the areas where ABCSDP could step up its efforts.

Table 9. Magnitude of Utilization of Services by Mothers in 1988 and in 1991, Comparing ExBs and CBs (in Percentage)

Services	*ExBs*			*CBs*			*Net Effect*
	1991	*1988*	*Diff.*	*1991*	*1988*	*Diff.*	
Prenatal Services							
Tetanus Tox.	8.7	3.6	5.1	7.5	4.3	3.2	1.9
Vitamins	9.0	3.8	5.2	7.2	2.7	4.5	0.7
Physical Exam	7.9	2.3	5.6	5.6	2.5	2.1	3.5
Other Health Services	3.9	0.3	3.6	2.3	.4	1.9	1.7
Mother's Classes	3.1	1.4	1.7	2.1	1.2	0.9	0.8
Reading Materials	4.3	1.0	3.3	2.2	.9	1.3	2.0
Training for Comm. Activities	3.1	1.4	1.7	2.1	1.2	0.9	0.8
Involvement in Comm. Activities	1.2	1.1	.1	4.6	.7	3.6	-3.5

A perusal of the different topics in preparation for involvement in community activities cater to such programs as beautification and environmental sanitation, bio-intensive gardening, training for barangay health workers, human relations, and cleanliness in children care. In both areas, at least 62% of the respondent mothers were exposed to topics devoted to beautification and environmental sanitation. (See Table 10.)

However, while there is a bigger percentage of mothers trained in community activities in the ExBs, a bigger percentage of the mothers from the CBs actually got involved in community activities. About 11.73% of the mothers from control barangays

mentioned participation in community activities but only 7.69% from the ExBs cited this experience. This difference is statistically significant with a chi-square test.

This situation points out that the ABCSDP has to hone its impact in the ExBs which are relatively less socioeconomically developed than the CBs. It could have been easier for the CB mothers to appreciate the significance of community participation. Further tests are performed in the latter part of this report to examine the relationship of community participation with other sociodemographic variables.

Table 10. Topics of Training Programs for Community Activities

Topics	*ExBs*		*CBs*	
	F	*%*	*F*	*%*
Beautification and environmental sanitation	111	(68.5)	52	(62.7)
Bio-intensive gardening	21	(13.0)	9	(10.8)
BHW training	9	(5.6)	3	(3.6)
Human relations	3	(1.8)	5	(6.1)
Cleanliness in child care	4	(2.5)	4	(4.8)
Others	14	(8.6)	10	(12.0)
Total	162	(100.0)	83	(100.00)

Another possibility is that nongovernmental institutions in the CBs have put a lot of impetus on mobilizing the community for participation.

The type of activities engaged in by mother respondents has something to do with the training programs they have been involved in, except for those who participated in adult education and other activities (i.e., campaign against drug abuse, family planning, bible study). (See Table 11.)

The prominent activities mothers had been involved which had an implication to the community pertain to beautification and cleanliness. In both the experimental and the control barangays, this activity had the most number of citation.

Mothers were also asked about the involvement of the households in income-generating projects (IGPs). Only a very small number mentioned this, although the edge of the ExB households is discernible compared to that of CB households. Close to 18% of the mother respondents in the ExBs cited this. This is nearly double the number of CB mothers registering this response with only 9.49% mentioning this.

The types of livelihood projects the households got involved in are livestock raising (i.e., piggery, poultry, and ducks), vegetable gardening and farming, weaving and handicrafts work, operation of sari-sari store and money lending.

Table 11. Actual Activities Engaged in the Community

Activities	ExBs		CBs		Total	
	Frequency	*%*	*Frequency*	*%*	*Frequency*	*%*
Adult Ed.	6	(7.23)	17	(15.45)	23	(11.92)
Beautification/ Cleanliness Drive	29	(34.94)	37	(32.63)	66	(54.20)
IGP-DA	3	(3.60)	3	(2.73)	6	(3.11)
BHW Training	9	(10.84)	1	(.90	10	(5.18)
Others	20	(24.10)	47	(42.73)	67	(34.71)
No Info	16	(19.28)	5	(4.54)	21	(10.88)
Total	83	(99.99)	110	(99.98)	193	(100.00)

A comparison of the ExBs and the CBs shows that the mothers in the former manifested a significantly higher level of availment with an overall mean level of 2.14 as against 1.65 for the CB areas. This difference is statistically significant with a t-test (t=5.92; d.f.=1987 for unequal variances; alpha=.0001). This finding therefore indicates the significant effect of ABCSDP in maximizing the availment of services for mothers in the experimental areas. However, further expansion of coverage is still suggested since the average availment of services in the ExBs has not reached close to 9 points.

Another proof of the impact of ABCSDP is the difference in the level of availment of services for mothers between the group who ever heard of ABCSDP as against those who did not have the benefit of exposure to the program. Among those who ever heard of ABCSDP (n=708), a mean level of availment of 2.52 was registered over the level of 1.57 for the group of mothers (n=1280) who did not have the benefit of this exposure. This finding further validates the earlier argument about the impact of ABCSDP. The difference between these two groups is statistically significant with a t-test (t=10.6001; d.f.=1312; for unequal variances; alpha=.0001).

Four factors which were considered in the availment of resources for children are also examined in the availment of services by mothers. Table 12 summarizes the statistical tests for each of the four variables: mother's educational attainment, the father's educational attainment, household size and family income.

Table 12. Summary of Correlation Tests for Selected Sociodemographic Characteristics and Utilization of Services by Mothers

Factors Related with Availment of Services by Mothers	*Correlation*	*Alpha Level*	*Result: S or NS*
Mother's education	.31	.0001	S
Father's education	.12	.001	S
Household size	.02	.36	NS
Family income	.01	.58	NS

Two factors emerge as critical in influencing the level of availment. These are the mother's and the father's educational attainment. Positive correlations are noted for each of these variables as each relates with availment. Mothers with higher mean level of schooling are more inclined to utilize services which redound to the improvement of their health and that of the family.

Fathers who are also highly educated significantly influence the utilization of services by mothers. This pattern may be attributed to the fact that fathers provide the strongest influence on the mothers' decisionmaking.

Household size has no significant influence on the mother's availment. This signifies that the size of the household does not in any way interfere with the utilization of services that would be beneficial to the mother's personal health and overall social condition of the family.

Furthermore, family income is significantly related with availment of mother's services. This implies that access to services has not prejudiced anyone from a low economic standing.

Since community participation is one of the factors that is argued to contribute to sustainability and institutionalization, other nonprogram variables are examined herein to further search for contributory factors to citizen participation.

Table 13 summarizes selected sociodemographic factors as they relate with participation.

Two factors surface as significant in determining citizen participation in both the experimental and control barangays. These are the educational attainment of the mother and that of the father. On the whole, mothers who were participative had a higher educational attainment (8.3 years of schooling) and had a husband with

a higher educational attainment (8.1 years of schooling) than those who were nonparticipative (5.6 years of schooling for the respondents and 5.8 years of schooling for the fathers).

Table 13. Mean Level of Selected Sociodemographic Characteristics Among Those Who Participated/Did Not Participate in Community Activities, by ExB and CB Areas

Areas	*n*	*Mean*	*T Test*	*Alpha*	*S/NS*
Mean Years of Schooling of Respondents					
	With Participation				
Experimental Bgys.	81	7.05	-4.07	.0001	S
Control Barangays	110	9.48	w/ unequal var.		
	W/O Participation				
Experimental Bgys.	972	5.14	-4.6	.0001	S
Control Barangays	828	6.17	w/ unequal var.		
Mean Years of Schooling of Household Head					
	With Participation				
Experimental Bgys.	80	6.9	-4.0	.0001	S
Control Barangays	110	9.3	w/ equal var.		
	W/O Participation				
Experimental Bgys.	951	5.3	-4.5	.0001	S
Control Barangays	807	6.3	w/ unequal var.		
Household Size					
	With Participation				
Experimental Bgys.	81	6.4	-1.04	.2979	NS
Control Barangays	110	6.8	w/ equal var.		
	W/0 Participation				
Experimental Bgys.	973	6.2	.9	.3634	NS
Control Barangays	828	6.1	w/ equal var.		
Family Income					
	With Participation				
Experimental Bgys.	80	2185.25	-.48	.6278	NS
Control Barangays	105	2311.26	w/ equal var.		
	W/O Participation				
Experimental Bgys.	965	1852.05	-3.45	.0006	S
Control Barangays	842	2123.76	w/ unequal var.		

Between the experimental and the control barangays, the participative mothers from the former had a lower educational attainment than the latter (7.05 vs. 9.48 years of schooling).

The influence of educational attainment on participation may be attributed to the fact that those with higher educational attainment appreciate better the value of community participation. Furthermore, those with higher educational attainment have the facility to articulate their views and demands. The father's educational attainment is related to the mother's involvement since the father may have encouraged the mother's decision on whether or not to get involved in community activities.

Family income is another factor which influences participation. On the whole, those who did not get involved in community activities have a generally lower income level than those who participated. Mothers who did not get involved in the ExB areas had a mean income level of ₱1,852.05 as against ₱2,185.25 among the participative mothers. Those with higher income are perhaps more inclined to get involved in community activities because they have less to worry about in terms of economic concerns.

Mothers in the control barangays, on the other hand manifested higher income levels than the ExBs. Like their ExB counterparts, mothers in the CBs who were participative had a higher family income level (₱2,311.26) than the nonparticipative ones (mean income=₱2,123.76).

No difference exists among the participative mothers in income level from both ExBs and CBs. While income level of ExB households is a bit lower than the CBs, the difference is not statistically significant. This implies that participation may require some amount of economic self-sufficiency to allow mothers to get involved as this takes away additional time and effort outside of the mother's regular activities and possible involvement in income-generating activities.

Finally, household size is not a significant factor in influencing participation. The average size of a household in the experimental and control barangays in a participative and nonparticipative household is a little over six.

(3) Health Practices in the Home

Table 14 reveals a slight edge of the ExB mothers over the CBs in terms of the availability of health facilities and reliance on selected health practices within their respective households. ExB areas surpass respondent mothers from the CBs in percentage manifesting health practices and facilities on six indicators. These pertain to the following: reliance on sanitary water facilities, planting of food bearing plants, planting of herbal plants, preparation of a well-balanced supper, practice of

breastfeeding for babies in the household, and putting the animals in the cage or leash to contain wastes. It is noticeable that respondents score high on practices that are strongly endorsed by ABCSDP such as bio-intensive gardening, breastfeeding and reliance on sanitary water facilities.

Respondent mothers from the CB areas score high on five health practices. These are with respect to: reliance on sanitary toilet facilities; intake of balanced meals for breakfast and dinner by preparing meals combining cereal, protein rich foods and vegetables or fruits; absence of or minimal garbage observed in the surrounding area; and the absence of stagnant water around the house.

Table 14. Facilities and Health Practices in the Household, by ExBs and CBs (in Percentage)

Facilities / Practices	*ExBs n=1054*	*CBs n=938*
Piped water/pump/artesian well	55.55	43.51
Flushed/antipolo toilet	23.05	31.02
Planting food-bearing plants	59.68	49.57
Planting medicinal plants	41.37	35.5
Combination of cereal, protein and vegetables/fruits for:		
Breakfast	30.65	41.15
Lunch	57.78	59.06
Dinner	66.17	61.83
Caged/tied animals	32.73	31.99
Absence of/minimal garbage/animal wastes in the surrounding area	59.48	62.68
Absence of stagnant water in the surrounding area	74.76	77.08
Breastfeeding	43.67	37.99

In the abovementioned practices, the use of a sanitary toilet facility is the most sparse. At least 30% of the respondents in both areas had access to flushed, water-sealed or antipolo system.

To ascertain if a difference exists between the experimental and control barangays in terms of overall utilization of the aforementioned practices, the mean score for the mother respondents was obtained.

No statistical difference exists between the two groups. The overall mean level of health practices for the ExBs is 11.43 as against 11.23 for the CBs. The t-test which ascertains the significance of the difference of means for the two areas is 1.52 with alpha of 0.12 for unequal variances.

However, a difference may be discerned between those who ever heard of ABCSDP as against those who are not familiar with the program. Those who ever heard of ABCSDP obtained a mean score of 11.92 (n=708) as against only 10.99 (n=1280) for respondent mothers unfamiliar with the program. T-test result is 6.92 with an alpha of .0001 for unequal variances. This suggests a possible impact of the program to those introduced to it.

Table 15 summarizes the factors related to health practices in the family. Three hypotheses are borne out by the statistical tests of correlation. These are for educational attainment of the mothers and the household head and income level of the family as related with health practices. The exception is household size which did not yield a significant result.

It is significant to note that implementation of the aforementioned practices is directly related with income level. This is because procurement of certain resources such as nutritious foods, toilet and water facility hinges on the financial capability of the families. In turn, mothers and fathers with high educational attainment are more prone to implement the suggested practices as they are likely to appreciate better their value to health.

Table 15. Summary of Correlation Tests for Selected Sociodemographic Characteristics and Health Practices in the Household

Factors Related with Health Practices	*Correlation*	*Alpha Level*	*Significant (S) or Not S (NS)*
Mother's education	.23	.0001	S
Father's education	.19	.0001	S
Household size	.03	.2164	NS
Income	.10	.0001	S

Impact Indicators

The ability of the program to make an impact in the reduction of mortality among the target beneficiaries is shown by the survey data. In particular, correlation tests of level of utilization of children's services and such factors as child mortality (r=-.07, alpha of .03) and cohort mortality (r=-.07, alpha of .03) in the experimental barangays signify inverse relationships which means that high availment leads to a reduction in mortality. These patterns are not obtained to a significant extent in the control barangays. Availment of children's services and child mortality obtained a

correlation of .04 which is not statistically significant (alpha=.2). The same is true for availment of children services and child mortality indicating an inverse correlation (r=-.05, alpha of 0.15).

Furthermore, direct attribution of impact on the program was determined by the improvement in child mortality among the experimental barangays whose mothers are familiar with ABCSDP and who had high availment of children's services (mortality is 7 to 1000) as against the familiar ones but had a low availment of services for children (mortality rate is 23.4 per 1000). (See Table 16.)

Table 16. Familiarity with ABCSDP, Availment of Children's Services

Heard of ABCSDP	*No. of Households*	*No. of Children*	*No. of Children Who Died*	*Rate Per 1000*
Low Availment of Services for Children (1-3 Services Only)				
Yes	304	599	14	23.4
No	263	522	13	24.9
High Availment of Services (More Than 3 Services)				
Yes	322	717	5	7.0
No	163	337	4	11.9

Among the unfamiliar ones to ABCSDP but who had high availment of children's services in the experimental areas, mortality rate (11.9 per 1000) was lower than the unfamiliar ones but depicted low availment of children's services (24.9 per 1000). This further proves that availment of services is important in reducing child mortality; that familiarity with the program could have facilitated availment of the services.

In the case of general mortality, both ExBs and CBs experienced a significant reduction in general mortality resulting from the availment of services by mothers. However, while the difference in general mortality is not significant for both areas (general mortality rate is 15 per 1000 in the ExBs as against 13 per 1000 in the CBs), the impact of the program is suggested by the fact that experimental barangays nearly have an equal footing with the control barangays on mortality. Considering that the experimental barangays are more socioeconomically deprived,

this equal footing on general mortality pattern in the two areas signify the gains of the program.

Direct attribution to the program in the reduction of general mortality may be gleaned from the difference between the mothers familiar with ABCSDP who availed of maternal services vis-a-vis the familiar ones but were nonavailers of services in the experimental barangays. The general mortality rate for the former is only 5.7 per 1000 as against 9.5 for the latter. (See Table 17.)

Table 17. Familiarity with ABCSDP, Availment of Maternal Services and General Mortality

Heard of ABCSDP	*No. of Mothers*	*No. of Household Members*	*No. Who Died*	*Rate Per 1000*
		Availed of Services for Mothers		
Yes	454	2,820	16	5.7
No	242	1,503	7	4.6
		Did Not Avail of Services		
Yes	172	1,054	10	9.5
No	184	1,148	14	12.2

The impact of the program may also be attributed to dissemination of IEC materials. The beneficiaries of the IEC materials in the experimental barangays have experienced higher level of service availment for children and maternal services than the nonbeneficiaries. The mean availment of services for children among the mothers who read IEC materials was 4.3 as against 3.3 among the nonbeneficiaries.

Mothers who availed of IEC materials also indicated a high level of availment of maternal services with an average of 4 services. Nonbeneficiaries only indicated two services.

Availment of reading materials in turn influenced the reduction in mortality. Beneficiaries of IEC materials registered child mortality of 9 per thousand vis-a-vis 33 among the nonbeneficiaries. Furthermore, beneficiaries of reading materials registered general mortality of 3 per 1000 as against 42 per thousand among the nonbeneficiaries. (See Table 18.)

Table 18. Readership of IEC Materials, Availment of Services and Reduction of Mortality in the ExBs

	Beneficiary of IEC Materials	*Nonbeneficiary of IEC Materials*
Child Mortality Per 1000	9	33
General Mortality Per 1000	3	42

Whether or not the program has been able to reduce morbidity as a result of an increase in availment of services is not borne out in this research. Rather, a positive correlation is noted between these two factors. This means that the higher the availment, the higher the morbidity. (In relating overall availment of services and general morbidity, a correlation coefficient of 0.26 was obtained and is highly significant at alpha of .0001. The relationship of availment of services and child morbidity is 0.24 and is also highly significant at 0.0001.) This finding may not be taken to mean that the program is not effective. Rather, the pattern of high availment and high morbidity is an indication that the program was indeed able to reach out to those who were physically ill. To consider morbidity as an impact indicator is not appropriate. Rather, morbidity is a factor that may be considered as an antecedent to utilization, which in turn could influence mortality.

High Performing and Poor Performing Barangays in the Experimental Group

Background

Since ABCSDP has argued that services will be maximized in the areas where the recommended strategies are implemented, availment is considered as a critical factor in determining the high performing and the poor performing barangays. The basis for selecting these cases is the total score each barangay obtained for the number of services availed of by the mothers for themselves and their children and the mothers' actual involvement in community activities.

Focusing on these barangays enables the study to trace other factors related to availment. In addition to the socioeconomic characteristics of the beneficiaries, other program factors like strategies and the administrative context in which ABCSDP operates may be witnessed in the actual dynamics of ABCSDP implementation in these barangays. Furthermore, a focus on these cases will enable us to determine the impact of the program on mortality.

A ranking of the barangays in terms of overall scores for availment yields high scorers and poor scorers in level of availment (Table 19). The overall score was obtained by getting the average of all the items pertinent to availment of services for mothers and children, including actual participation in community activities.

Table 19. Top and Low-Ranking Barangays According to Mean Availment of Services

Rank	*Barangay*	*Mean Availment of Services for:*		*Mean Level for Community Participation*	*Overall Score*
		Children	*Mothers*		
	High Scorers				
1	Manalad, Ilog Negros Occ.	4.45	4.09	.15	8.06
2	Lakit-Lakit, Bongao, Tawi-Tawi	4.3	3.24	.36	7.91
3	Miranda, Pontevedra, Negros Occ.	4.0	3.55	.08	7.62
	Low Scorers				
20	Buada Babai, Ditsaan Ramain, Lanao Sur	2.4	.54	.03	2.97
21	Anuling, Patikul, Sulu	2.34	.5	.0	2.84
22	Nabundas, Pagalungan Maguindanao	2.08	.31	2.31	2.39

The high scorers are two barangays from Negros Occidental which are Manalad from Ilog and Miranda of Pontevedra. The third one which is second in rank in level of availment is Lakit-Lakit of Bongao in Tawi-Tawi.

The poor performing barangays in availment are those from Nabundas of Pagalungan in Maguindanao, Anuling of Patikul in Sulu and Buada Babai of Ditsaan Ramain in Lanao del Sur.

Profile of the Barangays

All of the barangays are relatively poor being mostly categorized as fifth income class barangays. The exception is Barangay Buada Babai which is more depressed since its municipality is in the sixth class.

Miranda, Lakit-Lakit, and Buada Babai are coastal communities while Manalad and Nabundas are adjacent to a river. Hence farming and fishing are the predominant sources of livelihood in these areas.

Anuling's topography is most different since it is situated in the inner portion of the municipality of Patikul in Jolo. The dominant source of livelihood in this area is farming.

Anuling is the closest to the provincial capital being located near the capital town of Jolo. The farthest from the center of economic and political activities is Lakit-Lakit which is 15 kilometers from Bongao, the capital of Tawi-Tawi. While it is accessible to land transportation throughout the year, the roads are bumpy and difficult to traverse. Located in the northern part of Sanga-Sanga island, motor boats are the alternative modes of transportation to gain access to the place.

Four of the six barangays are predominantly Muslim communities although they vary in sociocultural characteristics as they belong to different Muslim groupings. Lakit-Lakit is made up of Samals who are noted for their cleanliness in their surroundings. This barangay was once adjudged as most outstanding in Tawi-Tawi in the sixties because of its contribution to agricultural projects and sanitation activities. In annual religious activities such as "hariraya," the residents go out of their houses to clean their surroundings. This may partly explain why it is also one of the three high ranking barangays in performance. The other groupings are the Maguindanaons, represented by those from Nabundas; the Tausugs, represented by Anuling respondents of Patikul in Sulu; and the Maranaos of Buada Babai of Ditsaan Ramain in Lanao del Sur. Miranda and Manalad are predominantly Christian communities.

All of the barangays were earmarked to serve as pilot barangays of the program when it was formally launched in 1988. However, the program was only initiated to the two barangays (Anuling and Miranda) only the following year.

Profile of the Respondents from the Six Barangays

Educational Profile. The high performing barangays generally have a little edge over the mothers from the poor performing barangays in terms of educational attainment. It may be reiterated that in the test of significance, educational attainment of the mothers surfaced with their level of availment.

Of the three top performing barangays, the educational profile of the mothers from the two barangays of Negros have the most advantage compared to the rest of the mothers. They have attained an educational level of about second year of high school. Lakit-Lakit, another top ranking barangay, had mothers who had achieved

close to five years of elementary education. However, these mothers are still a bit ahead over those in the poor performing barangays. Thus, the mother's educational profile could have influenced the level of availment of services made available to them in their respective communities. (See Table 20.)

On the other hand, mothers in the poor performing barangays like Buada Babai, Anuling and Nabundas show very low level of mean grade level of schooling. Of the three, the mothers from Buada Babai are close to the educational attainment of the mothers from Lakit-Lakit. A poor second are the mothers from Anuling with a mean grade of 3.82. The least educational attainment is demonstrated by the mothers from Nabundas with a mean of 2.31.

Table 20. Socioeconomic Profile of the Mothers from the Six Barangays

Rank	*Barangays*	*Mean Grade Level*	*Average Family Income*
1	Manalad	8.06	₱1,486.46
2	Lakit-Lakit	4.84	1,109.38
3	Miranda	8.03	1,283.36
21	Buada Babai	4.57	1,868.86
22	Anuling	3.82	2,367.44
23	Nabundas	2.31	1,046.19

Family Income. All the barangays examined are evidently depressed as they earn a family income way below the cutoff mark for poverty level. (See Table 20.) Five of the six barangays earn below ₱2,000.00. The exception are the families of mothers from Anuling who reported an average monthly income of ₱2,367.44. However, it may be recalled that Anuling is the only barangay which is adjacent to the provincial capital of Sulu and therefore provides the most economic opportunities for the residents.

The lowest in economic standing are the respondent mothers from Nabundas who also happen to be the lowest in educational standing among the rest of the mothers. Their respective families have only earned a mean income level of ₱1,046.19.

Facilities for Sanitation. Another feature that is considered is the basic facilities available to the households for the maintenance of health and sanitation. These facilities are the sources of drinking water and the toilet system. Table 21 depicts the percentage of households in the case barangays who have sanitary water facilities such as piped water, public faucet, artesian well, or private pump. Excluded as sources are those derived from open well, rainwater, spring, lake and river.

Sanitary toilet facilities include the flushed type or "antipolo" type. Excluded here are wastes deposited in open pits or those depending on the "splash" type commonly used in Tawi-Tawi. "Splash" toilet directly delivers waste from the house down to the river or lake.

The dire need for facilities to maintain health and sanitation in the households is shown in Table 21. The exceptions are the two barangays from Negros which have close to 50% of the sampled households relying on sanitary water and toilet facilities. Even Lakit-Lakit is disadvantaged with only a little over 15% of its households having sanitary water facilities. Households are reported to fetch water from Bongao during the dry season. In the case of toilet facilities, Lakit-Lakit households have built a makeshift system in their households with a passageway that directs wastes to the rivers.

Among the poor performing barangays, the most advantaged are the families from Anuling. Close to 100% of the households have sanitary water facilities. In contrast, only 23% of households from Nabundas have these amenities. Buada Babai is worst off. All of the households surveyed rely on rivers and lakes.

All of the three poor performing barangays have very few households relying on sanitary toilet facility.

Table 21. Percentage of Families with Sanitary Water and Toilet Facilities

Rank	*Barangays*	*% with Piped Water / Artesian Well*	*% with Flushed / Antipolo Toilet*
1	Manalad	43.09	46.16
2	Lakit-Lakit	15.15	3.03
3	Miranda	76.67	40.26
21	Buada Babai	0.0	2.86
22	Anuling	97.73	27.28
23	Nabundas	23.73	18.64

Health Resources and Outlets. The relative advantage of the high performing barangays may be attributed also to the availability of locally-based service delivery persons and service facilities. The poor performing barangays suffer by comparison. This may be seen in the number of locally-based frontline workers and service facilities available per barangay shown in Table 22.

The barangay with the strongest administrative support is Manalad. It has one Rural Health Midwife (RHM) serving the area through the Barangay Health

Station (BHS) of the Department of Health (DOH). It also has four active Barangay Health Workers (BHWs), the voluntary health workers who are supposedly the implementors of the primary health care strategy propagated by the DOH. It has also been able to activate one Barangay Nutrition Scholar (BNS), a voluntary worker who used to encourage proper dietary practices under the nutrition program of the Marcos administration. There is also a community organizing team composed of four members who mobilize residents for community participation. The community organizing team is composed of the barangay captain and one representative each from the community, from the DA and from the DOH.

Lakit-Lakit also has a BHS manned by an RHM who is from an adjacent barangay. Although this RHM also serves four other barangays, she gets additional support from one BHW who also doubles up as a Dare Care Worker (DCW) in the barangay. Occasional support is also extended by the *imam* (religious priest) who disseminates information when health services are being scheduled for delivery in the area. Then, there is also a community-based parateacher for female functional literacy classes.

Table 22. Available Frontline Personnel and Service Facilities in the Top and Low-Ranking Barangays

Barangay		*Service Personnel*		*Social Service Facility*
Manalad	2	Day Care Workers (DCWs)	1	Barangay Health Station (BHS)
	4	Barangay Health Workers (BHWs)	2	Day Care Centers (DCCs)
	1	Barangay Nutrition Scholar (BNS)	1	DA Sub-office
	4	Community Organizing Team (4 members)		
	1	Rural Health Midwife (RHM)		
Lakit-Lakit	1	BHW who also serves as DCW	1	BHS
	1	parateacher	1	DCC
Miranda	1	RHM	3	DCCs
	10	BHWs	1	BHS
	3	DCW	1	Barangay Reading Center +
			9	satellites
Buada Babai		No locally-based delivery persons		None
Anuling	1	DCW	1	BHS
			1	DCC
Nabundas		No locally-based delivery persons		None

In Miranda, the RHM serves through the BHS in the area. Support is further extended by ten BHWs and a DCW from the Department of Social Welfare and Development. Two other DCWs supervise two day care centers managed by Protestant churches. Adjacent to the BHS is a Barangay Reading Center which serves as a repository of various reading materials on health and related matters. This has nine satellite reading centers in the barangay.

Among the poor performing barangays, Anuling is the only one which can boast of the existence of a BHS. This is visited by a RHM who is not locally-based and serves a total of five barangays. A day care center also exists but this was only set up in 1991. This is manned by one day care worker.

The two other barangays do not have any locally-based health facilities and frontliners. In the case of Nabundas, a RHM in a nearby barangay serves the area together with two other barangays.

Preparedness for ABCSDP

Participation of the service delivery persons in training programs relevant to ABCSDP is indicated in Table 23. The data in this table suggest the edge of the high performing barangays in terms of their preparation for ABCSDP. Manalad, Lakit-Lakit and Miranda had frontliners who experienced participation in training programs averaging not less than 58 hours. The poor performing barangays only registered an average of at most, eight hours per person.

Table 23. Preparedness for ABCSDP of the Frontliners

Area	*Number of Frontliners*	*Mean No. of Trg. Programs Attended*	*Mean No. of Hours*
Manalad	2	3.5	132
Lakit-Lakit	4	1.25	136
Miranda	4	3	58
Buada Babai	1	0	0
Anuling	3	1	1.67
Nabundas	3	3	8

For example, in Manalad, a social welfare officer was exposed to a total of four training programs involving a total of 184 hours. One training program had to do with early childhood development and was conducted for 15 days. Another one was on capability-building of implementors involved in SEA-K (Self-Employment

Assistance—Kalusugan) undertaken for a total of six days. A third concerns value reorientation and was held for two days. The last one aimed at strengthening diagnostic skills to enhance frontliner's capacities for situation analysis.

Implementation of ABCSDP Strategies

The Manalad Experience (Negros). A perusal of the experiences of the different barangays in the implementation of the ABCSDP strategies reveals the edge of the high performing barangays in their attempt to comply with the ABCSDP model. The leading example is Manalad of Ilog. In fact, the experience of Ilog is the most atypical of the six barangays and all other barangays for that matter, with the exception of the Badjao community in Sulu. This is because Manalad serves as one of the pilot social laboratories of a nongovernmental organization, the International Institute for Rural Reconstruction (IIRR) in testing the validity of its model to enhance the convergence strategy.

Although IIRR is involved in all facets of the implementation of ABCSDP strategies, its main objective is to build the capabilities of the Social Development Committee of the municipality which is in charge of coordinating, monitoring and implementing the program in the area.

An important feature of the Ilog experience as witnessed in Manalad, is the impetus given to the participatory strategy which other barangays are not able to fulfill. A bottom-up strategy is encouraged by tapping community participants to get involved in the different phases of the program cycle. Community participation is encouraged starting with the identification of the target beneficiaries. They constitute as one of the members of the Key Informant Panel (KIP) aside from the NGO and GO implementors of the program. Community participants are also involved in the implementation process by tapping their potentials in community activities. The Department of Agriculture was able to inspire the organization of the Manalad Multipurpose Cooperative which boasts of 42 members and has been able to set up postharvest facilities. There are two food lot modules in the barangay which have been the source of supplemental food for the barangay. There is also a youth organization called the Manalad Achievers Youth Organization which was founded in 1990. Another club that was formed in 1987 is composed of mothers.

In the process of monitoring and evaluation, community participants are invited to sit in group meetings to assess the implementation of the program strategies and activities rather than rely merely on the perspectives of implementors.

Furthermore, community organizing teams deployed by the IIRR are responsible in the social preparation of the barangay residents for community participation. A lot of premium has been given to the mobilization of the

community to make them actually involved in the various phases of the program cycle rather than merely creating social awareness to maximize the utilization of the services.

All the four strategies emphasized by the program have been fully realized in Manalad if compared with the other five barangays. It has at the outset applied focused targeting of families by having determined the "poorest of the poor." Hence, a masterlist was available and became the basis for the identification of the sample households in this survey.

Participation was practiced in the identification of the poorest of the poor by having the Key Informant Panel assist in classifying families according to their socioeconomic standing (i.e., access to land, dwelling, education and number of children) and children suffering from malnutrition.

Manalad benefits from the aggressive posture of its municipal mayor and IIRR in realizing decentralization by urging for the devolution of major substantive responsibilities from the province to the municipality. This is with respect to the transfer of accountability of UNICEF funds to the municipality. A financial subcommittee under the SDC was as a result created for the purpose of safekeeping the financial resources of the program. The municipality has also taken the initiative of creating a credit subcommittee in order to formulate unified policies, interest rates and the manner of collecting loan repayments for livelihood projects.

Social mobilization is further enhanced not only by the training of political leaders and community leaders. House-to-house campaign conducted by implementors and the distribution of informational materials are instrumental in creating the awareness of the target beneficiaries.

Opportunities for decentralized efforts are manifested by the existence of functional development councils both at the municipal and the barangay levels.

Manalad itself has encouraged convergence by inviting various nongovernmental organizations to get involved in the implementation of the program, such as the Manalad Achiever's Youth Organization, mother's groups and cooperatives.

Lakit-Lakit (Tawi-Tawi). Lakit-Lakit is an interesting barangay to observe. While it does not possess all the amenities which Manalad derived from the initiatives of IIRR, it is a case where sectoral organizations have moved towards convergence and have managed to inspire high availment of their program services.

While the community did not have the opportunity of social preparation for community participation like the ones offered by IIRR through its community organizing

teams in Manalad and other pilot barangays in the municipality of Ilog, it has been able to benefit from GO frontliners and traditional leaders in the social mobilization of the community. GO frontliners, particularly the health workers (i.e., the barangay health worker and the midwife) had taken a serious effort in conducting a house-to-house campaign in disseminating information about sanitation, herbal gardening and disease prevention. Since there is only one midwife to serve five barangays, a mobile team has been set up with the assistance of barangay health workers in order to visit the barangays in the catchment area at least once a month. The community has been able to benefit from the reading materials disseminated by the frontliners such as *Gabay sa Kalusugan.* Mothers were also encouraged to listen to a radio program every Saturday on health education.

The involvement of the Philippine Information Agency is substantial in social mobilization through broadcast and print media. These informational campaign activities have incorporated Koran-based teachings on health.

An important avenue to hasten social mobilization is the announcement of key information on health (e.g., the availability of immunization) by the imam of the mosque which is located in the same barangay. The information is disseminated through a public address system.

Among the top three ranking barangays, Lakit-Lakit has indicated the highest level of community participation on the part of the mothers who were interviewed, even higher than the experience of the Manalad respondents. Various groups in the community had been organized such as the Rural Improvement Clubs and farmers' organizations. Volunteer canvassers were also deployed to make an assessment of the status of health in the community. Parateachers, who are community-based teachers, were hired by DECS to handle functional literacy classes for women. Functional literacy classes were started in 1990 with 15 mothers attending its initial class.

However, the extent of participation in planning, implementation, monitoring, and evaluation (PIME) is not as extensive as in Manalad. Participation in community activities in Lakit-Lakit has remained at the level of implementation rather than institutionalizing the opportunity for participation at the planning, monitoring, and evaluation phases.

Hence, in the application of focused targeting, the formulation of the criteria in the identification of the target beneficiaries was primarily performed by the provincial core group with the assistance of NEDA and UNICEF and in consultation with the governor, the mayors and MPDCs. The major criteria in the selection of the target areas were: concentration of population, accessibility of the area, the presence of minimum structures and facilities and political factors.

Unlike Manalad, Lakit-Lakit did not benefit from well-organized development councils at the municipal and barangay levels. Major decisions regarding the program then had been centralized at the level of the provincial core group members. It was only in 1991 when mayors became actively involved in program implementation reviews of the ABCSDP.

Miranda (Negros). The third ranking barangay in level of availment is Miranda. Unlike Manalad, Miranda initially applied focused targeting of beneficiaries under the initiative of the rural health midwife. However, convergence was not realized because the decision mainly relied on the midwife. The families targeted were those with children aged 0-6. At the municipal level, the major criteria adopted in identifying the target barangays are such factors as: most depressed based on health indicators, income, presence of social development agencies in the area, and peace and order condition. It is noticeable that premium is given to areas with social development agencies thus defeating the purpose of reaching out the underserved and depressed barangays.

Among the three top ranking barangays, social mobilization activities have not been given as much attention in Miranda. Dissemination of information about the program depended on the efforts of frontliners through a house-to-house campaign. However, unlike Lakit-Lakit, Miranda boasts of a very active barangay development council which conducts meetings every month. It was pointed out that the barangay captain of Miranda is reputed to be the most active among the barangay captains in Pontevedra.

Miranda is one of the pilot barangays considered for the Community-Based Child Monitoring System (CBCMS). This targets the participation of volunteer mothers to monitor the health status of the children in a group of households. A training program was undertaken by the Institute for Social Research and Development of the University of St. La Salle to prepare participants for community organization and participatory action research (CO-PAR).

Poor Performing Barangays. The last three barangays, Buada Babai, Anuling, and Nabundas, while targeted to be served by ABCSDP, have not sufficiently manifested the application of such strategies as focused targeting, social mobilization, convergence, and decentralization. For one thing, barangay development councils have not been reactivated in these three areas and have therefore limited the opportunity of discussing ABCSDP concerns at the barangay level. In Anuling, its municipal development council is not also activated.

While materials for social mobilization were printed by the provincial core group for ABCSDP, these were quite limited and did not filter down to the level of the barangay. For example, in Ditsaan Ramain, Lanao del Sur, IEC materials were produced by an NGO like PROMEX. However, the municipal frontliners and

implementors were not provided copies for distribution to target beneficiaries. Furthermore, in one of the municipalities subsuming one of the case barangays, it was reported that while the Department of Agriculture is expected to mobilize Rural Improvement Clubs and the Department of Interior and Local Government, to reactivate development councils, financial support to these activities were wanting. Although it was alleged that frontliners from these agencies was obliged to submit reports indicating that orientation meetings were conducted for these purposes.

Specific efforts for social mobilization had been manifested by the midwife in Buada Babai, Lanao del Sur, through house-to-house visits. However, the effort was not aggressive enough. Since the program was implemented in the area, there were only three occasions when immunization shots were delivered to the 0-6 year-old children.

Initiatives of various NGOs in Maguindanao, Lanao del Sur and Sulu are worthy to mention. For example, an NGO like PROMEX has taken a lead role in producing reading materials attuned to the sociocultural context of the Maguindanaons and the Maranaos. In the case of Sulu, the Jaycees of Jolo joined the project in 1990 with the task of publishing a quarterly newsletter on ABCSDP, and to coordinate the weekly ABCSDP radio hour. However, its dissemination at the barangay level is another matter to contend with. Frontliners and implementors in these barangays have very weak reckoning of the contribution of these materials produced and disseminated in their respective barangays.

The process of focused targeting applied by the respective provinces of these three barangays was not able to match the experience of Manalad where a masterlist of the target families was initially formulated before the project was introduced. Municipalities and barangays were the targets based on a set of criteria formulated by their respective core groups. It is only lately when initiatives to focus on specific families became the concern of these provinces.

Making convergence work at the level of the barangay found difficulty in taking off because of the absence of local development councils. While NGO participation in the provincial level is already manifested by their active involvement in the planning process, actual manifestations of coordinating efforts to target families at the barangay level have not been fully realized. In effect, implementation, monitoring and evaluation are still sectoral in orientation.

Level of Availment of Services

Actual Services Received for Children. A comparison of high and low performing barangays on the types of services received reveals the edge of the high

performing barangays in the availment of children's immunization, in the distribution of supplemental feeding and in growth monitoring. Table 24 shows the advantage of the top performing barangays in the number of children covered by each of the services listed here. More than 50% of the children in the sampled households were covered by each type of service with the highest percentage of 80% for growth monitoring being reported in Miranda. It may be recalled that Miranda is the pilot barangay for CBCMS.

Table 24. Percentage of Children Who Have Received Selected Services in the Case Barangays since 1988

Rank	*Barangays*	*Immunization*	*Supplemental Feeding*	*Growth Monitoring*
1	Manalad	67.2	51.2	68.9
2	Lakit-Lakit	72	67.6	67.6
3	Miranda	79.6	50.6	80.92
21	Buada Babai	42.8	17.1	8.6
22	Anuling	34.6	8.6	13.5
23	Nabundas	7.5	0	4.2

In the case of the low performing barangays, the biggest percentage of coverage for a type of service is observed in Buada Babai with 42.8% of the children having been immunized. The poorest in terms of coverage of a service for children is Nabundas with no one having benefited from supplemental feeding.

Availment of Services by Mothers. Among the mothers of the case barangays, the service that is most availed of is prenatal services. Prenatal health covers such services as physical examination, vitamin supplementation and injections for tetanus toxoid. The edge of the high ranking barangays over the poor performing barangays may be seen in Table 25. Three fourths or more of the mothers from the top ranking ExBs said they availed of this service. On the other hand, only 13.64% or less of the mothers from the poor performing barangays ever mentioned this.

The second ranking service with the most number of beneficiaries is mother's classes. However, the disparity between the high performing and poor performing barangays may be discerned once again in the same table. This service was availed of by about 40 to 60% of the mother respondents, with the most number of availment being reported by those from Manalad, followed by Miranda and then Lakit-Lakit. Poor performing barangays did not even reach the 15% mark among mothers who availed of the service.

Table 25. Percentage of Mothers Who Availed of Each Type of Service in the Case Barangays

Services	*Manalad*	*Lakit-Lakit*	*Miranda*	*Buada Babai*	*Anuling*	*Nabundas*
Prenatal	80.0	75.76	74.03	8.57	13.64	6.78
Other Health Services	6.15	12.12	16.88	5.71	0.00	1.69
Mothers' Classes	61.54	39.39	49.35	14.29	2.27	11.86
Training for Community Activities	36.92	54.55	31.17	11.43	2.27	5.08
Received Reading Materials	46.15	42.42	45.45	14.29	0.00	1.69
Other Services	36.92	3.03	14.29	0.00	0.00	0.00

The third in rank is the availment of reading materials concerning health matters. The top performing barangays had at least 42% of the mothers who received this material as a source of information. Among the poor performing barangays, Buada Babai mothers registered the highest percentage in level of availment with only 14.29% mentioning it. The two others fall very far behind with close to 0% who said having benefited from this.

The fourth in rank is training for participation in community activities. It is interesting to note that Lakit-Lakit ranks first in terms of the number of mothers (54.55%) who were exposed to this. This explains why they also registered the most number of mothers (36%) who actually got involved in community activities, as indicated in the earlier chapter. Manalad only registered a total of 36.92% of the respondents who got training for participation in community activities. The actual involvement of Manalad mothers is second in rank to Lakit-Lakit with a registered total of 15%.

A close third are the respondents from Miranda with 31.17% who reported being involved in this training activity. They are also third in rank in terms of the number of mothers who said they actually got involved in community activities.

The poor performing barangays indeed suffer by comparison since the highest percentage of participation that was reported is shown by the Buada Babai respondents with 15%.

Impact Indicators

Table 26 summarizes the performance of the case barangays on the mortality indicators to measure impact.

The high ranking barangays have an edge over the poor performing barangays on these measures. On the whole, if the six barangays are compared, Lakit-Lakit emerges as the number one in rank in terms of the reduction of mortality on three counts: child mortality, general mortality and cohort mortality.

Table 26. Selected Impact Indicators in the Case Barangays, in Percentage of the Total Number in their Cohort

Indicators	*Manalad*	*Lakit-Lakit*	*Miranda*	*Buada Babai*	*Anuling*	*Nabundas*
0-6 who died	1.5	0	0	1.43	3.85	5.83
Total who died	.76	.47	0	.49	1.61	2.01
Children born in 1988 who died	2.25	0	2.33	7.32	6.06	6.17
Rank of 6 cases on mortality indicators	3	1	2	6	5	4

It may be remembered that Lakit-Lakit had been able to cover the most number of participants for training in community activities and the most number who indicated actual involvement.

Lakit-Lakit also registered the most number of children who received supplemental feeding and second in rank to Miranda in terms of coverage of children who got immunization shots. Perhaps, Manalad initially paid more attention to facilitating convergence of the implementors before community organizing could be fully maximized. Thus, while Manalad has indicated the most number of household members in level of utilization, the conversion process of maximization of services to impact has taken a longer time to take effect. Service delivery may have been given attention much later since the initial thrust was putting into effect the realization of the convergence process.

The argument that Miranda only utilized services much later than Lakit-Lakit is confirmed in Table 27. Lakit-Lakit is ahead in level of availment of services for mothers and children in the first two years of program implementation. The reason for the lower level of impact on mortality in Manalad even if it has registered the highest level of utilization is because it has availed of these services only in the last two years. This is particularly noticeable for child mortality and cohort survival.

Manalad registered 1.5% mortality in the 0-6 age group. Lakit-Lakit and Miranda did not register any child mortality. This may be because food supplementation

was availed of by only 22.6% during the first year of program implementation in Manalad. Lakit-Lakit already had 26.1% who benefited from supplementation in the same period. In the case of growth monitoring, the difference is even more remarkable since only a measly 4.1% of Manalad households availed of this in 1988-1989 as against 15.2% of the households in Lakit-Lakit. No information is available for the year of availment of immunization shots. However, it may be reiterated that Lakit-Lakit is higher than Manalad in percentage of children who received immunization shots since 1988.

Table 27. Services Availed of for Children and Mothers in 1988/1989 of the Total Who Utilized the Service Among the Top Three Barangays (in Percentage)

Services	*Manalad*	*Lakit-Lakit*	*Miranda*
For Children			
Growth monitoring	4.1	15.2	2.4
Food supplementation	22.6	26.1	28.6
For Mothers			
Prenatal services			
Tetanus toxoid	18.4	72.7	37.2
Vitamin supplementation	45.6	57.1	41.9
Physical examination	30.0	56.25	29.6
Mothers' classes	33.3	50.0	60.0
Training for community activities	20.8	50.0	27.3
Readership of IEC materials	30.0	35.7	28.6
Involvement in community activities	30.0	58.3	50.0

Furthermore, there is also a generally high level of availment for maternal services such as prenatal services (i.e., tetanus toxoid, vitamin supplementation and physical examination), attendance of mothers' classes, readership of IEC materials and actual involvement in community activities for Lakit-Lakit.

Conclusions

The merit of institutionalizing ABCSDP is no doubt suggested by the impact it has made in reducing mortality among the 0-6 year-old children. Such reduction is a result of the improvement in availment of services for children in the ABCSDP areas.

The impact in the reduction of maternal mortality is not adequately proven in this research because it has been limited by the research methodology which automatically excluded mothers who passed away. The impact of the program is however suggested in the reduction of general mortality in the household resulting from high availment of services for mothers.

The findings in this research confirm the argument that compliance with the ABCSDP strategies contributes to the maximization of services and thus redounded to a reduction of mortality of children and other members of the household. The application of focused targeting has directed the concern and attention of the program implementors to the depressed and deprived mothers and their children. Focused targeting has concentrated the efforts of implementors on those envisioned to be served by the program.

Focused targeting is further enhanced by the application of the strategy of convergence as various institutions from government and nongovernmental organizations collaborated in planning, implementing, monitoring, and evaluating the implications of the outputs of the program on the target clientele. While programs such as maternal and child health, sanitation, and food and nutrition are existing programs of social service departments, the application of convergence maximized service delivery as frontliners either work together as a team or supplement other services which are in dearth in the community. For example, a barangay health worker doubles up as a day care worker.

The strategy of decentralization has filtered down the opportunity for substantive participation in the project among priority provinces. This was not normally experienced in a highly sectoral and centralist service delivery system of national programs. Decentralization has provided rich opportunities for local government officials in the prioritized barangays to be prepared for the impending implementation of the new Local Government Code. The decentralization of financial and technical responsibilities for the ABCSDP has geared local executives and field implementors to apply area-specific planning exercises.

The aforementioned strategies had been made possible through the application of the process of social mobilization. This strategy enabled executives from local government units and implementors from national line agencies and nongovernmental organizations to be immersed in training activities to make them aware of the concerns of mothers and children and to be able to apply the ABCSDP processes.

The administrative context of the program has facilitated or enhanced the delivery of services depending upon the availability of service delivery persons and health facilities. It may be argued that the convergence of various resources and facilities for ABCSDP could have emerged as a result of the effective application of ABCSDP strategies. Key implementors who manifested commitment to the program

have inspired the application of the strategies which in turn redounded to the provision of resources and facilities.

The social milieu of the program also influences the implementation of the strategies and services in the ABCSDP package. Critical factors which have affected the extent of implementation of the program are peace and order condition in the area, cultural characteristics hospitable to the mobilization of the community and the extent of mobilization of the community participants.

The parents' educational attainment has a lot to do with whether or not health maintenance is given due consideration in the household. Those with higher educational attainment manifest a higher demand for health services thus reducing mortality in the family. Hence, the prospects of sustainability of the program also hinges on the background of the parents.

In academic parlance, this research has contributed in elucidating GO-NGO collaboration. This has defined specific experiences in the partnership between various institutions from government and the private sector in order to enhance the delivery of services to the target clientele. Various modes of collaboration have been manifested in the implementation of ABCSDP. These are:

(1) NGOs can perform an advocacy role in inspiring the formulation of a policy framework which could be adopted by government. Collaboration is witnessed by working together with government in pursuing strategies and activities and embodying them as a policy perspective. This is clearly visible in the case of UNICEF.

(2) NGOs augment resources of government or venture into activities where government is not able to engage in. This is the experience with some media institutions like PROMEX or a civic club like JAYCEES which assumed responsibility in disseminating information of pertinent matters of concern to ABCSDP. Another is the International Institute for Rural Reconstruction which played a crucial role in preparing implementors for community organization in the municipality of Ilog.

(3) NGOs supplement resources or services which government is not able to effectively address. For example, UNICEF has provided additional financial and material resources to selected provinces in order to give priority attention to target beneficiaries and the application of services and strategies not fully responded to by sectoral line departments. In the case of some CO workers of the Notre Dame of Jolo College, they did not only perform as community organizing worker but also helped in disseminating nutribuns to children to supplement the services of the frontliners for health.

Recommendations

The prospect of institutionalization and eventual sustainability of the program is influenced by a number of factors which surfaced in the case study and the survey. The following are the recommendations to pave the way for the institutionalization of ABCSDP:

(1) Areas which have effectively tapped the participation of community participants in addition to local political leaders (i.e., the barangay captain) and service delivery persons are the most effective in encouraging availment of services which ultimately impacted on the reduction of mortality among the target beneficiaries. The most self-reliant and sustainable efforts are those which have encouraged participatory activities in the various phases of the management cycle—of planning, implementation, monitoring, and evaluation. This is because the kinds of activities undertaken in the area may be those relevant to the community as community participants draw from their personal experiences in program formulation.

This has an implication on the components of social mobilization strategy. A major recommendation is the application of a two-pronged perspective on social mobilization similar to what the International Institute for Rural Reconstruction is doing for the ABCSDP in Ilog. Ilog departs from the usual tack of ABCSDP in most areas which focuses only on the social preparation and awareness-building of the implementors from the national government, local government units and non-governmental organizations. Rather, community-based workers and representatives were tapped as active participants in the different phases of the management cycle.

In ABCSDP areas where community participation was not intensively harnessed but which effectively tapped traditional leaders like the imam and volunteer workers (i.e., the barangay health worker and the parateacher) in the dissemination of the program, these leaders and volunteer workers have contributed substantially in encouraging the availment of services for mothers and children. This is the experience of Lakit-Lakit of Bongao in Tawi-Tawi. Targeting these persons could be the starting point of social mobilization in the community. Although, motivating the community to be organized should be given due consideration in order to forge a "community-managed" rather than a "community-oriented" mode of development. Convergence at the level of the community and not merely of program implementors will assure sustainability.

Furthermore, social mobilization efforts in the political-administrative machinery can be fully harnessed at the level of the barangay to enable government participants at this level to develop deep awareness and commitment to the strategies and components of the program. After ABCSDP has devoted most of its social mobilization efforts to gain the endorsement and commitment of the provincial and municipal implementors from the national and local government units, a more

massive campaign can now be devoted to the service delivery persons who are directly interacting with the target clientele.

With the impending implementation of the Local Government Code, barangay captains will figure as important persons in the attainment of such programs as maternal and child health and primary health care which are mandated to be executed at this level of the local government unit. Intensive training to prepare this local executive can be initiated to sharpen their vision for ABCSDP strategies to strengthen the delivery of services for mothers and children.

The experiences of Local Resource Management (LRM) in forging citizen participation merits scrutiny. LRM has put a lot of impetus on preparing the citizenry for community organization by tapping the assistance of nongovernmental organizations which tested various models for citizen participation. These NGOs are the Philippine Business for Social Progress, International Institute for Rural Reconstruction and Ilaw International.

(2) It may be worth targeting the fathers in the campaign for awareness-building regarding the importance of maintaining the health of the mothers and the children. While the mothers are the major targets of ABCSDP, the fact that fathers figure prominently in household decisionmaking on health matters indicate their important role in health maintenance. Awareness of the mothers of the importance of health does not necessarily lead to investment on implements for the maintenance of health. Deciding on whether money can be spent on health matters is the prerogative of the father.

(3) To assure the sustainability of the strategies and programs advocated by ABCSDP, the reactivation of structures that are already embodied in other program perspectives may be considered. One example is the primary health care strategy. The program apparatus of primary health care, if activated at the municipal and barangay levels, is actually envisioned to exercise convergence, similar to the perspective of ABCSDP. Primary health care committees are expected to be evolved in the different subnational levels in order to monitor and supervise the implementation of PHC. Various institutions from government and the private sector are targeted to participate in these committees. At the level of the barangay, the key person envisioned to head the local PHC is the barangay captain who is expected to advocate this perspective in the barangay development council.

Furthermore, ABCSDP program planners and policymakers may take into consideration the current thrust of the Department of Social Welfare and Development (DSWD) in focused targeting. UNICEF can assume an advocacy role to motivate this department to fully harness its recently implemented thrust of targeting three most depressed barangays per municipality. These are to be identified on the basis of health and social indicators such as: the prevalence of poverty in at least 51%

of the population; the existence of malnutrition among 25% or more of their children; the reliance on nonpotable sources of water such as spring and river by 51% of the community; and the existence of multiple social problems such as drug addiction, prevalence of street children, etc.

Based on the program guidelines of DSWD, a masterlist of depressed families will be further drawn per barangay after a community survey is conducted. Priority attention will be given to the top 200 families with the most problem. The basic indicator for identifying them is if the family falls below the food threshold and other socioeconomic indicators. This may be an appropriate vantage point for other relevant criteria to be included to refine the bases for masterlisting of priority families such as for example the presence of children aged 0-6, pregnant and lactating mothers, etc.

It may also be suggested to DSWD to restructure its requirement of including 200 families as the target families per barangay. The basis for prioritizing a given number of families could be the prevalence of families who fall below the standard of the set of criteria considered important from the standpoint of ABCSDP.

DSWD's thrust to widen community participation through the program of its Community Welfare Services to hasten such strategies as community awareness, community mobilization, tapping social welfare structures and community resource development may provide an avenue for convergence with the ABCSDP model for social mobilization (see DSWD 1991a, 1991b, and 1991c).

Technical assistance may be extended to build the capacities of implementors undertaking these programs. Furthermore, capability-building may also be forged to enable these implementors to converge and share in their respective thrusts or strategies. For example, target beneficiaries for health by the DOH may be drawn from the list of beneficiaries defined by the DSWD.

Since these activities are highly sectoral in orientation, local government officials and frontliners from other institutions may also be invited to learn from the experiences and thrusts of the institution in focus (e.g., DSWD).

Another important structure that has to be contended with is the impending constitution of health boards at the municipal, provincial and city levels. With the passage of the new Local Government Code, health boards are to perform the critical function of formulating budgetary allocations for the operation and maintenance of health facilities and services and to serve as advisory committee to the sanggunian on health matters. The potential of this committee as a partner in undertaking ABCSDP concerns can be viewed within the context of the implementing guidelines of the Local Government Code.

(4) In the formulation of training programs for capability-building, modules on value commitments and concern for social services should be incorporated. There should be a balance between learning of techniques and the development of the appropriate outlook and commitment for the deprived and underserved segments of the community.

(5) Some program areas targeting the mothers may require further expansion. These are in such activities as mother's classes and training for community activities. Training of nonliterate mothers on the importance of maintaining health in the household and the strategies to promote health and sanitation in the community further assures the availment of services on the assumption that mothers are able to internalize the value of health.

(6) For a more rational planning at the level of the barangay, it is imperative to monitor and store appropriately basic health information about the community. This is an area which has been taken for granted by program implementors of various sectors. For example, some of the health workers interviewed have complained about the lack of space where they can store information collected about mortality and morbidity. Some have not assumed this task of safekeeping information seriously. Others had data swept away by floods or eaten up by termites. Still, some did not keep copies of their data submitted to the municipality. Hence, determining the extent of impact of certain services is hampered by the lack of reliable data.

The prospects of tapping community-based monitors may be explored. The experience of CBCMS may be examined to determine the feasibility of utilizing community participants in the important task of monitoring basic health data in the community.

Identifying facilities which are affordable and which can contain the requirements for data storage can be explored.

Furthermore, new modes of imparting information may be tapped to enable community residents become aware of the status of their health in order to be inspired to give their share in the program. Posting information on billboards can give an update to the residents and implementors the health status and the service availed of in the community.

(7) The development of sanitary water and toilet facilities is still a nagging problem in the seven priority areas. The efforts of UNICEF to improve water and sanitary facilities is commendable. However, the efforts on these areas may be further expanded considering that water and toilet are basic resources which have primary implications in the maintenance of health and sanitation in the family. New schemes for disposing of waste matter in communities residing in bodies of water may be explored to prevent the pollution of rivers or seashore where they reside. Attuning

toilet facilities to the living conditions of the communities may enhance the thrust of the program to deliver the services.

(8) Since the basic problem of the communities targeted by ABCSDP is poverty, encouragement of income-generating projects to augment the resources of the family may be further expanded. This is an area where the efforts of ABCSDP is sorely missed but may provide impetus to health maintenance activities in the family if the households become economically self-reliant.

(9) The wider dissemination of IEC materials which are attuned to the sociocultural milieu of the target beneficiaries can be given considerable attention. These influenced beneficiaries in availing the services for children and mothers and may augment the efforts of implementors in disseminating information on health maintenance.

(10) Community-based financing schemes may be encouraged in order to improve the capacity of the families to spend for the maintenance of health. Experiences in community-based financing may be reviewed to determine their potential and provide lessons for interested communities.

(11) A thorough-going review of the implications of the implementing guidelines of the recently approved Local Government Code on the ABCSDP has to be undertaken to be able to consider entry points for propagating ABCSDP strategies and services. While the Code has been passed, the Implementing Rules and Regulations awaits full implementation.

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