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Working Paper

Reaching Out: Gingoog City's Total Integrated Development Approach (G-TIDA)

PIDS Discussion Paper Series, No. 1998-21

Provided in Cooperation with:

Philippine Institute for Development Studies (PIDS), Philippines

Suggested Citation: Pineda, Virginia S.; Clarete, Clark (1998) : Reaching Out: Gingoog City's Total Integrated Development Approach (G-TIDA), PIDS Discussion Paper Series, No. 1998-21, Philippine Institute for Development Studies (PIDS), Makati City

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Gingoog City's Total Integrated
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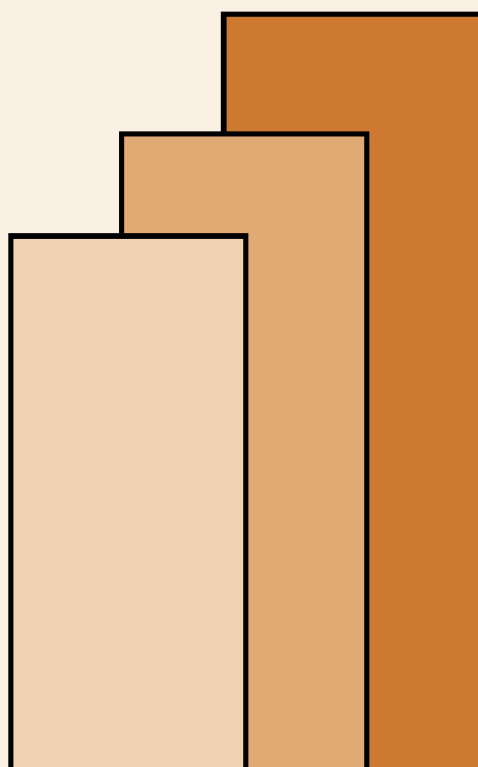
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DISCUSSION PAPER SERIES NO. 98-21 (Revised)

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October 1998

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PREFACE

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

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

This case study focuses on Gingoog City which was recommended by NEDA-Region X as a model city for health. Gingoog’s Total Integrated Development Approach (G-TIDA) was featured as one of the case studies on good health care management in the Philippines in the DOH-HAMIS (Department of Health – Health and Management Information System) publication, “Health Strategies and Intervention.”

The paper is organized as follows. The first section gives a backgrounder on the city, its land area and population, health facilities, financing, and performance. This is followed by a presentation of the G-TIDA Approach, how it started, its impact and problems encountered. The next part identifies the key elements for the success of the G-TIDA program. Some areas for improvement are then discussed in the subsequent section. The fifth portion focuses on the applicability and ways of replicating the G-TIDA approach. Finally, the paper ends with some concluding remarks.

REACHING OUT: GINGOOG CITY'S TOTAL INTEGRATED DEVELOPMENT APPROACH (G-TIDA)

Virginia S. Pineda and Clark Clarete¹

I. CITY BACKGROUND

Location, Land Area, and Population

Gingoog City is on the northern coast of Misamis Oriental, 122 kilometers east of Cagayan de Oro City and 74 kilometers west of Butuan City. It has a total land area of 404.6 square kilometers, 1.71 percent of which is classified as urban areas. Around 56 percent of its total area are public forest lands (both classified and unclassified forests). The city is composed of 79 barangays, of which 29 are classified as urban and 50 as rural barangays. As of 1995, it has about 17,128 households.

In 1990, the city's population was estimated at 82,852 persons. By 1995, it has grown to 87,530 persons or by about 5.65 percent (National Statistics Office). Of these, 32.51 percent live in urban areas and 67.48 percent in rural areas. Population density per square kilometer slightly increased from 204 in 1990 to 216 in 1995.

Family Income

Currently, about 3,924 households consisting roughly 23 percent of the population live within the poverty threshold level (with average gross family income of P6,000 and below per month). The middle income group (with average gross family income of P6,001 to P40,000 a month) constitutes 68 percent (11,601 households) while the high-income group (over P40,000 a month) makes up the remaining 9 percent (1,603 households).

Health Facilities

The health facilities of Gingoog City include one government hospital - the Gingoog District Hospital (run by the provincial government), two private hospitals, one Main Health Center (located within the urban core), and 50 Barangay Health Stations or BHSs (one for each rural barangay). It has also five family planning centers and a puericulture center for maternity services.

¹ Research Associate, Philippine Institute for Development Studies, and Senior Economic Development Specialist, NEDA-Region 10, respectively.

The Gingoog District Hospital has a bed capacity of 50 while the private hospitals have a combined bed capacity of 60. These hospitals serve the whole population of Gingoog City as well as the neighboring municipalities of Magsaysay and Medina. Because of the greater access of the urban barangays to the hospitals and the Main Health Center, only the rural barangays are provided with Barangay Health Stations.

Health Expenditures/Budget

In 1991, before devolution, the city's health expenditures amounted to P2.3 million which was around 6 percent of its total expenditures. This was spent almost wholly for basic health services. In 1994, after devolution, Gingoog's health expenditures and its proportion to total expenditures increased to P10.7 million and 9 percent, respectively. The city provided financial assistance of P500,000 to the Gingoog District Hospital and spent the remainder for basic health services and operation and maintenance of health facilities.

Of its P184.2 million total budget for 1996, the city appropriated P16.1 million for health services or an equivalent of 8.7 percent of the total city budget. It set aside P500,000 or 3.11 percent of the health budget for its annual financial aid to the Gingoog District Hospital. The rest of the health budget is for the operation and maintenance of the city health facilities which mainly provide primary health care services.

Health Performance

Gingoog City's infant, child, and maternal mortality rates have been declining and were lower than the average for the Philippines from 1990 to 1995 (Table 1). However, the percentage of its malnourished children remained almost the same: 62 percent in 1991 and 60 percent in 1995. Furthermore, the malnutrition rates were higher than the national average for the same years.

Table 1. Mortality and Nutrition Indicators, 1990 and 1995

Indicator	1990*		1995	
	Gingoog	Philippines	Gingoog	Philippines
Mortality Rates:				
Infant	44.7	56.7	36.7	48.9
Child	61.1	79.6	50.2	66.8
Maternal	190.3	209.0	156.1	179.7
Percentage of Malnourished Children (0-83 months old):				
Mild	40.4	41.3	38.2	30.7
Moderate	20.0	14.3	20.4	8.4
Severe	1.4	2.1	1.5	1.2
Total	61.8	57.7	60.1	40.3

*Malnutrition data are for 1991

Infant mortality: infant deaths per 1,000 live births

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

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

Sources: Herrin (1998), National Statistical Coordination Board, and DOH Nutrition Service.

II. THE G-TIDA APPROACH²

Background

In the late 1980s, the Gingoog City Government received reports from concerned citizens that people rated as ‘very poor’ and ‘very slow’ its delivery of services, particularly health and nutrition. The mayor at that time, Arturo Lugod, observed that the delivery of services by government agencies to rural areas was fragmented and uncoordinated. In the health sector, for instance, the Emergency Hospital and the City Health Office implement their respective outreach programs without coordinating with each other. Mayor Lugod also noted that people in remote rural barangays have limited access to services because they live far from government facilities and those with low education are shy or afraid to ask for help from government officials and personnel.

In response, the mayor's strategy was to bring the services to the people and make sure that the delivery of basic services is planned and integrated. At a certain date, various service agencies shall converge on a target barangay to deliver basic services.

² Information on G-TIDA were sourced from interview with the G-TIDA coordinator and team members and from a paper by R. Quieta, “Health Strategies and Intervention: Extended Case Studies on Good Health Care Management in the Philippines”, Department of Health (DOH) – Health and Management Information System (HAMIS) Occasional Paper No. 9, Manila:DOH-HAMIS, 1994.

He called the agencies to a meeting and presented this proposal. At first, the agency heads were hesitant because they thought it will require huge budgetary allocation. Mayor Lugod assured them that concerned agencies will be using only their regular allocation and resources in the implementation of the G-TIDA and that the city government would provide for overhead expenses like gasoline, transportation and food subsidies for the participants.

Starting with two target Barangays (Bal-ason and Hindangon) in December 1988, the program is now on its way to its tenth year. Its goals are as follows:

1. To bring the government closer to the people; and
2. To improve the delivery of frontline services to the people, especially in the hinterland barangays.

The G-TIDA Team

Through the G-TIDA, the mayor instituted a systematic and integrated outreach program to rural barangays. He organized a G-TIDA core group composed of the G-TIDA coordinator, G-TIDA Secretariat, transportation coordinator, logistics coordinator, and specific service coordinators represented by the department heads of the concerned agencies. The group, which is headed by the mayor, is responsible for planning, identification of the target barangays and the implementation of the G-TIDA program.

Before any outreach activity, the G-TIDA sends a survey team to assess the needs of the identified barangay and set with the people the date for the visit of the main team. After the assessment, all the concerned agencies are called to a G-TIDA meeting, informing them of the problems and needs of the barangay. The whole G-TIDA machinery is then set into motion bringing along all the necessary equipment and personnel to serve the target barangay. The food requirements of the team who will be staying in the barangay are served by the G-TIDA kitchen team.

During the G-TIDA Day, the members of the team meet directly with the people and their leaders to discuss the needs and problems of the barangay. If problems cannot be solved immediately, they are referred to the appropriate agency. The G-TIDA team informs the people about the functions and services provided by each agency in the city so they would know which to approach for their specific needs.

On the average, about 80 government personnel are involved in G-TIDA activities. The main G-TIDA team consists mainly of the personnel from the City Mayor's Office, City Planning and Development Staff, City Agriculturist Office, City Health Office, City Population Office, the City Engineer's Office, the City Treasurer's Office, The Assessor's Office, the Local Civil Registrar, the Provincial District Hospital, Department of Agriculture, Department of Social Welfare and Development, a non-government organization representing the religious sector, and other line agencies.

Services Offered

With Gingoog's integrated approach, the people in the barangays are provided with a cocktail of services. Topping the list of services are health and infrastructure support. Medical services include consultation, diagnostic tests, circumcision, tooth extraction, pre-natal care and counseling, family planning services and vaccinations, and provision of free medicines. Nutrition services are also provided like supplemental feeding of malnourished children and counseling of mothers.

Infrastructure services consist mostly of road repairs like grading, filling up of potholes, street lighting, installation and repair of water facilities, construction and repair of health and daycare centers and other structures.

Other services provided are mass weddings, registration of births, issuance of community/residence certificates, registration and issuance of certificate of ownership of large animals, and many others.

Frequency of G-TIDA Outreach Activities

The City conducts G-TIDA outreach activities usually once or twice a month. During the early implementation of the program, the G-TIDA team stays for two days and one night in the barangay. However, as requests for outreach activities increased, the conduct of G-TIDA outreach is now limited to about one day per barangay.

Budget Allocation

The expenses incurred by the various agencies in providing services during G-TIDA outreach are taken from their regular agency budgets. No new appropriations are given except for the budget for overhead expenses like gasoline, transportation and food. In 1996, the city government allotted P189,400.00 for G-TIDA.

Impact of the G-TIDA Program

1. Improvement in People's Access to Services

During their initial visits in remote barangays, the G-TIDA team found many people with untreated diseases and also crude ways of treating illness. Doctors get frustrated because of many cases of patients from the mountains who have let their diseases become serious before seeking medical attention.

When the G-TIDA goes to the barangay, its medical team members provide preventive, curative, and referral services. They teach the people proper health practices and disease prevention as well as provide medical and dental consultation and treatment.. If patients require hospital confinement or longer medical attention, the G-TIDA team brings or refers them to the hospital. Through the G-TIDA, more people in the mountains came to know of the Gingoog District Hospital where they could go for operation and other health services. In the absence of regular transportation, the people hitch in logging trucks or other means of transport.

Since 1988, a good proportion of the rural people have benefited from the program. For the period covering 1988-1991 alone, the G-TIDA has served a total of 17,034 persons, of whom 70 percent or 11,879 persons, availed of health services. It is only unfortunate that because of the absence of a program impact monitoring mechanism, it is difficult to evaluate the impact of the program. However, the testimonies of some key informants lauded the positive impacts of G-TIDA on the lives of the rural people.

2. *Enhancement of the people's participation in local governance*

The G-TIDA approach has contributed to the building of people's capabilities and participation in local governance. It fostered community planning and teamwork. During the public consultation, the people air their problems, views and ideas directly to the agencies and persons concerned. Their direct participation in solving their problems and the prioritization of their needs improved their cooperation with the local officials in the implementation of their programs and projects. One example is choosing between installing a water system or constructing a waiting shed or basketball court. As a result of meetings, the people come to realize that the installation of a safe water system for their health is more important. It will help prevent diarrhea and other gastro-intestinal diseases which are mainly due to lack of a potable drinking water supply. Encouraged and guided by the G-TIDA team, people in some of the far-flung barangays were able to install water pipes connected to a spring using their own local resources and relying on the bayanihan system.

3. *Improvement of the image of the government*

Particularly for the hinterland barangays where people feel only little presence of the government, bringing the services directly to them convinces them that the government really exists. Maybe for some people, G-TIDA day is the only time they get to see the medical practitioners. For some, it may be the only time in the year that their barangay roads are repaired and improved.

Implementation Problems Encountered

1. *Non-cooperation of some local leaders*

There have been instances wherein barangay captains hindered the implementation of community development projects because these do not benefit them personally. For example, a barangay captain blocked the opening of the Botikasa Barangay because his daughter was not chosen as the storekeeper. Another case is that of a barangay captain who did not cooperate in the installation of a water facility because this would lessen his chances of being re-elected. These may be isolated incidents but they point out the need to involve not only the barangay leaders but also all the people in the community in selecting and implementing barangay projects.

2. *People's Attitude*

Another problem concerns people who take advantage of free medicines. They pretend to be sick just to get medicines which they will keep as stock for possible future use. This is risky because the medicines people stock may be incorrect for their “future” ailments. Furthermore, medicines have expiration date. They may no longer be effective when people finally use them. The people should therefore be informed of the dangers of self-medication and expired medicines.

3. *Limited Resources*

The respective agencies can only provide so much of the services required by the barangays as the agencies draw their expenses for G-TIDA outreach from their regular funds only. The most common complaint is that the medicines distributed during the outreach day are not enough. In some instances, the team is not able to provide certain medicines such that they only give prescriptions slips to their patients.

4. *Scheduling of Outreach Activities*

Although the G-TIDA secretariat prepares a schedule for outreach activities, the conduct of G-TIDA outreach is still mostly on request basis. Barangays which make regular requests for G-TIDA services are the ones getting most of the services. The G-TIDA secretariat plans at least two outreach activities per month but the actual conduct greatly depends on the availability of resources, the urgency of requests and the availability of personnel. If G-TIDA strictly follows its twice-a-month schedule, only 24 barangays can be covered within one year. Considering that the city has 50 rural barangays, it will take two years to make a complete round. (G-TIDA is aimed at rural barangays which are far from city health facilities). Even after ten years since its initial implementation, some barangays (from the coastal areas) have been visited by the G-TIDA Team between two to three times only.

5. *Very limited time for outreach activities*

Previously, the G-TIDA team stays for two to three days in the target barangay. At present, outreach activities are carried out at an average of one day per barangay. With this very limited time, delivery of services, specifically along infrastructure, are often not completed. In one case, a barangay complained that the one-day availability of dump trucks and other equipment are not sufficient to finish the road repairs (filling up of potholes and road grading) that they requested.

6. *Lack of Impact Monitoring Mechanism*

Evaluating the impact of the program is difficult due to the lack, if not total absence, of area specific data such as the number of people served, the impact on health status (e.g., reductions in mortality and morbidity), and many other important information. The program should therefore include a mechanism for monitoring and evaluating its impact.

III. KEY ELEMENTS FOR SUCCESS

The sustained and successful implementation of the G-TIDA program for nearly ten years may be attributed to the following:

1. Leadership of the City Chief Executive

The G-TIDA was born out of the insistence of the local chief executive to bring the services directly to the people. It was the mayor who proposed a planned, integrated outreach program to rural barangays, convinced the concerned agencies of its viability, and organized the G-TIDA team. The outreach program has become a regular activity as the local chief executive continues to support it and allocates funds for its overhead expenses.

2. Organized Set-Up

The creation of a G-TIDA Secretariat to oversee the activities and the assignment of specific tasks to agencies and personnel facilitate mobilization of people and resources and make G-TIDA activities continuing.

3. Cooperation of the Barangay Officials

The barangay officials play crucial roles in the scheduling of the G-TIDA outreach and its actual implementation. Although the G-TIDA Secretariat prepares a calendar of activities, it admitted that, most often, the calendar is not followed and the actual conduct of the “outreach day” is dependent on the barangay officials’ requests. The barangay officials are the ones responsible for assembling the people and organizing them for the counterpart labor services and project follow-up activities that may be required.

4. The Local Government Code

Although the G-TIDA started before devolution, the full implementation of the Local Government Code contributed to the successful implementation of the G-TIDA. With the City Executive’s direct control over all the service departments, coordination in the delivery of services is facilitated.

IV. Areas for Improvement

1. Clustering of service areas

It may be advantageous if outreach services will be provided simultaneously in a cluster of adjacent barangays, such as two to three barangays. The service teams may be distributed in the barangays within the cluster and are free to move into the other barangays in the cluster as soon as they have completed servicing a certain area. This will lessen the logistical requirement of the team such as food and transportation and maximize the number of barangays served per outreach schedule.

2. Strengthening people's participation

As the G-TIDA outreach service is practically a one-shot approach, there is a need to follow it up in order to sustain its benefits as well as complete the components which cannot be finished during the G-TIDA day. Support in the institutionalization of programs as well as in strengthening supportive people's organizations may be necessary.

3. Minimizing dole-out approaches

Although a lot of the services offered during the G-TIDA are welfare services, there may be a need to institute cost-recovery measures so as not to unwittingly cultivate the dole-out mentality among the barangay people. Unless all the people in the barangay are indigents, it may be helpful if certain forms of payments will be collected for the services, materials and supplies being provided. Minimal fees can be charged and then turned over to the local organizations which will sustain or pursue the completion of programs or projects initiated during the G-TIDA outreach.

4. Setting up of an Impact Monitoring System

In order to fully appreciate the benefits of the program, an impact evaluation system needs to be instituted. It is necessary to gather and process data that would allow analysis of the impacts of the projects instituted, such as monitoring the decrease in the occurrence of diarrhea and skin diseases after the installation of a community water system.

V. Applicability and Replication

The G-TIDA was conceived at a time when only very few of the rural barangays have health stations. Although the G-TIDA consisted of all the services available, delivery of health services was the main concern especially in areas without any BHS. Presently, all the 50 rural barangays have BHSs manned by at least a barangay health midwife and volunteer health workers (the barangay health workers and barangay nutrition scholars). Because of their proximity and greater access to the hospitals and the Main Health Center in the city, the urban barangays are not provided with barangay health stations. Except for the services of BHSs in the rural areas, there is only little, if not none at all, of the other services which can be directly accessed by the people at the barangay level.

The G-TIDA approach can easily be adopted by other Local Government Units especially those which have not yet fully provided their barangays with BHSs. Such LGUs can conduct outreach activities to unserved barangays while they are working towards the setting up of additional BHSs. To undertake an integrated, planned, and coordinated outreach program like that of Gingoog City, the local officials could do the following steps:

1. Call a meeting with department heads to present the proposal, get their cooperation, and involve them in planning.
2. Form an outreach team, select the people and specify their duties and responsibilities. The team may be composed of an overall coordinator and specific coordinators (such as for transportation, logistics, food, medicines and other supplies), the department heads, and a representative from non-governmental organizations.
3. Organize a survey unit within the outreach team. The survey unit will be responsible for scheduling the barangays to be visited, undertaking a survey and assessment of the needs of the chosen barangay, setting with the people the date of the main outreach visit, and identification of the agencies which should participate in the outreach activities.
4. Based on the report of the survey unit, the coordinator could mobilize the persons involved to make the necessary preparations concerning the activities, transportation, food, medicines and other supplies that should be brought to the barangay.
5. The outreach team could stay for two or three days in the barangay, discuss with the people their problems and solutions, attend to the people's needs, and conduct health education and other information dissemination. The team should keep a database of the services rendered, the number of people served, and health indicators in the barangay for monitoring and evaluation purposes.
6. To sustain health activities after the departure of the outreach team, particularly in barangays without health stations, the city health office could train persons in the areas visited to serve as barangay health workers and nutrition scholars as well as organize people's groups to promote proper health care. The barangays could provide allowance to the BHWs and BNS depending on their financial capability.

VI. CONCLUDING REMARKS

In the final analysis, an outreach method of delivering health services is useful as an interim or temporary measure for coping with the problem of insufficient barangay health stations. People benefit from the curative and preventive health services provided during an outreach visit but this is sporadic or non-regular. They should have continuing access to health services. To make this possible, the long-term strategy is the provision of additional health stations and health workers to reach all the barangays.