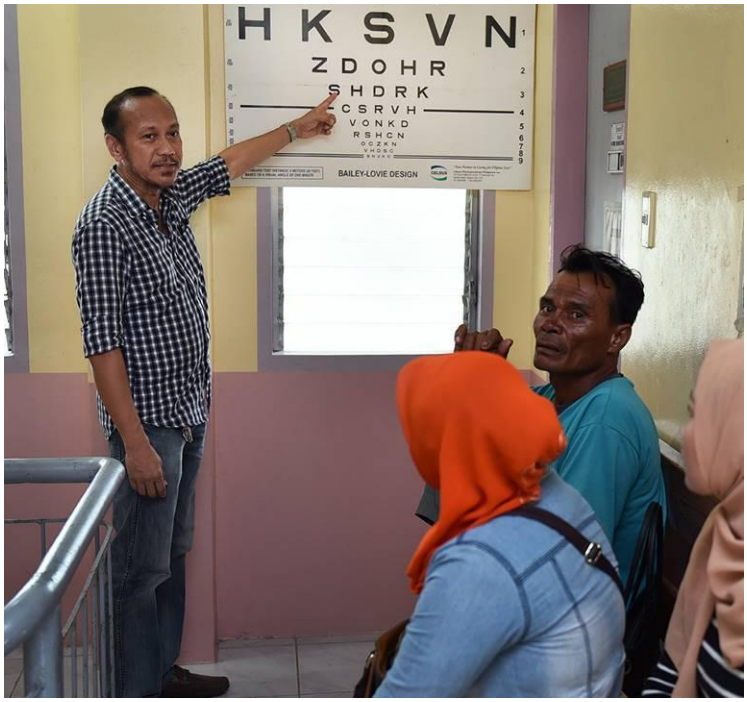

FINAL REPORT | JANUARY 2020

Department of Health Deployment Program Study

USAID's HRH2030/Philippines: Human Resources for Health in 2030 in the Philippines

Cooperative Agreement No. AID-OAA-A-15-00046

Cover photo:
Dr. Redentor Rabino, one of the first doctors to the barrios in Bongao, Tawi-tawi, conducts the Snellen's test to one of his patients. (Credit: Blue Motus, Chemonics International)

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Contents

Acronyms

AO	Administrative Order (specifically AO 2014-0025)
ARMM	Bangsamoro Autonomous Region in Muslim Mindanao
CME	Continuing Medical Education
DOH	Department of Health
DPO	Department Personnel Order
DTR	Daily Time Record
DTTB	Doctors to the Barrio
FP	Family Planning
HHRDB	Health Human Resource and Development Bureau
HRH	Human Resources for Health
IPHO	Integrated Provincial Health Office
IRA	Income Revenue Adjustment
IQR	Interquartile Range
KII	Key Informant Interview
LDI	Learning and Development Interventions
LI	Local Implementer
LGU	Local Government Unit
MNCHN	Maternal, Newborn, Child Health & Nutrition
MOA	Memorandum of Agreement
NCR	National Capital Region
NDP	Nurse Deployment Project
PDOHO	Provincial DOH Office
PHN	Public Health Nurse
RHU	Rural Health Unit
RPO	Regional Personnel Order
RHMPP	Rural Health Midwives Placement Program
RHTPP	Rural Health Team Placement Program
SD	Standard Deviation
SO	Specific Objective
TB	Tuberculosis
TWG	Technical Working Group
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

In order to address shortages in the health workforce of marginalized areas, the Philippine Department of Health (DOH) initiated human resources for health (HRH) deployment programs. Despite some success, many areas remain underserved. Further research is needed to evaluate the implementation of these deployment programs to provide direction and recommendations for their refinement. The United States Agency for International Development (USAID) Human Resources for Health in 2030 Philippines' activity (HRH2030/Philippines) conducted a rapid program review assessment of DOH deployment programs to provide evidence for developing recommendations to improve implementation for better tuberculosis (TB) and family planning (FP) outcomes. From January to August 2019, USAID's HRH2030/Philippines reviewed four types of deployed personnel (doctors, nurses, medical technologists, and midwives) in nine selected service-delivery networks located in nine regions.

USAID's HRH2030/Philippines' study objectives focused on prioritization of marginalized clients, distribution and retention of deployed workforce, training, change in access to health services, and program sustainability. USAID's HRH2030/Philippines employed a mixed methods study design, using both records review and key informant interviews (KIIs) with deployed workforce, organic staff, and local stakeholders of the program. Quantitative analysis included both descriptive statistics and time-series analysis, while qualitative analysis employed thematic analysis using Abbreviated Grounded Theory. A total of 19 deployed HRH, 22 organic staff, and 31 local stakeholders from nine regions were interviewed.[1]

Results found that less than half of the sites were considered poor, geographically isolated or disadvantaged areas (GIDA), but organic staff and deployed HRH mentioned that they did cater to marginalized patients within their regions. Deployed HRH showed high job satisfaction mainly due to fulfillment of their desire to serve and competitive salaries. The need for job security and other practical arrangements influenced their decision to leave after the end of contract. In terms of implementation fidelity, local stakeholders consistently mentioned that implementation is most efficient and organized when the guidelines are clear and well understood. However, aspects of the implementation, such as orientation process, report submission, and deployment allocation, remain inconsistently carried out in the regions. Deployed HRH and organic staff reported high satisfaction in working with each other, within the community, with their colleagues, at facilities assigned, and with patients that indicate high cultural acceptability between deployed HRH and their area. Deployed HRH were also generally accessible to their patients despite their full workload. Lastly, deployed HRH were involved in partnerships and programs in the community with minimal organizational support from local government units (LGUs) for HRH activities.

Policy recommendations include exploring how non-financial incentives can encourage retention and to address issues with employment and environment that influence their decision to remain in or leave their areas. Community and organizational/institutional networks may also be tapped for social support and training opportunities. Recruitment should prioritize applicants from rural backgrounds. The program may also consider arrangements for applicants who are in the later stages of their career. Strengthening the current system of monitoring and evaluation by uniform standards in the reporting templates and enforcing timely compliance may help LGUs implement Health Human Resource and

[1] Local stakeholders refer to provincial Development Management Officers and other personnel from the provincial government and health facility. DMOs are the designated supervisor of the deployed HRH as per contract. However, the study also interviewed other local stakeholders who had a role in the deployment program or interacted with them. Organic staff refer to those that are hired by the Local Government Unit. Local stakeholders refer to DOH Development Management Officers based either at the DOH regional offices or at the provincial health offices and DOH regional training specialists.

Development Bureau (HHRDB) guidelines more uniformly and clearly. This would also allow HHRDB to conduct easier and regular monitoring. Finally, research recommendations include studies into different methods of transitioning the financing for HRH employment, as well as into the decentralization of accountability in the regional and provincial levels of implementing the HRH deployment system.

Introduction

The Philippine government devolved centralized services from its national departments to LGUs from 1991 to 1992. The first wave of health sector reform happened in 1991 when the Local Government Code (LGC) was introduced which devolved basic health services to LGUs. Further devolution happened in 1992 when the management and delivery of health services were transferred from the DOH to locally elected officials in the provincial and municipal levels. The LGC mandated that provincial governments shall provide secondary hospital care while city/municipal governments provide primary care (i.e. maternal and child health and nutrition services) in the form of barangay health centers or rural health units (RHUs).

The Doctors to the Barrio program was introduced in 1993, a year after devolution of health services. It was created to address the lack of doctors in rural communities by mandating the national government to hire and deploy physicians to RHUs in resource-poor areas of the Philippines. Since then, the DOH has created more deployment programs, including one for midwives in 2008, dentists and medical technologists in 2010, and nurses in 2011[2]. The national government compensates deployed HRH working in the LGUs and providing primary care services. DOH deployment programs are meant to contribute in increasing availability and accessibility of health services and achieving targeted health outcomes in the communities in which deployed HRH are assigned.

DOH issuances provide the guidelines, structures, and mechanisms to operationalize the deployment program. The Administrative Order 2014-0025 (AO 2014-0025) of the DOH entitled "Guidelines on the Deployment of Human Resources for Health (HRH)" provides satisfactory guidance for implementing the program from pre-recruitment to program evaluation phase. Meanwhile the DOH's Department Order 2018-009 (DO 2019-009) provides updated guidelines informed by deployment program evaluations submitted by local chief executives, deployed HRH, and LGU-hired doctors, nurses, and midwives. These documents stipulate that the DOH central office and regional offices shall manage the pre-recruitment to pre-deployment phase for the deployed HRH. Orientations at the central office, regional offices, and the LGU shall take place prior to deployment. Deployed HRH shall have similar workloads as their local counterparts in the RHU but will be more closely monitored and evaluated by the LGU and corresponding DOH regional office. While deployed HRH enjoy additional capacity-building opportunities like trainings and graduate education, they lack job security since their positions are up for renewal every time their contract ends. The usual contract length for doctors is two years while the other deployed HRH are under contract for six months.

The deployment program is meant to temporarily augment HRH in underserved areas. LGUs are expected to promote retention of HRH by hiring them in government facilities or encouraging them to maintain practice in the area in other ways.

In the Philippines, there are few published studies to evaluate and monitor the deployment programs. Those that are available, mostly focus on doctor and nurse deployment programs. Further studies are needed to evaluate the implementation of the DOH deployment programs, namely for Doctors to the

[2] While the DOH had various programs related to deployment of Nurses prior to 2011, they were primarily training programs (Project NARS and RN Heals) for nurses and not employment programs (NDP).

Barrio Program (DTTB), Nurse Deployment Program (NDP), Rural Health Midwives Placement Program (RHMPP), and the Rural Health Team Placement Program for medical technologist (RHTPP). Additional studies can provide evidence for direction and recommendations to refine and improve the programs.

Based on this clear need, USAID's HRH2030/Philippines activity conducted a rapid assessment and review of the DOH deployment programs for four types of deployed personnel (doctors, nurses, medical technologists and midwives) in nine selected service-delivery networks located in nine regions. USAID's HRH2030/Philippines is part of a global initiative that helps low- and middle-income countries develop the health workforce needed to prevent maternal and child deaths, support the goals of Family Planning 2020, and protect communities from infectious diseases, such as TB. The activity contributes to DOH's goal of "Adequate number of health human resources at all levels with competence to deliver UCH through the continuum of preventive, promotive, curative, and rehabilitative health interventions." In order to support this goal, USAID's HRH2030/Philippines conducted a review study of the DOH's deployment program to better understand and assess it in selected regions of the Philippines according to the quality of implementation fidelity, access, and sustainability, as these deployed HRH provide essential primary care services including those covering TB and FP.

This review study also aligns with the fourth objective of World Health Organization (WHO) Global Strategy on HRH in 2030 which calls for "strengthen[ing] of data on human resources for health, for monitoring and ensuring accountability for the implementation of national and regional strategies, and the Global Strategy." This study supports the WHO Global Strategy on HRH in 2030 and assesses the implementation of DOH deployment programs in terms of fidelity of implementation and its associated outcomes. Results of this rapid assessment are expected to inform the revision and update of guidelines of DOH's ongoing deployment programs. The study also provides evidence in crafting new policies. The study may also contribute to international literature on the value and quality of HRH deployment programs in low-and-middle-income countries.

USAID's HRH2030/Philippines focused the study on four aspects of assessment: the program's degree of implementation, access, prioritization of recipient communities and sustainability. The study design was mixed methods, employing both a records review of deployment documents (Annex 2) from the select regions and KIIs with deployed workforce as well as organic staff from the health centers. Quantitative analysis included both descriptive statistics and time-series analysis, while qualitative analysis employed thematic analysis using Abbreviated Grounded Theory.

Study Objectives

General Objectives

To assess the DOH deployment program in nine regions of the Philippines according to the quality of implementation fidelity, access, and sustainability.

Specific Objectives

1. To determine and describe the proportion of recipient communities that were poor, marginalized, or indigenous
2. To determine the distribution and mean duration of retention of the deployed HRH
3. To describe the implementation fidelity of the HRH deployment program
4. To measure the changes in health service access in the nine regions
5. To determine the financial and outcome sustainability of the DOH deployment programs

Literature Review

In 2016, the WHO published the Global Strategy on Human Resources for Health: Workforce 2030, with the goal of improving outcomes by strengthening the health workforce through the implementation of effective policy at all levels (WHO, 2016). Two milestones for 2020 are "inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda" and to strengthen "health workforce assessment and information exchange." One of the strategies to move toward these milestones is to implement deployment programs that aim to promote equitable distribution of the national HRH, especially in rural and underserved regions.

Multiple evaluations of deployment programs' effects have been done worldwide. A 2006 WHO report estimated that places with less than 2.28 density per 1,000 population of physicians, nurses, and midwives generally failed to reach a target 80 percent coverage rate for skilled birth and child immunization (WHO report 2006, as noted in DOH AO 2014-0025). A 2011 review further investigated this point and showed that of the 57 countries that did not have a 2.3 health workers per 1,000 population (2006 WHO report) 79 percent had HRH plans and 71 percent had a budget, but only 55 percent of the plans were implemented.

Further studies in focal countries showed promising results, mainly measured by health worker to population density and health outcomes following HRH interventions. In Malawi, providing incentives were associated with health worker to population density rising from 0.87 to 1.44 per thousand from 2004-2009, with a subsequent improvement in health outcomes such as outpatient services, antenatal care, safe deliveries, and child immunization. Peru also developed a program of deployment similar to the Philippines, with mandatory service for newly graduated staff to rural and marginalized populations. These measures demonstrated increased HRH density and reduction in maternal mortality, whereas maternal mortality remained stable in the province where HRH density increased only minimally. While short-term outcomes about HRH density and immediate health outcomes are promising, long-term sustainable success has been limited. Thailand's long history of integrated policy includes local training, home-town placement, mandatory government bonding, financial and non-financial incentives for doctors in rural practice, and the influence of the rural doctors association. These measures contributed to a reduction in difference of density of doctors (between Bangkok and the poorest northeast region), but retention remains a challenge (Dayrit et al. 2011).

Some studies explore reasons for the limited effects of select deployment programs in other countries. A 2014 scoping review of HRH deployment policies for maternal, neonatal and child health and nutrition (MNCHN) in Africa used key-stakeholder interviews that showed South Africa's 2004 Rural Allowance policy had limited effect in the retention of relocated staff. Despite the presence of financial incentives, doctors and nurses were drawn toward non-financial incentives such as professional development and access to good education for children, rather than financial incentives which were not considered in this program (Nzala et al., 2014). Poor definition of implementation parameters and absent monitoring and evaluation also affected South Africa's Rural Allowance policy (Ditlopo et al., 2018).

In the Philippines, the DOH deploys nurses, doctors, midwives, and other health professionals to bridge the limited financial capacity of some LGUs, particularly marginalized areas, to recruit and maintain their own HRH in accordance with the LGC. Deployed HRH remain concentrated in urban centers while other areas have an average of four percent of the total HRH in health facilities - the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) in particular has less than one percent of the total HRH in the country (DOH NDHRHIS, June 2013, in DOH Administrative Order 2014-0025). In order to ensure successful and effective HRH deployment, several guidelines were created through the DOH

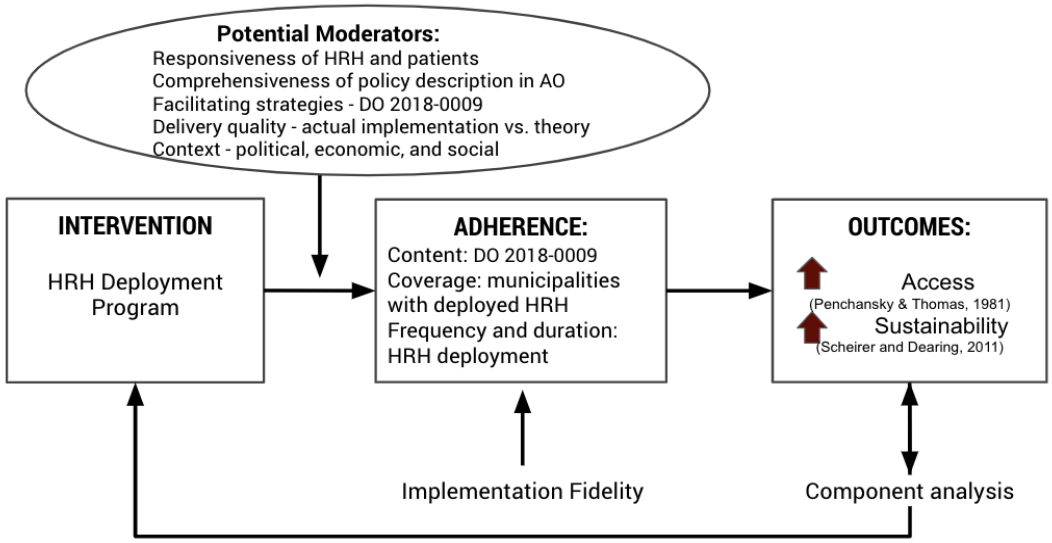
AO 2014-0025 to standardize operations and provide structure for the deployment programs. These guidelines include the harmonization of efforts among DOH HHRDB, the regional offices, recipient hospitals, LGUs, and deployed HRH to support the development of HRH in order to implement universal health care and to prioritize service delivery to the populace.

There have been few previous studies assessing the Philippine's deployment programs. These studies focused mainly on deployment programs for doctors and nurses. According to DOH monitoring of Doctors to the Barrios (DTTB), only 18 percent of participants from 1993-2011 remained at their deployed rural area. The number of those choosing to stay declined from 2006-2011. A 2011 assessment of retention factors conducted on DTTB alumni and policy makers adapted the "Stayers Questionnaire" developed by the University of Washington for health workforce assessment in Uganda. Results showed that though the main motivation of older DTTBs was their desire to serve rural populations, the current cohort at the time cited service obligations as their main motivation. The latter stated slightly less satisfaction, but those who joined out of interest in public health were more satisfied. DTTBs from the National Capital Region (NCR) who were deployed to rural areas, criticized compensation and mentioned limited options for leisure in rural areas. Finally, lack of support from LGUs, concerns on changes in compensation upon absorption, family issues, and career advancement were found to be main factors impeding retention (Ruppel *et al.*, 2012). Still, there is a lack of more recent published literature on the current status of the DOH deployment programs. Among these, deployment programs for some types of professionals have had little or no assessment at all.

Methodology

Conceptual Framework

Figure 1 Conceptual Framework for Implementation Fidelity



Implementation Fidelity

One of the main interests of the DOH was to find the extent and manner that national guidelines are implemented in practice at the municipalities, given the decentralized health system. This means that from the regional level downward, local health officials are given more authority in managing the health system. Thus, this study adapted Hasson's Framework for Implementation Fidelity, a modified version of the original version by Carrol et al. (Carroll *et al.*, 2007; Hasson, 2010), as a framework to compare actual implementation against the basic guidelines given. The modification adds recruitment and context

as categories of potential moderators. The conceptual framework above (Figure 1) shows how the study objectives fit into the theoretical framework of Hasson. The framework includes components of implementation fidelity as well as moderating factors that influence the degree of fidelity and potential outcomes of the intervention. Adherence, or the main evaluation of fidelity, includes content, coverage, frequency, and duration. Content refers to the 'active' parts of the intervention, while coverage, frequency, and duration are considered the 'dose', and are more easily quantifiable (Carroll *et al.*, 2007; Hasson, 2010). Determining and describing the proportion of recipient communities that were poor, marginalized, or indigenous refers to 'adherence' in the framework. The remaining objectives, namely determining the distribution and mean duration of retention of the deployed HRH, describing the implementation fidelity of the HRH deployment program, measuring the changes in health service access in the nine regions from, and determining the financial and outcome sustainability of the DOH deployment programs, are referred to in the outcomes.

Accessibility

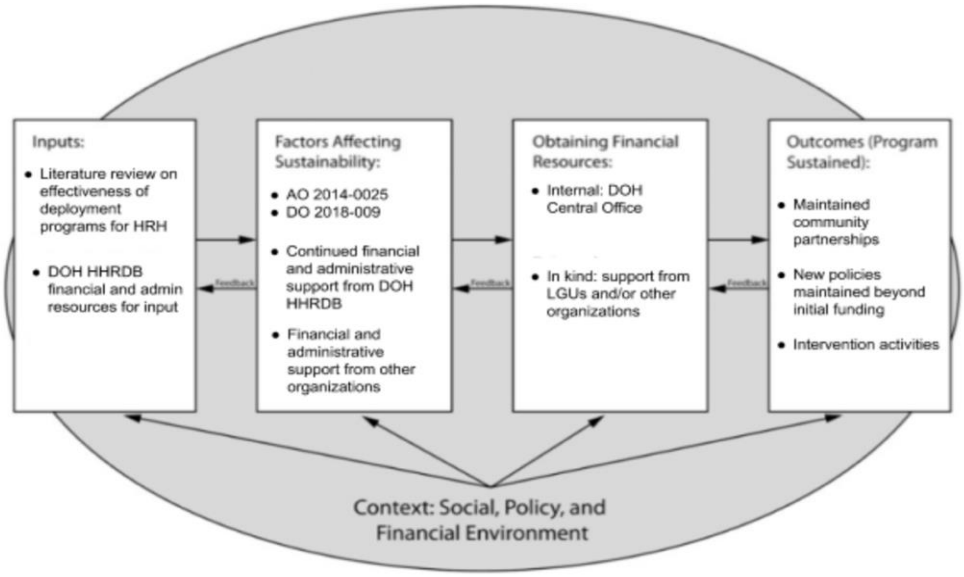
The definitions used to measure the changes in health service access are taken from Penchansky and Thomas' framework for access in health policy and health services. According to this, access is defined as availability, acceptability, accommodation, affordability, and accessibility (Penchansky and Thomas, 1981). While ideally all five components of access will be measured, for the purposes of this study, only physical availability and cultural acceptability will be used. Availability describes supply and demand, where an available service is defined as meeting the volume and needs of clients served. Cultural acceptability refers to consumer perception, particularly whether a service responds to a patient's social or cultural concern. As a component of access, acceptability was measured among both deployed HRH and organic staff. Deployed HRH were asked about their satisfaction with different aspects of their assignment (physical environment, social environment, colleagues, and patients) to estimate the acceptability of different aspects of their environment. The goal is to have an idea of how deployed HRH are assimilating or comfortable in their work environments. The organic staff were likewise asked for their perception on working with the deployed HRH to assess the acceptability of the deployed HRH as colleagues to measure cultural compatibility. Meanwhile, since all RHUs included in the study already have deployed HRH present, availability was measured using patient to physician ratio with consideration to consultation time and patient load.

Sustainability

For sustainability, Scheirer and Dearing's framework for research on the sustainability of public health programs was used (Figure 2). Sustainability refers to the "continued use of program components and activities beyond their initial funding period and sometimes to the continuation of desired intended outcomes" (Scheirer and Dearing, 2011). In the context of public health programs, Scheirer and Dearing take the perspective to emphasize the inclusion of both earlier relationships and the broader diffusion of a program. All four pillars of sustainability, namely inputs, factors affecting sustainability, obtaining financial resources, outcomes, sustaining activities and retaining deployed HRH were studied to determine the financial and outcome sustainability of the DOH deployment programs,

Sustainability inputs include evidence of effectiveness for deployment programs of a similar nature, and the capacity of DOH central office to provide administrative and financial resources to the program. Factors affecting sustainability include the programs' characteristics, as prescribed by the HHRDB central office guidelines, administrative and financial resources, and the political and social environment, namely in the form of partnerships with local and international organizations and LGUs. In this case, financial resources are from internal sources as funds for the program come directly from DOH central office, although LGUs sometimes supplement this financially or in kind. Outcomes are measured through continuity of partnerships, and the maintenance of new activities and policies created through the program. Finally, the sustainability of retention of the deployed HRH was also reviewed.

Figure 2 Adapted Scheirer & Dearing's framework for research on the sustainability of public health programs



Study Design

USAID's HRH2030/Philippines used a mixed methods study design employing both quantitative and qualitative data which included records review (Annex 2) and KIIs to form a holistic assessment of the four components of the DOH deployment.

Target Population and Sampling Design

Exhibit 1. Nine Sampled Areas

Region	Province	Municipality
NCR	City of Marikina	
III- Central Luzon	Bataan	Dinalupihan
IVA- Calabarzon	Batangas	Batangas City
IV-B Mimaropa	Palawan	Coron
VII- Central Visayas	Bohol	Loon
VIII- Eastern Visayas	Eastern Samar	Mercedes
XI- Davao Region	Davao City	
XII- Soccskargen	Sultan Kudarat	Bagumbayan
BARMM	Tawi-Tawi	Simunul

Participants for the KIIs were purposively sampled based on the availability of respondents at the deployed area and their willingness to be interviewed. This included current and formerly deployed HRH, local stakeholders including but not limited to HRH coordinators and point persons for HRH deployment program implementation (Annex 3), and organic health staff (i.e. staff from the local community and not deployed) from those respective LGUs. At least one, and at most three, participants from each profession in each region were invited for the KIIs.

KIIs were also conducted with community health workers who worked together with the deployed HRH. The review mainly focused on HRH deployed for service under the TB and FP programs. However, all services under the purview of the HRH were also considered (i.e. primary care services together with their work for the TB and FP programs) in the data analysis and overall recommendations.

Study Variables

Exhibit 2. Summary of Specific Objectives and Variables Measured

Specific Objective	Variable	Indicator
SO1: To determine and describe the proportion of recipient communities that were poor, marginalized, or indigenous	% recipient communities that were poor, marginalized, or indigenous	Class of municipality, geographic location of municipalities where HRH were deployed
	Perception on presence of, proportion, and prioritization of poor, marginalized, or indigenous recipients	Organic staff and deployed HRH's perception on the presence and number of poor, marginalized or indigenous clients in service delivery network
SO2: To determine the distribution and mean duration of retention of the deployed HRH	Distribution and mean duration of each possible type of retention for HRH (e.g. retention in system, in area, etc.)	Percentage of deployed HRH who stay in community beyond contract, for each area, or other forms of retention such as extending contract, or remaining in community under the same or different but related capacity
	Length of 'retention' of deployed HRH beyond initial contract	Mean duration of length of stay of deployed HRH beyond contract
	Perception of satisfaction with deployment and reasons for staying or leaving	Mean/median satisfaction level and qualitative description of reasons behind deployment stay
SO3: To describe the implementation fidelity of the HRH Deployment Program	Presence or absence of processes, documents, and systems listed in the implementing guidelines	Presence or absence of documentation samples for the processes, documents, and systems listed in the implementing guidelines
SO4: To measure the changes in the HRH access on the nine regions from 1993-2017	Availability of HRH (patient load)	• Daily patient volume (i.e., how many patients are in the program) • Daily patient encounters (i.e., how many patients can one doctor accommodate per day) • Length of consultations
	Cultural Acceptability	• Qualitative description of degree to which deployed HRH integrate into community (cultural acceptability)
SO5: To determine the sustainability of the DOH Deployment Program	Input: • Intervention with evidence for effectiveness (RRL) • Organizational capacity • Prior relationships and partnerships (existence of partnerships that lead to non-monetary support, whether other funders potentially available)	• Brief review of literature on effectiveness of similar intervention • Checklist on presence of support from the local government upon launching programs or partnerships • Consistent implementation of activities or partnerships (annual or otherwise regular events)

Data Collection Plan

Data collection occurred in two phases: records review and KII. The interview and discussion guides were pre-tested prior to formal qualitative data collection began in the nine areas. The tools were tested for face and construct validity. The interview tools were then revised accordingly. Interviewers and discussion facilitators attended a two-day training for interview etiquette and project tool introduction before the start of fieldwork. Final adjustments to the tool were carried out after the data collectors' training.

Records Review

The study reviewed available administrative and monitoring data on the municipalities where the HRH were deployed (SO1, SO2), directory and monitoring data on retention of deployed HRH (SO2), and documentation on implementation of the HRH deployment program (SO3). A list of these documents (Annex 2) was given to the interviewees and samples of available documents were gathered in each region.

Key Informant Interviews

Qualitative data were collected through KIIs with deployed HRH and community health workers in the chosen service delivery networks.

The KIIs with deployed HRH were conducted to obtain first-person perspective on the implementation of their deployment. An interview guide was used for face-to-face interviews with deployed doctors, nurses, medical technologists, and midwives, as well as for administrative personnel and organic health unit staff who interact with and/or facilitate the HRH deployment program at the local level (referred to as local stakeholders in this report). Project endorsement letters and a directory of deployed HRH including contact information for point persons were requested in advance from DOH HHRDB. Communication with regional point persons were sent to introduce the study and the intent to conduct interviews. Purposive sampling was used to select and invite participants who were deployed in the geographical areas of interest and actively involved in TB and/or FP services. Upon agreement to participate, a time and venue for the interview was scheduled with participants. Participants were asked for their informed consent before interview.

The KII questions for the deployed HRH covered the following:

- Perception of prioritization of marginalized areas (SO1),
- Satisfaction with the program and reasons for leaving/staying (SO2),
- Implementation fidelity of the HRH deployment program (SO3),
- Ability to integrate into community (acceptability) and daily patient volume, number of encounters, and length of consultation (geographic accessibility) (SO4), and
- Sustainability in terms of maintained community partnerships and new practices (SO5).

Most questions were framed into 'Yes' or 'No' questions especially for the implementation fidelity (SO3). A Likert scale of 1 to 5 (1 being the lowest (negative) and 5 being the highest (positive)) was used to determine self-reported satisfaction, and ability to integrate into the community, Follow-up questions on the reasons or examples for their responses were formulated and asked to gain deeper insight. Since this was framed as semi-structured interviews, interviewers were also instructed to ask probing questions when necessary (Annex 1). For SO4, the measure used for availability was meant as a partial estimate, given the constraints of the study and only measures the extent of deployed HRH-patients interaction. For more information on the availability of deployed HRH, full workload studies such as those that use Workload Indicator for Staffing Need (WISN) methods may be consulted.

The interviews took approximately 20 to 40 minutes and were conducted in a private area to ensure confidentiality of the information shared. Audio recording, taken with participants' consent, and transcription of the interview were done after the KII. To maintain confidentiality, each respondent was assigned a code name prior to the interview.

Data Analysis

Descriptive statistics were used to analyze quantitative data gathered from records review and KII. Measures of central tendency (means and medians) as well as the corresponding measures of variation (standard deviation (SD) and interquartile range (IQR)) were computed for continuous characteristics (e.g. waiting time, self-reported satisfaction, etc.). Frequencies and percentages were used to analyze categorical characteristics (e.g. presence/absence of deployment orientation) and multiple-choice questions.

Thematic analysis using Abbreviated Grounded Theory (Willig, 2013) was employed to analyze qualitative data gathered during the study. This method allows for new theories to emerge while also considering the grounding of context from the data.

Responses from the interview transcripts were coded using Nvivo 11.0. Similar responses were grouped together upon review of all transcribed responses for each question. Groups of responses were summarized into themes, which were then tabulated according to the number of times the sentiment was stated by a respondent. Responses containing multiple themes were coded more than once, according to the number of themes that portions of the statement applied to. The most common themes for each question were then highlighted for the results. Themes not commonly noted were also cited when it stood out from the rest of the responses.

Exhibit 3. Summary of Methods

Study Objective	Data collection method	Data processing and analysis	Sources of data*
SO1: To determine and describe the proportion of recipient communities that were poor, marginalized, or indigenous	Records review, and KIIs	Descriptive profiles of the areas, Thematic analysis using grounded theory	DOH Deployment database, LGU Records, primary qualitative data collection
SO2: To determine the distribution and mean duration of retention of the deployed HRH	Records review, primary data collection of LGU records, and KIIs	Descriptive statistics, Thematic analysis	DOH Deployment database, LGU Records, primary qualitative data collection
SO3: To describe the implementation fidelity of the HRH Deployment Program	Records review, primary data collection of LGU records, and KIIs	Descriptive statistics, Thematic analysis	DOH Deployment database, LGU Records, primary qualitative data collection
SO4: To measure the changes in the HRH access on the nine regions from 1993-2017	Records review, primary data collection of LGU records, and KIIs	Descriptive statistics, Thematic analysis	DOH Deployment database, LGU Records, primary qualitative data collection
SO5: To determine the sustainability of the DOH Deployment Program	Records review, KIIs	Descriptive statistics, Thematic analysis	DOH/LGU records, primary qualitative data collection

Results and Discussion

Profile

A total of 20 deployed HRH, 22 organic staff, and 31 local stakeholders from nine regions were interviewed.

A majority (80 percent) of the deployed HRH interviewed came from the cadre of the Nurse Deployment Program (NDP), 15 percent came from the DTTB, and 5 percent from the midwife program. No medical technologists (RHTPP) were interviewed, since they were unavailable during data collection. Nurses and midwives were the most represented organic staff interviewed, accounting for 77 percent of the sample. Among technical support staff, Development Management Officer (DMO) and training specialists represented majority of the sample.

Historically, nurses comprise the majority of deployed HRH, followed by midwives under the RHMPP. Doctors (DTTB) and medical technologists under the RHTPP were the least represented. The lack of midwives and medical technologists in the field may be attributed to pending budget discussions for the RHMPP and RHTPP at the DOH central office and Department of Budget and Management (as mentioned in stakeholder meetings).

Exhibit 4. Respondent Profile by Frequency of Type

HRH Program	Frequency	Percent
Municipal Health Officer	1	5.0
Rural Health Physician	2	10.0
Nurse Deployment Program	16	80.0
Midwife	1	5.0
Organic Staff Designation	**Frequency**	**Percent**
Midwife	9	40.9
Nurse	8	36.4
Medical Technologist	3	13.6
Admin	1	4.5
Municipal Health Officer	1	4.5
Technical Support Staff by Designation	**Frequency**	**Percent**
Development Management Officer IV (Region)	7	22.6
Training Specialist (Region)	6	19.4
Development Management Officer V (PHTL) (Region)	5	16.1
Administrative Officer (Province)	3	9.7
Deployment Program Assistant Coordinator (Region)	2	6.5
HRH Director	1	3.2
Nurse II	1	3.2
Nurse VI	1	3.2
Officer-in-Charge (PHO)	1	3.2
Supply Officer, Nurse	1	3.2
Unit Head Medical Technologist	1	3.2
Did not Report	2	6.5

Exhibit 5. Percentage mix of HRH among four programs from 2003-2018

Cadre	% ('93-'18)	% (2017)	% (2018)	% Study Sample
Doctors (DTTB Program)	2.45	1.78	1.40	15
Nurses (NDP)	80.08	75.42	73.06	80
Midwives (RHMPP)*	16.32	20.27	22.59	5
Medical Technologists (RHTPP)*	1.15	2.54	2.95	0

*During data collection, problems of budget allocation for these two cadres were still not resolved.

Deployed HRH interviewed had median service of three years (IQR=3.0), while local stakeholders had a slightly longer term with a median of five years (IQR=13.5). Organic staff had the longest median service of 17 years (IQR=20.5).

SO1: Prioritization of recipient communities that were poor, marginalized, or indigenous

Results found that only a small proportion of the health facilities where the interviews were conducted belonged to 5th/6th class municipalities and GIDA despite the AO explicitly mandating the deployment program to prioritize poor and GIDA communities. The interviews and document review conducted at the sample sites revealed that only 22.20 percent of sites were considered poor while 44.44 percent were considered GIDA barangays[3].

This finding runs counter to organic staff and deployed HRH respondents' perception that they were catering to marginalized patients and indigenous communities within their regions. Both deployed HRH and organic staff respondents strongly agreed that they serve patients who are poor, marginalized, and/or indigenous, giving a median score of 5[4]. All interviewed deployed HRH also mentioned attending to the medical needs of indigenous people, the poor, and those in distant or GIDA areas.

At the same time, organic staff and deployed HRH respondents maintain that they cater to the whole community and not just the underserved, including patients from high-income and low-income populations, and those located near and further out from the town center. One respondent noted, however, that sometimes supplies aren't enough to cater to all the needs of all patients, including the underserved who rely more on the free supplies from the health center. Another deployed HRH noted that some indigenous peoples are still left out. That respondents report that all deployed HRH in the community serve all types of patients, regardless of income status implies that prioritization of clients according to income status is not being practiced.

SO2: Retention

Data for distribution and mean length of duration of HRH deployment was unavailable and thus could not be analyzed. This data was initially meant to come from retention records of the LGUs. DOH HHRDB only began officially monitoring retention in 2018, so existing retention records before that were collected through the regional office's own initiative. Records were requested from the provincial and regional offices, but some offices did not submit or reported that these records are non-existent. Since only three regions managed to produce and submit such reports, there was insufficient data to complete a quantitative analysis. However, the study team was able to collect rich qualitative data to describe the nature and factors for retention of deployed HRH.

[3] Sample sites were cross-validated against Philippine Health Insurance Corporation (PHIC) 2010 Inventory to ascertain their municipal classifications.
[4] using Likert scale of 1 to 5

The deployed HRH reported high job satisfaction and strong intention to remain in service within the area beyond their contract terms which they attribute to their passion and sense of self-fulfillment with the job. These were answered using a Likert rating scale of 1 to 5, 1meaning "very dissatisfied", 3 as "neutral", and 5 as "very satisfied".

Exhibit 6. Summary of ratings for deployed HRH job satisfaction and intention to remain

Deployed HRH (n=20)	Mean	Median	SD	IQR
Satisfaction with current job	4.45	5.00	0.69	1.00
Intention to remain in service within the area beyond contract	4.55	5.00	1.00	0.75

Ratings were asked on a Likert scale of 1 to 5, with 1 meaning "Very dissatisfied", 3 as "Neutral", and 5 as "Very satisfied"

The top reasons cited for job satisfaction were: giving service (n=7), good financial compensation(n=6), and finding employment aligned with their education (n=5). The most common reason for dissatisfaction with their job was job instability (n=3). Many who mentioned job instability, however, still gave a high job satisfaction rating (above 3). Other reasons for dissatisfaction mentioned were work-related expenses, not getting along well with the community, and living far from their families.

Deployed HRH were asked what factors affect their decision to stay in the program or local health system, versus moving forward to a different path. By far, the desire to give service (n=10) was cited as the top reason for remaining at or near their area of assignment beyond the terms of their contract. Other factors mentioned were a supportive social environment (mainly work colleagues) (n=5) and being close to family (n=3).

The deployed HRH also reported high satisfaction with the facilities, colleagues, and communities to which they are deployed. The deployed HRH's satisfaction for working environment is corroborated by anecdotes on how they were treated by the local staff and their patients they handled, and experience in RHUs they served. Likewise, the local staff are also highly satisfied with the presence and performance of the deployed HRH. The local staff described the deployed HRH as hard-working, responsible, and considered as great contributions to their health centers.

The sentiments for job satisfaction—passion to serve and a good salary—correspond to those mentioned in 2012 DTTB program assessment stud which also mentions 'desire to serve' as main motivation (Ruppel et al., 2012). Furthermore, deployed HRH reported strong feelings of self-fulfillment which made them more satisfied with the job. The results also suggested symbiotic relationships between the deployed HRH and other stakeholders (organic staff and local stakeholders). This kind of social support from colleagues could have further led the deployed HRH to establish collaborations with other organizations and initiate programs and activities to serve more people in the community. The strong social capital and engagement at the workplace, together with the acceptance of the community as reported by local staff, may also be a reason why most deployed HRH reported very high satisfaction. In a study of Portuguese nursing staff, job satisfaction was seen to be predicted by social support from supervisors and colleagues as well as their work engagements (Orgambídez-Ramos & Almeida 2017).

Job instability was mentioned as the primary factor affecting the deployed HRH decision to leave. Specifically, job insecurity due to the contractual nature of the available position (n=9), looking for a different job outside of the deployment program (other jobs in the recipient LGU or going abroad) (n=3), and employment under the program being affected by government or other outside changes (i.e. sudden delays in compensation due to national budget issues) (n=3) were the top concerns. Meanwhile, the most common factor that motivated the deployed HRH to stay were the desire to give service to the underprivileged (n=10) and favorable salary (n=7). Other reasons commonly cited were to remain

close to family/hometown, good working relationship with RHU (n=3), professional training (n=3), and growth from working in the area (n=3).

The reported reasons for job dissatisfaction appeared to relate more to practical and daily concerns such as expenses, getting along with the community, and living far from their family. Reasons for dissatisfaction include the lack of security of tenure and external factors affecting the smooth implementation of the program such as salary delays in payment. These reasons provide a wider perspective on barriers to retention since these findings differ from the results of 2012 study of DTTBs, which cited lack of support from LGUs, concerns on changes in compensation upon absorption, family issues, and career advancement as main factors impeding retention (Ruppel et al., 2012).

Seeking job security away from primary health care environment was observed to be characteristic of rural health workers in decentralized health systems, such as in Nigeria. A 2015 qualitative study interviewing primary health care service providers, implementers, and community members emphasized that delays or irregular schedule of salary are likely because of the transfer through sub-national levels and the ability of government levels to blame delays on other levels. Thus, it was found that health workers are more likely to prefer secondary or tertiary care, where salaries are often higher and more regular (Abimbola et al. 2015). These reasons and sentiments were found to be common throughout Asian and Pacific countries, where common reasons for leaving one's original employment location are salary, training opportunities (and isolation from professional colleagues), desirable working conditions, and family ties (Henderson & Tulloch 2008). While the desire to serve and sense of self-fulfillment appeared to be strong among those interviewed, it is only one part of the complex decision-making process with regards to rural service.

All cadres except doctors were reported to almost always renew their contract. Likewise, nurses and midwives were more commonly absorbed by the LGU compared to doctors and medical technologists.. Moreover, salary differences among the deployed HRH could also be a factor as higher salaries mean that LGUs are less likely to afford absorbing the deployed HRH. This trend may be attributed to the difference in the professional growth of physicians who often move on to further residency training, compared to nurses and midwives that tend towards field experiences. This holds in other countries such as in Vietnam, where a study found health workers with higher education levels tend to stay in urban areas (Henderson & Tulloch 2008). Urban areas are likely where specialized graduate courses, formal institutions, and organizational networks are concentrated which may be attractive for doctors.

Apart from doctors preferring urban areas for further training, medical technologists tend to prefer urban areas since this is where they are more likely to find completely equipped facilities there—a strong requirement to fulfill their work. While the deployed HRH, organic staff, and local implementers are working harmoniously to serve the community, the long-term goal of the deployment program was still perceived by the respondents to be out-of-reach. Retention remains an issue as only few deployed HRH were found to remain in service in the communities to where they were initially deployed.

Given that non-financial incentives have been shown to have value for long-term attractiveness of deployment programs than purely financial incentives (Nzala et al., 2014) (Henderson & Tulloch 2008), the appropriate non-financial incentives should be considered, given the decentralized Philippine health care system and individual considerations per career stage.

Community health committees may also contribute to retention by encouraging primary care utilization, and providing social and financial support, including assistance in accommodation. Respondents have mentioned the lack of assistance for securing an accommodation as a reason for job dissatisfaction. Some go so far as to co-finance and co-manage primary care services and facilities (Abimbola et al 2014).

In extreme cases (such as when a deployed HRH reported that RHUs are transient because of the poor state of the Municipal Health Office building), RHUs may capitalize on the rich network of partnerships to consider how groups and local health boards can help in providing non-financial incentives. In some extreme cases, using international donor aid for salaries or other financial incentives may provide another model for addressing retention (Henderson and Tulloch, 2008). This would not be applicable in the Philippines since long-term non-financial incentives were cited as critical for retention and salary is satisfactory.

Deployed HRH respondents suggested the institution of job security measures (n=11) and provision of regular benefits (n=3) to improve the deployment program. They also recommended better orientation, endorsement, and coordination between the LGU and the central office (n=4).

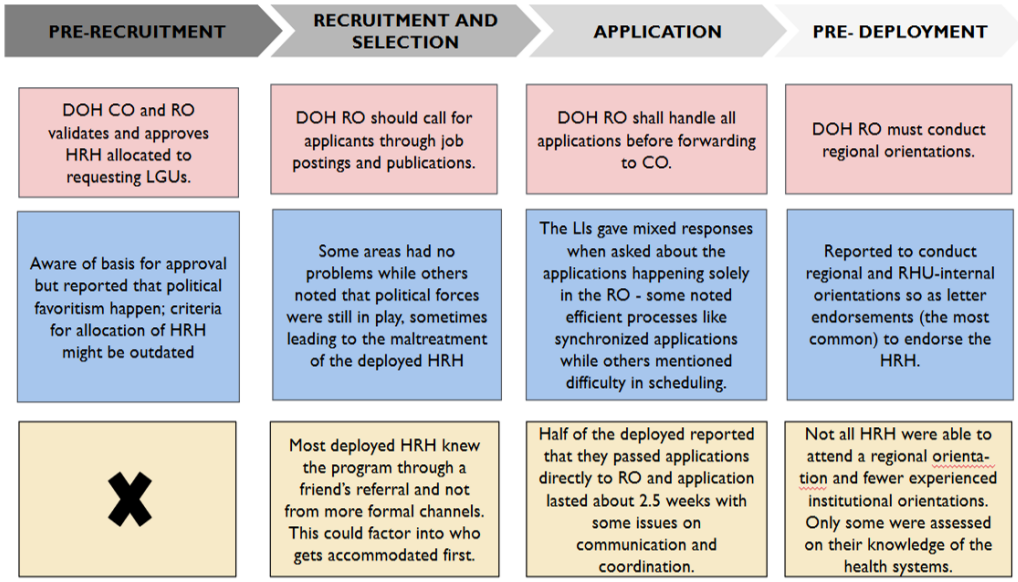
SO3: Implementation Fidelity

Implementation variations between the regions were still observed despite of clear implementation guidelines outlined for each phase of the program. Political influence affecting faithful implementation of the program, specifically during the recruitment and selection phases, were noted across multiple areas. Monitoring, evaluation, and retention phases were neglected as evidenced by the limited availability and quality of data in the said areas. For instance, in some regions some documents were not standardized (e.g. evaluation forms) or did not even exist at all (e.g. retention reports). Moreover, the ultimate but unspecified goal of retention (i.e. LGUs absorbing the deployed HRH and making them permanent local staff), was deemed unfulfilled due to the LGUs' budget constraints. Therefore, current efforts implemented by deployed HRH within their health centers became unsustainable as they are likely to be replaced or phased out after their contracts. Nonetheless, local stakeholders remained supportive of such efforts and even reported initiating programs for the development of the deployed HRH.

Pathway Analysis

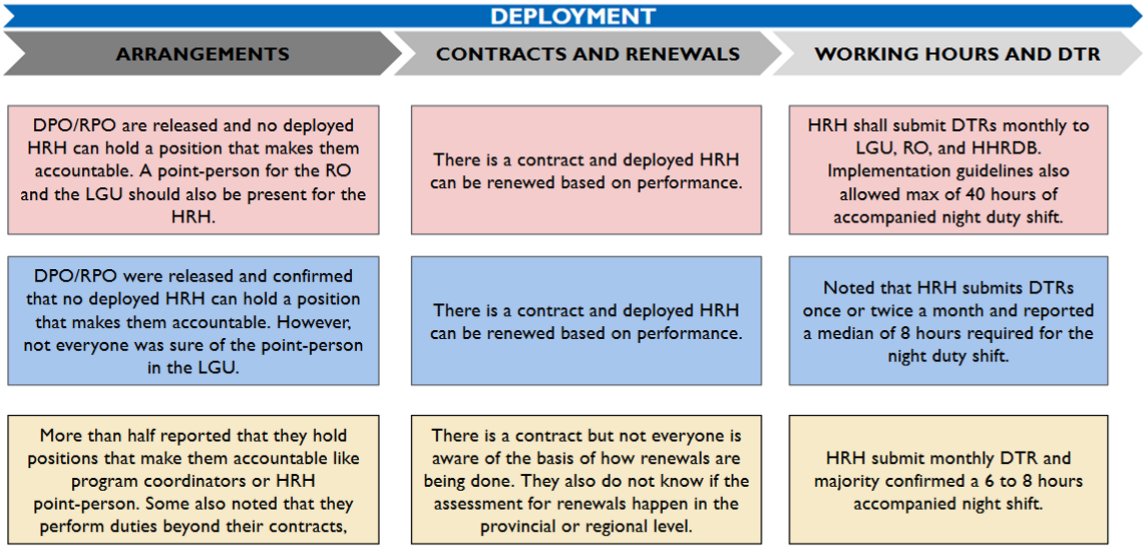
The detailed findings for implementation fidelity may be more easily summarized when placed in a pathway analysis. Here, we can compare the guidelines given by DOH HHRDB in the AO 2014-0025 (in red), the responses of local stakeholders of the guidelines (in blue), and responses of deployed HRH (in yellow).The pathway analysis is shown below in Exhibits 7, 8, 9 and 10.

Exhibit 7. Pathway analysis of the pre-deployment period



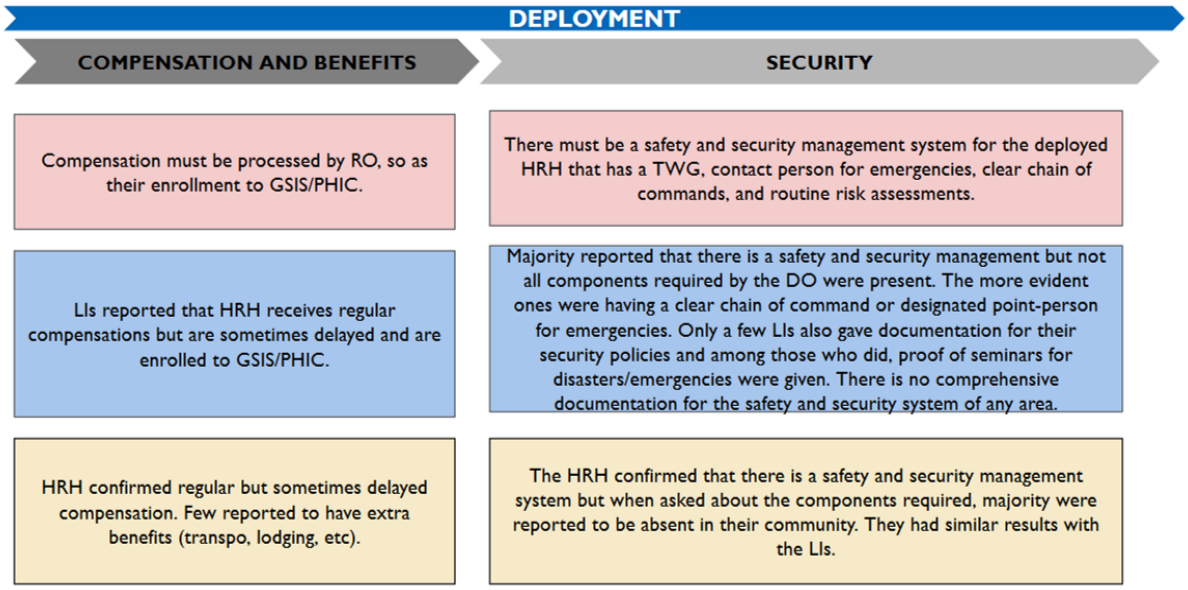
HRH guidelines in the first row from DOH central office (CO) and regional offices (RO) (red), placed in parallel with the corresponding responses of local stakeholders in the second row (blue), and responses of deployed HRH in the third row (yellow).

Exhibit 8. Pathway analysis of the deployment period



HRH guidelines in the first row (red), placed in parallel with the corresponding responses of local stakeholders in the second row (blue), and responses of deployed HRH in the third row (yellow)

Exhibit 9. Pathway analysis of the deployment period, as continued



HRH guidelines in the first row (red), placed in parallel with the corresponding responses of local stakeholders in the second row (blue), and responses of deployed HRH in the third row (yellow).

Exhibit 10. Pathway analysis of activities associated with the deployment program

CONTINUING EDUCATION AND CAPACITY BUILDING	MONITORING AND EVALUATION	RETENTION STRATEGIES
DOH CO and RO shall provide LDIs and LGUs/sending agencies shall shoulder transpo and living expenses unless otherwise stated.	DOH RO shall evaluate deployed HRH and reports shall reflect performances of the HRH, hindrances to utilizations, and their contributions to UHC.	DOH RO shall monitor retention and recipient LGUs shall endeavor to give regular items to deployed.
LIs agreed that there are LDIs for the deployed but noted that not all are being given allowances during trainings. Majority of the areas gave sample documentations of their LDI initiatives.	LIs reported to follow the AO but format of reports seem unstreamlined across areas. In general, the monitoring reports given ranged from evaluating the work of HRH, as professionals, and in reference to public health deliverables and indicators in the community.	Only half of the LIs reported that they submit updated list of deployed HRH, so as monitoring reports for retention. The LIs were also divided in terms of awareness of endeavours being done to provide regular items for the deployed HRH.
Deployed HRH agreed that there are LDIs and those sent for trainings were given allowances. Furthermore, they reported that LDIs given were sufficient and appropriate for their needs	HRH are aware of evaluations. Some submit their personal evaluations together with a satisfaction survey on the deployment program.	✖

HRH guidelines in the first row (red), placed in parallel with the corresponding responses of local stakeholders in the second row (blue), and responses of deployed HRH in the third row (yellow).

Pre-recruitment.

According to the AO, the DOH central and regional offices should validate and approve all the HRH requests made by LGUs. The LGUs submit requests to the regional office who is responsible for validating and approving the requests before forwarding the requests to the central office for final approval. A majority of the local stakeholders reported being aware of the process and noted issues and concerns in the current system of requests, such as the validation or evaluation of the requests.

The most common concerns raised by local stakeholders when submitting requests were the influence that LGU officials exerted in the entry of deployed HRH (i.e. nepotism or cronyism) (n=3), not having enough HRH to deploy (n=4), and receiving requests for deployed HRH even if HRH were not needed (n=3). The latter two contrast each other and may relate to concerns on allocation that will be further discussed later.

Local stakeholders from the provincial and regional offices are knowledgeable on the current mechanisms in shortlisting qualified LGU recipients and the process usually takes around three weeks. Such awareness is in contradiction to the instances of nepotism or cronyism by reported by some deployed HRH. While there are actual guidelines in requesting for HRH, instances of political influencing, reported by the interviewees, mean that guidelines are not strictly followed.

Exhibit 11. Awareness of pre-recruitment concerns and mechanisms among local stakeholders

PRE-RECRUITMENT	Yes	%
Local Implementer (n=31)		
Aware of any issues or concerns in the current system of requests	22	71
Aware of any issues or concerns with the current evaluation or validation of requests	8	25.8
Aware of the current mechanisms in shortlisting qualified recipients	25	80.6

The most common concerns reported in shortlisting deployed HRH candidates were incongruence of

the need and request for allocation of deployed HRH to the different municipalities (n=4) and the influenced that local government officials exerted in the hiring process(n=4). Apart from general observations that some allocations are inaccurate, many cite that the HRH allocation is still based on outdated GIDA classifications, leading to inappropriate or inaccurate allocation. Another potential reason for inaccurate allocation is related to political favoritism, such as when LGU officials use the deployment program as means to provide employment to those close to them, rather than HRH needs of their constituencies. And while 'favorites' often still undergo 'due process' most end up getting selected even if their qualifications fall short. Some local stakeholders noted that some of these hired HRH show lackluster performance after being accepted.

On the other hand, it was found that non-work related disagreements between local officials and deployed HRH may influence non-renewal of contract or be a source of pressure for the deployed HRH to quit. For those who responded with no concerns, they said it was because proper entry requirements were clear and well-followed (n=3), though one respondent reported not understanding the policy or process for shortlisting.

When asked for comments on the general pre-recruitment process, favoritism in hiring (n=5) and unclear guidelines (n=2) were the most common themes mentioned.

Recruitment and Selection

Recruitment refers to the actual call for HRH to apply to the deployment program. Selection refers to the screening process for the applicants. The AO states that the regional office should call for applicants through job postings and publications. Local stakeholders report being aware of the current mechanisms for recruitment and selection of HRH, but they had mixed responses when asked if recruitment and selections happen solely in the regional office, with some respondents thinking the central office or provincial offices were also involved in the process.

The deployed HRH reported that they learned of the deployment program and recruitment process through a friend or through online postings on the website or social media networking sites. Word-of-mouth among other health workers was another main source of knowledge of job postings.

Exhibit 12. Awareness of mechanisms and communication of recruitment

Recruitment and Selection	Yes	%
Local Implementer (n=31)		
Aware of the current mechanisms for recruitment and selection for the job	26	83.9
Recruitment and selection happen solely in RO	15	48.4
Deployed HRH (knew the program through; n=20)		
Friend's Referral	18	90
Webpage	10	50
Social Media	9	45
Traditional Mass Media	6	30
Others (internal staff)	4	20
Printed Publication	2	10
Civil Service Commission	0	0

The respondents rated the recruitment process satisfactory with one respondent attributing this to strong coordination between provincial and regional offices. However, the most common concerns

cited were requirement for a certain level of work experience that the respondents felt to be too high (n=3), and issues related to handling of documents (obtaining them for submission, receiving manipulated documents, and problems in storing them) (n=3). Local stakeholders shared that some applicants end up being ineligible since required work experience was 'too much.' Overall, the local stakeholders reported that the required length of experience for the deployment program was difficult fulfill.

LGU officials exerting influence on the selection process was mentioned as top concern (n=7) among respondents. The same observations were also mentioned for pre-recruitment process. Respondents report that LGU officials try to influence who will be hired. For instance, while favored applicants go through the correct process all the same, they are perceived to be given preferential advantage to be selected as deployed HRH. The respondents shared that whenever another candidate is chosen over the favored applicant, that candidate would end up being treated poorly until he or she eventually resign. The second most common response was that there were no issues because guidelines from DOH central office were well-followed (n=5).

When asked for suggestions for improving the recruitment and selection process, respondents suggested improved dissemination of deployment vacancies, uniformity of selection and creation of feedback mechanisms. Such improvements entailed assigning a dedicated HR staff to promote the program officially rather than by word-of-mouth (n=2), limiting LGU officials influence in the selection process (n=2), more feedback from the community (n=4), online application (especially for those applicants who must travel far for interviews) (n=2), standardized schedule (more time for processing) (n=3), and compliance to a standardized selection process (guidelines from central) (n=6). Although a standardized selection process already exists, the last suggestion implies that the process is not always followed or well-known.

It was notable that a very small proportion of the respondents represented the prioritized populations for deployment (national scholarship recipients and indigenous persons). In part, those with national scholarships may be prioritized because such scholarships are often attached to return service agreements. Bringing the concept of scholarship and return service further, policymakers may encourage retention of HRH by assisting in graduate course admission or tuition in exchange for return service. While this is currently practiced among DTTBs with the Masters in Public Health program, it may conceivably be extended to Masters in Nursing, or other training relevant to community or rural health and/or health management. Further or continuing training was one of the reasons cited by deployed HRH for potentially leaving their current deployment assignment. For example, senior posts at rural areas, attained with the help of further training and experience, provide career development options that does not entail leaving the rural area itself. Sponsorships and scholarship like those mentioned have been found to make long-term public sector work more attractive, despite comparison with private practice (Mathauer & Imhoff 2006). This is important to consider as Filipino medical practitioners often link private practice to more modern and well-maintained facilities, less bureaucracy, and other similarly alluring factors.

One informal practice currently carried out in the assignment of applicants is that those who are from particular rural backgrounds are often matched to their hometowns when possible. However, rural background is currently not a formal criterion for priority recruitment in the deployment program guidelines.

Strong evidence for the association of recruiting from those with rural background and continued rural medical practice was found in a systematic review in both developed and developing countries such as Canada and Thailand. According to a Cochrane systematic review, rural background "appears to be the single factor most strongly associated with rural practice" (Grobler et al. 2015). The trend seems to be

consistent in both developed and developing countries (WHO 2013). In Canada, where family medicine residency training is available, graduates of such training were 2.5 times more likely to engage in rural practice than colleagues from urban backgrounds (Woloschuk & Tarrant 2004). Thailand has also used rural recruitment, training in rural health facilities, hometown placement, and contractual agreements, accompanied by benefits in accommodation and learning materials to encourage rural practice (Wibulpolprasert & Pengpaibon 2003). Similar programs exist in the Philippines for medical school applicants, such as the University of the Philippines Manila College of Medicine Regionalization Program (UPCM RP), the University of the Philippines School of Health Sciences (UP-SHS) system, and Ateneo de Zamboanga College of Medicine (AdZU CM).

The UP School of Health Sciences system recruits and trains medical professionals at UP campuses across selected provinces in a ladderized educational system (Anon n.d.). A ladderized system is one in which students undergo intervals of study and return service, successively earning higher degrees with each round of study and service (midwife-nurse-medical doctor). The three programs recruit and provide scholarships to students from the provinces and include frequent immersions in their area of origin throughout training. The UPCM RP and UP-SHS programs also include a return service obligation equal to the number of years of medical education (University of the Philippines Manila, 2018). Admission into the UPCM RP includes knowledge of the local health system in the admissions interview. Immersions are monitored by the MHO in their province of origin. While the regionalization program in part aims for equitable recruitment (geographic origin of students), it shares similar goals to that of the UP School for Health Sciences. The programs strive to bring medical education closer to rural areas and include immersion in the local rural health systems in order to promote medical practice there. An evaluation of the AdZU program has been published and shows some success, with 80 percent of all graduates from 1999-2011 practicing in rural underserved areas, and with a 55 percent increase in Zamboanga municipalities with a doctor (Cristobal & Worley 2012). In the case of the UP-SHS and AdZU, maintaining schools in the provinces themselves were found to be more convenient to students, and avoid the influence of 'urban bias', where students who need to temporarily transfer to urban settings may more strongly consider staying and settling there.

It is unclear if formal coordination currently exists between medical school recruitment programs and the specific DOH deployment programs that target students from rural backgrounds, given opportunities for medical training elsewhere, and then deployed back to their rural origins to practice. If such mechanisms exist even informally, its institutionalization may be used as a model to encourage continuity in the transition through recruitment, training, and employment in rural practice.

Health workers' career stage and experience level are considerations for designing incentives. Designing such incentive packages are theoretically favorable in decentralized systems. However, local governments may not necessarily have the resources to provide them (Hongoro & Normand 2011). For instance, those at the beginning of their career are more likely to appreciate financial incentives, improved training, and career opportunities (Gruen et al. 2002). Flexible contracts have also been shown to attract health workers who prefer part-time arrangements, or to return from retirement, and thus lessen the burden for healthcare workers (Haji et al. 2010).

Professional associations such as the Philippine Nurses Association may be avenues for providing practicing HRH a network for potential opportunities to practice in their hometown later in their careers. Since most professional organizations employ a strong network of its members, this could help reach HRH later in their careers, especially those close to semi-retirement, who may want to consider working closer to their hometown - similar to the flexible contracts offered in Guyana and Tanzania (Haji et al. 2010). The usefulness of employing social networks through professional organizations is also supported by the finding that applicants are more likely to find out about the deployment program by

word-of-mouth rather than mass media or publications. Institutions and associations would likely facilitate knowledge of the program for late-career or part-time positions well through their wide networks.

Application

Application is under the recruitment and selection phase of the deployment program as stipulated by the AO 2014-0025. Like recruitment and selection, local stakeholders had mixed responses when asked whether all applications happen solely in the regional office, as prescribed by the AO. This implies that there may be other potential actors in play (potentially, the LGU). Only half of the deployed HRH reported submitting their applications directly to the regional office while the rest submitted them to the provincial DOH offices when present in their vicinity. Some deployed HRH reported facing difficulties with the application process.

Most of the local stakeholders found the application process already satisfactory (n=11). They noted that the system is working well and efficient. A few respondents mentioned having too short or late schedule of application (n=3). Notably, one respondent mentioned that their office conducted a synchronized application procedure, wherein all applicants are called for examination on one day, with interviews also held simultaneously in several areas. One local implementer recommended an online application process to ease the preparation process for applicants.

The length of time for DOH staff to process deployment applications was the most common concern raised by the HRH deployment program applicants. The respondents pointed out that applications may be better carried out if done online. Other notable concerns mentioned in the application process were the need for more modes of communication (commonly, landline was used but online channels were strongly recommended by respondents), unstable scheduling, long waiting time for response from DOH, and unclear instructions on application (requirements), all of which may be indirectly related to the first concern on difficulty coordinating. In terms of length of the whole application process, the local stakeholders and deployed HRH were consistent reporting a median of 3.5 weeks.

Exhibit 13. Description of procedure of application according to local stakeholders and deployed HRH

Application procedure	# reporting Yes	%	Application procedure	# reporting Yes	%
Local Implementer (n=31)			**Deployed HRH (n=20)**		
Applications go directly to the regional office	17	54.8	Applied by submitting an accomplished application form, which is complete in details required by the document, directly to the regional office	10	50
Length of the whole application process, in weeks (Median/IQR)	3	4.37	Length of the whole application process, in weeks (Median/IQR)	camera4	2.37

Another noteworthy observation of the study was that only one deployed HRH was a recipient of a national scholarship sponsored by DOH and only one represented the indigenous people sector[5]. According to the AO, government scholars and members of indigenous cultural communities should be granted priority in the program.

[5] This observation was taken at the time of interview. The lack of representation from the indigenous people sector and recipients of national scholarships may be attributed to sample size or timing of the study.

Exhibit 14. Deployed HRH with application priority according to the AO

Characteristic of deployed HRH (n=20)	# responding Yes	%
Recipient of a national scholarship sponsored and managed by the DOH	1	5
Member of the indigenous cultural community	1	5

Those who responded "NO" in the following questions are not reflected in this table

Pre-deployment

The AO requires the regional office to conduct regional pre-deployment orientations (RPDO). Local stakeholders confirmed that there were RPDOs done and reported that a regional order has been issued for compliance. While most of the deployed HRH were required to attend, a few reported that they were unable to attend. Reasons for not attending were not explored during the interview. Nine out of 10 of the local implementers interviewed confirmed that RHUs do internal orientations but only 65 percent of the deployed HRH confirmed receiving an orientation. The discrepancy might be attributed to the fact that less than half of the local implementers monitored attendance in these orientations.

Exhibit 15. Comparison of experience between local stakeholders and deployed HRH on pre-deployment procedures

PRE-DEPLOYMENT					
Local Implementer (n=31)	**Yes Respondents**	**%**	***Deployed HRH (n=20)***	**Yes Respondents**	**%**
DOH Regional Office (RO) conduct RPDOs for the HRH	30	96.8			
There was a department policy for the RO to comply to this	28	90.3	Was required to attend the RPDO	19	95
RHUs do internal orientations as well	27	87.1	Since required, was able to attend the RPDO of the DOH RO	17	85
There is a standard tool for the RO to monitor RHU orientations	12	44.4	Had an institutional pre-deployment orientation such as the ones in the health facility/LGU assigned to you	13	65
Other methods used for monitoring orientations	12	44.4	There are pre-deployment assessments done to assess baseline knowledge of the health systems and programs in deployment area	15	75
Endorsements (i.e. formal notice of deployed HRH arrival) are done between the deployed HRH and supervisors/other staff	29	93.5	Endorsements are done between the deployed HRH and supervisors and other staff	19	95
In-person	23	74.2	*In-person*	12	63.2
Letters	30	96.8	*Letters*	14	73.7
Others	6	19.4	*Others*	3	15.8

A majority of the areas provided reports and/or forms to confirm that an RPDO were indeed conducted. The files ranged from full documentation of the event (minutes), attendance sheets, regional personnel orders, participant evaluation of the RPDO, and even post-activity clearance. The submitted sample reports contained a comprehensive summary of the event, orientation agenda, highlights, activities, and speakers. It should also be noted that participant evaluations were done and mentioned in the report, making it a useful source for feedback and potential improvements. Likewise, the post-activity clearance was notable since it required the organizers to submit necessary documents prior to closing the activity. Attachments included were approved learning design, summarized evaluation with

analysis, and completion report. In sum, it was apparent that RPDOs were well-documented. The comprehensiveness of the RPDOs could not be fully evaluated since documents were not uniformly detailed. For this section and others below (such as *Arrangements)*, the content outline of reports submitted demonstrate what kind of data may be available for DOH HHRDB to use in monitoring and analysis.

During pre-deployment, many of the deployed HRH reported that they had not participated in assessments to check their baseline knowledge of the health systems and programs in their area.

Both local stakeholders and deployed HRH agreed that some form of endorsements (or formal notice) were done prior to the deployment of the HRH in the communities. However, the most common form of endorsement from the regional office to the RHU was via a letter. One respondent cited their endorsement as simply being a courtesy call to city hall or the LGU main administrative office.

Because of varying compliance to conducting and attending regional and local pre-deployment orientations, some local stakeholders and deployed HRH have difficulties working together due to varying familiarities with the local health programs. Deployed HRH also reported attending to responsibilities beyond the scope of their job description, and it is unclear how these roles are related to their regular task of disease monitoring and surveillance. Clear delineation of responsibilities of their roles and scope of accountability, as well as finding a job consistent to their training, contribute to deployed HRH's satisfaction with their job. This is consistent with responses on HRH job satisfaction in an Indonesian survey included in the review by Henderson and Tulloch (2008), where nurses and midwives reported that the clarity of their job descriptions (with clear standards of operation and procedures) were positively associated with their confidence in fulfilling their roles. Clarity of roles is also an element of good supervision and management, which is critical to health systems management and quality of care (Guilbert & -J. Guilbert 2006).

Arrangements

Arrangements are documented agreements (e.g. Memorandums of Agreement (MOAs) which specify scope of work) among stakeholders (LGUs, regional offices, deployed HRH). The local stakeholders confirmed that department personnel orders (DPO) and regional personnel orders (RPO) were released for the deployed HRH, as provided for by the AO. Orientations about the deployment program between the LGU and local health board were also conducted prior to the deployment of HRH.

The local health board is composed of the governor as chairman, the provincial health officer as vice-chairman, the chairman of the provincial health committee, a representative from the private sector or non-governmental organizations involved in health services, and a representative of the DOH in the province. The local health board performs duties in accordance with standards and criteria set by the DOH (i.e. propose annual budgetary allocations for the operation and maintenance of health facilities and services within the municipality, city, or province; serve as an advisory committee to the sanggunian concerned on health matters). The provincial DMOs conduct an orientation for the LGU to acquaint them with the guidelines for implementing the deployment program in their respective LGUs. A pre-deployment orientation is conducted for soon-to-be deployed HRH to introduce them to their responsibilities in the communities.

While there are various ways to document these orientations, only one study site managed to provide documentation of their orientations. The documentation contained a copy of the course evaluation of participants, program schedule, list attendees, letter of endorsement, evaluation form, and a report following the content prescribed by HHRDB guidelines. It also included feedback on the activity

(evaluations), analysis/summary of evaluation, detailed program, invitation letters, names and contact information of participants, and a summary table following Program Implementation Review (PIR) format. The report also included a section on areas for improvement that can be applied in future orientation.

Local stakeholders reported that MOAs were also signed among the DOH, LGU, and deployed HRH. A majority of deployed HRH confirmed this. However, local stakeholders gave mixed responses when asked if there was a specific point-person in the LGU assigned to manage the deployed HRH. Similarly, the local stakeholders were also not sure if the deployed HRH were allowed to hold key roles with high accountability in the health programs implemented in the RHU. Some deployed HRH confirmed this and reported that they indeed held positions that make them accountable which was inconsistent with the AO. These positions were being designated as HRH point person (n=2), public health associate (n=1), in-charge of vaccine cold chain (n=1), and various program specific roles, mainly as "coordinator" (n=7). It is unclear how these program specific roles are related to their regular monitoring and surveillance tasks stated in the AO. Nonetheless, a majority of the deployed HRH confirmed that they did participate in implementing health surveillance systems and health emergency preparedness.

Some local stakeholders' respondents also reported incidents of deployed HRH reporting to other areas not originally assigned to them during the interviews. They explained that this was in response to requests received from neighboring areas who needed HRH support. Moreover, some deployed HRH noted that they performed some services beyond the scope of their contracts. An example of this is encoding data and being the information technology point person of the RHU. As anticipated in LGUs without doctors, a majority of the deployed doctors confirmed that they were also enlisted into the local health board and expected to report about the status of health care services in the RHU.

Exhibit 16. Comparison of experience between local stakeholders and deployed HRH on deployment arrangements

DEPLOYMENT (Arrangements)					
Local Implementer (n=31)	**Yes**	**%**	**Deployed HRH (n=20)**	**Yes**	**%**
HHRDB / DOH RO issue DPO/RPO and endorsement for the deployed HRH	26	83.9	Reported to another area which was not the assigned deployment site, for any reason	8	40
Orientation occurs for LGU and local health board before receiving the deployed HRH	25	80.6			
Specific position exists for deployed HRH point-person in the LGU (i.e. a person deployed HRH can contact for program issues)	20	64.5			
There was a memorandum of agreement between DOH, LGU, and HRH	23	74.2	Aware of and have signed the MOA between HRH, the DOH, and the LGU	17	85
Confirm no deployed HRH are accountable as program coordinators or focal persons	21	67.7	Carry any position accountable as program coordinator or focal person	12	60
			Take part in implementing health surveillance systems and health emergency preparedness	17	85
			Served other functions that is not within the scope of your contract	6	30
			If a deployed physician (DTTB), they are a member of a local health board (n=3)	2	66.6

Contracts and Renewal

Both local stakeholders and deployed HRH confirmed that contract renewals and appointments are

carried out and that the basis for these were known to the deployed HRH. However, deployed HRH respondents believe that there are variations in the conduct of the renewal of appointments particularly at which governance level it is undertaken. Results of the survey/KIIs reveal that renewals are decided at the provincial level (n=9), while some say it is at the DOH regional (n=4) or central office (n=3).

Local stakeholders also noted that they are aware of requests for transfer. Requests for transfer are commonly attributed to distance from home (n=7) or presence of security threats (n=5) in the area of assignment. Respondents also stated that deployed HRH reporting incidents of sexual harassment were transferred[6]. One local implementer thought it was precarious for a female to regularly travel to a remote area alone. Another local implementer, meanwhile, pre-emptively made a transfer for deployed female HRH who was previously deployed in area where local militia were located as a security measure. Other reasons for transfers reported by local stakeholders were unwanted attitude or behavior of the deployed HRH (n=6), issues with the LGU like nepotism (n=4), and disagreements with the LGU (n=4). Another reason is a greater need for deployed HRH in other areas (i.e. some areas requested HRH for deployment but were not granted).

The local stakeholders were consistent in reporting the expected length of service for the four cadres: 24 months for doctors, and six months for nurses, midwives, and medical technologists. Since a majority of the deployed HRH sample were nurses, the median length of service of those interviewed was two months (IQR=4.5) but the median number of renewals they had was five times (IQR=5). Nurses, midwives, and medical technologists can renew their contracts more often while doctors are not usually renewed. This is because DTTBs are chosen in the central office and are commonly deployed in batches, while other arrangements such as two-month extensions are available for nurses.

Exhibit 17. Comparison of experience between local stakeholders and deployed HRH on contracts and renewal

Local Implementer experience (n=31)	Yes	%	Deployed HRH experience (n=20)	Yes	%
There are renewal of contracts/appointments among deployed HRH	30	96.8	Aware of renewal of contracts/appointments	20	100
Aware of the reasons accepted for possible HRH transfers	31	100.0	Aware of the basis for appointment/renewal for the position	19	95
HRH provided with Certificate of Employment, or Certificates of Completion and Deployment	31	100.0			
	Median	**IQR**		**Median**	**IQR**
Usual contract of service of deployed doctors (in months)	24	0.0	Length of the term of your current contract of service	2	4.5
Usual contract of service of deployed nurses (in months)	6	0.0	Number of times renewed already, if applicable	5	5
Usual contract of service of deployed medical technologists (in months)	6	3.0			
Usual contract of service of deployed midwife (in months)	6	0.0			

Working Hours and Daily Time Records

Both local stakeholders and deployed HRH confirmed that daily time records (DTRs) were submitted, usually once per month. Most areas studied provided a sample of their DTR, and almost all areas use the same DTR as the format provided by DOH HHRDB (Civil Service Form no. 48). One area changed the

[6] The study did not ascertain if the local stakeholder conducted any investigations or took any corrective measures against the offender.

format but the content was still very similar. The DTR contains information on arrival and departure times each day for a month, total hours rendered, and the assigned signatories for validation. Night duty shifts were reported by a majority of both local stakeholders and deployed HRH, adding that night duty shifts are limited to eight hours per shift. The two groups also noted that deployed HRH in night shifts are accompanied by organic staff which is compliant with the implementation guidelines of DOH (DO 2018-009).

Exhibit 18. Comparison of experience between local stakeholders and deployed HRH on DTR submission and night duty

DEPLOYMENT (Working Hours and DTR)					
Local Implementer (n=31)	**Yes**	**%**	**Deployed HRH (n=20)**	**Yes**	**%**
HRH submit daily time records	31	100.0	Submit daily time records	20	100
			Submit DTR to the Regional Office through the Provincial Health Office	19	95
Frequency of the submission (times per month)			Frequency of the submission (times per month)		
Once	17	56.7	Once	12	60
Twice	13	43.3	Twice	6	30
Deployed HRH do night duty shift	19	61.3	Do any night duty shift	7	35
Length of one-night duty shift for the HRH, in practice (most common answer)	8		Length of one night duty shift for the HRH, in practice (most common answer)	6 to 8 hours	
Confirmed that Deployed HRH are accompanied during night duty	20	64.5	Deployed HRH accompanied during night duty (Out of 7 eligible respondents)	6	85.7

Compensation and Benefits

Payments are given regularly but local stakeholders and deployed HRH were aware that there are occasional delays. Contribution for Government Service Insurance System (GSIS) and Philippine Health Insurance Corporation (PHIC) premium memberships for the deployed were provided. Local stakeholders and deployed HRH are aware on the mechanisms for salary computations. However, some local stakeholders reported that different salary guidelines, apart from the one prescribed by HHRDB, are still being implemented in their areas.

At least half of local stakeholders submitted documentation for the salary-related files of deployed HRH. The usual documents submitted were pay slips and payroll. While there was no standard form for pay slips, the contents of the sample show salary computations as well as information on basic salary, number of working days, absences, tardiness, and total deductions for benefits.

It is uncommon for deployed HRH to receive other allowances for transportation, lodging, or other expenses. However, when they do receive other benefits, these include extra pay for activities, food, per diem, gasoline for car transportation, bonuses from the LGU, and transportation allowance for additional activities. Interestingly, those who received benefits seemed to have generally lower mean job satisfaction and lower scores for intention to remain in service compared with those who did not receive any. That this contradicts the expectation that higher job satisfaction and intention to remain in service is co-related to benefits, indicate that other factors such as security of tenure or professional development actually drive job satisfaction.

Exhibit 19. Comparison of experience between local stakeholders and deployed HRH on compensation and benefits

Local Implementer (n=31)	Yes	%	Deployed HRH (n=20)	Yes	%
Payments for compensation of the HRH given regularly	25	80.6	Receive payment of compensation regularly	18	90
There are unexpected delays in giving payment	24	77.4	There are unexpected delays in when you receive your payment	12	60
Aware of deployed HRH enrollment to GSIS Group Personal Accident Insurance and PHIC membership	30	96.8	Provided regular (weekly, monthly, etc.) benefits for: Transportation	6	30
There are established mechanisms or official guidelines for salary computations of deployed HRH	29	93.5	Provided regular (weekly, monthly, etc.) benefits for: Lodging and Miscellaneous	1	5
Use any other basis aside from the official guidelines	11	35.5	Provided regular (weekly, monthly, etc.) benefits for: Other expenses	4	20

Exhibit 20. Benefits and Satisfaction

Benefits Reported	Satisfaction (Mean/SD)	Retention (Mean/SD)
Transportation		
Not Provided (n=14)	4.7 (0.47)	4.8 (0.58)
Provided (n=6)	3.8 (0.75)	4.0 (1.55)
Lodging and Miscellaneous		
Not Provided (n=19)	4.5 (0.70)	4.6 (1.02)
Provided (n=1)	4 (n/a)	4 (n/a)
Other Expenses		
Not Provided (n=16)	4.5 (0.74)	4.5 (1.13)
Provided (n=4)	4.5 (0.58)	4.75 (0.5)

Security

Seven out of every ten deployed HRH and local stakeholders confirmed that there is a safety and security management system to protect deployed HRH in the areas. However, only some noted the existence of a technical working group (TWG), timely risk assessments, and database of high-risk areas. A designated point-person for emergencies and a clear chain of command/hotline for reporting incidents were most commonly cited as security components implemented in the deployment program.

Exhibit 21. Comparison of knowledge between local stakeholders and deployed HRH on security management system

Deployment security system protocol	Local Implementer (n=31)		Deployed HRH (n=20)	
	# reported Aware	%	# reported Aware	%
There is a safety and security management system that protect and safeguard DOH deployed HRH	22	71.0	14	70
There is a TWG that involves representatives from Armed Forces of the Philippines, National Disaster Risk Reduction and Management Council, DOH Deployed HRH, LGUs	15	48.4	11	55
There is a designated point person for deployed HRH to report incidents (e.g. natural disasters, industrial and transport disasters, civilian threats, any nature of harassments, security threats, etc.)	24	77.4	14	70
There is an established hotline and clear chain of command for reporting	24	77.4	13	65

Deployment security system protocol	Local Implementer (n=31)		Deployed HRH (n=20)	
	# reported Aware	%	# reported Aware	%
of incidents from the LGU, PDOHO, DOH regional and central office				
This system does timely threat and risk assessments to determine the safety and security crisis of deployed HRH	13	41.9	7	35
This has a database containing the list of areas or municipalities with reported high risks of security threats for deployed HRH	13	41.9	6	30

Only two areas provided some form of documentation for the required safety and security management system. The documents were not comparable since they served different purposes. One area gave a copy of their safety advisory presentation and safety briefing which outlined what the deployed HRH need to do during emergencies and calamities and phone numbers they can contact. Another area submitted a regional office memo containing a short section on the guidelines for clear chain of reporting, expected time of response, persons-in-charge, and contingency plan in case of pull-out from the areas of assignment. A more comprehensive documentation of the safety and security management system was expected since the department order gave clear components on what it should be. The only additional security measure reported by HRH were direct orders from regional office or LGU to ban travel in the presence of a potential threat.

Monitoring and Evaluation

The AO requires the DOH regional office to "evaluate deployed HRH and reports shall reflect performances of the HRH, hindrances to utilizations, and their contributions to Universal Health Care". Local stakeholders reported that deployed HRH underwent periodic evaluations, which deployed HRH confirmed. While a common format for evaluation has been created by regional offices and is being used, the local stakeholders added that there is no DOH-mandated outline. Local stakeholders commonly conduct evaluations semi-annually. However, annual implementation review with analysis and recommendations and monthly utilization report were not commonly submitted by the local stakeholders as were the evaluation documents.

Exhibit 22. Comparison of experience between local stakeholders and deployed HRH on monitoring and evaluation

Local Implementer experiencer (n=31)	Yes	%	Deployed HRH experience(n=20)	Yes	%
Deployed HRH being evaluated periodically	29	94	Aware of any evaluations being done for the performance as a deployed HRH	19	95
Monitor the deployed HRH using a DOH-prescribed tool	20	65	Requested to make evaluation reports of your experiences as a deployed personnel, or of the deployment program	18	90
There is an available format	30	97	There is an available format	16	80
			Aware of their direct supervisors	20	100
Frequency of the evaluations/monitoring per year (most common answer)	2		Submit reports to DOH RO	17	85
Use other or additional tools	9	29	Submits Accomplishment Report	18	90
Submit annual program implementation review with analysis and recommendations	20	65	Submits Health-program specific Report	15	75
Submit monthly fund utilization report	19	61	Submits Other Reports	7	35
Prepare other monitoring reports to be forwarded to DOH RO or HHRDB	11	36	There is a standard tool/format for: Accomplishment Report	15	75

Local Implementer experiencer (n=31)	Yes	%	Deployed HRH experience(n=20)	Yes	%
			There is a standard tool/format for: Health Program (specifics) Report	16	80
			There is a standard tool/format for: Others specified	4	20

A sample documentation of program implementation review (PIR) from HHRDB includes the proceedings of consultative meetings between local stakeholders and deployed HRH, and the summary of agreements that took place. The content of the proceedings includes the objectives of the meeting, any highlights, an evaluation of the event, and recommendations.

About half of the regions interviewed gave documentation of their annual PIR. Some areas gave the actual report while others submitted a copy of the evaluation form of the event and attendance sheets. Respondents who gave samples of the report were compliant with the content suggested by HHRDB. These reports included summary of agreements (which listed day agenda, issues, agreement, timetable, and responsible parties involved) and proceedings of the consultation meeting (with sections on rationale, objectives, highlights, summary of agreements, and analysis of the evaluations).

Most regions were able to produce and share a copy of their Monthly Fund Utilization in the form of a Monthly Disbursement Report. Although one area submitted a document directly entitled "Monthly Utilization Report". The content is roughly the same. It appears there is no standard form for the Monthly Disbursement Report, though the contents are generally the same in accounting for total funds allocated and disbursed every month, differing only in additional details included. Line items for salaries and other expenses were outlined in these reports with slight variations on the level of specificity. Some forms also noted the sources of funds and sub-allotments. All forms showed a clear overview of the disbursement of funds through time and of different types of expenses under the program. The long "Monthly Utilization Report" contained information very similar to the "Monthly Disbursement Report".

Only a few local stakeholders mentioned submitting other reports to the DOH, which included monitoring reports made and submitted by supervisors on the activities and monitoring of the HRH. Other reports included those made by the deployed HRH themselves, such as performance evaluations, monitoring of behavioral competencies, accomplishment reports, municipal health plan, individual performance commitment and review, and monthly reporting forms. These forms mainly function to help supervisors monitor and evaluate the work of deployed HRH as professionals, public health deliverables and indicators in the community. See Exhibit 22 for further detail.

Deployed HRH are required to submit reports to the regional office. The most common ones submitted are accomplishment and program-specific reports. HHRDB has three types of tools specifically used in monitoring DTTBs. According to the documents reviewed, this included Documents and Observation Guide, Competency Discussion Guide, and Self-Assessment Guide. The Document and Observation Guide monitors the facilities of the RHU outside (e.g. garbage disposal segregation) and inside (e.g. mission and vision statements, organizational charts, toilets, records cabinets, etc.). Documents like annual health plan and municipal health plan were also submitted for review. The Competency Discussion Guide is used to evaluate the deployed DTTB personnel competencies in strategic decision-making, creativity and innovation, managing conflict, and people participation. The self-assessment guide was the sole tool filled by DTTB, including questions answered in narrative form. The usual questions revolved around DTTB implementation status of their self-initiated programs, reaction to colleagues, self-evaluation of decision-making skills, and experience with the local health board. Overall, documents evaluated the skills and reviewed the performance of the HRH, likely as potential basis for renewal. However, reports asking about the satisfaction of DTTB with their experience were still clearly lacking.

DOH HHRDB also receives a monitoring report for other deployed HRH. No uniform standard for monitoring was noted and different regions gave their own samples. Some examples received were individual performance assessments (targets and whether or not these were achieved), supervisors' evaluation forms (including skills, behavior, and program deliverables), an individual and team scorecard which graded the HRH's technical assistance, planning, policy-related, advocacy-related, mentoring, and collaborative skills together with their work ethic. The team evaluation was based on program outcomes, through validation of program accomplishment reports, like number of pregnant women with more than four prenatal visits and proportion of fully immunized children. The file also had a summary table that showed whether or not the deployed HRH should be eligible for renewal. This means that the data from the form affects renewal eligibility of the deployed. The files mentioned here came from different regions. Notable differences of the monitoring tools might be attributed to the lack of standardized forms.

Similarly, the deployed (DTTBs and other cadres) gave mixed responses when asked if the format for the reports they submit are standardized. Documents prepared and submitted by deployed HRH were in the form of monthly journals, program statistics, program evaluations, accomplishment reports, individual performance targets, individual performance commitment review, reporting matrix, and municipal and provincial reporting. Broadly speaking, many of these reports measure and document local public health progress, and deployed HRH's responses in observing, measuring, and responding to them according to their respective roles. A more detailed and specific description of each form can be seen in Exhibit 22.

It is also notable that the DOH HHRDB has a "Satisfaction Survey on Technical Advisory and Support" that should be filled up by LGU officials and senior technical staff from sample municipalities with deployed HRH. The survey focuses on utility (useful and responsive to the needs of the area), quality (competency, capability, and commitment of HRH), and timeliness (timely assistance). A section on the qualitative interviews summarizes issues raised in terms of sustenance of the deployment program, administrative concerns, capacity-building for the HRH, and policy suggestions. Since none of the local stakeholders from the study sites submitted nor made mention of the survey, actual usage of this form cannot be determined.

A robust monitoring system is always conducive for improvement. The deployment program does have a comprehensive system that has good compliance for key reports such as the Program Implementation Review, Daily Time Records, and Monthly Funding Utilization, specifically on consistency of format, content, and submission. However, other report formats and other kinds of reports submitted to DOH HHRDB appear to be inconsistent. Compliance among the recipient LGUs also varied. HHRDB has shown a wealth of specific tools, but since they were not consistently provided by regional and provincial offices and RHUs, local stakeholders may not be using these or may not even be aware of these. Lack of a standardization or lack of knowledge on the standard format for some reports may have led RHUs to create their own. This has the potential to be harnessed for more detailed and specific monitoring in the future, accompanied by a streamlined workflow and information system, so that it will not unduly increase workload for the RHU either

Continuing Education and Capacity Building

The AO also stated that "DOH central and regional office shall provide learning and development interventions (LDIs) and LGUs or sending agencies shall shoulder transport and living expenses unless otherwise stated". Interviewed local stakeholders and deployed HRH report that LDIs are available but not all agreed that the required documentation was always done.

Most deployed HRH responded positively to the learning and development interventions (LDIs) they

underwent. They believe the LDI are applicable to their work and done at a good frequency. The positive experience of deployed HRH on LDIs may be attributed to the close feedback between HRH and local stakeholders regarding the appropriateness and quality of delivery. The presence of training opportunities is a consistent theme for job satisfaction in Asia Pacific countries (Henderson & Tulloch, 2008). Trainings focused on local conditions and relevant to local needs has been suggested to limit attrition (Guilbert & J. Guilbert 2006).

A majority of the regions gave some form of documentation for LDIs; however, the documentation reports were not uniform in format. The records reviewed comprised of proposal for the training, personnel order, PowerPoint of the training, training certificates, post-activity report, and training evaluation analysis. The proposal provided enough overview on the content of the LDIs. One of the notable activities was the evaluation of baseline and post-training knowledge of participants. The reports gave comprehensive documentation of what transpired in LDIs conducted in their areas, while the evaluation gave performance statistics of the event. Although no area submitted standard comprehensive documentation of LDIs, the documents available were sufficient to describe the LDIs being conducted in the areas. Topics for LDIs include special health care topics (FP competency training and MNCHN training), training on reporting for other DOH bureaus (such as for Health Facility Profile), and general professional training (such as conduct and decorum).

There were also mixed responses when the local stakeholders and deployed HRH were asked about allowances during LDIs. The most common forms of allowances noted are per diem and transportation. The local stakeholders also had varying responses when asked if reimbursements could be given which confirm the responses of the deployed. Overall, a majority of the deployed HRH reported positive responses to the LDIs. They believe that the LDIs align with their jobs and are done frequently enough. While only some local stakeholders reported receiving support for the deployed HRH, more deployed HRH noted that there were indeed other available support services offered to them.

Exhibit 23. Comparison of experience between local stakeholders and deployed HRH on continuing education and capacity-building

Local Implementer experience (n=31)	Yes	%	Deployed HRH experience (n=20)	Yes	%
There are LDIs for the deployed HRH	24	77.4	Aware of any LDIs for you, as a deployed HRH, facilitated by DOH, HHRDB or DOH-RO	16	80
Confirmed that LDIs are to be documented	23	79.3	Confirmed that LDIs are documented* (out of 16 eligible)	13	81.3
When deployed HRH are sent for capacity-building activities, such as continuing professional development activities or other external training that are considered official business, they are provided allowances	16	51.6	Provided with allowances during LDIs/trainings	9	45
Person-day salary* (out of 16 eligible)	16	100.0			
Transportation* (out of 16 eligible)	16	100.0			
Food* (out of 16 eligible)	12	80.0			
Other* (out of 16 eligible)	8	50.0			
Deployed HRH are allowed to present other expenses incurred and get reimbursements	14	45.2	Allowed to present other expenses incurred and get reimbursements during LDIs/trainings	9	45
Aware of programs under Provincial DOH Office (PDOHO) or Integrated Provincial Health Office (IPHO) that lobby for additional incentives of support to HRH	13	41.9	HRH think that they are being provided with interventions that are fit for their job in terms of content	16	80

Local Implementer experience (n=31)	Yes	%	Deployed HRH experience (n=20)	Yes	%
			HRH think that these LDIs frequent enough to update their skills	14	70
			Other technical assistance or support services that DOH RO/LGU are offered to them	13	65

Monitoring Retention

The AO stipulates that the DOH regional offices shall monitor retention and recipient LGUs shall endeavor to give regular positions to deployed HRH. This section will focus on LGU efforts in monitoring and promoting retention. It supplements the previous discussion in SO2, which focused on the perceptions of deployed HRH and motivations about retention. This section was separated in order to clarify the discussion of implementation fidelity, or LGU efforts and actions with regard to the deployment program. Only half of the local stakeholders reported submitting updated lists of deployed HRH or monitoring reports for retention. The local stakeholders were divided in terms of awareness of efforts to provide regular job positions for the deployed HRH. Mixed responses were also recorded among the local stakeholders when asked whether the number of deployed HRH seemed sufficient in their regions.

Exhibit 24. Summary of local implementer experience on monitoring and retention promotion

Local stakeholders experience (n=31)	Yes	%
Local implementer submits updated list of HRH to DOH Central Office	16	51.6
Monitors retention of deployed HRH (To clarify, retention shall refer to the stay of a deployed HRH within the municipality or province for a period of at least 2 years after the termination of the contract or service agreement)	16	51.6
Confirmed that there are endeavors being done in the recipient facilities/LGUs with regards to providing regular items for deployed HRH	16	51.6

Half of local stakeholders provided an updated list of deployed HRH in their area to DOH central office annually. At the minimum, most reports include an aggregate list of total deployed HRH per province, per program, and their specific area of assignment at the municipality level. Unfortunately, only one sample was submitted by each LGU, thus retention could not be extrapolated from these reports. Some reports go further and included personal details of deployed HRH (date of birth, gender, contact information, and emergency contact persons), and assignment of specific information such as entrance to duty, GIDA type, and population of assigned area. This additional information, while not uniformly present, has value for evaluation, allocation, and for response in emergency situations.

However, when it comes to retention, only 33 percent of the local stakeholders gave a sample of retention monitoring reports, though in varying formats. These lists included data for the status of the deployed HRH that were active, inactive, absorbed and their area of assignments. A slightly more comprehensive format was submitted by one area, which included information on deployed HRH details, date of entrance to duty, date removed from program, reason removed (absorbed, transferred, or resigned) and area of transfer/absorb. Overall, the forms were sufficient to monitor the HRH retention in the areas for program evaluations. Though its use for decision-making was not probed further during the interviews.

Nurses and midwives (three each absorbed nurses and midwives, in a year) were the most common deployed personnel absorbed by the LGUs while doctors and medical technologists were the least likely

to be absorbed. In terms of re-application, doctors were the least likely to re-apply while the nurses, medical technologists, and midwives were almost always likely to re-submit their applications for the positions. The reason for this was not probed in the interviews.

Exhibit 25. Summary of deployed HRH hired by LGU (as reported by local stakeholders)

Type of HRH	Median no. of HRH reported to be hired by LGU	IQR
Doctor	0.5	1
Nurse	3	4.9
Medical technologists	1	1.5
Midwives	3	4

Exhibit 26. Proportion of deployed HRH who re-apply or renew contracts (as reported by local stakeholders)

Type of HRH	Median of HRH	IQR
Doctor	2	9.125
Nurse	9.9	0.5
Medical technologists	10	2
Midwives	10	0.5

According to local stakeholders, the most common factor affecting LGU's decision to absorb HRH was availability of positions, followed by the HRH's professional competence (often noted to be based on performance evaluation). The concern for availability of regular positions is commonly cited by the local stakeholders and deployed HRH. In interviews, a lack of regular positions was also mentioned as a form of job instability and a reason to leave by the deployed HRH.

Other reasons stated by local stakeholders affecting LGU decision to hire deployed HRH are priorities of the LGU and mayor (n=3), family and commitment to area (n=3), and perceived attitude or behavior (n=1). Getting along with the local government and behavior were also noted as a reason for transfer of deployed HRH. Personal interactions also appear to be a common theme in the relationship between local government and deployed HRH. Other ways that local stakeholders say HRH are retained in the local health system are by volunteering (n=2) or in being supported by NGOs or other agencies (n=1).

SO4: Access

Both organic HRH and deployed HRH found high cultural acceptability in working with each other. The deployed HRH also showed high cultural acceptability with the community, workplace, colleagues, and patients.

Acceptability

The study solicited perception on different aspects of their assigned environment from the deployed HRH to gain insights on the acceptability of their assignment. Similarly, organic HRH were asked for their perceptions on their deployed colleagues to understand if they are generally culturally acceptable. The deployed HRH reported high satisfaction with the facilities of their health center, communities they were deployed in, their colleagues, and patients they encountered. The mean rating for the above were all at 4.1 and above, on a scale of 1-5, with 5 being "very satisfied". Likewise, organic staff were highly satisfied in working together with the deployed HRH. Results of the satisfaction rating indicate that the deployed HRH and organic staff found working together highly acceptable. Deployed HRH also found working at their specific assigned facility and community highly acceptable.

Exhibit 27. Summary of satisfaction rating among deployed HRH and organic staff with regards to acceptability of their assignment

Deployed HRH (n=20)	Mean	SD	Median	IQR
Satisfaction with the features of facilities at the health center of deployment area	4.1	1.0	4.0	1.0
Satisfaction with the communities served in the deployment area	4.6	0.6	5.0	1.0
Satisfaction with the colleagues/coworkers in the deployment area	4.6	0.6	5.0	1.0
Satisfaction with the patients you usually see in your deployment area	4.3	0.6	4.0	1.0
Organic Staff (n=22)	**Mean**	**SD**	**Median**	**IQR**
Satisfaction with the services provided by the deployed HRH in your health facility	4.4	1.1	5.0	1.0
Community satisfaction with the services and presence of the deployed doctor	4.6	0.7	5.0	1.0
Community satisfaction with the services and presence of the deployed nurse	4.5	1.1	5.0	0.5
Community satisfaction with the services and presence of the deployed medical technologist	4.4	1.0	5.0	1.8
Community satisfaction with the services and presence of the deployed midwife	4.4	1.4	5.0	0.5

Acceptability among HRH

An almost equal number of deployed HRH responded being satisfied with the facilities of their assigned health center because of complete facilities (n=7) and dissatisfied due to incomplete facilities (n=8). Other reasons for dissatisfaction noted were distance and lack of permanent location.

The deployed HRH placed high regard for fellowships developed during their stay as well as in the health-seeking behavior of community. Good fellowship with the community, LGU, and colleagues (n=9) ranked as top reason for satisfaction. Followed by a responsive community and positive health seeking behavior (n=8). Positive health seeking behavior was described by the deployed HRH as seeking consult, listening to medical advice, and following prescribed medication. Similarly, reasons for dissatisfaction were poor health seeking behaviors (n=2), language or cultural barriers (n=1), not feeling secure (danger) (n=1), and personal problems with the community (n=1).

The responses were overwhelmingly positive with regard the deployed HRH's satisfaction with colleagues. Positive individual technical qualities (such as having competent and professional colleagues) (n=4), and team qualities (peaceful, harmonious relationships) (n=5) were cited as factors for being satisfied with colleagues.

Acceptability among Organic staff: Satisfaction with HRH

The organic staff interviewed were unanimously satisfied with the deployed HRH. According to them, the HRH are responsible, approachable, and expressed initiative. They acknowledged that without deployed HRH, their workload would be much heavier, and services would suffer. However, some organic staff report that there still aren't enough deployed HRH in their RHU. There were also some respondents who felt that while the deployed personnel were doing good, they were not performing 'above and beyond' what was expected of them. A staff likewise noted the varying levels of commitment of the different batches of HRH deployed to their communities.

Satisfaction with Doctors

Mixed satisfaction responses about the deployed doctors were noted from the organic staff respondents. The organic staff shared that while they appreciate the work being done by the DTTB, some felt that the doctors were not always visible and limited themselves to office work, while only mingling minimally, either formally or informally, in the community. However, some staff did note that some doctors also put in the effort to do home visits.

Satisfaction with Nurses
Most of the organic staff were highly satisfied with the nurses and appreciated their willingness to serve and do field work in the community. "[Our service is] affected without the HRH" and "[people] depend on them" were some of the feedbacks noted. However, the organic staff also said that services are not continuously provided due to disruptions or delays in contract renewal.

Satisfaction with Medical Technologists
Almost all organic staff gave positive remarks about their medical technologists. More sputum exam services and home visits were conducted with the help of deployed medical technologists. "*Malaki din ang naiambag nila sa amin [in the community] in terms of service,"* ("In terms of service, they make a big contribution to the community"). The presence of the medical technologists was especially appreciated in the ongoing dengue outbreak.

Satisfaction with Midwives
A majority of the organic staff responded positively with presence of the deployed midwives in their RHUs. One respondent shared: "Midwife is the hero for the community", being the first people that residents in the community go to. The deployed midwives are considered kind, skillful, flexible, and effective. However, some staff felt that midwives were underutilized since they are focused mainly on provision of care to pregnant women and babies, but could have been maximized to assist nurses and with other functions of the RHU. Organic staff say that the midwives act as frontliners. They also assist in preparing reports, community profiling and deliverables, and monitoring patients. These tasks ease the load for the whole RHU staff. One respondent noted that the midwives' scope of work is limited by the midwives' range of trained skills and the facilities in the RHU. For instance, it was reported that while the midwife has the skills to prove prenatal care and delivery care, the provision of services is limited because the RHU is ill-equipped to provide the same. In addition, according to some organic staff, it was noted that midwives can only assist nurses on other tasks.

Availability
As noted above, the measure used for availability is a partial estimate, given the constraints of the study. It is intended to only measure the extent of deployed HRH-patients interaction. For more information on the availability of deployed HRH, full workload studies such as those that use Workload Indicator for Staffing Need (WISN) methods may be consulted.

In a normal day, an RHU caters to around 50 patients. The interviewed deployed HRH and organic staff reported serving around 30 patients per day (workload is divided among other staff). They also reported the usual length of consultation to be around 10 minutes. This means that based on the interviews, the typical workload for patient consultation amounts to 500 minutes or roughly eight hours a day. This is only a partial estimate, measured based on self-reporting from KIIs, of the availability of deployed HRH since this only covers patient encounters and does not include other tasks done in the RHU.

Exhibit 28. Summary of measures for availability of HRH to community

Availability Indicator	Deployed HRH		Organic Staff	
	Mean	SD	Mean	SD
Number of patients visiting per day	58.7	45.0	55.3	43.4
Number of personal patient encounters	35.1	26.6	36.1	34.6
Length of Consultation (in minutes)	12.0	9.2	17.6	18.6

Availability Indicator	Deployed HRH		Organic Staff	
	Median	IQR	Median	IQR
Number of patients visiting per day	50.0	63.8	40.0	34.9
Number of personal patient encounters	30.0	35.6	23.3	52.0
Length of Consultation (in minutes)	10.0	8.0	12.5	21.9

Overall, it appeared that deployed HRH had more patient encounters than organic staff. This may be the case because deployed HRH are augmenting organic staff who may be diverted to other duties due to the presence of the deployed HRH.

Deployed HRH reported that they are stretched to a full capacity of working eight hours each day due to the volume of patients and time spent with each patient. While this means that they can accommodate and become available to all patients, these conditions may lead to feeling overworked and burnout. However, it is possible that good relationships with colleagues and community might mitigate this. This may be compared to the theme of 'social entrapment' common in literature about rural doctor retention, but which has been described in New Zealand to possibly have both a positive and negative aspect (Guilbert & -J. Guilbert 2006; Kearns et al. 2006). Negatively, doctors feel obligated to provide services, with a sense of little control over their work conditions due to the need in the community. However, the same 'loyalty' to patients was cited for enjoyment and fulfilment in their work. Additionally, in terms of rural practice, the ability to provide continuity of care as they develop closer relationships to patients and maintain contact was also considered a unique advantage over urban practice.

SO5: Sustainability

Deployed HRH, local stakeholders, and organic staff are aware of community partnerships conducted in their RHUs. They were also knowledgeable of new programs. Many of these partnerships are carried out on a need-basis, but some are held on a regular basis (some are yearly). Most of these partnerships are initiated by the organizations who approach the RHUs and LGUs and offer their cooperation. Very few are initiated by the HRH themselves, such as medical missions and school health lectures.

Both local stakeholders and HRH report that during times of deployment, there have been partnerships between the RHU and several groups, including international agencies such as USAID, World Bank, Oxfam, Zuellig, Plan International, United Nations Children's Fund (UNICEF), Doctors Without Borders (MSF), and Jhpiego of John Hopkins University. The local programs mentioned were *Usapan* series and organized Zumba sessions in the communities. The local agencies and organizations mentioned were Department of Social Welfare and Development (DSWD), Philippine Health Insurance Corporation (PHIC), Philippine Mental Health, and Bohol Alliance of Non-government Organizations Inc. ((BANGON) as well as private companies like Caltex, civic groups, and local institutions like universities, foundations, and clubs (Rotary, coast guard).

Exhibit 29. Summary of respondents' awareness of new partnerships, programs and LGU support of new programs

Statement	% Deployed HRH said Yes	% Organic Staff said Yes	% Local stakeholders said Yes
	n=20	n=22	n=31
They are aware of any community partnerships (such as with civic groups, NGOs, or other) that partnered with their office or RHUs with the deployed HRH during the time of deployment.	65	68.2	61.3
They are knowledgeable of any new programs, policies or practices established by the deployed HRH during their time. (Examples would be additional training for the benefit of the health facility, new no-smoking policy, monthly awareness campaign, etc.).	55	54.5	45.2
They perceive that their health facility was encouraged or supported in these activities by DOH/RO/LGU through financial and administrative means	45	72.7	41
There were new programs, policies or practices established with the regional/provincial office with regard to HRH in the RHU. (Examples would be additional training for the benefit of the health facility, etc.).			45.2

In terms of financial and administrative support, most deployed HRH and local stakeholders feel that they are rarely supported by the DOH regional offices and LGUs. In previous partnerships, the LGUs provided assistance mainly in the form of coordination and lending personnel to work on partner activities. Some local stakeholders reported receiving supplies and technical support.

More than half of the local stakeholders also reported that they lack new programs, policies, and practices established with regional offices that provide support for the deployed HRH in the RHU. Of the few local stakeholders who reported new policies or programs for deployed HRH, one noted quarterly rating and monthly meetings at PDOHO, coordinated and funded by PDOHO, outside of the deployment program. Other new programs for deployed HRH reported were additional trainings and seminars.

Throughout their assignment, the deployed HRH initiated programs that may continue beyond the duration of their assignment, as an intended outcome of the program's sustainability. The usual programs initiated by the deployed HRH are health clubs, campaigns on dengue and measles, program-specific task forces (TB task force, diabetes task force), mental health and LGBT awareness, anti-smoking campaigns, school lecture series, and even fertility awareness and family planning education. Other DOH programs reported to be implemented in the community are TB-related activities, deworming, and healthy lifestyle. One deployed HRH respondent cited involvement in creation of ordinances on health sanitation and creating a local water sanitation and hygiene committee.

Roles of Deployed HRH in Health Programs

The organic staff see the deployed HRH taking on the role of planning, organizing, implementing, and monitoring of the programs or campaigns in their community. They also act as intermediaries between the health facility and the community. An organic staff reported that sometimes, deployed HRH consulted with other deployed HRHs from different areas for suggestions on activities to implement, implying an informal network of communication and experience sharing among the deployed HRH.

Deployed HRH similarly reported being coordinators, facilitators, lecturers, and implementers of these new programs. In programs spearheaded by deployed HRH, respondents report that when the LGU do provide support, they are in the form of food, administrative assistance (such as logistics), manpower,

and transportation (lending of vehicles). For the most part, deployed HRH respond to and are part of implementation, though most activities are initiated by other actors. However, there are still some instances of deployed HRH initiating new partnerships and programs, such as medical missions, school health lectures, health clubs, and disease-specific campaigns.

The most commonly cited way that deployed HRH are supported at the LGUs is lobbying for the retention and absorption of HRH (n=7) in the LGUs. Local stakeholders also mentioned LGU support for lobbying for allowances or bonuses (n=1), and allowing deployed HRH to attend the same events as regular organic staff (n=1). The only form of direct organizational support from the LGUs with regard to the welfare of HRHs is lobbying for regular positions for the deployed HRH. While this is important, the scarcity of positions remain consistent and deeply felt among the respondents.

While the deployed HRH are not direct beneficiaries of health program partnerships between the RHU and other civic and local organizations, these offer them an opportunity for increased visibility and interaction with the community and building social capital that is key for environmental support. Studies of similar programs, such as those for community health workers also underline the importance of community fit and integration of the program into the broader environment, a concept defined in the Scheirer framework as environmental support (Pallas et al. 2013).

Community activities also indirectly facilitate the demonstration of organizational support, as LGUs are reported to provide administrative support, help from their personnel, supplies, and the like to deployed HRH during such activities. The extent and variety to which LGUs provide support to each activity signifies an openness to relationships and negotiation that has been noted to be common in programs that sustain new practices (Stirman et al. 2012). The variety of support may also point to potential approaches towards implementation where adaptability and flexibility have value over holding strict to implementation of guidelines and high fidelity, other sustainability studies included have also included adaptability (Stirman et al. 2012). Organizational and environmental support, on the other hand, may also affect sustainability. Culture and climate are also relevant considerations that are not always expressed due to the emphasis on processes (Stirman et al. 2012).

Finally, the continuity of such activities demonstrate the sustainability of partnering with HRH at RHUs as well. The presence of a champion/advocate was common among RHUs studied. However, their impact on lobbying for additional positions to absorb deployed HRH seem to have limited effect. It is possible that the current 'champions' are still lacking certain characteristics or abilities to be more effective. For instance, while many rural health programs in Australia have closed, three of the four surviving rural primary care programs had at least one physician advocate who "provided leadership, continuity, and stability" to the program. In the context of Australian programs, physician advocates addressed challenges in the program in part due to their membership in the entrenched power structure (Wright & Brad Wright 2009).

Limitations

Sample

The study intended to include deployed doctors, nurses, midwives, and medical technologists. The majority of the sample were from the nurses deployment program cadre, which reflects the current distribution of deployed HRH in the Philippines. The deployed doctors and midwives were also part of the sample. However, deployed medical technologists were not available during data collection due to internal the delays in budget allotment. Delays in the actual deployment affected the amount of information collected in some areas and cadres. Only 20 out of the 20,000 deployed HRH (2018) were

interviewed due to time and resource constraints. Nonetheless, additional stakeholders like local stakeholders and organic HRH were also interviewed to provide a better picture of how the deployment program works in the selected areas. These deployed HRH were also from different provinces in the country, thus giving a wider range of information.

Data quality

Upon review, interview data quality was found to be very good with a low percentage of missing data at only 1-3 percent per type of KII. The little missing data was also reviewed, and may be attributed to minor documentation errors, such as when respondents may have a hard time answering because they would need to have data on hand, when some catch-all or follow-up questions were left unmarked, or when the respondent did not answer directly and the interviewer did not probe further. However, the rate is low enough not to significantly impact the results of the study. The quality of interviews for highly qualitative data was also assessed to be good and highly acceptable for the study. Indicators used for grading were quality of documentation, completeness, appropriateness of responses, and probing.

Data Collection

The study meant to use a mix of methods in order to triangulate data. Some study sites failed to provide documents to the level of detail initially expected, such as in the retention records, documentation of orientations and LDIs, or security management system. Gaps in the detail were filled by qualitative input of local stakeholders and organic staff with long tenure at their respective offices and RHUs.

Local stakeholders interviewed had a median length of five years' experience, while organic staff had a median length of 17 years at the RHU. Due to this criterion, respondents have spent a lot of time exposed to the deployment program in their communities. Similarly, in cases when participants responded that they didn't know or were not aware of the answers to some questions, the sample reports gathered from the document review were used as an alternative source of information.

In line with this, we cannot assume the reasons as to why sites were unable to provide the requested documents. It is possible that some sites may have simply lost documents, forgot to include them, or chose not to send the complete list of documents requested. It was not possible to know whether these records truly do not exist or were just not submitted. In one study site, all local stakeholders of a certain level were absent due to a conference and couldn't retrieve documents that require their authority or be interviewed. Thus, a more general perspective of describing documentation practices of LGUs rather than a strict checklist analysis was employed.

Another limitation is that some interviews were conducted partly in the local language to accommodate for the comfort level of the interviewees. Nonetheless, all the information from these interviews were translated in English and Filipino to be sufficient for analysis.

Finally, a major limitation in the study was the ongoing measles outbreak that occurred during the data collection period. This affected the availability of the HRH in the areas which were severely hit by the disease as they had to be deployed for necessary measles vaccination field work.

Recommendations

Based on the above results and discussion, recommendations on policy and action have been identified. These recommendations reflect the current state of the DOH deployment program and do not take into account impending future changes due to full implementation of Universal Health Care law and the recent Supreme Court ruling on the computation of the Internal Revenue Allotment (IRA) for LGUs[7]. In regards to UHC, based on the forthcoming HRH Master Plan, the DOH will be establishing a larger Health Workforce Support System (HWSS) which may include the current deployment program, different financing schemes and the development of an emergency deployment program, among other potential interventions. In addition, the recent Supreme Court ruling on IRA computation will obligate funding to LGUs in such a manner that in the next one to two years, the current deployment program may have a significantly different structure.

Due to these impending future changes, of which the details are still not known of the writing of this report, the below policy and action recommendations reflect the findings and nomenclature from the current deployment program. Though this is the case, the recommendations can and should be adapted and applied by the DOH when considering improvements to the current deployment program and drafting future guidelines for health workforce augmentation in the context of UHC and the recent Supreme Court ruling.

SO1: Prioritization of recipient communities

Policy

- *Prioritizing applicants with rural backgrounds.* As part of the recruitment process, a policy should be developed to prioritize applicants for deployed HRH with rural backgrounds. More efforts in reaching these priority groups need to also be undertaken, including to both recent graduates and more senior HRH, who may want to return to work in their hometowns or be closer to family.

Action

- *Improve the pre-recruitment process through building the capacity of recipient communities.* To better ensure that recipient communities can effectively draft requests for and fulfill the requirements for HRH augmentation in whatever future form, tools, mentorship and even training/orientation on the pre-recruitment process should be enhanced and rolled out to recipient communities, particularly in 5th/6th class municipalities and GIDA. This action will both increase participation of these priority communities and reinforce the sustainability of any impact as recipient communities will be better able to express their true needs.
- *Strengthening capacity on determining equitable allocation of deployed HRH.* Tools and approaches to strengthen both the DOH's and LGU's capacity to determine the equitable allocation of deployed HRH may be institutionalized to ensure that HRH deployment and augmentation are pursued according to health needs, burden of disease, equity, and population demands.

SO2: Retention

Policy

- *Provision of non-financial incentives.* Given the limited financial capacity of LGUs, alternative and more actionable strategies for retention can be explored such as in the provision of non-financial incentives. Policies that allow for flexible work arrangements, assistance in finding favorable accommodation, and social support in adjusting to the local community should be explored to encourage retention.

[7] Referred to as the Mandanas Case

- *Use of development impact bonds to transition HRH from DOH to LGU support.* While this may need to be explored further in light of the recent Supreme Court ruling on LGU IRAs, policy implications should be explored to establish mechanisms to develop and implement strategies for transitioning deployed HRH from the DOH to LGU support. An example is on financing the salaries of deployed HRH via cost-sharing arrangements between central office and the LGU for a certain period. The use of development impact bonds, which are a performance-based investment instrument intended to finance development programs in low resource countries, may also be explored as another viable strategy for financing.

Action

- *Emphasize community networks.* Rich community networks may also be tapped in designing non-financial incentives, particularly in mobilizing social resources and support for adjusting to the local community, such as identifying local leisure activities, social events, where to find practical items, etc. Access to social support in adjusting to the local community may encourage a suitable environment for those who already are inclined to settle. Such resources for community integration may be included in orientations and encourage LGUs to develop such programs to inform deployed HRH of resources available for potentially settling or further integrating into the area. These community networks may engage the participation of local civic groups, LGUs, NGOs, and private local or national companies.

- *Increasing training opportunities.* Training opportunities are an important factor for retention among deployed HRH, networks among educational institutions or professional societies may also be tapped in order to design training opportunities to entice deployed HRH to stay in their deployed area, continuously update their skills, and/or aid in career progression for employment at the rural area. Updated guidelines may include a framework for such mechanisms. Training opportunities need not be limited to certificate courses but can include master's programs (for different types of medical professionals), priority in and access to residency opportunities, sponsorship to scientific conferences, and access to journals.

SO3: Implementation Fidelity

Policy and Action

- *Strengthening compliance through improved monitoring and evaluation.* The current system of monitoring and evaluation could be strengthened through both policy and action for point persons, managers, and the local health boards to better monitor compliance more frequently on the ground. Strengthened enforcement of compliance using prescribed forms and monitoring data will allow for regular, consistent and comprehensive program reviews rather than occasional specialized studies.
- *Strengthening transparency and accountability.* Strengthening transparency and accountability means ensuring that any manual of procedures is clearly understood by implementers on every level, and that procedures are uniform and transparent. Uploading any deployment program manual of procedures online will improve access for all stakeholders. Increasing transparency in the selection of deployed HRH can safeguard it from the influence and increasing involvement of the local health boards in the direct management of the HRH Deployment Program. With stronger compliance and standardization of monitoring through policy and action comes the possibility to create and publish an HRH deployment scorecard. Scorecards published and accessible online facilitate greater transparency and accountability.

Action

- *Reinforcing processes to improve implementation.* Two specific areas should be considered:

- Orientations for deployed HRH should be redesigned to be more comprehensive, with stronger emphasis on safety and security measures, current local health system activities and programs, and local environment. Linking attendance to salaries would also ensure orientation attendance at each level.
- A checklist to determine LGU receptiveness to and actual need for HRH should be explored as an approach for determining deployed HRH allocation.

- *Documenting best practices on deployment.* Case studies comparing different strategies for implementation and monitoring the deployment program across the country will provide valuable insights into practical approaches for effective implementation and consistent monitoring of the deployment program. Likewise, the advantages and disadvantages of different deployment program implementation and monitoring arrangements in the different regions and local contexts can also be assessed.

SO4: Access

Policy and Action

- *Using evidence to determine staffing needs.* When considering Access, any deployment program planning should be informed by use of the national staffing standards, further supplemented by the use of the Workload Indicators of Staffing Needs approach to determine the staffing needs of the facility, and subsequently inform requests for staff augmentation to inform these needs. A policy should be developed that requires an evidence base for staff augmentation. In addition, the DOH and LGUs should plan according to such staffing standards and needs results.

SO5: Sustainability

Policy and Action

- *Enhancing community partnerships.* Policy revisions are needed to, and should emphasize, the need for deployed HRH to ensure a partnership with in the community when planning of activities as currently local stakeholders believe that new deployment programs are lacking or are not coordinated with the needs of the community. Creating a stronger link between deployed HRH program planning and health objective of the local health system, as well as identification of legal frameworks (such ordinances), or other measures of community ownership and buy-in could support sustainability of deployed HRH programs.
- *Improving support systems.* Current support systems should be reviewed and revitalized as it was found that most deployed HRH and local stakeholders feel that they are rarely supported by the DOH regional offices and LGUs. This is critical for sustainability of impact of programs as deployed HRH, and their programs, need to operate in an enabling environment.

HRH Augmentation in UHC

According to the UHC Implementing Rules and Regulations, Section 23.5, LGUs should ensure the availability of HRH to implement the National HRH Master Plan. As such, it is recommendation that evidence staffing methodologies, such as Workload Indicators of Staffing Needs, are applied to identify the actual staffing needs of the LGU based on the population health needs. If done effectively, LGUs will be better equipped at optimizing existing resources and there will be less demand for support from the national government for augmenting HRH.

Conclusion

It is hoped that this review can be used as a resource for decision-makers and managers at the DOH, particularly with the implementation of UHC, which includes the DOH Deployment Program under a National Health Workforce Support System.

In summary, results found that less than half of the sites were considered poor or GIDAs, but organic staff and deployed HRH mentioned that they did cater to marginalized patients within their regions. Deployed HRH showed high job satisfaction mainly due to fulfillment of their desire to serve and competitive salaries. Although the need for job security and other practical arrangements factored into their decision to leave after the end of contract. For implementation fidelity, local stakeholders consistently mentioned that implementation is most efficient and organized when the guidelines are clear and well understood. However, there are still parts of implementation such as orientation, report submission, and allocation which are inconsistent between regions. Deployed HRH and organic staff reported high satisfaction in working with each other, working in the community, with their colleagues, facilities assigned, and patients; thus, it can be said that there was high cultural acceptability between deployed HRH and their area. Deployed HRH were also generally accessible to their patients despite their workday being full. Lastly, deployed HRH were involved in partnerships and programs in the community with minimal environmental and organizational support from LGUs for HRH activities.

Policy recommendations include exploring how non-financial incentives can encourage retention by addressing issues with employment and environment that influence their decision to remain in their areas. Community and organizational/institutional networks may also be tapped for social support and training opportunities. Recruitment should prioritize applicants from rural backgrounds, and the program can develop special arrangements for applicants who are in the later stages of their career. Strengthening the current system of monitoring and evaluation by uniform standards in the report formats and enforcing timely reporting compliance may help LGUs implement HHRDB guidelines more uniformly and clearly. This would also allow HHRDB to conduct easier and regular monitoring. Finally, research recommendations include studies into different methods of transitioning the financing for deployed HRH employment, as well as into the decentralization of accountability to the regional and provincial levels of implementing the HRH deployment system.

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Annexes

Annex 1. Interview Guides Used in the Study

Interview Guide for Local stakeholders

EpiMetrics HEALTH EQUITY THROUGH RESEARCH	Program Review of the DOH Deployment Program for Doctors, Nurses, Medical Technologists and Midwives in Service Delivery Networks in Nine Selected Regions Interview Schedule: Local stakeholders
CONTROL NO L - -	
L - Region - #	

RESPONDENT			
NAME		TITLE & AFFILIATION	
E-MAIL		PHONE NO.	

LOCATION Geographic Zone / Region / Province / Municipality		**YEARS SERVED UNDER LGU** (start and end year)	
		Recording	☐ Yes ☐ No

INTERVIEW RECORD					
DATE OF INTERVIEW	MM	DD	YYYY	**RESULT**	0 Completed 1 Did not finish
TIME START	**: AM / PM**			**TIME END**	**: AM / PM**
INTERVIEWER ID **Interviewer initials**				**INTERVIEWER** **Name and Signature**	
FIELD SUPERVISOR ID				**FIELD SUPERVISOR** **Name and Signature**	

.ENCODER ID		ENCODER Name and Signature	

Introduction

Good day!
I am _____, working with EpiMetrics, in partnership with DOH. Thank you for taking the time to speak with us. The purpose of this interview is to gather information on the implementation of the DOH human health resource deployment program. We want to find out how the implementation is practically being carried out at the rural health units, the way it was meant to be, according to DOH guidelines.

In particular, we want to understand in-depth insights on the prioritization of the marginalized, retention, implementation of guidelines, acceptability and sustainability of the program. With this, we hope to provide recommendations on improving the deployment program.

Did you see the fact sheet on the project? Do you have questions about it?

I first want to explain that a lot of the questions that I will ask may seem like common sense, or focusing on small details that you of course already do. I'd like to ask for your patience as we go through the checklist, as we just want to see and understand better how the guidelines are being implemented at the RHUs around the Philippines.

First of all, I would like you to introduce yourself and to talk to me briefly about the main areas you focus on in your work.

Questions:
Prompt: For this section, we would just like to go through a checklist of how you carry out the guidelines for the deployment program. Please bear with us for the detail of the questions and if they may seem matter-of-fact to you. We would really appreciate your honesty, so that we can also make recommendations to DOH on further developing the guidelines.

SO3: Implementation Fidelity

	Question **For this section, please answer yes/no only. Please wait for follow up questions before answering and explaining very briefly (1-3 sentences).**	Response		
		Yes	No	Don't know
301	Are you the Human Resource Coordinator that handles the HRH Deployment Program in close coordination with the Health Human Resource Development Bureau (HHRDB)?			
302	**If not**, who is this person and what is his/her official designation title?			
	Pre-recruitment			
303	Who submits the request for needed HRH?			

304	Are you aware of any issues or concerns in the current system of requests?			
305	Can you describe some of your experiences with these issues or concerns?			
306	Are there any issues or concerns with the current evaluation or validation of requests?			
307	Who is in charge for evaluation or validation of requests?			
		Yes	No	Don't know
308	Are you aware of the current mechanisms in shortlisting qualified recipients?			
309	Are there any issues or concerns with the current system?			
310	How long does the approval of recipients and number of HRH allocation during pre-recruitment take?			
311	Are there any issues or concerns during pre-recruitment?			
312	**If yes**, what are these?			
	Recruitment and Selection			
313	Are you aware of the current mechanisms for recruitment and selection for the job?			
314	**If yes**, are there issues or concerns with recruitment? Please state, if any.			
	If yes, are there issues or concerns with selection? Please state, if any.			

315				
316	How do you think recruitment and selection can be done better?			
		Yes	No	Don't know
	Application			
317	Do applications go directly to the regional office?			
317a	Does recruitment and selection happen solely there?			
318	**If no**, how does the applications usually happen?			
319	What can you say about the current deployment application process?			
320	What are usual mechanisms for validating selected applicants at the DOH RO?			
321	How long does the whole application process usually take?			
		Yes	No	Don't know
	Pre-deployment			
322	Does DOH Regional Office (RO) conduct regional pre-deployment orientations for the HRH?			
323	**If Yes**, *is there a department policy for the RO to comply to this?*			
324	Do the RHUs do internal orientations as well?			
325	**If yes,** *is there a standard tool for the RO to monitor this?*			
326	**If yes**, are there other methods used for monitoring?			

327	Are endorsements being done between the deployed HRH and supervisors and other staff? **If yes**, is it through:			
328	i. In-person endorsement during orientations			
329	ii. Endorsement letters only			
330	iii. Others			
331	Others (please specify)			
	Deployment			
332	Did HHRDB / DOH RO issue a Department Personnel Order (DPO)/ Regional Personnel Order (RPO) and endorsement for the deployed HRH?			
333	Was there an orientation for the LGU and local health board before receiving the deployed HRH?			
334	Is there a specific position for the HRH point-person in the LGU?			
335	**If yes**, what is the **name of the position**, and who does he/she report to?			
		Yes	No	Don't know
336	Is there a memorandum of agreement between DOH, LGU, and HRH?			
337	How long does the usual contract of service of deployed <u>doctors</u> last?			
338	How long does the usual contract of service of deployed <u>nurses</u> last?			
339	How long does the usual contract of service of deployed <u>medical technologists</u> last?			
340	How long does the usual contract of service of deployed <u>midwife</u> last?			
341	Is it correct that none of the deployed HRH are accountable as program coordinators or focal persons?			
342	**If no**, what is this program or designation?			
343	Do the HRH submit daily time records?			

344	**If yes**, *to which offices do they submit to?*			
345	*How frequent is the submission?*			
346	*Who is in-charge to monitor this? (position or designation)*			
347	Do deployed HRH do night duty shift?			
348	**If Yes**, how many hours make up one night duty shift for the HRH, in practice?			
349	**If Yes,** what is the maximum number of hours per month of night duty shift that the HRH can do, in practice?			
		Yes	No	Don't know
350	**If yes**, Are deployed HRH accompanied during night duty?			
351	**i. If yes,** who accompanies them? (Ask for the position/designation of person.)			
352	Is there a safety and security management system that protect and safeguard DOH deployed HRH? **If yes**, does this system have the following:			
353	*A Technical Working Group* that involves representatives from Armed Forces of the Philippines, National Disaster Risk Reduction and Management Council, DOH Deployed HRH, Local Government Units?			
354	*A designated point person* whom the deployed HRH can report incidents (such as but not limited to: natural disasters, industrial and transport disasters, civilian threats, any nature of harassments, security threats and insurgencies)?			
355	An *established hotline and clear chain of command for reporting of incidents* from the LGU, PDOHO, Regional Office and DOH Central Office?			
356	Does timely threat and *risk assessments* to determine the safety and security crisis of deployed HRH?			
357	A *database* containing the list of areas or municipalities with *reported high*			

	risks of security threats for deployed HRH?			
358	Are the payments for compensation of the HRH given regularly?			
359	**If yes**, who is the one in-charge of the payment of compensation for the deployed HRH? (position/designation)			
360	How frequent is the payment?			
		Yes	No	Don't know
361	Are there unexpected delays in giving payment?			
362	i. **If there are delays**, what do you think are the reasons for this?			
363	Are you aware of deployed HRH enrollment to Government Service Insurance System (GSIS) Group **Personal Accident Insurance** and Philippine Health Insurance Corporation (PHIC) membership?			
364	Are there established mechanisms or official guidelines for salary computations of deployed HRH?			
365	**If yes,** do you use any other basis aside from the official guidelines?			
366	Are deployed HRH being evaluated periodically?			
367	**If yes***, how often are the evaluations?*			
368	*Who is in-charge for this?*			
		Yes	No	Don't know
369	*Is there a format for this?*			

370	*Ask if we can obtain a copy.*			
371	Are there renewal of contracts/appointments among deployed HRH?			
372	**If yes**, who decides on this?			
373	What is the basis for appointment/renewal? Appointment/Renewal would be defined as them staying in the same position for the same facility and not other retention paths.			
374	Are you aware of the reasons accepted for possible HRH transfers?			
375	**If yes**, can you name some of these reasons?			
376	Are HRH provided with Certificate of Employment, or Certificates of Completion and Deployment?			
	Continuing Education and Capacity Building			
		Yes	No	Don't know
377	Are there learning and development interventions for the deployed HRH?			
378	**If yes**, what are these?			
		Yes	No	Don't know
379	Do you have documentation for these?			
380	i. If yes, how do you usually document these?			
381	When deployed HRH are **sent** for capacity-building activities, such as continuing professional development activities or other external training that are considered official business, are they provided allowances?			
	If yes, does this cover the following:			

382	i. Person-day salary			
383	ii. Transportation			
384	iii. Food			
385	iv. Other			
386	Others, please specify			
387	Are deployed HRH allowed to present other expenses incurred and get reimbursements?			
388	Are you aware of programs under Provincial DOH Office (PDOHO) or Integrated Provincial Health Office (IPHO) that lobby for additional incentives of support to HRH?			
389	**If yes,** can you provide examples?			
	Monitoring and Evaluation			
		Yes	No	Don't know
390	Do you submit your updated list of deployed HRH?			
391	**If yes**, how often? *(Please ask if we can we acquire a copy of this list.)*			
392	Do you monitor the deployed HRH using a DOH-prescribed tool? Note: For clarification, this is for internal use or for forwarding upward.			
	Please ask if we can have a copy of the Manual of Procedures for monitoring, if any, and/or a sample report.			
393	**If yes**, how often do you do the monitoring?			
394	Do you use other or additional tools?			

395	Do you submit annual program implementation review with analysis and recommendations?			
396	Do you submit monthly fund utilization report?			
397	Do you prepare **other monitoring reports** to be forwarded to DOH RO or HHRDB?			
398	**If yes**, what these other monitoring reports?			
399	Do you monitor retention of deployed HRH? To clarify, retention shall refer to the stay of a deployed HRH within the municipality or province for a period of at least 2 years after the termination of the contract or service agreement.			
399a	**If yes,** how?			
399b	*If they monitor it, please ask if we can acquire the document listing the distribution of those who were retained or not.*			
	HRH Retention Strategies			
399c	How many **deployed doctors** are absorbed by being hired by the LGU (outside of the deployment program) every year?			
399d	How many **deployed nurses** are absorbed by being hired by the LGU (outside of the deployment program) every year?			
399e	How many **deployed medical technologists** are absorbed by being hired by the LGU (outside of the deployment program) every year?			
399f	How many **deployed midwives** are absorbed by being hired by the LGU (outside of the deployment program) every year?			
399g	What do you think are the factors affecting the LGU decision to absorb the HRH?			
399h	For every 10 deployed doctors, how many would reapply or renew their contract?			
399i	Over the past two years, about how many **deployed nurses** reapply or choose to renew their contract at the end of its term?			
399j	Over the past two years, about how many **deployed medical technologists** reapply or choose to renew their contract at the end of its term?			

399k	How many **deployed midwives** reapply or choose to renew their contract at the end of its term?			
399l	Do you know of other ways that deployed HRH stay in the local health system, apart from being for regular positions by the LGU or renewing their contract?			
		Yes	No	Don't know
399m	Are there any endeavours being done in the recipient facilities/LGUs with regards to providing regular items for deployed HRH?			
399n	**If yes**, can you name some of these endeavours?			
399o	Do you think that the recipient facilities have sufficient number of deployed HRH to ensure the following: PHIC accreditation, continuation of development projects from funding of development partners, Implementation of critical health programs.			
	END of SO3			

Prompt: For this section, we would like to know your perception of the sustainability of activities done by the deployed HRH in your facility, and whether you support these activities, and in what way.

SO5: Sustainability in terms of maintained community partnerships and new practices

	Question	**Response**		
		Yes	**No**	**Don't know**
501	Are you aware of any **community partnerships** (such as with civic groups, NGOs, or other) that partnered with your office or RHUs with deployed HRH that you cover during the time of deployment of the HRH? If No, skip follow-up question.			
502	**If yes,** Which of these are you aware of? Please enumerate if possible. (Use space below and please count how many.)			

503	Did you provide any administrative or financial support to these partnerships?			
504	i. **If yes**, in what way did you support these?			
505	Were there any new **programs, policies or practices** established by the deployed HRH during your time? (Examples would be additional training for the benefit of the health facility, new no-smoking policy, monthly awareness campaign, etc.). **If No, end of interview** **If yes, please proceed to the next questions.**			
506	Did you provide any administrative or financial support to these programs?			
507	i. **If yes,** please tell us more about it.			
508	Were there any new **programs, policies or practices** established with your office with regard to HRH in the RHU? (Examples would be additional training for the benefit of the health facility, etc.). **If No, end of interview** **If yes, please proceed to the next questions.**			
509	Could you name and describe some of these?			
END OF INTERVIEW				

PLEASE THANK THE RESPONDENT.

EpiMetrics HEALTH EQUITY THROUGH RESEARCH	Program Review of the DOH Deployment Program for Doctors, Nurses, Medical Technologists and Midwives in Service Delivery Networks in Nine Selected Regions Interview Schedule: Deployed HRH Professionals
CONTROL NO H - -	
H - Region - #	

RESPONDENT			
NAME		TITLE & AFFILIATION	
E-MAIL		PHONE NO.	

HRH PROGRAM (encircle one)	1 Doctor of Medicine (MHO) 2 Doctor of Medicine (RHP) 3 Nurse 4 Medical Technologist 5 Midwife	**YEARS SERVED UNDER DEPLOYMENT** (start and end year)	
LOCATION Geographic Zone / Region / Province / Municipality		**Recording**	☐ Yes ☐ No

INTERVIEW RECORD					
DATE OF INTERVIEW	MM	DD	YYYY	**RESULT**	0 Completed 1 Did not finish
TIME START	: **AM / PM**			**TIME END**	: **AM / PM**
INTERVIEWER ID				**INTERVIEWER Name and Signature**	
FIELD SUPERVISOR ID				**FIELD SUPERVISOR Name and Signature**	
ENCODER ID				**ENCODER Name and Signature**	

Introduction

Good day!
I am _____, working with EpiMetrics, in partnership with DOH. Thank you for taking the time to speak with us. The purpose of this interview is to gather information on the implementation of the DOH human health resource deployment program. We want to find out how the implementation is practically being carried out at the rural health units, the way it was meant to be, according to DOH guidelines.

In particular, we want to understand in-depth insights on the prioritization of the marginalized, retention, implementation of guidelines, acceptability and sustainability of the program. With this, we hope to provide recommendations on improving the deployment program.

Did you see the fact sheet on the project? Do you have questions about it?

I first want to explain that a lot of the questions that I will ask may seem like common sense, or focusing on small details that you of course already do. I'd like to ask for your patience as we check on these, as we just want to see and understand better how the guidelines are being implemented at the RHUs around the Philippines.

First of all, I would like you to introduce yourself and to talk to me briefly about the main areas you focus on in your work.

Questions:
Prompt: For this section, we would like to know your perception of the kind of service users in your facility.
SO1: Perception of prioritization of marginalized
Please answer using the 5-point Likert scale, then explain briefly.

	Question	**1**	**2**	**3**	**4**	**5**
101	In your time of deployment, do you think you served patients considered poor, marginalized, and/or indigenous? (1-Not at all, 2- Not very much, 3 - Somewhat, 4 - More often than not, 5 - Yes, very much so)					
102	Why/why not?					

Prompt: For this section, we would like to know your perception of acceptability of conditions of your deployment.
SO2: Satisfaction with the program and reasons for leaving, extending or renewing their contract from the original 2-year contract, or staying without further contract extension/renewal.
Please answer the question using the 5-point Likert scale (strongly agree, strongly disagree), then explain briefly.

	Question	**1**	**2**	**3**	**4**	**5**

201	Considering everything, how satisfied are you with your job?					
202	Why/why not?					
203	Do you intend to remain in service at or near your area of assignment beyond the terms of your contract? (1-Not at all likely, 2- Not very likely, 3 - Neutral, 4 - somewhat likely, 5 - Very likely)					
204	Why/why not?					
205	(Open-ended) What would be the most important factors influencing your decision to stay?					
206	What would be the most important factors influencing your decision to leave?					
207	How do you think the deployment program could be designed better, for you?					

Prompt: For this section, we would just like to go through a checklist of how you carry out the guidelines for the deployment program. Please bear with us for the detail of the questions and if they may seem matter-of-fact to you. We would really appreciate your honesty, so that we can also make recommendations to DOH on further developing the guidelines.

SO3: Implementation Fidelity

Question **For this section, please answer yes/no only. Please wait for follow up questions before answering and explaining very briefly (1-3 sentences).**		Response		
		Yes	No	Don't know
	Recruitment and Selection			
	How did you know about the deployment program? (do not immediately prompt respondent) (May check more than one)			

301	Web page			
302	Printed publication			
303	Traditional Mass Media (TV, radio, billboard)			
304	Civil Service Commission bulletin			
305	Social media (Facebook, Twitter, etc.)			
306	Friend's referral			
307	Other			
308	Other: Specify			
	Application			
309	Did you apply by submitting an accomplished application form directly to the regional office?			
310	**If not**, how?			
311	How long did your application process take? (in weeks)			
312	Do have any issues or concerns about application you might want to raise?			
313	**If yes**, what are these?			
	Pre-deployment	Yes	No	Don't know
314	Did you ever receive a national scholarship sponsored and managed by the DOH?			
315	Are you a member of the indigenous cultural community?			
316	Was there a regional pre-deployment orientation held by the DOH RO?			

317	Were you able to attend the regional pre-deployment orientation of the DOH RO?			
318	Were you required to attend the regional pre-deployment orientation?			
319	Did you have an institutional pre-deployment orientation such as the ones in the health facility/LGU assigned to you?			
320	Are pre-deployment assessments being done to assess your baseline knowledge of the health systems and programs in your area of deployment?			
	Deployment			
321	Are you aware of and have signed the MOA between you, the DOH, and the LGU?			
322	How long (in months) is the term of your current contract of service?			
323	**H**ow many times have you been renewed already, if applicable?			
324	Do you carry any position that makes you accountable as program coordinator or focal person?			
325	**If yes**, what is this program or designation?			
326	Did a point-person from the DOH RO endorse you to the area of your assignment? **If yes,** was it through:			
327	In-person endorsement during orientations			
328	Endorsement letters only			
329	Others			
330	Others (please specify)			
		Yes	No	Don't know
331	Did you for any reason, report to another area which was not your assigned deployment site?			

332	Do you have any night duty shift?			
333	**If Yes**, how many hours make up one night duty shift, in practice?			
334	**If Yes,** what is the maximum number of hours per month of night duty shift you can do, in practice?			
335	Are you accompanied during night duty?			
336	**If yes,** who accompanies you? (position of person)			
337	Do you submit daily time records?			
338	Do you submit it to the Regional Office through the Provincial Health Office?			
339	*If no,* *to which offices do they submit to?*			
340	*How frequent is the submission of your DTR?*			
341	*Who is in-charge to monitor this? (position)*			
342	Who processes your payment of compensation?			
343	Do you receive payment of compensation regularly?			
344	If yes, how frequent is the payment?			
345	b. Are there unexpected delays in when you receive your payment?			
		Yes	No	Don't know
346	Are you provided regular (weekly, monthly, etc.) benefits for: Transportation			

347	b. Lodging and Miscellaneous			
348	c. Other expenses,			
349	d. Other - please specify			
350	Are you aware of any current mechanisms that promote your safety and security as deployed HRH?			
	If yes, are you aware if this system has the following: (Please ask the next 5 questions.)			
351	i. A *Technical Working Group* that involves representatives from Armed Forces of the Philippines, National Disaster Risk Reduction and Management Council, DOH Deployed HRH, Local Government Units?			
352	*ii. A Designated point person* whom deployed HRH can report incidents such as but not limited to: natural disasters, industrial and transport disasters, civilian threats, any nature of harassments, security threats and insurgencies?			
353	iii. An *established hotline and clear chain of command for reporting of incidents* from the LGU, PDOHO, Regional Office and DOH Central Office?			
354	iv. Does *timely threat and risk assessments to determine the safety and security crisis of deployed HRH?*			
355	v. A *database* containing the list of areas or municipalities with *reported high risks of security threats* for deployed HRH?			
356	b. **If yes,** are there other safety and security programs you are aware of?			
357	c. Could you name these? (Ask only if they answered Yes in above question.)			
		Yes	No	Don't know
358	Are you aware of any evaluations being done for your performance as a deployed HRH?			
359	**If yes**, who is in-charge of these evaluations? (Note: Ask for the designation, not the name.)			

360	Are you requested to make evaluation reports **of your experiences** as a deployed personnel, or of the deployment program?			
361	**If yes,** do you have a standard for this?			
362	b. **If yes,** how often do you submit this?			
363	Are you aware of your direct supervisors?			
364	**If yes**, can you tell us their designations?			
365	Are you aware of renewal of contracts/appointments?			
366	**If yes**, do you know who is in-charge for these renewals?			
367	Are you aware of the basis for appointment/renewal for the position?			
368	**If yes**, what do you think is the basis for it?			
	Continuing Education and Capacity Building	Yes	No	Don't know
369	Are you aware of any learning and development interventions (LDIs) for you, as a deployed HRH, facilitated by DOH, HHRDB or DOH-RO?			
370	**If yes**, do you have documentation for these?			
371	b. What are these documentations? (Note: Example of this is Certificate of Completion. But do not prompt this, in case they clarify only.)			
372	Do you also think that you are being provided with interventions that are fit for your job in terms of content?			
373	Are these learning and development interventions frequent enough to update your skills?			

374	When you are **sent** for capacity-building activities like trainings, are you provided allowances?			
375	**If yes,** what do these allowances cover?			
376	In relation to the previous question, are you also allowed to present other expenses incurred and get reimbursements?			
377	Are there other technical assistance or support services that DOH RO/LGU offers to you?			
378	**If yes**, what are these other services?			
	Specific Roles and Responsibilities			
379	If you are a deployed physician (DTTB), are you a member of a functional local health board? Note: This question only applies for deployed DTTB.			
380	**If yes,** what is your role?			
		Yes	No	Don't know
381	Do you take part in implementing health surveillance systems and health emergency preparedness?			
382	**If yes,** what is your role?			
383	Are there other functions that you perform that is not within the scope of your contract?			
384	**If yes,** what are these other functions?			
385	Do you submit reports to DOH RO?			

386	Do these include: Accomplishment Report			
387	Health Program (-specific) Report			
388	Others			
389	Others, please specify. Note: Only ask if they answered YES in others.			
	How often do you submit each of these?			
390	Accomplishment Report			
391	Health Program (specifics) Report			
392	Others specified			
	c. Is there a standard tool/format for each of the following: (Ask if you can have a sample of each form.)			
393	i. Accomplishment Report			
394	iii. Health Program (specifics) Report			
395	iv. Others specified			
	END OF SECTION			

Prompt: For the next section, we would like to know how you, as a deployed HRH, is able to integrate in your community.

SO4: Ability to integrate into community (access: acceptability, geographic availability)
Please answer first using 5-point Likert scale, with 1 meaning very dissatisfied, 3 being neutral, and 5 meaning very satisfied. Then, explain your answer briefly.

	Question	1	2	3	4	5
401	How satisfied are you with the features of the facilities at the health center where you are deployed? Note: If they ask for clarification, examples are appearance, equipment, etc.					
402	Why/why not?					
403	How satisfied are you with the communities that you are deployed in?					
404	Why/why not?					
405	How satisfied are you with the your colleagues/coworkers at your deployment area?					
406	Why/why not?					
	Question	**1**	**2**	**3**	**4**	**5**
407	4. How satisfied are you with the patients you usually see at your deployment area?					
408	Why/why not?					
Prompt: For this section, we would like to know the distribution of service users who visit you on a daily basis. Geographic availability						
409	By your estimate, how many patients go to this health center					

	each day, on average?	
410	Among these, how many patients do you encounter/consult with you each day in your work?	
411	How long does each encounter/consultation with you take? (in minutes)	
END OF SECTION		

Prompt: For this section, we would like to know your perception of the sustainability of activities done by the deployed HRH in your facility.

SO5: Sustainability in terms of maintained community partnerships and new practices

	Question	Response		
		Yes	No	Don't know
501	Were there any community partnerships (such as with civic groups, NGOs, or other) that partnered with your RHU/MHO before or during your time of deployment (that you are currently in some way participating in)? If No, skip follow-up question.			
502	If yes, How many?			
503	Could you name and describe these partnerships? (Please count how many)			
504	If yes, Which of these are personally-initiated? (Please count how many)			
505	If yes, Which of these are partnerships existing already in the facility but that you are not in charge of? (Please count how many)			
506	How many of these partnerships are still active now? (Do these groups still meet with the RHU, conduct projects or			

	programs with them?)			
507	Are there any new programs, policies or practices to promote healthy lifestyle to manage and prevent communicable and non-communicable diseases, established in the RHU that you participate in? (not necessarily as one who initiated, but including being a consultant, provider of services, etc. Examples would be a new no-smoking policy, monthly awareness campaign, etc.). If No, end of interview.			
508	If yes, how many of these are personally initiated? Note: For clarification, these are policies that are planned and implemented by the deployed HRH.			
509	Could you name and describe these programs/policies/practices?			
510	What is your role in creating and implementing these new policies?			
511	If yes, how many of these new policies are DOH-initiated? Note: For clarification, these are policies that are planned by DOH but was just implemented by the deployed HRH.			
512	Could you name these programs/policies/practices?			
513	How many of these programs, policies or practices are still being done now?			
514	g. If you have spearheaded projects or activities for health systems development, were you encouraged or supported by DOH/RO/LGU through financial and administrative means?			
515	If yes, can you describe the support they give you?			
END OF INTERVIEW				

PLEASE THANK THE PARTICIPANT.

Interview Guide for Organic Staff

EpiMetrics HEALTH EQUITY THROUGH RESEARCH	Program Review of the DOH Deployment Program for Doctors, Nurses, Medical Technologists and Midwives in Service Delivery Networks in Nine Selected Regions Interview Schedule :Organic LGU Staff
CONTROL NO S - -	
S - Region - #	

RESPONDENT			
NAME		TITLE & AFFILIATION	
E-MAIL		PHONE NO.	

LOCATION Geographic Zone / Region / Province / Municipality		YEARS SERVED UNDER LGU (start and end year)	
		Recording	☐ Yes ☐ No

INTERVIEW RECORD					
DATE OF INTERVIEW	MM	DD	YYYY	RESULT	0 Completed 1 Did not finish
TIME START	: AM / PM			TIME END	: AM / PM
INTERVIEWER ID				INTERVIEWER Name and Signature	
FIELD SUPERVISOR ID				FIELD SUPERVISOR Name and Signature	
ENCODER ID				ENCODER Name and Signature	

Introduction

Good day!
I am _____, working with EpiMetrics, in partnership with DOH. Thank you for taking the time to speak with us. The purpose of this interview is to gather information on the implementation of the DOH human health resource deployment program. We want to find out how the implementation is practically being carried out at the rural health units, the way it was meant to be, according to DOH guidelines.

In particular, we want to understand in-depth insights on the prioritization of the marginalized, retention, implementation of guidelines, acceptability and sustainability of the program. With this, we hope to provide recommendations on improving the deployment program.

Did you see the fact sheet on the project? Do you have questions about it?

I first want to explain that a lot of the questions that I will ask may seem like common sense, or focusing on small details that you of course already do. I'd like to ask for your patience as we check on these, as we just want to see and understand better how the guidelines are being implemented at the RHUs around the Philippines.

First of all, I would like you to introduce yourself and to talk to me briefly about the main areas you focus on in your work.

Prompt: For this section, we would like to know your perception of the kind of service users in your facility.

Please answer using the 5-point Likert scale, then explain briefly.

SO1: Perception of prioritization of marginalized

	Question	1	2	3	4	5
101	In your time of deployment, do you think you served patients considered poor, marginalized, and/or indigenous? (1-Not at all, 2- Not very much, 3 - Somewhat, 4 - More often than not, 5 - Yes, very much so)					
102	Why/why not?					
END OF SECTION						

Prompt: For the next section, we would like to know how the deployed HRH is able to integrate in your community.
SO4: Ability to integrate into community (access: acceptability)

	Question	1	2	3	4	5	N/A

401	How satisfied are you with the services done by the deployed HRH in your health facility?						
402	Why/why not?						
403	Do you think the community is satisfied with the services and presence of the deployed doctor?						
404	Why/why not?						
405	Do you think the community is satisfied with the services and presence of the deployed nurse?						
406	Why/why not?						
	Question	1	2	3	4	5	N/A
407	Do you think the community is satisfied with the services and presence of the deployed medical technologist?						
408	Why/why not?						
409	Do you think the community is satisfied with the services and presence of the deployed midwife?						
410	Why/why not?						

Prompt: For this section, we would like to know the distribution of service users who visit you on a daily basis.

GEOGRAPHIC AVAILABILITY (Only ask if respondent is MHO (not DTTB) or Organic Nurse/Public Health Nurse, see title and affiliation in 1st page. Put N/A if otherwise)		
411	By your estimate, how many patients go to this health center each day, on a typical day?	

412	Among these, how many patients do you encounter or consult with you each day in your work?	
413	How long does each encounter/consultation with you take? (in minutes)	
END OF SECTION		

Prompt: For this section, we would like to know your perception of the sustainability of activities done by the deployed HRH in your facility.

SO5: Sustainability in terms of maintained community partnerships and new practices

	Question	Response		
		Yes	No	Don't know
501	Were there any community partnerships (such as with civic groups, NGOs, or other) that partnered with your RHU/MHO during their time of deployment ? If No, skip follow-up question.			
502	Could you name and describe these partnerships?			
503	If yes, Can you give us an estimate of how many of these are personally-initiated by the deployed HRH? Note: For clarification, these are partnerships arranged and implemented by the deployed HRH.			
	Use the space below in case they enumerate.			
504	If yes, How many of these are projects that are existent before their deployment but was continued by the deployed HRH? Note: For clarification, these are partnerships already existing but was continued by the deployed HRH by assuming responsibility.			
	Use the space below in case they enumerate.			
505	How many of these partnerships are still active now? Active is defined as groups still meeting with the RHU, conduct projects or programs with them.			

	If none, write 0. If all are continuing, write the same number as in previous question.			
		Yes	No	Don't know
506	Are there any new programs, policies or practices to promote healthy lifestyle to manage and prevent communicable and non-communicable diseases, established by the deployed HRH in your RHU? If No, please end the interview.			
	b. If yes, please ask the next questions.			
507	i. If you are aware, how many of these programs, policies or practices are personally-initiated by the deployed HRH? Note: For clarification, the deployed HRH proposed and implemented these activities.			
508	Could you name and describe these programs/policies/practices which were personally-initiated?			
509	ii. What is the role of your deployed HRH in creating and implementing these new policies?			
510	ii. How many of these are DOH-initiated? Note: For clarification, DOH mandated these programs be implemented but the deployed HRH assumed responsibility in implementation.			
511	Could you name these programs/policies/practices which were DOH-initiated?			
512	Of all the activities discussed, how many of these programs, policies or practices are still being done now?			
	Use the space below in case they enumerate.			
513	How often do each of these activities are done in the RHU/MHO? Note: Please enumerate each program if possible.			

		Yes	No	Don't know
514	Do you think that your health facility was encouraged or supported in these activities by DOH/RO/LGU through financial and administrative means?			
END OF INTERVIEW				

PLEASE THANK THE RESPONDENT.

You may use this space for further notes.

Annex 2. Documents Review Checklist and Abstraction Tool

Checklist of records to request

- ❑ Documentation of regional pre-deployment orientations for the HRH to be deployed
- ❑ Documentation of recipient hospitals institutional pre-deployment orientations
- ❑ Documentation of orientation for LGUs and Local health board before receiving deployed HRH
- ❑ Deployed HRH daily time record (DTR)
- ❑ HRH Evaluation Forms and reports
- ❑ Documentation of learning and development interventions for the deployed HRH
- ❑ Monitoring reports of deployed HRH
- ❑ Retention monitoring reports
- ❑ Annual Program Implementation Review (PIR), with analysis and recommendations
- ❑ updated list of deployed HRH
- ❑ monthly fund utilization report
- ❑ Documentation of safety and security management system
- ❑ Documentation of established mechanisms for salary computations of deployed HRH, and payslips if available

Sample Abstraction Tool

Documentation Review Checklist							
Document Code (doc type_region)	Region	Document Type	Doc code	Presence/Absence	Standardized?	Compliance in Scope and Structure (yes = compliant, no = noncompliant)	Compliance to Scope and Structure (if Standardized) -- General Comments

Compliance (if Standardized) -- Nature of Data Asked (indicators used)	Compliance (if Standardized) -- How Different from the Standard Form	Scope and Structure (if non-standardized) -- General Comments	Nature of Data Asked (if non-standardized) (indicators used)	Clear Purpose (if non-standardized)	Purpose (if non-standardized) _Comments

Annex 3. Proposed Interview List

The below table represents the proposed persons for interview.

Category	Tool	Person to interview	Min #	Max #
Deployed HRH (HRH under the deployment contract of DOH)	Tool H	• Doctor • Nurse • Med Tech • Midwife	1 1 1 1	1 2 2 2
Local Stakeholders	Tool L	• Regional Office: Point person of the deployment program for Human Resource Development (knowledgeable about pre-recruitment, recruitment & selection, application, pre-deployment, deployment) • Provincial office: a. Provincial Health Team Leader aka Development Management Officer (DMO V); b. DMO IV aka DOH Rep*	1 1 1	2 1 1
Organic RHU Staff (HRH but not under contract with DOH)	Tool S	• MHO (if not the DTTB)* • Nurse II or PHN (Public Health Nurse)* • Other staff who are NOT deployed (natively from area)	0 1 1	1 1 1
Total			**9**	**14**
*Note: These are the priority-persons.				

Annex 4. Consent Forms

Informed Consent Form (English)

INFORMED CONSENT FORM

Program Review of the DOH Deployment Program for Doctors, Nurses, Medical Technologists and Midwives in Service Delivery Networks in Nine Selected Regions

This is an informed consent form for deployed human health resources, organic RHU staff, and local stakeholders. This document should be presented to the study participant. No sections should be omitted. The document's contents should be explained verbally.

Good day! We are doing a research on the DOH deployment program. I would like to invite you to be a part of this research.
Before you decide, I would like to tell you about the purpose of the study, the possible risks and benefits, and what your participation would entail. You can talk to anyone you feel comfortable with about the research. Additionally, please do not hesitate to ask me or my colleagues questions you might have about the consent form or about the study.
This Informed Consent Form has two parts:
1) Information Sheet (to share information about the study with you), and
2) Certificate of Consent (for signatures if you choose to participate)

Once you understand the study, if you decide to take part, you will be asked to sign a consent form. You will be given a copy of the full Informed Consent Form to keep.

I. STUDY BACKGROUND

Title of the Study	Program Review of the DOH Deployment Program for Doctors, Nurses, Medical Technologists and Midwives in Service Delivery Networks in Nine Selected Regions
Sponsor	USAID-HRH2030
Organization	EpiMetrics, Inc.
Principal Investigator	John Q. Wong, M.D., M.Sc.
Purpose of the Study	The study aims to gather information on the implementation of the DOH human health resource deployment program.

This study endeavors to fulfill the following objectives:

General Objective	To assess DOH deployment program in the nine HRH2030 regions of the Philippines according to degree of implementation, access, and sustainability
Specific Objectives	To determine and describe the proportion of recipient communities that were poor, marginalized, or indigenous To determine the distribution and mean duration of retention of the deployed HRH To describe the implementation fidelity of the HRH deployment program To measure the changes in health service access in the nine regions from 1993-2017 To determine the financial and outcome sustainability of the DOH

	Deployment Programs

II. DETAILS OF RESPONDENT PARTICIPATION

This research will involve your participation in a key informant interview/focus group discussion. Your answers will complement a records review on the program. The results of your participation will be analyzed and used to create recommendations for the improvement of the deployment program.

Participant Selection	You were chosen and invited to take part in this research, because you are a deployed human health resource/organic RHU staff/local HRH implementer at a chosen site of HRH deployment, and you previously expressed willingness and interest to join this KII. A total of 5-10 participants in your community will be interviewed.
Procedures	As a participant, you will be asked to participate in a one-on-one interview. The interview will center on the implementation of the DOH deployment program. The whole process is expected to take about 20-40 minutes. The interview/discussion will be conducted by 1 interviewer. If there are any questions you feel uncomfortable with answering, simply inform the interviewer and he/she will move on to the next question. Please answer truthfully and to the best of your abilities. A part of the interview may be audio-recorded and transcribed. You have the discretion to end or deny the recording at any point in the study. When necessary, we may also need to contact you to clarify or validate our understanding of your answers, so that we may remain truthful to your opinions and beliefs. The audio recordings will be deleted at most 1 year after the completion of the study. No medical procedures will be conducted, not will any biological specimens, genetic information, or medical records be collected nor sent to any secondary institutions for any purpose.
Voluntary Participation	It is important that you know the following: Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You may opt to not answer questions you find too sensitive or are uncomfortable answering. You may decide not to take part, withdraw, or quit from the study at any time. You may change your mind later and stop participating even if you agreed earlier. If at any point, the study team notices that other participants, members of the team, or the participant being interviewed feels distressed, threatened, or uncomfortable in any way, the study team may choose to terminate participation in the study.
Benefits of the Study	There will be no direct benefit for you by participating in this study. You will, however, contribute in providing evidence for improving public health policy and services for health workforce deployment in the Philippines.
Incentives/ Compensation	You will not be provided any incentive to take part in the research. You will be given a snack as a token of our appreciation.

	Compensation for transportation will not be provided.
Risks of the Study	No risk nor discomfort are anticipated in participating in this study. Likewise, non-participation will not affect your availment of DOH services. Thus there will be no compensation offered in case of study-related injury or disability.
Confidentiality	All your responses will be kept confidential. Anonymity will be strictly maintained at all times, and we will only use your codename. Only the members of the study group will see your individual responses. You will not be personally identified in any presentation about this study.
How the Findings will be Used	The research output of this project will be presented to the DOH and in various stakeholder foras within DOH and USAID. In addition, the output may also be presented in both local and international conferences. Finally, the research paper will also be submitted to an appropriate journal for publication. You may at any time inquire about or ask for access to your record, pending the approval of the study team.
Contact Information	This study is being conducted John Q. Wong, M.D., M.Sc. under EpiMetrics, Inc. You may contact Dr. John Wong through the following: 671-96-46 or at epimetricsph@gmail.com. You may contact EpiMetrics through this number or email for any questions about the conduct, result, or publication of the study. We will also be using these to contact you or a representative in case information arises that may be relevant to you. Dr John Wong serves only as the Principal Investigator of the study, but will not be the participant's healthcare provider. This study was reviewed by and granted full board review exemption by the Single Joint Research Ethics Board, with Protocol No SJREB-2018-33. For questions on your rights as a study participant or grievances, you may contact the Philippine Health Research Ethics Board (PHREB) represented by DEAN AGUILA at (02) 837-2071 to 82 loc 2112.

III. CONSENT FORM (STUDY COPY)

I have been invited to participate in a research titled: "Program Review of the DOH Deployment Program for Doctors, Nurses, Medical Technologists and Midwives in Service Delivery Networks in Nine Selected Regions" I have read or have been read the foregoing information. I have been given sufficient time and opportunity to ask questions and express any concerns I may have about the study. I voluntarily consent to be a participant in this research.

Signature of Respondent

Control No.	Signature of Respondent	Date of Signature

Signature of Witness or Legal Guardian *(if respondent cannot read or sign this informed consent form)*

Name of Witness/Legal Guardian	Signature of Witness/Legal Guardian	Date of Signature	Thumb print of participant

Name of Person who Obtained Consent	Signature of Person who Obtained Consent	Date of Signature

Contact Information	This study is being conducted John Q. Wong, M.D., M.Sc. under EpiMetrics, Inc. You may contact him or the study team through: 671-96-46 or at epimetricsph@gmail.com. This study was reviewed by and granted full board review exemption by the Single Joint Research Ethics Board, with Protocol No SJREB-2018-33. For questions on your rights as a study participant or grievances, you may contact the Philippine Health Research Ethics Board (PHREB) represented by DEAN AGUILA at (02) 837-2071 to 82 loc 2112.

III. CONSENT FORM

I have been invited to participate in a research titled: "Program Review of the DOH Deployment Program for Doctors, Nurses, Medical Technologists and Midwives in Service Delivery Networks in Nine Selected Regions" I have read and understood the foregoing information. I have been given sufficient time and opportunity to ask questions and express any concerns I may have about the study. I voluntarily consent to be a participant in this research.

Signature of Respondent

Control No.	Signature of Respondent	Date of Signature

Signature of Witness or Legal Guardian *(if respondent cannot read or sign this informed consent form)*

Name of Witness/Legal Guardian	Signature of Witness/Legal Guardian	Date of Signature	Thumb print of participant

Name of Person who Obtained Consent	Signature of Person who Obtained Consent	Date of Signature

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