Institutionalizing Community-Based Drug Rehabilitation in Inter-local Health Zones in Leyte Province

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HEALTH SYSTEMS STRENGTHENING ACCELERATOR

Context

- In 2016, the Philippine Government launched a campaign against illegal drugs. The campaign consisted of supply-reduction activities and demand reduction activities. The supply reduction focuses on law enforcement to disrupt the illegal drug trade and arrest drug suppliers, whereas the demand reduction activities involve preventive education, rehabilitation and reintegration of person who used drugs (PWUDs).
- As a result of aggressive case finding by law enforcement, as of March 2017, there were 1.18 million PWUDs who needed treatment March 2017. However, a baseline study of the USAID-funded RenewHealth Activity in 2019 revealed that only 15 percent of clients received appropriate treatment.
- According to the Dangerous Drugs Board (DDB) in the Philippines, around 90% of those PWUDs can be treated at the community level. It issued guidelines for care for PWUDs according to their risk level. According to the guidelines, low-risk, and moderate-risk PWUDs can be treated through community-based drug rehabilitation (CBDR). CBDR is a consolidated model of treatment beginning with screening, treatment, wrap arounds psychosocial support to aftercare and reintegration. Unfortunately, the Philippines had no history of CBDR and there were no evidence-based programs available. Moreover, because drug use is a crime in the Philippines, interventions were from a law enforcement rather than a health perspective.
- Many municipalities in the Leyte Province were struggling to implement CBDR. Because of the lack of budget, personnel and experience in evidence-based treatments, municipalities sent PWUDs to to the Dulag Treatment and Rehabilitation Center (TRC) managed by the Department of Health (DOH). However, this was an inpatient facility mean for those with severe drug dependence.
- The DOH-Center for Health Development (CHD) Region 8 conducted Drug Dependency Examination (DDE)[1] and and drug-testing kits for LGUs. However, there was a bottleneck due to the lack of doctors and trained screeners. As a result, low to moderate-risk PWUDs were not getting the appropriate treatment needed. Some PWUDs did not receive any intervention from a health professional months or years after seeking help.

[1] Drug Dependency Examination (DDE) as defined by DDB is a medical examination conducted by physicians accredited by the DOH to determine the extent of drug abuse and whether he/she is dependent or not.
[2] SBIRT stands for Screening, Brief Intervention, and Referral to Treatment. SBIRT involves 3 components: screening - to identify individuals engaging in substance use; brief intervention – short conversation with individuals about substance use and offering motivational support for behavior change; and referral to treatment, wherein individuals are referred to treatment as necessary.

Activity Description

- The Theory of Change (TOC) of the USAID RenewHealth Activity is that by 1) enhancing the capacity of communities and government agencies to provide drug recovery services, 2) creating evidence-based and culturally appropriate treatment interventions, and 3) fostering an enabling policy environment and culture, then PWUDs and their families will access treatment, thus reducing drug dependence in the country.
- This TOC was translated in a systemic response used in the development of an inter-local health zone (ILHZ)[3] model where CBDR was delivered from an inter-local health zone perspective.

- The ILHZ approach started with the municipality of Tolosa when in 2019, then mayor, Dr. Ofelia Alcantara got in touch with the Chief of Party of USAID RenewHealth and asked for assistance. The partnership was formalized in 2020 and the first activity conducted was a profiling of clients. It revealed that majority of Tolosa's PWUDs were low risk (43%) and moderate risk (51%) for drug use. However, 76% were moderate risk for alcohol use dependence. In addition, 29% of PWUDS were at risk for mental health illness. The results suggested the need for a community-based program that would not be limited to illegal drugs but to also consider mental health, cigarettes and alcohol use.
- The municipality became a pilot site in the implementation of the General Interventions for Health and Well-Being Awareness (GINHAWA) program a brief intervention that focuses on well-being; stress management; the effects of cigarettes, alcohol, and drugs; and refusal skills. The Municipality also adopted the Katatagan, Kalusugan at Damayan ng Komunidad (KKDK, Resilience, Health and Care in the Community) program created by the USAID RenewHealth and the Psychological Association of the Philippines for moderate-risk users PWUDs.
- Given the lack of mental health and addiction professionals, the USAID RenewHealth capacitated allied health service providers within the Municipality on CBDR competencies. Forty (40) service providers from Barangay[4] Anti-Drug Abuse Councils (BADACs) were trained on how to effectively reach PWUDs and their families; 33 were trained on Screening Brief Intervention and Referral to Treat (SBIRT); 36 were trained as facilitators to provide treatment which adheres to evidence-based principles, basic human rights, aligned to the National Client Flow for Wellness and Recovery, and cultural appropriateness.
- The health technologies and workforce enabled Tolosa to implement CBDR successfully. So much so that there was much interest in scaling up CBDR. However, the lack of resources and personnel in other municipalities were barriers. Mayor Alcantara suggested the use of existing inter-local health zones and an ILHZ model was presented to the Eastern Visayas Center for Health Development (EV CHD), the Leyte Provincial Health Office (PHO) and representatives of the municipalities of Golden Harvest and Leyte Gulf on April 5, 2022 in Tacloban. The ILHZ Board, Mayors and partner agencies were amenable and receptive to sharing resources and pilot-testing an integrated model for community-based drug rehabilitation and community-based mental health.
- To facilitate policy decision-making, the USAID RenewHealth supported the creation of a Technical Management Committee (TMC) as a recommending body to the ILHZ Board as well as the creation of ILHZ resolution adopting CBDR. A meeting was conducted with the TMC of the joint ILHZ (Leyte Gulf and Golden Harvest) to initiate the preparation of a resolution adopting CBDR in all ILHZ LGUs. Subsequently, a policy or a joint ILHZ resolution creating a TWG to operationalize the CBDR program for the joint ILHZs was created and approved.
- For leadership and governance, sites where selected based on the support from local leaders for the project and partnerships were formalized by Memoranda of Understanding (MOUs). By virtue of the project's formal partnership with the DOH, its regional Centers for Health Development became de facto partners. Hence, the main partner in the Inter-Local Health Zone (ILHZ) was the Eastern Visayas CHD. Through the CHD and the mayors of the ILHZ, the project was able to provide technical assistance in shaping the local policies and capacity building of service providers not only in the ILHZ but also in the region.
- To ensure the engagement of municipalities in the Golden Harvest and Leyte Gulf ILHZs, advocacy, mobilization, and social preparations were implemented. Numerous meetings and courtesy calls were conducted with the Municipal Health Officers (MHOs) to introduce the CBDR program and assess their interest and expectations. Meetings were also held with the municipal anti-drug abuse councils (MADACs) and local health boards of the ILHZ municipalities in preparation for the program implementation. The success of the Municipality of Tolosa inspired other LGUs that if a small municipality was able to do implement CBDR successfully, they could too.
- Several capacity-building activities for service providers in ILHZ (Barangay healthcare workers, DOH deployed nurses, or the barangay health emergency response team, Civil Society Organizations, and faith-based groups) were also conducted to enhance service delivery and enable collaboration among 8 municipalities.

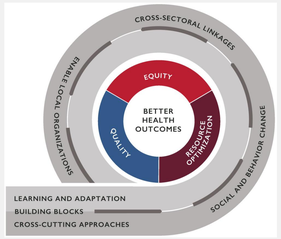
[3] An Inter-local Health Zone comprises a clearly defined population within a rural or urban area, along with all the institutions and sectors that play a role in enhancing healthcare provision within that zone.
[4] A barangay is the smallest political unit in the Philippines. It functions as the primary unit responsible for planning and implementing government policies, plans, programs, projects, and activities in the community.

Activity Impact

- The work done by the USAID RenewHealth through the CBDR ILHZ Model, strengthened the human resources, service delivery, and governance components of the LGUs' health system. Capacity building for service providers were implemented by the USAID RenewHealth, together with DOH-Eastern Visayas Center for Health Development, and these were hosted by member municipalities. Capacitating health workers in ILHZ, increased the availability of health services. By deploying trained health workers to areas with limited health services, equity is achieved. The increase in access to evidence-based treatment ensures that PWUDs, regardless of their location, will receive the care that they need. By delivering quality treatment, the health workers contribute to equitable health outcomes, ensuring that PWUDs receive that same standard treatment, regardless of their background, religion, location, and socioeconomic status. As a result, from a baseline number of 2,024 PWUDs reached, the program has now reached 2,703 PWUDs and 91% of these clients have been screened and almost half (80%) have been enrolled in treatment.

- In terms of governance, USAID RenewHealth provided technical assistance to the ILHZ Board, which is composed of local chief executives of the eight municipalities in ILHZ, representatives from Provincial Health Office and Department of Health. The assistance resulted in the issuance of a resolution adopting CBDR in the member LGUs. The resolution serves as a guiding document for ILHZ municipalities to commit to working together by sharing resources, and CBDR services, and identifying health workers to be trained within ILHZ. This also paved the way for the passing and approval of several resolutions which includes: (1) ILHZ Resolution encouraging all member LGUs to adapt Community-Based Drug Rehabilitation in their concerned LGUs, assisted by the USAID RenewHealth Activity (Resolution No. 06-022-2022 series of 2022); (2) Resolution approving the implementation of an Integrated Community-Based Mental Health and Drug Rehabilitation Program in all member LGUs of the Leyte Gulf and Golden Harvest ILHZs and allocating funds for this purpose from the Common Health Trust Fund and other financing mechanisms that may be further developed; and (3) Resolution adopting the creation of the ILHZ Common Health Trust Fund and its Implementing Rules and Regulations.

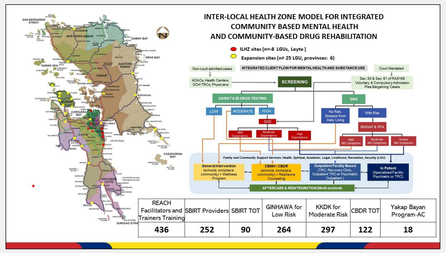
- The ILHZ Board oversees the hospital and public health functions, as well as the activities of private sectors, non-governmental organizations, and other government agencies on health. Given this function, the Board, with regular collaboration and coordination among municipalities and stakeholders, understands the needs of each municipality and can act on any challenges in a coordinated manner to prevent duplication of activities. Moreover, this collaborative approach can ensure that any resource that will be shared within the ILHZ will be utilized optimally. Furthermore, ILHZ facilitates the establishment of a referral mechanism wherein high-risk PWUDs are referred to the Rural Health Unit or the DOH-accredited Municipal Health Officer for drug dependency examinations (DDE) as well as mental and physical health assessments. For individuals with both substance use disorders and coexisting health conditions, appropriate referrals are made to the polyclinic or referral hospital at the provincial level.

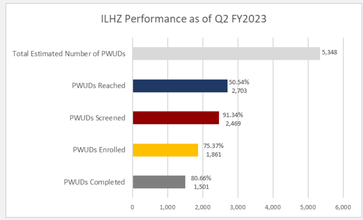


- Overall, the activities of USAID RenewHealth contribute to health equity and quality by capacitating health workers to increase the availability of health services and ensuring that PWUDs receive the same standard treatment, and resource optimization by minimizing duplication activities in through regular coordination among ILHZ members.

Evidence

In terms of accomplishments, the figure on the right shows the ILHZ cumulative Performance of the 8 LGUs in Leyte Gulf and Golden Harvest as of Q2 FY2023. The graph showcases the total estimated number of PWUDs for the ILHZ using the 2% (of the population within a geographic location) estimated national prevalence rate reported by the DDB. The ILHZs succeeded in reaching 50.54% (2,703) of the total estimated number of PWUDs (5,348) using Social Behavior Change Communication materials and promotional campaigns. Furthermore, the ILHZ screened 2,469 PWUDs (91.34%) using ASSIST, enrolled in CBDR the 75.37% (1,861) of the PWUDs screened, and facilitated the program completion of 80.66% (1,501) .





Health workers play a major role in CBDR service delivery. The service providers are composed of barangay health care workers, DOH-deployed nurses, or the barangay health emergency response team who screen and treat low- and moderate-risk PWUDs. High-risk PWUDs are referred to the Rural Health Unit or the DOH-accredited Municipal Health Officer for drug dependency examinations and mental and physical health assessments. PWUDs with comorbidities are referred to their polyclinic or provincial referral hospital. With this, the DOH-EV CHD commenced capacitating LGU personnel, specifically health care workers with CBDR competencies which resulted in the increase of quality trained service providers in the region.

The objective of the ILHZ model is to enable resource sharing across municipalities and allows for services to be outsourced to LGUs or providers when a municipality does not have resources. The figure on the left shows the number of people trained across the various intervention programs and skills needed for CBDR.

Currently, all the LGUs in the ILHZ can do screening and general interventions for low-risk clients. Given the scarcity of doctors accredited to conduct Drug DDE, part of an ILHZ agreement is to locate such services in a particular health facility. The ILHZ model would make it possible for small municipalities with court-mandated clients to send PWUDs to LGUs designated as providers for this population.

Facilitators

- An important facilitator in strengthening this health system was that the ILHZs of Leyte Gulf and Golden Harvest already existed by virtue of ILHZ Board Resolution 1 s. 2011. A Memorandum of Agreement between member municipalities, the Department of Health (DOH) and the Province of Leyte has already been in place.

- The presence of a strong champion Mayor Ofel Alcantara who is a doctor was critical in shaping a health-oriented approach to CBDR. Consequently support from other local chief executives was important in the creation of ILHZ for CBDR

- Also critical was the policy issuance of the DOH Administrative Order (AO) No. 2019 – 0021, "Guidelines in the Implementation of Healthcare Treatment Services for Community-Based Drug Rehabilitation Program (CBDRP)" that paved the way to deliver services at the level of communities for PWUDs with low to mild severity of use. This AO likewise mandated all regional health offices, local government units and other stakeholders to be guided by the procedures and minimum service requirements in implementing the health care services under the CBDRP.

- Support from the Department of Health – Eastern Visayas Center for Health Development was an important enabler because they spearheaded the capacity-building activities for screening and treatment services. In addition, partnership with the DOH-TRC Dulag became critical because their staff served as trainers for the ILHZ and the region.

- Partnership with civil society was another important enabler. The Psychological Association of the Philippines developed the intervention program for moderate users (KKDK Program) that was later improved by the USAID RenewHealth project. KKDK provided the basis for other CBDR interventions that were developed for low-risk and high-risk PWUDs.

- Finally, an important facilitators was the DOH's push for Universal Health Care law (Republic Act 11123) and the creation of Province – Wide Health Systems and SuperHealth Centers (DOH AO 2020 – 0021) within municipalities. The ILHZ model can facilitate primary care at the Primary Care Provider Network (PCPN), with efforts focused on prevention, early detection & prompt treatment. The model can likewise address resource scarcity problems through the activation of sharing human health resources across municipalities, allowing for the outsourcing of services within the region.

Challenges

- A critical challenge in the implementation of CBDR in the Philippines was the lack of evidence-based programs intervention. To address USAID Renewhealth conducted formative research and developed and pilot-tested interventions that were culturally-nuanced and appropriate to risk levels of PWUDs.

- Given the punitive and law enforcement perspective, stigma and discrimination against PWUDs was high. To address this USAID Renewhealth assisted LGUs in capacity building for community providers and in developing SBCC materials with positive messaging. The project also developed audio-visual presentation and primers in collaboration with the DOH and DDB to serve as easy and available references on government policies about community-based treatment.

- Lack of organic trained personnel to conduct screening and deliver CBDR interventions. Due to budgetary constraints, LGUs in the Philippines employ non-regular employees to carry out regular work. Since they are not regular LGU employees, there is a possibility that those trained personnel might choose to leave their current jobs in pursuit of more favorable employment opportunities. This was an expected challenge. Hence, the USAID RenewHealth in collaboration with DOH Eastern Visayas CHD created a pool of trainers and capacitated permanent LGU employees to ensure sustainable and efficient knowledge transfer in the future.

- Overburdened health workers. Human resources for health (HRH) are expected to implement various other health programs. The inclusion of CBDR adds to their already heavy case load. To address this, the project trained social workers, barangay health workers, BADAC focal persons, and other allied health workers have on various CBDR services particularly in screening and treatment.

Lessons Learned

- Forming strategic partnerships with various stakeholders, such as other national government agencies, universities, NGOs, and churches, operating at the local level, can offer the necessary support to implement CBDR.

- By anchoring activities with the direction and policies set by the government, a shared vision and priorities can be established, which in turn fosters trust and ensures support of national and local government officials.

- Addressing stigma associated with substance use is critical for the success of CBDR. Educating the community and raising awareness help create an environment that supports PWUDs in their journey to recovery

- Adopting a holistic approach that addresses the physical, psychological, social, and economic needs of individuals undergoing rehabilitation is essential. Providing comprehensive services such as counseling, medical support, vocational training, and social reintegration programs help address the multi-faceted challenges of drug addiction.

- Utilizing a socio-ecological and holistic model ensures that there are interventions provide life and recovery skills for the PWUDs, improves his/her relationships with others, strengthen the capacities of services providers to help individuals and their families, and provides the policies that enable these activities.

- Implementing robust monitoring and evaluation is essential to assess the effectiveness and impact of the program. Regularly collecting data, measuring outcomes, and evaluating program performance enables LGU officials to identify strengths, weaknesses, and areas for improvement.

- These are the identified lessons learned that can be useful and also be considered by other implementers and health system actors when implementing their own programs in their countries.

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