ORIGINAL ARTICLE

# Incorporating Praxis into Community Engagement-Self Monitoring: A Case Study on Applied Social Innovation in Rural Philippines

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## ABSTRACT

**Background.** Social Innovation in Health Initiative Philippines introduced the community engagement self-monitoring strategy in two community-managed social innovations in 2021. Phase 1 demonstrated the strategy's viability by identifying community "local monitors," selecting indicators, monitoring, and conducting feedback sessions. In 2022, a second phase was implemented to improve the process by integrating capacity-building activities and praxis sessions, and gathering insights on the strategy's sustainability.

**Objective.** In this paper, we sought to describe the stages of the CE-SM strategy applied within a Philippine local health system in geographically isolated and disadvantaged contexts. Specifically, we: 1) Identified the key competencies of the local CE-SM monitors; 2) facilitated capacity building to strengthen their skills and abilities; 3) explored sustainability mechanisms; and 4) identified integration points of the CE-SM in strengthening local health systems.

**Methods.** Two communities in a rural municipality implementing a social innovation called the "Seal of Health Governance" were chosen for the expanded community engagement self-monitoring (CE-SM) pilot. Profiling of local monitors and self-assessment of competencies were facilitated. Capacity-building activities were conducted for community engagement, data processing, and data analysis, complemented by praxis sessions guided by people-centered principles.

**Results.** Local monitors from both communities showed determination in performing their responsibilities but differed in their levels of participation. Their appreciation of their role increased as it broadened from merely collecting data to understanding and using it to advocate for their community's needs. The minimum resources for communities to implement the strategy include financial mechanisms to ensure the availability of resources. Local monitors have improved their ability to analyze their communities' realities, particularly regarding health leadership and governance.



** Mr. Ongkeko and Dr. Tiangco shared first authorship for this manuscript.*

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**Conclusions.** Community engagement self-monitoring is a feasible and sustainable strategy for monitoring and evaluating health interventions if adequate support is provided and complemented by capacity-building and praxis sessions. It promotes listening to the community and empowering them to participate in decision-making, which are vital in fostering ownership and sustainability of social innovations in health.

*Keywords: social innovation, community engagement, self-monitoring, community-grounded tool, praxis, people-centered development*

## INTRODUCTION

Community engagement (CE) in social innovation (SI) refers to the active engagement of a community with other partners to modify existing practice/s or introduce new methods to eliminate challenges to improve the individual and collective welfare of their community.[1] Self-monitoring is a process by which a community is empowered to monitor and oversee the performance of a project to ensure that intended objectives are achieved. The community engagement self-monitoring (CE-SM) strategy incorporates the two approaches to allow communities to be further involved in health programs and activities, and identify gaps to fill and how best to do so. This allows health services to become more responsive to the needs of the community and become more accessible to all. Integrating these relevant elements results in a strategy that helps ensure community ownership and sustainability of initiatives.

The Social Innovation in Health Initiative (SIHI) Philippines, hosted at the University of the Philippines Manila, introduced CE-SM for two social innovations in health (SIH) implemented in socially disadvantaged communities in the Philippines in 2021.[2] Inspired by a similar strategy

**Box 1.** CE-SM Phase 1: Unpacking processes and dynamics in the Philippine setting

With the objective of describing the processes and dynamics of communities as they implement the community engagement-self monitoring strategy, two community co-managed social innovations were selected. The first social innovation, Kalinga Health for tuberculosis care, was designated as the community-managed group, which was independent of any assistance from partners. On the other hand, the Seal of Health Governance (SOHG), a health leadership and monitoring program in the municipality of Del Carmen, Surigao del Norte, designated as the SIHI co-managed group, received minimal assistance from SIHI by being provided with a list of monitoring indicators. This was done to understand and compare the dynamics between communities receiving different levels of support.

Both communities identified their monitoring indicators and selected local monitors, who are primarily in-charge of collecting data to assess performance outcomes and document the entire process. Crucial to the implementation was the role played by the documenters, individuals assigned by the social innovators to observe and document the entire process the local monitors went through. They also served as the community's link to the research team (SIHI). They organized meetings with the local monitors to discuss the challenges they may have and the lessons they learned. These information were then relayed by the documenters to the SIHI team.

***Key Results***

This project aims to describe the processes the communities underwent as they implemented the CE-SM strategy; hence, results will be presented according to the step-by-step process.

- Choosing monitoring indicators: Monitoring indicators for both communities were chosen based on what community representatives perceived as important, feasible, and practical.
- Choosing local monitors: Individuals who were familiar with the community and had good interviewing skills were chosen as local monitors.
- Dynamics of the monitoring process: Local leaders considered representation, active participation, and co-creation as important factors in achieving the project's goals. The community's participation in the project was largely based on their trust in its purpose and benefits.
- Implementation of the monitoring process: Local monitors from Kalinga Health had access to an online dashboard which they could easily collect data from. On the other hand, local monitors from SOHG conducted house-to-house visits and utilized paper-based monitoring in their assigned catchment areas, with over twenty villages to cover. Hence, local monitors in the former were able to collect data weekly, but those from the latter were only able to collect data once during the entire duration of the project.
- Establishing feedback loops: Documenters met with the local monitors to identify challenges and discuss lessons that other local monitors can learn from. A joint assessment meeting with all relevant stakeholders was facilitated at the end of the project to synthesize findings and identify recommendations on the way forward.

***Challenges Encountered***

- An initial challenge for Kalinga Health was establishing rapport with community members, leading them to extend the social preparation phase.
- For SOHG, challenges faced include the lack of familiarity with technology, poor internet connection, a timeframe that needed to be expanded to complete interviews, and difficulty collecting relevant data due to the unavailability of heads of households and confusion of respondents. Some local monitors also received minimal support from their village leaders.

***Key Lessons***

- Community leaders' proactive leadership and community members' participation contributed significantly to the strategy's success.
- Regular feedback sessions served as a safe space for local monitors to voice out their opinions and learn from each other.
- The frequency and timing of monitoring were dependent on the availability of the workforce and their timeline.
- The level of external support needed by a community was determined by the scope of the project and the community's grasp of the strategy.
- The CE-SM strategy is a viable approach when tailored to the capacity of the community, the nature of the project being implemented, and its practicality and feasibility for the community.

adopted for control of onchocerciasis in Africa, this pilot project aimed to unpack fundamental components of CE-SM for SIs to facilitate the promotion of sustainability, community ownership, and people empowerment.[3] An initial phase was conducted in 2021 (Box 1), where documentation of the processes of communities in implementing the CE-SM strategy, resulted in the identification of factors and refinement of strategies to engage communities in monitoring SIs.[2] Furthermore, it demonstrated the viability of CE-SM when tailored to the capacity of communities through co-designed monitoring frameworks.

In Phase 1, the communities implemented the CE-SM strategy as they deemed fit, without interference from the research team. Some of the challenges the local monitors encountered include the hesitancy of the community members to be interviewed because of other engagements. A lot of them also mistook the local monitors as people who were providing financial aid ("ayuda"), only to be disappointed upon finding out otherwise. The research team later found out that the local monitors did not really have a good grasp of the strategy's principles and purpose, and were merely implementing it out of compliance. Recognizing these limitations, new elements introduced in this phase include capacity-building activities and praxis sessions grounded on people-centered development (PCD) principles. Praxis is "characterized by intentional reflection, mindful action and willingness to learn from our ongoing reflection and action in order to form new understandings of the world and our experiences of it".[4] It has been perceived to create opportunities to improve on their approaches and involves a much higher level of participation. This is a helpful tool to make sense of lived experiences and take action in response to their needs while taking unique contexts into consideration.[4] These sessions were guided by principles of PCD, which refers to an "approach to international development that focuses on improving local communities' self-reliance, social justice, and participatory decision-making".[5] It holds that human development is a complex process with its core elements including sustainability, justice, participation, and inclusivity – which are vital components of the CE-SM strategy. With these new elements, we intend to delve deeper into the strategy's effectiveness as a service delivery outcome through describing the process the communities went through and presenting insights from the participants, specifically the local monitors.

## OBJECTIVES

In this paper, we sought to describe the stages of the CE-SM strategy applied within a Philippine local health system in geographically isolated and disadvantaged contexts.

Specifically, we:

1. identified the key competencies of the local CE-SM monitors;
2. facilitated capacity building to strengthen their skills and abilities;
3. explored sustainability mechanisms; and
4. identified integration points of the CE-SM in strengthening local health systems.

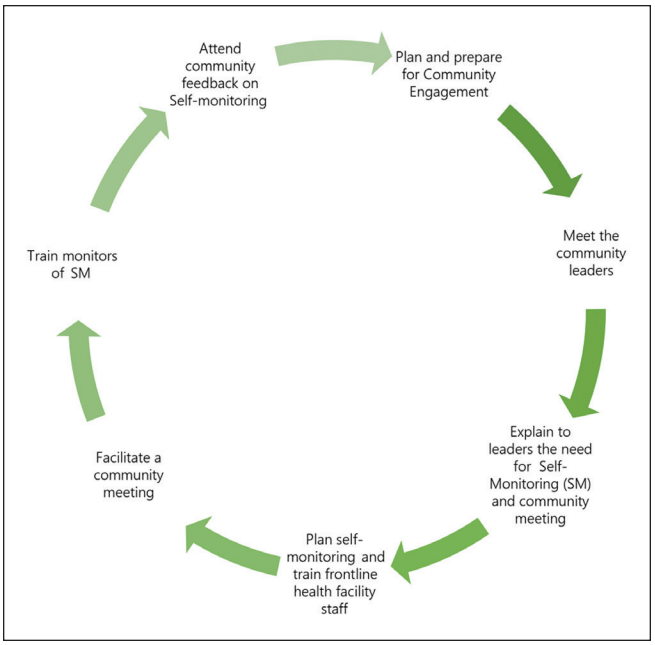


**Figure 1.** Seven steps in community engagement and self-monitoring.

*Adapted from the African Programme for Onchocerciasis Control and Duamor et al.*[7,8]

## MATERIALS AND METHODS

### Study Design

We employed a descriptive case study approach to document the implementation and nuances of the Community Engagement-Self Monitoring (CE-SM) strategy in two rural communities in the Philippines. This methodology was selected for its strength in facilitating the study of complex phenomena within their contexts, allowing for an in-depth exploration of the processes and community dynamics integral to the CE-SM strategy.[6] Through this approach, we aimed to provide a detailed depiction of the strategy's operationalization.

Figure 1 shows the community engagement self-monitoring process adapted from the community-directed treatment with ivermectin implemented by the African Programme for Onchocerciasis Control, World Health Organization, and Duamor and colleagues.[7,8] It starts with planning and preparing the community – exhibiting professionalism and assisting the community in drawing an agenda. It is important to engage the community leaders and to ensure that all stakeholders understand the relevance of self-monitoring in their context. Discussing its importance and utility is a central step in keeping them engaged. The self-monitoring process involves selecting indicators and training frontline health facility staff and local monitors,

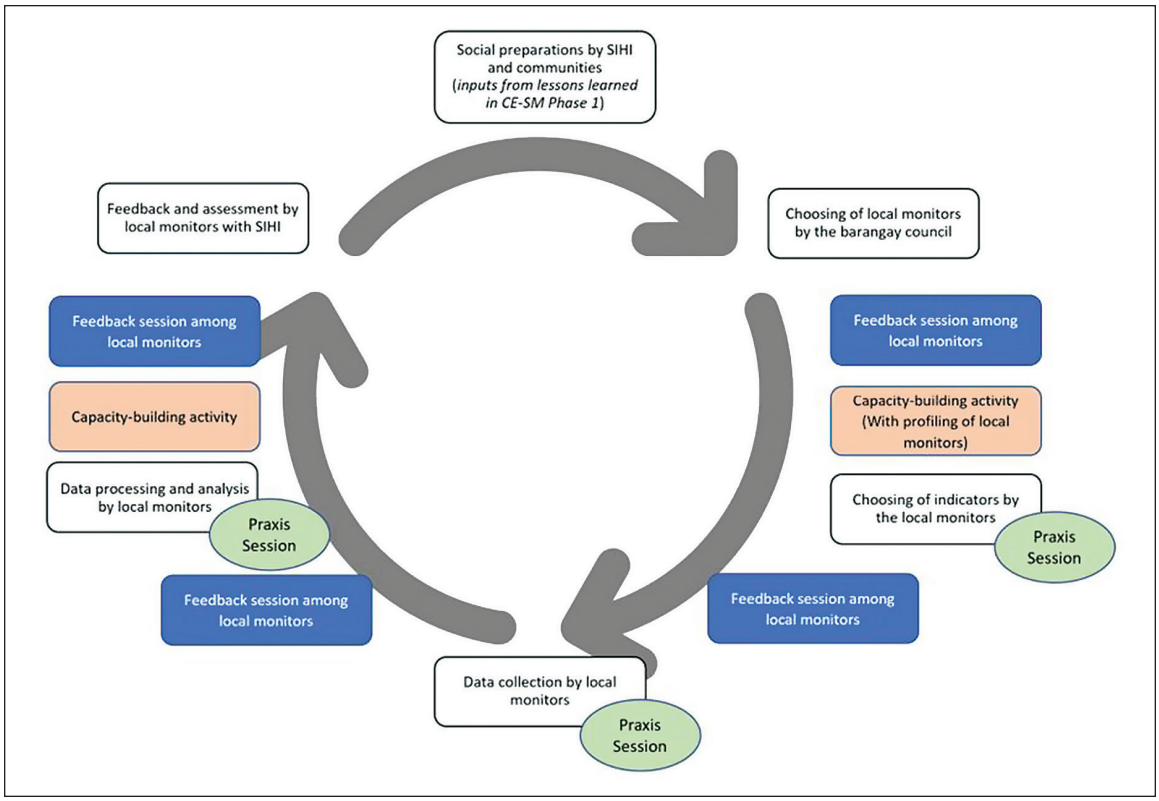


**Figure 2.** Steps and processes in the implementation of the CE-SM strategy. Capacity-building activities and praxis sessions were added to the second phase of CE-SM implementation.

*Modified and adapted from Duamor et al., and the African Programme for Onchocerciasis Control.*[7,8]

while facilitating community meetings in between. Lastly, community feedback must be conducted to take note of how the community intends to engage all community members to support the innovation. Encouraging them to facilitate innovation plans to ensure high community participation is a crucial step.

Recognizing the successes and challenges of CE-SM Phase 1, Figure 2 visualizes additional operational stages based on the community's needs. It begins with initial community engagement and stakeholder meetings, progressing through the training and active monitoring phases conducted by local monitors, and culminating in the analysis and feedback sessions that inform ongoing adjustments and enhancements to the strategy.

## Study Setting

We continued on our expanded implementation of the CE-SM strategy in the Municipality of Del Carmen. It is a low-income island municipality located in the province of Surigao del Norte with a population of 18,392 with 67% living below the poverty threshold as of 2020. Del Carmen is composed of twenty barangays or villages headed by local (village) leaders.[9] To address health challenges associated with maternal and child health, poor sanitation, and infectious diseases, the municipal government launched the Seal of Health Governance (SOHG). SOHG is a health leadership and monitoring program that encourages community leaders to be actively engaged in addressing their community's concerns through an open participatory competition.[7] Each village produces scorecards which include performance indicators and community health targets based on their priority health problems. Performance indicators refer to health outcomes (e.g., maternal death, infant death, rate of malnutrition) or service delivery (e.g., fully immunized child, facility-based child delivery). To foster innovativeness and encourage participation, incentives in the form of seal awards are given to those who meet their targets. These incentives also encourage and empower communities to create innovative solutions to address health issues.

Two barangays were selected based on their level of engagement and participation. The most (community A) and least (community B) engaged and participative barangays from the municipality during Phase 1 were chosen to execute the strategy over a six-month course. This was rated based on the following criteria: 1) complete and satisfactory documentation of the entire process and 2) completion of all requirements within the prescribed time frame. Adjustments were applied based on lessons they learned during Phase 1 of the project. Similarities and differences were also documented to see facilitators and barriers in strategy implementation. A comparison

was done to determine what works and what barriers may be present during the implementation of the strategy.

## Study Participants

Purposive sampling was utilized, with the study participants consisting of local monitors (LMs) - who were mostly village health workers and/or village leaders. Participants were selected by the village leaders based on their roles in the community, skills in interviewing, and willingness to participate.

## Data Collection Procedure

Data collection methodologies included review of related literature and praxis sessions which utilized the principles of focus group discussions and key informant interviews, with the aim of achieving methodological triangulation.

Qualitative data collection was centered on praxis sessions, which integrated aspects of focus group discussions and key informant interviews in a reflective debriefing format. This allowed for a dynamic and contextual exploration of participant experiences for deeper understanding of community perspectives without the formal structure of traditional FGDs and KIIs.

Consultative meetings were facilitated with the municipal mayor and field coordinator to orient them regarding the project's objectives and work plan. Emphasis was placed on new elements for Phase 2, including 1) profiling of LMs; 2) performance evaluation of LMs during Phase 1;3) evaluating facilitators and barriers during Phase 1; and 4) using lessons to improve upon implementation for the current phase. These were achieved through facilitating praxis sessions and capacity-building activities.

All participants read, signed, and received a copy of their Informed Consent Form (ICF). An orientation was conducted in both barangays to discuss SOHG and the CE-SM strategy, share lessons learned from Phase 1, including the importance of establishing rapport among community members, having a good grasp of the strategy's principles, purpose, and benefits, and equipping the local monitors with knowledge and skills to implement the strategy effectively, and discuss implementation with the village council, as will be discussed in the next sections. They also selected monitoring indicators and LMs.

During the stakeholder consultations, the participants were involved in refining the research question, and in the iterative process of redesigning and implementing the strategy. The communities, represented by their village officials and health workers, selected monitoring indicators and identified local monitors to collect data for assessment of performance outcomes and documentation of the process. Interactive discussions were conducted during the capacity-building activities. The aim of extending the implementation of CE-SM was to evaluate the strategy's sustainability and practicality while examining the factors and processes at play. Other key persons involved throughout the process are listed in Table 1.

**Table 1.** Key Persons and their Roles

| Key Person | Roles |
|---|---|
| ***Social Innovation in Health Initiative (SIHI) Hub*** | The SIHI Philippines conducted the project with TDR, the Special Programme for Research and Training in Tropical Diseases to develop a community-grounded and contextualized CE-SM strategy for SIs in health that could be disseminated to enhance the effectiveness and sustainability of SIH. The Hub is hosted by the Department of Clinical Epidemiology, College of Medicine, University of the Philippines Manila. |
| ***Innovator*** | A community-based organization that has developed and implemented SIs to address relevant health problems in the country. |
| ***Field coordinator*** | Assigned to document how communities plan, implement, analyze, and report data. This individual was in charge of gathering relevant community members during meetings with the SIHI team. |
| ***Local monitors*** | Volunteers who have been selected by the community to plan, collect, document, and analyze data throughout the CE-SM implementation. |

## Profiling and Training Needs Assessment of Local Monitors

To facilitate profiling of LMs, a thirty-nine-item self-administered questionnaire (Appendix) was created for and answered by LMs. This served as the training needs assessment, measuring the self-assessed level of competence of local monitors in various areas including planning, data collection, and data analysis. The tool also evaluated behavioral competencies such as self-management, professionalism and ethics, innovation, and self-reflection. Additionally, it assessed the factors affecting their levels of competence.

The tool adapted elements from the Self-Assessment for Teacher I-III (Proficient Teachers) for SY 2021-2022 by the Department of Education[10] and the Barangay Health Workers' Level of Competence by Taburnal et al.[11], both of which were relevant context-wise.

## Capacity-building Workshops and Praxis Sessions

### *Capacity-building Workshops*

The need for training was evident in the reports by the field documenter and the LMs from Phase 1. Their feedback emphasized the need to expound on basic concepts of community, community engagement, and self-monitoring. During the praxis sessions, it was also found that a session on data processing, analysis, and presentation was necessary. Hence, two key capacity-building activities were carried out with LMs from both villages from August to December 2022.

The initial activity assessed the LMs' competencies in planning, data collection, and analysis. For this purpose, a behavioral checklist was used to identify influencing factors. This first workshop also served to enhance LMs' understanding of CE-SM through interactive sessions led by a social development expert. During these sessions, LMs had the

opportunity to discuss among themselves and identify essential attributes for effective local monitoring. A secondary focus of this workshop involved guiding LMs on how to better organize their teams. Informed by feedback and insights from the praxis sessions, the second workshop focused on improving LMs' data processing, presentation, and analysis skills.

### *Praxis Sessions*

Praxis sessions were conducted once a month from September to November, with each session lasting for 45 minutes to an hour. These sessions integrated participatory community development (PCD) principles into CE-SM. The method employed to facilitate this integration was an action–reflection–action process, which deepened the community's engagement and understanding of CE-SM. Regular self-assessment and evaluations by LMs were essential components, serving as criteria for adjustments to the current LM roster. The sessions also served as a forum for sharing innovative ideas and discussing how current initiatives could be optimized.

The topics for each praxis session was informed by the first workshop conducted by the team in August 2022 and was enhanced by the insights shared by LMs during the preceding praxis session. Furthermore, these praxis sessions have been crucial in obtaining the insights, successes, and challenges faced by local monitors, which facilitated the selection of topics for the next workshop session. These were focused on knowledge and skills LMs needed more support on: data utility, processing, analysis, and reporting. (Table 2)

### *Indicator Selection and Tool Development*

Monitoring indicators and its corresponding data collection tools were selected during Phase 1 and were retained by the LMs for both communities. They shared that the indicators they have selected in Phase 1 were important and relevant, and were hence retained.

**Table 2.** Praxis Sessions Agenda and Key Takeaways

| Date | Guide Questions | Summary of Lessons |
|---|---|---|
| ***October 8, 2022*** | 1. Enumerate five things you learned from the last exercise/workshop you took part in.<br>2. Which of these were you able to utilize while you were fulfilling your role as a local monitor?<br>3. How do you utilize the things you learned as you fulfill your role as a local monitor? | • During phase 1, the LMs themselves had difficulty understanding the objectives of the project and were collecting data mainly out of compliance. The workshop was instrumental in developing a better understanding of the strategy and its application to health problems in the community.<br>• The LMs shared that their learnings from the first workshop, mostly relational skills, were applied to their data collection process.<br>• Proper coordination between the village captain and the community members paved the way to a more cooperative and engaged community. Since they have an understanding of the purpose of the interview and were informed ahead of time, they were more open to being interviewed, which is in stark contrast to phase I.<br>• Since the LMs were already familiar with the questionnaire, it was easy for them to explain the questions to the community members. |
| ***October 22, 2022*** | 1. Were there changes in your list of monitoring indicators? Why did you change or maintain it? Did the first praxis session help you in finalizing your monitoring indicators?<br>2. What monitoring indicators will you use?<br>3. Now that you have collected data and information, how do you plan to use them as local monitors? How will the community members make use of this? How will this benefit the barangay/village as a whole?<br>4. What is the result or effect of this to you as local monitors? What is its effect on the community members? The barangay/village as a whole?<br>5. Where can you use the data you collected?<br>6. How do you plan to organize/process the data and information you collected? | • No changes were made with the monitoring indicators because these have all been well-thought of and relevant to them.<br>• The data they collected will be utilized to maintain cleanliness, promote proper waste segregation, reduce malnutrition cases, and be integrated in other activities related to health.<br>• During Phase I, LMs were involved only until the consolidation of data. Hence, skills on data processing, analysis, and processing were lacking.<br>• During Phase 2, one LM shared, "*It broadened our abilities, knowledge in maintaining cleanliness and good health. This will help the community members avoid diseases because they know that cleanliness is important*."<br>• When asked how they plan to organize and process data, they shared that they will be using the same process as Phase 1, where someone organizes, encodes, and consolidates the data. |
| ***November 19, 2022*** | 1. What process did you go through from the beginning until the end of the CE-SM implementation?<br>2. You mentioned that you would want to present your data during the barangay assembly and among non-government organizations, what will you make out of the data you collected? How will you present them? What steps do you have in mind?<br>3. What do you think is the importance and benefit of the data you collected at the barangay level? For non-government organizations? The local government level? | • One LM shared, "*This program paved the way for more knowledge regarding health*."<br>• Another LM intends to use the skills she learned from CE-SM to ensure that their new restaurant will comply with the prescribed standards of cleanliness and sanitation. |

### *Monitoring and Feedback Loops in the Communities*

Local monitors were assigned to their catchment areas and conducted one-on-one interviews with community members using the tool they developed. They employed an open feedback mechanism that ensured all members of the project have been well-informed and may continuously contribute to the process. Feedbacking practices from Phase 1 were continued in Phase 2. This was integrated in the praxis sessions between the SIHI team and LMs.

## Data Processing and Analysis

Data gathered through surveys and interactive discussions, with field notes, were organized in a word document. To ensure data quality and integrity, unclear responses from LMs were clarified during the second session of the capacity-building activity and insights were summarized every after session to ensure that their insights were accurately captured and understood. Descriptive statistics was utilized for quantitative data, while relevant processes, community dynamics, and outcomes were described in this manuscript. Constant comparative method was utilized for qualitative data, a process where themes emerge from the data via inductive reasoning as opposed to coding the data based on predetermined categories. Themes were expounded based on the responses and insights of the local monitors and the observations and field notes of the research team during the workshops and praxis sessions.[12]

## Ethical Considerations

The University of the Philippines Manila Research Ethics Board Review Panel 2 approved this study (UPMREB 2022-0452-01). It was explained that their participation was voluntary and that they can decline or choose to discontinue participation at any point in time. Throughout the research, the researchers ensured that the participants' confidentiality was safeguarded. Audio files and paper copies of documents will be stored for a period of up to five years following the completion of the study, after which paper documents will be permanently destroyed by shredding the physical paper copies. This data will only be accessible to the research team. Privacy was also ensured by not referring to the respondent's answers of participation when interacting with them in other settings unless they consent to it. Moreover, participants were provided with enough information to be able to assess risks and potential benefits of their participation in the research.

## Researcher and Participant Relationship

Our research team built a foundation of trust and collaboration with community participants and the local government in implementing the CE-SM strategy. We engaged a local coordinator to help us facilitate communication with our target sites and in navigating the community dynamics to enhance participant engagement. We also consistently worked with the municipal mayor, providing him with regular updates and feedback. Additionally, we collaborated with the leaders of the two villages, incorporating their insights, especially during feedback sessions, to ensure cultural sensitivity and alignment with real community needs.

## Reflexivity

Reflexivity was facilitated by the research team through analysis and writing by recording, discussing, and challenging established assumptions. Group discussions also facilitated the processing of biases and backgrounds, allowing us to be attentive and conscious about our cultural, political, and social perspectives, ensuring that these personal biases do not interfere with our approach to the study and the participants.

# RESULTS

This section presents a brief documentation of the implementation of the CE-SM strategy highlighting the implementing communities' adaptations, results of the profiling of LMs, self-reported competencies gained, integration of PCD principles, and other outcomes.

## Process Outputs: Engagement Strategies for CE-SM Implementation

### *Choosing Local Monitors and Monitoring Indicators*

Community A added one (1) LM while Community B added two (2) LMs, with a total of 15 and 10 LMs, respectively, to cover more households. Both communities retained monitoring indicators and questionnaires used in Phase 1. These indicators evaluated relevant involvement of stakeholders during development, implementation, and monitoring of SOHG; type and coverage of community-based initiatives; and the community's perception of and response to the initiatives. Retaining indicators and questionnaires was opted to avoid confusion among LMs and community members. The communities perceived familiarity with the tool to be critical to data collection. They emphasized that the indicators they chose were well-thought-out and relevant to their SI. This affirms the active role that LMs play in decision-making regarding the monitoring process.

### *Data Collection and Processing by Local Monitors*

Both communities facilitated house-to-house visits based on their assigned catchment areas. LMs shared that they decided to follow the same process as Phase 1, utilizing the same set of indicators and method of paper-based monitoring through house-to-house visits based on the LM's catchment area, as this worked efficiently in the previous phase. Community A held regular meetings to discuss insights and difficulties they encountered in order to deliver timely solutions. LMs from Community B carried out tasks but noted the lack of support from village officials.

**Table 3.** Minimum Support Resources for CE-SM Strategy Implementation

- Transportation allowance
- Food allowance
- Availability of resources: paper for printing questionnaires, pens
- Availability of equipment: software, computers, printer, projector
- Availability of meeting venue

**Table 4.** Sociodemographic Characteristics of Participants

| Variables | Community A | | Community B | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| ***Sex*** | | | | | | |
| Male | 0 | 0 | 1 | 11 | 1 | 4 |
| Female | 15 | 100 | 8 | 84 | 23 | 96 |
| ***Age*** | | | | | | |
| 15-19 | 0 | 0 | 0 | 0 | 0 | 0 |
| 20-24 | 2 | 13 | 0 | 0 | 2 | 8 |
| 25-29 | 1 | 7 | 1 | 11 | 2 | 8 |
| 30-34 | 1 | 7 | 2 | 22 | 3 | 13 |
| 35-39 | 4 | 27 | 2 | 22 | 6 | 25 |
| 40-44 | 0 | 0 | 0 | 0 | 0 | 0 |
| 45-49 | 2 | 13 | 1 | 11 | 3 | 13 |
| 50-54 | 3 | 20 | 1 | 11 | 4 | 17 |
| 55-59 | 1 | 7 | 2 | 22 | 3 | 13 |
| 60-64 | 1 | 7 | 0 | 0 | 1 | 4 |
| ***Marital Status*** | | | | | | |
| Single | 0 | 0 | 1 | 11 | 1 | 4 |
| Married | 13 | 87 | 3 | 33 | 16 | 67 |
| Separated | 0 | 0 | 0 | 0 | 0 | 0 |
| Widowed | 0 | 0 | 2 | 22 | 2 | 8 |
| Live-in | 2 | 13 | 3 | 33 | 5 | 21 |
| ***Educational Attainment*** | | | | | | |
| No formal education | 0 | 0 | 0 | 0 | 0 | 0 |
| Primary level | 0 | 0 | 0 | 0 | 0 | 0 |
| Elementary level | 1 | 6.6 | 0 | 0 | 1 | 4 |
| Elementary graduate | 1 | 6.6 | 0 | 0 | 1 | 4 |
| High school level | 7 | 46.6 | 0 | 0 | 7 | 29 |
| High school graduate | 3 | 20 | 5 | 55.6 | 8 | 33 |
| College level | 3 | 20 | 2 | 22.2 | 5 | 21 |
| College graduate | 0 | 0 | 2 | 22.2 | 2 | 8 |
| Vocational | 0 | 0 | 0 | 0 | 0 | 0 |
| Post-graduate | 0 | 0 | 0 | 0 | 0 | 0 |
| ***Religion*** | | | | | | |
| Catholic | 14 | 93.3 | 9 | 100 | 23 | 96 |
| Iglesia ni Cristo | 0 | 0 | 0 | 0 | 0 | 0 |
| Born-again | 0 | 0 | 0 | 0 | 0 | 0 |
| Protestant | 0 | 0 | 0 | 0 | 0 | 0 |
| Mormon | 0 | 0 | 0 | 0 | 0 | 0 |
| Muslim | 0 | 0 | 0 | 0 | 0 | 0 |
| Baptist | 0 | 0 | 0 | 0 | 0 | 0 |
| Jehova's Witness | 0 | 0 | 0 | 0 | 0 | 0 |
| Left blank | 1 | 6.7 | 0 | 0 | 1 | 4 |

### *Community Performance Outcomes and Feedback from Phase 1*

Majority of LMs during Phase 1 identified the following as important factors in carrying out duties of LMs during Phase 1: regular communication, clearly defined tasks, respect for the opinion of other LMs, formulation of strategies to effectively implement CE-SM, and data validation and data storage strategies. On the other hand, they identified that the following were not as important as those previously mentioned: support from colleagues and experts explaining meanings and implications of data, and utilizing knowledge and skills to determine important elements in data. These were not observed and exercised by LMs during Phase 1.

LMs were noted to be enthusiastic to accept new responsibilities and determined to learn new knowledge and skills. They mentioned that they were able to accomplish tasks despite the lack of resources and were happy to have completed them. The latter was accomplished through the help of training, self-confidence, rapport-building, efficient communication systems, accurate use of data, and access to appropriate facilities. The use of technology, formal education related to their job, and ample resources, were limited but regarded as facilitating factors. For instance, only one computer was available in Community B. This meant that LMs had to take notes, compile data, and analyze manually. This highlights the importance of financial support in providing resources needed to carry out the CE-SM strategy. LMs voiced out difficulties in terms of resources such as lack of paper for questionnaires that delayed their data collection and hampered progress. Transportation was also a challenge. Not all LMs could afford fares to get to designated venues for praxis sessions. Identified minimum support resources for communities to implement CE-SM are presented in Table 3.

Local monitors shared that community members were more cooperative during Phase 2, which was attributed to the community members' familiarity with SOHG and CE-SM. This was made possible through the announcement of Community A's village captain made, notifying community members to expect to be interviewed. LM's also noted being more well-versed with the questionnaire, making it easier for them to conduct the interviews. However, problems with transportation and resources persisted.

## Competencies Developed and Immediate Outcomes

### *Profile of Local Monitors*

#### *Socio-demographic Characteristics*

A total of twenty-five LMs were selected by the communities with 60 percent from Community A and the rest from Community B. It is of note though, that one participant from Community B was unable to answer the profiling tool.

Ninety-six percent (96%) of LMs were female and sixty-seven percent (67%) were married. Twenty-five percent (25%) belong to the 35-39-year-old age group, followed by those

who belong to 50-54 years old (17%). All the participants who stated their religion are Catholics. The average household size was five (5) members, ranging from two (2) to seven (7) members. Most LMs graduated from high school (33%), followed by those who reached high school level (29%). All LMs have monthly family earnings less than 9,520 pesos (~170 USD). Table 4 summarizes the sociodemographic characteristics of participants.

For the past year, the majority of LMs participated in training sessions on TB, WASH, and social determinants of health. Some participated in activities facilitated by relevant agencies, training against hunger, farming and planting of crops, and an integration program for child development.

### *Organizational Mapping*

LMs from both barangays identified the following organizations in their respective communities: the barangay council, parent-teacher association, barangay development council, and non-government organizations. In Community A, all LMs are members of at least one organization, with the majority (73%) being members of Community A's Marine Association – a people's organization promoting marine protection and sustainable fishing. Other organizations are generally focused on health and nutrition, education, environmental causes, and peace and order. The same is true for Community B, with the majority being members of community development projects facilitated by national government agencies.

### *Socio-economic Characteristics*

In Community A, the main sources of livelihood include fishing and business enterprises, while main sources in Community B are farming, animal husbandry, and business enterprises, as seen in Figure 3. Businesses present in both barangays include micro-retail stores (sari-sari). The hospitality industry was also prominent in Community A due to tourism spots within the island community. All LMs from Community A noted that sources of livelihood exist within their barangay, while majority of LMs from Community B answered that no livelihood programs were present in their community (67%) with the rest identifying tailoring and upholstery as income sources.

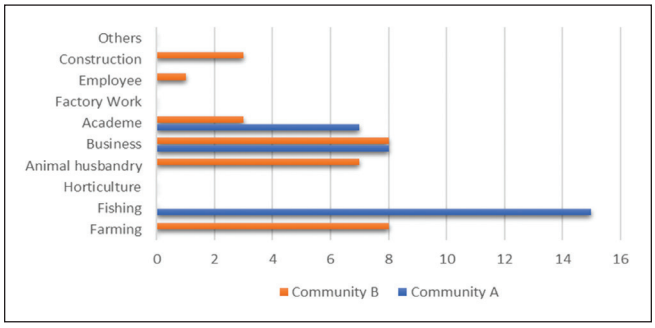


**Figure 3.** Sources of livelihood in both communities.

## Competencies Developed by Local Monitors

Three key competencies have been developed by the LMs. These include effective community engagement and adaptive communication skills, an enhanced understanding and application of health indicators, and the capacity to conduct insightful SWOT analyses. Each competency underscores the LMs' evolving role in effectively addressing the health needs and challenges of their communities.

### *Community Engagement and Adaptive Communication Skills*

Community A defined CE-SM as a "*good project for the barangay as we learn a lot from it especially when it comes to the health of the community. This is a big help for us and we are proud of it. Through it, we serve as role models for the barangay.*" Patience, humility, friendliness, and perseverance were important values LMs continued to uphold, as reported by the LMs themselves. They shared that during Phase 1, LMs roaming the community with pen and paper was often associated by community members as government financial assistance, and people would often get frustrated to find out otherwise. However, during the current phase, they noticed that community members were more open and willing to be interviewed. One of the LMs mentioned, "*When you explain extensively and they understand how and why it is being done, they no longer complain.*" The village head also informed community members to expect house-to-house visits by LMs which helped community members plan their schedules. This provided a solution to a prominent challenge during Phase 1. This emphasizes the important role community leaders play in encouraging community members to participate and engage in initiatives, which are key elements to sustainability.

LMs from Community B provided a similar definition of CE-SM, "*It is a means of assessment where the health needs of each household can be determined so that appropriate solutions can be done.*" They shared the same values and challenges and identified similar opportunities as Community A. They discussed the need to effectively communicate objectives of the strategy to community members and to encourage them to attend meetings. Moreover, passing an ordinance or resolution to effectively implement the strategy was essential.

### *Enhanced Understanding and Application of Health Indicators*

Capacity-building activities, which included two separate face-to-face interactive workshops with social development and social innovations experts, and four virtual praxis sessions with the research team, proved helpful for LMs, as one shared, "*During Phase 1, we really had a difficult time understanding the indicators. I was thinking, what are these for? Since there was no workshop to guide us. This workshop is really a big help for us.*" Moreover, they shared that the strategy provides opportunities to promote health and cleanliness in the barangay and see it as a means to provide livelihood and lobby for policy. In their words, "*..this will be instrumental in helping more people.*"

**Table 5.** SWOT Analysis by LMs of Community A

| | |
|---|---|
| ***Strengths***<br>• You will be encouraged to continue what you are doing<br>• Having a good and positive perspective<br>• Family support | ***Weaknesses***<br>• Negative responses<br>• No support from the family<br>• Having a negative disposition in life |
| ***Opportunities***<br>• Creating an ordinance<br>• Having an effective health center in the community<br>• Cleanliness and sanitation<br>• Beneficial for community members<br>• Livelihood program | ***Challenges***<br>• Negative comments/ responses, but we soldier on<br>• *"My husband told me to stop engaging in volunteer work such as being a local monitor."* |

**Table 6.** SWOT Analysis by LMs of Community B

| | |
|---|---|
| ***Strengths***<br>• Unity in the community<br>• Understanding among members<br>• The drive to continue despite negative responses<br>• Always be ready to engage people | ***Weaknesses***<br>• Making excuses so as not to be interviewed<br>• Hurtful and negative comments |
| ***Opportunities***<br>• Awareness of CE-SM and its importance<br>• To raise awareness on the importance of health in the community<br>• To promote safety | ***Challenges***<br>• How to overcome negative experiences<br>• How to deal with people<br>• How to encourage them to actively participate in the project implementation |

The agenda of each praxis session and its key takeaways are discussed in Table 2.

### *Community-driven Health Initiative Insights: Strengths, Weaknesses, Opportunities, and Challenges*

The purpose and process of mapping and analyzing their strengths, weaknesses, opportunities, and challenges as local monitors were extensively discussed during the first capacity building activity. They were asked to write their insights and discuss their answers to the group afterwards. A social development expert guided them through the process of filling out and reflecting on their answers on the table. The SWOT mapping and analysis done by the LMs are provided in Tables 5 and 6.

### *Engaging Future Potential Local Monitors*

LMs from both barangays shared a similar list of potential LMs. They included daycare workers, barangay treasurers, record keepers, neighbors, community leaders, and youth organizations. LMs from Community B also mentioned that any individual can be a LM as long as they are willing to participate in the CE-SM strategy. This is validated further by the results of praxis sessions where they mentioned that no strict qualifications or skill sets are required for the role. However, it was noted that having good communication and social skills, and familiarity with the community are important qualities. Both barangays shared that humility, kindness, good interpersonal communication skills, and helpfulness are important characteristics of effective LMs.

The LMs shared that to motivate community members to be LMs, the following must be facilitated: 1) provide information on what the job entails, 2) emphasize the importance of building rapport with the community, and 3) ensure that their basic needs are met for them to be able to fulfill their responsibilities.

### *Integration of People-centered Principles of Development towards Health Governance*

CE-SM considers community members as the main stakeholders of and primary actors in their own development. Hence, it was important to engage LMs and help them hone their critical thinking and decision-making skills through capacity-building activities. Additionally, praxis sessions encouraged utilization of a mutual approach of mentoring and coaching to deepen learning and enrich the insights of the community.

Through praxis sessions, CE-SM provided an opportunity for LMs to think about enhancing health indicators used and participate in decision making. They became more engaged and critical during reflection sessions geared towards enhancing SOHG and keeping local leaders accountable.

*"Why should we attend barangay meetings when the officials themselves don't?"* This was shared by a community member from Community B. This emphasizes another important role of government officials in serving as role models for their communities. In contrast, LMs from Community A shared that their challenges in Phase 1 have been mitigated through the support of their village captain. Results of the praxis sessions and capacity-building activities also validate the important role of proactive leadership and support in ensuring efficiency of LMs and sustainability of initiatives. Hence, a dialogue with officials of both villages, particularly the captain and councilor for health, was facilitated as a parallel session during the second capacity-building activity. The session presented factors that facilitated and hindered the performance of LMs in order to identify areas that needed more support from the local government. The captain of Community A, along with four councilors, actively participated in the discussion. They recognized that CE-SM is a strategy that can also be utilized in other non-health initiatives as well. Unfortunately, officials from Community B were not able to join the discussion due to previous commitments.

With the positive results of the expanded pilot implementation and with commitment of the LGU, CE-SM has been incorporated into local policy through a municipal ordinance.

## DISCUSSION

The Seal of Health Governance (SOHG), operational since 2012, provided the foundation for the Municipality of Del Carmen to scale-up community participation and adopt participatory community development principles in the delivery of their health services though the CE-SM strategy. Both communities identified health indicators that were relevant and useful for their contexts, and developed prioritization and critical thinking that ultimately promoted accountability and sustainability.[1] This is consistent with Rifkin's literature review, which emphasized the importance of community-led initiatives for sustainability. It considers community structures, cultural norms, levels of community cohesion, and the specific ways in which participation is facilitated and measured.[13]

Comparing the dynamics and performance of both barangays, it was evident that Community A had a more organized approach to the CE-SM implementation, with strong leadership and commitment of their barangay officials significantly contributing to this, which in turn, boosted the morale of LMs. Despite having competent LMs in Community B, they were not mobilized efficiently. Based on Arnstein's ladder of citizen participation,[14] Community A has freely participated up to the level of partnership to delegation, where they have been part of planning and decision-making. Meanwhile, the level of participation of LMs from Community B falls between consultation and placation, where they actively participate in the implementation but are unable to take part in the decision-making process thus limiting their ability to perform their duties. This is attributed to the lack of political support they receive from their village leaders. Nevertheless, there is room to scale up and move forward if political commitment from barangay officials is established, as facilitative and supportive leadership are known to initiate and sustain community initiatives.[15]

Competencies on decision-making, critical thinking, data utility, processing, and analysis were enhanced during capacity-building and praxis sessions, while interpersonal and relational skills were boosted during performance of their duties. These were recognized as important to ensuring sustainability of the strategy. These sessions served as catalysts to further understand the monitoring and evaluation process and the role of the LMs in improving the social innovations through their observations, analysis, and suggestions, bringing with them the perspectives of their communities, and not just mere gatherers of data – as what they thought in Phase 1.

Characteristics that LMs identified as necessary to carry out tasks were the same characteristics they associate themselves with, such as openness to learning and motivation to work. This is consistent with Holland's theory of interests, which posits that individuals with similar personalities work well together as they create an environment that fits and rewards their type.[16] Fulfilling basic needs is also perceived as a prerequisite for tasks to be effectively carried out, which is consistent with Maslow's idea of the hierarchy of needs.[17]

In summary, CE-SM implementation is deemed viable and sustainable if previously described minimum requirements are provided and are complemented with capacity building-activities and praxis sessions which are grounded on PCD. Political support and commitment, and shared governance with the community are also necessary.

### Assumptions, Limitations, and Recommendations

This study is limited to the initial description of the outputs and outcome of implementing the CE-SM strategy in two remote village communities in the Philippines, which has led to the promulgation of a local municipal ordinance supporting the strategy. Since the study only spans a year, in-depth monitoring and evaluation of the outcomes have not been conducted.

While institutionalizing the CE-SM strategy through a municipal ordinance is expected to provide the necessary enabling environment for its effectiveness, change takes time. Consoli and Mina argue that the diffusion of innovation requires consistent development of training programs to address the varying levels of competencies among local monitors.[18] Additionally, implementers of innovations must feel valued and motivated, as innovation diffuses faster and is more sustainable among highly motivated public health workers.[19]

Achieving a truly sustained policy impact would require structural, procedural, and cultural changes within institutions.[20] One lasting change that should be pursued in the long term is recognizing the critical roles of volunteer local monitors, primarily the barangay (*village*) health workers. During the COVID-19 pandemic, their important role as part of the primary health care team was undeniable.[21] Offering them plantilla (permanent) positions would provide long-term security of tenure and appreciation of their purpose. We acknowledge that creation of plantilla positions may still be an ambitious goal at the moment, but there are non-monetary rewards such as recognition, supervision, and continuous training and support that can be afforded to them to maintain their motivation.[22] The initial project's engagement with Surigao del Norte State University - Del Carmen Campus must be continued, as it can serve as a model academe-local government unit (LGU) partnership for CE-SM. The academe serves as the research and training partner of the LGU to ensure continuous training and supervision of local monitors for long-term sustainability.

Ultimately, staying true to the project's intent of *self-monitoring,* and although still far off in the highly hierarchical nature of the Philippine health system, we anticipate that the continued implementation of the CE-SM strategy will enable a cultural shift. This shift, we hope, would involve changing power dynamics and facilitating more equitable and collaborative practices, where local monitors actively contribute to and influence health strategies and policies.

## CONCLUSION

The study demonstrates the pivotal role that community engagement and leadership play in motivating and empowering communities to actively participate in SIs. It has demonstrated that integrating praxis sessions and capacity-building activities in the strategy provide safe spaces for grounded reflection and learning exchange that ensure relevance and sustainability of CE-SM. Furthermore, integrating PCD approaches towards health governance is crucial. Proactive leadership and political commitment are important aspects of the strategy, which has significantly influenced the performance of both barangays.

Communities were shown to be capable of implementing projects and programs aimed at improving their well-being. Implementation as an organized group simultaneously increases human capital and maximizes social capital.[23] The important role of human and social capital has been highlighted throughout the strategy implementation. These findings may inform creation of a manual that can help disseminate the strategy and serve as a guide for communities. Ultimately, CE-SM has been proven to be a viable and sustainable strategy that can be integrated into health projects and shows promise for initiatives that extend beyond health.

It is of note that the CE-SM strategy was implemented in a rural area in the Philippines, hence, future studies would need to contextualize the strategy as the community sees fit. A follow up study would also be beneficial to assess long-term health outcomes and provide more insights into the strategy's sustainability.

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### Availability of Data and Materials

The datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

### Statement of Authorship

All authors certified fulfillment of ICMJE authorship criteria.

### Author Disclosure

All authors declared no conflicts of interest.

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# APPENDICES

## **Appendix A.** Self-Evaluation Questionnaire (in English)

### Self-Evaluation

Community Engagement Self-Monitoring (CE-SM) Strategy for Social Innovations in Health:
Phase II of the Pilot Implementation in the Philippines

**I. Demographics**

*Instructions: Please fill out legibly.*

| | |
|---|---|
| Name | |
| Age | |
| Barangay | ___ Single ___ Married ___ Separated |
| Designation | |

**II. Level of Competence**

*Instructions: Please put an "x" in the space that corresponds to how you rate the following statements based on: (1) level of capability as reflected by the question: Was this accomplished during Phase I? and (2) level of priority for development as reflected by the question: How important is this for the project?*

| 1 = Did not do at all<br>2 = Seldom done<br>3 = Frequently done | 1 = Not important<br>2 = Slightly important<br>3 = Very important |
|---|---|

| *Level of Competence*<br>**Planning Phase** | **Was this accomplished during Phase I?** | | | **How important is this for the project?** | | |
|---|---|---|---|---|---|---|
| | **1** | **2** | **3** | **1** | **2** | **3** |
| 1. Maintain regular communication with community leaders and community members | | | | | | |
| 2. Identification of individual roles and responsibilities within the team environment | | | | | | |
| 3. Seeking advice and assistance from legitimate sources when appropriate | | | | | | |
| 4. Respect for other local monitors' opinions and insights | | | | | | |
| 5. Able to strategize on how to approach the implementation of CE-SM | | | | | | |

| *Level of Competence*<br>**Data Collection** | **Was this accomplished during Phase I?** | | | **How important is this for the project?** | | |
|---|---|---|---|---|---|---|
| | **1** | **2** | **3** | **1** | **2** | **3** |
| 1. Able to explain the purpose and objectives of CE-SM to the community members/ participants | | | | | | |
| 2. Exhibits effective questioning, active listening and speaking skills to gather and convey information | | | | | | |
| 3. Able to document all responses from participants | | | | | | |
| 4. Uses data validation techniques | | | | | | |

| *Level of Competence* Data Analysis | Was this accomplished during Phase I? | | | How important is this for the project? | | |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 1 | 2 | 3 |
| 1. Able to explain the implications of data gathered and collected in real life settings | | | | | | |
| 2. Summarizing, analyzing, and generalizing skills are used to extract salient points in the data | | | | | | |
| 3. Utilized defined workplace procedures for the location and storage of information | | | | | | |

### III. Core Behavioral Competencies

*Instructions: Please shade the circle of the competency indicators that you demonstrated during the performance cycle.*

| Core Behavioral Competencies | Total |
|---|---|
| ***Self-management*** | |
| ○ 1. Sets personal goals and directions, needs, and development. | |
| ○ 2. Undertakes personal actions and behavior that are clear and purposive and takes into account personal goals and values congruent to that of the organization. | |
| ○ 3. Personal strengths and achievements, based on self-assessment strategies and peer feedback, are contemplated. | |
| ***Professionalism and Ethics*** | |
| ○ 1. Maintains a professional image: being trustworthy, regularity of attendance and punctuality, good grooming and communication. | |
| ○ 2. Exhibits willingness to learn new skills and competencies. | |
| ○ 3. Own work is adjusted, incorporating recommendations that address performance issues. | |
| ***Innovation*** | |
| ○ 1. Examines the root cause of problems and suggests effective solutions. Foster new ideas, processes and suggests better ways to do things. | |
| ○ 2. Demonstrates an ability to think "beyond the box". Continuously focuses on improving personal productivity to create higher value and results. | |
| ○ 3. Demonstrates resourcefulness and the ability to succeed with minimal resources. | |
| ***Self-reflection*** | |
| ○ 1. Feels accomplished after doing tasks. | |
| ○ 2. Willing to be of service for the community. | |
| ○ 3. Believes in the purpose and the objectives of CE-SM. | |

### IV. Factors Affecting Level of Competence of Local Monitors

*Instructions: Place a checkmark on the items you think influences your level of competence as a local monitor.*

1 = Low
2 = Moderate
3 = High influence

| Personal Factors | Level of Importance | | |
|---|---|---|---|
| | 1 | 2 | 3 |
| 1. Formal education related to current work | | | |
| 2. Previous training and seminars | | | |
| 3. Self-confidence in doing tasks at hand | | | |
| 4. Communication skills | | | |
| 5. Proficiency in using technology (computers, etc.) | | | |

1 = Low
2 = Moderate
3 = High influence

| Environmental Factors | Level of Importance | | |
|---|---|---|---|
| | 1 | 2 | 3 |
| 1. Proper information & communication system | | | |
| 2. Appropriate utilization of records and reports | | | |
| 3. Enough supplies, materials & equipment | | | |
| 4. Condition of barangay facilities | | | |

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## **Appendix B.** Community Engagement Self-Monitoring Profiling Tool

**A. Lokasyon**

| 1. Bilang at Pangalan ng Kalye | 2. Purok / Village | 3. Barangay | 4. Bayan | 5. Probinsiya |
|---|---|---|---|---|
| | | | | |

**B. Katangiang Demograpiko**

**B.1. Katangiang Demograpiko ng Respondente**

| 5. Pangalan<br>I-tsek kung ikaw ay "head" ng iyong pamilya ☐ | 6. Kasarian | 7. Edad | 8. Katayuang Sibil | 9. Edukasyong Natapos | 10. Trabaho | 11. Kabuuang kita / buwan (PhP) | 12. Relihiyon | 13. Wika | 14. Diyalekto |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

**B2. Katangiang Demograpiko ng Kasambahay**

| 15. Pangalan | 16. Relasyon mo sa kanila | 17. Kasarian | 18. Edad | 19. Katayuang Sibil | 20. Edukasyong Natapos | 21. Trabaho | 22. Kabuuang kita / buwan (PhP) | 23. Relihiyon | 24. Wika | 25. Diyalekto |
|---|---|---|---|---|---|---|---|---|---|---|
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| **26. Kabuuang Bilang ng Kasambahay*** | | **27. Kabuuang Kita kada buwan**** | |
|---|---|---|---|

*isama ang sarili sa bilang

**Relasyon mo sakanila**
1-asawang lalake
2-asawang babae
3-anak
4-magulang
5-kapatid
6-manugang
7-apo
8-hipag/bayaw
9-lolo/lola
10- pamangkin
11-pinsan
12 - biyenan
13 - iba pa

**Kasarian**
1-lalake
2-babae

**Katayuang Sibil**
1-binata/dalaga
2-may-asawa
3-hiwalay
4-biyudo/biyuda
5-live-in

**Edukasyong Natapos**
1- No formal education
2 - Primary Level
3 - Elementary level
4 - Elementary graduate
5 - HS level
6 - HS Graduate
7-college level
8-college graduate
9-vocational
10-below school ag
11-post-graduate (MA, Ph.D)

**isama ang kita mo sa bilang

**Relihiyon**
1-Katoliko
2-Iglesia ni Kristo
3-Born-Again
4-Protestante
5-Mormon
6-Muslim
7-Baptist
8-Jehova

**Wika**
1-Filipino
2-English
3-Arabic
4-Niponggo
5-iba pa, tukuyin

**Diyalekto**
1-Ilokano
2-Kapampangan
3-Panggalatok
4-Bisaya
5-Ilonggo
6-Chabacano
7-Waray
8-Ibanag
9-Bikolano
10-Tagalog
11. Iba pa, tukuyin

**B.3. Migrasyon**

**28. Orihinal po ba kayo sa barangay?** ☐ Oo *(dumiretso sa 29)* ☐ Hindi (*magtungo sa 28.a at 28.b* )

28. a. Kung hindi, orihinal sa barangay, saan po kayo galing o nagmula? _____

28. b. Ilang taon na po kayo sa barangay? _____ taon

**29. May plano pa po ba kayong lumipat ng ibang lugar?** ☐ Meron (*magtungo sa 29a. at 29.b* ) ☐ Wala (*magtungo sa 29.c* )

29. a. Kung meron, bakit?_____

29. b. Kung meron, saan niyo plano lumipat? _____

29. c. Kung wala, bakit? _____



**C. Mga Organisasyon sa Barangay**

**30. Anu-ano po ang mga organisasyon na nasa inyong barangay?**

☐ samahan ng kababaihan ☐ PTA (Parent-Teacher Association) ☐ homeowner's association ☐ barangay council ☐ barangay dev't council ☐ NGOs (non-government organizations) ☐ POs (people's organization) ☐ hindi ko alam ☐ iba pa: _____

**31. Miyembro po ba kayo ng anumang organisasyon sa baranagay?** ☐ Oo (*Magtungo sa 31.b at sagutan hanggang 31.d)* ☐ Hindi *(Magtungo sa 31.a)*

31.a. Kung hindi, bakit? _____ *(Magtungo sa 32)*

**31.b. Sa anu-anong organisasyon kayo miyembro?** _____

**31.c. Opisyal po ba kayo ng mga organisasyong ito?** ☐ Oo ☐ Hindi

**31.d. Ano ang pangunahing layunin ng inyong organisasyon?**

☐ pangkabuhayan/pautang ☐ kagalingan ng mga babae ☐ katiwasayan at kaayusan ☐ pagprotekta sa kalikasan ☐ kagalingan ng kabataan ☐ kalusugan at nutrisyon ☐ politikal ☐ isports at rekreasyon ☐ edukasyon ☐ agrikultura ☐ relihiyon ☐ lupa ☐ iba pa _____

**C.1. Partisipasyong Pang-komunidad**

**32. Kayo po ba ay nakikiisa sa mga gawaing barangay?** ☐ Oo *(Tumungo sa 32.a)* ☐ Hindi *(Dumiretso sa 33)*

**32.a. Kung oo, ano po ang uri ng inyong partisipasyon?** ☐ pag-enganyo sa iba na sumali ☐ aktibong pakikilahok sa mga proyekto/gawain ☐ pakikilahok sa mga pagpupulong ☐ pag-ambag ng perang kontribusyon ☐ iba pa _____

**33. Anu po ang ginagagawa ng lokal na opisyal para mahikayat ang partisipasyon ng mga tao sa gawaing pang-barangay?**

☐ nagbabahay-bahay ☐ pag-aanunsiyo ng mga proyekto ng barangay ☐ pagsasagawa ng pulong sa barangay ☐ pagbibigay ng mga sulat ☐ iba pa: _____

**34. Sa anu-anong pagkakataon nagkikita at nagsasama-sama ang mga miyembro ng komunidad?**

☐ pagpupulong sa barangay ☐ medical and dental mission ☐ gawain sa paaralan ☐ kasal ☐ libing ☐ pista ☐ iba pa, tukuyin _____

**35. Maliban sa mga opisyales ng barangay, meron pa po bang ibang indibidwal ang nangunguna sa gawaing pang-barangay o gawaing pangkaunlaran ng barangay?** ☐ Meron *(Tumungo sa 36.a at sagutan hanggang 36.d.1)* ☐ Wala (*Dumiretso sa 37)*

**36.a. Kung meron, anu-anong organisasyon ito?** _____

**36.b. Ano ang / ang mga proyekto ng nasabing organisasyon sa barangay?**

☐ pangkabuhayan/pautang ☐ kagalingan ng mga babae ☐ katiwasayan at kaayusan ☐ lupa ☐ pagprotekta sa kalikasan ☐ kagalingan ng kabataan ☐ kalusugan at nutrisyon ☐ politikal ☐ isports at rekreasyon ☐ edukasyon ☐ agrikultura ☐ relihiyon ☐ iba pa _____

**36.c. Sinu-sino ang nakikinabang sa mga proyekto o gawaing pangkaunlaran ng mga nasabing organisasyon o indibidwal?**

☐ lahat ng kabahayan ☐ karamihan sa kabahayan ☐ kaunting kabahayan lang ☐ di ko alam

**36.d. Nakikiisa ba kayo sa gawain o proyekto ng mga organisasyong ito?** ☐ Oo *(Tumungo sa 36.d.1)* ☐ Hindi *(Dumiretso sa 37)*

**36.d.1. Kung oo, ano ang uri ng inyong partisipasyon sa nasabing gawain o proyekto?**

☐ pakikilahok sa pagpupulong ☐ paggamit ng serbisyo o pagtangkilik sa proyekto ☐ pagtulong sa pagsasagawa ng proyekto ☐ pagtulong pinansiyal ☐ iba pa, tukuyin _____

**36.d.2. Mayroon po ba kayong nalahukang training nitong nakaraang taon?**

☐ Oo, tukuyin: _____ ☐ Wala

**D. Katangiang Sosyo-Ekonomiko**

**D.1.Estadong Pang-ekonomiya ng Komunidad**

**37. Anu-ano ang mga klase ng trabaho meron sa inyong barangay?**

☐ pagsasaka ☐ pangingisda ☐ horticulture ☐ paghahayupan ☐ pag-nenegosyo ☐ pagtuturo ☐ factory worker ☐ empleyado ☐ konstruksyon ☐ Iba pa, tukuyin _____

**38. Anu-ano ang mga klase ng negosyo o kumpanya meron sa inyong barangay?**

☐ retail shops o sari-sari store ☐ agricultural products ☐ factory ☐ negosyong pang-serbisyo (paaralan, bangko, iba pa) ☐ kainan ☐ resorts ☐ Iba pa, tukuyin _____

**39. Meron po bang mga proyektong pangkabuhayan ang inyong barangay?** ☐ meron (*Tumungo sa 39.a. at 39.b* ) ☐ wala (*Dumiretso sa paglagda ng pangalan, petsa, at pirma sa baba* )

**39.a. Kung meron, anu-ano ito?** _____

**39.b. Sino ang nagpopondo ng mga ito?** ☐ lokal na pamahalaan ☐ NGOs / Pos ☐ korporasyon o negosyo ☐ kooperatiba ☐ micro-finance ☐ iba pa _____

| Pangalan ng sumagot | Petsa | Pirma |
|---|---|---|
| | | |

## **Appendix C.** Post-Workshop Evaluation Form (English Version)

Community Engagement Self-Monitoring (CE-SM) Strategy for Social Innovations in Health:
Phase II of the Pilot Implementation in the Philippines

*We would like to hear from you. Your honest assessment will help us improve the training course. Please fill out the form. We will treat your responses with confidentiality.*

*Please rate (x) the following items in terms of your satisfaction:*
*Pakilagyan ng (x) ang kahon na sumasalamin sa iyong sagot.*

5 = Strongly agree
4 = Agree
3 = Neutral
2 = Disagree
1 = Strongly disagree

| Workshop Evaluation Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| ***Workshop Objectives*** | | | | | |
| a. The objectives were clearly stated. | | | | | |
| b. The objectives were met. | | | | | |
| ***Topics*** | | | | | |
| a. The topics were relevant to the stated objectives. | | | | | |
| b. The topics were discussed clearly. | | | | | |
| c. The topics offered me insights and/or knowledge about community engagement. | | | | | |
| d. The topics offered me insights and/or knowledge about praxis. | | | | | |
| e. The content can be applied to my work. | | | | | |
| ***Methodology*** | | | | | |
| a. The methods used (group discussion, lecture-type) were appropriate to achieve desired outputs. | | | | | |
| b. The methods used provided optimum interaction between and among the resource persons and participants. | | | | | |
| c. The course dynamics were conducive to optimum learning | | | | | |
| ***Presentation and Visual Aids*** | | | | | |
| a. The presentation was clear and concise. | | | | | |
| b. The visual aids and materials were adequate and suitable to facilitate learning. | | | | | |
| ***Time*** | | | | | |
| a. The workshop started and ended on time. | | | | | |
| b. Time allotted was sufficient to cover all activities. | | | | | |
| c. Time spent in the workshop was worthwhile. | | | | | |

*What other suggestions or comments do you have regarding the workshop?*