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Strengthening Local Governance for Health (HealthGov) Project

First Annual Work Plan
October 1, 2006 to September 30, 2007

Cooperative Agreement No. 492-A-00-06-00037
(Revised) March 30, 2007

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This publication was produced for review by the
United States Agency for International Development/Manila

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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List of Acronyms

AO	administrative order
ARMM	Autonomous Region in Muslim Mindanao
BHW	<i>barangay</i> (village) health worker
CA	cooperating agency
CDLMIS	Contraceptive Distribution and Logistics Management Information System
CEDPA	Centre for Development and Population Activities
CHD	Center for Health Development
COP	Chief of Party
CSO	civil society organization
CSR	Contraceptive Self-reliance
CTO	Cognizant Technical Officer
DBM	Department of Budget and Management
DCOP	Deputy Chief of Party
DILG	Department of the Interior and Local Government
DOH	Department of Health
F1	FOURmula ONE
FHSIS	Field Health Services Information System
FP	family planning
FPS	Family Planning Survey
GAD	gender and development
HealthGov	Strengthening Local Governance for Health Project
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	health management information system
HPDP	Health Policy Development Project
HR	human resource
HRHMD	Human Resource for Health Management and Development
HSR	Health Sector Reform
ILHZ	inter-local health zone
IR	intermediate result
IRA	internal revenue allotment
IT	information technology
LAC	local AIDS council
LCE	local chief executive
LEAD	Local Enhancement and Development for Health Project
LGU	local government unit
LMP	League of Municipalities of the Philippines
LPP	League of Provinces of the Philippines
LSI	Living Standards Index

M&E	monitoring and evaluation
MARP	most-at-risk population
MCH	maternal and child health
MHO	Municipal Health Office/Officer
MIS	management information system
MOA	memorandum of agreement
NCDPC	National Center for Disease Prevention and Control
NCR	National Capital Region
NDHS	National Demographic and Health Survey
NEDA	National Economic and Development Authority
NGA	national government agency
NGO	non-governmental organization
OIDCI	Orient Integrated Development Consultants, Inc.
OP	operational plan
PBG	performance-based grant
PHB	Provincial Health Board
PHIC	Philippine Health Insurance Corporation
PhilHealth	Philippine Health Insurance Corporation
PHN	Public Health Nurse
PHO	Provincial Health Office/Officer
PHTL	Provincial Health Team Leader
PIPH	Province-wide Investment Plan for Health
PMG	Project Management Group
PMT	Provincial Management Team
PNGOC	Philippine Non-governmental Organization Council on Population, Health and Welfare, Inc.
POPCOM	Commission on Population
PPA	program, projects, activities
PPT	Province-wide Planning Team
PRISM	Private Sector Mobilization – Family Planning
PSEP	Public Service Excellence Program
QPA	quick participatory appraisal
RCT	Regional Composite Team
RH	reproductive health
RHM	Rural Health Midwife
RICT	Regional Implementation and Coordination Team
RNA	rapid needs assessment
RTI	Research Triangle Institute
SA	situational analysis
SBMR	Standard-based Management with Recognition
SDAH	Sector Development Approach to Health

SDIR	Service Delivery Implementation Review
SHIELD -ARMM	Sustainable Health Initiatives through Empowerment and Local Development Project – Autonomous Region in Muslim Mindanao
SOAG	Strategic Objective Agreement
SPA	selective participatory appraisal
STI	sexually transmitted infection
STTA	short-term technical assistance
TA	technical assistance
TAP	technical assistance provider
TB	tuberculosis
TB LINC	Linking Initiatives and Networking to Control Tuberculosis Project
TL	Team Leader
TOT	training of trainers
TPA	total participatory appraisal
USAID	United States Agency for International Development
USAID/OH	United States Agency for International Development/Office of Health
USG	United States Government

1. Purpose and Program Overview

The *Strengthening Local Governance for Health* (HealthGov) Project is USAID's flagship effort to strengthen LGUs' commitment to and support for public health services and their capacity to provide, manage, and finance quality health services sustainably, particularly family planning (FP), maternal and child health (MCH), tuberculosis (TB), and HIV/AIDS services. The project focuses on empowering LGU staff and developing their capacity to meet the organizational, financial, and systems development challenges to meet emerging health needs. It also addresses building the capacity of NGOs and civil society to advocate successfully for improved health services. The HealthGov Project is managed by RTI International in partnership with JHPIEGO, CEDPA, PNGOC, and OIDCI.

Focusing on sustainable solutions, HealthGov will develop LGU capacity for continuous participatory problem solving, build support for investing in health within the LGU, and increase the participation and advocacy skills of civil society. At the same time, HealthGov will develop a network of technical assistance providers or TAPs (e.g., universities, NGOs, consultants, government agencies) that LGUs may engage to provide them with customized training and technical assistance (TA) services to solve key problems. In addition to improved health outcomes, sustainable "success" as a result of HealthGov assistance will be achieved when an LGU can properly identify its health sector problems and practical solutions in a participatory manner, and has access to sufficient resources (financial and technical, internal and external) to solve these problems.

HealthGov will build the capacity of as well as help broker and develop long-term sustainable relationships between (1) LGUs and local technical assistance provider organizations that will help build LGU skills and knowledge; and (2) LGUs and their constituents to improve the quality and accessibility of health services. To build this capacity, HealthGov will focus on four key activity areas, which correspond to the results framework of USAID's SO3: Improved Family Health Sustainably Achieved:

- ***Strengthening LGU management systems (IR 1.1)*** – HealthGov will help LGUs (1) effectively integrate health planning and budgeting functions into the overall government system; (2) improve management systems including inter-local health zone (ILHZ) management, planning and budgeting, financial management, drug/commodity logistics and procurement, and the use of self-assessment techniques and health management information system (HMIS) to diagnose priority problems; and (3) institutionalize multi-stakeholder coordination mechanisms at the provincial level to share best practices, plan together, and leverage resources.
- ***Improving and expanding LGU financing for health (IR 1.2)*** – HealthGov will (1) support LGUs integrate priorities into multi-year investment plans, explore national and local partnerships to sustain HIV/AIDS surveillance and prevention activities, and work on ensuring LGU GAD (gender and development) planning and budgeting includes health; (2) introduce performance-based budgeting to LGUs; (3) help LGUs diversify their financial base; and (4) help LGUs complete market segmentation.

- **Improving service provider performance (IR 1.3)** – HealthGov will (1) help LGUs improve human resource management, (2) strengthen health service quality assurance systems, (3) strengthen health provider training systems, and (4) help LGUs improve their response to infectious diseases including TB and HIV/AIDS.
- **Increasing advocacy for health (IR 1.4)** – HealthGov will (1) increase LGU officials’ and leaders’ commitment to health by providing advocacy training for TAPs and introducing advocacy concepts during LGU orientation and participatory planning workshops; (2) strengthen the capacity of health providers and civil society champions to develop and deliver effective health advocacy messages to local government officials and decision-makers; (3) increase civil society advocacy and participation with training and grants; and (4) increase partnerships between health providers and civil society to promote supportive policies and priority health programs, and increase opportunities and forums where information is shared and consensus is built.

Over the five-year project period, HealthGov will build local capacity to improve health services and systems in over 500 LGUs located in 23 provinces spread across three major areas of the country: Luzon, Visayas, and non-ARMM Mindanao (see map below). The provinces where HealthGov will work were selected in close consultation with the Department of Health (DOH) and USAID and include three categories of provinces and HIV/AIDS high-risk zones:

F1 sites:	Pangasinan, Capiz, Oriental Negros, Misamis Occidental, South Cotabato
F1 Roll-out sites (convergence sites):	Isabela, Zamboanga del Norte, Zamboanga del Sur, Zamboanga Sibugay, Compostela Valley, Sarangani
Other HealthGov sites:	Bulacan, Nueva Ecija, Albay, Negros Occidental, Agusan del Norte, Bukidnon, Davao del Sur, Tarlac, Cagayan, Aklan, Bohol, Misamis Oriental
HIV/AIDS high-risk zones:	Clark Development Zone (Angeles and San Fernando), Metro Manila (Pasay City and Quezon City), Iloilo and Bacolod, Metro Cebu (Lapu-Lapu, Mandaue, and Cebu City), Zamboanga City, Davao City, and General Santos City

This First Year Work Plan describes the proposed activities during the first year of the project. This introduction (**Chapter 1**) is followed by an overview of project management and mobilization and details of the progress to date of key mobilization activities (**Chapter 2**). Our project implementation approach is described in **Chapter 3**, which includes an overview of the LGU engagement strategy for the life of the project and the detailed activities that will be implemented in Year 1. A different approach was developed for each of the four categories of LGUs described above (i.e., F1 sites, F1 roll-out sites, other HealthGov sites, and HIV/AIDS high-risk zones).

To start the provision of technical assistance (TA) to the LGUs and set the stage for broader and more long-term support provided by TAPs, we will focus on a limited number of strategic interventions in Year 1. These are described in **Chapter 4** and include (1) support for the implementation or preparation of the Province-wide Investment Plan for Health (PIPH); (2) support for the implementation of Contraceptive Self-reliance (CSR), and; (3) the preparation of a province-wide Service Delivery Implementation Review (SDIR). Other TA will also be available to LGUs and provided selectively upon request.

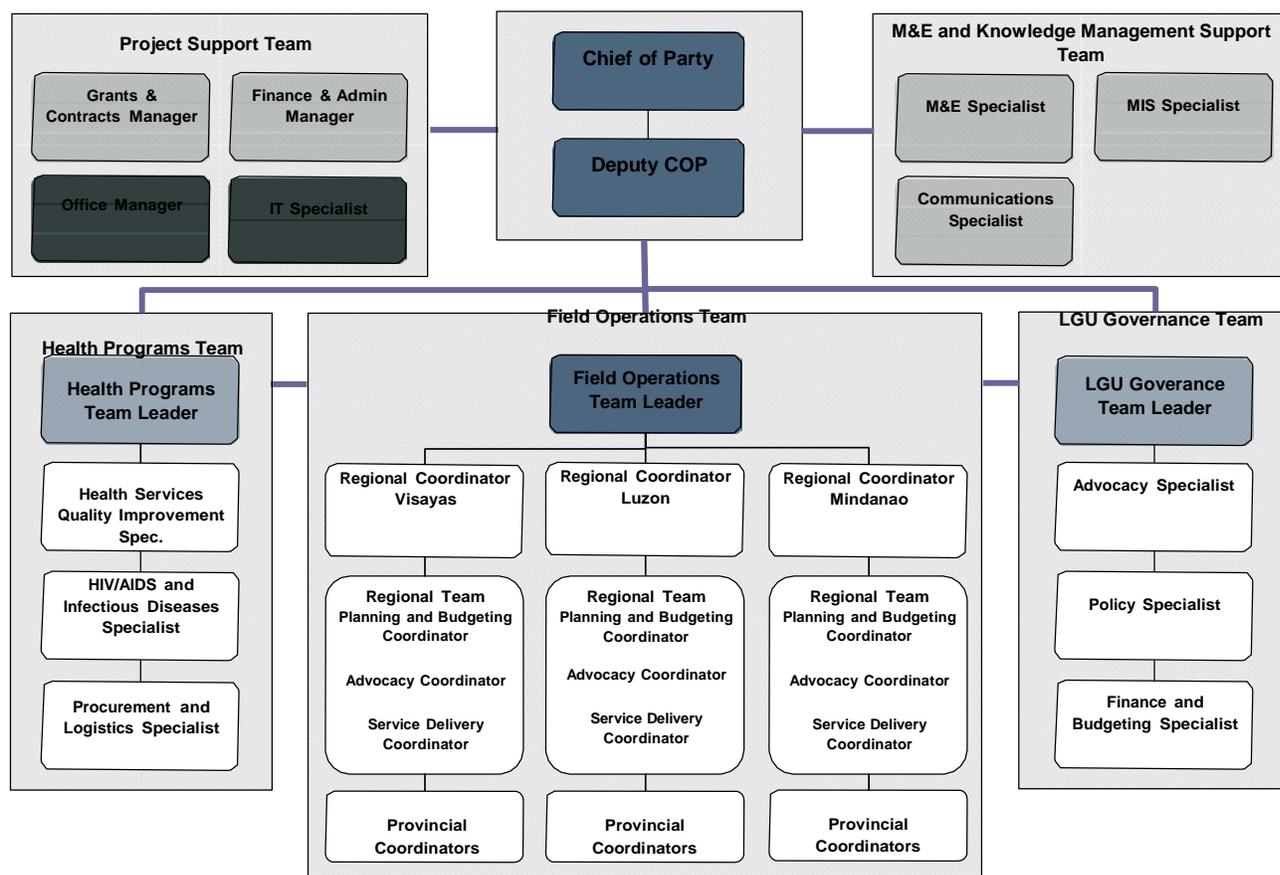
Chapter 5 summarizes the monitoring and evaluation plan for the project and describes the proposed activities for Year 1 to define indicators and determine baseline conditions. Details of the phasing of project activities during Year 1, including a timeline and indicative budget for the main components of the work plan, are included in **Chapter 6**.

2. Project Management and Mobilization

2.1 Organizational structure

HealthGov’s organizational structure is based on a commitment to build a unified team, not a collection of partner-organizations. The HealthGov project comprises three inter-related teams (see organization chart below), which are organized to avoid “silos.” Technical staff will work together in an integrated way across disciplines and in close cooperation with field staff.

HealthGov Organizational Chart



The HealthGov project mobilized in early October 2006 with all five key staff members engaged and on board. Other senior technical staff identified in RTI’s proposal were also mobilized early during the first quarter and the recruitment of additional project staff got under way quickly in time for them to participate in the annual planning workshop. By the end of the second quarter, the majority of the vacant positions were filled according to the required qualifications set.

To build team cohesiveness and a common vision, project staff members attended a number of internal conferences during the first and second quarters. The purpose of these forums was to plan the first-year work plan and cross-train staff in all

project technical areas. Topics covered in the cross-orientations included: the local government code, Tiaht Amendment and the Mexico City Policy, advocacy concepts and processes, civil society dynamics, Standard-based Management with Recognition (SBM-R) approach, DOH/HRHMD, the inter-local health zone concept, and administrative orders (AOs) issued by the DOH that require the participation of and implementation by the LGUs, and USAID cooperating agencies (CAs) coordination. Orientation was also provided on the DOH FOURmula ONE for Health policy framework and the implementation of the Province-wide Investment Plan for Health (PIPH).

Cross-training has created a common understanding of all project activities and of all team members' roles and responsibilities. Training will continue to be provided on an as-needed basis throughout Year 1 of the project and will serve as one of the avenues for information updating and sharing among the staff.

2.2 Responsibilities of project management and lines of authority

The overall organizational structure of the project supports its internal organization. The organizational structure delineates clear lines of authority, allocates responsibilities and tasks to individual team members, and provides venues and open communication channels between the project teams and individual team members.

- Project Management Group** – Chaired by the Chief of Party or the Deputy Chief of Party, the Project Management Group (PMG) provides overall technical and operational management to the project; it will meet weekly or as needed. PMG members will also maintain and participate in a network of alliances, contacts, and communications that will enable HealthGov to successfully engage, coordinate, and leverage resources from counterparts in USAID, other USAID/OH projects, the DOH and other line departments (DILG, NEDA, DBM), PhilHealth, and other donors. The PMG leads work plan development and project monitoring, integrates technical inputs needed for field activities, and ensures that field, technical, and administrative support staff coordinate and work together to cross-fertilize project activities. USAID and members of the management teams of other OH projects will be periodically invited to PMG and project staff meetings to ensure coordination of project activities.
- Project Management Group**

 - Chief of Party
 - Deputy Chief of Party
 - LGU Governance Team Leader
 - Health Programs Team Leader
 - Field Operations Team Leader
 - Finance Manager
- Chief of Party** – The Chief of Party (COP) will provide overall project technical vision and be the focal point for all management decisions. He will coordinate partner organizations' input into project implementation and be the principal point of contact with USAID, line departments, and donors to coordinate project activities and disseminate information on lessons learned. The COP will bear ultimate responsibility for all project management tasks, including financial

management, cost control, grants management, performance monitoring, reporting, and client relations. He will chair the Project Management Group and provide technical support in local governance systems. He will coordinate with and receive support from the RTI International Home Office Technical Manager.

- **Deputy Chief of Party** – The Deputy Chief of Party (DCOP) will have direct management oversight of the Field Operations Team, including the three regional offices based in Luzon (at the project head office in Manila), Iloilo (for Visayas), and Cagayan de Oro (for Mindanao), and the Health Programs and LGU Governance Teams. She will have responsibility for resolving project operational, management, and implementation issues; leading the project's progress monitoring and reporting tasks; and providing technical support to health systems and service activities. The DCOP will be the alternate chair of the PMG and support the COP in communicating with and being responsive to the USAID mission and Philippines government counterparts.
- **Team Leaders** – Each field and technical team will be led by a Team Leader (TL). The TLs bring to the project management experience and technical leadership in their respective areas. TLs will provide technical supervision and support to their staff and form strategic partnerships with national-level stakeholders. Team Leaders of the LGU Governance and Health Programs teams will provide technical supervision and support to staff and project consultants and will ensure that TA requests are dealt with promptly and that staff and consultants are quickly mobilized to provide support to the field teams. The Field Operations Team Leader will directly supervise the regional teams based in the three project field offices and will oversee work done on behalf of the project by PNGOC members.
- **Regional Coordinators** – Regional Coordinators will provide direct oversight and support to field-based technical staff and provincial coordinators based in project supported provinces. They will also be responsible for developing strategic partnerships with regional stakeholders and for organizing and convening annual best practice workshops that will be held at the regional level. Regional technical staff will work with national office counterparts to identify and provide capacity building TA to TAPs and to LGUs as needed.
- **Provincial Coordinators** – Provincial Coordinators will provide support to all project activities in the provinces. It is anticipated that each Provincial Coordinator will be responsible for two provinces, depending on size, accessibility, and other factors. They will coordinate activities with Provincial Management Teams and Municipal/City Health Planning and Management Teams and foster strategic partnerships with LGU stakeholders. They will help organize and ensure the quality of LGU participatory planning and needs assessments as well as observational visits of local chief executives (LCEs).

2.3 Other roles and responsibilities

- **Field and Technical Teams** – Field and technical teams will work closely together to provide capacity building assistance to LGUs and TAPs. Technical

team members will have primary responsibility for organizing LGU orientation and best practice workshops; and for identifying, assessing, and building the capacity of TAPs. They will work with their counterparts in regional offices to respond to TA requests; identify and mobilize technical and training TAPs as needed; develop training modules and materials for the field; and conduct training of trainers (TOT). Field Teams will market the project with LGUs (along with provincial coordinators); interact with LCEs, LGU officials, and civil society organizations; conduct participatory planning and needs assessment workshops; help LGUs develop scopes of work for TAPs; identify and coordinate TA needs that require national office and outside support; and provide capacity building TA and training.

- **Monitoring and Evaluation/MIS/Knowledge Management Team** – Reporting to the COP and DCOP, the Monitoring and Evaluation (M&E) and Management Information System (MIS) Specialists are responsible for overseeing and entering activity, performance, and reporting data into the HealthGov database system and tracking project progress. The Communications Specialist is responsible for managing the content and presentation of all project outputs, including project reports, publications, and newsletters. The three specialists will work closely with the Information Technology (IT) Manager and RTI home office to maintain and update the project website, which will contain a knowledge base of all reports, best practice tools, and approaches generated by the project. The website will also post regional, provincial, and LGU-based meetings and events. Any province with internet connectivity can log on and find out what is happening and where.
- **Project Support Team** – Reporting to the COP, the Project Support Team provides project staff and USAID with timely and accurate financial information and supports the PMG and field and technical teams in budgeting, administration, financial management, goods and services procurement, grants management, information technology, and travel coordination.

2.4 Set-up of project offices

HealthGov moved into temporary office space in Ortigas Center in October, while a permanent office was being identified. A permanent national office was subsequently selected and a lease agreement was executed. After the completion of the internal fitting out and furnishings the project moved into the new offices in March 2007. The regional team for Luzon is based at the same office with the national team.

Space has also been identified for the Mindanao regional office, which will be located in Cagayan de Oro, and a lease agreement was signed in January 2007. The office is currently being fitted out and will be occupied in April. A suitable location for the Visayas regional office, based in Iloilo City, was also identified and a lease agreement will be signed in March 2007.

For the procurement of project equipment like computers and printers and project vehicles, RTI requested (and was subsequently awarded) Contracting Officer

approval to purchase budgeted nonexpendable equipment from the GSA schedule. RTI has also submitted a waiver request to purchase certain IT items in the Philippines, and will submit another regarding the purchase of project vehicles.

Office policies and procedures related to travel (i.e., transportation and per diem), expense reimbursements, financial management, procurement, and office communication were established; the Human Resources Handbook is awaiting final approval from the RTI head office.

2.5 Registration and payroll services

RTI has engaged the services of a Philippines-based firm of accountants and management consultants, KPMG Laya, Mananghaya & Co., to assist with the registration of RTI as a legal entity in the Philippines. RTI's registration with the Securities and Exchange Commission was completed in early March 2007 and registration with the Bureau of Internal Revenue is ongoing. KPMG will also manage the payroll services for all RTI employees of the project.

3. Project Implementation

3.1 LGU engagement

Over the life of the project, HealthGov will provide assistance to over 500 LGUs in 23 provinces which were selected by DOH and USAID with input from the project and based on a set of criteria that include population size; health conditions in the areas of FP, MCH, TB, HIV/AIDS, and child nutrition; poverty level; other donor activities; and LCE commitment to pursue health reforms.

To jumpstart a national presence for the project and pave the way for the field activities of the other USAID/OH-supported projects with which HealthGov will be closely coordinating, the project will engage during the first project year all 23 selected provinces and HIV/AIDS high-risk zones (see Figure 1). From Year 2 onwards the project will focus on extending TA to clusters of municipalities and cities while continuing support at the provincial level to maintain the momentum of health reform. The total number of LGUs (including provinces, municipalities and cities) that may benefit directly from HealthGov support could reach 576, although the involvement of LGUs will depend on local needs and priorities and the commitment of local decision-makers to health sector reform.

Year 1 Focus

- Project start-up: staff recruitment, office set-up, registration, procurements, etc.
- Engagement of all participating provinces
- Selection and training of TAPs
- Provision of key TA to support PIPH, CSR and SDIR
- Preparation of annual work plan, marking plan, and M&E plan

The LGU engagement plan takes into account different categories of provinces with respect to health sector reform and other activities. These LGU categories are:

- 1) Initial F1 convergence sites for health sector reform (5 provinces): Pangasinan, Capiz, Oriental Negros, Misamis Occidental, and South Cotabato.
- 2) Roll-out convergence sites for F1 health sector reform (6 provinces): Isabela, Zamboanga del Norte, Zamboanga del Sur, Zamboanga Sibugay, Compostela Valley, and Sarangani.
- 3) Other HealthGov sites (12 provinces): Bulacan, Nueva Ecija, Albay, Negros Occidental, Agusan del Norte, Bukidnon, Davao del Sur, Tarlac, Cagayan, Aklan, Bohol, and Misamis Oriental.
- 4) HIV/AIDS high-risk zones:
 - Clark Development Zone (Angeles City and San Fernando)
 - Metro Manila (Pasay City and Quezon City)
 - Iloilo and Bacolod
 - Metro Cebu (Lapu-Lapu, Mandaue and Cebu City)
 - Zamboanga City
 - Davao City and General Santos City

HealthGov defines LGU engagement as a continuum of activities that starts with the first contact with the LGU – be it a courtesy call with the local chief executive or a meeting with a health program manager – and progresses to the provision of technical assistance and other support, supported by monitoring and evaluation. The engagement process ends with the LGU’s “graduation” from any need for HealthGov-provided TA, training or other support.

HealthGov sees LGU engagement as building and nurturing a relationship with the participating LGU, with each party having its respective roles and responsibilities. Depending on the needs of an LGU, TA may be provided at different points of the continuum. For example, TA to support the province-wide investment planning for health may be provided early on in the engagement process, and is expected to help identify other TA needs.

At regular intervals HealthGov will meet with the LCE, health program managers and other local stakeholders to assess the impact of the TA provided and identify the need for further support. The engagement process will vary in duration depending on an LGU’s readiness and capacity to absorb and pursue its own TA needs in the future, but it is anticipated that a typical LGU will require about two years of TA support. An LGU graduates from the engagement process when it can demonstrate that it has established the capacity to independently sustain the various health systems that have been supported with HealthGov assistance. The readiness of the LGU to graduate will be assessed by a joint team of HealthGov, the CHD and the LGU.

3.2 Start-up of LGU engagement process

The process of engagement commenced with courtesy visits by HealthGov staff to introduce the project and other USAID-supported technical assistance projects to various national government agencies (NGAs) involved in health. The visits sought to secure the commitment and support of these partners who will officially endorse the program to their regional offices. The NGAs include the DOH, the Commission on Population (POPCOM), the Philippine Health Insurance Corporation (PHIC), the Department of the Interior and Local Government (DILG), and the Leagues of Provinces and Municipalities of the Philippines (LPP and LMP). HealthGov will pay similar courtesy visits to national and local partners working on HIV/AIDS.

To start the engagement of the participating provinces, HealthGov regional staff carried out scoping missions in all 23 provinces. These scoping missions included consultations with the directors of the DOH Centers for Health Development (CHDs) and other regional partners such as POPCOM and PHIC to obtain information on individual provinces in the region. For each province, the information gathered included the commitment of local government executives (LCEs) to health; recent health sector developments; and areas where technical assistance may be needed. Subsequently, HealthGov visited individual provinces to introduce the new USAID-funded projects in the health sector, to obtain information from key stakeholders and decision-makers on health sector developments and to identify possible areas for technical support. In some instances, courtesy visits to the Governor were made at the request of the Provincial Health Officer (PHO). The results of the scoping missions were presented during a COP meeting at USAID on 12 March 2007 to

inform other USAID CAs about the needs and opportunities for providing technical assistance.

3.3 LGU engagement by LGU category

3.3.1 Engaging F1 provinces (initial convergence sites)

The first group of provinces supported by HealthGov consists of five of the first set of 16 provinces that DOH, with assistance from donors including USAID, has worked with to implement the F1 health sector reform strategy. Each of these provinces has already prepared a PIPH. Selected national and regional field staff of HealthGov visited the Governor to introduce the HealthGov project and other USAID-supported technical assistance projects. The team offered assistance to work with the appropriate provincial government staff to review the first year implementation plan, consisting of the operational plan, training plan, procurement plan and facility rationalization plan. The first-year PIPH implementation plan includes, among other actions, procedures for incorporating the PIPH into the Local Development Plan, Local Development Investment Plan, and the Annual Investment Plan; procedures for accessing donor grant funds and LGU counterpart funds; financial management; procurement and logistics; and monitoring and evaluation. The preparation of the PIPH implementation plan involves an orientation of appropriate staff on implementation modalities.

In addition, if requested by the Governor, HealthGov will assist the appropriate provincial government staff to review the PIPH and its first-year operational plan to identify additional technical assistance requirements that HealthGov and other USAID-supported projects can provide to help with its execution. These additional requirements may be in the areas of CSR+ implementation, micronutrient supplementation for children, intensified TB control, and M&E system strengthening.

The HealthGov field staff together with provincial government counterparts will prepare for the Governor's approval an overall technical assistance plan that covers the following: (1) preparation or finalization of the PIPH implementation plan; (2) provision of additional technical assistance identified in the review; and (3) provision of technical assistance identified and planned for execution in the PIPH. Based on this plan, TA will be provided by HealthGov staff in coordination with other USAID-supported projects and other donor-funded programs.

3.3.2 Engaging F1 roll-out provinces

The second group of HealthGov provinces includes six of the 19 new sites that DOH has identified for expansion of its F1 assistance program together with a number of donors including USAID. For these roll-out sites, the focus of HealthGov assistance will be on helping the provinces to prepare the PIPH. A Regional Composite Team (RCT)¹ will visit the Governor to introduce HealthGov and the other USAID-

¹ Composed of CHD Regional Director, HealthGov, and other CAs who will train the Province-wide Planning Team

supported TA projects. The team will offer to assist the Governor to prepare the PIPH, which may serve as basis for identifying priority areas for which LGU resources could be utilized as well as for potential donor assistance. The team will formulate a plan for the preparation of the PIPH for approval by the Governor. This is expected to occur in July 2007.

The preparation of the PIPH will consist of a number of activities organized by the RCT. This will start with an orientation on health sector reform principles and strategies and the health investment planning process for the PHO and other provincial government staff who will comprise the Province-wide Planning Team (PPT). The PPT of each province will organize and oversee the PIPH preparation process with assistance from the RCT. The process will be organized around a number of provincial-level meetings and workshops.

Upon completion, the PPT will present the PIPH to the Governor, who will then present the plan to a wider body of stakeholders for discussion, review and possible revision, and to donors for funding support. Where DOH and donors require, a joint DOH and donor review committee may be formed to review and offer recommendations for finalization of grant or loan approval. The next step will be to help integrate the approved PIPH into the Local Development Plan, Local Development Investment Plan, and Annual Investment Plan. This process will take up to end of September 2007, in time for submission of the budget request for year 2008. An implementation plan will then be prepared for the actual provision of further TA by HealthGov, other USAID-supported TA projects, and other donor-assisted TA projects.

3.3.3 Engaging other HealthGov provinces

The third group of provinces includes the remaining HealthGov project sites outside of the initial F1 sites and the F1 convergence sites. As in the F1 roll-out sites, the RCT will visit the Governor to introduce HealthGov and the other USAID-supported TA projects. The team will offer to assist the Governor in the preparation of a PIPH. Since donor assistance in these provinces has not been identified, the PIPH will serve as a basis for determining priority areas where the LGUs can invest resources to improve health outcomes. The RCT team will formulate a plan for the preparation of this PIPH for approval by the Governor. The plan will include the formation of a PPT that will oversee the development and completion of the PIPH in the respective provinces.

The preparation of the PIPH will consist of a number of activities organized by the RCT similar to those to be undertaken by the F1 roll-out provinces. This will start with an orientation of the PPT on health sector reform principles and strategies and the health investment planning process, followed by planning workshops on key activities in plan preparations. These activities will start after the elections and will be completed by August 2007.

The PPT will present the PIPH to the Governor, who will present the plan to a wider body of stakeholders for discussion, review and possible revision, and for final approval and incorporation into the Local Development Plan, Local Development

Investment Plan, and Annual Investment Plan. This process will take up to the end of September 2007 in time for submission of the budget request for 2008.

3.3.4 Engaging HIV/AIDS high-risk zones

HealthGov will adopt some of the steps used in the FI roll-out sites to engage the HIV/AIDS high risk zones. As a first step, HealthGov will organize an orientation on health sector reform principles and strategies and the investment planning process for HealthGov staff, DOH-NCDPC (NASPCP - National AIDS/STI Prevention and Control Program) as well as CHD program coordinators for HIV/AIDS in the National Capital Region (NCR) and Regions 3, 6, 7, 9, 11 and 12. From the participants a core team similar to the RCT will be selected to engage HIV/AIDS high-risk zones.

The project team will visit the respective mayors in the zones to offer assistance in updating the HIV/AIDS strategic plan and the formulation of an investment plan and operational plan as the basis for mobilizing financing from local and external sources. Similar to the PPT in F1 roll-out sites, a local planning team designated by the mayor will be organized. The team will include the City Planning and Development Officer, City Health Officer, Chief of the Technical Division, Social Hygiene Clinic Physician, *Sangguniang Panglungsod* (city legislative council) member who chairs the Committee on Health and others selected by the mayor. The local planning team will also be oriented on the principles and strategies of health sector reform as applicable to HIV/AIDS.

The planning process in the HIV/AIDS high risk zones will follow the general guidelines used for PIPH with some modifications to specific HIV/AIDS concerns. A situation analysis will be conducted to involve selected *barangay* (village) stakeholders with most-at-risk populations (MARPs) and members of the local AIDS council (LAC).

The expected outputs from the planning process include:

- update on current HIV/AIDS status;
- goals and targets with appropriate measurable indicators;
- a matrix detailing interventions, activities, indicators and time line, with interventions to include improved access to HIV/AIDS/ STI services and voluntary counseling and testing;
- a set of cost tables and financing sources, including grants to NGO for implementing identified priority interventions;
- barangay, private sector, NGO, and civil society participation, and the roles and responsibilities of the members of the LAC;
- monitoring and evaluation system; and
- a technical five-year investment plan and a one-year operational plan.

This planning process will result in an investment and operational plan which will be presented to the mayor who will then present it to a wider stakeholder group for discussion, review, and approval and adoption by the city government including the Sangguniang Panglungsod. HealthGov will assist in identifying local and external donor resources that could be used to implement the plan. This may include TA

requirements that could be addressed by HealthGov, other USAID-assisted projects and other donors.

3.4 Rapid Needs Assessment

As part of the PIPH preparation TA, a Rapid Needs Assessment (RNA) or situational analysis (SA) will be conducted at the provincial level, in cities, and in clusters of municipalities. The RNA/SA will serve two critical purposes: to collect data for evidence-based decision making about reform plans, and to create opportunities for broad stakeholder participation in identifying the needs and priorities for local health sector reform and health systems strengthening. Data collected will also provide an input to determine the baseline for the project M&E system. Provincial and municipal RNAs/SAs will identify the problems, gaps and needs in the areas of (1) key LGU management systems, (2) LGU financing for health, (3) LGU service provider performance, and (4) local advocacy for health. The RNA/SA will tie specific issues or priorities to responsible functional units of LGU operations (e.g., provincial health office, municipal health office, rural health units, budget office). The results of the RNA/SA will provide the framework for the various interventions that HealthGov and the other CAs can assist LGUs in undertaking to achieve desired health outputs and outcomes; these results and findings will be analyzed and disseminated to LGU stakeholders. The findings of the RNA/SA will form an input to the preparation of LGU investment plan for health which will detail the list of priorities that the LGU commits to undertake and for which HealthGov and other CA assistance may be tapped.

In the second quarter of the project, HealthGov, in consultation with other CAs and USAID, developed the RNA methodology and protocol to assess the current conditions, needs, and priorities of LGUs related to the provision of health services.

Depending on the LGU categorization (initial F1 site, F1 convergence site, other HealthGov site) and local conditions and preferences, different types of provincial-level needs assessments will be conducted to update available plans; determine existing conditions, needs, and demand for health services; and establish a baseline for engagement. Since the five initial F1 sites where HealthGov works have already formulated their PIPH, no RNA is necessary unless the province selects a specific area of appraisal to enhance local knowledge of the situation.

In the six new F1 convergence sites and 11 other HealthGov sites the project will offer support in carrying out a full RNA. The other HealthGov sites include seven former LEAD sites that already participated in an Assessment and Planning Workshop: a quick participatory analysis (QPA) or selective participatory appraisal (SPA) may be best suited. The remaining five sites which have not undergone any analysis of their health sector could opt for a total participatory appraisal (TPA). In the F1 convergence sites and the other HealthGov provinces, the results of the RNAs will be presented in a provincial multi-stakeholder forum that will feed into the preparation of a province-wide investment plan (PIPH).

The provincial RNA/SA will help identify high priority areas for TA at the provincial level and identify clusters or groups of municipalities that may require particular capacity-building TA. Groups of municipalities could be organized as ILHZs or other

logical organization based on common conditions, needs or priorities. HealthGov will provide TA (directly by project staff or through the engagement of TAPs) to groups of LGUs wherever feasible – this ensures that technical assistance packages that are perceived as important by several LGUs are prioritized and that resources are allocated efficiently (i.e., wholesale instead of retail).

3.5 The provision of Technical Assistance

HealthGov will offer Technical Assistance to LGUs and other project partners through its own team of technical specialists, the use of short-term TA, and a network of Technical Assistance providers (TAPs). HealthGov's own team of specialists in health governance, finance, service delivery, and advocacy will provide technical leadership, develop TA interventions, and identify the need for STTA and TAPs. STTA will be used only to provide highly specialized services to compliment the skills of HealthGov's own team.

Technical assistance providers (TAPs) are universities, NGOs, government agencies (CHDs, regional POPCOM and PhilHealth Offices), consulting firms and even individuals that will provide services to LGUs under the project. HealthGov will give preference to TAPs that have core competencies in priority areas (strengthening health management systems, expanding health finance, improving service provider performance, increasing advocacy) that would be valued by LGUs, and that already operate close to target LGUs to minimize transportation costs.

In the second and third quarters, HealthGov staff will finalize the list of TAPs identified to have the aforementioned qualifications and assess their capabilities. From this assessment, and based on an inventory of best practices, the project will develop training of trainers (TOT) curricula, manuals, and programs to ensure that TAPs offer the best possible services to LGUs. TAP capacity-building training in all activity areas will take place in year 1.

By the end of year 1, HealthGov will have begun to establish an extensive network of TAPs short listed and “accredited” by the project that LGUs can call on to help develop their capacity.

3.6 The use of vouchers to fund Technical Assistance

The voucher system is a method of providing a temporary partial subsidy to LGUs for purchasing training and TA services from TAPs to meet priority needs as defined in the PIPH. The detailed guidelines for HealthGov's voucher program, including bids and awards processes that will conform to RA 9184 (the Government Procurement and Reform Act) and USAID policies, will be developed with consultant support and will be ready by the end of the third quarter.

A HealthGov voucher will be worth a pre-set amount that LGUs can use to “buy” TAP technical and training services. Vouchers for TAP services will be designed to jumpstart systems improvements without compromising long-term sustainability. After identifying priorities in the PIPH, LGUs will select from a menu of training scholarships, technical services, and products. Project staff will help LGUs develop

scopes of work with clear deliverables on which TAPs will bid. Competitive bidding will encourage cost-efficiency on the part of TAPs. To maximize sustainability, most project vouchers will cover only one year of assistance with some portion to be covered by LGUs; less advanced LGUs may require two years of subsidized assistance. Because the LGU handles the voucher (although HealthGov will make its share of payments directly to TAPs) and is involved in defining the scope of work and selecting the TAP, this system increases LGU awareness of the true cost of the services. It also helps develop among LGUs the capacity to define assistance objectives, evaluate TAP proposals, and manage contractors, all of which are key to sustainability of the improvement program.

Most of the TA in Year 1 will be focused on supporting the preparation or implementation of the F1-mandated PIPH. Because F1 is a national policy, TA provided by HealthGov for the preparation of the PIPH does not lend itself to the use of the voucher system. Hence, it is expected that the actual use of vouchers during the first year of the project will be limited. Vouchers may be used to fund some of the selected TA that was identified during the scoping missions. This may offer an opportunity to test and modify the voucher system in year 1 and prepare for the use of the vouchers on a much larger scale in subsequent project years.

3.7 Coordination with other USAID Cooperating Agencies

HealthGov being USAID's flagship project for SO3, will prime the coordination of activities in a number of key areas that other cooperating agencies (CAs) and National Government Agencies (NGAs) have also identified as critical to the achievement of their respective key result areas. Following a series of consultative meetings with USAID/OH, the CAs and NGAs, the creation of Technical Working Groups (TWG) and Task Forces (TFs) was proposed as one of the mechanisms to address these areas and to ensure that collective results are generated in support of SO3. HealthGov will serve as chair of the TWGs/TFs on LGU planning and financing (including improved planning system, performance-based budgeting and use of data for decision-making); PhilHealth support (related to speeding up accreditation processes, promoting LGU funding of indigent's premiums and expanding the participation of private facility accreditation); human resource management (related to compensation, benefits and incentives for local health care providers, staff supply and demand, performance appraisal and staff turnover); LGU logistics management (including procurement methods and sources, commodity and drug distribution system and public drug supply to the private sector); and service quality improvement (dealing with quality assurance, service standards and protocols, supervision, referrals and training).

TWGs and TFs are based on actual coordination needs and they can be quickly established or abolished. For example, the Task Force on site selection was abolished as soon as the selection of participating LGUs was finalized and a TWG on the LGU Engagement Strategy was established by HealthGov to involve other CAs in the preparation process.

The HealthGov project will also assume leadership in managing the coordination of the various committees under IR.1 of SO3 and the team will participate in a number of other TWGs/TFs. On top of this, HealthGov will work closely with HPDP on

issues involving the NGAs, in particular DOH. HealthGov will also adhere to recommended protocols for coordination with DOH, related agencies and other stakeholders to facilitate implementation of TA at the LGU level.

4. Technical Interventions

4.1 Introduction

During the first project year, HealthGov's program activities and TA will revolve around assisting the government to implement its health sector reform agenda through the F1 policy framework. The project will ensure that priority reform processes are localized and institutionalized within the local health systems as reflected in the PIPH of the 23 target provinces. Based on the results of the provincial scoping and requests for assistance by LCEs and local health staff, HealthGov will focus its TA on four major areas that have been identified as crucial in ensuring that reform interventions address improvements in the delivery of key health services, namely FP, MCH, TB, micronutrient deficiency, HIV/AIDs, and emerging and reemerging diseases. These major areas of technical assistance are briefly described below. While these TA will have specific key result areas, their strategic importance is integrated in the development and operationalization of the PIPH process and is expected to impact positively on the different intermediate results (IRs) of the project.

- **Development of and operational support to PIPH** – HealthGov will play a major role in the development and completion of the PIPH in six of the 19 F1 roll-out convergence sites and its scaling-up in 12 other provinces outside of the current F1 coverage areas. The project will also provide TA to five of the initial 16 F1 sites in the implementation of their operational plans. With its in-house experts serving as technical resource and the tools already developed, HealthGov is expected to contribute significantly to enhance four critical areas in the PIPH process that have been identified as in need of strengthening and improvement: (1) baseline data collection/situational analysis; (2) identification of programs, projects, and activities (PPAs); (3) alignment of financial planning to existing and approved LGU procedures and practices; and (4) advocacy for multi-stakeholder participation. The TA to support PIPH preparation and implementation will address a number of the SO3 Intermediate Results but most specifically IR 1.1: improving key LGU management systems to sustain delivery of selected health services.
- **Province-wide implementation of CSR initiatives** – HealthGov will provide technical assistance to enable the CHDs and PHOs to improve the monitoring of the progress of CSR implementation based on AO 158 at the regional and provincial levels. TA will include the development or enhancement of tools being used to serve this purpose. HealthGov will tap its in-house specialists to assist LGUs in developing appropriate processes and measures to address gaps and inefficiencies in the various elements of CSR (e.g., planning and budgeting, procurement, logistics management, service delivery) thereby mainstreaming and institutionalizing the CSR cycle in all the 23 provinces covered by the project. TA on CSR will address elements of IRs 1.1. and 1.2: improving management systems and financing for health.
- **Carry out Service Delivery Implementation Review (SDIR)** – HealthGov will provide assistance to the CHDs, PHOs, and MHOs in the use of SDIR to assess and analyze the current status of FP, MCH, micronutrients supplementation, TB,

and STI/HIV/AIDS by provincial and municipal LGUs. SDIR will also identify interventions and action plans to improve coverage, service delivery performance, and quality of service provision which were not highlighted in the planning and budgeting of PPAs in the current F1 sites. TA in the implementation of SDIR will lead to the development of interventions that will address elements of IR 1.3, specifically on improving the quality of health services and service provider performance.

- **Mobilizing advocacy support** – HealthGov will ensure that every TA activity situates itself within the broader health sector reform framework. Accordingly, orientations, workshops or training will always include the topic on health sector reform. As part of social mobilization and in preparation for the participation of NGOs and civil society in health sector reform, HealthGov (in coordination with PNGOC, its local partner) will hold regional NGO and civil society forums to assist these stakeholders identify their role and participation in health sector reform. HealthGov will also provide TA to provide local health and LGU personnel with new skills and tools to gain support for the PIPH and related TA interventions from local leaders and the Sanggunian. This TA responds to IR 1.4: increasing advocacy for the financing and delivery of health services.
- **Other related TA** – In addition to the four major areas above, HealthGov will provide TA to DOH through the CHDs in initiating the process of mainstreaming the Public Service Excellence Program (PSEP) that integrates a Standard-based Management with Recognition (SBMR) approach in the human resource development initiatives of LGUs especially for health care providers. HealthGov will assist in developing the tool and pilot-testing this integrated approach in three provinces. HealthGov will also continue to provide TA to build local capacity in the implementation of informed choice and voluntarism in the provision of family planning services in local health facilities. These interventions are geared towards building appropriate mechanisms for improving service provider performance (IR 1.3).

4.2 Strengthening key LGU management systems to sustain delivery of selected health services (IR 1.1)

Under a devolved structure of government, the effectiveness of health service delivery depends strongly on efficient and effective local government management systems. These systems include information generation and analysis, long- and short-term planning, financial management including budgeting, procurement and logistics management, quality assurance and supervision and management of resources.

During Year 1, HealthGov will provide TA in two key interventions under program activity IR 1.1: (1) effectively integrating health planning and budgeting activities into LGU health systems through the PIPH, and (2) improving management systems to strengthen the ability of LGUs to deliver high quality health services with particular attention to CSR implementation and monitoring.

4.2.1 Province-wide Investment Planning for Health (PIPH)

Under the F1 policy framework, the PIPH is the key instrument in forging a DOH-LGU partnership to achieve better health outcomes, more responsive health system, and equitable health care financing. HealthGov will play a major role in assisting six F1 roll-out sites and 12 other provinces to develop, plan, and implement their PIPH.

The PIPH serves as a vehicle for implementing and consolidating support for health reforms at the provincial level. Its features (namely, a health sector perspective; planning using a province-wide, five-year strategic timeframe; well-defined critical interventions and targets; a financial plan; and implementation through performance-driven agreements) make it a comprehensive and effective tool for attaining health system goals. Given its mandate, HealthGov will provide TA to LGUs to support the preparation and implementation of their PIPH. The assistance to PIPH by HealthGov is the initial step in providing TA to LGUs to improve their health planning systems. It will also allow the project to identify specific technical interventions required to address gaps and inadequacies in local health systems.

TA to PIPH development and implementation will vary depending on the LGU category as follows:

F1 Sites – In the five F1 sites covered by HealthGov the PIPH has already been completed. HealthGov national and regional staff have visited these five provinces for consultations with the governor and provincial health and LGU staff. The outputs of the consultation meetings included: (1) an update on the status of PIPH preparations; (2) identification of further TA needs; and (3) initial agreement on next steps. HealthGov technical specialists from the national and regional offices will work with the CHD, PPT, and other provincial health and LGU staff to provide TA in the following areas:

- **Pangasinan**: (1) development of the implementation plan for the PIPH Operational Plan, (2) assistance for strengthening of the Provincial Health Board;
- **Capiz**: identification and planning of TA needs to implement specific programs and activities (i.e. service delivery assessment to increase health outcomes for FP, MCH, immunization, TB, nutrition);
- **Oriental Negros**: (1) review of the PIPH to determine priority areas for TA support by HealthGov and other USAID CAs, (2) development of updated TA and financial plan plan for presentation to and approval by the governor;
- **South Cotabato**: development of the implementation plan for the PIPH Operational Plan;
- **Misamis Occidental**: (1) development of the implementation plan for the PIPH operational plan, and (2) technical assistance for the strengthening of the ILHZs.

F1 Roll-out Sites and other Provinces – HealthGov technical staff from its governance team will work closely with HPDP, other CAs, and DOH to finalize the guidelines and tools to improve the efficiency of the F1 planning process.

In the F1 roll-out sites and other provinces covered by the project, HealthGov, working closely with the CHDs and other members of the RCT, will take the lead in providing TA for the development and preparation of the PIPH. HealthGov already has developed or identified tools for many of these capacity-building activities and these will be adopted for use in providing TA in topics that may include:

- Orientation on health sector reform (F1) to local decision-makers and stakeholders. Typically, the orientation will include concepts, principles, and analytical tools for health sector reform and their application to national and local settings. It will build on the current level of understanding and capability of key stakeholders in health sector reform;
- Extensive and comprehensive capacity building TA to the Province-wide Planning Team (PPT) that will take the lead in developing and formulating the PIPH. The TA will result in skills enhancement in assessing baseline conditions, identifying key interventions needed, costing of interventions, financial planning and performance-based budgeting, and strengthening of management support systems which are necessary to implement the plan (such as M&E, financial management, procurement and logistics, and human resource management);
- Capacity building on the development of a rolling operational plan updated annually and/or implementation plan for the operational plan which details the scope, budget requirements, and monitoring arrangements for the proposed interventions;
- Advocacy activities targeted at different levels to effectively and adequately “market” the PIPH plan to LGUs and other stakeholders (from getting the mandate to plan, designation of the planning team, mandate to implement, and getting support from DOH/CHD and Sector Development Approach to Health [SDAH] partners);
- Strengthening capacity of the LGUs to implement and track the progress of their PIPH plans.

Due to the number of LGUs in a province, the PIPH development and planning workshops will be organized by batch of LGUs, i.e., by ILHZ or by a cluster of cities/municipalities as suggested by the LCE or his designate. In the course of PIPH development, other TA needs will surface and will serve as basis for HealthGov’s continuing TA to the provinces in the second year and beyond.

The Province-wide Planning Team, as designated by the LCE, will lead the formulation of the PIPH. The composition of the planning team may vary by province, but it would typically include the Provincial Health Officer (PHO), Planning and Development Officer and Budget Officer, the *Sangguniang Panlalawigan* (provincial legislative council) member who chairs the Committee on Health, and representatives from component LGUs, NGOs, and civil society groups. HealthGov will provide the PPT, other LGUs and stakeholders where appropriate TA in any of the following modes: design and development of manuals and tools (e.g., situation analysis tools); capacity building through training of trainers, workshops, and skills training; follow-on coaching; development of advocacy messages; and design of materials.

HealthGov will tap its in-house pool of specialists on service delivery, governance, financing, and advocacy. It will also coordinate with national, regional, and local partners such as the CHDs, POPCOM, PhilHealth, and DILG, which will likewise

significantly act as TA providers. STTA consultants will be engaged on a case-by-case basis and only when TA can neither be provided by HealthGov experts nor national/local partners.

The formulation of the PIPH requires undertaking a number of critical steps in three phases: preparation, planning, and implementation.

Preparatory Phase (estimated duration: 1-3 weeks)

This includes the following key activities:

- Training program for PIPH trainers, including core trainers from among the CAs (to be trained by HPDP/DOH), and a training team from the CHDs (to be trained by the core trainers);
- Formation of the Regional Composite Team (RCT) that will advocate the PIPH to their respective target LCEs;
- A series of meetings with the governor to conduct an orientation on Health Sector Reform and PIPH, secure a mandate to undertake the PIPH planning, and form the Province-Wide Planning Team (PPT);
- Orientation/Training of PPT and planning for PIPH workshops.

Planning Phase (estimated duration: 3-4 weeks)

This phase includes the following key activities:

- **Workshop 1** (3 days) – establishing the baseline and situation analysis, setting goals and identifying critical interventions. For provinces that are able to undertake the SDIR, the outputs of the review will be used for this workshop. For others, the rapid needs assessment (RNA) tool will be used to generate baseline information. The maximum number of participants per workshop is 40-50 to achieve best results. Therefore, large provinces will have to consider doing this workshop by groups of LGUs (i.e., by ILHZ or other cluster).
- **Workshop 2** (2 days) – costing of critical interventions and financial planning. Participants will be requested to prepare some data for this workshop, including records and reference data pertaining to costing. HealthGov field staff will assist and monitor the preparation of the requested information to ensure completeness and availability during this workshop. If needed, HealthGov staff will also provide the necessary TA in refining the final drafts of the costing/financial plans after the workshop.
- **Workshop 3** (3 days) – finalizing costing and financial plans, identifying management system requirements, and consolidating the final draft of the PIPH (writeshop). At the end of this workshop the responsibility for the completion of the draft PIPH will be clearly assigned. HealthGov staff will facilitate and monitor this activity to ensure the timely submission of the output.

Implementing Phase (estimated duration: 2-3 months)

The key activities during this phase include:

- Meeting with the governor to submit the PIPH for approval. Once approved, the necessary documents need to be prepared to support the mandate (e.g., ordinances, MOAs);
- Securing support from DOH and SDAH partners (this activity is expected to spillover into the second project year);
- Preparation of Operational Plan (to take place on Year 2).

It is anticipated that by the end of the project year, all F1 roll-out sites and other provinces will have completed the PIPH planning process.

4.2.2 Contraceptive Self-reliance (CSR) monitoring

The gradual phase-out of foreign donated contraceptives between 2004 and 2008 has prompted the government to assume responsibility for assuring the availability of contraceptive supplies for family planning services through the formulation of the Contraceptive Self-reliance² (CSR) strategy. On July 9, 2004, DOH issued AO 158 s. 2004 entitled “Guidelines on the Management of Donated Commodities under the Contraceptive Self-reliance Strategy” to guide the transition process. Successfully achieving contraceptive self-reliance requires the completion of the CSR cycle which comprises 1) formulating a local CSR plan; 2) enacting executive or legislative issuances in support of the CSR plan implementation; 3) resource mobilization, i.e., providing funds for implementing the CSR plan; 4) approving CSR policy guidelines, training staff on the updated contraceptive distribution and logistics management and distribution system (CDLMIS), and procurement of CSR commodities; and 5) distribution of services and commodities.

The AO provided the guidelines on the orderly and fair disposition of declining quantities of donated contraceptives in a way that encourages domestic stakeholders to take pro-active steps to assure continued access to contraceptives among those who need them. Since the issuance of AO 158 a number of LGUs, initially with assistance from USAID and later by CHDs, have implemented CSR through local policies, budgets, and services to achieve the CSR objectives of assuring no disruption in contraceptive supplies particularly among the poor; expanding alternative sources of financing LGU contraceptive requirements; and developing alternative private sources of supplies of contraceptives. Attempts have been made by both DOH and POPCOM to obtain information on the status of CSR implementation nationwide to guide DOH on what assistance it might provide to LGUs. However, the information gathered to date is incomplete.

HealthGov has received requests for TA from several provinces which have initiated the implementation of CSR either through previous support from USAID or through the initiative of the CHDs or regional POMCOM offices. Continuing assistance to the CSR initiatives will help LGUs to sustain their family planning programs.

POPCOM in Mindanao, which have initiated efforts to develop a more systematic monitoring and data collection strategy. These partners have requested HealthGov for TA in developing a monitoring tool, formulating a data collection strategy, and implementing such a strategy in all non-ARMM regions in Mindanao. If the data can be obtained quickly, the information can be an important input to the current DOH CSR Technical Working Group (TWG) discussions on next steps towards assisting LGUs strengthen and sustain CSR implementation. If this strategy works, the

² For purposes of TA provision, CSR as defined here focuses on family planning. Called CSR Plus (as opposed to LEAD’s CSR+ which covers pills, DMPA, anti-TB drugs, and vitamin A capsules), it considers all family planning methods in the context of a strong and sustainable family planning program within the maternal and child health program supported by the entire health system.

experience can be quickly replicated in Luzon and the Visayas to come up with nationwide information on the status of CSR implementation.

HealthGov, in partnership with PRISM and the CHDs, will organize a workshop to develop a plan to respond to this request from the project partners in Mindanao. Based on the learning from the workshop in Mindanao, similar workshops will be conducted in Luzon and Visayas to complete the 11 regions responsible for the 23 provincial target sites of HealthGov. Depending on the results of these workshops, HealthGov will provide technical assistance in the form of the following:

- Technical notes on the information that needs to be collected as the basis for development of a CSR monitoring tool by the CHDs, PHO, and regional partners;
- Assistance in the formulation of an action plan for collecting information from LGUs in the provinces of Mindanao;
- Assistance in the analysis of the data, and reporting the analysis to DOH for discussion in the CSR-TWG;
- Assistance in the identification of recommended responses by DOH, CHDs, provinces, and partners to help LGUs strengthen and sustain their CSR activities;
- Assistance in the rapid replication of the Mindanao experience to the rest of the country to come up with national-level data on the status of CSR implementation.

Depending on the results of the monitoring of LGU CSR implementation activities and the technical assistance needs identified, further TA, particularly to LGUs, will be provided by HealthGov. This TA may include:

- Updates on provincial technical, logistics, and financial assistance to LGU implementation of CSR;
- Updates on LGU CSR planning and policy development, including:
 - Forecasting contraceptive requirements and FP method mixes as well as financing options in the context of eliminating unmet needs and increasing contraceptive prevalence rate;
 - Assistance in the development and strengthening of an integrated procurement and logistics system;
 - Completing the CSR cycle: client classification, cost-recovery schemes, market mapping, public-private sector dialogue, and public-private sector referral systems;
- Development of LGU-level monitoring system

Technical assistance will be provided mainly by HealthGov in-house specialists based at the national and regional field offices. The principal mode of delivery is through workshops convened by the DOH MHDO with the participation of DOH regional directors, family planning coordinators, POPCOM regional directors, selected PHOs, and central DOH staff.

It is expected that by the end of Year 1 of the project TA to CSR implementation will be mainstreamed in the 23 provinces and specific TA needs for province-wide implementation will have been identified.

4.3 Improving and expanding LGU financing for key health services (IR 1.2)

In the context of the devolved government structure LGUs need to diversify their sources of funding in order to sustain and increase the amount of financing for health. These sources include PhilHealth, gender and development funds, locally generated revenues (e.g., property taxes, public enterprise, user fees), earmarked revenues for health, loans (e.g., Municipal Development Fund), grants and donations (public, private, foreign), resource allocations from non-health sectors, and efficiency gains from better financial management. In addition, there is a need to expand the role of the private sector in financing key health services while protecting the poor through mechanisms that include client classification, market mapping, referral system, and cost-recovery schemes.

Following its market-driven approach, HealthGov will respond to specific requests of provinces for TA related to health financing. For instance, **Pangasinan** (an F1 site) has expressed the need for continued assistance in client classification, designing and operationalizing of a client referral system, and identifying indigents qualified for the PhilHealth Sponsored Program.

4.3.1 Client classification using Standard Living Index (LSI)

HealthGov will provide assistance in the implementation of a client classification scheme using a Living Standard Index. The LSI will be used to identify family planning clients that could receive continued subsidies for their contraceptive supplies. Pangasinan has expanded its implementation of a client classification scheme to two other ILHZs covered by the F1 grant in addition to three ILHZs that had previously implemented the scheme with TA from USAID. The Pangasinan Provincial Population Office has competent staff to carry out the scheme, particularly its field data collection and processing components. However, they still require mentoring in the analysis and estimation of the LSI and assistance in disseminating the information to the municipalities for validation.

Municipalities that opt to develop a public-private client referral system will have additional resources for health or free up resources otherwise used to subsidize clients with ability to pay. HealthGov will provide assistance in the implementation of models developed under the LEAD project.

Assistance for identifying indigents for PhilHealth coverage will be provided using the LSI. HealthGov will also provide assistance in estimating the premium subsidies required by a municipality with differing income classes, estimate the reimbursements and capitation payments that would flow back to the province and component LGUs to finance health services, and planning for covering the non-indigents.

During Year 1 of the project, TA in all of the above will be provided by HealthGov specialists. It is expected that provincial staff in the PPO and municipal staff in the MHO will have developed competence to continue the work in the second year with occasional mentoring from HealthGov specialists.

4.3.2 Development of Local Health Accounts (LHA)

Agusan del Norte (a HealthGov province that is not one of the initial F1 sites or roll-out sites) has requested for TA in the development of a monitoring tool that will track the province's expenditures of PhilHealth capitation funds.

HealthGov will recommend that monitoring expenditures of PhilHealth capitation funds be done in conjunction with the development of Local Health Accounts (LHA). The LHA will track total health expenditures by financing agent (national, provincial, and municipal government; PhilHealth; households; and others). PhilHealth expenditures for health will be in the form of reimbursement for hospitals and capitation funds associated with enrollment of indigents. Such expenditures will provide the base upon which to track how individual facilities have actually used the reimbursement revenues and capitation funds for health. Attention will be given to RHUs' actual implementation of the PhilHealth guidelines on the use of capitation funds.

HealthGov, together with the province and selected municipal finance staff, will develop an additional tool for monitoring actual expenditures of both reimbursement and capitation funds. In addition, assistance will be provided in crafting policy issuances regarding the use of hospital revenues from reimbursements and capitation funds from the indigent program to ensure that such revenues/funds are used to expand resources for health.

During the first year of HealthGov, the TA on the development of the monitoring tool and necessary policy issuance will be provided by HealthGov specialists. For the development of LHA, HealthGov will extend TA through STTA provided by the Philippine Institute for Development Studies, which will be taken in as the principal LHA TAP for Agusan del Norte and other provinces requesting similar assistance.

4.4 Improving service provider performance (IR 1.3)

Service provider performance is an integral part of ensuring high-quality health care provided by LGUs. In a devolved set-up, local government leadership is vital in the proper management of human resources, strengthening procurement and logistic management systems, and ensuring quality assurance and supervision at all levels of the service delivery system.

In Year 1, HealthGov will focus on improving delivery and quality of services through the following: (1) conduct of a service delivery improvement review (SDIR) in 15 provinces and the six HIV/AIDS high-risk zones, (2) integrating the Standard-based Management with Recognition approach with the Public Service Excellence Program and modeling this approach in three sites, (3) updating the Core Competencies Manual for Rural Health Midwives, (4) updating the Family Planning Competency-based Training Manual, and (5) developing a guide on the principles of family planning, including informed choice and voluntarism. These activities will

support the four key interventions under this IR which include: 1) improving human resource management; 2) ensuring high quality in health service delivery; and 3) strengthening the health provider training system. HealthGov will provide a separate set of TA that will help improve responses to TB and HIV/AIDS.

4.4.1 Service Delivery Implementation Review (SDIR)

SDIR is intended to provide program managers, service providers as well as policy and decision-makers with information on the status of service delivery in their municipality or city. It will allow them to identify and analyze the factors that contribute to and constrain the achievement of service delivery objectives and targets particularly for MCH, micronutrients, FP, TB, and STI/HIV/AIDS. It will help them identify and prioritize areas (e.g., service delivery, quality assurance) for improvement. SDIR will enable them to decide on strategic interventions, and formulate a plan of action to improve service delivery performance in the aforementioned health programs. Service enhancements that the health facility will pursue are expected to lead to improved availability of and access to health services especially among the poor, and ultimately to increased service utilization and better health outcomes.

SDIR provides the advantage of generating two important outputs: 1) an “acceleration plan” that may be used by the health personnel as an advocacy tool for LGU officials, and 2) baseline municipal/city data on the indicators for health service delivery, governance, financing, and regulation³. The LGU acceleration plan specifies milestones that need to be achieved to increase service delivery coverage and it helps PHO, CHO, CHD, and DOH representatives to identify the specific TA needs of the LGU.

SDIR will be conducted as a two-day live-in workshop that the Provincial Health Office will organize. A workshop may have a maximum of 50 participants and each LGU will select 3-5 participants. TA providers or facilitators will include PHO and program coordinators, the DOH Provincial Health Team Leader (PHTL), CHD program coordinators, as well as staff of POPCOM, PhilHealth, TB LINC, A2Z and HealthGov. SHIELD ARMM will be invited to participate in the first SDIR.

TA provided through the SDIR includes the following:

- Gathering health service delivery information by providing a guide to assessing and analyzing health service delivery and a matrix that summarizes assessment of health service delivery status;
- Analyzing service delivery indicators that will adopt the PIPH situational analysis framework and consider the different health program components;
- Formulating an “acceleration plan” to increase service delivery coverage;
- Facilitating SDIR.

The implementation of SDIR requires the following steps:

³ While the province-wide investment planning for health generates provincial data, SDIR provides the advantage of providing LGU-specific data on various health indicators.

- HealthGov technical specialists will develop the SDIR design in consultation with DOH – NCDPC and other CAs. The Provincial Health Office may adapt the generic tool based on provincial needs and priorities;
- The PHO and public health nurses (PHNs) will be oriented on the use of the tool for gathering data on service delivery indicators. PHNs will be tasked to fill up the data-gathering tool;
- A pre-workshop meeting will be held at the provincial, municipal, and city levels to assess service delivery status and analyze contributing and constraining factors affecting the achievement of objectives and targets. At the LGU level this will allow all the midwives and selected barangay health workers (BHWs) to participate in the analysis. At the provincial level, technical staff of the provincial and city health offices and other stakeholders will be encouraged to participate in the process;
- To orient facilitators on their roles and the mechanics of the workshop, a meeting with them will be conducted a day before the workshop. The meeting will walk the facilitators through the different steps of assessment, analysis, and planning;
- The two-day SDIR workshop will be conducted;
- Based on the action plan generated by the LGU, TA planning workshops with the PHO, PHTL, CHD, and other CAs will be conducted to formulate a TA plan that responds to the identified needs of the LGU. HealthGov may provide TA in the following areas:
 - SBMR-PSEP training for TAPs (CHDs/OHOs) who in turn will train LGUs that will use the SBMR-PSEP approach;
 - Strategic management information systems for PHOs and CHDs. This TA will help improve accuracy and completeness of reporting and data management and utilization;
 - Improving quality of service delivery supervision. Supervisors of service providers will be assisted in maximally utilizing the Sentrong Sigla supervisory guide.

Monitoring of service delivery improvements will be conducted regularly through the use of the monitoring checklist that HealthGov will develop.

4.4.2 Service Delivery Improvement Review in HIV/AIDS high-risk zones

In Year 1 HealthGov will provide HIV/AIDS high-risk zones with TA in the conduct of an HIV/AIDS service delivery implementation review and the formulation of a strategic plan that highlights the prevention of HIV/AIDS. The planning process will follow the SDIR design and will be conducted in June-July 2007 initially in three zones: Angeles City, Metro Cebu, and Davao City. Outputs of the planning activity will be presented in August-September 2007 to a wide stakeholder group for discussion, approval, and adoption by the city government including the Sanggunian. HealthGov, other USAID-assisted projects and other donors may provide selected TA identified in the plan.

In non-high-risk zones, HealthGov will provide LGUs TA in integrating HIV/AIDS into the planning process and conducting a review of the other health programs. LGUs,

especially cities, will be mobilized to plan for HIV/AIDS prevention as part of their PIPH plans.

4.4.3 Modeling the Integrated SBMR - PSEP approach

HealthGov's TA to LGUs will consist of supporting the development of an integrated SBMR-PSEP guide, training of trainers on SBMR-PSEP, and implementation of the integrated approach in three model sites. Integration of the two approaches as well as development of the implementation guide and the SBMR-PSEP TOT design will be done by a consultant each for SBMR and PSEP that HealthGov will engage.

SBMR-PSEP will ensure the institutionalization of the assessment component in the existing health service delivery structure using detailed performance standards and timeframe for achieving the standards. PSEP is a planned change effort designed to improve service delivery. It focuses on improving key service provider behaviors as well as service coverage and scope, including service delivery systems and processes. On the other hand, the SBMR approach employs the systematic use of performance standards (both client and provider standards) and rewards compliance with these standards. The integrated SBMR-PSEP approach marries the strengths of SBMR and PSEP into a single efficient and effective mechanism for improving service delivery.

The SBMR-PSEP guide that will be developed will delineate the steps on how and what to improve in service provider performance and quality of health service delivery to ensure customer satisfaction. *Senrong Sigla* (center of excellence) quality standards will be used as LGU reference in setting local standards. Assessment of the progress in implementing SBMR-PSEP will be built into the health system.

A pool of core trainers will be trained in SBMR-PSEP. Thereafter, these trainers will train other LGUs on the use of SBMR-PSEP and monitor its implementation. In Year 1 of HealthGov the integrated SBMR-PSEP approach will be modeled in three provinces, namely Capiz, Pangasinan, and Misamis Occidental. HealthGov and the CHDs will monitor the effectiveness of the SBMR-PSEP models in the three model sites. Other CAs are expected to roll out the developed integrated quality assurance system in their respective project sites.

4.4.4 Developing a guide on the principles of family planning including informed choice and voluntarism

To ensure high quality FP service delivery through compliance with informed choice and voluntarism, HealthGov will provide TA in the development of a guide on the implementation of and compliance with informed choice and voluntarism, and a compliance monitoring tool. A Technical Working Group composed of the different CAs and the DOH central office will develop these tools.

The guide and monitoring tool will include establishment of a compliance monitoring and reporting system, and corrective action for any vulnerability and violations. The

guide will describe the principles of informed choice and voluntarism, who is responsible for monitoring, what tools to use in monitoring, and how and when to report violations.

HealthGov will support the training of service providers on informed choice and voluntarism by trained trainers from DOH central office, CHDs, and PHOs. HealthGov, other CAs, CHDs, and PHOs will monitor compliance with the requirements of informed choice using the tools that will be developed.

In Year 1 the project will complete the development of the guide and the compliance monitoring tool.

4.4.5 Updating of the core competencies manual for rural health midwives (RHMs)

The PIPH developed for the 16 initial F1 sites highlighted the need to update the core competencies of current and newly hired service providers. The retraining and retooling plan of the training and development needs analysis system of the DOH Health Human Resource Development Bureau affirmed this need. HealthGov will respond to this challenge by providing TA in updating the core competencies manual for RHMs. The project will also support the training of trainers for the use of the manual and the roll-out training.

The aforementioned TA is expected to improve service provider performance. It will help achieve the Human Resources in Health Master Plan's goal of establishing a critical mass of competent and well-motivated HRH to deliver quality health services.

In the first year of the project, HealthGov will complete the updating of the core competencies manual for RHMs. TOT and roll-out will be implemented in the project's second year.

4.4.6 Updating of the family planning competency-based training manual

Health facilities in several provinces and municipalities have expressed (through the DOH-NCDPC) the need for an updated FP competency- and evidence-based manual. This was echoed during the roll-out of the FP clinical standards manual in several LGUs. In many RHUs, frontline service providers have not been updated on the latest evidence-based FP service provision because the manual itself has not been updated. In response to this need, HealthGov will provide TA in the updating of the FP competency-based training manual and TOT on its use. Subsequently, the project will support the roll-out training on the FP competency-based manual among untrained midwives and BHWs as well as service providers who need updating on FP.

In Year 1 of the Project HealthGov will complete the updating of the manual. TOT and roll-out will be initiated in the project's second year.

4.4.7 Improving response to selected infectious diseases

In the area of infectious diseases, HealthGov will ensure improvements in service quality and delivery through the following key activities:

HIV/AIDS

- Assist DOH, CHDs, and LGUs in high-risk zones to strengthen the intervention programs for most-at-risk populations (MARPs). TA will include reviewing existing tools, best practices, and approaches for HIV/AIDS program implementation as well as services for MARPs. Consultative meetings with stakeholders will be conducted and TA packages developed to support TAPs in assisting LGUs. The TA package will include a performance-based system for NGOs that provide direct services to MARPs;
- Develop the capacity of local AIDS councils in HIV/AIDS high-risk zones to formulate and manage education programs on HIV/AIDS. TAPs will be trained to provide LACs technical assistance in enhancing and updating their HIV/AIDS strategic plans to include an education component. Using small NGO grants under RTI's sub-agreement with PNGOC, HealthGov will support the mobilization and training of NGOs as service providers in community education focusing on HIV/AIDS prevention programs for MARPs.
- Work with HPDP in mobilizing DOH to institutionalize the funding and implementation of the integrated HIV/AIDS behavioral and serological surveillance system.

Tuberculosis

- Provide LGUs technical support for the improvement of provincial TB laboratory efficiency. This will be done in coordination with TB LINC;
- Work on the integration of national laboratory standards into performance-based tool by introducing in SBMR-PSEP model sites TB performance standards;
- Collaborate with the regional offices of DOH and PhilHealth to accelerate TB-DOTS accreditation of health facilities. HealthGov staff will attend the regular meetings of the Regional Implementation and Coordination Teams (RICTs) to advocate for accelerating TB-DOTS health facility accreditation and help RICTs draw up concrete action plans;

4.5 Increasing advocacy on service delivery and financing (IR 1.4)

Public sector provision of quality health services depends on the commitment of public officials to invest in health and on policies that promote both the supply of and demand for health services. Under component IR1.4, HealthGov will work with LGU staff, public sector champions, public health staff, and civil society to strengthen their ability to advocate for sufficient funding and a favorable policy environment for public health. The outcomes of such work include:

- Commitment of LGU leaders to health and health system strengthening for improved financing and service delivery
- LGU staff confident in
 - gaining commitment from public officials for improved health services

- justifying and obtaining adequate financing for improved health services
- NGOs and civil society successfully advocating for good health services
- Participatory local decision-making institutionalized
- Partnership among public health providers and NGOs/CSOs enhanced

For Year 1, advocacy will be carried out to build support for: 1) health sector reform in general, 2) PIPH formulation, 3) CSR, and 4) health service delivery improvement.

Advocacy support to PIPH

Advocacy support to PIPH formulation and implementation will include the following: (1) development of an advocacy material for LCEs on “Why PIPH”; (2) designing a process to secure LCE mandate to develop PIPH (orientation, etc); (3) designing a process (NGO/CSO orientations on PIPH) to prepare NGOs/CSOs to actively participate in PIPH formulation (and review) alongside LGU health staff.

Getting the NGOs/CSOs involved in PIPH formulation is a major step in forging strategic partnerships uniting various stakeholders such as LGU officials, local health staff, NGOs/CSOs, and communities in developing local policies related to FP/MCH, TB, and HIV/AIDS. Technical assistance will enhance consensus-building among local health boards or similar groups, local NGO/CSO networks, local advocacy networks, health councils, and others so that they join forces in advocating for increased funding and for the passage of appropriate policies supporting the delivery of quality services to address current priorities and emerging infections such as HIV/AIDS and avian influenza. Engaging the NGOs/CSOs in the PIPH process will help ensure that community feedback/inputs on health needs and services are incorporated in the baseline data gathering and situation analysis to surface health issues and concerns of different sectors in the community and serve as bases for LGU action and advocacy for health.

Advocacy support to CSR

Advocacy support to CSR implementation will include: (1) development of an advocacy material on “Why CSR”; (2) designing a process including the incorporation of a session on “Communicating Results of CSR Monitoring to LCEs” in the planned CSR monitoring and review workshops; (3) designing a process (workshop, mentoring) to develop and implement local CSR advocacy plans and messages based on analysis of results of CSR; and (4) designing a process (CSR orientation) to prepare NGOs/CSOs to participate in CSR advocacy. Local advocacy plans for CSR will include selling CSR or getting the buy-in of local DILG, PPDO, etc. to incorporate CSR in the formulation of the executive and legislative agenda (ELA) and selling the concept and getting the support of barangay captains for CSR.

Advocacy support to SDIR

Advocacy support to health service delivery implementation review will include: (1) designing a process to develop and implement local advocacy plans and messages based on SDIR results, (2) designing a process (NGO/CSO orientation on SDR) to prepare NGOs/CSOs to participate in service delivery improvement.

Advocacy support to SMBR-PSEP integration

HealthGov will provide TA in LGU advocacy efforts to obtain LCE funding support to the implementation of the integrated SBMR-PSEP approach. The provider will also provide TA in marketing the approach to LGUs as well as establishing a community feedback system that would provide information on how well SBMR-PSEP is being practiced in health facilities.

Advocacy support to HIV/AIDS work

HealthGov will provide technical assistance in strengthening advocacy for NGOs to implement HIV/AIDS prevention activities to selected most-at-risk populations. Corollary to this, HealthGov will assist high-risk zone-LGUs in developing guidelines for performance-based grant (PBG) for NGOs that will agree to provide HIV/AIDS services for MARPs. In the first year, the PBG scheme will be modeled in one sentinel site.

Advocacy support to NGOs/CSOs

Working closely with PNGOC, HealthGov will engage NGO/private sector representatives in the local health boards, local development councils, and other LGU special bodies. The project will foster their collaboration with the provincial, municipal/city health officers in terms of building a constituency for health from among sectoral groups, community associations, local NGOs, and private sector groups. This is to broaden stakeholder involvement and participation in health planning and policy formulation, as well as health service delivery.

Specifically, NGO/CSO orientations on health sector reform will be conducted in Luzon, Visayas, and Mindanao. The objective is to prepare the NGOs/civil society groups for engagement in the PIPH formulation process and in the activation, reconstitution or formation of provincial health boards and creation of PMTs as mechanisms for LGU-NGO/CSO/private sector partnerships. The orientations will prepare them as well for advocacy for CSR and health service delivery improvement. In these forums, NGOs/CSOs will: 1) understand health sector reform concepts, principles, and strategies; 2) define and agree on their roles in HSR; 3) identify and select from among themselves focal NGOs that will lead, manage, and sustain health advocacy activities in the provinces (based on set criteria and scoring); and 4) come up with an action plan on how best to initialize NGO/CSO mobilization and community participation in health sector reform.

Building support for health sector reform will require the following: 1) inventory/scanning/advocacy scoping including the mapping of support of newly elected/reelected LCEs to health; 2) development of advocacy materials (e.g., powerpoint presentations, briefing kits, primers) and orientation modules for LCEs and health advocates (PMTs/LHBs) on health and development, health governance, HSR/F1, PIPH, and CSR; 3) preparation of an orientation material on the role of NGOs/CSOs in health sector reform for discussion in NGO/CSO orientations on HSR; and 4) designing a process to help LGUs identify, assess, and document best practices in health governance for replication and LGU sharing.

4.6 Regional Implementation Plans

LGU engagement and TA provision will be accomplished through the regional plans which are anchored primarily on the major TA programs discussed in this Chapter. The regional plans respond to the specific TA opportunities that have been identified and agreed upon during the scoping missions in the individual provinces in the three regions: Luzon, Visayas, and Mindanao. Continuous consultation with the LGUs and the regional partners will be undertaken to ensure the strategic matching of TA needs and the provision of TA by HealthGov working closely with the potential TAPs from the regional partners and/or the private sector in the respective regions and provinces.

The first set of activities which cuts across the three regions includes:

- Assistance to DOH central office in the conduct of TOT for CHDs on the HSR/F1/PIPH program;
- M&E baseline data gathering;
- Orientation of the regions, provinces, municipalities/cities, and barangays on informed choice and voluntarism;
- Participation in the TOT on the integrated SBMR-PSEP program;
- Periodic meetings on inter-agency collaboration at two levels: regional CA partners and the regional NGAs (RICT or its equivalent in the regions being covered);

The second set of activities will be implemented between April and September 2007 and includes the following:

Luzon

HealthGov supports seven provinces in Luzon as follows: Pangasinan (initial F1 site), Isabela (F1 roll-out site), and Cagayan, Bulacan, Nueva Ecija, Albay and Tarlac (new sites). Support is also provided to HIV/AIDS high risk zones in the Clark Development Zone and Metro Manila.

In Pangasinan, key activities identified for Year 1 include: (1) development of the implementation plan for the PIPH operational plan; (2) development of a PIPH roadmap as requested by the governor; (3) assistance to strengthen the Provincial Health Board (PHB); (4) the conduct of the CSR monitoring plan workshop; (5) continuing assistance for poverty mapping which is an essential input to the design and operationalization of the client referral system, ILHZ operations, and universal PHIC coverage.

For Isabela, key activities will include: (1) advocacy for the HSR/F1/PIPH to the governor, PHO and civil society as well as strengthening of the PHB; (2) conduct of SDIR which will serve as input to the PIPH development; (3) preparation of the PIPH up to the level of a draft report; and (4) conduct of the CSR monitoring plan workshop.

In the *other* provinces (new sites), key activities will include: (1) advocacy of the HSR/F1/PIPH to the governor (especially for newly-elected ones) and civil society; (2) development of the draft PIPH; (3) conduct of the CSR monitoring plan workshop; (4) carry out SDIR in Bulacan and Albay; (5) continuing dialogue with the

provinces to plan for the following program areas: CBMIS/HMIS review, local health zones assessment and advocacy for user fees/client referral program.

Visayas

The five provinces in the Visayas that receive assistance from HealthGov are as follows: Capiz and Oriental Negros (F1 sites); Negros Occidental, Aklan and Bohol (new sites).

In the F1 provinces, the assistance requested from HealthGov during the second half of Year 1 was determined in the planning sessions and in-depth analysis of the health programs and outcomes by the provincial health teams. Capiz formalized its TA request through a letter from the PHO and the governor to HealthGov and immediate TA activities will be in the following areas: (1) CSR review and development of a province-wide strategic monitoring plan; (2) conduct of an SDIR review, results of which will serve as inputs to their PIPH implementation plan; (3) advocacy on HSR/F1 and PIPH plans to new LCEs; (4) pilot-testing of the integrated SBMR-PSEP approach to enhance quality of service provision; (5) expanding the pooled procurement system to include drugs and other supplies for RHUS; and (6) documenting and packaging best practices and marketing these for replication.

In the *other* provinces, key activities will include: (1) advocacy on HSR/F1 and PIPH to new governors and LCEs; (2) development of the draft PIPH, including follow-on coaching to PPT; (3) initial consultative meetings and planning sessions with provincial health officials, results of which will be a request for immediate TA outside of PIPH and will serve as inputs to PIPH development; (4) CSR review and development of a province-wide monitoring plan (region-wide); (5) conduct of an SDIR in Aklan as part of the baseline or situation analysis for the PIPH; and (6) strengthening of ILHZs in Bohol in preparation for PIPH development.

Mindanao

In Mindanao HealthGov covers 11 provinces grouped as follows for purposes of TA provision: Misamis Occidental and South Cotabato (F1 sites); Zamboanga del Sur, Zamboanga del Norte, Zamboanga Sibugay, Compostela Valley, Davao del Sur, Sarangani (F1 roll-out sites); and Bukidnon, Misamis Oriental and Agusan del Norte (new sites).

In the F1 provinces key activities will include: (1) the development of the implementation plan for the operational plan of the PIPH; (2) assistance for the strengthening of ILHZs (in Misamis Occidental); (3) conduct of the CSR monitoring plan workshop; and (4) continuing assistance for the CSR and advocacy activities (in South Cotabato).

In the F1 Rollout sites HealthGov support will include: (1) advocacy for the HSR/F1/PIPH to governors (especially newly-elected ones), PHOs, and civil society; (2) conduct of SDIR in the three Zamboanga provinces; (3) development of the draft PIPH; (4) implementation of the CSR monitoring plan workshop; and (5) TA to incorporate the LSI (Living Standards Index) outputs into the PIPH development (in Compostela Valley).

For the three provinces in the Zamboanga Peninsula, HealthGov will also support the ongoing data gathering efforts of the CHD and PHOs in preparation for PIPH. Assistance will come in the form of an orientation of regional and provincial health workers on F1 and TA on data gathering and analysis. TA for CSR monitoring and SDIR will be viewed as part of data gathering and analysis. The results of these activities will form part of the inputs to the preparation of the PIPH.

In the *other* provinces (new sites) the key activities include: (1) advocacy of the HSR/F1 and PIPH to the governors (especially newly-elected ones) and civil society; (2) development of the draft PIPH, (3) carrying out the CSR monitoring plan workshop; (4) development of an expenditure monitoring tool for the rationalized spending of capitation funds coming from a multi-payor scheme; and (5) specific assistance which includes restructuring and strengthening ILHZs (in Bukidnon and Misamis Oriental), review of the health code (Bukidnon), applying governance to the National TB Program (Bukidnon), and human resource competency assessment and HR development planning for the CHD in Northern Mindanao. Preparatory activities for the eventual development of PIPH like orientation on F1 and data gathering will also be provided technical support in close coordination with the CHDs.

HealthGov will also support the strategic role of the CHDs in F1 and a number of capacity development activities have been identified. Priorities in Year 1 include developing the capacity of DOH representatives to provide TA to LGUs in strengthening inter-local health zones.

5. Monitoring and Evaluation

5.1 M&E plan finalization

As required in the Cooperative Agreement, the draft HealthGov Monitoring and Evaluation Plan covering the 5-year implementation period of the project was submitted to USAID Philippines on December 29, 2006. The draft M&E Plan outlines the list of indicators to be tracked by the HealthGov M&E system, the various sources of data, and the timing of data collection and reporting. The M&E indicators include:

- project activity output indicators for the first year of implementation as outlined in the preceding section on project activities;
- project performance outcomes or results, which are quantitative and/or qualitative measures of project performance in terms of policy outputs, health systems and health outcomes at the LGU level; and,
- USAID Operational Plan (OP) indicators, which are intermediate outcome indicators that measure the effects of USAID and other health initiatives on health outcomes in the Philippines, including indicators of utilization of FP/RH, MCH, TB and HIV/AIDS services.

The draft M&E Plan consists of a Project Performance Monitoring Plan, which presents the list of 46 preliminary indicators comprising both USAID's Operational Plan objective/program/element-level priority indicators and the HealthGov performance indicators. All the 46 indicators have been fully described in USAID's Performance Indicator Reference Sheets, with their precise definitions, units of measure, sources of data, method and schedule of data collection, and plans for data quality assessment.

The M&E Plan will be finalized following the approval of the annual work plan for year 1 by the USAID CTO, and it will reflect the revised list of OP indicators, now totaling 55 (Annex 1), and the major changes initiated by the SOAG M&E Team regarding CA collaboration on baseline data collection for OP indicators. It will also involve fine-tuning of the indicators, both the OP indicators and those of HealthGov, synchronizing the latter with the SOAG M&E framework. Moreover, further refinements are expected as soon as the F1 ME3 and the Score Card indicators have been finalized.

5.2 Baseline data collection and storing of information

Following the setting up of the SOAG M&E Team composed of the M&E consultants and concerned project staff of the different CAs (HPDP, HealthGov, TB LINC, SHIELD-ARMM, PRISM and A2Z), the need for major changes in the HealthGov M&E Plan arose. HPDP has been tasked by USAID to coordinate data collection activities for the OP indicators for the period October 2005-September 2006. The information to be collected will serve as OP baseline data.

A total of 55 OP indicators have been identified for monitoring USG-assisted health programs in 29 provinces. These indicators cover the following areas of concern: HIV/AIDS, TB and FP/RH. Out of these 55 indicators, 15 are deemed equally relevant but treated as "internal indicators" until such time that they will be submitted to USAID Washington. A review made by the SOAG M&E team and USAID on the

nature and availability of the 55 indicator values indicated the need to conduct the following:

- Generation of province-level estimates for the 17 indicators using national survey data (NDHS, FPS) that are representative only at the region level;
- A household survey to collect four indicator values which are not present in the existing surveys); and,
- Facility-based surveys covering provincial health offices, rural health units, public and private hospitals, private clinics including TB-DOTS centers, microscopy laboratories, and community-based organizations to collect 25 indicators values.

Given the shared responsibilities of collecting the 55 OP indicator values among the CAs and the scarce resources available in terms of funds, manpower, and time, the decision was made to pool CAs' resources and contract out the activities of data collection to a qualified firm or group on the basis of technical merit and price. The data collection and processing/tabulation are expected to be carried out beginning mid-April till mid-June 2007, in time for submission to USAID Washington before end of June. All the collected OP indicator values will be uploaded by the HPDP into the USAID/DOS FACTS database, and likewise shared with all the CAs.

The 27 HealthGov performance indicators, on the other hand, will utilize secondary data, sources of which include training reports of HealthGov technical assistance providers, health budget, and expenditure data obtained from LGU financial and budget records/reports. Other information regarding the local health system (health sector planning, health information system, procurement and logistics, inter-local health zone activities, health financing, etc.) will be collected through interviews of key informants and review of relevant records and documents in the LGUs. Moreover, equivalent OP indicator values which are available in the existing local health information system (FHSIS), procurement and logistics reporting system, PhilHealth records, and LGU reports will be collected from the HealthGov provinces and municipalities/cities as the project progresses.

All collected data will be stored in databases set up by the project:

- HealthGov Performance Management Information System (PMIS), which is a database that the HealthGov M&E Team and field staff will maintain; and
- HealthGov Training Management Information System (TMIS), which stores a more detailed set of information about the training activities of the project such as training design, schedules, participant profile, training costs, and training outputs.

Both databases will be managed and maintained by the HealthGov M&E Team, which is composed of the M&E Advisor, MIS Specialist, and Communications Specialist, supported by the IT Specialist and others. While the Training Database is already in place and currently available for training data inputs, the creation of the PMIS will be contracted out to a local IT firm. The set-up of this data base is expected to commence in mid-April 2007. Training data will likewise be entered in the USAID TraiNET/Web data base.

HealthGov will establish and maintain its own project website which will feature relevant health-related news, health statistics, program accomplishments, and LGU best practices. Initially, the website will feature two database portals: the PMIS data base and the OP indicators data base. However, there is an opportunity for integrating the TMIS module and other modules to the website in the course of the

HealthGov program. Data for HealthGov activity indicators and benchmarks will be collected by the Provincial Coordinators and uploaded in the regional offices. HealthGov staff will have access to both the PMIS data and TMIS data bases.

5.3 Monitoring of activity outputs and project performance during Year 1

Given the scope and nature of the planned project activities for its first year of implementation, HealthGov is expected to produce partial accomplishments in terms of the four intermediate results that they contribute to.

Provision of TA on PIPH development and completion as well as on finalizing PIPH implementation plans will contribute to the *strengthening of LGU management systems (IR 1.1)* by helping the LGUs effectively integrate health planning and budgeting functions into the overall systems, and institutionalize provincial-level multi-stakeholder coordination mechanisms. Intermediate results of the TA activities may be indicated by:

- # of LGUs with health sector investment plan (Province-wide Investment Plan for Health),
- # of LGUs with functioning ILHZs,
- # of health-related ordinances, resolutions, and executive orders,
- # of LGUs that increased the share of their health budget over total LGU budget,
- # of LGUs with more comprehensive and well-presented health plans and budgets,
- # of LGUs showing evidence of LGU input to health sector program or budget deliberations at the provincial level.
- # of LGUs that have passed an ordinance earmarking a proportion of IRA for health,

Provision of TA on CSR preparation and implementation will facilitate the mainstreaming and institutionalization of the CSR cycle in the 23 provinces, and may be indicated by:

- # of LGUs with procurement and distribution system for FP and commodities and hopefully other essential drugs
- Amount of in-country public financial resources budgeted for FP/RH in project LGUs.

Provision of TA on LSI implementation, and monitoring of expenditures of PhilHealth capitation funds and reimbursement using the Local Health Account will likely result in the *improvement and expansion of LGU financing for health (IR 1.2)*. The key results may be indicated by:

- # of LGUs that increased the share of their health budget over total LGU budget,
- # of people who are covered by USG-supported health financing arrangements (PhilHealth),
- # of LGUs who have completed market segmentation as a basis for introducing user fees,
- # of health-related ordinances, resolutions, and executive orders for increased provision of health funds.

TA on the use of SDIR and the integrated SBMR-PSEP approach, and on the development of a compliance monitoring tool for FP informed choice and voluntarism, as well as the updating of the Core Competencies Manual for RHMs and FP Competency-based Training Manual will lead to the development of interventions that will *improve service provider performance (IR 1.3)* by helping LGUs improve or strengthen systems for human resource management, health service quality assurance, provider training, and responses to infectious diseases will likely result in:

- # of LGU health facilities that have increased the number of facilitative supervisory visits to support performance improvement,
- # of LGU health facilities that are Sentrong Sigla-certified,
- # of LGUs monitoring compliance with informed choice and voluntarism on FP use.

On the whole, the TA to be provided by HealthGov during its first year of implementation is expected to produce various LGU plans (PIPH, CSR plans, health service delivery acceleration plans), training manuals, and monitoring tools. Effective implementation of local plans and use of the updated manuals and monitoring tools are likely to improve the LGUs' health management systems (e.g., planning and budgeting, health information, health financing, procurement and logistics, service delivery, etc.). These enhancements in the management of the various health systems will result in improved health service utilization of the FP/MCH, TB, micronutrients supplementation, and HIV/AIDS which, in the long run, will produce improved health outcomes.

List of 55 Selected OP indicators and Data Source/s

	INDICATOR	Data Source
	OBJECTIVE LEVEL INDICATORS	
1	Number of deaths among children under age 5 in a given year per 1,000 live births (note: this OP indicator is both an objective level and program area indicator)	NDHS
2	Percentage of in-union women of reproductive age using or whose partner is using a modern method of contraception.	NDHS
3	Cumulative number of HIV infections prevented by USG assistance	IHBSS
4	Immunization Rate	NDHS
5	Public expenditure on health	NSCB National Health Accounts (NHA)
	PROGRAM AREA INDICATORS: HEALTH	
1	Number of deaths among children under age 5 in a given year per 1,000 live births in that same year	NDHS
2	Number of children born per woman	NDHS
3	Percent of births attended by a doctor, nurse, or trained midwife	NDHS
4	Percent of GDP spent in health	NSCB NHA, National Income Accounts
	PROGRAM ELEMENT INDICATORS: HIV-AIDS	
1	Number of individuals reached thru community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	Household Survey (New)
2	Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	Facility (private), Community Based Organization - CBO, Facility (Facility (public))
3	Number of individuals trained in HIV- related community mobilization for prevention care and/or treatment	Facility (private), Community Based Organization - CBO, Facility (public)
4	Number of people trained in strategic information management with USG assistance on HIV/AIDS	Facility (private), Community Based Organization - CBO, Facility (public)
5	Number of monitoring plans prepared by the USG for HIV AIDS	KII (USAID and CAs)

	INDICATOR	Data Source
	INTERNAL INDICATORS: HIV-AIDS	
6	Number of local organizations provided with technical assistance for HIV-related policy development	Community Based Organization - CBO
7	Number of individuals trained in HIV-related policy-development	Facility (private), Community Based Organization - CBO, Facility (public)
8	Number of individuals trained in institutional capacity-building for HIV/AIDS	Facility (private), Community Based Organization - CBO, Facility (public)
9	Number of service outlets providing counseling and testing according to national and international standards	Facility (private), Community Based Organization - CBO, Facility (public)
10	Number of individuals trained in counseling and testing according to national and international standards for HIV/AIDS	Facility (private), Community Based Organization - CBO, Facility (public)
11	Number of individuals who received counseling and testing according to national and international standards	Facility (private), Community Based Organization - CBO, Facility (public)
12	Ratio of LGU public health expenditure for HIV/AIDS to total LGU Public health expenditures.	LGU
13	Ratio of DOH public health expenditure for HIV/AIDS to total DOH public health expenditure.	KII (Central DOH)
	PROGRAM ELEMENT INDICATORS: TUBERCULOSIS	
1	Case notification rate in new sputum smear positive pulmonary TB cases in USG-supported areas	LGU (NTP reports)
2	Number of people trained in DOTS with USG funding	LGU (NTP reports)
3	Number of TB cases reported to NTP by USG-assisted non-DOH sector	LGU (NTP reports)
4	Number of people covered by USG-assisted health financing programs for TB	LGU (NTP reports)
5	Number of people trained in strategic information management with USG assistance for TB	LGU (NTP reports)
6	Number of monitoring plans prepared by the USG (CAs) for TB	USAID

	INDICATOR	Data Source
	INTERNAL INDICATORS: TUBERCULOSIS	
7	Average population per USG-supported TB microscopy laboratory	PPMD, Facility (public)
8	Percent of USG-supported laboratories performing TB microscopy with over 95% correct microscopy results	NTRL/QI, DOH Central
9	Percent of LGUs in CA sites with at least one DOTS facility accredited by PhilHealth for TB Out-Patient Benefit Package	LGU (NTP Reports)
10	Percent of private health facilities accredited as DOTS facilities	LGU (PHO)
	PROGRAM ELEMENT INDICATORS: MATERNAL AND CHILD HEALTH	
1	Number of people trained in maternal/newborn health through USG-assisted programs	Facility (private), Facility (public)
2	Number of deliveries assisted by skilled birth attendants through USG-assisted programs	NDHS
3	Number of people trained in child health and nutrition through USG-assisted programs	Facility (private), Facility (public)
4	Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-assisted programs	Household Survey (new)
5	Number of children < 12 months old who received DPT3 from USG-assisted programs	NDHS
6	Number of children under 5 years of age who received Vit A through USG-supported programs	NDHS
7	Number of cases of child diarrhea treated in USG-assisted programs with ORT only	NDHS
8	Number of cases of child diarrhea treated in USG-assisted programs with zinc only	NDHS
9	Number of cases of child diarrhea treated in USG-assisted programs with both zinc and ORT	NDHS
10	Number of people covered by USG-supported financing programs for MCHN	NDHS
11	Number of people trained in strategic information management with USG assistance for MCHN	Facility (private), Facility (public)
12	Number of monitoring plans prepared by the USG CAs for MCH	USAID
	INTERNAL INDICATORS: MATERNAL AND CHILD HEALTH	
13	Number of pregnant women with at least 4 ANC visits by skilled providers from USG-assisted facilities	Household Survey (new)
14	Percent of fully immunized children (All vaccines including Hepa B and measles)	NDHS

	INDICATOR	Data Source
	PROGRAM ELEMENT INDICATORS: FAMILY PLANNING AND REPRODUCTIVE HEALTH	
1	Couple years of protection (CYP) in USG-supported programs	FPS
2	Number of people trained in FP/RH with USG funds	Facility (private), Facility (public)
3	Number of people that have seen or heard a specific USG-supported FP/RH message	Household Survey (new)
4	Amount of in-country public and private financial resources leveraged by USG programs for FP/RH	KII (DOH Central)
5	Number of people covered by USG-supported financing programs for family planning	NDHS
6	Number of people trained in strategic information management with USG assistance for FPRH.	Facility (private), Facility (public)
7	Number of monitoring plans prepared by the USG (CAs) on FPRH	USAID
	INTERNAL INDICATORS: FAMILY PLANNING AND REPRODUCTIVE HEALTH	
8	Number of counseling visits for FP/RH as a result of USG assistance	Facility (private), Facility (public)
9	Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the service delivery point	Facility (private), Facility (public)

Source: HPDP