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**EVALUATION TRIP REPORT (PHASE I)  
THE PHILIPPINES LOCAL GOVERNMENT  
UNIT PERFORMANCE PROGRAM (LPP)**

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**FAMILY PLANNING MANAGEMENT DEVELOPMENT**

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## **I. EXECUTIVE SUMMARY**

The evaluation of FPMD's support to the Philippines Local Government Unit Performance Program (LPP) forms one of five major country evaluations in FPMD's overall evaluation plan. It focuses on documenting lessons learned about designing and implementing a performance based project within a rapidly changing, devolved health system. The Philippines evaluation consists of three phases. Phase I, the subject of this report, is an assessment of the LPP design and implementation (excluding the MIS component). Phase II consists of focus group discussions in four LGUs, conducted by a local NGO. Phase III will be the evaluation of the MIS component.

FPMD support to the LPP was designed as a bridge project, leading to the Integrated Family Planning and Maternal Health Program (IFPMHP), slated to start in 1995. Working with the Office of Special Concerns (OSC) of the DOH, FPMD is to (a) assist local government units (LGUs) with the development of comprehensive plans for the expansion of targeted MCH and family planning services; (b) develop a system to monitor the implementation of these challenge grants and their impact on selected MCH and FP indicators; and (c) develop capacity within the OSC/DOH to monitor projects and assist LGUs.

The LPP is forging new ground as a performance based project in a devolved health system. National level managers saw the design as appropriate and timely, though some of them felt it was too closely focused on family planning. The capacity building benchmarks were perceived to be particularly beneficial. Implementation difficulties have clearly been underestimated, however, by both the USAID and the DOH. USAID/Manila acknowledged that all participants in the LPP - the USAID, DOH, and the FPMD staff - have had to "learn as they go along."

The LPP is placed in a highly complex environment, characterized by rapid changes in organizational structures, fluid management systems, and shifting health program priorities. Most of these challenges are beyond the immediate control of the FPMD staff, but can severely impact on LPP performance. Given these constraints, it is notable that USAID/Manila staff saw FPMD as "extraordinarily effective" in the way it has implemented the LPP so far. Similar praise was given by the DOH managers and counterparts. With one exception, the CAs were also satisfied with their collaboration with the LPP.

The evaluation reviewed FPMD's performance at three levels: the LGU, the OSC, and the LPP itself. At the LGU level, the four workshops to launch the LPP improved as experience was gained, and the final two were considered excellent. The workshop binders were deemed a very valuable planning tool. Intensive technical assistance to the LGUs seems to be highly appreciated by the LGUs. With the anticipated human resources available under the IFPMHP, it can not be sustained at the same level.

At the OSC level, FPMD staff have carried the primary responsibility for detailed review of LGU plans. These plans were sent to regional health and population staff and DOH counterparts for their review, but the quality of some of the comments received was

disappointing. It is a considerable credit to the FPMD team that all, except one, of the LGU plans were approved. Two organizational development consultancies on national and regional roles have not resulted in any visible changes in either the DOH or the DIRFOs. This may be, because the intense controversy over devolution, and subsequent difficult personnel issues still hamper clear role definitions at both levels.

Given the policy priorities of the USAID, institutional weaknesses of the DOH, and the turbulence of devolution, the FPMD technical advisors and consultants have been caught in a vortex of differing expectations. Their scope of work has had to change, and the staff have been drawn into a wider than advisable management role. This has included a leading role in defining and documenting DOH policies in FP and CS, researching and recommending funds flow mechanisms and procurement systems, etc. This is a dangerous precedent to set, as it allows the DOH to evade the structural and personnel changes that its devolved role demands. It is no surprise then that the LPP is still seen by many DOH managers as a "donor-led project," rather than an integral part of the DOH work plan. While this is certainly not unique to the LPP, sustainability requires a much higher level of involvement by DOH staff in the project.

FPMD/Manila has made a vital contribution to the implementation of the LPP by addressing five issues outside its scope work. These issues are essential for the implementation of the LPP, but were overlooked in the project design. They include (a) the classification of cities, (b) LGU funding formula, (c) provincial/municipality links, (d) funding flow mechanisms, and (e) procurement.

FPMD has gleaned valuable lessons from implementing this performance based project under devolution. These include the importance of (a) clarifying essential management roles, responsibilities, and systems in the design phase, (b) securing adequate numbers of national counterpart managers, and (c) building sufficient flexibility into the project design to allow periodic adjustments.

While FPMD's involvement in the LPP finishes in September 1995, the LPP continues under the IFPMHP. The three most important recommendations for future project implementation are to (a) redefine roles and responsibilities between the project team and the DOH staff, (b) develop links with key units of the DOH, and (c) network with relevant CAs, local NGOs, and government agencies. It is strongly recommended that USAID/Manila take the lead in addressing the issue of redefinition of roles with the highest management levels of the DOH, focusing on maximizing the sustainability of the LGU support structures that FPMD has developed.

## **II. INTRODUCTION**

The evaluation framework for the Family Planning Management Development (FPMD) project includes five major country evaluations. One of these is the Philippines, where FPMD, since October 1993, has been helping the government implement the Local

Government Unit Performance Program (LPP) under a delivery order from USAID/Manila. FPMD support to the LPP was designed as a bridge project, leading to the Department of Health's (DOH) new Integrated Family Planning and Maternal Health Program (IFPMHP), of which the LPP forms an integral part. The IFPMHP is slated to start in 1995, and will receive substantial funding from USAID. The project paper for the IFPMHP has only recently become available to the FPMD staff implementing the LPP.

The scope of work for FPMD's input into the LPP states that FPMD, working with the Office of Special Concerns (OSC) of the DOH, will:

- a) assist local government units (LGUs) with the development of comprehensive plans of action for the expansion of targeted MCH and family planning services;
- b) develop a system to monitor both the implementation of these challenge grants and the impact they have on selected MCH and FP indicators; and
- c) develop capacity within the OSC/DOH to monitor projects and assist provinces.

### III. EVALUATION METHODOLOGY AND SCOPE OF WORK FOR PHASE I

The Philippines evaluation focuses on documenting lessons learned about designing and implementing a performance based project within a rapidly changing, devolved health system. This is a modification of the framework used for the other in-depth country evaluations, necessitated by the fact that under the LPP, the first financial flows are not expected to reach the LGUs until the first quarter of 1995 at the earliest. Thus, any attempt to assess the impact of FPMD management interventions on family planning service delivery, before the Philippines buy-in ends, would have been premature.

The Philippines evaluation plan consists of three phases. Phase I is an assessment of the LPP design and implementation, excluding the development of systems to monitor implementation and impact of LGU performance grants (the MIS component). A document review in the home office of FPMD preceded semistructured interviews, conducted in Manila by this evaluation analyst of the FPMD/Boston Evaluation Unit in December 1994. Over 20 key managers were interviewed in the USAID/Manila, FPMD/Manila, DOH, Population Commission, and relevant cooperating agencies. The scope of work for Phase I evaluation is included in Annex 1. Annex 2 shows the list of people interviewed.

Phase II of the evaluation will be undertaken by an in-country NGO, Kabalikat. Kabalikat was selected through competitive bidding to carry out focus group discussions in four LGUs (Laguna, Isabela, Davao del Norte and Bacolod City) during January 1995. This visit to the Philippines for Phase I evaluation also included the necessary meetings to set up the Phase II evaluation with Kabalikat, and to field test the focus group questions in Bulacan. Phase III of the evaluation is planned for May 1995, and will target the MIS component.

This evaluation report is confined to Phase I. It first describes the unique project setting, crucial for appreciating the achievements and challenges of the project team. It next discusses the evaluation findings under two headings: the LPP design, and the LPP implementation. The latter section makes general observations on the implementation, and reviews the accomplishment of the measurable indicators in the FPMD project work plan for October 1993 to December 1994, shown in Annex 3. As mentioned above, this first phase of the evaluation excludes an assessment of the fourth objective/activity in the project work plan ("Develop systems to monitor implementation and impact of LGU performance grants"), which responds to item (b) of the project scope of work (see previous page). This will be the focus of Phase III of the evaluation. The next section of the evaluation report discusses some special issues which were not anticipated under the LPP scope of work, but which have considerably influenced it. The report concludes with lessons learned about project design in a devolved setting, and recommendations specific for project implementation. Annex 4 includes an executive summary of an internal evaluation, conducted by the FPMD/Manila staff in September 1994, which forms a valuable assessment of the implementation lessons learned in 1994.

#### **IV. PROJECT SETTING**

The LPP is placed in a highly complex environment, characterized by rapid changes in organizational structures, fluid management systems, and shifting health program priorities. Many, if not most of these challenges are beyond the immediate control of the FPMD staff. All of them, however, have the potential of severely impacting on LPP performance. The description that follows highlights some of the key concerns facing the FPMD implementors.

##### **A. Regarding Devolution**

Since January 1993, health services devolution from the central DOH to the LGUs has progressed with unprecedented speed. There was little time either to plan appropriate management systems for devolution or to prepare staff at central, regional or local levels for their new roles and responsibilities. Implementation of donor funded projects, such as the LPP, continues to uncover essential aspects of project management (such as funds flow mechanisms from the national DOH to the LGUs, legal aspects of signing memoranda of understanding between DOH and LGUs, etc.) that were not worked out in sufficient detail prior to the signing of the Delivery Order with MSH.

##### **B. Regarding Family Planning**

At the time when the FPMD Delivery Order was written, the charismatic new Secretary for Health, Dr. Juan Flavies, gave priority attention to revitalizing family planning. In recent months, however, the strong opposition of the Catholic Church has dampened such visible publicity for family planning, thus raising concerns about ongoing national commitment to a strong FP program effort. The 1995 DOH priority programs list, "Five for

Life in '95," announced in the national Health Assembly held on the last two days of this evaluation, does include family planning among the five priorities. Two key events, both likely to impact on the family planning program, will occur in 1995: the visit of the Pope in January and the national and local elections in May.

Delivery structures for FP services at the community level deteriorated during the previous Aquino administration. Responsibility for FP service delivery was transferred from the Population Commission (POPCOM) to the DOH in the 1980s. Remnants of the "turf battles" between the two are still discernible at local levels, whereas at the national level, these have largely been resolved. POPCOM has a new, dynamic leader who is focusing the organization's efforts on advocating the concept of "population management." Family planning is a component of this, but clearly seen as the responsibility of the health sector.

### **C. Regarding the DOH**

Devolution left the DOH highly divided. A senior Filipino observer likened the DOH to a Rubik cube: divided over several lines and showing different sides at different times. Various organizational interventions intended to develop a unity of purpose have yet to yield visible results. The reasons for this are not immediately clear to an outside observer. At the time of this evaluation, the institutional climate at the DOH was further disquieted by reports that the President had asked Dr. Flavier, who continues to be very popular with the general public, to be a senatorial candidate in the upcoming May 1995 elections. This would require the Secretary to resign his present post by February 8, 1995, a change which is likely result in considerable organizational changes in the DOH.<sup>1</sup>

The organizational chart of the DOH is characterized by ad hoc structures, created under the Flavier administration, and by staff on contractual, rather than permanent ("plantilla") positions. These institutional weaknesses are particularly noticeable in the Office of Special Concerns (OSC). The Family Planning Service (FPS), a subunit of the OSC, recently lost half of its staff and several "plantilla" positions to another unit of the DOH. The OSC "head" office, an "ad hoc" structure, has only one technical staff member besides the Assistant Secretary to manage the multiple commitments of the OSC. This is of particular concern, since the OSC will soon be charged with implementing several other donor funded projects besides the LPP. These include the Women's Health and Safe Motherhood project, the Integrated Community Health Development project, projects on AIDS, etc.

In 1994, the DOH engaged in drafting Comprehensive Health Care Agreements (CHCAs) with individual provinces and cities, and in arranging for their signing by the Secretary for Health and the local chief executive of each province/city. These agreements govern the relations between the DOH and LGUs by specifying what central and local inputs

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<sup>1</sup>After this report was written, Dr. Flavier resigned to run for the Senate, effective January 31, 1995.

will be made available for LGU health programs. The process of reaching consensus on the CHCAs has at times proved more arduous than expected. At the time of this evaluation, it was anticipated that the LPP Memorandum of Understanding (MOA) would form an annex to each CHCA. It was unclear, however, whether this MOA would need to be passed separately by each LGU's governing body, the Sanggunian, thus potentially delaying the project start-up.

## V. FINDINGS

### A. LPP Design

LPP is a performance based, grant funded project, intended to augment funding for population/FP/child survival (CS) programs at the LGU level. It is an integral component of the new IFPMHP. Funds are made available annually to the DOH and the LGUs, dependent on their reaching certain performance benchmarks. The LGUs are supported under the LPP through planning workshops, intensive technical assistance, and provision of necessary materials and equipment. The performance benchmarks change over time. After the year 1 start-up benchmarks, they focus on capacity building in year 2, service access in year 3, and program performance in years 4 and 5. In the start-up year, 1994, the DOH was required to reach seven benchmarks and the LGUs three. The LGU benchmarks for this first year of the project were set at the national level. Future benchmarks are negotiated jointly between the national and LGU levels.

DOH managers interviewed uniformly saw the LPP design as appropriate and timely. Coming so soon after devolution, its support to LGU capacity development and the augmentation of LGU funds were considered very valuable. The workshops and follow-on technical assistance to the LGUs were seen as a concrete demonstration of how to plan at the LGU level. The capacity building benchmarks were perceived to be particularly beneficial, since they would give the DOH some needed leverage with the LGUs.

Some informants from inside and outside the DOH commented that the initial design was focused almost exclusively on family planning, overlooking wider population concerns and including child survival almost as an afterthought. Support to child survival is limited to EPI, ARI, CDD and micronutrients, and to approximately 30 per cent of the funding. Since the project design is flexible (a design feature which was much appreciated), FPMD technical advisors were able to adjust it to respond, at least partially, to these two concerns.

Several individuals commented that both the USAID and the DOH underestimated the difficulties of implementing a performance based project like the LPP under a devolved health care system. Three particular issues that can seriously jeopardize LGU performance were commented on. These were (a) funds flow from central to peripheral coffers, (b) procurement, and (c) the "pass/fail" system of performance benchmarks. The funds flow mechanism, which USAID had assumed would be clarified in the design phase, turned out to

be a much more complicated issue than anticipated. The complexity of procurement under devolution was another surprise. These two issues are explored further in a later section of this report. The FPMD staff responded to these two concerns by engaging a subcontractor and an outside consultant, respectively, to study the issues, and to make recommendations to the Local Government Unit Performance Program Advisory Committee (LPPAC) and the USAID.

The LPP design is "pass/fail" in that it excludes from the program any LGUs who do not meet the performance benchmarks. In 1994, at least one LGU was given additional time to reach the benchmarks for inclusion in the project. Will such extensions be given in later years, and if yes, for what reasons? Who will grant such extensions? If an LGU is short only on one benchmark, can any money be allocated to continue the program in the areas not covered by that benchmark? These are design issues that have yet to be faced.

The original design anticipated the first phase of the LPP, implemented by FPMD, to cover 100 LGUs in approximately eight workshops, together with the necessary technical assistance. This proved far too ambitious, and was scaled down to 20 LGUs in the first year and four workshops, by the time FPMD commenced the implementation. Even this has been a considerable workload for the limited staff. Interviews revealed clear support among the DOH managers for more flexibility in the number of LGUs to be absorbed into the LPP annually. Several managers felt that it would be preferable to include only 10 LGUs into the program in 1995, in order to consolidate the work done so far. More LGUs could be incorporated in later years, when both the DOH and the LGUs have gained more experience with the project.

## **B. LPP Implementation**

USAID/Manila staff stated unequivocally that FPMD has been "extraordinarily effective" in the way it has implemented the LPP so far. They acknowledged freely that the LPP is forging new ground as a performance based project in a devolved health system. They also recognized that the DOH is still struggling with the impact of devolution, and that all participants in the LPP - the USAID, DOH, and the FPMD technical advisors - are "learning as they go along."

Similar praise for the FPMD staff was given by the DOH managers and counterparts. Several of them commented favorably on the quality of documents that FPMD/Manila sent for their review, the smooth working relationship between FPMD technical advisors and their DOH counterparts, and how well prepared FPMD staff were at meetings. A key informant remarked that the FPMD technical advisors were "credible with program managers." The evaluator was, however, left with a clear impression that the LPP is still seen by many DOH managers as a "donor-led project," rather than an integral part of the DOH work plan. This is not unique to the LPP. Discussions with other donor agencies revealed it to be a common issue with most donor projects in the DOH.

The rigidity of the DOH's organizational structure and management systems, and the amount of donor funding available in recent years appear to mitigate against DOH's ability to integrate donor projects. This is of great concern, since the sustainability of the LPP requires a much higher level of involvement by DOH staff in the LPP: the workshops, TA to LGUs, benchmark monitoring, etc. The financial support for hiring two additional staff members for the OSC under the LPP will help, but unless at least one of these positions is a "plantilla," rather than contractual, position with primary responsibility for managing the LPP, this DOH structural problem will not be solved.

Interviews with USAID funded cooperating agencies (CAs) revealed that they were generally satisfied with their collaboration with the LPP. The Family Planning Logistics Management (FPLM) project manager was particularly appreciative of LPP support, and stated that the LPP program grants are serving as a clear incentive for LGUs to conduct regular quarterly CDLMIS deliveries. This is documented in the FPLM quarterly reports nos. 12 and 13, which were made available for the evaluator. Only one CA manager interviewed felt that there was no clear working relationship with the CAs that would best use their skills.

The creation of the LPPAC, on the suggestion of the Assistant Secretary of the OSC, was a very constructive move. The LPPAC brings together the key stake holders at the national level, thus increasing ownership of the project. The addition of POPCOM and more recently, the Local Government Assistance and Monitoring Service (LGAMS) were important. It was clear from the interviews that both POPCOM and LGAMS saw the LPPAC as an important organ, though the LGAMS director acknowledged that his other duties have not allowed him to participate as much as he would have wished.

Finally, interviews by the evaluator, and observations by a member of FPMD's home office's Operations Unit staff whose TDY coincided with the evaluation mission, showed that an effectively functioning office has been established. (This is the indicator measuring the first objective/activity of the work plan.) The LPP experienced initial problems in recruiting qualified candidates for the TA positions, as these posts were seen to be without job security, but eventually managed to employ some highly motivated and skilled staff. The office space is well laid out within the confined space, and incorporates individual working spaces, a small meeting area and a tiny staff kitchen. Files are in order, each TA visit is documented in a trip report, minutes of meetings are kept well, and administrative staff are able to produce requested documents promptly.

### *1. The Local Government Unit Level*

The second objective/activity of the work plan calls for assistance to twenty LGUs with the development of plans for FP/MCH. The indicators related to selection of LGUs for 1994 and 1995; designing a workshop curriculum and conducting the workshops; and technical assistance to LGUs. At the time of the evaluation, all the indicators, except one, had been accomplished. The remaining one was the final selection of the 1995 LGUs, for

which extensive analyses of LGU commitment had been conducted. Final selection was to be made by the LPPAC in its December 20, 1994 meeting.

Workshops: Four workshops were conducted in the first half of 1994. These were intended to introduce the LPP to the LGUs and to begin the planning process. Those interviewed uniformly concurred that the workshop design improved greatly as more experience was gained. The attempt in the first workshop to mix content areas with follow-on planning sessions proved confusing to the participants. The workshop design was modified to concentrate the content areas at the beginning of the workshop, thus freeing more time for planning, and shortening the workshop duration. While the first workshop thus clearly had room for improvement, the final two were considered excellent. The central level staff deemed the workshop binders to be a very valuable planning tool. The Officer-in-Charge of FPS even asked extra copies for the use of her own staff. The opinions of the LGU staff on the usefulness of the workshop will be probed further in the focus groups discussions of Phase II evaluation.

Technical assistance: The TA plan of at least one visit to each of the 20 LGUs has been greatly exceeded. As of December 5, 1994, the FPMD technical advisors had conducted 83 TA visits to the LGUs, using a detailed guideline that they had prepared. This increase in the number of TA visits resulted from two observations by the FPMD staff. Firstly, the LGUs did not proceed as far in their planning process during the workshops as had been anticipated. Secondly, many LGUs made little or no progress with their plan between the TA visits.

Technical support to the LGUs has been a very valuable but extremely time-consuming activity for the FPMD staff. It has allowed the FPMD technical advisors the opportunity to meet personally with the chief executive officer of the LGU, and to strengthen planning skills of LGU staff. The limited observations made during this phase of the evaluation showed that this intensive support from the FPMD staff has been greatly appreciated. This finding will be verified in the focus group discussions.

The TA visits revealed that the LGU planning team usually consisted of the Provincial/City Health Officer, Assistant Provincial Health Officer for Public Health, Chief of the Technical Services, different program coordinators, and the Provincial/City Population Officer. In many LGUs, the LPP planning sessions seemed to be the only time the relevant staff came together. Team work between the planners and the LGU's relevant administrative staff (Planning Officer, Budget Officer, Commission on Audit staff, etc.), however, was generally not strong. This is regrettable, since budgeting skills of the LGU planners were generally found to be in short supply.

During 1994, only selected regions and none of the DOH counterparts participated in the TA visits. The DOH Integrated Regional Field Offices (DIRFOs) have been quite unsettled by the devolution, and the DOH counterparts have multiple other responsibilities besides the LPP. However, with an average of over four TA visits per participating LGU in

a year, and with the increasing number of LGUs each year, FPMD technical advisors can not sustain this level of LGU support alone. Ways must be found to increase the involvement of national and regional staff in LGU-level support.

## *2. The Office of Special Concerns Level*

The observations of this evaluator confirm the concerns raised by the FPMD/Manila in its third quarterly report (July 1 - September 30, 1994). To quote:

The lack of full-time DOH/OSC staff dedicated to the management of the LGU Performance Program continues to be a serious concern. This is the key stumbling block to sustainability of the program and ownership of the system being created for provision of technical and financial assistance to local governments. Due to lack of available counterpart staff, FPMD technical advisors are making management and funding decisions that the DOH should be making for itself...

Although FPMD's work is always submitted to the DOH for approval, it must be said that FPMD staff worked... alone in developing the planning standards, plan outline, and required justification for the budgeted items, and in designing procedures for LGUs to access and report on use of funds.

In order to accomplish the work program, FPMD has been forced to assume a much wider role than was either anticipated under the work plan or that is advisable. FPMD technical advisors and consultants have been drawn into helping define and document DOH policies in FP and CS, researching and recommending funds flow mechanisms and procurement systems, etc. This is understandable, given the staffing difficulties of the OSC, and FPMD's responsibility for making the project operational. It is, however, a dangerous precedent to set, as it allows the DOH to evade the structural and personnel changes that its devolved role demands. Addressing this issue with the highest management levels of the DOH requires strong support from USAID; it can not be undertaken by the FPMD technical advisors alone.

Plan review and approval: The third objective/activity of the project work plan calls for the development of a system for LGU plan review and approval. All of the three indicators have been met. The first refers to the development of criteria for funding the first year LGU plans and for communicating these criteria to the LGUs. Three criteria were developed with the DOH: (a) accomplishing an integrated population/FP/CS plan; (b) having an operational contraceptives distribution system (CDLMIS); and (c) submitting an administrative order defining roles and responsibilities of health and population offices. All 20 LGUs submitted their plans to the OSC in a timely manner (second indicator). All, except one of these plans were recommended for approval, exceeding the third indicator which required 75 per cent to be recommended. (The Negros Occidental province submitted a plan to the DOH, but it had not been endorsed by the Governor.)

One national manager commented that there was a marked improvement in the quality of LGU plans from those submitted under the previous USAID-funded Child Survival project. That all plans were of sufficient quality to be recommended for approval is a great credit to the FPMD team, who devoted numerous hours to reviewing the plans line by line, recommending revisions.<sup>2</sup> The review process was obviously very thorough, since the staff at Bulacan related that they all went to church to pray prior to sending in their final draft!

The detailed review of the plans has primarily been the work of the FPMD staff. They developed a plan review guideline, and sent the plans to be reviewed by regional health and population staff, and their DOH counterparts. It was reported, however, that the quality of some of the comments from central and regional reviewers was disappointing. Comments often came late, were superficial, and did not expound on issues that the FPMD reviewers needed clarification on. Regional POPCOM offices were not involved in reviewing all provinces; this will be amended in 1995. Several collaborating agencies were also included in reviewing relevant sections of the plans. The present level of detailed review of the plans by FPMD staff is extremely time consuming, and not supportable when the LPP includes annual plans from 40, 60, and 100 provinces, especially if there is no corresponding increase in staffing.

OSC capacity to manage assistance to LGUs: This is the fifth objective/activity of the project work plan. The first indicator, the development and dissemination of a detailed explanation of the LGU funding mechanism, has been accomplished. The second indicator refers to an overseas study tour for one or more OSC/LGU staff. This was planned for the second quarter of 1994, but cancelled due to scheduling difficulties of the proposed candidates. The third indicator is the participation of DOH and LGU staff in an organizational development intervention to define roles under devolution. Two organizational development consultancies have been undertaken: the first to look at the national roles, the second focusing on the regional roles. At the time of this evaluation, only a verbal report from the first consultancy was received. The written report of the second consultancy was circulated widely. It was difficult to discern any concrete changes in either the DOH or the DIRFOs that would have resulted from either consultancy. For an external evaluator, the reasons are not immediately obvious. One can only assume that the intense controversy over devolution, and subsequent difficult personnel issues are still hampering clear role definitions at both levels.

### 3. *The LPP Level*

Scope of work: The FPMD input to the LPP has evolved considerably over the last year. The delivery order gave FPMD primary responsibility to run workshops and give follow-up technical assistance to LGUs, and a lesser role to develop DOH experience in monitoring LGU proposals by working together at the LGU level. In addition, some short-term TA in MIS, personnel management and strategic planning was included. From this

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<sup>2</sup>One plan was not approved because it lacked the Governor's signature.

relatively straightforward set of activities, the FPMD work has developed into a complex web of interlinking management interventions.

After the years of the Aquino administration which were unresponsive to family planning, USAID/Manila was keen to grasp the opportunity presented by the new administration, and wanted FPMD to implement LPP quickly. It underestimated, however, the complexity of project implementation under a devolved system, where management systems and organizational relationships have fundamentally changed, and are still blurred. The DOH, caught in the maelstrom of devolution, and faced with a government dictate to downsize, is still deeply divided over the issue of decentralization. Saddled with a rigid, pre-devolution organizational structure, it has been ill-prepared either to grasp its new support role to the LGUs or to devote the necessary human resources to institutionalizing donor projects. It has essentially handed the management of the LPP to the FPMD staff. The LGUs, in turn, have seen the LPP largely as a source of additional funding, not as an attempt to improve management. While they have been happy to accept the additional funding, they have not necessarily been similarly prepared for the additional planning and administrative requirements that the LPP dictates. POPCOM staff are keen to promote the concept of population management, and see the LPP as an important partner. The CAs are generally also eager to participate in the LPP, primarily to promote their own areas of activity. FPMD technical advisers are thus caught in a vortex of differing expectations.

The FPMD technical team does not possess special expertise either in decentralization or the intricacies of the Local Government Code, but does carry the main responsibility to make the LPP operational. Given the institutional weaknesses of the DOH and the turbulence of devolution, clarification of essential management details, such as how donor funding was to flow to the LGUs, has not been forthcoming from the DOH. Little by little, the FPMD scope of work has had to change. Instead of being able to "introduce (workshop) participants to the mechanism through which provinces and cities will be granted DOH challenge grants," as the Delivery Order states, FPMD has had to devote considerable energy to researching and reaching a consensus on the appropriate classification of cities, best mechanism for LGU grants, procurement systems, etc.

In the special circumstances of post-devolution Philippines, with the constraints referred to frequently in this evaluation report, it is difficult to see how the changes in the scope of work could have been avoided. It is crucial, however, now to make a concerted effort to reach a clear understanding of respective roles and responsibilities in the management of the LPP between FPMD technical advisors, the new IFPMHP staff and the DOH central and regional staff. Furthermore, it is important to continue to promote the LPP among the LGU executives, and to correct any misunderstandings of its purpose and structure that they might have. It is regrettable that the FPMD staff did not lobby with the DOH for an opportunity to do so during the First Philippine National Health Assembly, held during this evaluation.

Documentation of the project and FPMD/Boston TA visits: The sixth and seventh objective/activity of the project work plan cover timely submissions of field expenses and activity progress reports, the production of an evaluation report, and several itemized TA visits by FPMD/Boston staff. All the relevant indicators have been or will be reached on schedule.

The assistance of FPMD's Kenya Administrative Officer in establishing administrative systems was clearly worthwhile. The Philippines administrative staff have learned MSH's standard management systems with surprising speed. Still, of all the Asia projects in FPMD's portfolio, the Philippines one continues to require the most intensive management attention from the home office, because of its large and complex workload and quite limited human resources.

## **VI. CRITICAL CONCERNS OVERLOOKED IN PROJECT DESIGN**

Reference has been made above to the relatively simple scope of work that FPMD was initially given, and how this evolved into a much more complex set of management interventions. Five particular issues, of vital importance to the launch of the LPP, were overlooked in designing the project. These were (a) classification of cities, (b) LGU funding formula, (c) provincial/municipality links, (d) funds flow mechanisms, and (e) procurement.

### **A. Classification of Cities**

The LPP is designed to assist 76 provinces and 24 cities by 1999, but the design does not specify which individual cities the project is to work in. In selecting the first year LGUs, it soon became evident that the selection of LGUs was hampered by the ambiguous classification of cities. Various definitions for cities, such as "component," "chartered," "independent component," "special" etc., were in use, but their use was not consistent. While resolving this issue was not in FPMD's scope of work, it was an essential prerequisite for the start of the project. FPMD undertook to research the issue on behalf of the DOH and USAID. As a result, the start of the first workshop was delayed from November 1993 to February 1994.

### **B. LGU Funding Formula**

The delivery order did not include any details on the funding formula that would be applied to divide the LPP funding from USAID among the LGUs. This was another area, where FPMD staff took an initiative. Through the assistance of a subcontractor, FPMD developed a funding formula that took account of provincial/city population and per capita income. This was accepted by USAID/Manila and the DOH.

### **C. Province/municipality Link**

The LPP provides financial support to provinces, but most FP and CS program activities take place at the municipal level. Devolution made both of these government units independent of each other. How will the provinces know what the municipalities need and want from the LPP? Does the provincial government possess the necessary management systems to support the municipalities? Who will be held accountable for the performance benchmarks? How will the monitoring be done? These are just some of the myriad planning and implementation issues that arise.

Addressing the issue of province/municipality links was not in the FPMD scope of work, but it had the potential of jeopardizing the success of LPP implementation. FPMD responded by providing subsidies to the LGUs to fund provincial/municipality consultations. FPMD managers noticed that many of the provinces did not really know how to structure such consultations, even when funding subsidies made arranging them possible. FPMD developed suggested material, such as a meeting agenda, for LGU use.

### **D. Funds Flow**

Under the LPP, the USAID will disburse funds to the DOH in five annual tranches, based on the attainment of performance benchmark. These dollar tranches will be used by the Philippine Government (GOP) to repay U.S. debt. The GOP has agreed to make equivalent peso amounts available to the DOH to finance the LPP. Fulfillment of the benchmarks by the LGUs is clearly dependant on how promptly and regularly the DOH can channel these GOP funds to the LGUs, and the extent to which these funds can be earmarked for the LPP.

When designing the LPP, the USAID presumed that the funds flow mechanisms for donor funds from the central to the local government coffers had been worked out. However, when the FPMD team began to examine the issue, it soon became evident that the Philippine government financial and accounting systems and intergovernmental transfers from the national to the local governments, as dictated by the requirements of the GOP Department of Budget and Management and the Commission of Audit, were far more complex than anticipated. While defining the funds flow mechanisms was again not included in the FPMD's scope of work, they were clearly essential for the launch of the project. The FPMD managers responded by commissioning a subcontractor (CEPR), who appointed Dr. Bing Alano to research the issues, and develop a funds flow process for the LPP.

### **E. Procurement**

Reaching the performance benchmarks depends not only on the financial resources being made available, but also on timely procurement of necessary drugs and equipment. This was another area that devolution profoundly transformed. The LGUs are now expected to do their own procurement, but have little experience or practice doing this in the health

field. Just as for financial flow mechanisms, this issue was not anticipated at the design phase of the project, and was thus excluded from the FPMD scope of work. Since it is crucial to the success of LPP implementation, the FPMD team contracted with a consultant to develop procurement options, study their advantages and disadvantages, and present these for the LPPAC's consideration.

## **VII. LESSONS LEARNED ON PROJECT DESIGN**

As mentioned before, USAID/Manila has acknowledged that the Philippines LPP project has been a learning experience. Therefore, the opportunity should not be lost to gain from the valuable lessons FPMD has gleaned about designing performance based projects for decentralized health systems. Three are singled out here as deserving critical attention. These are (a) clarifying essential management roles, responsibilities, and systems in the design phase, (b) securing adequate numbers of national counterpart managers for sustainability of the project, and (c) building sufficient flexibility into the project design to allow periodic adjustments.

### **A. Clarify Essential Management Roles, Responsibilities and Systems**

A performance based project design ties the release of funding tranches to the achievement of predefined benchmarks. Reaching such benchmarks is, in turn, dependant on necessary resources being made available at an appropriate time to those implementing the integrated plans at the LGU level. In a newly decentralized health care system, management roles, responsibilities and systems that can secure the necessary resources require careful development and nurturing. Foremost among the issues that should be clarified in the design phase are those determining (a) funds flows between the central and LGU governments, (b) procurement of drugs and equipment, and (c) provincial/municipality collaboration in project planning and implementation.

### **B. Secure Adequate National Counterpart Management Staff**

The sustainability of a performance based project beyond the departure of the donor-funded project team is seriously jeopardized, if senior managers at the national level fail to become closely involved in the design and implementation of necessary management structures and supportive linkages between the center and the periphery. While periodic, part-time counterpart involvement can be very valuable in various aspects of project implementation, it is no substitute for intensive senior level management oversight of the project. In future project designs, serious consideration should be given to making the provision of such a senior full-time, national counterpart manager a precondition for project implementation.

### **C. Build Flexibility into the Project Design**

The Philippines experience has demonstrated that project implementation under decentralization is very complex and labor-intensive. Available human resources under the project design for the implementation of the LPP are stretched thin to cover the myriad demands on them. Many of these demands were either not foreseen under the project design or have been considerably larger in magnitude than anticipated. In rapidly changing health systems, such as the one in the Philippines, flexibility is a crucially important element in project design. With sufficient flexibility, the demands of the project work plan, and the financial and human resources that can be made available to meet them can periodically be realigned to ensure that performance benchmarks are met.

## **VIII. RECOMMENDATIONS ON PROJECT IMPLEMENTATION**

While FPMD's involvement in the LPP finishes in September 1995, the LPP continues under the IFPMHP. Findings of this evaluation can thus serve to guide the ongoing implementation of this project. The three most important recommendations are to (a) redefine roles and responsibilities between the project team and the DOH staff, (b) develop links with key units of the DOH, and (c) network with relevant CAs, local NGOs, and government agencies.

### **A. Redefine Roles and Responsibilities**

This report has raised the serious concern over the wide management role that FPMD staff have had to adopt in implementing the project so far. The arrival of the new project team for the IFPMHP is an opportune time to take a fresh look at the roles of the present FPMD team, the new team, OSC counterparts, and DIRFO staff. It is strongly recommended that USAID/Manila take the lead in addressing this issue with the highest management levels of the DOH, focusing the redefinition of roles to maximizing the sustainability of LGU support structures that FPMD has developed.

Special emphasis should be given to the DIRFOs in identifying promising individuals and units who will be trained to take over responsibilities in running workshops, technical assistance, and monitoring. An analysis should be made of what support - or even incentives - the DIRFOs would need to make them a fully involved partner in the LPP.

The role of the FPMD and IFPMHP staff should gradually shift from implementation to planning and training. They should focus more on collaboration in the development and refinement of appropriate planning standards, management systems for LPP implementation, and monitoring systems for population/FP/CS than on maintaining primary responsibility for running LPP workshops, providing technical assistance to the LGUs, reviewing plans, and monitoring performance benchmarks. Close collaboration with counterparts and with

representatives of relevant CAs is essential in transferring these responsibilities gradually to the DOH staff over the life of the project.

FPMD's primary role in technical plan review should be handed over to the person the OSC designates as the LPP manager. This will ensure that the experience with and insights into LGU planning capacity and problem issues will accrue to the DOH staff, not just to the project. It will free the FPMD project staff to revise the plan review guide, and conduct comparative analyses of the plans, such as the unit price comparisons of the first set of plans. It will also allow a streamlining of the review process, with the first draft being reviewed by the LPP manager, together with relevant DIRFO staff.

### **B. Develop Links With Key Units of the DOH**

The FPMD staff are establishing a project which pioneers DOH assistance to the devolved local government health services. So far, the project has mainly been involved with those units of the DOH that have primary responsibility for FP and CS. In order to increase knowledge about the LPP and to facilitate its implementation, the staff should now begin to build links with other key units of the DOH. Collaboration with LGAMS has already started, and should serve to promote the LPP among LGU executives and to correct any possible misunderstandings they might have. Links with other key units, such as the Internal Planning Service (IPS), Health Policy Development staff, the National Health Planning Program, and the Foreign Assistance Coordination Service (FACS), are, however, still tenuous, and should be strengthened.

### **C. Network with Other Relevant Partners**

An efficient and effective integrated population/FP/CS program at the LGU level utilizes the strengths of both public and private sector resources to enlarge and improve the program. The aim of the FPMD/IFPMHP unit should be to link such national and LGU level resources with local needs. To do so effectively, the project staff should keep abreast with current program activities and the technical strengths of relevant partners, such as other donor funded projects, NGOs, and government agencies, and channel this information to the DOH counterparts and the LGU staff.

**ANNEX 1**  
**SCOPE OF WORK FOR PHASE I EVALUATION**

**DR. RIITTA-LIISA KOLEHMAINEN-AITKEN**  
Senior Evaluation Analyst, MSH/FPMD  
(November 28 - December 16, 1994)

The FPMD contract mandates the contractor, Management Sciences for Health, to undertake extensive evaluation of project activities. A key component of the evaluation framework, approved by the USAID/Washington, is an in-depth evaluation of five major focus countries, Bangladesh, Bolivia, Kenya, Mexico and the Philippines.

The evaluation of the Philippines LPP Program subproject has as one of its main objectives the documentation of lessons learned in the design and implementation of a project of this type within a devolved health system that is undergoing rapid change. The findings will help improve the support to the new LGUs entering the LPP in 1995, and the implementation of the follow-on project.

The scope of work consists of three phases: (1) the initiation of the evaluation and interviews with Manila based managers by the evaluator during this visit; (2) focus group discussions with LGU managers, conducted by a subcontractor in January/February 1995; and (3) a repeat visit by the evaluator in April/May 1995 to evaluate the MIS component and to finish interviewing key staff.

During this visit for Phase 1, the evaluator will:

1. Meet with USAID staff, DOH managers, LPP Advisory Committee members, LPP Program staff, and other key individuals who have participated in the LPP Program to present the LPP Program evaluation and its objectives, and to interview them for their views on the LPP Program design and implementation.
2. Meet with a local agency contracted to conduct focus group interviews in four LGUs in order to finalize the focus group questions and protocol. Attend to any outstanding contract issues with the agency.
3. Participate in a field test of the focus group questions in one to two LGUs, and revise questions, based on the results.
4. Synthesize the findings from the interviews with managers, listed in Task 1 above, in a preliminary report of the first phase of the evaluation.

This scope of work for Phase 1 is expected to take about three weeks.

**ANNEX 2**  
**PERSONS INTERVIEWED**

**USAID/Manila**

Ms. Eilene Oldwine, OPHN

**FPMD/Manila**

Ms. Taryn Vian, Resident Advisor  
Ms. Eireen Villa, Senior Technical Advisor  
Dr. Cecile Lagrosa, Technical Advisor

**Department of Health**

Dr. Jaime Galvez-Tan, Chief of Staff  
Dr. Carmencita Reodica, Assistant Secretary, OSC  
Dr. Maria Otelia Costales, OIC, MCHS  
Dr. Rebecca Infantado, OIC, FPS  
Dr. Gerry Bayugo, OIC, NS  
Dr. Juan Perez, OIC, LGAMS  
Dr. Marvi Ala, Medical Specialist III, OSC  
Ms. Emily Maramba, FPS  
Dr. Carmen Gervacio, Medical Specialist IV, MCHS  
Dr. Odette Paulino, Medical Specialist III, NS  
Dr. Wilbert Eleria, Medical Officer, LGAMS  
Mr. David Alt, Resident Advisor, FPLM  
Mr. Patrick Coleman, IECM Resident Advisor, JHU/PCS

**Population Commission**

Ms. Cecilia Yasay, Executive Director

**UNFPA**

Mr. George Walmsley, Country Director

**WHO**

Dr. A. Romualdez, Country Representative

**AVSC International**

Dr. Nelie Antigua, Country Director

**JSI Research and Training Institution**

Ms. Jet Riparip, Resident NGO Advisor

**Center for Economic Policy Reseach**

Dr. Bienvenido Alano, Jr., President

**Kabalikat**

Ms. Teresita Bagasao, Executive Director

Ms. Ruthy Dionisio-Libatique, Deputy Executive Director

**ANNEX 3**  
**MEASURABLE INDICATORS OF FPMD WORK PLAN ACTIVITIES**  
**(OCTOBER 1993 - DECEMBER 1994)**

Objective/Activity	Indicator
1. Establish project office	1. Office is established and functioning effectively.
2. Assist 20 LGUs with the development of plans for FP/MCH	1. Workshop curriculum specifying components of LGU plans 2. OSC has selected LGUs for 1994 3. OSC has selected LGUs for 1995 4. Initial visits have been conducted to all 20 LGUs 5. 4-5 workshops have been conducted with participation from 20 LGUs 6. At least one TA visit has been conducted to each of the 20 LGUs
3. Develop a system for LGU plan review and approval	1. Criteria for funding Year 1 LGU plans developed and communicated to LGUs 2. All 20 LGUs submit plans to OSC in timely manner 3. 75% or more of plans are recommended by OSC for approval for funding
4. Develop systems to monitor implementation and impact of LGU performance grants	1. Pangasinan and Iloilo City have received three TA visits each for MIS development 2. Pangasinan and Iloilo City have MIS systems which meet internal planning and monitoring needs 3. At least 10 LGUs (in addition to Pangasinan and Iloilo City) have received TA visits for MIS development 4. Description of MIS resource organizations has been developed and distributed to LGUs 5. Prototype software for project management and service statistics has been developed and tested
5. Develop OSC capacity to manage assistance to LGUs	1. Detailed explanation of mechanism for LGU funding has been written and disseminated 2. One or more OSC/LGU staff has participated in an overseas study tour 3. DOH and LGU staff have participated in an organizational development intervention to define roles under devolution
6. Document project activities and resource use	1. Field expense reports have been submitted monthly 2. Activity progress reports have been submitted quarterly 3. Project evaluation report completed in December 1994
7. FPMD/Boston staff conduct TA visits	1. Two office set-up consultancies 2. Four project management consultancies 3. Four consultancies for LGU workshops 4. One or more consultancies for organizational development (national and regional roles) 5. Six or more MIS consultancies 6. One evaluation consultancy

**ANNEX 4**  
**REDESIGN FOR 1995: EXECUTIVE SUMMARY**  
**FPMD/MANILA, SEPTEMBER 12, 1994**

The Family Planning Management Development Project (FPMD) of Management Sciences for Health (MSH) has been assisting the Department of Health's Office for Special Concerns (DOH/OSC) to implement a new program of financial and technical assistance to local government units for implementation of integrated population, family planning and child survival programs, with funding from USAID. The LGU Performance Program (LPP) is a performance based disbursement program which awards grants to local governments based on the achievements of certain benchmarks. During 1994, FPMD worked with the DOH/OSC to select and orient 14 provinces and six cities to the program. FPMD staff conducted four planning workshops for 84 local officials, and provided over 80 technical assistance visits to the LGUs to help them develop plans for integrated population, family planning (FP) and child survival (CS) programs.

On September 12, FPMD staff held a retreat to assess how the first year of LPP implementation had gone, and to make recommendations for improvements. This is the report of the meeting. The key lessons learned are summarized below:

1. Understanding about the LPP has evolved over time, so that now many DOH central and regional staff, collaborating agencies, and LGUs are able to describe the basic features of the program. Some early confusions about the LPP were due to the fact that the program agreement between the DOH and USAID was still being negotiated until August, and as a new program many design features were not completely worked out in advance.
2. LGU staff seem to understand the LPP, and all 20 LGUs contacted were eager to participate. Some LGU staff need help in strengthening their ability to expound on the program to local implementing agencies or even to defend it from possible critics.
3. There are very good examples of collaboration between FPMD and DOH services, and between FPMD and collaborating agencies (CA). LGUs need more information about what resources they can tap from central DOH services and CAs for implementing their plan.
4. Training and technical assistance on plan development was helpful to many local governments. Worksheets and plan organization seem generally sound. More specific guidance on what can be funded, how to budget, implementation arrangements, and other planning standards could help make expectations clearer and ease the task of local planners. However, some LGUs did not seem to master the planning process even with large amounts of technical assistance. More hands-on sessions may be needed, both during workshops and during subsequent TA visits.
5. Situation analysis forms are a good planning tool and helped quantify gaps in LGUs. Problems of data accuracy and reliability remain, though. Also, the situation analysis tool could be revised to capture strengths and opportunities as well as quantifying gaps.
6. Local planning subsidies were used to further clarify and gain consensus on plan content and to determine implementation arrangements. More guidance is needed for LGUs on

strategies, curriculum, and suggested invitation lists for conducting local planning meetings.

7. LGUs skills in budgeting are sometimes weak. Additional assistance could be provided in this area, along with more assistance for calculating the baseline LGU budget for health and population.
8. The criteria and process for selection of LGUs could be made more transparent. Personal orientation visits to LGUs, as well as orientation/planning workshops, were very good strategies and should be continued next year with some modifications. The strategy for technical assistance visits might be re-examined to provide less frequent but more concentrated hands-on help in filling in worksheets and analyzing planning data.
9. The plan review process, while highly participatory on paper, was disappointing in that DOH reviewers did not provide much feedback. FPMD reviewers provided summaries to LGUs of the feedback from all reviewers. LGUs were often "amazed" that anyone had read their plan, and were grateful for the feedback. FPMD analysis and comparison of LGU budgets yielded very interesting information and should be continued.
10. The LPP Advisory Committee is working well, and provides a good forum for strategic decision-making. Some further clarity is needed about what types of decisions need to be elevated to the LPPAC and what decisions can be made by OSC or FPMD.
11. The process of setting benchmarks for 1995 was very participatory. Benchmark setting needs to happen earlier next year, and in fact it would be best if the DOH and LGUs could agree right away on benchmarks for the remainder of the program (1995-1999).
12. More frequent meetings are needed for coordination purposes between FPMD and USAID, FPMD and OSC (including the FPS, MCHS, and Nutrition Services), and among FPMD staff themselves. OSC staff should be assigned full-time to the LGU Performance Program as program managers and implementors.