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**INTEGRATED FAMILY PLANNING
MATERNAL HEALTH PROGRAM
(492-0480)**

PROGRAM ASSISTANCE APPROVAL DOCUMENT

**Department of Health
USAID/Manila
April, 1994**

AGENCY FOR INTERNATIONAL DEVELOPMENT

**PROGRAM ASSISTANCE
APPROVAL DOCUMENT
(PAAD)**

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		4. Date		April 28, 1994
5. To		THOMAS W. STUKEL Director		
7. From		DON MASTERS Chief, Office of Portfolio Development and Implementation Support		
9. Approval Requested for Commitment of		\$ 50,000,000		
11. Type Funding		12. Local Currency Arrangement		13. Estimated Delivery Period
<input type="checkbox"/> Loan <input checked="" type="checkbox"/> Grant		<input type="checkbox"/> Informal <input type="checkbox"/> Formal <input checked="" type="checkbox"/> None		March 1994-February 2000
15. Commodities Financed		1. MEDICAL EQUIPMENT 2. TEXTBOOKS 3. COMPUTERS 4. VEHICLES		
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U.S. only \$26,760,000		u.s. \$23,170,000		
Limited F.W.		Industrialized Countries		
Free World		Local \$26,830,000		
Cash \$23,240,000		Other		

18. Summary Description

The Integrated Family Planning Maternal Health Program will provide \$50 million in grant assistance to the Government of the Republic of the Philippines. Of this total, approximately \$23.24 million will be disbursed in exchange for agreed policy changes needed to establish a new, post-devolution relationship between the Department of Health and Local Government Units to support family planning and selected maternal/child health interventions. The remaining \$26.76 million will finance technical assistance, training, commodities, monitoring, evaluation and audit needs of the program. The \$23.24 million in program assistance will be disbursed in five annual tranches beginning in early FY'95. The planned technical assistance, training, commodities, monitoring, evaluation and audit services will be provided through AID-direct contracts. Source and origin will be the U.S. Local procurement will be approved only in accordance with HB 1, Chapter 18.

The provision of the payment verification policy regarding methods of implementation and financing, financial capability of recipients, and adequacy of audit coverage have been adequately addressed in the document.

19. CLEARANCES	DATE
OPHN:BEOldwine/Edoulgaropoulos(draft)	2-25-94
PRM:RMcLaughlin(draft)	2-28-94
ONRAD:JGrayzel(draft)	3-18-94
OPE:JMudge(draft)	
OLA:LChiles	4/13/94
PESO:BCornelio(draft)	3-17-94
ORP:NEdin(draft)	3-18-94
OCP:RBarnes(draft)	3-17-94
OVC:JHeard(draft)	3-17-94
OD:RAJohnson	4/25/94

Mary Lewellen
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20. Action

APPROVED DISAPPROVED

Authorized Signature: *Thomas W. Stukel* Date: *4/28/94*

Title: Director

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EXECUTIVE SUMMARY

The Integrated Family Planning Maternal Health Program (IFPMHP) is a jointly funded program combining \$50 million in USAID bilateral assistance with \$50 million in services, commodities and training provided through centrally funded projects managed by G/RD/POP and the equivalent of \$20 million in GOP and local government counterpart funding.

IFPMHP is a six year program, national in scope, with the development goal of improving the health of women and children by reducing the unmet need for family planning services and a limited number of child health interventions. The program purpose is to 1) expand the availability of reproductive health services in the public and private sectors and to increase use of those services by women in high-risk groups: women under 20 years of age; women over 35 years of age; women whose pregnancies have occurred less than 24 months apart and women who have had four or more pregnancies; and 2) foster continued provision of other selected child health interventions at the local government level.

IFPMHP expands USAID's assistance for family planning and maternal/child health (FP/MCH) services in response to the historic opportunity created by the Ramos Administration's exceedingly strong support for promoting family planning. Over the past decade, support at the national and local levels of government for FP has languished. Consequently, the Philippines Family Planning Program (PFPP) has produced at best modest results. This lackluster performance accounts for the Philippines lagging far behind neighboring Asian countries, as well as other Catholic and Muslim countries worldwide. Moreover, an estimated 36 percent of married women have an unmet need for contraception in the Philippines, compared to only six percent in Thailand. The comparatively low acceptance of modern contraceptive methods, estimated recently to be approximately 24.9%, deprives women and children of the health benefits of proper child spacing and avoidance of high-risk pregnancies.

To accelerate the expansion and improvement of FP/MCH services, IFPMHP is guided by an urban strategy which emphasizes program development in rapidly expanding urban areas. Although the IFPMH is a national program, it is recognized that the potential for achieving a significant impact on population growth by accelerating the provision of FP/MCH services in urban areas is considerable. More than 50 percent of women of childbearing age now reside in urban areas, a demographic trend which is predicted to continue for the foreseeable future. IFPMHP-supported activities will be directed to support this urban thrust.

IFPMHP also follows a strategy of integrating FP services with support for four key MCH interventions - ARI, EPI, ORT and micro-nutrients (including Vitamin A). Experience worldwide shows that strengthening MCH programs underpins and

facilitates acceptance of FP. IFPMHP will give particular attention to the integration of these services at the Local Government Unit (LGU) level where responsibility for service delivery is now located. Moreover, IFPMHP's strategy is consonant with recently formulated population policies and strategic objectives of USAID and the DOH which calls for the integration of FP and MCH interventions.

An important strategic objective of IFPMHP is to work towards institutional and financial sustainability in all activities the program supports. Expanding the demand for contraceptive methods is a key element in achieving sustained increases in acceptance of modern contraceptive methods. The overall thrust of IFPMHP interventions works toward this outcome. Financial sustainability is a guiding principal of IFPMHP's assistance to NGOs and the expansion of commercial and private sector provision of FP/MCH services and commodities. Expanding NGO and commercial channels for FP/MCH services will eventually shift individuals who can pay for all or a major part of service costs from free or highly subsidized government services to these non-government channels. Consequently, limited government resources can be better targeted towards individuals who are truly unable to pay for FP/MCH services. Though this process will occur slowly, IFPMHP's assistance will contribute to greater efficiency in government expenditures for FP/MCH services.

IFPMHP consists of three components. Component 1 expands support for the development of National Services which includes: contraceptives procurement; national contraceptives logistics; information, education, communication and motivation (IECM); training; operations research (OR); voluntary surgical contraception (VSC) services; advocacy and policy development and national program monitoring. On-going work on the National Services initiated under the USAID-funded Family Planning Assistance Program (FPAP) will be continued in some areas (contraceptives and logistics); expanded in others (IECM, OR, VSC, advocacy and monitoring) and substantially re-directed for training. These National Services constitute a comprehensive package of services necessary for the development of a national family planning program that are most efficiently and effectively provided at the national level.

Component 2 expands assistance for: a) strengthening NGO capability for FP/MCH service delivery, b) expanding in-plant, industry-based FP/MCH programs and c) developing private sector channels for provision of FP/MCH services and commodities through social marketing. A U.S.-based NGO will be selected to provide training and technical assistance to approximately 80 local NGOs. Financial sustainability is a major objective of this assistance; assisted NGOs are expected to cover 80 percent or more of their operating costs by the end of IFPMHP. FPAP supports an on-going program implemented by a local NGO to promote the development of industry-based, in-plant FP/MCH services. IFPMHP will expand this activity to achieve broader coverage throughout the country. Initial results of FPAP's social marketing campaign are exceedingly promising. IFPMHP will expand this program into cities throughout the country.

Component 3 of IFPMHP advances policy and institutional reforms needed to establish a new, post-devolution relationship between the DOH's Office for Special Concerns (OSC) and LGUs in support of expanding and improving FP/MCH services through \$23.240 million in non-project assistance. The IFPMHP is part of the GOP's major commitment to rapid population growth as an important development concern in the Philippines. The GOP commitment is quite openly endorsed by the President, the Cabinet, and several members of the House and Senate. Nevertheless, there is still controversy over the program and it has become a highly charged political issue from time to time. The program must be recognized as "Philippine Program" if it is to achieve sustainable results. Therefore, the program will not generate pesos for local expenditures, but instead will rely on the regular GOP budgetary process. Given the sensitivities that exist, USAID and the Department of Health have determined the performance-base approach, as designed, is the most appropriate and effective way to reach the mutually agreed objectives.

USAID will support this process through performance-based disbursements linked to the achievement of significant progress, i.e., benchmarks, toward the institutionalization of reforms needed in light of the devolution of service delivery responsibilities to the LGUs. The DOH will provide technical and financial assistance to selected LGUs to accelerate the development of their FP/MCH programs. In addition to performance disbursements, USAID will fund technical assistance to OSC to enable it to meet program management requirements, including achievement of benchmarks, and to the participating LGUs for program and management development.

Benchmarks for the DOH, National Services and LGU have been developed for the first year of IFPMHP, with illustrative benchmarks for the following two years. Greater specificity on the benchmarks will be a part of annual performance reviews. OSC will assess LGU program results annually, determining which performed adequately and should receive further assistance, and which failed to achieve satisfactory progress and should be selected out of the program. USAID will review the results of this assessment and the achievement of DOH, National Services and NGO/Private Sector benchmarks. USAID will base the decision to make performance disbursements on its assessment of overall annual progress.

The cumulative development result of all the various activities and interventions supported by IFPMHP will contribute to the contraceptive prevalence rate, expected to increase by 1.5 to 2.0 percent annually through 1999. As the contraceptive prevalence rate increases, the Total Fertility Rate will decline from its present level of 4.08 to at least 3.29 by 1999, indicating a significant decrease in the population growth rate of the Philippines.

LIST OF ACRONYMS

<i>ADB</i>	Asian Development Bank
<i>AIDAB</i>	Australian International Development Assistance Bureau
<i>A.I.D.</i>	Agency for International Development
<i>AID/W</i>	Agency for International Development, Washington, D.C.
<i>ARI</i>	Acute Respiratory Infection
<i>AVSC</i>	Association for Voluntary Surgical Contraception
<i>BHW</i>	Barangay Health Worker
<i>BSPO</i>	Barangay Service Point Officer
<i>BUCEN</i>	Bureau of the Census
<i>CARE</i>	Cooperation for American Relief Everywhere
<i>CDLMIS</i>	Contraceptives Distribution Logistics and Management Information System
<i>CPR</i>	Contraceptive Prevalence Rate (program contraceptive methods only)
<i>CPs</i>	Conditions Precedent
<i>CPT</i>	Contraceptives Procurement Table
<i>CS</i>	Child Survival
<i>DHS</i>	Demographic and Health Survey
<i>DOH</i>	Department of Health
<i>DMPA</i>	Depot Medroxyprogesterone (Depot Provera)
<i>EPI</i>	Expanded Program for Immunization
<i>FP</i>	Family Planning
<i>FPAP</i>	Family Planning Assistance Project
<i>FPLM</i>	Family Planning Logistics Project
<i>FPORTP</i>	Family Planning Operations Research Training Program
<i>FPS</i>	Family Planning Service (DOH)
<i>FPT</i>	Family Planning Training
<i>FSN</i>	Foreign Service National
<i>FY</i>	Fiscal Year
<i>GOP</i>	Government of the Republic of the Philippines
<i>IBRD</i>	International Bank for Reconstruction and Development
<i>ICS</i>	Interpersonal Communications Skills
<i>IECM</i>	Information, Education, Communication and Motivation
<i>IFPMHP</i>	Integrated Family Planning Maternal Health Program
<i>IMCH</i>	Institute of Maternal and Child Health

<i>IMCCSDI</i>	Institute for Maternal Child Care Service and Development, Incorporated
<i>IUD</i>	Intrauterine Device
<i>JHU-PCS</i>	John Hopkins University - Population Communication Service
<i>JICA</i>	Japan International Cooperation Agency
<i>JHPIEGO</i>	Johns Hopkins Program for International Education in Reproductive Health
<i>MCH</i>	Maternal Child Health Service (DOH)
<i>MWRAs</i>	Married Women of Reproductive Age
<i>MOA</i>	Memorandum of Agreement
<i>NGO</i>	Non-governmental Organization
<i>NSO</i>	National Statistics Office
<i>O/PHN</i>	Office of Population, Health and Nutrition (USAID/Philippines)
<i>OR</i>	Operations Research
<i>ORT</i>	Oral Rehydration Therapy
<i>OSC</i>	Office for Special Concerns (DOH)
<i>PAAD</i>	Program Assistance Approval Document
<i>PACD</i>	Project Activity Completion Date
<i>PCPD</i>	Philippine Center for Population Development
<i>PFPP</i>	Philippine Family Planning Program
<i>PLCPD</i>	Philippine Legislators Committee for Population and Development
<i>PMTACT</i>	Program Management Technical Advisors Contract Team
<i>POPCOM</i>	Population Commission
<i>R&D/POP</i>	Research and Development Bureau/Population Office (AID/W)
<i>RP/MCH</i>	Responsible Parenthood/Maternal Child Health
<i>RTI</i>	Reproductive Tract Injections
<i>SOMARC</i>	Social Marketing for Contraceptives Project
<i>UNFPA</i>	United Nations Population Fund
<i>USAID</i>	United States Agency for International Development (Manila, Philippines)
<i>VSC</i>	Voluntary Surgical Contraception

INTEGRATED FAMILY PLANNING AND MATERNAL HEALTH PROGRAM
(IFPMHP)
PROGRAM ASSISTANCE APPROVAL DOCUMENT
SUMMARY AND RECOMMENDATIONS

1. Grantee: The Government of the Philippines (GOP)
2. Implementing Agency: The Department of Health (DOH)
3. Grant Amount: U.S. \$50 million
4. Source of Funds: Development Assistance: Population Account
5. Program Purpose: to expand the availability of reproductive health services in the public and private sectors and to increase the use of these services by high risk groups.
6. Program Definition: the proposed program will support the Philippine Family Planning Program in the core delivery of family planning and reproductive health services. In general, other assisted areas are supportive of service delivery.

The following are the components of the GOP program to be supported by bilateral contributions under IFPMHP:

- o National Services: Information, Education, Communication, Motivation
Training
Monitoring
- o Private Sector and NGOs: NGO Strengthening
In-Plant based FP Services
- o Local Government Unit Performance Program
- o Evaluation and Audit

Goods and Services to be funded in-kind from existing authorized projects with USAID's Global Bureau of Research and Development/Population (G/RD/POP) which support the bilateral initiatives include:

- o National Services: Information, Education, Communication
Contraceptives
Logistics
Voluntary Surgical Contraception
Operations Research
Policy Planning
- o Private Sector: Social Marketing
- 7. Grantee Contribution: The GOP is expected to contribute the total amount of \$20 million (equivalent) over the five year life-of-program.
- 8. Grant Request: The GOP has requested A.I.D. to participate in providing assistance to the Philippine Population Program (see Annex A).
- 9. Mission Views: The Mission Program Committee recommends that the approved and the Program authorized.
- 10. Statutory Requirements: All statutory requirements have been met. See Program Statutory Checklist (see Annex B).
- 11. Initial Environmental Examination: Categorical Exclusion (see Annex F).
- 12. Recommendation: That a grant in the amount of \$50 million be authorized on terms and conditions set out in the Draft Authorization included in this PAAD.
- 13. Program Committee :

CSO:AAstores	OPHN:BEOldwine
OFM:VMunoz	EGAquino
OPE:FDakila	EDespabiladeras
PDIS:CPippitt	PMoser
OLA:LChiles	EVoulgaropoulos

I. PROGRAM RATIONALE AND DESCRIPTION

I.A. PROGRAM RATIONALE

I.A.1 Opportunities and Challenges for Family Planning Development in the 1990's

The Philippine Government, under the Ramos administration, has identified the provision of quality family planning as one of the most effective interventions in improving women's reproductive health and child survival. By helping women bear their children during the healthiest times for both mother and baby, FP helps prevent the deaths of infants, children and mothers. In the Philippines, maternal mortality has remained about 100 per 100,000 live births for a decade. Infant mortality has not decreased markedly over this same time period. All other things being equal, spacing births two or more years apart has the potential to reduce maternal mortality by 29 percent, child mortality by 20 percent and infant mortality by 25 percent¹. FP also enables women to decide for themselves the spacing of births as well as the total number. The Department of Health (DOH) recognizes that effective use of FP allows women to avoid unwanted pregnancies, the dangers of illegal abortions, and childbearing under circumstances that will be a threat to their infants' and their own health.

A "population management" program has also been deemed vital to the development of the Philippine economy and environment. The total population currently stands at 67.1 million people. More than half of all Filipino families live below the poverty line. With 800,000 persons entering the job market each year, unemployment is at least 11 percent and rising. Social services are not able to keep pace with growth rates, leading to worsening conditions, especially in urban areas. Environmental degradation has depleted natural forest cover, coastal resources, and air quality. However, due to past neglect and political indecision, the Philippine Family Planning Program (PFPP) remains in a nascent stage of development.

The PFPP faces clear challenges. Although knowledge of contraceptive methods is extremely high (95.9 percent), a much smaller percentage (67.7 percent) of all women actually know where to acquire FP services. Although only 9 percent of women want another child within the next two years, only 25 percent of women are actually using a modern contraceptive method to space or limit their births. An estimated 36 percent of married women have an unmet need for services. This is a significant percentage when compared to Thailand where unmet need is only six percent. Women's stated fertility preferences indicate that Filipinas want smaller families (ideal family size has

¹Ross, J. and Frankenberg, E., 1993, Findings from Two Decades of Family Planning Research, The Population Council, New York.

declined from 4 children/woman in 1988 to 3.2 currently). In addition, 78 percent of the voting public favor candidates who support free choice of FP methods.

Childbearing by women under 20 years of age, older than 35 years of age, those who have already had four or more births, or have delivered less than two years ago places these women at high risk for health complications. In the Philippines, 5.6 million women fall into one or more high risk categories if they become pregnant. The large number of high-risk births, especially births spaced less than two years apart, indicates the need to generate greater use of FP services by women in high risk groups to assure their health and the health of their children.

PFPP confronts a fundamental shortage of human and material resources necessary to expand FP services. A recent nationwide study of FP services in the Philippines found serious shortages of training and equipment throughout the country. For example, the vast majority of hospitals in 1993 do not have both trained staff and adequate supplies for FP services.

Large-scale migration from rural to urban areas also presents a challenge to the PFPP. Although current fertility is still higher in rural areas, the bulk of women (approximately 54 percent of all women) between the ages of 20 and 39 currently reside in densely populated urban areas. These women represent a vitally important segment of the population PFPP must reach if it is to succeed.

In response to these challenges, USAID, in cooperation with the DOH, has designed the Integrated Family Planning and Maternal Health Program (IFPMHP). Its goal is to improve women's health through the long-term reduction of unmet need and the generation of increased demand for FP services by women in high-risk categories. Consequently, IFPMHP is designed to increase contraceptive prevalence and minimize high-risk childbearing. IFPMHP will provide a range of reproductive health services in addition to FP, including reproductive tract infection screening and treatment, in cooperation with the DOH. In support of the DOH's and USAID's policies of promoting integrated MCH, selected child survival interventions will also be included in support to local government units (LGUs). Progress towards programmatic sustainability is a major objective of the IFPMHP. Creating greater demand for FP, combined with reliable sources of supply, is the first, and most important, step to achieving sustainability.

1.A.2 The Potential for Significant Increases in FP

Family planning in the Philippines has reached a critical juncture. Since 1968, the PFPP has experienced moderate success in responding to women's needs for FP and reproductive health services and in reducing fertility. Throughout the 1980s, however, political commitment to the provision of FP services vacillated which weakened quality service provision. As a result of these setbacks, the program lags behind its more

consistently committed Asian neighbors and other countries with large Catholic or Muslim populations. The lackluster performance of the PFPP has delayed improvements in women's and children's health, increased pressure on the environment and undermined socio-economic development. Given the large disparity between contraceptive prevalence in the Philippines at this time and other developing countries where major advances have been achieved, the potential for expanding FP here is now significant.

I.A.3 Justification and General Considerations for Program Assistance

Riding on the success of the performance-based Child Survival Program (CSP), the Mission and the Department of Health (DOH) have determined that to facilitate the LGUs' ability to manage their new responsibilities for the delivery of health and family planning services, a performance-based disbursement program, modelled on the CSP, is the most effective means of accomplishing program goals. Under CSP, the DOH transformed its management culture to utilize performance-based management techniques for service delivery. With devolution, the DOH wishes to push LGU health service delivery systems to move towards a similar performance-based system. To do this, policy changes will be required at the GOP, DOH and LGU levels. This will include the use of performance-based criteria in allotting resources to LGUs, development of a mechanism to transfer additional GOP resources to LGUs to accelerate priority health programs and transformation of the Office for Special Concerns (OSC).

The IFPMHP is part of the GOP's major commitment to rapid population growth as an important development concern in the Philippines. The GOP commitment is quite openly endorsed by the President, the Cabinet, and several members of the House and Senate. Nevertheless, there is still controversy over the program and it has become a highly charged political issue from time to time. The program must be recognized as "Philippine Program" if it is to achieve sustainable results. Therefore, the program will not generate pesos for local expenditures, but instead will rely on the regular GOP budgetary process. Given the sensitivities that exist, USAID and the Department of Health have determined that the performance-base approach as designed is the most appropriate and effective way to reach the mutually agreed objectives.

To support the DOH in institutionalizing this new approach with the LGUs, USAID will continue the momentum gained under CSP by establishing another performance-based program with the DOH. The GOP estimates that the direct costs of achieving the goals of their women's health and safe motherhood objectives, including the delivery of family planning services are approximately \$250 million over the next five years. In order to ensure that the performance objectives are met, and that the \$250 million in GOP resources are utilized effectively. USAID has agreed to provide up to \$25 million through a performance-based disbursement program.

I.A.4 Maximizing Impact: IFPMHP's Urban-based Strategy

All successful national population strategies in populous countries such as the Philippines which now ranks 14th in the world include the following elements:

- Policy Development and Advocacy
- Training in Clinical and Management Skills
- Family Planning Services
- Contraceptives and Related Supplies
- Information, Education, Communication and Motivation (IECM)
- Operations Research and Evaluation

Indeed, the current USAID project (FPAP) supports all of these elements in the PFPP through assistance to the public, private and NGO sectors. Now that these elements are in place and largely functional, albeit not at one hundred percent capacity, IFPMHP must ensure that resources are allocated in such a manner that maximum health/demographic impact can be achieved and sustained.

A careful review of the results of the 1990 National Census and the 1993 Demographic and Health Survey (DHS) strongly suggests that a strategy be developed to reach urban couples on a priority basis. Unlike its Asian neighbors with whom it is often compared (Thailand and Indonesia with urban populations of 19 and 31 percent respectively), the Philippine urban population is approximately half of the total population. Moreover, the majority (54 percent) of women aged 20 - 39 live in urban areas. Although the program focus is one of national family planning service delivery covering urban and rural areas, the urban woman in this age group is the principal target of the urban thrust. It is also the main target of the new program to improve women's reproductive health.

The current population dynamic of the Philippines is similar to large Latin American countries at the inception of their major efforts to reduce population growth rates. Without exception, these countries designed their strategies for impact based on full blown urban efforts. Today, all of these countries rank among the world-class FP programs. These Latin American programs were initiated more recently than the Asian programs and in Catholic-based populations, another commonality to the Philippines.

Although in no way suggesting that rural efforts should be slowed down, the urban focus will take advantage of the following numerous efficiencies of scale:

- Trained staff can be mounted more quickly and more completely in urban health facilities, particularly in the DOH-retained hospitals, chartered cities and provinces.
- Private sector physicians and other health professionals are more readily available in urban areas for training and services.

- Urban providers, public and private, are closer to the source of contraceptives and therefore less likely to have stock-outs.
- Urban-based populations have greater access to a wide range of IEC channels than their rural colleagues.
- Urban families are already accustomed to going to hospitals for other health care. Seeking FP services at the same place is convenient and also more likely to be a private matter than in a rural or village health unit.
- Because greater numbers of procedures are carried out at hospitals and large urban health centers, staff can offer a wider choice of methods, including long-term, more cost-effective clinical methods. With a higher client load, a greater number of FP procedures are done at urban units, enabling staff to retain and sharpen their clinical skills more readily than their rural-based colleagues where only an occasional IUD is requested.
- Supervisory visits are more feasible in urban settings, which is important to the program's quality of care goals.
- Urban centers, including hospitals, because of their greater patient loads, can also serve as training points for students of medicine, nursing and midwifery as well as for refresher training for current staff.
- Another important aspect of this program, reproductive health care, can be more easily initiated in hospitals, where certain laboratory tests can be run for proper diagnosis before drugs are prescribed for reproductive tract infections (RTI).
- Likewise, the problem of declining rates of breastfeeding, particularly among urban mothers, can be mitigated in mother baby-friendly hospitals and with intensive IECM in urban areas.

1.A.5 The Development Objectives of IFPMHP

The principal objectives of IFPMHP include decreasing unmet need, improving the health status of women through increasing the utilization of services, increasing contraceptive prevalence, decreasing high-risk childbearing, and increasing programmatic sustainability.

a. Reduce Unmet Need for Family Planning to Improve Women's Health Status

Unmet need provides information on the number of women at risk of pregnancy with an apparent need for family planning services based upon their expressed desire to limit or space future births, but who are not using contraception. Unmet need in the

Philippines stands at 36 percent of currently married women, or 3.2 million women. Although filling unmet need for services is a priority for the program, unmet need can be expected to rise in the short-term as improved IECM convinces more women to adopt small family. Therefore, a decrease in unmet need will be more effectively measured every five years. High rates of unmet need point to the potential impact FP programs can have on women's health. The program recognizes that by increasing service utilization, and thereby filling unmet need for services, women's health status will improve significantly.

b. Increase Utilization of Family Planning Services to Increase Contraceptive Prevalence

Increased use of FP services by Filipino women is key to the success of the PFPP. Utilization of services will indicate progress made towards closing the gap between knowledge of methods and knowledge of a source of methods. The IFPMHP will increase utilization through a vigorous IECM campaign, the improvement of services offered, and a reliable contraceptive logistics system. IFPMHP expects that its client population will change over time, with an increasing number of women aged 25-35 using modern contraception. Method mix figures, user characteristics and continuation rates will allow program planners to assess progress towards these goals.

c. Decrease High-risk Childbearing

To provide contraception to women currently at high-risk for childbearing, the FP program needs to expand services to an additional 2.4 million to 3.8 million women. This number will continue to grow over time as the absolute number of married women of reproductive age increases. Not all women at high-risk for childbearing currently wish to space or limit their births. The gap between those practicing modern contraception and those at high-risk for childbearing is 3.8 million women. As a result, increasing the demand for services among potential high-risk groups is a critical first step to reduce high-risk births. The IFPMHP anticipates a significant decline in high-risk births as more women in high-risk categories recognize the health benefits of FP through IEC efforts and gain access to reliable services.

d. Achieve National Programmatic Sustainability

Sustainability indicators have been widely discussed in family planning literature, but there have been relatively few attempts to measure these dimensions in the context of international family planning programs. The central programmatic goal of the PFPP and IFPMHP's assistance is to reduce fertility that has undesirable individual and/or social consequences, and thereby contribute to national economic growth and an improved standard of living for the Philippine population. To achieve that central goal, the program must attain the objectives outlined above. For these improvements to be

sustained over time, the PFPP and the institutions within it must develop the capacity to provide their current and potential clients with the information, motivation and services necessary to obtain the benefits of FP on a continuing basis and without substantial external aid.

At present, government FP services fail to discriminate adequately among truly needy clients, those who are able to pay for services to some extent, and those who can afford to pay the entire cost of services and commodities. Under the IFPMHP, public sector assistance will be increasingly targeted to those elements of the population who are unable to pay for services at all. Services supported by the DOH will be delivered more efficiently to reduce the overall cost of the program. The NGO sector will focus their services at those segments that are able to pay some of the cost of services, with subsidies covering their operating expenses on a declining basis. By the end of IFPMHP, the NGO sector should be 80 percent self-sustaining except for the cost of contraceptives provided by the DOH. A social marketing program will promote commercial contraceptives at reduced cost to acceptors and become 100 percent self-sustaining by the end of the program. Finally, private doctors and clinics will be encouraged to provide services to those able to pay. By the end of IFPMHP, progress toward sustainability will be increased through these various mechanisms.

Preliminary DHS data indicate that 72 percent of modern contraceptive users reported the public sector as their source of services. A combination of new acceptors and switchers from the public sector might lead to a growth in the private sector share (estimates range to 60 percent), but public sector services will still have to shoulder the burden of an increasing client load for the foreseeable future.

Although 58 percent of Philippine families have income levels below the poverty line, almost 30 percent of modern contraceptives are purchased in the private sector, which includes NGO services, pharmacies and private doctors. Non-governmental organizations are now being encouraged by USAID to achieve at least partial sustainability, by charging fee for service. Efforts to expand private sector services will need to take into consideration the varying ability to pay for services and the availability of social insurance across the population of contraceptive users.

Indicators of national programs moving toward sustainability will be developed from an analysis of the targeting of public sector monies to low-income individuals, or other individuals for whom provision of FP services connotes a social good. Another indicator might be the extent to which public sector resources devoted to FP are sufficient to provide (or finance) services for target populations. A range of providers should be available to clients according to their ability to pay for services, thereby segmenting the contraceptive services market in the most cost-effective manner for the public and private sectors. Operations research will play a key role in assessing the effectiveness of these components.

1.A.6 Present GOP Policy Environment

With the election of President Fidel Ramos in 1992, the policy environment and potential for impact of population programs and family planning services has improved dramatically. The Ramos Administration has declared unequivocal support for a strong program. As further evidence of this commitment, President Ramos appointed a long-time FP proponent as Secretary of Health, Dr. Juan Flavio. Secretary Flavio's leadership has already led to profound changes within the DOH. The DOH has created the Office for Special Concerns (OSC) which is responsible for administering national-level FP activities. This office, headed by an Assistant Secretary and reporting directly to Secretary Flavio, has drawn up an impressive action agenda which includes the following elements: ensuring the reliable provision of FP services; increasing knowledge of methods and sources among married women of reproductive age; meeting existing unmet need for services; fostering community based service and information outlets that provide services; maximizing the participation of the private sector; encouraging LGUs to be active advocates, implementors and partners in the PFPP; and expanding the commercial market for contraceptives.

New leadership at POPCOM has also led to an extremely positive climate for collaboration between the two organizations. A Memorandum of Agreement has been signed by the DOH and POPCOM to formalize the distribution of responsibilities. All FP implementation at both the local and national levels will be the responsibility of the DOH, and the LGUs with selected technical assistance to LGUs from POPCOM. POPCOM will play a strong advocacy role for the program, as well as broader population and development issues.

1.A.7 Devolution

An important opportunity for developing the PFPP resulted from the enactment of the Local Government Code in 1992. To maximize resources and establish local ownership and responsibility for programs, the Code devolved DOH service delivery functions, putting nearly two-thirds of funds, delivery facilities and personnel under the control of provinces and municipalities. To gain insight into how best to capitalize on devolution to improve FP services, the DOH and two selected LGUs have undertaken pilot programs designed to increase access to and raise local resources for family planning services. These pilot efforts are providing valuable insights into how best to provide assistance to LGUs to strengthen their FP programs under the IFPMHP.

1.A.8 GOP Population and Country Development Goals

Although the linkages between population management and development have been articulated at all levels, President Ramos expressed this best in a recent speech. Ramos noted that "serious imbalances that today threaten the sustainability of both our economy and our environment have risen primarily from our pervasive and

proliferating population growth." The need to balance population growth with available resources and consumption is clearly a high priority for the GOP. President Ramos has strongly articulated his positive stance toward "population management" as a vital element in seeking Newly Industrializing Country status, improving health and well-being, and preserving the environment.

I.A.9 Relationship to A.I.D. Development Assistance Strategy

USAID/Washington has identified population and health as one of four major assistance priorities in the coming decade, along with democracy, environment and economic growth. These priorities are consonant with USAID/Manila's recently approved Philippine Assistance Strategy: 1993 to 1998. Under the strategic objective of "Reduced Population Growth Rate and Improved Health", the rapid expansion and increased utilization of FP is a top priority for USAID development assistance. Moreover, population management and health improvement are fundamental to USAID's efforts in the areas of democracy, environment and economic growth. Managing population growth lessens pressure on the environment and natural resources.

As early as 1991, USAID/Washington's Office of Population (G/RD/POP) designated the Philippines as a priority country to receive central population assistance funding. The designation is based on a three-factor index of unmet need for services, number of high-risk births, and number of new users needed to track the UN low fertility population projection. Subject to the availability of funds, RD/POP plans to provide \$50 million for Cooperating Agency inputs and central contraceptive procurement for the IFPMHP.

Coinciding with this historic window of opportunity in the Philippines, USAID/Manila, with assistance from the G/RD/POP, is prepared to capitalize on the present opportunity to assist the Philippines in a significant and long overdue leap forward in FP. President Ramos' term of office will end in 1998. The DOH and USAID/Manila must move quickly and decisively to make the most of this unprecedented opportunity. Decentralized planning for local program mobilization must begin now, and national-level support for LGU family planning programs must be expanded immediately. The quality of life for future generations of Filipinos will depend on the success of these initiatives.

I.A.10 Other Donor Assistance

A number of on-going and planned donor-funded projects are complementary to the FP/MCH objectives of IFPMHP. USAID is currently the major donor providing assistance in the population and health sector via its FPAP and its highly successful Child Survival Program which is nearing completion.

The United Nations Population Fund (UNFPA) is planning a new five year project to promote MCH expected to start in 1994. At this time funding levels are still being discussed, ranging from a low \$25 million to a high of \$45 million. The project will work through the DOH, POPCOM and NGOs. Special population-related activities will be developed with the Departments of Labor and Employment, Agriculture and Social Welfare and Development.

The Australian International Development Assistance Bureau (AIDAB) is providing A\$7.1 million for its Maternal and Child Health Care project which aims to reduce maternal and child mortality and morbidity through an immunization program, improved maternal and child care services and training to health care providers. AIDAB provides A\$4.8 million in funding for the Information, Education and Communication component of the Urban Health and Nutrition Project (a World Bank funded project) which operates in Metro Manila, Cebu and Cagayan de Oro. AIDAB also funds a number of much smaller, highly focused projects throughout the country which address health and population problems.

The Japanese International Cooperation Agency (JICA) is providing approximately \$750,000 per year over a five-year period for a FP/MCH project in the province of Tarlac. The project aims to improve FP/MCH service delivery.

The World Bank has held discussions with the DOH for over a year on a \$20 million loan for a Safe Motherhood project, but final agreement has not been reached at this point. Similarly, the Asian Development Bank is currently discussing the possibility of providing \$50 million in co-financing for this project with the DOH.

I.B. PROGRAM DESCRIPTION: GOAL AND PURPOSE AND COMPONENTS OF THE INTEGRATED FAMILY PLANNING MATERNAL HEALTH PROGRAM

I.B.1 Development Goal

The goal of IFPMHP is to improve the health of women and children by reducing the unmet need for family planning services and selected child health services.

I.B.2 Program Purpose

The purpose of IFPMHP is to 1) expand the availability of reproductive health services in public and private sectors and to increase use of those services by women in high-risk groups: women under 20 years of age; women over 35 years of age, women whose pregnancies have occurred less than twenty-four months apart and women who have had four or more pregnancies, and 2) foster continued provision of other selected child health interventions at the local government level.

I.B.3 Program Components

IFPMHP consists of three interrelated components. The first program component will provide support in the public and private sectors for national services including: information, education, communication and motivation (IECM); contraceptives; logistics; training; operations research (OR); policy planning and monitoring. These activities constitute the core of government managed family planning programs that are most efficiently and effectively provided on a nationwide basis. Given the demographic trend of increasing urbanization in the Philippines, IFPMHP will support an urban strategy that will accelerate the expansion and improvement of services in urban areas where more than 50 percent of potential users now reside.

The second component will continue support to NGOs and the social marketing program. Much of the first two components extend important work initiated under the FPAP which ends in 1994. Assistance provided under these two components will also support local government programs for FP/MCH.

The third component is IFPMHP's Performance-based Program which will advance policy and institutional reforms needed to establish a new, post-devolution relationship between the LGUs (now responsible for service delivery) and the DOH (specifically, the OSC). USAID will support this process via performance-based disbursements linked to satisfactory progress toward institutionalizing these reforms. These disbursement will serve as a strong inducement to expedite the establishment of needed changes in the DOH/OSC - LGU relationship.

To develop this new relationship, the DOH will initiate the LGU Performance Program. The program will provide technical and financial assistance to selected LGUs to enable them to expand and upgrade their FP/MCH programs. Four key child survival programs will be targeted - ARI, EPI, ORT and micro-nutrients, including Vitamin A. USAID will fund technical assistance to OSC and participating LGUs to facilitate the reform process and improve the LGUs FP/MCH services.

The Program will operate on the basis of LGU FP/MCH program planning and successful implementation of those plans, resulting in expanded and improved services. Specifically, the Population and Health Offices of selected LGUs will develop proposals for expanding and improving their FP/MCH activities which comply with planning standards established by OSC. OSC will evaluate the proposals, and if acceptable, approve funding for the LGUs to implement their proposed programs. OSC will assess LGU performance annually based on pre-established benchmarks for program development. LGUs which achieve satisfactory performance, i.e., meet their program benchmarks, will receive funding for the following year in support of their programs. OSC will be responsible for achieving benchmarks linked to its management of the Program and for the National Services and NGO/Private Sector components. Satisfactory performance by OSC and the participating LGUs will be the

basis for USAID's decision to make performance-based disbursements.

a. **COMPONENT 1: NATIONAL SERVICES**

1) **Contraceptive Logistics Management**

An essential feature of a sustainable FP program in the Philippines is a fully functioning and effective contraceptive logistics system. While the current logistics system - CDLMIS - is being implemented with substantial external assistance, important aspects of the system remain the responsibility of the national and local governments. Within LGUs, the contraceptive logistics system is the responsibility of the local governments (e.g., the operation of the delivery teams).

Under IFPMHP, no significant changes are envisioned in the logistics area. The system designed and implemented under FPAP will continue. The DOH's Contraceptive Logistics Section will be responsible for overall implementation and management of the system, with the logistics contractor responsible for national contraceptive distribution (to the LGUs), field monitoring and training. Local delivery of contraceptives (within the LGUs) will remain the responsibility of the LGUs.²

2) **Information, Education, Communication and Motivation (IECM)**

The information, education, communication and motivation (IECM) component of the family planning program has been identified as a key element in energizing the PFPP. Although the IECM program has moved ahead under FPAP, the political change in the GOP and the renewed commitment to FP/MCH have raised the visibility of such efforts and acknowledged the important role these efforts play in the overall program. While much of the infrastructure for IECM is in place, and public, private and NGO agencies are currently active in providing these services, gaps remain that will be addressed by the IECM program of IFPMHP.

With 54 percent of all women between the ages of 20-39 residing in urban areas it will be necessary to have an urban IECM strategy designed to reach these women. Additionally, as men play an important part in reproductive decision making, more work needs to be done to better understand the role men play in supporting their wives decisions to use contraception. IECM activities under IFPMHP will be designed, to provide information to both men and women in order to help couples make informed choices about their reproductive and sexual behavior.

² Distribution and delivery of IEC materials will also continue to be the responsibility of the CDLMIS.

For the PFPP to play a strong role in meeting President Ramos' goal of a population growth rate of two percent or less by 2000, it is essential that more than 50 percent of the married couples in the Philippines internalize the concept of small family-norms. Since the ideal family size is 3.2, an enormous task remains to be accomplished through the combined efforts of IECM specialists, FP service providers and population development experts. If anyone of these actors is not contributing fully, the success of the program will remain problematic.

The coordinated IECM efforts, combined with the training and wide-spread availability of contraceptives should insure that Filipino couples who want and need FP services, will be able to access them.

3) Training

a) Competency-based Family Planning Training

The quality of FP services can be significantly upgraded by addressing the inadequacies in training of both public and private service providers that have emerged over the past several years. The five most serious problems affecting training at this time are:

1. Too few fully trained personnel in FP,
2. Lengthy training programs which discourage participation by health care providers,
3. Poor attendance by trainees and high attrition when sessions are not relevant to the development of FP skills,
4. High levels of frustration among both trainers and trainees when inadequate numbers of methods acceptors delay the development of clinical skills by trainees, and
5. Single method training that prepares service providers competent in only that method.

IFPMHP will provide substantial assistance to resolve these problems. This assistance will be focussed on three main activities: 1) implementation of humanistic, criterion-referenced, competency-based training; 2) revision of accreditation activities under the existing board and 3) strengthening the FP certification program for health care providers. IFPMHP will provide a long-term training advisor to OSC who will help to assure progress is made in these three areas.

IFPMHP will support the introduction of a new approach to training, which is referred to by health training professionals as humanistic, criterion-referenced, competency-

based training. Humanistic refers to the use of training models and case simulations rather than actual clients. The trainee's first exposure to the client is only after competent technical skills have been attained. Trainees will develop clinical skills according to minimum performance criteria; this is criterion-referenced training. Achieving competent performance of these skills results in the development of a competent service provider; this is competency-based training. Models, equipment kits and references will be supplied to both DOH (about 2,700 pcs. each of pelvic models, IUD insertions, Contraceptive Technology book and Infection Prevention manual) and NGOs (about 250 pcs. each of the same).

As a result of this training, the following service delivery improvements are expected:

- consistent, competent performance of all clinical FP skills,
- effective health assessment and screening for Reproductive Track Infections (RTIs) for all clients,
- prevention of infections through appropriate counseling on high risk behaviors and infection prevention measures,
- comprehensive counseling in all program family planning methods,
- follow-up and continued counseling for all clients, and
- prompt and appropriate referral of clients needing more specialized care.

A major advantage of competency-based training is that it reduces total training time by focusing on the essential information and skills needed to develop competent clinical skills. Information not essential to acquiring the basic skills are excluded from the training course (though this may be offered in follow-up programs for trainees after certification). Humanistic training further reduces time requirements because development of clinical skills is not dependent on the availability of method acceptors during the program period. Criterion-referenced training standardizes the skills trainees acquire so that family planning services are provided at a comparable level of quality and safety to clients. According to current research conducted by the University of the Philippines National Teacher Training Center for Health Professionals (UP-NTTC-HP), competency-based teaching applied to nursing education in the Philippines has reduced formal teaching time by 65 percent. Adoption of these techniques for FPT could reduce training time by half, decreasing costs and the time a trainee is away from her job.

Approximately, 16,147 DOH/LGU FPS delivery personnel will be trained (this represents a 75 percent coverage of untrained DOH/LGU FPS personnel):

<u>Course</u>	<u>MDs</u>	<u>RNs</u>	<u>MWs</u>	<u>TOTAL</u>
Basic-Comprehensive FP	1,087	1,074	2,410	4,571
Interpersonal Communication Skills (ICS)	1,476	1,406	4,169	7,051
IUD	<u>660</u>	<u>633</u>	<u>3,232</u>	<u>4,525</u>
TOTAL	<u>3,223</u>	<u>3,113</u>	<u>9,811</u>	<u>16,147</u>

To set competent-based training in its perspective, a national level workshop for DOH/FPS Team and all NGO's involved in FPS training on design and implementation of humanistic, criterion-referenced, competency-based training using local expert from UP (NTTC-HP) will be conducted. Another important requirement for introducing competency-based training is to reorient and expand the existing Accreditation Board to meet the demands of a competency-based curricula. The Board will be composed of a group of health professionals including an expert in training and education, a family planning clinical specialist and representatives from each health disciplines, i.e., midwifery, nursing and medicine. The role of the Accreditation Board is to assess the facilities and training materials used by organizations providing family planning training. Accreditation will require the use of humanistic, criterion-referenced, competency-based training programs. Training institutions will also maintain current enrollment lists in support of the trainee certification process and establish follow-up programs to assist trainees to maintain their certification (see Annex G).

All graduates (about 13,300 DOH/LGU FPS delivery personnel trained in basic/comprehensive FP) of accredited training programs will be certified as FPS providers by the professional Board through which they maintain licensure. While initial certification cannot be revoked, it must be maintained. For this reason, each of the Boards will develop a Certification Maintenance Program. The follow-up programs offered by accredited training institutions will enable certified service providers to maintain their certification through activities such as: continuing education workshops, independent study programs, retraining and/or skills development workshops in new methods and techniques. Each Board will determine the period of time for re-certification and the means for documenting certification maintenance. (A diagram summarizing the elements of the competency-based training approach is included in Annex G).

The resident Training Advisor will assist the DOH/OSC to: a) develop the training criteria, minimum performance criteria and minimum content guidelines for all family planning methods; b) establish accreditation and certification systems; and c) provide guidance and support as needed to NGO and DOH training teams to develop competency-based training materials based on minimum performance criteria.

b) Pre-service Family Planning Training

Under FPAP, Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) worked with Colleges of Nursing and Schools of Midwifery. This established the basis for more effective pre-service education in reproductive health for nurses and midwives. IFPMHP will continue to support JHPIEGO's training activities in pre-employment and in-service projects. Pre-employment training targets newly graduated nurses and midwives who have taken the licensing exam and await the results prior to employment. An accredited FP training program will be offered at selected Schools of Midwifery and Colleges of Nursing during the waiting period. This will allow graduates interested in becoming certified FP service providers to take an accredited training course at their institution. They will then become certified in FP service delivery as well as licensed to practice in their chosen discipline. About 15,000 new graduates will be supported.

Training for IFPMHP will also support JHPIEGO's training efforts by integrating reproductive tract infection (RTI) services into 5 existing family planning service delivery points. The Fertility Care Center (FCC), JHPIEGO's major training organization, will assist with site selection, equipment procurement and prepare trainers for each of the new centers. The five RTI centers will integrate RTI services with FP services and train local service providers in the diagnosis and management of RTI's. The training efforts includes RTI training for 15 personnel in the new centers and about 500 midwifery/nursing school faculty who will in turn provide training to local service providers.

c) Other IFPMHP Training Activities

In addition to redesigned FP training, IFPMHP also support the following training activities:

- Mid-level management courses will be extended to more NGO's (about 4,500 NGO managers) involved in FP service delivery
- Logistics training activities for about 2,500 LGU/NGO logistics staff will be continued to maintain and expand the provision of FP supplies to the LGUs.
- Social communications outreach activities will be expanded to reach about 10-15 adolescent groups on the development of values and about 100 women's groups for comprehensive reproductive health education.
- A pilot initiative will be supported in a private institution to develop 25 future FP leaders from social science disciplines.

- VSC training provided to DOH and NGO FPS providers (about 6,390) will be expanded to include a VSC service delivery component (i.e., assure that trainees have the equipment necessary to provide VSC services).
- The TA intended for LGUs will provide in-service training to about 3,000 LGU staff and about 50,000 community volunteers.
- Five to 10 U.S. and 10 to 20 Third Country participant-training slots (short-term courses, study-observation tours, attendance in technical conferences, etc.) will be provided to DOH, NGO and LGU FPS managers and staff.
- In order to make up for the years during which the thrust of FP training consistently favored field staff at the expense of urban and hospital training, a strategy to accelerate urban training will be developed and implemented. This training will include services, ICS and management. Training will involve DOH, LGU, NGO and private sector providers.

4) Operations Research

The Family Planning Operations Research and Training Program (FPORTP) has just completed its first year of operation. FPORTP will expand and institutionalize the role of OR to make IFPMHP more effective. The four main objectives of FPORTP during IFPMHP are:

- 1) Develop mechanisms which can work within the DOH, LGUs, NGOs, and other institutions to identify important OR topics, conduct OR and utilize findings to improve overall program implementation.
- 2) Conduct a Situational Analysis on the potential capability of various institutions to conduct and use OR at the LGU-level. The Situational Analysis will be conducted in concert with the LGU component of the program, phasing in groups of LGUs as they participate in the grant program. An additional Situational Analysis is planned to assess program performance in various service delivery points, with particular reference to quality of care issues and user characteristics. This Situational Analysis will be used as a baseline for qualitative program evaluation.
- 3) Conduct a regular series of OR studies on high priority topics at both the national and local levels.
- 4) Disseminate timely OR results to all users. Special emphasis will be placed on working with policy makers and program managers to inculcate the regular utilization of OR and its findings.

Given the context of devolution to the LGUs, a strong series of linkages must be established between implementing agencies and OR researchers. Regular consultations involving LGUs, line agencies, NGOs and researchers will be established on a pilot basis. A mutually useful OR agenda will be articulated. A program of research dissemination for programmatic utilization will be implemented. Additional planned studies will focus on a variety of topics to be determined by program managers and other interested parties in collaboration with researchers. A pilot OR study will be conducted on the introduction of competency-based training courses into the DOH family planning training curricula. Dissemination activities will include an OR newsletter to be published by the National Resource Center.

A series of 11 workshops will be held with LGU officials and program managers to increase awareness and appreciation of OR as a tool for advocacy and program management. OR is only useful if decision makers understand its potential and are willing to implement study findings. Two national-level training workshops on OR techniques will also be conducted. Topics covered will include research methodology, improved understanding of innovative family planning concepts and program emphases (such as quality of care), and proposal writing.

5) Voluntary Surgical Contraception

IFPMHP will continue to support the current scope of the Association for Voluntary Surgical Contraception (AVSC) activities being conducted under FPAP, but the focus of AVSC's activities will be modified. First, all VSC training will be placed within the scope of AVSC's program in the Philippines. This will require further outreach to the private sector for VSC training while maintaining activities in the public sector with the DOH. Second, more attention must be devoted to the service delivery component of VSC so that skills developed during training can be used fully and maintained. In fact, AVSC's current program has already begun to incorporate these new directions in its current activities. IFPMHP's support will allow AVSC to complete the expansion of its program in these areas.

IFPMHP supports AVSC's plan to promote VSC service delivery in the LGU's at provincial and district hospitals. About 150 hospitals (75 public and 75 private) will be provided 300 minilap kits, 50 vasectomy kits and assorted basic surgical equipment. Some of these activities have been initiated through FPAP and they will be expanded further in IFPMHP. AVSC's efforts to develop self-sustainability and fee-for-service mechanisms in VSC service delivery will be supported by IFPMHP.

The additional resources provided by the DOH through the performance-based program will be used to provide the necessary commodities and expendable supplies for conduct of voluntary surgical contraception services.

6) Advocacy for Population and Development (Policy Planning)

New, dynamic leadership at POPCOM is re-vitalizing this important organization. POPCOM's new role in support of family planning will be to heighten awareness and understanding of the relationship between population and development. POPCOM and the DOH are completing the process of defining distinctive roles, with POPCOM primarily involved in advocacy at the national and LGU levels. USAID support to the revived POPCOM will ensure that new divisions of responsibility are institutionalized and that the organization's comparative strengths are used most effectively.

TA to POPCOM and the Philippine Legislators Committee on Population and Development (PLCPD) will strengthen the commitment of national and local leaders to support population programs and to institutionalize the capability to conceive, plan, and implement population policies. Policy models and presentations will meet these objectives in four broad categories: advocacy/constituency building, development of supportive population policies, strategic planning and institution building.

Current work in advocacy with POPCOM and PLCPD will be continued. Support for the publications "People Count," "Talk Point," and "Advocacy Alert" will continue. A 1992 cost-benefit study of family planning will be updated for advocacy purposes. Computer presentations developed under the FPAP with POPCOM will be updated with recently released data and disseminated to a variety of groups at the national level, including policy makers, program managers and universities. POPCOM plans to develop a new population policy in the coming year and assistance will be provided to support POPCOM's policy development process.

Since LGU level support for the population program is critical to the success of a devolved population program, TA will assist POPCOM to generate local support by developing computer models and presentations for provinces and municipalities using data from the LGUs, the DHS and the census. Training will be provided to POPCOM central and regional staff in data and survey analysis and in developing local level presentations so that local data can be disseminated to LGU officials and other decision makers who determine the local resources to be allocated to FP programs.

Assistance will be provided to POPCOM to develop new materials to train LGU population and health offices on basic demographic concepts and analysis. These skills will assist LGU population and health offices to plan and implement their population programs. POPCOM staff will be trained in program target setting and estimating resources required to achieve stated benchmarks. These skills will be subsequently transferred to national and local planners. Training will also be provided for local planners to conceptualize and implement alternative program strategies such as improving method use effectiveness, examining issues of cost effectiveness of different strategies or focusing on, delaying the age at marriage.

As POPCOM's role becomes more clearly defined, assistance will be provided in the areas of policy development and implementation. POPCOM's capabilities will be enhanced through the transfer of additional computer equipment and the employment of a computer consultant to assist POPCOM in computer maintenance and operations.

IFPMHP will provide a resident advisor to POPCOM to increase the continuity of expert technical advice and to accelerate the implementation of POPCOM's new areas of responsibility. In January 1995, the resident advisor will begin working with POPCOM for a two-year period. From 1997 until the end of IFPMHP, short-term technical assistance will again be provided as needed by POPCOM, perhaps four or five times a year.

7. National Program Monitoring

The DOH needs to monitor the progress the PFPP is making toward increasing contraceptive prevalence and slowing the national population growth rate. In the broadest sense, the DOH needs to know whether its efforts and those of LGUs are effective. To perform this monitoring, the Family Planning Service (FPS) within the OSC will establish the capacity to make such assessments annually. This monitoring function is expected to be useful for OSC's internal program management purposes (e.g., where is progress being made, where are greater efforts needed), by USAID and other donors, as well as for external reporting by OSC (e.g., making a case for and defending its annual budget).

Substantial amount of data will be generated from existing data collection activities for national program monitoring. This includes vital statistics, census data and annual population-based surveys conducted by the National Statistics Office (NSO); logistics data from CDLMIS, NGO service delivery data and commercial marketing data from pharmaceutical companies and SOMARC. These data will be used to construct a composite assessment of the progress being made by Philippines PFPP. A number of key indicators will be monitored for this assessment (discussed in Section IV - Monitoring). Periodic data which provide additional insight into the progress of the PFPP will also be used as it becomes available (e.g., the results of OR studies IFPMHP will support).

To support this function, IFPMHP will fund a contract position for a demographer/analyst who will be responsible for generating the annual report as well as assisting OSC with other information and analysis requirements. This individual will be assisted by existing FPS staff, the BUCEN Advisor and IFPMHP's technical assistance team and a U.S. Bureau of Census (BUCEN) advisor. By 1996, OSC is expected to cover the costs of this position or regularize the position within its FPS staffing.

Because of the critical role the NSO plays in producing necessary demographic and population related data, IFPMHP will provide TA via a PASA with BUCEN, training and equipment to strengthen the NSO's operations. The NSO will be a principal source of demographic and family planning data needed for the national program monitoring described above. This includes conducting the DHS in 1998, annual nationwide population-based surveys and timely reporting of vital statistics.

In addition, monitoring of implementation of the Program's urban strategy will be an important element of national program monitoring.

As IFPMHP will give priority to expanding FP services in urban areas to accelerate and increase IFPMHP's impact, a resident advisor will be provided through IFPMHP's TA contract to OSC to serve as an Urban Advisor. This individual will be a health professional and will have three major monitoring responsibilities:

1. To meet with urban officials/leaders from the public/private sectors to insure a full blown strategy for expanding training, IECM initiatives, and services for family planning and RTIs is developed.
2. To work with DOH, USAID and USAID contract officials to ensure resources are provided on a timely basis to carry out the approved urban strategy, including the expansion and improvement of selected DOH post-partum mother-baby friendly hospitals in urban hospitals.
3. To provide to DOH/OSC a semi-annual report of progress in meeting IFPMHP's urban strategy objectives.

b. COMPONENT 2 - NGOS AND OTHER PRIVATE SECTOR ORGANIZATIONS

More than any other component in this PAAD, the NGO sector reflects USAID's concern for sustainability. Without grassroots level participation, successful, self-sustaining programs are not possible. By grassroots level, this paper means collaborative efforts in planning, designing and implementing activities through NGOs. In turn, these NGOs work with smaller NGOs, community and professional associations, cooperatives, factories (both staff and management), private providers, credit unions, environmental groups and LGU Health Boards.

To be successful, all FP programs must involve local leaders and resources. Both local commitment and political will are essential to the long-term sustainability of the program. Fortunately IFPMHP is ideally timed to coincide with the new expanded role of LGUs, including NGO participation, in the Philippines. Because of continuing GOP support for NGO participation and because of past NGO successes in the FP field, a critical mass of NGO involvement is planned in this program. By the end of IFPMHP, it is anticipated that the proportion of FP users at government clinics will have dropped

from its current rate of 72 percent to 40 percent. It should be noted, however, the absolute number of acceptors using government facilities is likely to increase over time as more women enter the fertile-age group and as a greater proportion of these women decide to plan their families. Of the remaining 60 percent of FP users, 50 percent would be served through the NGO component and the remaining 10 percent would secure their services outside the government or NGO sectors. Finally, within the NGO component, it is projected that half would be serviced by the non-profit NGO outlets and the remaining half through the social marketing scheme (managed by an NGO) of this Component.

In line with the Agency's Development Strategy, a major element in the NGO strategy is its emphasis on sustainability. Except for the associations of FP volunteers, participating NGOs will secure payment for services from users or their employers to carry out family planning activities. Because the various sustainability elements were designed with local leaders and local NGOs, they are remarkably creative, maximize limited resources and, most importantly, recognize that the internalization of FP demand is the key to long-term sustainability. In other words, until the majority of Filipino couples decide to use effective methods of FP there is no fiscal gimmick which can make the FP program sustainable. The NGO activities to be supported through this component are described below.

1) The NGO Strengthening Project

Under FPAP the NGO Strengthening Project has grown from one of the least effective to one of the strongest resources in the PFPP. IFPMHP will build on these strengths and creativity by expanding the programs to non-FP NGOs, by transferring the NGO training component to the NGO Strengthening Project and by directing substantial support (IECM and services) to the LGUs participating in the LGU Performance Program and to urban areas. As under FPAP, the NGOs will continue to provide quarterly reporting of their activities to the DOH.

Specifically, the NGO Strengthening Project will:

- Continue to provide support to the four national FP NGOs to continue their expansion and self-sustaining efforts either through the franchising of certified midwives and nurses as FP/MCH providers or through fee for service schemes. For the most part, these providers will be located in the urban and semi-urban areas, where clients can afford to pay reasonable charges for services. By the end of Year 5 of IFPMHP, it is expected that the national NGOs will have attained at least 80 percent cost recovery.
- Establish FP activities (IECM and/or FP services) in 41 existing NGOs which previously had not been involved in FP. Past experience has shown this approach to be a very cost-effective and sustainable means of expanding FP. Of the 41

NGO, 10 are envisioned to be based in urban areas. Of the remaining 31, 10 will be people's organizations such as the associations of FP or health volunteers. Initially, the members are not expected to be paid or to charge for contraceptives. Since almost no costs are involved with these associations, financial sustainability is not an issue.

- Continue the very successful deficit financing - cost recovery program for making cash advances to establish clinics in nine small NGOs.
- Make a phased effort to establish sustainable activities to increase the participation of urban private health care providers and associations of FP volunteers which are urban based. Urban NGOs will be encouraged to establish evening and Saturday hours to meet the special needs of working women.

These NGOs range from national in scope to LGU based and have come together for many purposes, including FP, health care, credit, environmental concerns, educational or professional interests, community revitalization and cooperative activities. The NGO Strengthening Project will assist them through training in technical skills, e.g., FP service delivery, IECM and management skills to develop more self-sustaining programs. IFPMHP will also sponsor an advocacy workshop for all NGO representatives on the newly constituted LGU Health Boards.

2) Responsible Parenthood/Maternal Child Health (RP/MCH) Program for the Industrial Sector

The RP/MCH Program for the Industrial Sector is a very successful NGO effort which will be continued and expanded under IFPMHP. Activities under FPAP have shown it to be cost effective and remarkably sustainable. The Industrial Program involves both labor and management, and it requires the participating industry to make an annual cash contribution from the start of the three-year cycle. The industry also contributes staff time and physical space for the FP program. USAID's managing NGO provides TA and FP training to the participating industries. The DOH provides the required contraceptives for the employees who can avail themselves of quality FP services at or near the plant. After a three year cycle, during which the industries make increasingly large cash contributions to the program, the industry is graduated as a self-sustaining RP/MCH entity.

During the seven years of the RP/MCH Project, three cycles, involving 113 companies with a combined workforce 126,900, have been conducted. This excellent base will be expanded by: a) covering more agro-industrial companies, b) tapping into the smaller companies at industrial complexes where by combining resources a joint clinic for the use of all companies can be established to meet the health needs including FP and c) working with organized workers or associations in support of work-based FP services.

Within five years, RP/MCH will have:

- Institutionalized the RP/MCH program in a) approximately 40 agro-industrial companies in Mindanao with an estimated work force of 40,000 persons, and b) four industrial complexes located in Luzon and the Visayas with an estimated work force of 35,000 persons.
- Developed an RP/MCH advocacy program for organized groups of workers/professionals in support of company-based RP/MCH programs.
- Developed a scheme whereby a company clinic will be able to serve the RP/MCH needs of residents in the immediate vicinity of the participating agro-industrial businesses as a manifestation of the company's corporate social responsibility.

3) **The Social Marketing Project**

The Social Marketing Project in the Philippines is unusual, if not unique, in that as a commercial effort, it is managed by a Philippine NGO with TA provided through the G/RD/POP SOMARC project. In turn, the NGO uses SOMARC's technical resources to work collaboratively with pharmaceutical firms, distributors, pharmacists, private health associations and providers plus the various media required to implement a program designed to achieve self-sustainability.

Under FPAP, the Contraceptive Social Marketing (CSM) activity negotiated arrangements with pharmaceutical firms whereby the price of pills and condoms are sold at significantly lower prices to individuals. In exchange, the CSM provided training, technical assistance, and promotion costs. Both products are off to good starts in terms of sales in the three largest cities (Manila, Davao, and Cebu) where the products have been launched.

Before IFPMHP begins, the CSM activity will go national on television. In 1994, DMPA (injectables) will be launched in the three big cities via a radio campaign. Finally, oral and condom launches will take place in five additional cities via point of purchase promotion and "below the line" publicity through private sector doctors, nurses, midwives and pharmacists. This aspect of the Social Marketing Project is a key element in IFPMHP's Urban Strategy.

During implementation of IFPMHP, the mass media campaign for injectables will be national in Year 1 and a concerted effort to involve additional physicians throughout the country will be undertaken in Year 2. Five additional cities will be selected for full-scale launches each year. Thus, at the end of Year 5, there will have been product launches in 33 cities. It is anticipated that 25 percent of modern contraceptives will be sold through the CSM activity by the end of Year 5, which includes NGO sales.

In terms of financial sustainability, the project does not provide subsidized products. Instead, the project provides technical assistance, quality assurance training, and product promotion. These same elements will be pursued on an ever-widening scale throughout IFPMHP. At the conclusion of IFPMHP, the social marketing concept should be fully in place with low-priced products widely available and regularly promoted by the commercial sector. In brief, this aspect of IFPMHP should be 100 percent sustainable by the conclusion of IFPMHP.

4) CARE's Assistance to Participating NGOs

CARE is a registered NGO in the Philippines and United States. Under FPAP, CARE performs two major functions. The first involves CARE's implementation and management of the contraceptives distribution system for the DOH. The second involves CARE integrating FP into the activities of NGOs with whom CARE has an existing relationship. Since the election of President Ramos, NGOs are demonstrating growing interest in FP. CARE can also direct greater attention to NGO provision of FP services as its work on the logistics system progresses and nears completion. Under IFPMHP, CARE will organize a network of up to 50 NGOs nationwide which, after proper training under the NGO Strengthening Project, will provide information and/or FP services at a very low cost. This activity is expected to be cost-effective if enough of CARE's NGO partners elect to participate. However, it is doubtful that this will be totally self-sustaining by the end of IFPMHP.

c. COMPONENT 3 - IFPMHP'S PERFORMANCE-BASED PROGRAM

1) Performance-based Disbursements

The Local Government Code of 1991 devolved responsibility for health care service delivery, including FP, to LGU, specifically, to provinces, cities and municipalities. Prior to the Code, the DOH was responsible for these services. Under devolution, DOH personnel and facilities at the provincial level and below were transferred, i.e., devolved, to the LGUs. To offset the increased costs LGUs incurred for staff salaries, service delivery and maintenance and operations of facilities, LGUs received a greater budget allocation from the central government. However, LGUs have claimed that the increased budget allocated to them is insufficient to cover costs of devolved functions, personnel and facilities. This raises serious concerns about the ability of LGUs to maintain, let alone expand, basic health services.

For the DOH, devolution meant a fundamental change in the functions and operations of the central Department vis-a-vis the LGUs. DOH officials agree that the Department must become a "servicer of service providers", i.e., the DOH needs to develop the capacity to assist and support the LGUs which now are the actual providers of services. This will require a major re-orientation of DOH policies, procedures and modes of operation. Similarly, the LGUs must expand their planning, administrative

and budget systems to assume responsibility for the provision of health services.

IFPMHP will support the policy and institutional reform process needed to establish a new, post-devolution relationship between the DOH and the LGUs in support of FP and selected MCH services. Performance-based disbursements will be made by USAID contingent upon satisfactory achievement by the DOH and the LGUs of benchmarks measuring progress toward the enactment and institutionalization of these reforms. Achievement of these benchmarks will be solely the responsibility of the DOH and the LGUs. Assuming satisfactory performance, USAID plans to disburse \$23.2 million in five annual tranches. Performance disbursements will be used for the repayment of foreign debt as approved by USAID. However, in accordance with USAID policy, this will be reviewed periodically whether use of the dollar for U.S. exports is feasible. If any U.S. debt is payable, the funds will be used for those payments.

To advance the reform process, the DOH/OSC will establish the LGU Performance Program (henceforth, the Program) which will assist the LGUs to expand and improve FP/MCH service delivery. First year benchmarks for USAID's performance disbursements have been established with illustrative benchmarks suggested for Years 2 and 3 (benchmarks for Years 4 and 5 are to be developed during the first three years of the Program).

(see Benchmark Matrix)

Benchmarks for OSC involve the planning, implementation and monitoring of a performance-based assistance program for selected LGUs. OSC must establish the administrative systems, allocate budget and assign personnel necessary to manage this program. Given the large number of LGUs nationwide, the management and financial requirements for assisting all LGUs simultaneously would exceed OSC's capabilities. Therefore, the Program will expand in phases. This will require OSC to establish criteria for selecting a set of LGUs to enter the program each year (Annex I suggests one approach). OSC will contact the selected LGUs, explain how the Program functions, and assist participating LGUs to meet their benchmarks.

Participating LGUs will prepare FP/MCH program proposals, initially a one-year start-up plan, followed by a multi-year program plan, which meet OSC standards (Annex J suggests possible planning standards). Once OSC approves the plans, a Memorandum of Agreement (MOA) will be established between OSC and each participating LGU which specifies approved program activities and LGU performance benchmarks. OSC will then allocate funding to LGUs for implementation of their approved programs.

As the Benchmark Matrix indicates for Years 2 and 3, the preceding process of selecting additional LGUs to participate in the Program is repeated annually. The expansion of the Program is itself an important measure of OSC's increasing capacity

**BENCHMARK MATRIX FOR IFPMHP'S
PERFORMANCE BASED ASSISTANCE**

<p align="center">YEAR 1 (Review: 12/94)</p>	<p align="center">YEAR 2 Illustrative (Review: 12/95)</p>	<p align="center">YEAR 3 ILLUSTRATIVE (Review: 12/96)</p>
<p>I. DOH: A. OSC</p> <ol style="list-style-type: none"> 1. Issues a description of the LGU Performance Program, including program planning and performance standards. 2. Reviews, revises and approves benchmarks for National Programs and participating LGUs for Year 2 program review. 3. Designs and implements a system for monitoring FP/MCH status and issues a National Family Planning Status Report. <p>B. LGU Performance Program 1. For Group 1 LGUs</p> <ol style="list-style-type: none"> a. Selects first group of twenty LGUs to participate. b. Contacts LGUs, explains program, encourages participation through technical assistance. c. Evaluates LGU "start-up" proposals. d. Issues a Memorandum of Agreement (MOA) between OSC and each participating LGUs which sets performance benchmarks for capacity building for Year 2. 	<p>I. DOH: A. OSC</p> <ol style="list-style-type: none"> 1. Reviews, revises and approves benchmarks for the National Programs and participating LGUs for the Year 3 program review. 2. Issues Annual National Family Planning Status Report. <p>B. LGU Performance Program 1. For Group 1 LGUs:</p> <ol style="list-style-type: none"> a. Assesses the progress of Group 1 LGUs toward achieving capacity building benchmarks. Identifies LGUs that: a) will continue in the program, (b) those that did not achieve fully satisfactory performance and (c) select-out poor performers. b. Evaluates, negotiates and approves/rejects LGU multi-year FP/MCH program plan and annual workplan including Year 3 benchmarks for service availability. c. Issues a MOA between OSC and each participating LGU which sets performance benchmarks focused on expanded FP/MCH service availability for the Year 3 program review. <p>2. For Group 2 LGUs:</p> <ol style="list-style-type: none"> a. Selects the second group of twenty LGUs to participate. b. Contacts LGUs, explains program, encourages participation through technical assistance. c. Evaluates LGU "start-up" proposals. d. A MOA between DOH/OSC and each participating LGUs which sets benchmarks focused on capacity building for the Year 3 review. 	<p>I. DOH: A. OSC</p> <ol style="list-style-type: none"> 1. Reviews, revises and approves benchmarks for the National Programs and participating LGUs for the Year 4 program review. 2. Issues Annual National Family Planning Status Report. <p>B. LGU Performance Program 1. For Group 1 LGUs:</p> <ol style="list-style-type: none"> a. Assesses the progress of Group 1 LGUs toward achieving their service availability benchmarks under their "start-up" programs. Identify LGUs that: a) will continue in the program, (b) those that did not achieve fully satisfactory performance and (c) select-out poor performing LGUs. b. Reviews and approves/rejects LGU annual work plan for Year 4, including benchmarks/targets for program performance indicators. c. Issues a MOA between OSC and each participating LGUs which sets benchmarks focused on FP/MCH Program Performance for the Year 4 program review. <p>2. For Group 2 LGUs:</p> <ol style="list-style-type: none"> a. Assess the progress of Group 2 LGUs toward achieving their capacity building benchmarks. Identifies LGUs that: (a) will continue in the program, (b) those that did not achieve fully satisfactory performance and (c) select-out poor performers. including Year 4 benchmarks for service availability. b. Evaluates, negotiates and approves/rejects LGU multi-year FP/MCH program plan and annual workplan including Year 4 benchmarks for service availability. c. Issues MOA between DOH/OSC and each participating LGUs which sets benchmarks focused on expanded FP/MCH service access for the Year 4 program review.

**BENCHMARK MATRIX FOR IFPMHP'S
PERFORMANCE BASED ASSISTANCE**

<p align="center">YEAR 1 (Review: 12/94)</p>	<p align="center">YEAR 2 Illustrative (Review: 12/95)</p>	<p align="center">YEAR 3 ILLUSTRATIVE (Review: 12/96)</p>
<p>II. Local Government Units A. For Group 1 LGUs:</p> <ol style="list-style-type: none"> 1. Submits a one year "start-up" program which meets DOH standards and sets capacity building benchmarks for the Year 2 program review.* 2. Issues an Administrative Order specifying the roles and responsibilities of the LGU Population and Health Offices for planning and management of the FP/MCH program. 3. At least 75% of participating LGUs meet Year 1 benchmarks 	<p>II. Local Government Units A. For Group 1 LGUs:</p> <ol style="list-style-type: none"> 1. Submits a multi-year FP/MCH program plan which meets DOH standards.** 2. Submits a workplan for the coming year which implements the multi-year program plan, sets service availability benchmarks for the Year 3 program review and includes increased LGU budget for FP/MCH program. 3. At least 75% of participating LGUs meet Year 2 benchmarks <p>B. For Group 2 LGUs:</p> <ol style="list-style-type: none"> 1. Submits a one year "start-up" program which meets DOH standards and sets capacity building benchmarks for the Year 3 program review. 2. Issues an Administrative Order specifying the roles and responsibilities of the LGU Population and Health MCH Offices for planning and management of the FP/MCH Program. 3. At least 75% of participating LGUs meet Year 2 benchmarks. 	<p>3. For Group 3 LGUs:</p> <ol style="list-style-type: none"> a. Selects the third group of twenty LGUs to participate. b. Contacts LGUs, explains program, encourages participation through technical assistance. c. Evaluates LGU "start-up" proposals. d. Issue a MOA between DOH/OSC and each participating LGUs which sets benchmarks focused on capacity building for Year 4 review. <p>II. Local Government Units A. For Group 1 LGUs:</p> <ol style="list-style-type: none"> 1. Prepares a workplan for the coming year which implements the multi-year program plan, sets benchmarks/targets for program performance indicators for the Year 4 program review and includes increased LGU budget for FP/MCH program. 2. At least 75% of participating LGUs meet Year 3 benchmarks. <p>B. For Group 2 LGUs:</p> <ol style="list-style-type: none"> 1. Submits a multi-year FP/MCH program plan which meets DOH standards. 2. Submits a workplan for the coming year which implements the multi-year program plan, sets service availability benchmarks for the Year 4 program review and includes increased LGU budget for FP/MCH Program. 3. At least 75% of participating LGUs meet Year 3 benchmarks. <p>C. For Group 3 LGUs:</p> <ol style="list-style-type: none"> 1. Submits a one year "start-up" program which meets DOH standards and sets capacity building benchmarks for the Year 4 program review. 2. Issues an Administrative Order specifying the roles and responsibilities of the LGU Population and Health Offices for planning and management of the FP program. 3. At least 75% of participating LGUs meet Year 3 benchmarks.

* See Annex L for "start-up" program planning standards.
**See Annex L for multi-year program planning standards.

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to assist LGUs to expand and improve their FP/MCH services. The expansion of the Program also reflects the gradual institutionalization of a new, post-devolution relationship - a partnership between OSC and the LGUs as "co-equals" working together to expand and improve FP/MCH services.

Benchmarks for the LGUs focus on the development of an initial, one-year "start-up" program plan to re-vitalize their FP/MCH programs. This "start-up" program, if successful, is followed by a multi-year FP/MCH program plan. Performance benchmarks which measure the progress of the LGU's FP/MCH program will be specified in these plans. Continued participation in the program will be contingent upon satisfactory performance by the LGU in achieving its program benchmarks. Because of the strong interrelationship between FP maternal health and child survival, participating LGUs will be expected to include benchmarks for both FP service delivery and four selected MCH interventions. The latter are EPI, ARI, ORT and micro-nutrients (including Vitamin A). In general, FP/MCH performance benchmarks will measure the expansion of services and/or the maintenance of adequate service coverage.

The participating LGUs must maintain their commitment to their FP/MCH programs. The best measure of commitment is the LGU's annual budget allocations for FP/MCH services which will be included in program plans and annual work plans. As the illustrative benchmarks for Years 2 and 3 suggest, LGUs are expected to assume an increasing share of total program costs for their FP/MCH programs. This will be an important measure of program sustainability.

The benchmarks for Years 1, 2 and 3 reflect the phased expansion of the Program as well as the expected development of the LGU FP/MCH programs. The Program will expand in stages, beginning with approximately 20 LGUs in the first year and adding 20 more in each following year. Over a five-year period, approximately 100 LGUs will have participated in the Program. The actual expansion of the Program might proceed at a slower or faster pace than this depending on the LGUs' interest in participating and their ability to respond to the requirements of the Program. At the mid-project evaluation DOH, with technical assistance from the PMTAT, will develop a contingency plan. This plan will assist the last two batches of LGUs which will enter the program in the latter period, to ensure that FP/MCH services continue to be provided in the respective LGUs.

Corresponding to the two-step process of the Program (i.e., a one year "start-up" program followed by a multi-year program), the emphasis of the benchmarks used for assessing performance change over time from initial capacity building, to service availability measures in the second year of participation, to program performance measures in the later years.

Capacity building benchmarks include outputs such as: a) the completion of proposed staff training at provincial, city and municipal levels; b) MOAs between the

province and municipalities regarding program funding, support and development; c) the establishment and operation of service delivery and management systems.

Service access benchmarks will include indicators such as: a) the number of LGU, NGO and other service delivery outputs; b) the availability of methods at each delivery point (e.g, the number of service points providing pills, condoms, IUD, etc.); and c) the number of barangays serviced by a Barangay Service Point Officer (BSPO).

Program performance benchmarks will include FP/MCH measures such as: a) annual percentage increase in the number of new acceptors of modern methods; b) percentage increase in CPR from the 1993 DHS estimate; c) the percentage of children under five fully immunized.

Schematically, the phased expansion of the program and the shift in type of the benchmarks can be presented as follows:

PROGRAM IMPLEMENTATION YEAR

LGU Groups:	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5</u>
1	Start-up Plan	Capacity Building	Service Access	Program Perform.	Program Perform.
2		Start-up Plan	Capacity Building	Service Access	Program Perform.
3			Start-up Plan	Capacity Building	Service Access
4				Start-up Plan	Capacity Building
5					Start-up Plan

2) Performance Monitoring

Performance monitoring will occur at three levels. OSC will monitor the annual progress of participating LGUs on the basis of OSC-approved FP/MCH benchmarks established in the LGU's program plans. Each year OSC and the LGUs will establish program performance benchmarks for the following year. These benchmarks will be included in the MOA between OSC and each participating LGU. On the basis of the approved benchmarks, OSC will conduct an annual LGU performance assessment.

The LGUs will submit documentation satisfactory to OSC showing that their FP/MCH benchmarks have been accomplished. Participating LGUs will receive technical

assistance funded by IFPMHP to assist them with the necessary monitoring and reporting systems to meet this requirement. An OSC Program Management Team will evaluate the performance of each participating LGU.

An important element of OSC's annual review is to establish LGU performance benchmarks for the following year. Participating LGUs will propose benchmarks in their program plans and/or annual work plans. OSC is responsible for reviewing and reaching mutual agreement with the LGUs on accepted benchmarks. The results of this review, including OSC decisions about continued LGU participation in the Program, will be summarized in an annual LGU Performance Report prepared by OSC for USAID's review.

OSC will be responsible for documenting that it has achieved annual benchmarks pertaining to management of the Program. This documentation will be submitted to USAID. Benchmarks for the following year will be proposed in OSC's submission.

USAID will conduct an independent review of LGU and OSC performance. The review will focus on OSC's management of the LGU Program and on LGU performance overall. USAID will not be involved in the individual performance reviews of each participating LGU. Rather, USAID will expect to see credible evidence that OSC:

- followed reasonable and objective criteria for selecting LGUs to participate in the Program;
- conducted careful reviews proposed programs and that the plans contained meaningful benchmarks;
- established standards for documenting achievement of benchmarks;
- provided assistance sufficient for the LGU to implement its expanded FP/MCH program plan;
- received documentation from the LGUs adequate for the annual performance assessment;
- organized and conducted careful assessments of LGU performance; and
- made decisions to retain or select out LGUs based solely on program results and the LGU's continuing commitment to FP/MCH service expansion and improvement.

The basis of this review will be the LGU Performance Report submitted by OSC (which will receive TA in support of performance monitoring and reporting). An important part of USAID's review is to reach agreement with OSC on general benchmarks at the LGU

level and on specific benchmarks for OSC, for the following year. The ultimate outcome of USAID's performance assessment is the decision whether to disburse the next tranche or not.

3) Technical Assistance

USAID's performance-based assistance is intended to help the DOH/OSC and LGU's to develop a new mode of working together to expand and improve FP/MCH services. The Program will advance this new relationship and strengthen the capabilities of LGUs to deliver FP/MCH services. To support both efforts, IFPMHP will fund a Program Management Technical Advisors Contract Team (PMTACT). OSC will initially need assistance to meet its management responsibilities for the Program. Setting planning and performance standards, selecting LGUs, working with the LGUs to develop program plans, establishing performance benchmarks, documenting progress toward achieving program benchmarks and evaluating LGU performance will all be new activities for OSC. PMTACT will help OSC develop its capacity to undertake these new tasks. As OSC staff gain experience, they are expected to work with PMTACT in assisting the LGUs, transferring this function to OSC over time.

A particularly difficult management task OSC will confront is determining the criteria for continued participation by LGUs in the program. For example, if OSC determines that satisfactory progress has been made toward achieving all performance benchmarks, the LGU will be eligible to remain in the Program and receive additional assistance from OSC. LGUs whose progress is inadequate, or whose newly elected officials lack sufficient commitment to their FP/MCH programs, will be put on probation or selected out of the Program. If an LGU fails to meet its FP benchmarks, it will be selected out regardless of its performance on MCH benchmarks. This is only one possible approach. PMTACT will assist OSC to identify options and select an approach which makes OSC's decision-making process transparent to the LGUs.

Though the particular requirements of each LGU will vary, it is expected that participating LGUs will face a common set of problems and require comparable types of assistance. On-going pilot LGU programs sponsored by FPAP suggest that LGUs will need a wide range of assistance for program planning, staff training, organizational and management systems development, field supervision, program implementation, benchmark monitoring and information management. PMTACT will be staffed to assist participating LGUs in all phases of program development.

1.B.4 IFPMHP Beneficiaries

In addition to the 15 million women aged 15-49 (of whom 8.96 million are married, who are the potential beneficiaries of IFPMHP, other social categories of people are expected to benefit directly and indirectly from the program, including:

- Service delivery providers who will be trained, giving them updated information on contraceptive technology;
- NGOs whose capacities for program development and service delivery will be strengthened and put on a sounder financial footing;
- The companies and their employees who participate in the in-plant RP/FP program; and
- National and LGU officials and decision-makers who will be better informed about the importance of family planning programs for the improvement of the quality of life of their constituents.

1.B.5 End of Program Status

In addition to reducing unmet need for FP services, increasing contraceptive prevalence and increasing services to women in high-risk categories, additional outputs that will indicate IFPMHP success include the following:

- The program will have contributed to the reduction of the total fertility rate from 4.08 in 1993 to 3.29 by 1999.
- The program will have contributed to the increase in contraceptive prevalence of modern methods from 24.9 in 1993 by 1.5% to 2.0% annually to 1999.
- At the end of CSP and FPAP, the percent of public health facilities delivering a broad range of FP services appropriate to the type of facility was as follows: **BHS 40%; RHU 50%; District Hospitals 25%**. These numbers will increase to **80%** across the board by the end of the Program.
- "An additional **150** companies with a workforce of more than **300** women will have in-plant FP services available to their employees. (At present, **150** firms offer such services to their employees)."
- "A total of **99** NGOs (an increase of **80** NGOs from the number at the beginning of the program) will be providing high quality useful FP services which reach a total clientele of approximately **400,500**. Fees and other charges levied for the services they provide will be serving to offset at least **80%** of the operational costs, excluding the cost of the contraceptives of these NGOs."
- "Contraceptives at an affordable price will be reliably available through firmly established commercial channels which reach throughout the country. (At present, it is estimated that only **19%** of the target population has access to commercially affordable contraceptives available.

TABLE I
INTEGRATED FAMILY PLANNING AND
MATERNAL HEALTH PROJECT

BUDGET SUMMARY
(\$ 000)

Component	USAID Bilateral	DOH/ LGU	Total HC & Bilateral	USAID/ Washington	Total HC, Bilateral & R&D/POP
A. Private Sector and NGOs					
1. NGOs	9,400	-	9,400	-	9,400
2. Social Marketing	-	-	-	7,960	7,960
B. National Services					
1. IE&C	3,000	238	3,238	5,700	8,938
2. Contraceptives	-	-	-	22,099	22,099
3. Logistics	-	475	475	5,752	6,227
4. Training	5,535	350	5,885	-	5,885
5. Voluntary Surgical Contraception	-	71	71	2,872	2,943
6. Operations Research	-	317	317	1,500	1,817
7. Policy Planning	-	322	322	2,357	2,679
8. Monitoring	1,065	-	1,065	1,760	2,825
C. IFPMHP Performance-Based Program					
1. Performance Disbursements	25,000	17,575	42,575	-	42,575
2. OSC & LGU Program Management	5,400	652	6,052	-	6,052
D. Evaluation and Audit					
1. Evaluation	350	-	350	-	350
2. Audit	250	-	250	-	250
SUB-TOTAL	50,000	20,000	70,000	50,000	120,000

**TABLE 2
INTEGRATED FAMILY PLANNING AND
MATERNAL HEALTH PROJECT**

**SUMMARY OF COST ESTIMATE AND FINANCIAL PLAN
(\$ 000)**

Component	USAID Bilateral		DOH/ LGU		Total HC & Bilateral	USAID/ Washington		Total HC, Bilateral & R&D/POP
	FX	LC	FX	LC		FX	LC	
A. Private Sector and NGOs								
1. NGOs	6,275	3,125	-	-	9,400	-	-	9,400
2. Social Marketing	-	-	-	-	0	7,960	-	7,960
B. National Services								
1. IE&C	3,000	-	-	238	3,238	7,460	-	10,698
2. Contraceptives	-	-	-	-	0	22,099	-	22,099
3. Logistics	-	-	-	475	475	5,752	-	6,227
4. Training	5,320	215	-	350	5,885	-	-	5,885
5. Voluntary Surgical Contraception	-	-	-	71	71	2,872	-	2,943
6. Operations Research	-	-	-	317	317	1,500	-	1,817
7. Policy Planning	-	-	-	322	322	2,357	-	2,679
8. Monitoring	2,825	-	-	-	2,825	-	-	2,825
C. IFPMHP Performance Based Program								
1. Performance Disbursements	23,240	-	-	17,575	40,815	-	-	40,815
2. OSC & LGU Program Mgt.	5,400	-	-	652	6,052	-	-	6,052
D. Evaluation and Audit								
1. Evaluation	350	-	-	-	350	-	-	350
2. Audit	-	250	-	-	250	-	-	250
SUBTOTAL	46,410	3,590	0	20,000	70,000	50,000	0	120,000

TABLE 3
INTEGRATED FAMILY PLANNING AND
MATERNAL HEALTH PROJECT

PROJECTION OF PROJECT EXPENDITURE BY YEAR
(\$,000)

Component	FY 95		FY 96		FY 97		FY 98		FY 99		FY 00		TOTAL
	USAID	DOH/ LGU*	USAID	DOH/ LGU*	USAID	DOH/ LGU*	USAID	DOH/ LGU*	USAID	DOH/ LGU*	USAID	DOH/ LGU*	
BILATERAL FUNDING													
A. Private Sector and NGOs													
1. NGOs	1,400	-	2,025	-	2,116	-	2,139	-	1,711	-	-	-	9,400
2. Social Marketing	-	-	-	-	-	-	-	-	-	-	-	-	0
B. National Services													
1. IE&C	750	47	750	47	500	48	500	48	500	48	-	-	3,238
2. Contraceptives	-	-	-	-	-	-	-	-	-	-	-	-	0
3. Logistics	-	95	-	95	-	95	-	95	-	95	-	-	475
4. Training	917	70	964	70	1,183	70	1,365	70	1,100	70	-	-	5,885
5. VSC	-	14	-	14	-	14	-	14	-	15	-	-	71
6. Operations Research	-	63	-	63	-	63	-	64	-	64	-	-	317
7. Policy Planning	-	64	-	64	-	64	-	65	-	65	-	-	322
8. Monitoring	955	-	665	-	400	-	425	-	380	-	-	-	2,825
C. IFPMHP Performance Based Program													
1. Performance Disbursements	3,200	3,514	4,200	3,514	4,875	3,515	5,170	3,516	5,796	3,516	-	-	40,815
2. OSC & LGU Program Mgt.	1,331	130	1,020	130	1,020	130	1,020	131	1,009	131	-	-	6,052
D. Evaluation and Audit													
1. Evaluation	0	-	0	-	175	-	0	-	-	-	175	-	350
2. Audit	0	-	0	-	50	-	100	-	-	-	100	-	250
SUBTOTAL	8,562	3,997	9,624	3,997	10,319	3,999	10,719	4,003	10,501	4,004	275	0	70,000

TABLE 4

PROJECTION OF PROJECT EXPENDITURE BY YEAR
(\$,000)

Component	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	TOTAL
	USAID/W	USAID/W	USAID/W	USAID/W	USAID/W	USAID/W	
R&D/POP FUNDING							
A. Private Sector and NGOs							
1. NGOs	-	-	-	-	-	-	-
2. Social Marketing	1,600	1,990	1,770	1,700	700	-	7,960
B. National Services							
1. IE&C	1,600	2,000	1,800	1,500	560	-	7,460
2. Contraceptives	4,605	5,046	5,097	5,150	2,201	-	22,099
3. Logistics	1,450	1,500	1,500	1,000	302	-	5,752
4. Training	-	-	-	-	-	-	-
5. VSC	1,000	809	453	400	210	-	2,872
6. Operations Research	450	400	350	200	100	-	1,500
7. Policy Planning	700	600	530	400	127	-	2,357
8. Monitoring	-	-	-	-	-	-	-
C. IFPMHP Performance-based Program							
1. Performance Disbursements	-	-	-	-	-	-	-
2. OSC & LGU Program Mgt.	-	-	-	-	-	-	-
D. Evaluation and Audit							
1. Evaluation	-	-	-	-	-	-	-
2. Audit	-	-	-	-	-	-	-
SUBTOTAL	11,605	12,945	11,500	10,350	4,200	0	50,000

* GOPCC rounded off to the nearest thousand dollar.

31C

- At least **100** LGUs, representing all **76** provinces and **24** cities, will have developed an internal capability to plan, finance, and implement FP/MCH service programs.
- "There will be no decline from the 1994 EPI or ORT coverage rates in those LGUs participating in this program. There will be at least a **5%** per annum (up to **90%**) increase in ARI and micro-nutrient coverage indicators in the participating LGUs."

II. COST ESTIMATE AND FINANCIAL PLAN

II.A COST ESTIMATE

The total estimated cost of IFPMHP is \$120 million. USAID bilateral funding will finance \$50 million of the total program costs. The Government of the Republic of the Philippines (GOP) counterpart contribution to the program will be \$20 million. The GOP counterpart contribution will come from its regular budget allocation for FP/MCH programs. This amount will consist of DOH personnel, capital and operating expenses and LGUs' population and health budget allocations.

Over and above the Bilateral and GOP funding, an additional \$50 million will come from USAID Washington's Bureau of Research and Development/Office of Population (G/RD/POP). No GOP counterpart is required for G/RD/POP's funding. G/RD/POP will provide commodities, training and technical services through its centrally funded projects.

The total budget for IFPMHP is summarized in Table 1 showing bilateral, GOP and G/RD/POP funding.

The distribution of the \$50 million bilateral funding over the life of the program are as follows: NGO, 18.80%; IECM partial, 6%; training, 11.07%; monitoring, 5.65%; performance disbursements, 46.48%; OSC and LGU Program Management, 10.80%; and evaluation and audit, 1.20%.

Under the G/RD/POP funding of \$50 million, the distribution over the life of the project are as follows: social marketing, 15.92%; IECM, 14.92%; contraceptives, 44.2%; logistics, 11.5%; VSC, 5.75%; OR 3.0%; and advocacy/policy planning, 4.71%.

The bulk of the budget goes to key program components, NGO and private sector strengthening, contraceptives and the cash transfer in support of policy and institutional reforms needed to develop a new DOH - LGU relationship in support of FP/MCH service delivery.

All estimated costs in the above budgets are projected from existing contracts of the on-going Family Planning Assistance Project (FPAP) for similar services and commodities.

Note that contingency/inflation has been included in each budget line item.

II.B FINANCIAL PLAN

The summary cost estimates of the AID dollar commitments and Philippine peso commitments are presented in Table 2. The dollar commitments will go to contractors who will provide TA, training and commodities, i.e., contraceptives. This dollar commitment amounts to \$46.410 million from Bilateral funding and \$50 million from G/RD/POP funding.

The peso commitments from the USAID bilateral funding is estimated at \$3.340 million. This amount will go to a local NGO who will be responsible for expanding the industrial in-plant FP program and a local university who will be responsible for the young population professionals program.

The \$20 million GOP counterpart contribution is all in local currency. This amount will finance DOH and LGUs expenditure for activities in population and health programs supported by IFPMHP.

IFPMHP will be implemented over a five year period. Projected expenditures for the project by fiscal year are shown in Table 3 for the Bilateral funding. The largest expenditures will be in Fiscal Years 1996, 1997, 1998 and 1999.

This projection of expenditures estimates that the fifth tranche disbursement for the cash transfer mechanism will occur around December 1998. Table 4 shows the projected expenditures by fiscal year for the G/RD/POP funding. Under this funding, the largest expenditure will be in FY 1995 and 1996.

II.B.1 Financial Sustainability

The financial sustainability of the project will depend heavily on the strong commitment of the GOP. The GOP will incur increased costs for training of its health and population workers for FP service delivery, increased provision of services, logistics support, monitoring and supervision.

The planned DOH public investment into women's health and safe motherhood for national level services over the next five years is \$250 million. This will be sufficient to cover the costs for FP. The projected combined contribution by the DOH and participating LGUs is \$20 million for IFPMHP. To sustain activities initiated under IFPMH, the DOH has already included a substantial line item budget for FP/MCH in

their 1995 budget. It is expected that this line item will increase over the length of the project to include the cost of some family planning commodities. In 1994 with the re-allocation of health budget resources to LGUs in line with the Local Government Code, LGUs are projected to spend approximately \$35.0 million for women's health and safe motherhood activities which includes FP services. LGUs will be expected to increase their share of total FP/MCH program funding on an annual basis by approximately 5-10 percent. Given the high priority assigned to health and FP by the Ramos Administration and by Secretary Flavio, and the growing support for FP by LGU officials, there is good reason to believe that these expenditures will be made.

An important contribution to the financial sustainability of IFPMHP activities will come from the expanded role of NGOs and the private sector in the provision of FP services. NGOs and commercial organizations will help ensure that FP services will remain available on the expanded basis supported through IFPMHP. Cost-recovery schemes to be developed by NGOs and the "fees-for-services" basis of private sector providers will ensure long-term sustainability. The social marketing activity supported by IFPMHP will expand commercially based service provision. With the development of private channels for contraceptive service delivery, those able to pay will probably shift from the highly subsidized or free services provided by government to commercial providers.

The in-plant, industrial program supported by IFPMHP will also contribute to sustainability. Participating companies will continue to be encouraged and assisted to support their own FP programs.

II.C PROGRAM DISBURSEMENTS AND CONTROLS

II.C.1 Program Disbursements

USAID will disburse funds by cash transfer, \$23.2 million, to GOP. Annual tranche releases will be based on progress toward achieving policy and institutional reforms needed to establish a new working relationship between the DOH and LGUs for FP/MCH services. The benchmarks and indicators will be mutually established by USAID, the DOH and the participating LGUs. Upon USAID review and approval of annual performance, dollar disbursements will be made into the bank account(s) specified by GOP. The proceeds may be used to retire offshore, foreign debt designated by the Philippine Central Bank and deemed acceptable by USAID or for other such purposes as USAID may agree to in writing.

Funds for TA, training, evaluation and audit will be disbursed directly by USAID to the contractors. This will also be true for the cooperative agreement with the local NGO which will be governed by USAID's regulations on PVOs. All program implementation costs will be funded through USAID contracts or cooperative agreements.

TABLE 5
INTEGRATED FAMILY PLANNING AND
MATERNAL HEALTH PROJECT
METHOD OF IMPLEMENTATION AND FINANCING*

Component	Method of Implementation	Award Agent	TOTAL
BILATERAL FUNDING			
A. Private Sector and NGOs			
1. NGOs			
a. NGO strengthening (p. 22)	USAID Direct Cooperative Agreement a/	USAID/M/ORP	6,275
b. Industry-based FP services (p. 23)	USAID Director Grant b/	USAID/M/ORP	3,125
2. Social Marketing (p. 24)	USAID Direct Cooperative Agreement a/	USAID/M/ORP	-
B. National Services			
1. IE&C (p. 12)	USAID Direct Cooperative Agreement c/	USAID/W/OP	3,000
2. Contraceptives (p. 44)	-	-	-
3. Logistics (p. 12)	-	-	-
4. Training (p. 13)			
a. in-country and off-shore	USAID Direct Contract d/	USAID/M/ORP	3,620
b. contraceptive/RTI skills training	USAID Direct Cooperative Agreement e/	USAID/W/OP	1,700
c. social science related to population	USAID Direct Grant f/	USAID/M/ORP	215
5. VSC (p. 18)	-	-	-
6. Operations Research (p. 17)	-	-	-
7. Policy Planning (p. 18)	-	-	-
8. Monitoring (p. 20)	PASA g/	USAID/M/ORP	2,825
C. IFPMHP Performance Based Program			
1. Performance Disbursements (p. 25)	Cash Transfer	USAID/M/OFM	23,240
2. OSC & LGU Program Management (p. 29)	USAID Direct Contract d/	USAID/M/ORP	5,400
D. Evaluation and Audit			
1. Evaluation (p. 48)	USAID Direct Contract h/	USAID/W/OP	350
2. Audit	USAID Direct Contract i/	USAID/M/ORP	250
TOTAL			50,000

***Method of Financing for all actions is direct payment**

a/Competitive award through IFA process.

b/Grant to PCPD as per waiver contained in Annex K.

c/Buy-in to JHU/PCS Agreement No. DPE-3052-A-00-0014-00.

d/Competitive award through RFP process for \$9.02M; includes training and OSC & LGU program management activities.

e/Buy-in to JHPIEGO Agreement No. DPE-3045-A-00-7004-00.

f/Grant to de La Salle University as per waiver in Annex K.

g/Participating Agency Services Agreement with U.S. BUCEN.

h/Buy-in to Poptech Agreement No. DPE-3024-Z-00-8078-00.

i/Competitively awarded contract.

TABLE 6
INTEGRATED FAMILY PLANNING AND
MATERNAL HEALTH PROJECT
METHOD OF IMPLEMENTATION AND FINANCING*
(\$000,000)

Component	Method of Implementation	Award Agent	TOTAL
R&D/POP FUNDING			
A. Private Sector and NGOs			
1. NGOs			
2. Social Marketing (p. 24)	USAID Direct Contract a/	USAID/W/OP	7,960
B. National Services			
1. IE&C (p. 12)	USAID Direct Cooperative Agreement b/	USAID/W/OP	7,460
2. Contraceptives (p. 44)	USAID Direct Contract c/	USAID/W/OP	22,099
3. Logistics (p. 12)	USAID Direct Contract d/	USAID/W/OP	5,752
4. Training (p. 13)	-	-	-
5. VSC (p. 18)	USAID Direct Cooperative Agreement e/	USAID/W/OP	2,872
6. Operations Research (p. 17)	USAID Direct Contract f/	USAID/W/OP	1,500
7. Policy Planning (p. 18)	USAID Direct Contract g/	USAID/W/OP	2,357
8. Monitoring (p. 20)	-	-	-
C. IFPMHP Performance Based Program			
1. Performance Disbursements (p. 25)	-	-	-
2. OSC & LGU Program Management (p. 29)	-	-	-
D. Evaluation and Audit			
1. Evaluation (p. 48)	-	-	-
2. Audit	-	-	-
TOTAL			50,000

*Method of financing for all actions is direct payment from USAID/W.

All activities are to be financed by USAID/W.

a/CSMI: Agreement No. CCP-3051-C-00-2016-00.

b/JHU/PCS: Agreement No. DPE-3052-A-00-0014-00.

c/Under Agreements under the Contraceptive Procurement Project No. 936-3018.

d/FPLM: Agreement No. DPE-3038-C-00-0046-00; CARE: Agreement No. DPE-3058-00-1011-00.

e/AVSC: Agreement No. DPE-3049-A-00-8041-00.

f/OR: Agreement No. DPE-3030-C-00-0022-00.

g/POPTECH: Agreement No. DPE-3024-Z-00-8078-00.

II.C.2 Financial Controls

II.C.2.1 Tranche Controls

Before any tranche releases are made, GOP is expected to provide the following to USAID:

a. An implementation plan specifying: 1) an annual workplan for the year from DOH/OSC; 2) documentation that existing benchmarks for the past year have been met and that new benchmarks for the coming year have been established mutually acceptable to OSC, the LGUs and USAID; 3) a schedule of payments, identifying payees, amounts and due dates of the debts proposed to be paid by GOP using dollars provided in the tranche releases and any interest earned thereon; and 4) the type of documentation to be obtained and maintained by GOP for accounting the dollars disbursed from funds provided through the cash transfer program; and

b. A statement of the name, branch and U.S. Federal Reserve Bank Branch number of each bank with which the dollars to be disbursed will be deposited and the respective amount of dollars to be deposited in each account.

The submission of the documents with the schedule of payments and the implementation plan is a Condition Precedent (CP) to each dollar disbursement. This is to guarantee that agreed-upon uses of the dollars are identified before each tranche releases are made. USAID will give a written notification, once the CP has been satisfied, to the GOP who may in turn disburse the dollars. After payments have been made, the GOP will provide USAID with documents that the dollar accounts were used for agreed-upon purposes.

II.C.2.2 Audit Coverage

The audit will cover the financial and compliance aspect of the project. Primary responsibility for audit of USAID projects lies with the Regional Inspector General/Audit (RIG/A); however, independent non-federal auditors maybe contracted by RIG/A or by a non-U.S. non-governmental recipient organization for the purpose. The Philippine Commission on Audit will be responsible for auditing the use of dollars transferred under the performance-based disbursement program. Of the total project funds, \$250,000 has been allotted for non-federal audit services to be rendered by a local auditing firm.

III. IMPLEMENTATION PLAN

III.A IMPLEMENTATION SCHEDULE

III.A.1 Pre-Obligation Actions

IFPMHP is designed to have a six-year implementation period. The Mission is expected to authorize the program by the end of March 1994. Final negotiations, the program agreement should be signed by the end of April, 1994. IFPMHP's PACD is February 28, 2000.

IFPMHP will be given a significant headstart by the work currently underway through FPAP which initiated support for the National Programs Component and the NGO and Private Sector Component. This assistance will continue until December 1994. As described in Section I, IFPMHP will continue this assistance, expanding work in some areas (e.g., NGOs and the Private Sector), bringing other elements to a sound basis for implementation (Logistics) and, in the case of training, re-directing the activity to address current inadequacies. As FPAP reaches its PACD, IFPMHP will have started up assuring a smooth transition from FPAP to IFPMHP.

FPAP has also begun to provide important TA to OSC and the first group of LGUs selected to participate in the LGU Performance Program. This assistance began in October, 1993 and will continue until the end of FPAP. As a result, it is expected that OSC and the first group of LGUs will be able to meet the benchmarks established for the initial program performance scheduled for December 1994.

There are several actions that the DOH and USAID will undertake prior to the initial disbursement of funds that will expedite implementation. These include:

- The DOH will establish a program for supporting LGUs' performance.
- OSC will select the first round of LGUs to participate in the LGU Performance Program;
- The DOH and USAID will reach agreement on the terms of reference for the competitive procurement of the short-term and long-term technical assistance team that will work with OSC and the LGUs, as well as the advisors for the National Programs and NGO/Private Sector Components of IFPMHP.
- Scopes of work for advisors to be provided via AID/W's central projects funded by R&D/POP will be agreed to by R&D/POP, USAID and the DOH

III.A.2 Implementation Schedule

The following table estimates the timing of major events in the implementation of IFPMHP.

<u>Action</u>	<u>Estimate Date</u>
Program authorization	March 1994
Pre-Obligation actions and negotiation of the Program Agreement with the DOH	March 1994
Program Agreement signed	May 1994
Conditions Precedent satisfied	June 1994
RFP issued for TA Contract/CBD Announcement	June 1994
Cooperative agreement awarded to local NGO and local university	June 1994
IA issued for NGO Cooperative Agreement/CBD Announcement	June 1994
TA contract awarded	October 1994
Cooperative Agreement for U.S.-based NGO awarded	October 1994
Annual estimate of contraceptive requirements	September 1994
Annual contraceptive order cable	October 1994
First Performance Review	Oct./Nov. 1994
First USAID tranche disbursement	December 1994
TA in-country	January 1995
Short-term TA to POPCOM begins	January 1995
National Services long-term advisors in-country	January 1995
Training accreditation policy issued by DOH	February 1995
Training Accreditation Board organized	March 1995
Annual contraceptive requirements	September 1995
Annual contraceptive order cable	October 1995
Second Performance Review	Oct./Nov. 1995
Second USAID tranche disbursement	Dec. 1995
Long-term advisor to POPCOM in-country	January 1996
Annual contraceptive requirements	September 1996
Annual contraceptive order cable	October 1996
Mid-term evaluation	Oct./Nov. 1996
Third Performance Review	Oct./Nov. 1996
Third USAID tranche disbursement	December 1996
Annual contraceptive requirements	September 1997
Annual contraceptive order cable	October 1997

<u>Action</u>	<u>Estimate Date</u>
Fourth Performance Review	Oct./Nov. 1997
Fourth USAID tranche disbursement	December 1997
DHS completed	August 1998
Annual contraceptive requirements*	September 1998
Annual contraceptive order cable*	October 1998
5th performance review	Oct./Nov. 1998
Fifth USAID tranche disbursement	December 1998
Close-out procedures initiated	August 1999
1998 impact evaluation	November 1999
PACD	February 2000

* *only if follow-on project is anticipated*

III.B. PROGRAM MANAGEMENT

III.B.1 Overview

The major participants involved with the implementation and monitoring of IFPMHP - the LGUs, the DOH, POPCOM, NSO, USAID, NGOs and the technical assistance contractors - will need to coordinate closely because most of their activities are highly interrelated. The DOH and USAID will have the principal responsibility for assuring that this coordination occurs. Periodic coordinating meetings, distribution of annual work plans and supervision and direction by OSC and USAID will be the principal mechanism used for this purpose. Specific responsibilities for program management are discussed below.

III.B.2 USAID/Manila

Under the guidance of the Chief, Office of Population, Health and Nutrition, USAID's Population Officer will have overall responsibility for the management and direction of USAID's role in the implementation and monitoring of IFPMHP. As Program Officer, she will be the principal liaison representing USAID to the DOH for all matters concerning IFPMHP. She will be assisted by two very experienced FSN population specialists. Management of FPAP has required the full-time attention of these three individuals. However, IFPMHP more than doubles the scale of current activities (i.e., the National Programs and the NGO/Private Sector Components) and adds an entirely new element to USAID's assistance, i.e., the IFPMHP Performance-based Program. As with any new activity, the LGU Performance Program is likely to be more staff intensive at the outset as modes of operation are defined, implemented and subsequently modified. This suggests that the current USAID staffing for FPAP will be insufficient for IFPMHP. To meet the greater management requirements of IFPMHP,

including the management of G/RD/POP inputs, an additional program manager will be recruited from the Population Fellows Program to work under the direction of USAID's Population Officer. Per standard USAID practice, OPHN staff will be assisted by the IFPMHP Program Committee.

As a team, they will work with DOH and OSC counterparts to direct, supervise and monitor the implementation of IFPMHP. They will also have principal responsibility for directing and supervising technical advisors working under direct USAID contracts, centrally funded projects and the NGO grant and cooperative agreement. All contract teams and cooperating agencies involved with IFPMHP implementation will prepare and submit to them and the DOH annual workplans. In effect, the USAID management team will be the focal point for contractors' annual workplans, quarterly reports and other reports, written and oral, dealing with implementation progress and issues. This will facilitate both the supervision and direction of contract personnel as well as contribute to program coordination among the various groups involved with IFPMHP's implementation.

III.B.3 G/RD/POP - USAID/Washington

The USAID management team will, from time to time, require highly specialized skills in the areas of training, preparation of detailed specifications for contraceptive procurement and logistics and other subjects central to IFPMHP assistance. To the fullest extent possible, these services will be provided by G/RD/POP and the staff resources available through centrally funded projects.

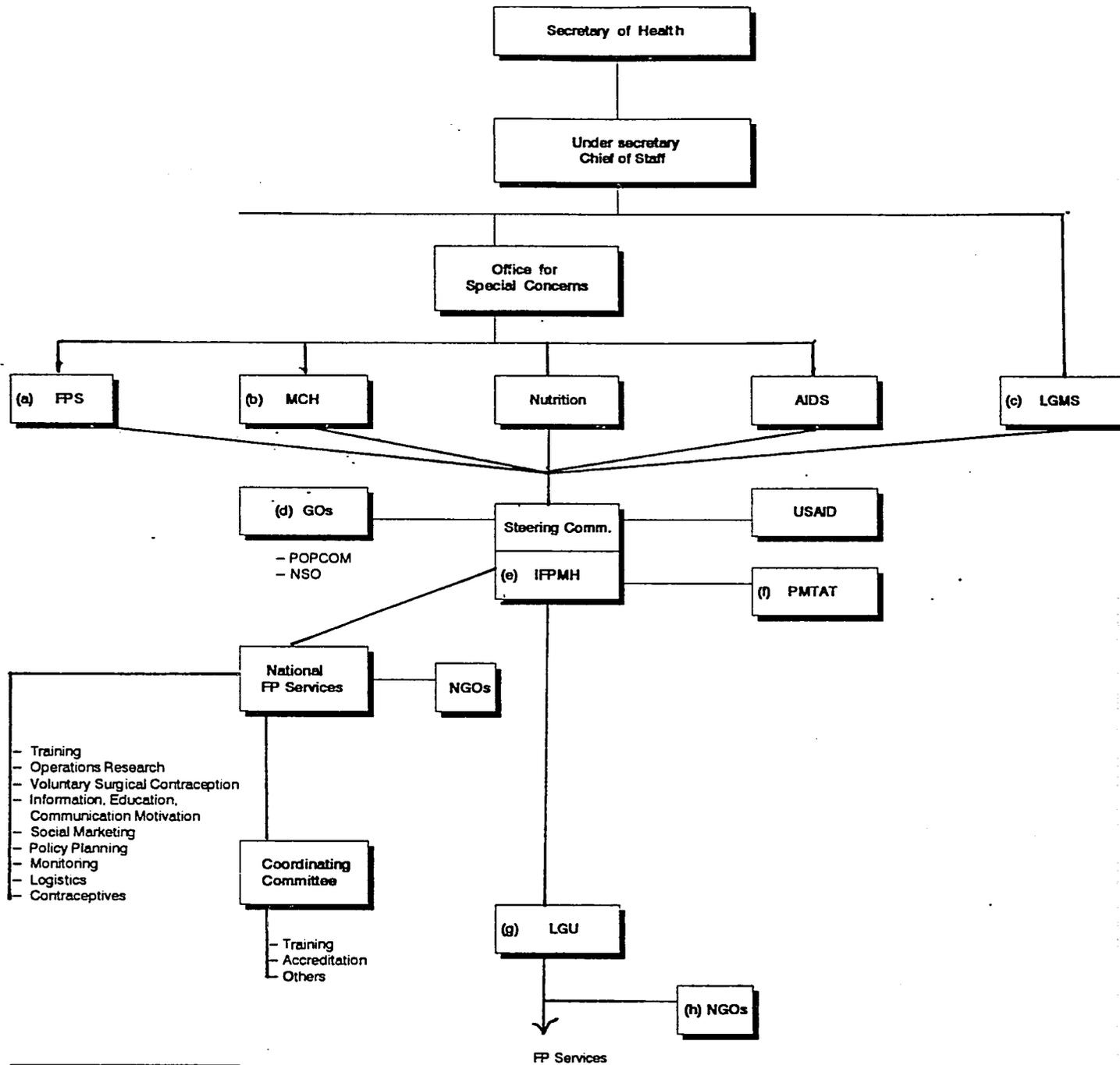
III.B.4 Participating Agencies/Organizations

a) DOH

The mandate, responsibilities and resources of the DOH for FP were radically changed with the introduction of the Local Government Code. To enable the LGU's to assume the service delivery functions of the DOH, a significant proportion of the DOH's former budget was re-allocated to LGU's via their annual Internal Revenue Allotment. The most important structural change produced by the Code is to limit the extension of the DOH's operations to the regional level. While still responsible for setting and monitoring national health quality standards, the LGUs now determine staffing patterns, how services will be provided and the amount of funding to do so.

This massive transfer of resources and personnel has, quite predictably, produced a number of problems since its inception in 1992. The DOH and the LGUs are presently working toward resolving these problems and, in so doing, defining their new, respective roles and responsibilities for assuring quality service delivery.

This process is likely to continue for the next two or three years. In short, the start-up of IFPMHP will occur in an administrative environment that is still in transition.



- (a) FPS - Family Planning Service
- (b) MCH - Maternal Child Health
- (c) LGMS - Local Government Management Service
- (d) GOs - Government Organizations
- (e) IFPMH - Integrated Family Planning Maternal Health
- (f) PMTAT - Program Management Technical Assistance Team
- (g) LGU - Local Government Units
- (h) NGOs - Non-governmental Organizations

39a

IFPMHP design anticipates the situation it will face regarding the relationship between the DOH and the LGUs and takes this in account in assigning program management responsibilities. In particular, the IFPMHP Performance-based Program is specifically designed to facilitate and clarify the DOH - LGU working relationship.

OSC currently has responsibility for both the FP/MCH Services. OSC will have responsibility for performing the DOH's management responsibility for IFPMHP. The implementation of IFPMH will be managed by a steering committee under chairmanship of the Assistant Secretary for Special Concerns. Membership committee will be from all the relevant divisions in the Department of Health, USAID, and other government agencies, i.e. POPCOM, NSO. The national family planning services will be primarily coordinated by the Family Planning Services (FPS) in the DOH. Implementation of these activities will be through FPS, POPCOM and NGOs. Coordinating committees such as the training and accreditation committees will review implementation plans of the national family planning services. Family planning service delivery at the LGU level will be provided through the LGU delivery system, as well as through NGOs and other private groups. (See organizational chart). IFPMHP will initially fund two contract staff positions for OSC for this management unit for two years until OSC receives adequate budget to assume these costs or authority to regularize the positions. This team will be responsible for managing the operations of the LGU Performance Program and will receive assistance from the PMTACT.

Similarly, OSC will require one mid-level analyst and two support staff to run the national program monitoring. IFPMHP will fund the analyst's position for two years until OSC assumes responsibility for this.

b) LGUs

The LGUs participating in the LGU Performance Program will have management responsibility for their FP/MCH programs. Basic staffing capability for a population program, is a minimum requirement for provinces and cities to participate in the Program. This typically consists of a senior Population Officer who heads the Population Office with approximately 10 or more staff. Augmenting staff at the Provincial or City levels are the Population Officers at the municipal level and the volunteers (BSPOs) at the barangay level. LGU FP/MCH programs will use existing financial and accounting systems used by their governments.

In addition to a Population Office, the Health Office of participating LGUs will be involved in the program, particularly for the MCH interventions. Provincial and city Health Offices are typically staffed by physicians and nurses at the central level; physicians, nurses and midwives at the Rural Health Unit level; and midwives and volunteers (BHWs) at the barangay level. The number of staff at each level varies by province and city. For provinces, this system consists of the staff and facilities devolved from the DOH to the LGUs. Cities have been responsible for the provision of

health services, including FP since the 1970s.

In short, capacities to manage family planning services and the quality and coverage of those services vary among LGUs, but there is a definite need for substantial improvement in all areas. Upgrading LGU capacities and the quality of services is indeed the objective of the LGU Performance Program.

c) NGOs and the Private Sector

IFPMHP will build on the impressive accomplishments of NGOs under FPAP. NGOs will continue to receive training in the provision of FP services and the management of family planning facilities, program support and the use of cost recovery schemes to sustain services. A U.S.-based NGO will be selected for a cooperative agreement to provide this assistance. FPAP's experience demonstrates that U.S.-based NGOs can provide sound management and direction of these activities.

IFPMHP will expand assistance to the PCPD to enable it to expand its industrial in-plant RP/FP program. PCPD has also demonstrated excellent program management capability in addition to financial management capability in accordance with USAID requirements.

The social marketing project of FPAP has shown impressive results thus far. Continued use of the centrally funded SOMARC Project will assure sound management capability for this activity as it expands to other urban areas of the Philippines.

d) Population Commission (POPCOM)

POPCOM is currently in a process of re-vitalization. With strong support from the current administration, a new leadership and a new mandate, POPCOM has the potential to regain its former effectiveness as an advocacy agency in the FP program.

IFPMHP will provide short-term and long-term assistance to POPCOM to strengthen its program as well as its management capabilities. At the regional level, LGUs participating in the LGU Performance Program may also use POPCOM staff resources to assist in the areas of population program planning and budgeting.

III.B.5 Sustainability Concerns

Achieving full sustainability, or at least making significant progress toward sustainability, is fundamental to all of the activities IFPMHP will support. This will result, in large part, from the institutional strengthening IFPMHP will support in all three program components. Cost recovery schemes introduced in the NGO/Private Sector and the LGU Performance Program and increased local budget allocation for FP/MCH

programs will address sustainability concerns in these areas.

As discussed earlier, increased demand for contraceptives generated by IECM and advocacy campaigns is fundamental to achieving long-term sustainability for the family FP. Such demand results in expanded provision of contraceptives by the private sector, and greater attention and budget allocation in the public sector at national and local levels. In the Philippines, the private sector is clearly responsive to consumer demand, and politicians at the national and local levels are increasingly aware that support for FP is a political asset, not a liability, among their constituencies. The DOH has already included a substantial line item budget for FP/MCH in their 1995 budget (including commodities). However, USAID recognizes that national-level political constraints may continue to effect this decision over the life of the Program.

The greatest potential for improving the sustainability of the PFPP over the life of IFPMHP exists in better targeting of public sector resources to those who need free or highly subsidized services. Those who can afford to make full or at least partial payment for services will increasingly turn to alternative service providers. IFPMHP's assistance will contribute to this market segmentation through its support for developing and expanding these alternative channels - i.e., via the NGOs and the private commercial sector.

III.C PROCUREMENT PLAN

Source and origin for all goods and services will be the U.S. Local procurement will be approved in accordance with the requirements of Handbook 1B, Chapter 18. TA, commodities contraceptives and training will be procured through the following mechanisms:

III.C.1 G/RD/POP Provision of Services through Centrally Funded Projects (Table 2, USAID/W A1, USAID/W B1-3, 5-8)

The Mission and G/RD/POP have agreed that IFPMHP will be funded by USAID through \$50 million in bilateral funds and \$50 million by G/RD/POP for services, commodities and contraceptives via their centrally funded projects. Use of the centrally funded projects will include the procurement of short-and long-term TA available through these projects. Ninety-six person-months of long-term TA and 39 months of short-term technical assistance will also be provided through G/RD/POP centrally funded projects. The long-term TA will consist of the following specialists:

<u>Job Title</u>	<u>Location</u>
a. Social Marketing Advisor	Kabalikat (local NGO)
b. IECM Advisor	DOH/Family Planning Services
c. Logistics Advisor (2)	DOH/FPS/CARE Philippines

- d. Operations Research Advisor DOH/FPS Evaluation Unit
- e. Policy Planning (2) POPCOM/USAID

III.C.2 Direct Grants to NGOs (Table 2, Bilateral A1 LC)

One grant will be used to fund a local NGO to expand the industrial, in-plant RP/FP program.

III.C.3 Invitation for Application (Table 2 Bilateral A1 FX)

USAID will invite U.S. PVOs, who are involved with the promotion of FP information and services in developing countries, to develop a collaborative assistance project to strengthen local NGOs. This project will support program management development and the achievement of financial self-sustainability. Under FPAP, the "NGO Strengthening Project" has made impressive progress which will be expanded under IFPMHP.

III.C.4 USAID Direct Contract (Table 2 Bilateral C2)

A USAID direct contract will be competitively let for the procurement of TA needed to assist the OSC. The contract will provide 32 person-years of long-term technical assistance and 36 person-months of short-term TA. The contract will utilize a combination of expatriate and local advisors. All long-term bilaterally funded advisors will be based at the OSC. The long-term TA team will consist of the following specialists:

Job Title

- a. Chief of Party/Program Manager (expatriate)
- b. Planning Advisor
- c. Training Advisor
- d. Urban Program Advisor
- e. Monitoring Advisor
- f. Management Information System Advisor
- g. LGU Program Planning Management Specialist (2)
- h. Performance Monitoring Advisor (2)

This contract will also provide training and commodities. USAID expects to issue the request for proposals in June and award the contract by October, 1994.

III.C.5 Training (Table 2 Bilateral B4)

Under the TA contract (PMTACT, see III.C.4 above), a long-term training advisor will be provided. A sub-contract to a local NGO to support DOH training as well as the

procurement of models, equipment kits and references that will be supplied to DOH, LGUs and NGOs are included in the overall PMTACT contract. A buy-in will be executed with JHPIEGO to provide the TA for the pre-service FP training for nurses and midwives and the RTI training program. For the training of future FP leaders from social science disciplines, a grant to a local private academic institution will be executed. Information on available off-shore participant training will be disseminated by DOH-FPS. A training committee composed of representatives from DOH-FPS, POPCOM (an attached agency of NEDA), and USAID will determine the approved training courses and select the candidates. This will be contained in a Participant-Training Plan for every implementation year. DOH and other participating agencies will secure all necessary GOP clearances and fund the international travel of their participants for overseas training. USAID will then obligate funds and assist in the travel procedures and securing the required visas.

III.C.6 Procurement of Contraceptives (Table 2 USAID/W FX)

The G/RD/POP managed Centralized Contraceptive Procurement Project (CCPP) will be used to purchase contraceptives for the PFPP based on the annual contraceptive requirements. G/RD/POP will include the Philippines requirement in its annual estimate for the CCPP. Funds will be transferred directly from the AID/W budget office to the Central Contraceptive Project; no funded PIO/C or OYB transfers will be used.

III.C.7 Performance Disbursements (Table 2 Bilateral C1 FX)

USAID will use a performance disbursement mechanism for the IFPMHP Performance-based Program to support policy and institutional changes at the national and local levels. Satisfactory development and management of the LGU Performance Program by OSC, expansion of the National Programs and strengthening LGU FP/MCH service delivery will be the focus of the program. On achievement of pre-established performance benchmarks, USAID will disburse funds to the Department of Finance that will be used for USAID-approved loan payments of the GOP.

III.C.8 Use of Socially and Economically Disadvantaged Businesses (Table 2 Bilateral B4/C2 FX)

TA under this program will be provided by a U.S. contractor. Since diverse services will be delivered under the contract, the Request for Proposal will require interested firms, as part of their proposals, to use the services and resources of socially and economically disadvantaged entities, particularly small and disadvantaged firms and PVOs and women owned and 8(a) organizations. Because the technical assistance contract is funded by the Development Assistance Account, a minimum of 10 percent of the contract is required to go to such organizations. The prime contractor is urged to sub-contract the services of an 8(a) or Gray Amendment Procurement Services Agent firm to procure commodities. Potential contractors should also examine the

opportunities offered by historically black colleges and universities, where appropriate, particularly for short-term training.

IV. MONITORING AND INFORMATION PLAN

Three levels of monitoring will be carried out over the course of IFPMHP. They are:

- a) National Program Performance Monitoring
- b) IFPMHP Implementation Monitoring
- c) LGU FP/MCH Program Performance Monitoring

IV.A NATIONAL PROGRAM PERFORMANCE MONITORING

As describing in Section I, the DOH needs to monitor the progress of the national family planning program so that it can assess progress being made an increasing contraceptive prevalence and slowing the national population growth rate. National, hierarchial information systems have a very mixed track record when it comes to producing useful and timely information for planning and decision making. The DOH's experience with the Field Health Service Information System (FHSIS) is a case in point. Despite careful planning and investment of substantial staff time and financial resources to make the system operational, few place confidence in the quality and coverage of the data it generates. The DOH is again in the process of modifying the system.

An alternative approach will, therefore, be followed for national program performance monitoring. OSC/FPS will make use of the substantial amount of data generated from existing data collection activities. This includes vital statistics, census data and annual population-based surveys conducted by the NSO, logistics data from CDLMIS, NGO service delivery data and commercial marketing data from pharmaceutical companies and SOMARC. This data will be synthesized and analyzed to construct a composite assessment of the progress being made by the PFPP.

A number of key indicators will be monitored to support this assessment; they include the following:

<u>Indicators:</u>	<u>Data Sources:</u>	<u>Frequency:</u>
- Total Fertility Rate (FTR)	DHS Vital Stat. Census	5 years annual
- Infant Mortality Rate (IMR)	Vital Stat.	annual

- Maternal Mortality Rate (MMR)	Vital Stat.	annual
- Contracept. Preval. Rate (CPR)	DHS NSO surveys	5 years annual
- Method Mix	NSO surveys	annual
- Unmet Need	DHS	5 years
- Proportion of high-risk births	Vital Stat. DHS	annual 5 years
- Supply of contraceptives	CDLMIS	annual
- Frequency of stock-outs	CDLMIS	annual
- Private Sector sales	SOMARC Pharmaceutical Firms	annual annual

Additional indicators may also be identified once this function is operating. Urban versus rural and regional comparisons will be possible for each of these indicators (the former will provide a useful means for monitoring the progress of IFPMHP's urban strategy). NSO surveys will include annual household enumerations and labor force sample surveys. NSO has agreed that a few "rider" questions can be added to these surveys concerning FP and MCH practices.

Monitoring at the national level will also include an analysis updated annually on the performance of the LGU Performance Program. Ten cities (five participating, five non-participating) and 10 provinces (five participating, five non-participating) will be selected for this purpose. Data from the same set of 20 LGUs will be collected annually by the appropriate NSO survey (e.g., the annual labor force survey). The following questions will be added to the survey:

- knowledge about contraceptive methods and use (CPR) by method;
- knowledge about sources of contraceptives and family planning services;
- continuation rates among contraceptive acceptors; and
- use of EPI, ARI, ORT and micro-nutrient services.

IV.B IFPMHP IMPLEMENTATION MONITORING

IFPMHP implementation monitoring will consist of: a) standard input and output reporting by the program's contractors and participating NGOs which will be used in USAID's Quarterly Project Status Report (QPSR), and b) purpose-leveling monitoring

that will require contractors and NGOs to design and manage the information systems necessary for this reporting. The former is typically part of any USAID contract or grant agreement; the latter is simply a requirement for good program management by those implementing IFPMHP activities.

In addition to quarterly reports, IFPMHP contractors and NGOs will be required to report on a very limited number of key indicators which monitor progress toward the development purposes of their activities. The OSC's Program Management Team and PMTACT will be responsible for: a) working with the contractors and NGOs to identify a few (i.e., no more than five) key indicators; b) obtaining this information from the contractors and NGOs; and c) producing a semi-annual IFPMHP purpose-level progress report. An important element of this report will focus on the IFPMHP's urban strategy.

IV.C LGU PERFORMANCE PROGRAM MONITORING

The IFPMHP design team carefully considered the options for developing management information systems (MIS) as part of the FP/MCH programs of participating LGUs. In light of the history of establishing comprehensive monitoring and reporting systems at the field level, the team decided that a minimalist approach should be followed at least during the first several years of IFPMHP. Participating LGUs and NGOs will use the same basic MIS consisting of the following indicators:

- Contraceptive supply by method,
- Stock-outs of more than one month duration experienced by service points,
- The number of high-risk women counseled about family planning options, and
- The number of high-risk women counseled who accepted a modern contraceptive method.

The first two indicators come directly from the CDLMIS which will be accessible to the LGUs. These indicators will monitor the operation of the distribution system within the LGU is working as well as offer a measure of the increasing acceptance of modern methods.

The second two indicators will be reported by service providers (i.e., BSPOs and BHWs, midwives, nurses and physicians). This information will provide a basis for assessing the effectiveness of service provider training and whether services are reaching high-risk women.

Consolidation of these data on a semi-annual basis will be the responsibility of the OSC Program Management Unit and PMTACT. This information will be included in the semi-annual report on IFPMHP purpose-level progress. Once this basic system is

operating smoothly, additional indicators might be included in the MIS at some later point.

Participating LGUs will develop a monitoring system which documents achievement of annual performance benchmarks as specified in their MOA with the DOH. Assisting the LGUs to do this will be an important part of the support services provided by the PMTACT and OSC's Program Management staff.

V. SUMMARIES OF ANALYSES

See Annexes F1-6 for the following analyses:

- Technical Analysis
- Financial Analysis
- Economic Analysis
- Social Soundness Analysis
- Administrative Analysis
- Environmental Analysis

The analyses reviewed the present design and provided valuable inputs. Analyses indicate the Program is cost-effective, socially sound, and technically and administratively feasible. The Program as analyzed should have the desired impacts on the purpose and goal.

VI. EVALUATION ARRANGEMENTS

The monitoring activities and the OR activities supported through by IFPMHP, in effect, constitute a continuous process of evaluating IFPMHP during the course of implementation. The annual reviews of the IFPMHP Performance-based Program introduces another major evaluation function in IFPMHP.

In addition to these evaluative elements of IFPMHP, two external evaluations are scheduled for the program: a) a mid-term, process evaluation to be conducted in the second quarter of FY 96 (i.e., just prior to the third LGU Program Assistance review), and b) a final impact evaluation scheduled for the last quarter prior to the PACD.

The mid-project evaluation will consider the issue of extending the life of program to ensure that sufficient time is provided to carry out program activities. The final evaluation will focus on the institutional, operational (i.e., service delivery) and demographic impact of IFPMHP. Specific scopes of work focusing on the development impact questions the IFPMH Program will be developed. Approximately six weeks will be required for each evaluation.

VIII. CONDITIONS PRECEDENT, COVENANTS AND WAIVERS

VIII.A CONDITIONS PRECEDENT AND COVENANTS

In addition to regular Conditions Precedent (CPs), these CPs will be included in the program agreement:

VIII.A.1 CP to Initial Disbursement of Funds

No special CPs are required for the program.

VIII.A.2 Special Covenants

- a. Adequate Resources. The DOH will provide adequate resources to ensure the Program is implemented successfully.
- b. Program Evaluation. USAID and the GOP will agree to establish a monitoring and evaluation program as part of the program. Except as USAID and the GOP otherwise agree in writing, the program will include, during the implementation of the program and at one or more points thereafter:
 - (1) Evaluation of progress toward attainment of the objectives of the program;
 - (2) Identification and evaluation of problem areas or constraints which may inhibit attainment of program objectives;
 - (3) Assessment of how such information may be used to help overcome such problems; and
 - (4) Evaluation of the overall development impact of the program.
- c. Voluntary Sterilizations Policy. The GOP will agree that surgical sterilization activities supported in whole or in part by funds made available under the Agreement will conform to A.I.D. sterilization policy guidelines set forth in Section II of A.I.D. Policy Determination 3, dated September 1982.
- d. Voluntary Informed Consent The GOP will agree to assure that all individuals participating in FP programs (whether involving distribution of contraceptives or sterilization, or both) supported in whole or in part by funds provided under the Agreement, do so on the basis of an informed consent voluntarily given with knowledge of the benefits, risks, principal effects and available alternatives. The GOP will further assure that no individual is coerced to practice methods of FP inconsistent with his or her moral, philosophical or religious beliefs.

- e. Timely Procurement of Program Commodities. The GOP will furnish to USAID program implementation orders on a timely basis with respect to all equipment and supplies, with the exception of contraceptive commodities, which the GOP wishes to be procured on its behalf by agencies of the United States to ensure the efficient and cost effective procurement of such commodities by agencies of the United States Government.
- f. DeConcini Amendment. Funds shall only be available to organizations offering natural family services which also offer, either directly or through referral to or information about access to, a broad range of family methods and services.

VIII.B WAIVERS

Two waivers to permit awarding of grants to a local NGO to implement the in-plant, industrial family planning program and a local private university for the FP future leaders training program are included in Annex K.

ANNEXES

- A. GOP Request for Assistance**
- B. Statutory Checklist**
- C. New Activity Description Approval Cable**
- D. Logical Framework**
- E. Gray Amendment Certification**
- F. Analyses**
 - 1. Technical**
 - 2. Financial**
 - 3. Economic**
 - 4. Social Soundness**
 - 5. Administrative**
 - 6. Environmental**
- G. Training Activities**
- H. National Program Performance Indicators, Data Sources and the Role of the National Statistics Office**
- I. Initial Selection of LGUs**
- J. LGU Start-up and Multi-year Planning Requirements**
- K. Waivers**
- L. Bibliography**



REPUBLIC OF THE PHILIPPINES
NATIONAL ECONOMIC AND DEVELOPMENT AUTHORITY
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MAR 29 1994

MR. THOMAS W. STUKEL
Mission Director
U.S. Agency for International Development (USAID)
Ramon Magsaysay Center
1680 Roxas Boulevard
Ermita 1000, Manila

RECEIVED
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USAID/UC&R

Dear Mr. Stukel:

We wish to convey the request of the Government of the Philippines for USAID grant assistance in the amount of US\$100 million (broken down to US\$50 M in USAID bilateral assistance and US\$50 M to be provided through centrally-funded projects managed by G/RD/POP, to finance the Integrated Family Planning and Maternal Health Program (IFPMHP). The said six-year (1994-1999) program is envisioned to be a major component of the Philippine Family Planning Program. The lead GOP implementing agency for the project will be the Department of Health (DOH).

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A-14-94		

We would like to acknowledge receipt of the Program Assistance Approval Document (PAAD) for the subject Program. We are quite pleased that the Joint Working Team (JWT) arrived at basic agreements on the objectives, strategies and scope of the proposed program in its meeting held on 25 March 1994. What remains is a matter of documentation to amply reflect such agreements in relevant sections of the document where needed (please refer to the attached aide-memoire).

We will keep you informed of developments regarding the project's evaluation by the Investment Coordination Committee (ICC) which we hope can be completed by May 1994.

Thank you and best regards.

Very truly yours,

CIELITO F. HABITO
Secretary of Socio-Economic Planning
and Director-General

ACTION TAKEN	
NAN	Other
Type	No.
Dated 4/5/94	Initials: [Signature]

cc : Secretary Juan M. Flavier, DOH

ANNEX B-1

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

Yes.

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to:
(a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

The program will not impact directly upon these activities and institutions.

2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

The program will not impact directly upon trade or investment.

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3. Congressional Notification

a. **General requirement (FY 1993 Appropriations Act Sec. 522; FAA Sec. 634A):** If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of substantial risk to human health or welfare)?

A Congressional Notification was submitted and the waiting period expired in _____ without objection.

b. **Notice of new account obligation (FY 1993 Appropriations Act Sec. 514):** If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. **Cash transfers and nonproject sector assistance (FY 1993 Appropriations Act Sec. 571(b)(3)):** If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

Yes

4. Engineering and Financial Plans (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes

(b) Yes

5. Legislative Action (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action

Host country legislation is not required.

ANNEX B-1

- 3 -

will be completed in time to permit orderly accomplishment of the purpose of the assistance?

6. **Water Resources** (FAA Sec. 611(b); FY 1993 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A

7. **Cash Transfer and Sector Assistance** (FY 1993 Appropriations Act Sec. 571(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

Yes

8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

This is not a capital assistance project.

9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

The program will not impact directly upon these activities and institutions.

55

10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

The program will not impact upon trade or investment.

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The Program Grant Agreement contains a covenant that the grantee will maintain adequate resources for project implementation. Grantee contributions will include logistical and administrative costs to support contractors, salaries of government participants during training, office space, and other support costs.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

c. **Separate Account** (FY 1993 Appropriations Act Sec. 571). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

Local currencies will not be generated by this program.

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

- 5 -

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

12. Trade Restrictions

a. Surplus Commodities (FY 1993 Appropriations Act Sec. 520(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

Assistance is not for the production of any commodity.

b. Textiles (Lautenberg Amendment) (FY 1993 Appropriations Act Sec. 520(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of

No.

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textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3) (as referenced in section 532(d) of the FY 1993 Appropriations Act): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

No.

14. **PVO Assistance**

a. **Auditing and registration** (FY 1993 Appropriations Act Sec. 536): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

Yes. All PVOs receiving assistance will be registered with A.I.D.

b. **Funding sources** (FY 1993 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

Yes. All U.S. PVOs will have to meet this requirement.

15. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

This information will be cabled within the required time period.

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16. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?
- Yes
17. **Women in Development** (FY 1993 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?
- Yes. There are expected to be a significant number of women participants in the program, both as beneficiaries and as program implementors.
18. **Regional and Multilateral Assistance** (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.
- No.
19. **Abortions** (FY 1993 Appropriations Act, Title II, under heading "Population, DA," and Sec. 524):

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a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No

b. Will any funds be used to lobby for abortion? No

20. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? No

21. U.S.-Owned Foreign Currencies

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1993 Appropriations Act Secs. 507, 509): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. N/A

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No

22. Procurement

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes. The technical assistance contractor will be required to submit a subcontracting plan for use of economically and socially disadvantaged organizations which could include U.S. small businesses.

b. U.S. procurement (FAA Sec. 604(a) as amended by section 597 of the FY 1993 Appropriations Act): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section? Yes

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- c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? The Philippines does not discriminate against U.S. marine insurance companies.
- d. **Non-U.S. agricultural procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A
- e. **Construction or engineering services** (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) N/A
- f. **Cargo preference shipping** (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No
- g. **Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the Yes

facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

h. U.S. air carriers

Yes

(International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

i. Termination for convenience

All contracts will contain this provision.

of U.S. Government (FY 1993 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

j. Consulting services

Yes

(FY 1993 Appropriations Act Sec. 523): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

k. Metric conversion

Yes

(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest

documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

1. Competitive Selection Yes
Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

23. Construction

a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? This is not a capital project.

b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A

c. Large projects, Congressional approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

24. U.S. Audit Rights (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

25. Communist Assistance (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes

26. Narcotics

a. **Cash reimbursements (FAA Sec. 483):** Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes

b. **Assistance to narcotics traffickers (FAA Sec. 487):** Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes

27. **Expropriation and Land Reform (FAA Sec. 620(g)):** Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes

28. **Police and Prisons (FAA Sec. 660):** Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes

29. **CIA Activities (FAA Sec. 662):** Will assistance preclude use of financing for CIA activities? Yes

30. **Motor Vehicles (FAA Sec. 636(i)):** Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes

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31. **Military Personnel** (FY 1993 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes
32. **Payment of U.N. Assessments** (FY 1993 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? Yes
33. **Multilateral Organization Lending** (FY 1993 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes
34. **Export of Nuclear Resources** (FY 1993 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? Yes
35. **Repression of Population** (FY 1993 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes
36. **Publicity or Propaganda** (FY 1993 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? No

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37. Marine Insurance (FY 1993 Appropriations Act Sec. 560): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? Yes

38. Exchange for Prohibited Act (FY 1993 Appropriations Act Sec. 565): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? No

39. Commitment of Funds (FAA Sec. 635(h)): Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement? No

40. Impact on U.S. Jobs (FY 1993 Appropriations Act, Sec. 599):

(a) Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business? No

(b) Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.? No

(c) Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country?

No

3. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. Agricultural Exports (Bumpers Amendment) (FY 1993 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

Assistance is not for agricultural development activities.

2. Tied Aid Credits (FY 1993 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

No

3. Appropriate Technology (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

No

4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

The program will reduce unmet need for family planning services and strengthen Maternal/Child Health programs throughout the Philippines. Further, it will utilize and enhance the technical capability of Filipino professionals in implementing this program.

5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes

6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

The program will expand NGO and commercial channels for FP/MCH services so that limited government resources can be targetted towards those who are unable to pay, i.e., the poor.

b) Responsibility for family planning and health service delivery now resides at the local level.

c) N/A

d) There are expected to be a significant number of women participants in the program, both as beneficiaries and as program implementors.

e) N/A

7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes

8. **Benefit to Poor Majority (FAA Sec. 128(b)):** If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes

9. **Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):**

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? Yes

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? No

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to

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methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?

No

10. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes

11. **Disadvantaged Enterprises** (FY 1993 Appropriations Act Sec. 563): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

The request for proposal for the technical assistance contract will require the submission of a sub-contracting plan setting out how the contractor intends to utilize the services and resources of economically and socially disadvantaged entities. Contractors shall show a minimum of ten percent in their proposals.

12. **Biological Diversity** (FAA Sec. 119(g)): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

N/A

13. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):

Assistance does not relate to tropical forests.

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

Yes

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation,

N/A

and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity? \

c. Forest degradation: Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? N/A

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

N/A

14. **Energy (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):** If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

Assistance does not relate to energy.

15. **Debt-for-Nature Exchange (FAA Sec. 463):** If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

The program will not finance a debt-for-nature exchange.

16. **Deobligation/Reobligation (FY 1993 Appropriations Act Sec. 515):** If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as

Deob/reob-authority is not sought to finance this assistance.

originally obligated, and have the House and Senate Appropriations Committees been properly notified?

17. Loans

Not a loan.

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

18. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical

See response to B.16.

assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

**19. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A): **

Assistance is not being made available for agriculture, rural development or nutrition.

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the

poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

20. **Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

This program will expand the availability of family planning and maternal health services at the local level particularly in urban areas. The program is intended to meet the objectives of the legislation as described to the left.

21. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

Assistance is not for education, public administration or human resources development.

22. **Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

Assistance is not¹ energy.

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of

N/A.

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research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

23. Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?

CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. Economic and Political Stability (FAA Sec. 531(a)): Will this assistance promote economic and political stability?

A U.S. NGO will be selected to provide training and technical assistance to approximately 80 local NGOs. A full description of this can be found within the program paper.

N/A.

N/A.

N/A.

N/A.

This is not a capital project.

The program will not use Economic Support Funds.

N/A.

To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

2. **Military Purposes (FAA Sec. 531(e)):** Will this assistance be used for military or paramilitary purposes?

N/A.

3. **Commodity Grants/Separate Accounts (FAA Sec. 609):** If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1993, this provision is superseded by the separate account requirements of FY 1993 Appropriations Act Sec. 571(a), see Sec. 571(a)(5).)

N/A.

4. **Generation and Use of Local Currencies (FAA Sec. 531(d)):** Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1993, this provision is superseded by the separate account requirements of FY 1993 Appropriations Act Sec. 571(a), see Sec. 571(a)(5).)

N/A.

5. **Cash Transfer Requirements (FY 1993 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 571(b)).** If assistance is in the form of a cash transfer:

N/A.

a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds?

b. **Local currencies:** Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and

conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

c. **U.S. Government use of local currencies:** Will all such local currencies also be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, or to carry out development assistance (including DFA) or ESF purposes?

d. **Congressional notice:** Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

6. **Capital Projects (Jobs Through Exports Act of 1992, Sec. 306, FY 1993 Appropriations Act, Sec. 595):** If assistance is being provided for a capital project, will the project be developmentally-sound and sustainable, i.e., one that is (a) environmentally sustainable, (b) within the financial capacity of the government or recipient to maintain from its own resources, and (c) responsive to a significant development priority initiated by the country to which assistance is being provided. (Please note the definition of "capital project" contained in section 595 of the FY 1993 Appropriations Act.)

N/A.

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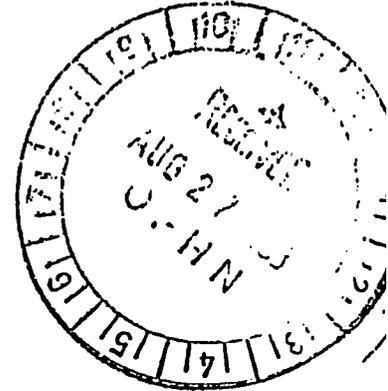
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E.O. 12356: N/A

TAGS:

SUBJECT: INTEGRATED FAMILY PLANNING AND MATERNAL HEALTH
PROJECT (IFPP) (492-0480) - APPROVAL OF REVISED NAD

REFERENCE: REVISED POPULATION STRATEGY AND NEW ACTIVITY
DESCRIPTION (NAD) FOR IFPP (JUNE 1993)

1. A-AA/ASIA APPROVES THE REVISED NAD FOR THE IFPP AND, PURSUANT TO DOA 400, AND INTERIM DOA 9, HEREBY REDELEGATES AD HOC AUTHORITY TO THE DIRECTOR, USAID/PHILIPPINES, TO APPROVE SUBSEQUENT PROJECT DESIGN DOCUMENTATION AND TO AUTHORIZE THE PROJECT FOR UP TO 110 MILLION DOLLARS. THE ACTUAL AUTHORIZATION LEVEL MAY BE SUBSTANTIALLY LESS, DEPENDING ON HOW THE AUTHORIZATION OF CENTRAL POPULATION FUNDS IS HANDLED. ASSUMING THAT FUNDS ARE STILL HELD AND ALLOCATED BY R AND D/POP, WE ASK THAT BEFORE THE PROJECT AUTHORIZATION IS SIGNED, YOU SEND THE PROJECT PAPER AND ANY ISSUES REGARDING R AND D/POP FUNDING TO THE AA/ASIA TO WORK WITH R AND D/POP TO FINALIZE FUNDING ARRANGEMENTS.

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INCREASED SUPPORT FOR FAMILY PLANNING UNDER PRESIDENT RAMOS, AND THE A.I.D.'S STRATEGIC FOCUS ON POPULATION MAKE A STRONG CASE FOR A REVITALIZED AND EXPANDED POPULATION PROGRAM NOW.

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3. POPULATION STRATEGY:

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8-31-93		

ANNEX B-1

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B. IFPP SHOULD NOT BE BASED ON THE "PROGRAMMATIC GUIDELINES" ITEMS (2) AND (3) ON P. 26 OF REF A:

-- ITEM (2) STATES THAT WE WILL NOT "ABRUPTLY" CLOSE OUT PROGRAM ELEMENTS AS LONG AS RESOURCES ARE USED PRODUCTIVELY. THIS UNDERCUTS IFPP FLEXIBILITY TO REALLOCATE RESOURCES AWAY FROM MARGINAL TO MORE PRODUCTIVE COMPONENTS. RESOURCES ARE TOO SCARCE TO BE LEFT IN POOR PERFORMING PROJECT COMPONENTS JUST BECAUSE THEY ARE DOING SOME GOOD.

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4. SUSTAINABILITY:

WE AGREE THAT A 50 PERCENT INCREASE IN THE RATE OF CONTRACEPTIVE PREVALENCE IS AN IMPORTANT PROXY FOR SUSTAINABILITY. HOWEVER, WE BELIEVE THAT SUSTAINABILITY MUST BE CONSIDERED MORE BROADLY, INCLUDING:

--A. GOP SUPPORT FOR FAMILY PLANNING - WHILE SUPPORT FOR FAMILY PLANNING AT THE HIGHEST LEVEL OF THE PHILIPPINE GOVERNMENT IS NOW STRONG, SUCH SUPPORT IS EXCEPTIONAL IN PHILIPPINE HISTORY. IT MAY NOT CONTINUE LONG ENOUGH FOR PROJECT SUCCESS -- THE TEN-YEARS NEEDED TO ATTAIN THE

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2/2 ANNEX B-1

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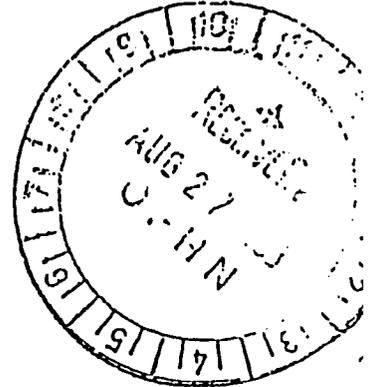
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ANNEX D LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>PROJECT SECTOR GOAL:</p> <p>To improve the health of women and children by reducing the unmet need for family planning services.</p>	<p>MEASURES OF GOAL ACHIEVEMENT</p> <p>Total Fertility Rate decreases from 4.08 presently to 3.29 by 1999.</p>	<p>MEANS OF VERIFICATION</p> <p>Comparison of results from the 1993 DHS with those from the 1998 DHS. Annual NSO population based surveys.</p>	<p>ASSUMPTIONS FOR ACHIEVING GOALS</p> <p>Increased numbers of couples will choose the more effective methods and they will use those methods correctly and effectively. The GOP maintains its commitment to promoting the use of modern contraceptive methods</p>
<p>PROJECT PURPOSE:</p> <p>To expand the availability of reproductive health services in public and private sectors and to increase the use of those services by women in high-risk groups.</p>	<p>CONDITIONS THAT WILL INDICATE PURPOSE HAS BEEN ACHIEVED</p> <p>The contraceptive prevalence rate of modern methods increases from 25 in 1993 by a minimum of 1.5 to 2.0 percent annually through 1999.</p>	<p>MEANS OF VERIFICATION</p> <p>NSO annual surveys and data from the CDLMIS. Comparison of 1993 and 1998 DHS results.</p>	<p>ASSUMPTIONS FOR ACHIEVING PURPOSE</p> <p>Clearer information on the health benefits of family planning and the safety of contraceptive methods leads to increased acceptance of modern methods.</p>
<p>PROJECT OUTPUTS</p> <ol style="list-style-type: none"> 1. Family planning services and information expanded nationwide through public, NGO and private sector channels. 2. FP service providers acquire better knowledge of FP methods and interpersonal skills necessary to provide quality services to acceptors. 3. The contraceptives logistics system is operational on a nationwide basis. 4. IECM materials are disseminated at all FP service points and national campaigns heighten about and acceptance of modern contraceptive methods. 5. Voluntary surgical contraception is available in all provinces and chartered cities. 6. NGOs providing FP/MCH services are operating in all provinces. 	<p>MAGNITUDE OF OUTPUTS</p> <ol style="list-style-type: none"> 1. Specific outputs cited below 2. Competency-based training is established for all FP training, accreditation and certification systems are functional. 3. All provinces, cities and FP service points throughout the country are regularly supplied with contraceptives and do not experience stock-outs due to internal system failures. 4. Method specific and general IECM materials are available at all service points and at least two major, annual campaigns are completed. 5. 100 medical personnel trained in VSC are providing services at regional and/or provincial hospitals or private clinics throughout the country. 6. 80 NGOs have received training to strengthen their service delivery and cost-recovery systems. 	<p>MEANS OF VERIFICATION</p> <ol style="list-style-type: none"> 1. CDLMIS monitoring data and national program monitoring reports. 2. Routine monitoring of project implementation by USAID and OSC, quarterly progress reports by PMTACT and site visits. 3. CDLMIS data and site visits. 4. CDLMIS data, site visits and KAP survey data. 5. Routine project monitoring by USAID and OSC, contractor reports and site visits. 6. Cooperating agency reports, USAID and OSC monitoring, site visits. 	<p>ASSUMPTIONS FOR ACHIEVING OUTPUTS</p> <ol style="list-style-type: none"> 1. CDLMIS becomes operational on a nationwide basis and a national program monitoring unit is established by OSC. 2. OSC is able to facilitate the active participation of the appropriate medical associations to establish the accreditation and certification systems. 3. The DOH develops the capacity to assume responsibility for managing the logistics systems on a nationwide basis. 4. Effective IECM materials are developed which are culturally acceptable and effective. 5. Competency-based training is established for VSC training and service delivery can be incorporated with training activities. 6. DOH continues its encouragement of developing NGOs as FP/MCH service providers.

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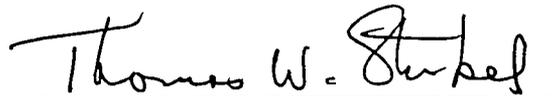
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																		
7. In-plant, industry-based FP/MCH programs are operating on a sustainable basis throughout the country.	7. 150 industries have received assistance to develop and maintain in-plant FP/MCH programs and are supporting these without external assistance.	7. Cooperative agency reports, USAID and OSC monitoring and site visits.	7. The DOH continues to encourage the development of private sector channels for the provision of FP/MCH services.																		
8. The contraceptive social marketing program is expanded to secondary urban areas.	8. Social marketing campaigns have been undertaken in at least 20 urban areas throughout the country.	8. Cooperating agency reports, USAID and OSC monitoring and site visits.	8. The DOH continues to encourage the development of private sector channels for the provision of FP/MCH services.																		
9. Selected research studies and projects are completed.	9. A new, national network using local institutions is established to conduct operational research on FP/MCH issues.	9. Cooperative agency reports, USAID and OSC monitoring, site visits.	9. Operational research studies can be identified and conducted which improve FP/MCH service delivery.																		
10. Policy planning and advocacy efforts heighten awareness of decision-makers about the relationship between population	10. Advocacy campaigns result in increased support, reflected in budget allocations, for family planning programs at the national and LGU level.	10. Cooperating agency reports, USAID and POPCOM monitoring, national and LGU budgets for family planning programs.	10. Government leaders remain receptive to advocacy regarding population and development and act on such information by increasing budget allocations for family planning.																		
11. LGU's develop greater capacity for expanding and sustaining effective FP/MCH programs, and a new working relationship is established between the DOH and LGUs in support of these programs.	11. At least 100 LGUs participate in the LGU Assistance Program.	Annual benchmark reviews and supporting documentation, contractor reports, site visits, and USAID and OSC monitoring.	11. The DOH maintains its commitment to re-orienting itself in line with the devolution process. A workable arrangement can be established which permits the DOH to assist LGUs to strengthen their FP/MCH service delivery.																		
PROJECT INPUTS: COMPONENT 1: National Services IECM: Long and short-term technical assistance, materials development, production and distribution, mass media campaigns. Contraceptives: Pills, condoms, IUDs Logistics: long and short-term technical assistance, warehouse maintenance, distribution of contraceptives, contraceptives inventory. Training: long-term technical advisor, short-term training in FP service delivery, organizational arrangements for accreditation and certification, funding for training sessions.	IMPLEMENTATION TARGET: <table border="1" data-bbox="548 1004 1043 1488"> <thead> <tr> <th colspan="2">Cost Estimates (\$ 000)</th> <th></th> </tr> <tr> <th></th> <th>USAID/M</th> <th>R&D/POP</th> </tr> </thead> <tbody> <tr> <td>IECM</td> <td>3,000</td> <td>7,460</td> </tr> <tr> <td>Contraceptives</td> <td></td> <td>22,099</td> </tr> <tr> <td>Logistics</td> <td></td> <td>5,752</td> </tr> <tr> <td>Training</td> <td>5,535</td> <td></td> </tr> </tbody> </table>	Cost Estimates (\$ 000)				USAID/M	R&D/POP	IECM	3,000	7,460	Contraceptives		22,099	Logistics		5,752	Training	5,535		MEANS OF VERIFICATION: Contracts executed, materials available at FP service delivery points, media spots aired. Bills of Lading Contracts executed, contraceptives available at all service points per CDLMIS data. Contracts executed, competency-based training materials developed and used, accreditation and certification systems in place.	ASSUMPTIONS FOR PROVIDING INPUTS: Family planning messages which stress the health benefits of contraception will increase contraceptive use and prevalence. A well managed logistics system will assure availability of contraceptives at all service points. A well managed logistics system will assure availability of contraceptives at all service points. Competency-based training can be introduced as the standard for all FP training and this will lead to improved service delivery.
Cost Estimates (\$ 000)																					
	USAID/M	R&D/POP																			
IECM	3,000	7,460																			
Contraceptives		22,099																			
Logistics		5,752																			
Training	5,535																				

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
VSC: long-term technical advisor, short-term training.	VSC 2,872	Contracts executed, training sessions conducted.	Demand exists for VSC among MCRAAs.
Op. Research: studies conducted on social, cultural, clinical and service delivery-related topics, long-term TA.	Op. Research 1,500	Studies completed and used to improve service delivery.	Op. research can be effective in improving the effectiveness of service delivery systems and other FP/MCH related activities.
Policy/Advocacy: Advocacy campaigns distributed, advocacy of POPDEV conducted (e.g., RAPID Model), short and long-term technical assistance.	Policy/Advocacy 2,357	Materials developed, workshops held, contracts executed.	Decision makers continue to be receptive relationship between population and development. Such efforts result in increased FP budgetary support.
Monitoring: Long and short-term technical assistance, equipment, contract for 1998 DHS	Monitoring 2,825	PASA established, TA provided equipment procured, long and short-term training conducted, 1998 DHS conducted, annual surveys conducted.	National program performance monitoring contributes to overall program management and bolsters arguments for increased FP budget allocations.
COMPONENT 2: NGO/Private Sector			
NGOs: Cooperative agreement with U.S. based NGO for long and short-term technical assistance, training for local NGOs, program support, cooperative agreement with a local NGO for the in-plant industrial program	NGOs 9,400	Cooperative agreement established, NGOs receive training and program support.	NGOs are an effective channel for providing FP services
Social Marketing: long and short-term technical assistance to expand the social marketing program.	Social Marketing: 7,960	Cooperative agreement established, social marketing conducted in secondary cities.	A significant market exists for provision of contraceptives via commercial channels.
COMPONENT 3: IFPMHP Performance-based Program			
Cash transfer: financial support for policy and institutional reforms.	Cash transfer 23,240	Annual performance benchmarks are met.	LGUs are able to develop and implement plans to expand their FP/MCH programs.
Program Management: long and short-term technical assistance, equipment procured.	Program Mgt. 5,400	Contracts executed, quarterly reports document provision of services.	LGUs need and can use effectively technical assistance to improve their FP/MCH programs.
	TOTAL \$50,000 \$50,000		

CERTIFICATION PURSUANT TO THE UTILIZATION OF
GRAY AMENDMENT ORGANIZATIONS

I, Thomas W. Stukel, Director of the Agency for International Development in the Philippines, have fully considered the potential involvement of small and/or economically and socially disadvantaged enterprises, and do hereby certify that in my judgment the U.S. technical assistance can best be provided through open competition. Since diverse services will be required under the contract, the Request for Proposal will require that interested firms, as part of their proposal, to use the services and resources of socially and economically disadvantaged entities, particularly small and disadvantaged firms and PVOs, women-owned and 8(a) organizations. Because the technical assistance contract is funded by the Development Assistance account, a minimum of ten percent of the contract is required to go to such organizations. In addition, for the scheduled evaluations, efforts will be made to award contracts to Gray Amendment firms. My judgment is based on the recommendations of the Gray Amendment Officer, the Program Design Team and the Mission Review Committee.



Thomas W. Stukel
Director, USAID/Philippines

This analysis presents the rationale for selecting the program components to be assisted in the Integrated Family Planning Maternal Health Project (IFPMHP).

IFPMHP is totally in-line with recent strategic planning of the Department of Health (DOH), the Mission's program strategy, O/PHN's Population Assistance Strategy and A.I.D.'s new strategic focus for the Agency. The DOH has identified maternal health and child survival as among its top priorities. USAID/Philippines's recent strategic plan lists health and family planning as one of the Mission's main objectives. IFPMHP essentially operationalizes O/PHN's Population Strategy which was prepared collaboratively with R&D/POP. Similarly, AID/Washington has recently announced that population and health are one of the Agency's four main strategic objectives. Moreover, Missions have been instructed to use integrated approaches in new health and population projects because of the close interrelationship between proper child spacing and the promotion of maternal and child health. In this respect, IFPMHP represents a melding of highly consistent strategic objectives of A.I.D. and the DOH.

With more than twenty-five years of experience with population projects, USAID arguably has greater competence and depth of experience than other donors providing assistance in this area. USAID's track record in the areas of family planning and maternal/child health demonstrates that such assistance is effective - i.e., it works. This is also an area where USAID has a comparative advantage in bringing to bear the various technologies and management approaches needed to achieve development results.

By all measures, recent studies have shown acceptance of modern contraceptive methods in the Philippines lags far behind other Catholic and non-Catholic developing countries. Despite a sound start to the promotion of family planning in the 1960s and 1970s, these efforts languished throughout the 1980s and into the 1990s. The early years clearly showed that modern contraception was culturally acceptable and did not create a serious moral dilemma in the minds of many Filipinos. In recent years, the need for contraception has only grown greater, as has the expressed demand for family planning services throughout the country. The 1993 DHS found that unmet need for contraception was 43 percent among urban women and 51 percent among rural women. With the change in support for family planning at the national level and within the DOH, the potential now exists to assist the country to make significant strides toward a more manageable pace of population growth.

There is every reason to believe that fertility will decline as a result of the assistance IFPMHP will provide. Better understanding and greater knowledge about the safety and efficacy of hormonal contraceptives should encourage increased acceptance. The health and economic benefits of child spacing is also well established and there is an increasing awareness of the connection between rapid population growth and environmental degradation. This type of information will be more widely disseminated through the IECM and advocacy activities supported by IFPMHP. Training of family planning service providers will also lead to individuals receiving more accurate information so that they can choose the family planning method that is best for them.

The choice of agencies to work with is in large part dictated by the GOP's division of responsibilities between the DOH and POPCOM. It is technically feasible for both organizations to expand and improve significantly the quality of their family planning services and related operations. Providing assistance directly to LGUs is highly consistent with the DOH's new post-devolution role. The DOH foresees itself as becoming "a servicer of servicers" in assisting LGUs which now have responsibility for actual service delivery. The LGU Assistance Program will accelerate the development of the respective roles of the DOH and the LGUs as well as fast-track the expansion of FP/MCH services in the participating LGUs. Though this approach will be new, the DOH will be able to draw on its experience with the highly successful Child Survival Program, which involved performance-based program assistance to Provincial Health Offices nationwide.

With the exception of the LGU Assistance Program, all of the other activities IFPMHP will support draw from on-going work, which has clearly demonstrated the technical feasibility of this assistance.

Assistance to NGOs and the commercial private sector envisioned for IFPMHP has also been demonstrated to be technically feasible and highly effective. The development of family planning services through these channels is fundamental to a more rational allocation of funds for family planning services by the public sector for those truly in need of free or subsidized assistance.

ANNEX F-2

FINANCIAL ANALYSIS

The Integrated Family Planning and Maternal Health Project (IFPMHP) is aimed at and designed for improving the socio-economic infrastructure of the Philippines. This Project is primarily a "human infrastructure" project where financial justification using the traditional method of financial analysis considering the value of money and time is not possible.

1. AID Financing

The total USAID bilateral funding is \$60 million. R&D/POP will provide the equivalent of \$50 million in technical services, training and commodities through their centrally funded projects. 94.4 percent of USAID bilateral funding covers foreign exchange costs of IFPMHP. This will finance social marketing and NGO strengthening, technical assistance to both DOH and LGUs, IE&C, research studies, commodities and various forms of training to enhance FP/MCH delivery service. All implementation costs will be funded through AID direct contracts, a PASA and cooperative agreements.

The local currency cost will consist of a Peso Grant to a local NGO and direct payments to local contractors. For local currency costs, Project Implementation Letters will be issued to earmark and commit funds. All cost estimates are based on existing FPAP contracts for similar services and commodities (see Attachment A).

The planned obligations of AID Bilateral funding are as follows:

<u>Year of Obligation</u>	<u>Annual Obligation (US \$000)</u>	<u>Cumulative Obligation</u>
FY '95	11,254	18.76%
FY '96	11,666	38.20%
FY '97	12,256	58.63%
FY '98	12,161	78.90%
FY '99	<u>12,663</u>	100.00%
Total	\$ 60,000	

The planned obligations of R&D/POP funding are scheduled as follows:

<u>Year of Obligation</u>	<u>Annual Obligation (US \$000)</u>	<u>Cumulative Obligation</u>
FY '95	9,895	19.79%
FY '96	11,394	45.58%
FY '97	13,143	68.86%
FY '98	11,436	91.74%
FY '99	<u>4,132</u>	100.00%
Total	\$ 50,000	

2. GOP Contribution

The GOP counterpart contribution is approximately \$ 20 million dollars consisting of personnel, operational and maintenance costs incurred by DOH and the LGUs in support to IFPMHP related activities (refer to Attachment B). The GOP's counterpart contribution in local currency will satisfy the statutory requirement for 25 percent counterpart contribution to the project costs. The GOP share will finance local costs such as expendable supplies, personnel salaries, monitoring and coordination of programs, contraceptive storage and distribution, vehicle and equipment maintenance. During the life of the project, the GOP will continue to provide funds to the DOH and LGUs, through its regular cycle of budgetary appropriations.

3. Sustainability Analysis

a. Recurrent Costs

The recurrent costs in IFPMHP budget include personnel, materials and supplies, transportation, IE&C, management support and training (although this is more of an investment). There are no available national budget projections that will permit closer analysis of funding these recurrent costs of the project. But based on FPAP's past performance, strong support for family planning by the Ramos Administration, dynamic leadership by DOH Secretary Flavier and broad-based support by LGU local executives, there is good reason to believe that these recurrent costs will be covered at an acceptable level. In addition, the successful campaign of DOH programs have helped raise awareness in Congress about the importance of the health sector in boosting the economy of the country. A separate budget line item for family planning is expected for the DOH in 1995 or 1996.

In the long run, a reduction in financial requirements may be realized when an increased share of costs for service delivery is borne by the private sector, e.g., payment for services and family planning services offered by industries. It is estimated that 40 percent of the MCRAs, i.e., the truly indigent segment of the population, will remain dependent on the government for services in health related activities. Even at this early stage in the development of the social marketing project, there are clear indications of acceptors shifting to commercial channels for contraceptives.

b. Cost-Reducing Strategies for Health Services Delivery

At present the DOH has shifted its emphasis on health care financing from curative to preventive services. Numerous programs currently undertaken by DOH like the immunization program, "sangkap-hirap" (addressing nutritional deficiency), "sagip-mata" (addressing cross-eyed children) and others are aimed at

prevention. This strategy aims at reducing the costs of providing health services. It is an established fact that preventive practice is much cheaper than curative care.

Moreover, the devolution process begun in 1992 is expected to result in more cost-efficient and effective service delivery. These savings are anticipated in the health sector as former DOH services become the responsibility of LGUs. Bringing the planning and decision-making process to the LGUs is expected to produce better use of scarce resources.

In the past, the Philippines Family Planning Program (PFPP) made extensive use of barangay-level volunteers - i.e, the Barangay Service Point Officers (BSPO) and the Barangay Health Workers (BHW). They proved highly effective in providing information and motivating acceptance. Many are still active, supplying pills and condoms to acceptors. IFPMHP will help strengthen this cost-effective means of family planning.

c. Other Sources of Financing for Health Services

The financial requirements of the health sector cannot be met solely by the GOP through its budgetary allocations alone. Some areas that may be tapped to provide additional financing for health services and family planning are: collection of service fees, expansion of Medicare and insurance coverage to include family planning services, encouragement of company-provided family planning services for their employees, expansion of NGO family planning programs, encouragement of other organizations to include population services to their health programs and strengthening of private sector initiatives.

3. Flow of Funds and Financial Reporting

a. GOP

The Project Agreement executed between USAID and NEDA will specify the details of the flow of funds. A cash transfer of \$22.2 million made in five tranches over the course of IFPMHP will be released by USAID to the GOP.

Per discussions among DBM, DOF and DOH, the GOP will provide the funds necessary for the LGU Assistance Program. This funding will be used to finance LGU activities to expand family planning and maternal health services. Since these are GOP funds, established GOP financial reporting mechanisms will be applicable.

b. USAID

Once the funds for the project have been obligated and earmarking of project funds will be based on the annual implementation plan. USAID will make direct payments to all its contractors and BUCEN,

subject to approval. For the local NGO cooperative agreement, USAID will be provide local currency to the receiving NGO subject to existing USAID regulations on PVOs. Also USAID upon evaluation of DOH/OSC and LGU performance will authorize a cash transfer to GOP. Tranche releases are expected to be made annually.

BUDGET ALLOCATIONS			- BILATERAL FUNDS (US \$)					ATTACHEMENT A	
NO.	ITEM	COMPONENT	FY95	FY96	FY97	FY98	FY99	Subtotal	TOTAL
1	NGO Mid-Level Mgt (Strengthening NGOs) plus	NGO	2,326,000	2,391,000	2,465,000	1,965,000	1,853,000	11,000,000	
2	RP/MCH Program for Industrial Sector	NGO	640,000	591,000	608,000	631,000	655,000	3,125,000	
3	SUBTOTAL		2,966,000	2,982,000	3,073,000	2,596,000	2,508,000		14,125,000
1	Contractual Training Team (3 staff) DOH/FPS	TRAINING	25,000	25,000	25,000	25,000	25,000	125,000	
2	National Workshop for DOH/FPS	TRAINING	2,000	2,000	2,000	2,000	2,000	10,000	
3	Accreditation Board	TRAINING	0	40,000	30,000	15,000	10,000	95,000	
4	Boards of MW, Nursing & Medicine revised certification Sys	TRAINING		20,000	10,000	10,000	5,000	45,000	
5	Overhead & FEE on (#NGO, TRNG 1, 2, 3, 4) plus contingency	TRAINING	19,000	19,000	20,000	20,000	20,000	98,000	
6	Competency Based FPS Training (3 weeks) NGO/DOH (Clinical & Counseling, study tours, & other Insti. bldg.) DOH/NGO: IUD Kit, Pelvic Model, Contraceptive Tech Manual, Infection Prevention Ref Manual Contingency 10.0%	TRAINING	400,000	400,000	400,000	400,000	0	1,600,000	
7	Pilot Initiative for FP fellowships in Social Science	NGO	43,000	43,000	43,000	43,000	43,000	215,000	
8	Participant Training		50,000	50,000	50,000	50,000	50,000	250,000	
9	FPS Training for new graduates of Schools of MW & Nursing plus RTI Centers (5): Eqpt. Training	TRAINING	570,000	557,000	745,000	942,000	1,132,000	3,946,000	
10	TA for DOH Training		301,000	301,000	301,000	301,000	301,000	1,505,000	
11	SUBTOTAL		1,410,000	1,457,000	1,626,000	1,808,000	1,588,000		7,889,000
1	Resident Advisor, Personnel plus FP Campaign Partial Print Materials, FP Audio Visuals, Educate Programs, Collaterals, etc.	IECM	1,094,000 98,000	1,094,000 98,000	844,000 98,000	844,000 98,000	844,000 98,000	4,720,000 490,000	
2	SUBTOTAL		1,192,000	1,192,000	942,000	942,000	942,000		5,210,000
1	MIS Advisor, TA for MIS	MONITORING	310,000	310,000	40,000	20,000	20,000	700,000	
2	Computers, Supplies, etc. for NSO Survey	MONITORING	345,000	5,000	5,000	5,000	5,000	365,000	
3	SUBTOTAL		655,000	315,000	45,000	25,000	25,000		1,065,000
1	LGU - Policy & Insti. Reform	LGU Asst	1,500,000	3,000,000	4,125,000	4,970,000	5,805,000	19,200,000	
2	OSC - Policy & Insti. Reform	LGU Asst	1,500,000	1,000,000	500,000	0	0	3,000,000	
3	SUBTOTAL		3,000,000	4,000,000	4,625,000	4,970,000	5,805,000		22,200,000

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BUDGET ALLOCATIONS - BILATERAL FUNDS (US\$)

ATTACHMENT A

NO.	ITEM	Expenditure per Year/ GRAND TOTAL					TOTAL
		FY95	FY98	FY97	FY98	FY99	
1	TA & Performance Monitoring OSC TA & Performance Monitoring LGU Program Mgt Person For USAID Vehicles, computers for OSC, LGU Program	1,720,000	1,720,000	1,720,000	1,720,000	1,720,000	8,600,000
2	OSC & LGU Mgt	311,000	0	0	0	0	311,000
3	SUBTOTAL	2,031,000	1,720,000	1,720,000	1,720,000	1,720,000	8,911,000
1	Evaluation	0	0	175,000	0	175,000	350,000
2	Audit	0	0	50,000	100,000	100,000	250,000
3	SUBTOTAL	0	0	225,000	100,000	275,000	250,000
BUDGET ALLOCATIONS - CENTRAL FUNDS		11,254,000	11,666,000	12,256,000	12,161,000	12,663,000	\$ 60,000,000

BUDGET ALLOCATIONS - GRAND TOTAL

NO.	ITEM	Expenditure per Year/ GRAND TOTAL					TOTAL
		FY95	FY98	FY97	FY98	FY99	
1	Social marketing (Source: FPAP Contract) FP Campaign POP/DEV Advocacy Campaign	1,592,000	1,592,000	1,592,000	1,592,000	1,592,000	7,960,000
2	IECM IECM	1,250,000	1,250,000	1,250,000	1,250,000	0	5,000,000
3	Contractives	4,705,000	5,406,000	6,209,000	5,779,000	0	22,099,000
4	Advisor & Staff Support	788,000	698,000	119,000	122,000	0	1,725,000
5	Logistic Support & Training	242,000	557,000	981,000	1,187,000	1,060,000	4,027,000
6	VSC Training & Services	718,000	718,000	718,000	718,000	718,000	2,872,000
7	OR, SA Studies, TA, etc	364,000	410,000	242,000	242,000	242,000	1,500,000
8	Advocacy, Strategic planning, Institution Building, Expat	456,000	573,000	592,000	358,000	380,000	2,357,000
9	DHS MONITORING	0	0	900,000	190,000	0	900,000
10	Training Casuals	150,000	190,000	190,000	190,000	140,000	860,000
BUDGET ALLOCATIONS - GRAND TOTAL		9,895,000	11,394,000	13,143,000	11,439,000	4,132,000	\$ 50,000,000

INTEGRATED FAMILY PLANNING AND MATERNAL HEALTH CARE
 Estimated Annual GOP Counterpart Contribution, 1994

Attachment B

	Monthly Salary	No. of Personnel	Total Months	Total Amount	IE&C	Logistics	Training	VSC	Operations Research	Policy Planning	LGU Assistance	OSC & LGU Program Management
PERSONNEL SERVICES												
A. CENTRAL OFFICE												
Technical Adviser	15,180	1	4	60,720	12,144	0	12,144	0	12,144	12,144	0	12,144
Officer-in-Charge	11,385	1	4	45,540	9,108	0	9,108	0	9,108	9,108	0	9,108
Medical Officer VII	11,385	2	5	113,850	22,770	0	0	22,770	22,770	22,770	0	22,770
Medical Specialist IV	12,048	1	4	48,192	12,048	0	12,048	0	12,048	12,048	0	0
Medical Specialist II	8,250	4	4	132,000	26,400	0	26,400	26,400	26,400	26,400	0	0
Nurse VI	8,250	3	4	99,000	24,750	0	24,750	0	0	24,750	0	24,750
Midwife III	3,309	1	2	6,618	2,206	0	2,206	0	0	0	0	2,206
HEPO III	5,670	1	4	22,680	11,340	0	11,340	0	0	0	0	0
HEPO II	4,091	1	4	16,364	8,182	0	8,182	0	0	0	0	0
HEPO I	3,102	1	4	12,408	6,204	0	6,204	0	0	0	0	0
Statistician IV	8,250	1	3	24,750	0	0	0	0	12,375	12,375	0	0
Statistician III	4,418	1	3	13,254	0	0	0	0	6,627	6,627	0	0
Statistician II	4,418	1	3	13,254	0	0	0	0	6,627	6,627	0	0
Statistician I	3,309	1	3	9,927	0	0	0	0	4,964	4,964	0	0
Admin. Officer	3,309	1	6	19,854	3,971	3,971	3,971	0	3,971	3,971	0	0
Records Officer	3,102	1	4	12,408	2,482	2,482	2,482	0	2,482	2,482	0	0
Sociologist	4,418	1	3	13,254	0	0	0	0	6,627	6,627	0	0
Proj. Eval Officer	4,418	1	4	17,672	0	0	0	0	8,836	8,836	0	0
B. REGIONAL HEALTH OFFICE												
Regional Director	15,180	14	4	850,080	0	0	0	0	283,360	283,360	0	283,360
Chief, Technical Div	11,385	14	4	637,560	0	0	0	0	212,520	212,520	0	212,520
Chief, Training Div	11,385	14	6	956,340	0	0	478,170	0	159,390	159,390	0	159,390
Reg'l Training Nurse	6,798	14	4	380,688	47,586	0	190,344	0	47,586	47,586	0	47,586
Nurse III	4,786	14	4	268,016	67,004	0	67,004	67,004	0	0	0	67,004
FP/MCH Coordinator	8,250	14	10	1,155,000	231,000	0	231,000	0	231,000	231,000	0	231,000
FP/MCH Nurse	6,798	14	10	951,720	237,930	0	237,930	0	237,930	237,930	0	0
Nurse II	4,786	14	8	536,032	268,016	0	134,008	134,008	0	0	0	0
Nurse III (hospital)	4,786	14	4	268,016	134,008	0	0	134,008	0	0	0	0
Clerk I	2,156	14	2	60,368	30,184	0	30,184	0	0	0	0	0
Driver/Utility	2,156	14	2	60,368	0	60,368	0	0	0	0	0	0
C. PROVINCIAL LEVEL												
Prov'l Health Officer	12,650	76	4	3,845,600	0	0	0	0	0	0	2,884,200	961,400
FP/MCH Coordinator	5,670	76	10	4,309,200	0	0	0	0	0	0	3,447,360	861,840
Nurse II (hospital)	4,091	76	4	1,243,664	0	0	0	0	0	0	1,243,664	0
Statistician I	3,309	76	4	1,005,936	0	0	0	0	0	0	1,005,936	0
Clerk I	2,156	76	2	327,712	0	0	0	0	0	0	327,712	0
Driver/Utility	2,156	76	2	327,712	0	0	0	0	0	0	327,712	0
D. MUNICIPAL LEVEL												
Rural Health Physician	6,798	1858	2	25,261,368	0	0	0	0	0	0	24,629,834	631,534
Public Health Nurse	4,091	3344	3	41,040,912	0	0	0	0	0	0	41,040,912	0
Midwife II	2,752	1858	3	15,339,648	0	0	0	0	0	0	15,339,648	0
SUB-TOTAL				99,507,685	1,157,332	66,820	1,487,474	384,190	1,306,764	1,331,514	90,246,978	3,526,612

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INTEGRATED FAMILY PLANNING AND MATERNAL HEALTH CARE
 Estimated Annual GOP Counterpart Contribution, 1994

Attachment B

MOOE AND CAPITAL OUTLAY

Office Location									
Central Office	150,000	37,500	37,500	37,500	37,500	37,500			
Regional Office	50,400	12,600	12,600	12,600	12,600	12,600			
Provincial Level	273,600							273,600	
RHUs	4,459,200							4,459,200	
Office Equipment (Central Office)									
Typewriter - manual	2,400	600	600	600	600	600			
Typewriter - electronic	6,000	1,500	1,500	1,500	1,500	1,500			
Computer	10,080	2,520	2,520	2,520	2,520	2,520			
Contraceptive Delivery Cost	2,450,000	2,450,000							
	0								
Communications	88,900	22,225	22,225	22,225	22,225	22,225			
Supplies	1,030,200	75,000	75,000	318,400	318,400	318,400			
SUBTOTAL	8,520,780	151,945	2,450,000	395,345	0	395,345	395,345	4,732,800	0
TOTAL	108,028,465	1,309,277	2,516,620	1,882,819	384,190	1,702,109	1,726,858	94,979,778	3,526,512

Five Year Projected GOP Counterpart Contribution
 (In Thousands)

	Pesos	U.S. Dollars
NATIONAL SERVICES		
IE&C	6,546	242
Contraceptives	0	0
Logistics	12,584	466
Training	9,414	349
VSC	1,921	71
Operations Research	8,511	315
Policy Planning	8,634	320
Sub-total	47,610	1,763
LGU ASSISTANCE PROGRAM		
LGU Assistance	474,899	17,589
OSC & LGU Program Management	17,633	653
Sub-total	492,532	18,242
TOTAL	540,142	20,005

NOTE: This is an abbreviated version of a more extensive economic analysis conducted for the IFPMHP design. Copies of the full analysis are available from the Mission's Office of Population, Health and Nutrition.

1. Introduction and Summary

Population growth has an impact on sustainable growth through its effects on human capital, poverty, and the environment. Likewise, economic growth is not sustainable if a large majority of the population do not share its benefits. In addition to its indirect effects, population growth and increased dependency directly reduce the savings rate of a society, thereby compromising physical capital formation and productivity growth. For the developing economies with historically low rates of capital formation, continuing rates of expansion in population further reduce the chances for these countries to attain economic growth. The implications of these demographic realities on the requirements for investment, employment, social and physical infrastructures, environmental preservation, and so forth, are staggering. The challenge is unprecedented in terms of its nature, given the limited availability of natural resources in many countries, burgeoning fiscal deficits, and declining resource flows from the developed countries.

Questions of whether family planning programs can have a fertility effect are now essentially trivial. The evidence derived from surveys of national scale programs show that most contraceptive uses, and the fertility reductions associated with them, have rested upon public supplies and services in these countries. Furthermore, studies show that some latent demand for contraception is present throughout much of the developing world, even in poor rural settings. Interest in the control of childbearing is generally present in significant population groups, and it can be stimulated by putting into the environment actual contraceptive means and sympathetic information and encouragement.

The goal of the Integrated Family Planning and Maternal Health Project (IFPMHP) is to improve women's health through the long-term reduction of unmet need and the generation of increased demand for family planning services by women in high risk categories. Consequently, IFPMHP is designed to increase contraceptive prevalence and minimize high risk childbearing. IFPMHP will provide a range of reproductive health services in addition to family planning, including reproductive tract infection screening and treatment, in cooperation with DOH. In support of the DOH's and USAID's policies of promoting integrated

maternal and child health, selected child survival interventions will also be included in support to local government units (LGUs). Progress towards programmatic sustainability is a major objective of the IFPMHP. Creating demand for family planning, combined with reliable sources of supply, is the first, and most important, step to achieving sustainability. Viewed from an economic angle, the IFPMHP is highly justified as an important intervention into the population problem.

2. Information Problems and Externalities

In the economic theory of fertility, couples are rational in their fertility behavior, in that they balance the costs and benefits of different alternatives and choose those that are most rewarding. Presumably, couples are fully informed of the consequences of different courses of action and have the means at their disposal to assure desired fertility outcomes. However, many couples, especially in less developed countries are ignorant of the opportunity for birth control. Thus, the first argument for a conscious public policy to reduce the growth of population stems from the imperfect information about and access to the means of fertility control. In the Philippines, information about the health risks to mothers and children from high parity births is not universally available to family planning program managers, policy makers or clients. In addition, information about how to access and utilize knowledge of the means to control fertility is lacking, even among those who have such knowledge. For those with knowledge about the benefits from family planning, there is a high percentage of unmet needs for contraceptive information and resources.

Another major rationale for policy intervention arises from the existence of externalities due to the divergence between private and social costs and benefits of having many children. When confined to their own limited informational base and their own valuation of welfare effects of family size, the social costs above are not included in the individual family's decision function. Whenever a family decides to have another child, the additional member is expected to increase the happiness of the family (i.e., their private valuation) and also to enjoy a happy life. However, in the real world where there is uncertainty, not all decisions turn out as expected, and current decisions which are perceived to be optimal may not remain as such in the future because of informational limitations not realized earlier. Parent may perceive the costs of additional children to be low, especially in rural settings, where human capital considerations and work situations are different from urban areas. On the other hand, the social costs of each additional birth could be significant.

3. Macroeconomic Dimensions of Benefits

A Population and Development Planning (PDP) Model developed for the Philippines, traces out the consequences of alternative demographic scenarios on key macroeconomic magnitudes that are commonly considered as indicators of welfare (Orbeta, 1989b). The main objective of the PDP Model is to quantify the socioeconomic and demographic interactions in the course of development. A recent study uses the model to conduct two types of simulation in tracking the macroeconomic consequences of the different demographic outlooks (Orbeta, 1989a).

The PDP Model simulations are initialized for 1985, but the relative trends are indicative of the improvements in macroeconomic indicators of welfare that can be achieved with lower population growth rates. The results of the simulations are reproduced in Table 1 (where initial values of the variables have been reindexed to 100 for easier comparability, and for emphasis on the relative rather than the absolute magnitudes). The first set of runs with demographic variables taken as exogenous, the high scenario (slow fertility decline with unit Net Reproductive Rate (NRR) achieved by year 2020) would take 20 years before the per capita gross national product (GNP) would double. On the other hand, it would take only 16 years for per capita GNP to double under the low variant (NRR = 1 by year 2000). Looking from another perspective, by year 10, per capita GNP under the low assumption would be 11.0 percent higher than per capita GNP under the high scenario; by year 20, the difference would be 26.1 percent, magnifying further by year 30 to 35.3 percent.

Another welfare indicator, the "full-time" unemployment rate (which includes visible underemployment), shows a less dramatic impact of reduced population growth in the medium term, although the gains clearly increase in the long term. While, even by year 10, the "full-time" unemployment index in the low variant is only 4.6 percent lower than that in the high variant, the difference climbs up to 17.3 percent by year 20 and 38.4 percent by year 30. The drop in "full-time" unemployment rates gets expressed ultimately in a more equitable income distribution.

These differences in the movement of the economic welfare indicators over time under alternative fertility scenarios stem mainly from a higher saving per capita and higher investment per worker that a lower population growth rate occasions. Table 1 shows that by year 20, saving per capita would be 40.0 percent higher and investment per worker would be 38.3 percent higher

¹Mortality decline is assumed to be moderate, with life expectancy at birth rising from 62 years in 1980 to 68 years in 2000 to 74 in 2030.

under the low variant compared to the high variant. With the second set of simulations (Table 2), the levels of per capita GNP over the long term in the base case are seen to lie in-between the high and medium population growth variants. With a reduction in the marital general fertility rate of 20 per thousand, by year 30 saving per capita would be higher by 22.4 percent over the base case, while investment per worker would be higher by 14.6 percent. These changes translate into a difference in per capita GNP of 12.9 percent, with the full-time unemployment rate that is lower by 21.0 percent.

4. Microeconomic Considerations

Since a number of potential benefits that relate to concerns like health, the environment, and quality of life in general are difficult to quantify accurately, direct estimation of the value of benefits from a population project is difficult. In addition, because of lags in the labor market impact of population changes, most of the benefits of successful efforts at curbing population growth will be realized long after the project is completed. The total benefits of present investments in fertility reduction will not be fully realized for at least a generation. However, the extent by which the Project will have a positive impact on improving the government's fiscal situation may serve as a minimum estimate of the gains that may be realized with a family planning program. The reduction in the fiscal burden with a lower population growth rate may be considered as real resource savings from the economy's viewpoint as long as the program is not coercive and addresses unmet family planning needs.

a. Fiscal Impact: A recent evaluation of the Philippine Family Planning Program covering the period 1970-2000 examines the costs and benefits of the Program in terms of such fiscal savings (Tarvid, Chao, and Rice 1992). The study uses the FamPlan system of computer models to calculate impacts, costs, effectiveness, and benefits of the program, both retrospectively and prospectively. The FamPlan system consists of four modules: impact, cost, effect, and benefit. The impact run begins with a set of initial conditions, estimates the effects of changing determinants of fertility, and produces fertility rates. The effect routine compares two family planning runs (with and without family planning) and relates the difference in production (averted deaths) to the difference in cost. Benefit compares two benefit streams (in terms of reduced government sectoral expenditures) to two family planning cost streams. From this comparison, the exercise estimated departmental savings, total sectoral savings, family planning program costs, net savings, benefit-cost ratios, and internal rate of return. The "with family planning" scenario was based on historical data for the retrospective period and constant prevalence for the prospective period. The "without" scenario was based on estimated 1970

levels of family planning. Since the program began in 1970, the second scenario was based on contraceptive use for that year, with constant prevalence assumed to the year 2000.

The FamPlan study shows that by 1978, the Program was already paying for itself, when the annual saving in government expenditures on social services began to exceed the Program outlays. At a 15 percent social discount rate, the Program was able to recoup its expenses by 1985 (with the benefit-cost ratio at 1.05). For the full course of the Program, i.e., to the year 2000, the benefit-cost ratio would reach 3.05 at the 15 percent discount rate, as the savings in social services expenditures far exceed the Program expenses. The internal rate of return of the Program is estimated at 27 percent.

In a sense, the proposed IFPMHP may be viewed as a continuation of the Philippine Family Planning Program begun in 1970, so that one could expect the IFPMHP to be yielding at least the same returns as the "old" Program. At the same time, however, unit costs and benefits may have changed, so that new estimates may be in order. Also, the Program experience of more than two decades offers the opportunity to introduce changes in design that would enhance the benefits even further.

Other earlier studies of the Family Planning Program have also come up with estimates of the fiscal benefits arising from reduced population growth. The World Bank (1988) poverty study places the budgetary saving for basic social services at \$300 million by the year 2015 if a rapid fertility decline is achieved. The 1990 Project Paper for the Philippines Family Planning Assistance Project (USAID 1990) calculates a 16 percent internal rate of return for the Project over a 20-year period out of such fiscal benefits. The following section updates the estimates of fiscal savings in the light of current budgetary magnitudes.

b. Updating Earlier Estimates of Costs and Returns: The IFPMHP envisions a significant increase in the amount of resources to be devoted to the family planning program. Over the five-year coverage of the Project, the total cost is estimated at \$130 million, of which \$60 million is USAID Bilateral funding and \$20 million is the GOP counterpart. Table 3 presents the annual flow of costs in constant prices of 1993, taking off from the cost estimate and financial plan and using the following official NEDA projections: an exchange rate of P29/\$1 for 1994 onwards, and inflation rates of 6.5 percent for 1994, 5.5 percent for 1995 and 1996, and 5.0 percent from 1997 onwards. The foreign exchange component is assumed to have a constant annual inflation rate of 3.0 percent. With these assumptions, the equivalent constant annual flow at a 15 percent social discount rate is P669.31 million in 1993 prices.

The FamPlan study discussed earlier estimates the cost per birth averted at about P500 in 1991 prices, or P585 in 1993 prices. A more recent study comes up with a lower estimate of P351 per birth averted for 1991, which amounts to P411 in 1993 prices (Dimalanta 1993). The IFPMHP resources, using this range of cost estimates, could therefore be expected to generate an annual output of 1.0 million to 1.5 million births averted. When compared to estimates of over three million married women with still unmet family planning needs and some six million women belonging to the high risk pregnancy category, the expected "production" is clearly at a range that would not lead to any wasteful "excess capacity."

For education, a recent study of the Department of Education, Culture and Sports (DECS) cost structures estimates expenditures on elementary education at P1,659 per student for school year 1990, in current prices (Canlas 1991). The corresponding cost for high school was P3,356 per student. Brought forward to 1993 prices, the cost per student would now be at P2,078 for elementary and P4,203 for high school, if the 1990 "quality" of public schooling were to be maintained. This is based on education inflation rates of 7.0 percent for half of 1991 (as the school year begins in June), 8.9 percent for 1992, and 7.5 percent for 1993. Applying 1990 life expectancies (from Flieger and Cabigon, 1993) and enrollment ratios of 100 percent for elementary and 65 percent for high school, the present value of the cost saving would equal P4,323 per birth averted (at a social discount rate of 15 percent), compared to the cost incurred of P585 per birth averted. This yields a discounted benefit-cost ratio of 7.4 and an internal rate of return of 40 percent.

Public health expenditures, on the other hand, amount to P200 per capita for 1993. Again applying year-to-year survival probabilities conservatively up to age 10, the present value of the P200 annual per capita expenditures on health would yield a present value of P1,034 of saving per birth averted. The benefit-cost ratio at 15 percent rises to 9.2, while the internal rate of return for both education and health saving increases to 66 percent. Table 4 shows the annual flow of fiscal benefits and costs per birth averted.

One major reason why the returns are so high is because the IFPMHP benefits from the over two decades of existence of the Family Planning Program started in 1970. Despite the slack in official commitment experienced in the 1980s, earlier expenditures on the Program have occasioned behavioral changes that allow substantially reduced cost per birth averted. Cost estimates for the early years of the Family Planning Program (from the 1970s up to the mid-1980s), as reported in the FamPlan study, run to the thousands of pesos per birth averted, expressed in present-day prices.

It may be noted that fiscal savings are real economic benefits and not just financial or accounting entries that are counter-balanced by "costs" to the users of forgoing the enjoyment of raising additional children. As mentioned earlier, to the extent that the Project is simply addressing unmet needs and has no coercive element to it, then these magnitudes represent real resource savings which generate the improvements in macroeconomic welfare indicators like per capita GNP and employment absorption. These returns may even be seen as minimum orders of estimate, as they do not yet take into account the benefits to the acceptors and users themselves, whose own cost-benefit calculus must be positive in the net, given that their participation in the Project is purely voluntary. With respect to private decisions, however, household preferences may change after an unwanted pregnancy.

c. Cost Effectiveness Issues: While the previous discussion shows that the IFPMHP's benefits far exceed the costs, it remains to be seen whether the Project as designed is in fact cost-effective. The priority strategy of the IFPMHP which will contribute to its cost-effectiveness is the urban targeting for a significant portion of expected beneficiaries. As suggested in the 1990 National Census and the 1993 Demographic and Health Survey, urban couples have to be the main target inasmuch as the majority of women in their high fertility years (20-39 years old) are found in urban areas. While rural fertility rates are still higher than urban levels, it appears that young urban mothers space their births more closely than rural mothers, with implications about maternal health and labor force participation rates. Thus, it is also the main target of this urban strategy to improve women's reproductive health.

Without implying that rural efforts should be reduced, the urban focus of the project rests on several advantages in urban settings. Trained medical staff, private sector physicians, and other health professionals are readily available in urban areas, and can be mobilized and utilized more efficiently given the infrastructure already in place. Since more services are provided by hospitals and large urban health centers, the staff can offer a wider choice of methods, including long-term, more cost-effective clinical methods. Likewise, stocks of contraceptives are less likely to run out, as urban providers are closer to the source of these devices. Conversely, because of greater patient loads, urban hospitals can become training centers for medical, nursing, and midwifery students. The urban populations will also have greater access to a wide range of IEC channels than their rural counterparts, mainly on account of the presence of more communication media. In terms of acceptance of and demand for family planning services, urban populations tend to be more accustomed to hospitals for health care, and seeking these services at the same place would be convenient.

5. Sustainability

Family planning programs play an important role in fertility reduction by helping to crystallize the latent demand that may first appear in ambiguous form. While interest in small families and in family limitation will not necessarily appear suddenly as an unambiguous rational decision of all Filipinos, the large amount of unmet need for contraceptives and family planning services are strong manifestations of the desire to limit family size, even among the poorer sections of society. New ideas about health, the value of education, new consumption goods, and greater possibilities for social mobility, generate rising aspirations among parents, both for themselves and their children. This complex process forms the basis for the development of a demand for fertility control, first latent, then manifest. The role of the Project is to make the conditions more favorable, stimulating the program demand to be more quickly manifest and self-conscious. Once the demand for FP becomes manifest, the process started by the project will be self-sustaining.

The IECM component is the most potent instrument to crystallize and legitimize the latent demand. With vigorous IECM activities in the forefront of the Project, attitudes of parents could be changed to become more receptive to family planning services, eventually encouraging them to actively seek for these services. IECM activities will enable families and couples to move beyond the confines of pretransition behavior where familial relationships are foremost in satisfying economic, emotional, recreational, educational, and security needs. With the supplies and services adequately addressed, there should be minimal problems in mounting a significant FP effort, and IECM can move forward and achieve maximum impact. The social marketing component under the FPAP should likewise provide a stimulant for the start of IECM activities under the present project.

The training component will complement IECM in building up and sustaining demand for FP services. The Project's thrust is to upgrade the services by addressing the inadequacies of past FP training programs which hindered effective service delivery and attainment of higher contraceptive prevalence. The focus on three main activities, namely: (a) implementation of humanistic, criterion-referenced, competency-based training; (b) revision of accreditation activities under a separate board; and (c) strengthening the FP certification program for health care providers, should resolve present problems with service delivery. These activities should lead to increased sensitivity to existing demand for contraception and better responsiveness to client needs. In addition, providing for a long-term training advisor to the DOH's Office of Special Concerns, whose principal responsibility will be to assure progress is made in these three areas, should reinforce the reform efforts.

The presence of a favorable political environment provides a strong impetus for the Project to succeed. While it would not necessarily ensure sustainability after project resources are expended, this environment should build the foundation for sustained interest on FP activities at both the national and local levels. The interest and momentum of activities could only be reversed if a pro-natalist government succeeds the present administration. At the local level, however, the history of the Philippine Population Program has shown that, even during the period of "policy debate," the Outreach Program, although seriously hampered by logistics and political support, continued. Under a different political setting, the devolution of health services, and the growing recognition by local government executives of the importance of family planning, there is a unique opportunity to revitalize, develop and expand FP programs at the local level. Part of the special assistance programmed under this project is a short-term intervention designed to help LGUs set in place the basic institutional capacities, human resources and management systems needed for expanding FP services. After a few years of special assistance, the LGUs should be in a better position to sustain their expanded family planning programs.

Activities to strengthen the non-governmental organizations (NGOs) will complement efforts of the LGUs in expanding their FP programs. Under the FPAP, the NGO Strengthening Project has become one of the strongest resources of the USAID Mission's family planning package. The present Project will build on these strengths by expanding the programs to non-FP NGOs, transferring the NGO training component to the NGO Strengthening Project, and directing substantial resources (IECM and services) to the participating LGUs in the LGU Assistance Program. Since the NGOs were not dependent on the FPAP for their existence, they have continued to use their family planning capabilities and creativity to sustain their services. The same conditions will ensure that FP activities will continue after the present project has ended. Moreover, a major favorable factor is the emphasis on sustainability. Participating NGOs will secure payment for FP services from users or their employers under the industrial component. The NGOs are conscious that cost recovery and the internalization of demand will ensure long-term sustainability of the Project.

Table 1
SIMULATION RESULTS FROM THE PDP MODEL
(with exogenous population growth)

Year	Per capita GNP			"Full Time" Unemployment Rate		
	High	Medium	Low	High	Medium	Low
0	100.0	100.0	100.0	100.0	100.0	100.0
5	112.9	116.1	118.1	82.8	81.9	81.7
10	134.9	143.4	149.7	78.1	75.3	74.5
15	162.5	177.7	192.7	73.8	69.2	66.9
20	200.2	225.0	252.6	70.5	63.6	58.3
25	247.5	286.6	326.1	68.8	59.5	50.0
30	303.0	360.8	409.8	68.8	56.5	42.4

Year	Total Saving per Capita			Total Investment per Worker		
	High	Medium	Low	High	Medium	Low
0	100.0	100.0	100.0	100.0	100.0	100.0
5	171.3	199.6	209.6	120.2	145.0	153.3
10	261.8	302.0	331.1	200.6	231.8	249.2
15	325.5	388.8	455.8	254.0	299.4	336.5
20	412.4	514.3	629.1	321.3	388.2	444.4
25	519.5	684.5	823.9	397.0	497.4	553.0
30	643.0	890.0	1014.3	474.7	617.1	645.2

Note: "High" refers to a slow fertility decline where the net reproduction rate (NRR) does not reach unity until the year 2020; "medium" is for a moderate fertility decline where the NRR reaches unity by 2010; and "low" is for a rapid fertility decline where NRR equals unity by the year 2000. See text for further discussion.

Source: Aniceto C. Orbeta, Jr., "Policy Implications of Alternative Demographic Scenarios," Policy Paper Series, PDPR Project, NEDA (1989).

Table 2
SIMULATION RESULTS FROM THE PDP MODEL
(with economic-demographic interactions)

Year	Per capita GNP			"Full Time" Unemployment Rate		
	Base Case	MGFR Adjusted	pct diff.	Base Case	MGFR Adjusted	pct diff.
0	100.0	100.0	0.0%	100.0	100.0	0.0%
5	116.5	116.7	0.2%	81.3	81.4	0.1%
10	142.7	145.2	1.8%	69.4	69.4	0.0%
15	175.0	182.2	4.1%	60.1	59.8	-0.6%
20	219.3	234.6	7.0%	51.9	51.0	-1.7%
25	273.7	300.8	9.9%	44.0	39.9	-9.5%
30	331.2	374.1	12.9%	36.9	29.1	-21.0%

Year	Total Saving per Capita			Total Investment per Worker		
	Base Case	MGFR Adjusted	pct diff.	Base Case	MGFR Adjusted	pct diff.
0	100.0	100.0	0.0%	100.0	100.0	0.0%
5	204.8	206.8	1.0%	152.3	153.9	1.0%
10	301.2	314.3	4.4%	229.7	238.2	3.7%
15	384.5	419.9	9.2%	292.9	314.0	7.2%
20	506.4	582.5	15.0%	379.3	423.0	11.5%
25	646.6	764.1	18.2%	471.3	530.4	12.6%
30	762.2	933.1	22.4%	540.8	619.7	14.6%

Note: The "base case" considers childbearing decisions as endogenous; "MGFR Adjusted" refers to the effects of a reduction in the marital general fertility rate of 20 per thousand married women.

Source: Aniceto C. Orbeta, Jr., "Policy Implications of Alternative Demographic Scenarios," Policy Paper Series, PDPR Project, NEDA (1989).

Table 3
 ANNUAL FLOW OF PROJECT COST,
 AT CONSTANT PRICES OF 1993
 (In thousands)

	FY95	FY96	FY97	FY98	FY99
In current US dollars					
Foreign Exchange	20,838	21,276	24,525	23,606	16,630
Local Currency	4,622	4,622	4,624	4,628	4,629
In current RP pesos					
Foreign Exchange	604,302	617,004	711,225	684,574	482,270
Local Currency	134,038	134,038	134,096	134,212	134,241
In constant 1993 pesos					
Foreign Exchange	569,613	564,646	631,914	590,520	403,894
Local Currency	119,296	113,077	107,739	102,697	97,828
TOTAL	688,909	677,723	739,653	693,217	501,721
Equivalent Annual Cost at 15%					
	669,311	669,311	669,311	669,311	669,311

Table 4
ANNUAL FLOW OF FISCAL SAVING PER BIRTH AVERTED
(In pesos at 1993 constant prices)

Age	Prob. of Survival	Educ. Cost per Pupil		Health Exp. on Child		Net Benefit Flow
		Unadjusted	Adjusted	Unadjusted	Adjusted	
0	0.9341			200	187	(399)
1	0.9173			200	183	183
2	0.9030			200	181	181
3	0.8912			200	178	178
4	0.8815			200	176	176
5	0.8765			200	175	175
6	0.8715			200	174	174
7	0.8667	2,078	1,801	200	173	1,974
8	0.8619	2,078	1,791	200	172	1,963
9	0.8571	2,078	1,781	200	171	1,952
10	0.8525	2,078	1,771			1,771
11	0.8474	2,078	1,761			1,761
12	0.8418	2,078	1,749			1,749
13	0.8360	4,203	2,284			2,284
14	0.8299	4,203	2,267			2,267
15	0.8228	4,203	2,248			2,248
16	0.8152	4,203	2,227			2,227
17	0.8072	4,203	2,205			2,205

Present Value at						
	15%		4,323		1,034	4,771
	20%		3,287		860	4,147
Benefit-Cost Ratio at						
	15%		7.4		1.8	8.2
	20%		5.6		1.5	7.1
Internal Rate of Return						
			40.2%		43.2%	66.2%

Notes:

1. Project cost is P585 per birth averted.
2. Survival probabilities are from Flieger and Cabigon (1993).
3. See text for assumptions on public expenditures on education and health.
4. The net benefit flow is the sum of adjusted education and health cost saving, less the Project cost per birth averted for year 0.

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I. Introduction

The Philippine population/family planning program has had a checkered history. Launched in 1970 under the administration of President Marcos, it had everything going for it - political will from the President and the Congress, funding from the government and foreign donors, a development vision, a dynamic organizational structure, an extensive network of service providers and information workers, highly literate Filipino women. The program was bound for success. Instead, after peaking in the early '80s, the program lost steam and started to founder. It reached an all-time low in the late '80s under the Aquino administration when program funding had dwindled and political support became almost nonexistent as a result of the active opposition of the Catholic Church.

Today, family planning remains a highly controversial program as the Catholic Church continues to actively oppose what it calls the program's "contraceptive mentality." As portrayed in the mass media, the on-going population and family planning debate pits the Ramos government against the Catholic Church. But the current debate is different from past controversies. And the difference has been articulated by no less than President Ramos himself: "In the past ... the national tendency was to run away from the argument. And the result was invariably to reduce our previous family planning program into a muddle - while our population growth meantime went galloping on. We are here today to ensure that the same fate does not overtake us... We seek to present the facts and the merits of the program so that our people can make their own personal and intelligent decisions. We will strive by this to dialogue with everyone - including those who oppose the program."

The government under President Ramos is firmly committed to the vigorous implementation of the family planning program. In no uncertain terms, the President said during the launching of the national communication campaign of the family planning program in August 1993, "The challenge before us now is to bring this program from the plane of discussion to the plane of action. We must bring it to the homes and the communities ... There is no time to waste. The hour is late. This program was needed yesterday."

Deriving support from the President, Secretary Juan Flavio of the Department of Health - the agency mandated to implement the family planning program - has made family planning one of his top priorities. In his high-profile advocacy of the program, Secretary Flavio has earned the opprobrium of the Catholic Church. He nevertheless continues to be the most popular member of the Ramos cabinet. Various opinion poll surveys give him consistently high

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approval ratings.

It is the thesis of this Social Soundness Analysis that President Ramos and Secretary Flavio have correctly diagnosed the situation. This analysis will further argue that a population/ family planning program is not only imperative; it is also socially sound and acceptable to the majority of the Filipino people.

2. The Context of the Population/Family Planning Program in the Philippines

A. The Demographic Context

The Philippine population was placed at 60.5 million in 1990, an increase of more than 12 million over the 1980 population. The 1990 annual growth rate was estimated at 2.4 percent. This means that more than one million new Filipinos are added to the population each year. The Philippine population is the 14th largest in the world today.

The crude birth rate, according to the preliminary estimates of the 1993 Demographic and Health Survey (DHS), is 29.7, which is still high compared with those of Thailand and Indonesia. The crude death rate is already low at seven and cannot go much lower. Thus, a wide gap exists between the crude birth rate and the crude death rate, which results in the high growth rate.

The life expectancy at birth of Filipinos has improved. Female life expectancy increased from 59 years in 1970 to 66 in 1990; male life expectancy increased from 56 to 62 in the same period.

Women constitute almost half of the total population. Of the 30.1 women enumerated in the 1990 census, slightly more than 15 million belonged to the 15-49 reproductive age group, comprising 25 percent of the total Philippine population. More than 8.6 million or 57.6 percent of these women were currently married. About 5.8 million or 39 percent were single.

The Philippines is fast urbanizing. In 1980, urban dwellers composed only 37 percent of the total population. By 1990, they already composed 48.6 percent of the population.

Rural women of all ages comprised 51 percent of all women population. But among women 15-49 years of age, 53 percent were based in the urban areas while 47 percent were rural women.

With a mean age at marriage of 24 years, Filipino women are giving birth to fewer children. The preliminary data from the DHS show that the total fertility rate (TFR) is now 4.09, down from 4.51 in 1983 and 5.92 in 1973. Rural women tend to have higher TFR: 4.82 as against 3.53 of urban women. The TFR of urban women already

approximates the ideal number of 3.5 children as expressed by currently married women.

B. The Socio-Cultural Context

The Philippine population is highly literate. The 1990 census placed the literacy rate for all population at 94 percent and female literacy at 93 percent. The literacy rate of women 15-49 years old was 96 percent, with a slight disparity between urban literacy (98 percent) and rural literacy (93 percent). The lowest literacy rate for women were registered in Sulu (57.4 percent), Basilan (62.6 percent), Maguindanao (65.6 percent), Ifugao (75.8 percent), Mountain Province (77.1 percent) and Tawi-Tawi (77.8 percent) - provinces which are predominantly Muslim or mountainous provinces with cultural communities.

Though Filipino women are as literate as the men, their employment status differs considerably. Only 34 percent of women 15-49 years old were employed in 1990, as against 72 percent of the males in the same age groups. About 61 percent of women were outside the labor force as against 24 percent among the males.

Among women 15-44 years old, the vast majority (65 percent) are engaged in non-gainful occupations (a lot of housewives whose work in and outside the home is not being paid). The next highest group of working women (8.8 percent) is categorized as engaged in elementary occupations. Only 3.4 percent are professionals and 2 percent are in the managerial, supervisory category.

The employment status of Filipino women as described above is a reflection of the economic status of the country. The Philippines continues to have high levels of poverty. More than half of Filipino families live below the poverty line.

Nevertheless, despite the high poverty incidence, there have been some modest improvements in the health status of children. The infant mortality rate declined from 63/1000 births in 1980 to 61/1000 in 1990. Child mortality rate declined from 6/1000 in 1980 to 5/1000 in 1990. Severe and moderate malnutrition among preschool children declined from 18 percent in 1987 to 14 percent in 1990.

3. The Social Acceptability of Family Planning

The various demographic and contraceptive surveys conducted locally have consistently shown almost universal awareness by Filipino women of reproductive age about the family planning program and the various contraceptive methods. Attitude towards family planning have also been consistently favorable. However, contraceptive practice has been something else. There has always been a wide gap

between wanting to practice family planning and actually practicing family planning.

The trend in overall contraceptive prevalence rate (CPR) has fluctuated, particularly during the '80s. The trend in the CPR for modern methods shows a consistent though by no means steady increase. The CPR data from various demographic and contraceptive surveys are as follows:

	CPR (%) (All Methods)	CPR (%) (Modern Methods)
1968:	16	2
1973:	24	11
1978:	37	12
1983:	32	18
1986:	45	20.4
1988:	36	20.6
1993:	40	24.9

The preliminary results of the DHS reveal the following reproductive and fertility behavior of married Filipino women in 1993:

Currently using:	<u>40.0%</u>
Modern methods:	24.9%
Traditional methods:	15.1%
Not currently using:	<u>60.0%</u>
Unmet need:	<u>36.3%</u>
Spacing:	14.5%
Limiting:	21.8%
Want no more children:	<u>50.6%</u>
Want after two years:	<u>18.7%</u>

In other words, more than six million married women are currently using some form of contraception, with almost four million of them using modern methods. More than nine million married women are not currently using contraceptives. Of these non-practicing women, more than 5.5 million have an unmet need for family planning, with more than three million wanting to limit and more than two million wanting to space. More than 7.5 million want no more children while about three million want to have a children after two years.

All these numbers, particularly the unmet need, point to the fact that family planning is not only necessary but is also desired by

those for whom it is primarily intended. The lower percentage of women using modern methods is not due to the unacceptability of contraception. The reasons may be traced to certain gaps in program implementation, such as:

- 1) lack of trained service providers;
- 2) lack of a reliable supply of contraceptives;
- 3) inadequate services;
- 4) lack of contraceptive choices and family planning information;
- 5) lack of information on existing service centers;
- 6) inaccessible service centers;
- 7) lack of proper counseling by service providers to counter clients' fear of side effects.

Male knowledge, attitudes toward and practice of family planning have not been sufficiently studied. One of the few studies was done in 1992 to establish baseline information on condom use in connection with the Contraceptive Social Marketing Project, one of the major activities under the Family Planning Assistance Project. This study, which randomly sampled 600 males in Metro Manila and in the cities of Cebu and Davao, reported that majority of the respondents had a positive attitude towards condoms. About 83 percent of them perceived the product as an effective method of contraception. Another study, conducted in 1991 for the Johns Hopkins University and the DOH involving 3,200 respondents (both males and females 16 to 45 years old, both single and married) reported that while 69 percent strongly approved of family planning, only 4 percent strongly disapproved; while 21 percent moderately approved, only 4 percent moderately disapproved.

Nevertheless, despite the paucity of research studies on male family planning knowledge, attitude and practice (KAP), it can be safely assumed that the Filipino woman's family planning KAP is a reflection of that of her husband's. Family planning in the Philippine context is very much a joint decision-making process involving the couple. As the 1992 midterm evaluation of the current project found out, "Men play an important part in reproductive decision making, with discussions between husband and wife a key factor in contraceptive adoption and continuation."

As to religion, service statistics and survey data reveal that it has never been an important factor in influencing decisions about contraception. Demographic and contraceptive surveys have consistently shown that religion does not significantly influence decisions by a woman or a couple to practice or not practice family planning. The 1993 DHS reports that Catholics account for 84 percent of all family planning acceptors and 83 percent of users of modern methods.

The most significant survey to explore the role of religion in the family planning behavior of the Filipinos was conducted in 1991 by the Social Weather Stations, Inc. Using a statistically representative nationwide sample of 1,200 voting age respondents, the survey found that "Filipinos do not feel strongly restricted from using family planning methods, either by the rules of their religion, by the teaching they received in school, or by the advice given by their physicians. Filipino interpretation of the teaching of their religion regarding family planning is actually more permissive than what the Catholic Church actually teaches."

In short, the Catholic bishops may continue to issue pastoral letters condemning the family planning program, but majority of the Filipinos will continue to believe in the importance and the need for a family planning program that offers a full range of legally and medically approved contraceptives, whether natural or artificial.

4. The Political Acceptability of Family Planning

This new bilateral project, which integrates family planning and maternal and child health, involves the local government units (LGUs) as program implementors. In response to the Local Government Code, which gives greater responsibility, authority and decision-making power to the LGUs, the project will be working directly with selected LGUs to develop and expand their capacity to provide family planning services to their constituents.

Questions therefore arise: Does it make sense for an LGU to implement the population/family planning program and thereby risk the ire of the Catholic Church and the Catholic voters? Is the program considered priority enough by the local chief executives to be included in the LGU's development program?

The Social Weather Station survey mentioned above was intended to determine whether there was any empirical basis to the fear of elected public officials that espousing family planning would risk their rejection by the electorate at the polls. The survey reported that about 80 percent of the respondents believed that candidates in the 1992 election should support the free choice by couples of a family planning method. Thus the survey concluded:

"In fact, Filipinos would like electoral candidates to support, rather than oppose, the freedom of couples to choose family planning methods; and

"In fact, and contrary to the stereotype, elected political officials who are perceived by the public as being anti-

family planning run a grave risk of NOT being reelected to their posts."

Early in 1993, the Commission on Population (POPCOM) did a nationwide study which analyzed, among other things, the extent of support and commitment by the recently elected local chief executives (provincial governors and city mayors) to the population program. The study reported that 60 percent of the governors and 68 percent of the city mayors had high commitment; 30 percent of the governors and 25 percent of the city mayors had medium commitment; and 11 percent of the governors and 7 percent of the city mayors had low commitment.

These findings are consistent with the findings of a 1992 study on local institutions for the family planning program. According to this study, 79 percent of the provinces have retained their provincial population offices while 85 percent of the cities have retained their city population offices.

At the national level, a survey conducted after the 1992 election among legislators of both houses of Congress, with 91 percent of the legislators responding, revealed the following findings:

- 98 percent of respondents believed that rapid population growth was related to development and 91 percent believed it to be serious problem;
- 90 percent of 199 respondents said they were in favor of a family planning program while only 4 percent were not in favor;
- 85 percent of 199 respondents said they were in favor of a family planning program that offered both natural and artificial methods while 10 percent said they were not in favor.

Legislators who have expressed support for family planning are in the majority in both chambers of Congress, although it must be admitted that the minority legislators who oppose the program have so far been effective in blocking initiatives to strengthen the family planning program.

These empirical studies go against the common belief that politicians are wary of supporting the family planning program for fear of their political careers. These studies are unanimous in their finding: being pro-family planning makes good political sense.

5. Spread Effects of Family Planning

Family planning is no longer an innovation in the Philippines. After more than two decades as a national program, family planning has become an inescapable part of the social landscape, even if only 40 percent are currently practicing it. As reported by Project Platypus, a research study commissioned by the Johns Hopkins University/Population Communication Services and the DOH, "Education and other institutional efforts over the years to sell family planning have succeeded as far as making couples realize and understand that it is the most sensible option for any couple." But as the same study further stated, "there seems still to be a great divide between accepting the idea intellectually and carrying it out in their own lives."

Thus, the main challenge of the Philippine Family Planning Program and by extension, this Project, is how to narrow down this "great divide," how to diffuse and spread the practice of family planning beyond the 24.9 percent current users of modern methods.

This Project will be national in scope, i.e., certain family planning inputs - contraceptives and IEC materials, for instance - will be made available to all the family planning service outlets all over the country. However, a group of the most populous LGUs, with strongly supportive local officials, will be selected for special assistance under this Project. In these select LGUs, the family planning inputs will be much more intensive - priority in training activities, more technical assistance in population planning and advocacy, equipment support, etc.

The preliminary DHS data show that the largest areas - regions like Southern Tagalog, the National Capital Region, Central Luzon, Western Visayas and Southern Mindanao - have the most number of family planning users of both modern and traditional methods. These areas also have the most number of non-users. Thus, by concentrating program inputs in the largest LGUs in these areas, as well as in other demographically big LGUs in the other regions, the chances for program success would be much greater.

To succeed however, the Philippine Family Planning Program should ensure two things: maintain the continuing users and respond to the unmet need for family planning.

Through the years, program emphasis has been on the recruitment of new acceptors to the neglect of the continuing users. Program planners and implementors should instead ensure that those who are already in the program are sufficiently followed-up and provided with post-acceptance quality care so that their decision to use contraception is reinforced and dropping out is minimized. As for the unmet need, according to the DHS, 21.8 percent of married women want to limit births and 14.5 percent want to space

births. It is important for program planners and implementors to identify who and where these women are.

Further analysis of the DHS data would give us a profile of the married women with unmet need. Among those wanting to limit, the highest number of these women belong to the 40-44 age group, followed by women in the 35-39 age group. These women also belong to one of the high-risk groups, i.e., women 35 years old and above. Even younger women, i.e., those in the 30-34 age group, have already unmet need for limiting childbirths (18.6 percent of them). In terms of geographic area, women in the two most depressed regions - Eastern Visayas and Bicol - have some of the highest unmet need for limiting. Women in Southern Tagalog have also very high unmet need for limiting. In terms of education, women with only primary education have the highest unmet need for limiting.

Women with unmet need for spacing generally belong to the under-30 age group. Married women in their teens have the greatest need for spacing though their number is not very large. Married women in their 20s constitute more than half of all women wanting to space. These women tend to be more in the rural areas - especially in the Mindanao regions, in Western Visayas and in Ilocos. The majority of them (about 72 percent) have had primary and secondary education.

These two large groups of women have already expressed their desire to limit childbearing. It is up to the health professionals to assist them to find the family planning method that best meets their expressed needs. By maintaining current users to ensure higher continuation rates and by motivating those with unmet need to practice family planning, the CPR will definitely increase.

One way of achieving this is to include Filipino men among the important target groups of the program, if not as contraceptive users themselves then as supporters of their wives' decision to practice family planning. The Project needs to think of various studies to reach the men such as through the military, the police, industry, employment associations (jeepney and tricycle drivers), farmers' cooperatives.

Crucial to the increase in the CPR is a more responsive and comprehensive information/education/communication/motivation (IECM) strategy. The IECM component under this project is right on track by recognizing the importance of ICS training and making it top priority. ICS training is expected to improve the skills of service providers and other family planning workers in communicating with the clients. These skills are especially needed to allay clients' fear of side effects, which, research studies have shown, is the single biggest reason for non-use of contraception among those who have never used family planning and

for dropping out among those who have ever used a method. It is important that the IECM strategy at the interpersonal communication level be strengthened to address this pressing concern.

Training service providers and IEC workers on ICS is therefore a must. Service providers need to devote more time to counseling clients before contraceptive use starts. Once a client has accepted family planning, follow-up is necessary to enhance quality of contraceptive care.

Having an overall urban IECM strategy also makes a lot of sense, considering that urban-based women of reproductive age are now more predominant than rural women of reproductive age. In this urban IECM strategy, television can play a crucial role in two aspects:

1. presenting scientific facts about the various program methods to counter rumors and misconceptions;
2. constantly reminding clients about the availability and accessibility of family planning service centers.

Using television to promote a controversial program like family planning invariably invites further controversy, as what happened before and during the launch of the National Communication Campaign in August 1993. But the television ad itself, because of its careful, factual and non-controversial presentation of the need for family planning, has not been the object of controversy. There is a lesson to be learned here in implementing the urban IECM strategy.

An important element in an IECM strategy that should be considered is the role of the volunteers. In the Philippine Family Planning Program, the two most important volunteers are the Barangay Health Workers (BHWs) and the Barangay Service Point Officers (BSPOs).

The BHWs are attached to the Barangay Health Stations (BHS) of the devolved rural health units. They are multi-purpose volunteer workers, i.e., they assist the BHS midwife in promoting the various health programs of the government, including family planning.

The BSPOs are attached to the Provincial or City Population Offices. They are population/family planning volunteers; they refer new acceptors to the clinics and resupply continuing pill acceptors and give out condoms. During the peak of the program in the mid-80s, the BSPOs, by resupplying pill acceptors and motivating sterilization acceptors, were responsible to a large extent for the increase in the prevalence of modern methods.

Under IFPMHP, the BHWS and the BSPOs will be given updated training on the program. They need to be taught the skills in identifying the high-risk groups for referral to the clinics:

- those who have given birth less than two years before (17 percent of married women gave birth during the previous 12 months, according to the 1990 census);
- those who have had more than four live births (26 percent of all married women, according to the 1990 census);
- those younger than age 20 or older than 35 years old (46 percent of all married women, according to the 1990 census);
- those who are suffering from tuberculosis, goiter, high blood pressure, heart problems, etc. (data unavailable).

Both the BHWS and the BSPOs must be given the supply/resupply functions. Currently, many BHWS are not given condoms to supply and pills to resupply the clients, the reasoning being that contraceptives are best handled by medically trained personnel. This reasoning, which is applied at the implementing levels but is not DOH or program policy, severely curtails the accessibility of both pills and condoms. The DOH, as the agency in charge of setting policies and standards, should categorically spell out the supply/resupply functions of the BHWS and the BSPOs.

With a revitalized motivators' network backed up by mass media campaigns, it is expected that these demand generation activities will increase the number of clients seeking family planning services. For the clinic network to be able to cope with this increased demand, the Project will continue to strengthen the NGOs as well as other private sector organizations.

The existing national family planning NGOs will be assisted to expand their self-sustaining efforts through the franchising of midwives and nurses as service providers. This innovative cost-recovery scheme is basically intended for clients in the urban and semi-urban areas who can afford to pay for the services.

Family planning clinics will be established in nine small NGOs. And 41 NGOs and People's Organizations (POs) which have previously not been involved in family planning will be assisted in establishing their family planning activities (IEC and/or service delivery).

The Project will also continue to assist the Responsible Parenthood/Maternal and Child Health Program for the Industrial

Sector of the Philippine Center for Population and Development (PCPD). Expected to be served by this program are approximately 40 agro-industrial companies in Mindanao and four industrial complexes in Luzon and the Visayas, with a combined work force of 75,000 persons. To date, PCPD's program has reached out to 113 companies with a combined workforce of about 127,000.

Lastly, the Social Marketing Project will be expanded. This project is aimed at those clients who can afford to pay for contraceptives. Under FPAP, the condom and the pills were launched in 1992 and in 1993 respectively in three areas - Metro Manila, Davao and Cebu. The radio was the main mass medium used for marketing the products. Preliminary reports indicate very high product recall by the consumers of the products advertised. Thus far, sales of the two products are going up and no backlash from the conservative elements in the pilot areas have been reported.

The plan is for the Social Marketing Project to go national on TV next year. This is a strategy whose implementation will receive very careful planning considering the very high visibility of television.

Under the Social Marketing Project, DMPA will be launched in 1993 in the three cities via a radio campaign. The addition of DMPA as a program method will definitely increase CPR. Studies conducted by the Population Council show that the mere addition of a method to a national program will increase the percentage of contraceptive practice. Before it was taken out of the program in 1989, DMPA was already well-received by the clients. Making it available as a program method will be welcome by those with unmet need for spacing but who cannot tolerate the pills or the IUD.

All these strategies in the new Project are intended to diffuse the benefits of family planning and to translate the unmet need of our women into effective demand for family planning services.

6. Social Consequences and Benefit Incidence

If the Project succeeds, i.e., the millions of Filipino women who want and/or need family planning services are actually using modern methods of contraception, the effects on Philippine society will be manifold.

Asked what are the benefits of family planning, a typical Filipino survey respondent of reproductive age (whether male or female, single or married) would overwhelmingly cite improved economic status as the reason. This means that parents would find it easier to send their children to school and to save money for rainy days.

Another reason, though not as often cited, is that family planning allows family members more quality time for each other. Parents can monitor and supervise their children's development, and they can devote more time to each child.

A third reason would be improvement of mother's health.

These perceived benefits do have empirical bases. Studies done by economists, including those of the World Bank, have concluded that an effective family planning program can improve the socio-economic well-being of the poor. Which is not to say, as President Ramos has put it, "that the family planning program will by itself banish poverty and misery from our midst. Clearly, it is only one program among many that we must undertake. But it is an important part of the solution."

The health benefits of family planning, though not as appreciated as the economic benefits by most couples themselves, are in fact the most substantial, studies have shown.

Family planning saves the lives of infants, children and mothers. This claim is supported by statistics. The Philippine maternal mortality rate in the '80s was estimated at 100 per 100,000 live births. The leading cause, accounting for almost one-fourth of all deaths, was illegal and induced abortions. Other causes were hemorrhage, eclampsia, toxemia, hypertension and other complications during pregnancy and child birth. Thus, if couples have only the children they really want and practice family planning, then both the incidence of abortion and the number of maternal deaths would decline.

If women in the high-risk categories (i.e., those below 20 and above 35, with four or more children, with a baby younger than 15 months, and those suffering from illnesses) do not get pregnant, the effect on infant and child death would be dramatic. The infant and child mortality rates would decline by about 25 percent and the number of infants and children dying would be reduced by as much as 50 percent. It is no exaggeration to say that a successful family planning program could have a greater effect on mortality than other child survival interventions.

Well-spaced births result in healthier infants. They are more likely to have high birth-weight and be less vulnerable to illness. Their chances of surviving the critical first year of life are much greater. Not only the well-spaced infant but also the next older sibling is better off. Since the last childbirth is not followed so soon, the youngest child can be breastfed longer and thus, be better nourished. The child in turn is better able to withstand diarrhea attacks and respiratory infections, which are the common causes of infant and child deaths.

As the mortality rate declines, so would the fertility rate decline, if the program succeeds.

If the CPR increases due to higher continuation rates and effective family planning practice by those with unmet need and those in the high-risk groups, then the TFR of 4.09 would decline and go beyond the current reported "ideal number" of 3.5 children. Though this would certainly be a positive trend, both the TFR and the number of desired children need to be further reduced. This will in turn lead to the decline of the annual population growth rate from its 1990 level of 2.4 percent. If this happens, the Philippine population will not have to double in the year 2020 but at some later time. This would give the Philippines a breathing spell and time to accomplish other development objectives.

In a word, all evidence points to the fact that a successful Philippine Family Planning Program, with assistance from the IFPMH Project, will contribute meaningfully to the improvement of the quality of life of the Filipino people.

USAID/Philippines and R&D/POP reached agreement that IFPMHP would be jointly funded by the two organizations. USAID/Philippines will provide \$60 million in bilateral funding, while R&D/POP will provide \$50 million in funding for services, training and commodities through its centrally funded technical assistance projects. This agreement was confirmed by R&D/POP in May, 1993 (see attached correspondence). It is clearly essential that both parties hold to this arrangement for IFPMHP to provide the inputs required to capitalize on the current opportunity to accelerate the family planning program in the Philippines. Budget cutbacks will certainly jeopardize the progress that can be made over the coming years to slow the country's population growth and achieve the associated development results this will produce.

The National Economic and Development Authority (NEDA) will be the signatory for the Government of the Republic of the Philippines on the Project Grant Agreement to undertake the Integrated Family Planning Maternal Health Project. Public sector implementing agencies will be the Department of Health, POPCOM and selected Local Government Units (LGUs) participating in the LGU Assistance Program. Various Non-governmental Organizations (NGOs) involved with the provision of family planning services and information and the R&D/POP SOMARC project will implement private sector activities under IFPMHP.

The procedures by which USAID and the population grantees reach agreement on annual implementation plans and formalize their respective commitments, have proven to be functional during many years of USAID population assistance projects. This process will be continued under IFPMHP. The implementing agencies and USAID negotiate the details of the work to be undertaken each year, their respective budget commitments and the administrative procedures to be followed. These mutual understandings are made binding by the agencies' signatures on the annual implementation plans. The signed plans become a part of the annual Project Implementation Plan which is jointly signed by the DOH and USAID.

The DOH's Office for Special Concerns will have primary responsibility for representing the Department's interests and providing management direction for IFPMHP. This includes all aspects of IFPMHP and OSC will clear all financial and contractual documents involved with these activities. OSC currently has management responsibility for the National Programs and NGO/Private Sector components of IFPMHP. OSC will need to exercise similar administrative responsibility for the LGU Assistance Program that IFPMHP will support. OSC currently lacks adequate staff to perform this function; therefore, IFPMHP will provide technical assistance and contractual staff to enable OSC to meet its expanded responsibilities. The Office will also receive additional budget

resources (through the GOP's funding of the LGU Assistance Program and a budget line item for family planning expected in 1995 or 1996). Unlike past projects, an advance and reimbursement system will not be used. All project implementation costs will be covered through the cooperative agreements and contracts USAID will establish. USAID will use a cash transfer mechanism to support the policy and institutional reforms needed to establish a new relationship between the DOH and LGUs. The Department of Finance will use the dollars received to pay off USAID-approved foreign debt. The GOP will totally fund the LGU Assistance Program itself.

The contraceptives logistics system being developed under the current FPAP will be completed and institutionalized within the DOH during IFPMHP. A long-term advisory team will be provided through IFPMHP to assure that this nationwide distribution system for contraceptives is completed and sustained.

The technical aspects of IFPMHP will be managed by OSC's Family Planning and Maternal Child Health Services. They will receive assistance from IFPMHP's contract advisors team, including long-term Urban, Rural and Training advisors. Similarly, a long-term expatriate advisor will be funded to develop the IECM program during IFPMHP.

A U.S.-base NGO will be selected for a cooperative agreement to handle training, program support and self-financing assistance to NGOs. USAID will make a direct grant to PCPD to expand its industrial, in-plant program for family planning services. The R&D/POP SOMARC project will be used to expand the social marketing program to urban areas throughout the country.

USAID's Office of Population, Health and Nutrition (O/PHN) is the cognizant technical officer for IFPMHP. Its professional staff for administering the assistance consists of one U.S. Direct Hire Project Officer and two FSN staff who are experienced professionals in the population field. O/PHN also has full-time procurement and financial personnel who will assist the project officers. USAID's management of FPAP requires the full-time attention of O/PHN's professional staff. IFPMHP will more than double the level of assistance currently being provided and introduce a new project component. Therefore, an additional project manager will be funded through the project using R&D/POP's International Population Fellowship Program. External consultants will be used for project evaluations and audits.

ATTACHMENT TO ANNEX F-5: ADMINISTRATIVE ANALYSIS



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

May 7, 1993

Dr. Emmanuel Voulgaropoulos
Chief, Office of Population,
Health, and Nutrition
USAID/Philippines
APO AP 96440

Dear Dr. Voulgaropoulos:

The purpose of this letter is to confirm R&D/POP's endorsement and support for the draft Philippines Population Assistance Strategy which was presented during Secretary Flavier's April 26-28, 1993 visit and discussed with you during the week of May 3-7, 1993.

Following meetings with the Department of State, the Asia and R&D Bureaus of A.I.D., our understanding is that the draft strategy is well received and generally supported in A.I.D./Washington. Certainly, the R&D Bureau endorses the approach outlined in the Strategy.

As you know, A.I.D. will soon be receiving new leadership, and new organizational and budget proposals are being reviewed. Until these processes are complete, we cannot confidently provide firm commitments. However, we are optimistic that the population budget of A.I.D. for FY 1994 will be larger than FY 1993, and the Agency will be in a position to respond along the lines outlined in the Strategy. We are confident that expanded support will be available, but we cannot specify where (i.e. which Bureau or budget).

For planning purposes, as you approach project/program design, R&D/POP confirms, subject to the availability of funds, our support for planning along the lines outlined in Annexes I and II attached. That is, support over a five year period of around \$50 million from R&D/POP for Cooperating Agency inputs and bilateral support of around \$60 million for local costs. Obviously, we may mutually agree to increase or decrease this amount during the life of the project. But let me emphasize that we endorse planning for success, and you can depend on the Office of Population to help in any way we can to meet the challenges

outlined. If program performance meets expectations, we are confident that resources will follow.

With best wishes.

Sincerely,


Elizabeth S. Maguire
Acting Director
Office of Population

Enclosure

ANNEX F-6 EXAMINATION OF THE NATURE, SCOPE AND MAGNITUDE OF THE ENVIRONMENTAL IMPACT

A. DESCRIPTION OF THE PROGRAM:

The Integrated Family Planning Maternal Health Project (IFPMHP) continues and extends U.S. support to the Philippines Family Planning Program. The purpose of IFPMHP is to expand the availability of reproductive health services in public and private sectors and to increase use of those services by women in high-risk groups: women under 20 years of age; women over 35 years of age, women whose pregnancies have occurred less than twenty-four months apart and women who have had four or more pregnancies.

The project will finance technical assistance, commodities (mostly contraceptives), short-term and long-term training and audit/evaluation requirements. At this time, there is no construction anticipated. It is envisioned that training will include proper disposition of contraceptives.

B. RECOMMENDED ENVIRONMENTAL ACTION:

A categorical exclusion from A.I.D.'s Environmental Procedures is proposed in accordance with A.I.D. Regulation 16, Section 216.2(c) (2) (viii), which provides for such an exclusion for "programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water systems, waste water treatment, etc.)" The proposed project meets these criteria.

According to Section 216.2(e) of A.I.D. Regulation 16, the categorical exclusions under Section 216.2(c) (2) are not applicable to assistance for the procurement and use of pesticides. A.I.D. project funds will not be used for pesticide procurement under the IFPMHP.

INITIAL ENVIRONMENT EXAMINATION

(A) COUNTRY: Philippines
(B) ACTIVITY: Integrated Family Planning Maternal Health Project No. 492-0480
(C) TOTAL A.I.D. FUNDING: \$110,000,000
(D) LIFE OF PROJECT: FY 1994 - FY 1999
(E) STATEMENT PREPARED BY: B. Eileen Oldwine and Donald Masters
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ANNEX

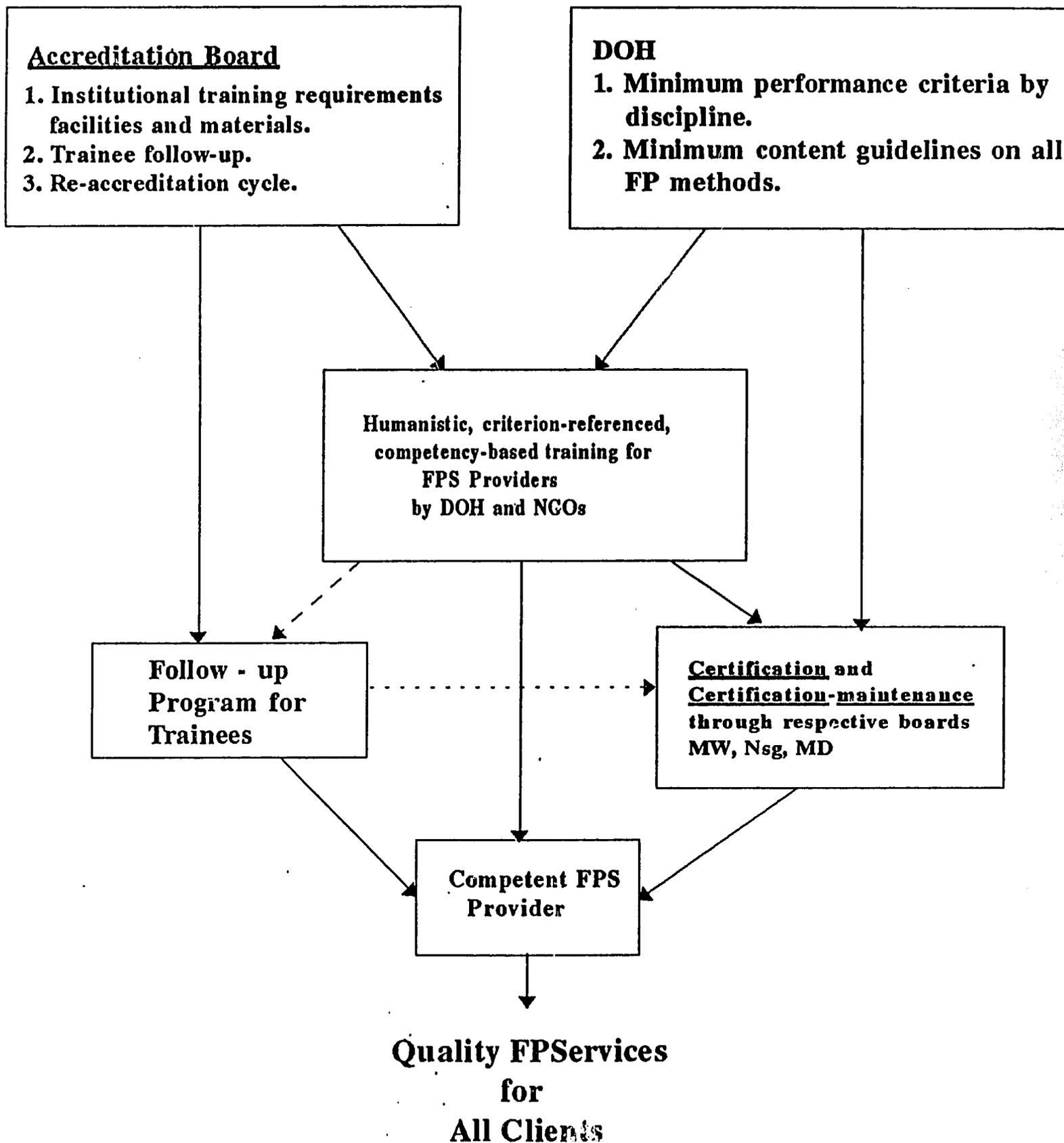
Training Need	Supporting Data	Proposed Strategy
<ul style="list-style-type: none"> Minimum Performance Criteria 	<p>1993 AMAR Research describes need.</p>	<p>Permanent 5–member DOH/FPS Training Team with Resident Training Advisor establish national FPS performance criteria.</p>
<ul style="list-style-type: none"> Guidelines on essential information about all FPS methods to be included in all FPS training programs. 	<p>Of all DOH hospital–based FP personnel 1/6 are active in FPS but limit services to VSC and IUD.</p> <p>NGO institutions focus FPS on the methods emphasized in their training.</p>	<p>DOH/FPS Training Team in collaboration with Resident Training Advisor delineates content guidelines for all FP methods to be included in all FPS training programs.</p> <p>Accreditation Board requires integration of content guidelines for all FP methods in training materials of accredited institutions.</p>
<ul style="list-style-type: none"> Refine training programs to essential training time. 	<p>Preliminary response to DOH/FPS Training evaluation indicates 15 IUD insertions not needed – suggests 5 only.</p> <p>DOH Training activities focus on related training issues during practicum due to insufficient IUD acceptors for trainees.</p> <p>FCC training experience shows competency–based training needs. 2–3 weeks only.</p>	<p>Implement humanistic training maximizing use of anatomical models and simulation reducing demand for new acceptors.</p> <p>Implement criterion–referenced, competency–based training focussing on skill development rather than numbers of clients.</p>
<ul style="list-style-type: none"> Accreditation of all FPS training institutions. 	<p>DOH/FPS Training currently implementing accrediting strategies, but unable to respond to other training issues concurrently.</p> <p>Other NGO's expressing awareness of need for effective accreditation system.</p>	<p>Accreditation Board established at UP–Manila under auspices of NTTC–HP</p> <p>Accreditation Board Membership</p> <ul style="list-style-type: none"> (1) Education/Training Specialist (2) FP technology specialist

Training Need	Supporting Data	Proposed Strategy
		<p>(3) Rotating position for MD, RN, MW as applicable for type of review</p> <p>(4) Rotating position for DOH/POPCOM as indicated for materials review</p> <p>Accreditation Board develops institutional training requirements in collaboration with Resident Training Advisor.</p>
<ul style="list-style-type: none"> Apply consistent accreditation standard to all FP training 		<p>Accreditation Board is housed in separate center and members do not engage in FP training or development of training materials for FPS.</p>
<ul style="list-style-type: none"> Humanistic, criterion-referenced competency-based training programs. 	<p>FCC the only NGO currently using competency based FPS training.</p> <p>Philippine Colleges of Nursing have been using competency-based BSN curricula since 1984.</p>	<p>National level workshop for DOH/FPS Team and all NGO's involved in FPS training on design and implementation of humanistic, criterion-referenced, competency-based training using local expert from UP (NTTC-HP)</p>
<ul style="list-style-type: none"> Focus training on competency in FPS rather than number of procedures. 	<p>FCC training in competency-based programs verifies effectiveness and reduces training time to 2-3 weeks.</p>	<p>Reduce training time and costs through use of competency-based accredited courses.</p>
<ul style="list-style-type: none"> Long-term follow-up program for previous trainees. 	<p>DOH circulates informational updates to past trainees.</p> <p>Selected NGO's planning retraining effort.</p>	<p>DOH/FPS Training Team as well as NGO Trainers establish long-term follow-up program for trainees (including informational and skill updates).</p> <p>Accreditation Board requires documentation of follow-up program as part of institutional accreditation.</p>

Training Need	Supporting Data	Proposed Strategy
<ul style="list-style-type: none">• Certification Maintenance Program for all FPS providers	<p>Record systems exist for licensure through respective Boards</p> <p>Boards of MD, RN, MW have been involved in previous FPS certification efforts</p>	<p>Boards of Medicine, Nursing and Midwifery design and implement certification maintenance system for respective disciplines based on:</p> <ol style="list-style-type: none">1. Attainment of minimum performance criteria in training2. Participation in follow-up training program3. Documentation of #1 and #2 from an Accredited Training institution.
<ul style="list-style-type: none">• Clarify certification requirements by discipline.	<p>Certification requirements exist.</p> <p>CEU requirements exist for relicensure</p>	<p>Modify certification requirements to focus on attainment of competent skills as appropriate to each discipline.</p> <p>Implement discipline specific certification maintenance system requiring FPS provider to demonstrate on-going training through:</p> <ul style="list-style-type: none">• CEU activity in FP• independent study in FP (documented by paper or test)• update training or (diploma/certificate)• other.

Other Training Needs	Supporting Data	Proposed Strategy
<ul style="list-style-type: none">• Expansion of logistics system and related training	JSI has designed and implemented an effective delivery system for FPS supplies.	Continue support of system through JSI/CARE including training for newly added drugs and training for attrition.
<ul style="list-style-type: none">• Social Communications training initiatives.	PCS/JHU has actively analyzed IEC needs	Support PCS/JHU training efforts in <ul style="list-style-type: none">- community outreach for adolescents- Program Planning Training- Advocacy training
<ul style="list-style-type: none">• Provide FPS training programs to new nursing & midwifery graduates• Support pilot programs for fellowships in social science disciplines to develop future leaders in FPS	DOH and NGOS's have training materials that can be adapted by Schools of Midwifery and Colleges of Nursing Selected Colleges of Nursing are exploring possibilities for Nurse Practitioner Programs in Reproductive Health Selected universities are proposing fellowships in social sciences focussing on FPS	Support initiative to implement accredited training programs at preservice educational institutions. Support pilot initiative to implement FP fellowship in social sciences.

DIAGRAM 1



1. Indicators**- Contraceptive Prevalence Rate (CPR) and Method Mix**

The CPR is defined as the proportion of married women of reproductive age (15-49) who use some form of contraception. The CPR is generally broken down by contraceptive method, yielding method mix. Program (modern) methods include pills, condoms, IUDs, tubal ligations, vasectomies, and injectibles. Non-program methods include rhythm, abstinence and withdrawal.

The CPR is a very direct measure of the effectiveness of the IFPMHP in promoting the use of family planning. The CPR, especially for modern methods, is expected to rise steadily over time. The experience of other countries with successful family planning programs, such as Thailand and Indonesia, has shown that a two percent increase in CPR per year is possible over a decade or so. Given that the current CPR for the Philippines is so low (25% for modern methods), an even faster increase is expected.

Method mix refers to the percentage distribution of contraceptive users by method. Changes in method mix over time suggest future trends and allow the forecasting of commodity needs and IECM thrusts.

Baseline figures for CPR and method mix are available from the 1993 DHS. The DHS will be repeated in 1998. In the intervening years, CPR will be measured annually by way of population-based surveys conducted by the NSO.

- Total Fertility Rate (TFR)

The TFR is defined as the number of children that would be born per 1000 women if they were to pass through the child-bearing years bearing children according to a current schedule of age-specific fertility rates. The age-specific fertility rate is defined as the number of births per 1000 women of a given age occurring during a given year.

The TFR is a widely-used indicator to evaluate the impact of family planning programs throughout the world. It allows for easy international comparisons. The TFR in the Philippines has been declining over the last two decades and stands at 4.01 as of 1990. The IFPMHP is expected to cause the TFR to decrease further. The TFR is related to the rate of population growth; a decrease in TFR generally means a decrease in the growth rate, although the latter is also affected by mortality rates and changes in age structure.

The TFR can be derived from vital statistics (births) and census data (population of women).

TFR generally changes slowly; annual changes are generally too small to measure with statistical accuracy. TFR is therefore best measured at longer intervals. Baseline data is available from vital statistics applied to the 1990 Census of Population and Housing. The TFR will be recomputed in 1994 and 1998.

- **Unmet Need for Family Planning**

Unmet need for family planning is defined as the number or proportion of fecund women currently married or in union who desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method. Unmet need therefore consists of two components: the need for limiting and need for spacing.

This indicator may be interpreted as the number of additional women that would be using contraception if all women at risk of pregnancy and desiring to terminate or postpone childbearing were to adopt contraception.

Unmet need is best measured at intervals of several years. Annual estimates of unmet need are unreliable because of short term fluctuations in the fertility rate (pregnant women have no unmet need). Furthermore, unmet need may actually increase in the short term as a result of a successful IECM campaign. More women may desire smaller families without yet having adopted contraception. By definition, this would create unmet need. In the longer term, however, successful service delivery will decrease the level of unmet need.

Baseline figures for unmet need are available from the 1993 DHS. Unmet need will be measured at the end of the project by way of the 1998 DHS. The NSO can continue to conduct compatible surveys at five year intervals to measure unmet need over the longer term.

- **Proportion of high risk births**

High risk births are defined as births which meet one or more of the following four criteria: (1) the age of the mother at birth of the child is less than 18, (2) the age of the mother at birth of the child is greater than 35, (3) the parity of the birth is four or higher, and (4) the interval from birth of the previous child is less than two years.

The proportion of high risk births, that is, the percentage of total births which are defined as high risk, is expected to decline.

This indicator can be measured annually from vital statistics records. In addition the DHS can provide this information in 1993 (baseline) and in 1998.

- Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR)

The IMR is defined as the proportion of infant births (usually per 1000) which result in the death of the child within the first year of life. The MMR is defined as the proportion of women who die as a result of childbearing.

Both the IMR and the MMR will decline as the proportion of high risk births decreases.

The IMR and MMR can be measured annually from vital statistics. The IMR can additionally be calculated from the DHS.

- **Acceptor levels**

Acceptor levels are service delivery measures which refer to the number of people who use modern contraceptive methods in a given year. New users are defined as people using a modern method for the first time during the year. Continuing users are defined as people who have continued to use a modern method throughout the year. The discontinuation rate is the proportion of people who were using a modern method at the beginning of the year, but not at the end of the year.

The number of new users measures the success of the IFPMHP to attract new clients. This is expected to increase. An increase in new users is related to reduced unmet need and increased CPR.

The number of continuing users and the discontinuation rate measure the effectiveness of IFPMHP services in enabling clients to sustain contraceptive use. The number of continuing users is expected to increase, while the discontinuation rate is expected to decrease.

Statistics on new users, continuing users and discontinuation rates, broken down by method will be available from the LGU and NGO management information systems. These statistics will not attempt to explicitly count every client, but rather represent a national sample.

- **User characteristics**

User characteristics provide a socio-demographic profile of current users of contraceptive methods. The specific user characteristics which will be measured by the IFPMHP are urban/rural residence, educational level, income level, employment status and source of contraceptive supply.

These indicators will measure the effectiveness of the urban thrust of the IFPMHP. They are useful in targeting the IECM campaign. A shift in source of contraceptive supply among users with higher income levels toward the private sector implies an increase in the sustainability of the family planning program. It is expected that those who can afford to pay for contraceptives will do so, while those who cannot will avail of contraceptives from the public sector.

The 1993 and 1998 DHS surveys provide baseline data on these user characteristics. Population-based surveys conducted by the NSO will provide user characteristics annually on a nationwide basis.

- **Supply of pills and condoms to service delivery points**

The number of cycles of pills and condoms delivered to service delivery points through the DOH/CARE system will be tracked on a quarterly basis through the CDLMIS.

These supply statistics provide an alternate way of measuring levels of consumption of these commodities. Even allowing for pipeline wastage, valuable trend data will emerge.

The number of pill cycles and condoms delivered to service delivery points will increase over time, as user levels climb.

- **Frequency of stock-outs**

The frequency of stock-outs is defined as the percentage of service delivery points that encountered a stock-out of pills or condoms within a given year. This indicator provides a measure of the extent to which service delivery points have been unable to serve clients due to inadequate supplies.

The DOH/CARE logistics delivery system records whether a stock-out has occurred at any given service delivery point within the most recent three months. This means that each service delivery point is automatically checked for a stock-out condition four times each year. In addition, "flash-point orders" resulting from stock-outs can be made from any service delivery point at any time. This information is tracked by the CDLMIS. The frequency of stock-outs will decrease as the logistics system becomes more efficient.

- **Private sector sales figures**

Sales figures from the SOMARC project and from Philippine pharmaceutical industry reports will measure pill and condom usage through private sector outlets.

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Private sector sales figures indicate the effectiveness of the social marketing component of the IFPMHP. A successful social marketing program will result in increased sales.

The following table summarizes the uses of the preceding indicators, their expected direction of change over the course of IFPMHP, data sources, frequency of reporting and estimated reliability.

2. Data Sources

The following data sources and institutions will be utilized to produce the statistical indicators defined above.

- Demographic Health Surveys (DHS)

The 1993 DHS, conducted by the NSO with technical assistance from IRD/Macro, provides a wealth of baseline data. Indicators such as CPR, unmet need and high risk births are available. The questionnaire is complex and detailed. Therefore, a large number of other supporting statistical measures can be derived, including attitudinal data, knowledge of methods and sources, and women's and children's health status. The DHS will be repeated in 1998, again with the assistance of IRD/Macro. The NSO can then conduct compatible surveys at subsequent five year intervals in order to continue to make detailed measurements over the long term.

- Population-based Surveys

In 1995 the NSO will conduct the Integrated Survey of Households (ISH). This is essentially a listing operation conducted every two years for the purpose of updating the household sample frame. Approximately one million households are surveyed nationally during the ISH. This is obviously a huge undertaking (about 9% of all households in the Philippines) requiring that a bare minimum of information be collected. Therefore, only CPR and method mix will be obtained. The very large sample size guarantees that these indicators will be statistically reliable at the provincial level. The ISH will be repeated in 1997.

The Labor Force Survey (LFS) is conducted quarterly by the NSO for the purpose of computing the unemployment rate, among other things. During one quarter of each year the NSO will attach a rider (additional set of questions) to the LFS. The rider will contain questions from which CPR, method mix, and source of contraceptive supply can be determined. In addition, user characteristics will be available. These include urban/rural residence, educational level, income level and employment status. The sample size of the LFS is comparable to that of the DHS, meaning that statistically valid figures will be produced for the larger provinces.

- **Vital Statistics**

Vital statistics are a valuable source of data from which TFR, high-risk births, infant mortality and maternal mortality can be measured.

Unfortunately, vital statistics summary data are neither timely nor accurate. Births and deaths are recorded at Civil Registries throughout the Philippines. Philippine law requires that all birth and death certificates be submitted to the central office of the NSO. The NSO central office is currently overburdened by its mandate to collect and maintain these forms and make copies available to the public. Although there is a computerized system in place at the central office to produce tabulations based on these forms, it is antiquated and ineffective. The backlog of forms to be entered into this computerized system currently stands at two years.

The NSO plans to decentralize processing of vital statistics to alleviate these problems. The provincial offices are already forging links with the local civil registries in anticipation of computerizing the data locally. Timely data would then be available at the local level and national reports could then be produced by consolidating the provincial data. Support for this effort under the IFPMHP will greatly accelerate this process. A system which will allow the production of annual high-risk birth, IMR and MMR will be in place by 1995. Vital statistics data will be used in 1998 to compute the TFR.

- **CDLMIS**

The Contraceptive Distribution and Logistics Management Information System (CDLMIS) is being launched by the DOH under the Family Planning Logistics Management Project, involving John Snow, Inc. and CARE. Under this system, the quantities of pills, condoms and IUDs supplied by CARE are recorded as quarterly deliveries are made to all RHU, NGO and other GO clinics and hospitals. Authorized stock levels are determined based on actual recent past consumption. The order forms, which are completed at time of delivery, are collated at the DOH central office and entered into a computer data base.

In the first few quarters of operation, the authorized stock levels will swing up and down due to the formula by which they are calculated. After a few quarters (by the end of 1994), the authorized stock levels are expected to stabilize, by which time reliable estimates of consumption levels will be possible.

From its inception, the CDLMIS will track service delivery points within the DOH/CARD supply system and identify stock-out conditions, so that the frequency of stock-outs can be accurately determined. Stock-outs are automatically checked at each service

delivery point within the DOH/CARE logistics supply system four times a year. In addition, "flash-point orders" resulting from stock-outs can be made from any service delivery point at any time.

Proper implementation of the CDLMIS will require continued technical assistance from John Snow, Inc. and CARE. The CLDMIS is currently managed by a group contracted by John Snow, Inc. This group will be replaced by DOH personnel, for which budgets have already been approved. By the end of the IFPMHP, the system will be fully institutionalized within the DOH.

- Private Sector Reporting

The SOMARC Couple's Choice program will work with the commercial pharmaceutical network, private health care providers and NGOs. The SOMARC project collects private sector sales figures through reporting forms. Annual summaries will be provided to the FPS Statistical Monitoring Unit.

In addition, the Philippine pharmaceutical industry compiles sales figures. The FPS Statistical Monitoring Unit will avail of annual summaries from this source.

3. FPS Statistical Monitoring Unit

A small unit within the Office for Special Concerns' Family Planning Service (OSC/FPS) will be responsible for collecting the key statistical indicators from the data sources described above. This unit will consolidate and analyze these statistical outputs, performing cross-correlations as needed to identify the statistical validity of the indicators. It is important to emphasize that this unit will perform no primary data collection (i.e., will conduct no surveys). The output of the unit will be an annual report on the status of the national family planning program.

The unit will be headed by an analyst with skills in demographic data analysis who has extensive experience with population and family planning issues. This individual will be responsible for making sure that reports are collected on a timely basis from the institutions involved and for producing the annual report. Two staff from OSC/FPS will assist the analyst with collecting and collating the data and reports from the various sources.

The unit will require three microcomputers with word-processing, spreadsheet and presentation graphics software. A laser printer will also be required.

Technical assistance will be necessary on a periodic basis to set up this unit, establish the proper linkages with the institutions providing statistical inputs, identify the strengths and weaknesses of these inputs, perform the required analyses and prepare the

annual report. Assistance can be obtained from the resident advisor to the NSO.

4. The Role of the National Statistics Office

a. NSO's Role in National Program Monitoring

Because of the critical role the NSO plays in producing necessary demographic and population related data, IFPMHP will continue to provide technical assistance, training and equipment to the NSO to strengthen its operations.

The NSO will be a principal source of demographic and family planning data needed for the national program monitoring described above. This includes conducting the DHS in 1998, annual nationwide population-based surveys and timely reporting of vital statistics. NSO has also started work with the pilot LGUs (Iloilo City and Pangasinan Province) to disseminate available population data, specifically, the Public Use Files (PUFs) of the 1990 Census of Population and Housing. The PUFs allow users with a minimum of computer literacy to produce their own simple tabulations down to the level of the barangay. IFPMHP will support expanding this activity at the LGU level.

b. NSO Strengths and Weaknesses

The NSO has developed a high level of competence in conducting population-based surveys. Central office staff are skilled in the design of field operations, preparation of manuals, training of field staff, and computer data processing. Field staff are skilled in simple data collection.

Expertise is lacking, however, in the area of sample design. Strengthening NSO's sample design skills is critical to decentralizing its operations and for producing accurate provincial level indicators from population-based surveys. The NSO, with technical assistance from BUCEN, is currently refining the master sample frame of households based on the results of the 1990 Census of Population and Housing. The master sample frame will provide the backbone for samples drawn for all surveys throughout the 1990s. While the master sample frame represents an important beginning, sample design skills among NSO staff must be developed to be able to draw efficient samples from the sample frame.

Technical assistance will also be required in the overall design of NSO's survey program which will provide the data for national program monitoring. Questionnaire design for the "rider" questions concerning family planning to be attached to the Household and Labor Force Surveys is particularly important to produce accurate indicators.

Additional technical assistance is required in the production of timely and accurate vital statistics. The current centralized, main-frame based system is ineffective and will be overhauled. It will be replaced by a decentralized microcomputer-based system. This system will require that field office personnel work with the providers of civil registration forms to manage the new system. Field office staff will be trained to develop skills in the areas of management and microcomputer processing.

Achieving the goals of effective population-based surveys, improved vital statistics and increased support to the LGUs requires strengthening of the NSO provincial offices. Fortunately, an existing base on which to build has been developed over the last several years. Valuable experience has been gained with the decentralized processing of the 1990 Census of Population and Housing, the 1991 Census of Agriculture and Fisheries and the quarterly Labor Force Survey (on-going). The NSO Administrator has assigned a high priority to strengthening the field offices.

The microcomputers in the provincial offices, while adequate for simple data entry, are inadequate for maintaining vital statistics and for the data dissemination required in support of LGUs and other local institutions. Provincial office staff skills in data dissemination are nascent. The distribution of the PUFs is the first step. Field office staff have only recently begun to learn how to use the PUFs to handle local data requests. While the PUFs can be accessed using the existing microcomputers in the field offices, future expansion of data dissemination capabilities will require more powerful machines with mass-storage capacity.

- Equipment Requirements

Each NSO provincial office will be provided the following equipment:

- (1) 80486 microcomputer with 8MB+ RAM, and 200MB+ hard disk space
- (1) external mass-storage unit
- (1) UPS
- (1) dot-matrix printer

A total of 80 systems will be funded through IFPMHP.

- Long-term Training

Three NSO staff members will attend two-year university programs to obtain Master's degrees in the areas of survey sampling, statistics and demography. The long term training will serve to expose staff members to the latest technologies and contribute to the sustainability of the IFPMHP.

- Short-term Training

An average of five NSO staff members per year will attend short-term (4-6 weeks) workshops, training, and study tours. The purpose of the short term training is to develop and sharpen skills in the area of sampling, family planning statistics, vital statistics, data dissemination, field office management and microcomputer utilization.

- Resident Advisor

The NSO will require a resident advisor from BUCEN for two years, i.e., through 1996. The advisor will be responsible for providing assistance for the population-based surveys, the development of the decentralized vital statistics system, and the strengthening of the provincial offices. In addition, the advisor will assist the FPS Statistical Monitoring Unit in assembling and analyzing data from the various sources. The current resident advisor to the NSO is funded through the end of calendar 1994. His scope of work supports activities which are preparing the NSO and the DOH to undertake these new operations.

- Short-term Technical Assistance

The NSO will require ten short-term (2-4 week) technical assistance visits and/or in-country workshops over the course of the IFPMHP. These visits will be more frequent in the first two years. The purpose of the short-term technical assistance is to address specific issues related to overall sample design, questionnaire design, vital statistics and data dissemination.

- Casual Employees

The NSO is severely constrained by a five year hiring freeze. In some areas the institutional expertise exists but not the sufficient level of staffing. This problem is expected to increase with time due to the effects of attrition and ever-increasing demands for data. There is a risk that the staff may become stretched to the point where timeliness of the population-based surveys is compromised. In order to alleviate this problem, ten local hires with expertise in statistical operations, analysis, demography and computer systems analysis will be provided over the lifetime of the IFPMHP.

- Incremental survey costs

The NSO will require funding over and above that provided by the GOP to implement the riders to the population-based surveys. This funding is critical to ensure that the surveys are accomplished on a timely basis. Incremental costs include additional enumerators, printing and freight costs.

ANNEX IINITIAL SELECTION OF LGUs

To maximize the impact of the LGU Performance Program, priority will be given to those LGUs where the greatest potential exists for reducing national population growth rates and for improving maternal and child health by rapidly expanding FP/MCH services. Therefore, LGUs with the largest populations where locally elected officials are highly committed to family planning programs receive top priority. Because IFPMHP is national in scope, geographic dispersion is also important for the initial selection of LGUs. Selecting cities as well as provinces to participate in the Program is consistent with IFPMHP's urban strategy.

Following these criteria, provinces with the largest populations distributed across four geographic areas/regions were selected to disperse the first two years of assistance throughout the country. Next, the largest cities were selected within each of these regions. Using the results of "An Analysis of Provinces and Cities' Demographic and Socio-economic Profile of Local Government Capacity and Commitment" (POPCOM, 1993), basic staffing capacity and commitment to family planning by local government executives was evaluated as **satisfactory** (adequate staff in place or being hired combined with strong commitment by LGU executives) **mixed** (questionable staffing and/or only moderate commitment) or **lacking** (no FP staff or no commitment). The NCR was excluded in this initial selection process to assure greater geographic coverage of assistance. The following are priority LGUs:

LUZON

<u>Province</u>	<u>Population</u>	<u>Cap. & Commit.</u>	<u>City</u>	<u>Population</u>	<u>Cap. & Commit.</u>
Pangasinan	2,020,273	satis.	Baguio	183,102	satis.
Isabela	1,080,341	satis.	Angeles	236,685	lacking
Bulacan	1,505,219	satis.	San Pablo	161,630	satis.
Fampanga	1,532,682	satis.	Olongapo	193,327	satis.
Nueva Ecija	1,312,610	mixed	Batangas	184,970	satis.
Batangas	1,476,783	satis.	Cabanatuan	173,453	satis.
Cavite	1,152,534	lacking			
Laguna	1,370,232	satis.			
Quezon	1,372,381	lacking			

BICOL

<u>Province</u>	<u>Population</u>	<u>Cap. & Commit.</u>	<u>City</u>	<u>Population</u>	<u>Cap. & Commit.</u>
Camar. Sur	1,305,919	satis.	Naga	115,329	satis.
Albay	903,023	satis.	Legaspi	121,116	satis.

VISAYAS

<u>Province</u>	<u>Population</u>	<u>Cap. & Commit.</u>	<u>City</u>	<u>Population</u>	<u>Cap. & Commit.</u>
Iloilo	1,765,476	satis.	Tacloban	137,190	satis.
Bohol	948,315	satis.	Bacolod	364,180	satis.
Cebu	2,645,735	satis.	Bago	122,863	satis.
Neg. Oriental	925,311	satis.	Cadiz	119,772	lacking
Leyte	1,486,522	satis.	Iloilo	309,505	satis.
Neg. Occid.	2,256,908	satis.	Cebu	610,417	satis.
			Lapu-Lapu	146,195	satis.
			Mandaue	180,285	mixed
			Toledo	119,970	satis.
			Cadiz	119,772	lacking

MINDANAO

<u>Province</u>	<u>Population</u>	<u>Cap. & Commit.</u>	<u>City</u>	<u>Population</u>	<u>Cap. & Commit.</u>
Bukinon	843,959	satis.	Butuan	227,829	satis.
Misamis Or.	865,051	satis.	Cag. de Oro	339,595	satis.
Dav. del N.	1,055,016	satis.	Iligan	226,568	satis.
Dav. del Sur	1,482,648	satis.	Zamboanga	442,345	satis.
S. Cctabato	1,072,617	satis.	Davao	849,947	satis.
Maguindanao	757,730	lacking	Cotabato	127,065	satis.
N. Cotabato	763,995	lacking	Gen. Santos	250,389	mixed
Zam. del Sur	1,544,520	satis.			

Excluding those LGUs judged mixed or lacking capacity and commitment, the preceding process identifies 40 priority provinces and cities where the LGU Performance Program will be initiated. They are distributed as follows:

	Provinces	Cities
Luzon	6	5
Bicol	2	2
Visayas	6	7
Mindanao	6	6
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TOTAL	20	20

These 40 LGUs will serve as the starting point for the program, i.e., they will constitute the core of the first two groups of LGUs to participate in the program. If all these 40 LGUs participate in the Program, approximately 40% of the country's total population will be covered.

As the program expands in the out-years, a "second priority" set of LGUs will be identified. POPCOM's assessment of capacity and commitment will be expanded to cover this second set and the results of its preceding assessments will be monitored for changes over time. LGUs identified in the initial selection process which

lacked satisfactory commitment to FP/MCH but later become strong supporters of FP/MCH (perhaps due to a change in administrations), will become eligible in the subsequent phases of the program. Conversely, LGUs participating in the program which lose their commitment to FP/MCH (e.g., failure to provide adequate budget or absorb increasing shares of program costs) will be selected out.

This selection process also identifies where advocacy efforts are most needed, i.e., those LGUs with the largest populations but lacking capacity for and/or commitment to expanding FP/MCH services. OSC/FPS and POPCOM will direct advocacy activities to these LGUs to encourage stronger support for FP/MCH and participation in the LGU Performance Program.

NOTE: The following is an illustrative example of the guidance that the DOH's Office for Special Concerns will issue to participating LGUs for start-up and multi-year FP/MCH plans. On the one hand, planning standards need to allow LGUs to address the specific problems they confront, while on the other hand, these standards should focus all plans on the same general objective of expanding and improving FP/MCH services. Experience gained from working with the initial set of participating LGUs during the last year (1994) of the Family Planning Assistance Project is expected to result in better specification of program planning requirements.

I. "START-UP" PLAN REQUIREMENTS:

To participate in the LGU Performance Program, LGUs entering the Program will be required to submit a one year "start-up" plan focusing on capacity building for FP/MCH service delivery. The plan will cover the following topics:

1. Situational Analysis

Using the most recent available date, the situational analysis should report on basic demographic, health, economic and socio-cultural characteristics of the LGU's population and on the current state of the FP/MCH system in the LGU. If possible, earlier baseline data should be reported, e.g., five years prior to the most recent reporting period. The following data should be reported if available:

Demography:

- the annual population growth rate
- age structure of the population,
- the number of women of childbearing age (15-44)
- the number of married women of reproductive age
- the Total Fertility Rate
- Contraceptive Prevalence Rate (modern methods)
- Average Parity
- Average age at first marriage

Health:

- Infant Mortality Rate
- Maternal Mortality Rate
- Percentage of malnourished children
 - second degree
 - third degree
- Children 0-5 years of age fully immunized

- Three major causes of infant mortality
- Three major causes of infant morbidity
- Three major causes of maternal mortality
- Number of ARI cases for children under 5
- Number of diarrheal cases for children under 5
- Percentage/number of post-partum mothers with anemia
- Percentage/number of mothers with anemia
- Number of women receiving iron supplement
- Percentage/number of women breastfeeding

Economic

- Population 15 years of age and above
- Population below 15 years of age
- Size of current labor force
- Percentage/number of employed men
- Percentage/number of employed women
- Percentage/number unemployed
- Percentage/number not in the labor force
- Five major sources of employment
- Total number of households
- Percentage/number of poor households
- Total literacy rate
- Percentage/number of literate men
- Percentage/number of literate women

Socio-cultural

- Total population of cultural minorities
- Percentage/number of municipalities with cultural minorities
- Religious composition
- Linguistic composition
- Number of educational facilities

FP/MCH System

- Public Health Facilities:
 - District Hospitals
 - Community Hospitals
 - Medicare Hospitals
 - Rural health Units
 - Barangay Health Stations
- Private Sector Providers of FP/MCH Services
 - Number of NGO clinics providing FP/MCH services
 - Number of private physicians providing FP/MCH services

- Family Planning Service Availability
 - number of public facilities providing full range of FP services;
 - number of public facilities providing selected FP services;
 - number of public facilities which do not provide FP services;
 - Number of NGOs offering FP services
 - Number of Physicians offering FP services
 - Number of industry-based FP clinics operating
 - Number cooperatives and other private organizations offering FP services;
 - total number of private facilities providing full range of FP services;
 - total number of private facilities providing selected FP services;
 - total number of private and public facilities offering VSC.

- Personnel:
 - a) Health
 - Provincial/city Health Office
 - Municipal health nurses
 - Rural health midwives
 - District Nurses/Supervisors
 - Barangay Health Workers
 - Other

 - b) Population
 - Provincial/city Population Office (PPO/CPO and staff)
 - Municipal Population Office (MPO and staff)
 - Barangay Service Point Officers
 - Other

- Number of Current FP Acceptors by Method

These data should be used to assess important characteristics of the LGU population as it pertains to the expansion and improvement of FP/MCH services. The capacity of the system to expand and improve FP/MCH services should be assessed, noting strengths and weaknesses.

2. Major Problems Affecting FP/MCH Service Delivery

The plan should address the major problems affecting the delivery of FP/MCH services within the LGU. The preceding situational analysis should have led to the identification of several of these problems. Others might pertain to organizational, financial or staffing constraints. These major problems should be the immediate focus of efforts to re-vitalize the FP/MCH program and progress toward overcoming, (such as training staff,

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equipping facilities, enlisting new BSPOs) should serve as progress benchmarks for the start-up plan.

3. FP/MCH Start-up Plan Objectives

Having identified the major problems/constraints the LGU's FP/MCH program confronts in the near-term, the plan should specify its one-year objectives and the progress benchmarks which it will meet. The number of objectives cited should be in line with the financial and staff resources available to the program. To the extent possible, both the objectives and benchmarks should be specific outputs, e.g., an objective of increasing the number of staff recently trained in FP/MCH skills with a benchmark of 200 hundred health and population staff trained by year's end.

4. Activities to be Undertaken to Achieve Program Objectives

Given the objectives of the one-year start-up program, the plan should specify the activities that need to be undertaken to accomplish those objectives. The level of effort or magnitude of those activities should be stated where appropriate, e.g., conduct ten comprehensive FP training courses, purchase examining tables for RHUs, train 50 midwives to provide ORT packets and Vitamin A capsules, conduct five workshops for municipal and barangay level service providers/volunteers, contact 50 percent of municipal officials to encourage adequate funding for FP/MCH services. The following sections discuss particularly important activities that the start-up plan should address.

5. Staffing and Work Plan

This section should present a work plan for the one-year program. This work plan include an estimate of the scheduling of activities over the course of the year. It should discuss which activities will be the responsibility of the Population Office and which are the responsibility of the Health Office and how the two offices will coordinate and/or carry out certain activities jointly. Staff resources to carry out the work plan should be cited, noting where additional personnel will be added or are needed.

6. Program Management Development Plan

The start-up plan should discuss the types of management improvements that will be made to support the FP/MCH program. This might include clarifying roles and responsibilities between Health and Population staff, including areas where they can work together as a team; changes in staff assignments and job descriptions; recruitment, motivation and supervision, of BHWs and BSPOs; and development of a basic management information system using contraceptives logistics data and reporting by service providers on a few key indicators.

7. Training Plan

The start-up plan should present a table listing the types of training to be obtained over the over and number of staff by job category that will attend. This plan should include all training pertaining to the FP/MCH program for staff at all levels of the program, e.g., at the provincial, city, municipal and barangay levels.

8. The Role of Cities and Municipalities within the LGU

The start-up plan should discuss how greater participation, including the funding of staff and program activities, will be encouraged on the part of cities or municipalities within the LGU. Targets, such as the number of municipalities that hire a population officer and provide budget support for FP/MCH activities, should be established as start-up program benchmarks if possible.

9. The Role of Non-Government Service Providers

The start-up plan should discuss how the role of local NGOs, private physicians, local industries, cooperatives and other organizations that provide, or could provide, FP services can be expanded. Specify outputs if appropriate.

10. Role of the Regional DOH and POPCOM

The decision to use Regional DOH or POPCOM staff is entirely up to the participating LGU. The plan should discuss whether or not these organizations will be used. For example, they might obtain assistance from Regional DOH and POPCOM staff for planning and budgeting, development of management systems, etc. If the LGU determines that these organizations lack the technical skills needed, the plan should simply state this.

11. IEC Plan

Consideration should be given to whether IECM activities designed specifically for the LGUs' population, and/or linguistic or cultural groups within that population, are needed in addition to national IECM activities. The plan should present a brief description of these activities, including groups to be targeted, materials that need to be prepared, how many times the activities will be held who or how they will be conducted and cost estimates.

12. Equipment and Supplies Requirements

The start-up plan should carefully consider the various clinical and office equipment and supplies that are needed for the program. LGUs may propose to purchase equipment, materials,

supplies and any other commodity with the financial resources requested under the start-up plan as long as these uses will build capacity for FP/MCH service delivery. Proposed purchases should reflect realistic appraisals of the best use of additional program resources in line with government standards and regulations. This section should take into account the necessity for LGUs to pay the Value Added Tax on all equipment purchased.

13. Technical Assistance Requirements

The plan should specify all anticipated technical assistance requirements for implementing the program its outlines. This includes assistance from the Nationa' Family Planning Services supported by IFPMHP as well as from the technical assistance team specified assigned responsibility to assisting participating LGUs.

14. Other Donor Assistance

The start-up plan should note additional assistance the LGU is or will receive from other donor agencies, such as staff training from a UNFPA program and integrate this assistance into its overall start-up program to prevent duplication of assistance.

15. LGU FP/MCH Budget

A detailed budget presentation should be part of the start-up plan. This budget should cover all LGU planned expenditures for FP/MCH program implementation, including personnel as well as operations and maintenance expenditures. The budget should incorporate the expenditures that cities and municipalities within the LGU will make for FP/MCH activities. This budget should provide tangible evidence of the LGU's commitment, as well as the commitment of participating cities and municipalities, to supporting FP/MCH services. Funding for the distribution of contraceptives and IECM materials provided by the national family planning program is a required budget line item.

II. MULTI-YEAR PLAN REQUIREMENTS:

Specific guidance for the multi-year plans will be developed during the first year of IFPMHP (1995) as experience is gained from the initial set of participating LGUs. In general, the multi-year plan will expand upon the situational analysis - problem identification - program objectives development process initiated with the start-up plan. In contrast to the start-up plans which focus on problems to be addressed over a 12 month period, under the multi-year plan, attention will be given to more systemic problems that will require longer-term interventions. Sustainability of FP/MCH program improvements will be a major concern.

Though each multi-year plan will reflect the specific situation and particular problems of the participating LGU, several common objectives will underlay all plans. Increasing contraceptive prevalence rates and reducing high-risk pregnancies, and maintaining the improvements made in these areas, will be addressed by all LGU multi-year plans. Similarly, maintaining EPI, ARI, ORT and micro-nutrients coverage where acceptable levels have been achieved, or increasing coverage where current levels fall below acceptable standards, will be standard MCH objectives for participating LGUs.

only \$22.2M or \$4.4M/year remained available for performance-based disbursements. Thus, the design team determined that if any savings became available from projectized elements of the PAAD, these would revert to the performance based disbursement element. Since contracting will be accomplished in the first year of the project, we will know at that time if funds will be available to augment the performance based element. Note: It was after the committee meeting that we were advised that this would be a PAAD document.

OPHN discussed the draft SOW for the RFP on 11/17 with the CSO. The draft does contain deliverables and we will strengthen it as CSO advises. In my discussion with CSO we determined that 118 days would be required to contract and OPHN agreed to revise schedule accordingly.

Abortion is not a family planning method. It is what some women resort to when their chosen family planning method fails. Additionally, abortion is illegal in the Philippines. Consequently no USAID funds could be used for illegal activities. Further, the anti-abortion language is always included in the ProAg.

This is a PAAD whose focus is on improving the health of women and children. A separate WID section seems redundant. Page 18 of the PAAD clearly discusses the need to do more work in understanding the role men play in supporting their wives decisions about FP. Additionally, page 3-7 of the social soundness analysis describes what we do know about men and FP as well as the need to obtain more information re men and FP. It also provides an excellent discussion the socio-cultural context of FP in the Philippines. While it is important how women make decisions about FP, this is beyond the scope of the project. From surveys over the last 20 years, we know that FP is acceptable and that reasons for lack of use are categorized as gaps in service delivery or fear of side effects of some methods. All of the IEC and training materials are geared to address these lacuna. We believe the social soundness analysis is more than adequate for a FP project that is geared to improving the health of women through access to FP.

Focus on urban women. The paper clearly states on page i in the executive summary that the paper has an urban strategy because more than 50% of women 15-49 live in urban areas. Thus if we want to improve the lives of women in high risk groups and reduce population growth, we need to reach the women where they are. Additionally on page 29, the paper points out that we need to continue to work with rural women. However, given the rapid urbanization of the Philippines, it is also more cost effective to focus on women in urban areas.

UNITED STATES GOVERNMENT

ANNEX K

Memorandum

TO : Neil C. Edin, ORP

DATE: February 7, 1994

FROM : B. Eilene Oldwine, OPHN 

SUBJECT: Justification for Non-Competitive Award of Grant to the Philippine Center for Population and Development (PCPD) under the Integrated Family Planning and Maternal Health Program (IFPMHP) (492-0480)

PROBLEM: Your concurrence is requested to award a noncompetitive assistance instrument to PCPD for a follow-on industry-based family planning project, under a grant agreement financed by IFPMHP. Under Handbook 13 Chapter 2, Section 2B3b, this request is allowable where the recipient is considered to have exclusive or predominant capability based on an existing relationship with the cooperating country. The estimated amount of this grant is \$3,125,000 over a five-year period.

DISCUSSION: The labor force employed in the private sector is a natural target for the family planning program. With this concentration of people of reproductive age found in the workplace, the industry sector has always presented the program with a very good opportunity for promoting responsible parenthood (RP) and family planning (FP).

PCPD has an established track record in the implementation of industry-based family planning programs. Under a previous bilateral project, Population Planning III (1980-88), which had the Commission on Population (POPCOM) as its host country implementing agency, PCPD undertook 2 RP programs for the industrial sector. The first in 1985 with thirty companies in Metro Manila and the second in 1987, with another set of 21 companies in the National Capital Region and Regions III and IV. These projects increased the demand for FP information and services through the use of interpersonal motivation by volunteer worker-motivators, supported by an intensive in-plant information, education, communication (IEC) campaign.

PCPD, at the request of the Department of Health (DOH) being the host country implementing agency, with funding from the Family Planning Assistance Project (FPAP), has an existing direct grant with USAID. AID Grant No. 492-0396-G-SS-0140 with project title "An Expansion of the Company-based Responsible Parenthood Program to Five Regions " commenced in September 1, 1990 and has a completion date of December 31, 1994. The total project cost is P2,023,256.70. Drawing from PCPD's experience in the management and implementation of company-based RP programs, the project is

institutionalizing the provision of RP/FP education and services in 120 companies in Metro Manila, Regions III, IV, X and XI. The DOH has requested USAID to continue funding PCPD in the new bilateral IFPMH program in order to expand service delivery through the industrial sector.

AUTHORITY: Chapter 2 Section 2B3b of Handbook 13 provides for an exception from competition for assistance awards (grants and cooperative agreements) when the recipient is considered to have a predominant capability, based on experience, or based on an existing relationship with the cooperating country or beneficiaries. As discussed above, PCPD meets this criteria.

RECOMMENDATION: OPHN recommends that you exercise your authority as the Mission's Grant Officer to award a non-competitive grant to PCPD to carry out the proposed assistance activity, since this is fully justified in accordance with the requirements established in Chapter 2 Section 2B3b of Handbook 13.

APPROVE:

Neil Jain

DISAPPROVE:

DATE:

2/8/94

The program fellows - 10 per trimester - will be given the opportunity to be involved in the population/family planning and health programs of the country. A two-week pre-service training/orientation will provide the fellows an overview of the various population/health programs in the country in their multiple dimensions, a framework for the analysis of the various programs, and tools for critical thinking in examining program/research issues from a comprehensive perspective. After this training/orientation, the fellows will immerse in an agency or community that provides service or research facilities in line with their area of interest. At the end of the three-month period, a three-day workshop will be convened to enable the fellow to present his or her output - a research paper, an evaluation report or a proposal which examines the particular organization's policies and procedures in meeting its stated mission and goal and provides recommendations for program improvement through objective appraisal.

DLSU is generally acknowledged as one of the top three institutions of higher learning in the country. The graduate program in Health Social Science is the first and so far the only one of its kind in the country today. The faculty of this program has superlative credentials - all are either PhDs or PhD candidates and experts in their own fields of interests. Thus, OPHN would like to tap the expertise of DLSU through this grant.

AUTHORITY: Section 2B3(b) of handbook 13 provides for an exception from competition for assistance awards (grants and cooperative agreements) when the recipient is considered to have a predominant capability, based on experience, specialized facilities or technical competence, or based on an existing relationship with the cooperating country or beneficiaries. As discussed above, DLSU is the only organization that has the capability to carry out this project.

Chapter 2, 2B3b, HB 13, authorizes the cognizant Grant Officer to review and approve this justification for noncompetitive award.

RECOMMENDATION: OPHN recommends that you exercise your authority as the Mission's Grant Officer to concur in the determination that DLSU is the only organization that can carry out the activities outlined in the PAAD and that a non-competitive award of a grant to DLSU to carry out the proposed assistance activity is fully justified in accordance with the requirements established in Chapter 2, 2B3b of Handbook 13.

APPROVE: Neil Ordan
DISAPPROVE: _____
DATE: 2/8/94

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