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LESSONS LEARNED FROM THE
FAMILY PLANNING MANAGEMENT DEVELOPMENT PROJECT
1993-1995

Manila, Philippines

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FAMILY PLANNING MANAGEMENT DEVELOPMENT

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A. Background and Objectives of FPMD in Manila

In 1993, in response to challenges posed by the devolution of basic government health services, including health, USAID/Manila provided funds from the bilateral Family Planning Assistance Project (FPAP) for a buy-in to the Family Planning Management Development (FPMD) Project of the Boston-based Management Sciences for Health. The buy-in was intended to achieve two basic objectives:

1. to develop the capacity of local government units (provinces and selected cities) to plan and implement a comprehensive program of targeted integrated family planning/maternal and child health services; and
2. to assist the Department of Health OPHS (formerly OSC) to define and adapt to its new role of providing technical assistance to and monitoring the performance of the local government units (LGUs).

B. Accomplishments

Between 1993 and 1995, FPMD assisted the DOH to start-up the LGU Performance Program (LPP), one component of the large bilateral program called the Integrated Family Planning and Maternal Health Program. The LPP was designed to provide performance-based grants to local governments based on their accomplishments of yearly benchmarks. FPMD provided technical advice and administrative support to the LGU Performance Program through long-term advisors (1 expatriate and 5 Filipinos), short-term technical assistance, and a project management staff. Accomplishments included:

Selection, Orientation, and Training of LGUs and LGU Staff

1. Twenty LGUs (14 provinces and six cities) were selected and invited to participate in the program in 1994, and 10 additional LGUs (nine provinces and one city) were selected for 1995. FPMD helped the DOH to refine the process for selection to be more transparent. This included an updated definition of eligible cities, amended population statistics, and a more complete analysis of both Commission on Population (POPCOM) and DOH national and regional managers' assessments of LGU commitment and capability to implement family planning, child survival and population programs.
2. Twelve workshops were held for around 400 local officials (including population, health, planning and administrative officers) and national and regional staff. These workshops covered LPP requirements, national policies and strategies, technical program and management systems updates, resources available to the LGUs, and strengthening of planning/budgeting skills. They also covered implementation arrangements and benchmark monitoring.
3. Several guides for LGU managers were produced and disseminated, including the *LPP Procurement Guide*, *LPP Information Resources Briefs*, *Profile of Cooperating Agencies*,

and DOH Policies Binder. Model management systems were also developed for use by LGU managers, including manual and computerized systems for monitoring FP coverage at the barangay level, and a management accounting system.

LGU Management Development Through Technical Assistance and Monitoring

4. Guidance in the conduct of local planning meetings, and subsidies in the amount of 397,500 pesos total (\$16,000) were distributed to 30 LGUs during their start-up year to assist in conducting consultative meetings with municipalities and other key provincial and city government officials and collaborating partners.
5. Over 180 technical assistance and monitoring visits were made to LGUs by FPMD staff, to assist in orienting local government officials, situational analysis, planning, troubleshooting grant management problems and to monitor implementation of the plan and achievement of benchmarks. National and regional health and population staff were given guidance and opportunities to participate in these activities.
6. Start-up and capacity-building performance benchmarks were set for the first, second and third years of the program, through a consultative process with LGUs, regions, national services and USAID/collaborating agencies.
7. Planning standards, review guidelines and a review committee were established. Plans submitted by the LGUs were reviewed by representatives of all concerned services/offices at the national level, as well as the Regional Health and Population Offices, CAs and FPMD Technical Advisors. This process was developed and monitored by FPMD.
8. A system was developed for monitoring benchmarks and tracking LGU performance at the LGU, regional and national levels. The LGU tracking system produced input indicators, such as percentage of facilities offering specific methods, which were not available from any other data source.
9. FPMD helped the DOH in compiling and presenting documentation of benchmarks. With FPMD's assistance, 20 LGUs met the required start-up benchmarks for 1994, and so received performance grants ranging from 900,000 to 6.8 million pesos (\$40,000 to \$285,000) per LGU. Total funds released in 1995 to these successful LGUs were 71.7 million pesos (\$3 million). FPMD researched, documented, and expedited the funds flow process leading to an earlier release of funds than ever before experienced.

Management Capacity Building at the National Level

10. Implementation agreements between the DOH and the LGUs were codified in a Memorandum of Agreement (MOA) drafted by FPMD through a participatory process.

FPMD assisted the DOH in negotiating the agreements with the LGUs, and in conveying and monitoring MOA compliance guidelines. This was a new process required for the performance-based disbursements under devolution.

11. A high-level LPP Advisory Committee (LPPAC) was established and met bimonthly to consider important policy and programmatic decisions. Members include the heads of FP, MCH, Nutrition, and LGAM, Services, as well as the POPCOM Executive Director and the Acting Undersecretary for Public Health Services (chairperson). FPMD acted as secretariat. FPMD also assisted with the design and justification of the DOH Project Management Office, as well as providing on-the-job training of LPP Coordinators assigned by the PMO.
12. Two organizational development studies were conducted which provided recommendations on appropriate roles and responsibilities of regional offices, and the program management structure within the OSC. Many of the recommendations regarding regional roles were implemented.
13. Policy guidance was provided on diverse issues from the strengthening of the promotion, management and delivery of natural family planning methods, to the definition and use of terms such as Married Women of Reproductive Age (MWRA).

C. Lessons Learned

Lessons learned are discussed according to three broad categories: lessons about factors that make local government units successful implementors of health and population programs under devolution, lessons about the performance-based disbursement system, and lessons on how LPP can truly become sustainable.

On factors that make LGUs successful program implementors under devolution.

- 1. Commitment of the Local Chief Executive and Senior Health/Population Staff is Important, But Difficult to Measure.**

Commitment and capacity of the LGU were a required condition before an LGU could be selected for participation in the LGU Performance Program. FPMD found that implementation was faster and more problem-free in LGUs with a strongly supportive Governor or Mayor (as in Davao del Norte and Pangasinan). However, program goals can also be furthered without such strong commitment, as long as the senior staff have the confidence of the Local Chief Executive, and the LCE will not interfere with implementation. Having the support and confidence of the LCE seems to empower the LPP coordinator to overcome many kinds of problems.

At the same time, FPMD found that the best efforts of DOH and POPCOM to measure an LGU's commitment to FP/CSP and Population programs prior to selection for the LPP were unreliable. It turned out that several LGUs that rated highly for commitment later exhibited only lackluster support, professed their belief that the Local Government Code specifies no role for provinces in managing public health programs except for hospital support, or experienced other problems. Local elections held in 1995 also resulted in changing levels of commitment. Pressure to have nationwide coverage of the LPP may result in the admission of more LGUs with weak commitment and capacity as the program expands.

2. The LPP Coordinator Can be Equally Effective Whether from Health, Population, or Even Another Office.

Surprisingly, it seemed irrelevant whether the LPP Coordinator came from the Population, Health, or the Program Planning and Development Office. There are examples of LGUs where effective LPP Coordinators came from each of these backgrounds, e.g. Davao del Norte (Health), Iloilo City (Population) and Bukidnon (Planning and Development). As mentioned above, what was more important was the individual's level of involvement, problem-solving ability and relationship with the local chief executive. Sometimes FPMD saw an LPP coordinator chosen because of title or presumed stature, while the true coordination took place at lower levels. In general, these LGUs are less effective at implementation.

3. Broad Participation at the LGU Level is Needed for Decentralized Program Management to Work.

LGUs that seemed better able to manage and implement their comprehensive plan were those that had established effective working relationships outside the health and population staff. Important players were the Local Chief Executive and his/her staff, legislators, the Planning and Development Officer, General Services Officer, Accountant and Auditor. The support of other LGU offices is important to ensure timely availability of program resources. Formal and informal venues are needed to provide opportunities to bring health/population staff together with these administrative and other local government officials, for team building and training. The LPP provided some of these opportunities through workshops and monitoring meetings, though more options can be explored. Individuals are important to the success of decentralization. FPMD's experience shows it is wise to cast the net widely, involving as many people as possible, to identify the ones who are most capable and influential.

4. A Process-Oriented Approach to Building an LGU's Management Capacity Works Better than Task- or Program-Oriented Assistance.

After an initial effort to organize staff in several management specialty areas (i.e. planning, training, MIS, benchmark monitoring), FPMD and the DOH Project Management Office eventually elected to cross-train staff to handle LGU management capacity building as an integrated process. Each LGU was assigned a "case manager" as their technical advisor and

contact, to guide them through the entire management cycle from start to finish. From the initial orientation and situation analysis, through the planning workshops, program implementation, and documentation of benchmarks, that same technical advisor was there for the LGU to field questions, to provide training and hands-on problem-solving, and to advise the LGU on who to contact about the many programmatic issues or special concerns that arose. FPMD found that this approach was most effective, and the LGUs confirmed this during focus group discussions. This shows the importance of developing DOH technical staff to be both program specialists and generalists.

5. Clear Guidance from the National Level on Policies and Standards is Essential for Effective Program Implementation; the Role of National Services is to Develop this Information, and to Monitor How it is Applied in the Field.

The LPP is essentially a funding mechanism and management development process. It does not and should not define or develop content for the national policies, strategies and standards of the Philippines Family Planning, Child Survival and Population Programs, or determine what activities proposed by LGUs should or should not be funded with DOH grant monies. Yet without clarity on these policies, strategies and standards for awarding grants, it is impossible for the LGUs to develop their plans. To some extent the cart is now before the horse. LPP provides incentives for the LGUs to implement programs according to national standards, but many of the national standards and policies do not exist or have not been updated post-devolution. Specific examples are a moribund accreditation system for service delivery outlets and trainees/training institutions, no policies or standards on NFP service delivery, lack of guidance and a rapid response team for handling FP complications, and few standard and up-to-date monitoring tools.

Lack of clearly defined and conveyed policies and standards makes the LGU Performance Program less effective, because funds are used in ways that might not support national objectives. FPMD found that LGUs lack basic information even about standards and policies which have been set already; however, most LGUs seem willing to follow national norms, once they know about them. The DOH and POPCOM may not yet fully appreciate how dependent the LPP is on progress in formulating national level policies, strategies, and standards, and clearly defining available resources from the national level. Also, LGUs seem to need this information to be conveyed in writing and through multiple channels, rather than merely being mentioned during a consultative meeting or other single forum.

The need for clearly defined national guidance for LGUs does not mean that all policies and standards for local government health programs must emanate from the DOH. It is clearly good for local officials to begin making more policy decisions themselves and setting some of their own standards taking account of their particular situation. This promotes autonomy and strengthens devolved management, and sometimes makes for better outcomes. At the same time, however, local policies and standards should fall within the boundaries of a more broadly defined national program framework. If LGUs want to pursue policies or initiatives that are not endorsed

by the DOH, then they are still free to use their own funding rather than LPP grant funds to support such initiatives.

6. Close Monitoring and Intensive Technical Assistance are Required at the Start, and Yield Results.

LGUs have expressed surprise and satisfaction at the close attention that LPP case managers pay to their plans, making sure that the approaches are realistic, adequately financed, and are related to the objectives of the national programs and the LGU's situation. Even more striking, the seeds of a new "culture of accountability" have been planted through the monitoring of implementation of the plan and achievement of benchmarks. One senior DOH staff member remarked that it is the first time that plans are used to monitor, and that LGUs are being asked to explain their performance. Under the CSP performance-based disbursements, benchmarks were evaluated by national averages, which allowed high performing provinces to compensate for the low performers. Yet, once the national benchmark was met, all provinces shared in the reward. In the LPP, every LGU's performance stands on its own. LPP case managers further encourage accountability by emphasizing that the program can be flexible and accommodate changes in plans--for example there is complete line item flexibility--but that modifications have to be justified at the local or (if changes are significant) regional level.

FPMD learned that the skills required for management in devolved settings are best learned through on-the-job training during implementation. Formal seminars were most successful when tailored to the LGUs through practical problem-solving exercises and role plays based on real life. While the approach of intensive technical assistance and close monitoring was effective, it is endangered by the planned rapid expansion of the program, the pace of which may exceed the ability of the DOH and the Project contractor technical assistance team to provide the required close attention and TA.

7. Provinces Need to Have Clear and Collaborative Relationships with Municipalities.

Since devolution, the relationship between provinces and municipalities has weakened. This phenomenon has been described in the Child Survival Evaluation Report:

Technical and functional linkages...between provincial and municipal level devolved personnel, were inadvertently severed along with the loss of administrative line authority. As a result, technical supervision, monitoring and support to the RHUs/BHSs has been substantially weakened...The DOH and donors are attempting to interface with LGU health services at the level of the province, but province-municipality links are weak to non-existent, and primary services are under the administration of the municipality, not the province. There is no practically feasible means for interfacing directly with some 2,000 municipal LGUs; hence, it is vital that strong functional provincial-municipal linkages be established. (p. 52)

FPMD learned that without special assistance, few provinces were likely to re-establish these strong functional provincial-municipal linkages on their own. Many of the problems were financial (lack of travel expense funds to make supervision visits), but more importantly, the provinces and municipalities were confused about their roles post-devolution. For example, more than a few provinces perceived that the Local Government Code does not provide any role for the province in public health services, other than management of hospitals. Also, technical staff felt that they were required to get the Mayor's permission for every invitation to have municipal staff attend meetings or trainings. FPMD found that specific instructions on how to relate to municipalities post-devolution, clarifications on the content of the Local Government Code, and provision of subsidies helped to encourage provincial level staff to consult with municipal staff, and to host joint local planning sessions that proved quite productive. Provincial staff were also responsive to suggestions such as the establishment of one-time agreements with Mayors that would allow municipal health staff to attend monthly technical meetings hosted by the province, or to be visited by a provincial technical supervisor, or other procedures designed to re-establish linkages post-devolution.

FPMD considered other possible options, such as requiring area-program based health plans from municipalities as a benchmark, or requiring a formal provincial-municipal Memorandum of Agreement, and rejected these as creating too much paperwork without stimulating the internal incentives that would make the linkages really work. More effort is needed, however, to clarify roles and continue re-establishing provincial-municipal working relationships within the newly decentralized health care system.

On performance-based disbursements:

1. Within a Decentralized System, all LGUs are Not Created Equal.

The project design assumed that a common set of benchmarks could be determined for all LGUs, and that LGUs entering in any given year would progress as a "class" through several stages of development (i.e. focusing first on capacity building, and later on service delivery, and performance). In fact, the LPP has learned that each LGU is in many ways unique. Not only do all have different baselines from which they are starting (for example, the percentage of staff trained on Comprehensive Family Planning ranges from 7% to 100% among the first 20 LGUs), but all have different management structures, priorities of LCEs, and personalities of management, technical and administrative staff to deal with. It has been extremely difficult for the LPP to gain consensus each year on a common set of benchmarks which are challenging without being too difficult. Unfortunately, compromise is often created by making sure that the benchmarks suite the "least common denominator," i.e. they are not very challenging for the best LGUs, but can be accomplished (with effort) by the least advanced LGUs. This process results in the LPP being more of a disincentive program, with the objective of trying not to fail, rather than a performance-based incentive program that truly rewards outstanding performance. More

thought is needed about how to create these positive incentives, without undue burden on LPP management and record-keeping.

2. Plans Based on Budget Allocations Set in Advance Foster Accountability.

Under the previous Child Survival Program, LGUs were encouraged to develop an area-program based health plan, and to meet certain performance benchmarks. The national level then used these local plans as input to national-level planning, and as the basis for performance-based "augmentation" grants. However, the flaw in this system was that LGUs were not required to determine a realistic plan or budget; instead, they enumerated all their needs and set budgets that sometimes exceeded available resources by many times. The relatively small performance-based grants (500,000 pesos per province in one year) made hardly a dent in the resource gap (in one LGU, the budget submitted was 90 million pesos, so the performance grant covered only 0.6%). LGUs were frustrated because they didn't get the funds they needed and requested, and then couldn't implement all planned activities.

The LPP tried to correct this problem by providing LGUs with a budget allocation figure in advance. The budget allocation model used several factors to determine grant size, including population size, local government income, and whether the LGU had received previous assistance from the LPP. Some questioned whether it was "fair" to allocate performance-based grants according to pre-set criteria, rather than according to need. But in fact, the LPP model was much fairer than the previous formula of equal grants for all participating provinces and cities. And it is plain that in the Philippines as in other parts of the world, total resources are limited and are always outstripped by needs, so resources must be rationed by other means as well. LGU plans in excess of the pre-set allocation needed to show other sources of revenue, or were turned back for revisions to reinforce to LGUs that they needed to set priorities within a total resource constraint. For the very first time in the DOH, provinces and cities then received almost exactly the amount they had requested, and therefore had no excuse for not delivering on their plans. This greatly improved the accountability of the LGU managers, and the ability of DOH and FPMD monitors to discern real reasons for performance problems.

3. Performance Grants Need to Reward Good Performance.

While requiring LGUs to plan in accordance with a total budget figure has been effective in improving accountability, FPMD found that the LPP still does not really reward outstanding performance. Rather, it threatens to penalize LGUs that do not meet basic minimum performance standards (i.e. the benchmarks) by refusing them grants. This is not the same thing as providing positive rewards to outstanding performers. In practice, it has proven difficult to penalize LGUs which show lack of commitment and are not performing well. Legal remedies are unclear and time-consuming, and the DOH is reluctant to lose face and program momentum by admitting that any LGUs have had to be penalized. One way to preserve and reinforce the positive benefits of a performance-based disbursement program is to begin providing extra funds

to those LGUs that not only meet the minimum benchmarks, but that show excellence and high outcomes. Other, non-financial incentives could also be explored.

Another feature of the fund assistance that LGUs perceive as a disincentive is that while the performance benchmarks become progressively more difficult each year, the fund assistance available per LGU decreases (since more and more LGUs are entering the program each year, but the tranches do not increase proportionately). Measures to address this issue should be explored.

4. Successful Implementation of Plans and Achievement of Benchmarks is Dependent on Prompt Receipt of Funds.

In 1995, it is already obvious that LGUs which received their funds late (due to delays with local banking or signing of MOA) are lagging behind on benchmark performance, and may not realize their benchmarks in time for the final presentation to USAID. This is so even though specific efforts were made to set benchmarks that would not be so dependent on the receipt of the LPP funds. It is essential for the DOH to manage the funds flow carefully, and to expedite signatures and actions at every phase of the process. Lack of attention to this requirement could create organizational chaos, as LGUs from different batches require extensions and deadlines are pushed back into subsequent years. FPMD learned that by closely managing the grant flow, LGUs can receive funds up to six months sooner than experienced under the Child Survival Program.

At the same time, successful implementation also depends on mechanisms that the local government has put in place to assure that the funds flow is fast-tracked at their own level as well. These local "lessons learned" about how to disburse funds quickly should be shared among LGUs through LGU-to-LGU technical assistance, conferences and exchange programs.

5. Management by Benchmarks Doesn't Replace All Other Management Decision-making Needs.

The process of negotiating acceptance of benchmarks each year with the participation of DOH, the LGUs, USAID, and cooperating agencies/POPCOM, was lengthy. Often the participants to the discussion wanted every management objective of the FP/CSP and Population programs to be codified in a benchmark. Also, there was a reluctance to reduce or eliminate the "capacity-building" benchmarks (such as the operation of the contraceptives distribution system, information system, and procurement tracking system), even once they had been met, because the national level felt that if these requirements were not benchmarks, the LGUs would relax and neglect the operation of these basic systems. If each year's list of benchmarks not only includes the "next level" of management development measures, but also continues to include the previous year's benchmarks as well, the monitoring system is destined to become more complicated, time-consuming, and susceptible to errors. At the LGU level, there was sometimes confusion that the activities proposed in their plan needed to focus only on the benchmarks, and

FPMD needed to remind LGUs not to manage "exclusively by benchmarks" but to include all other relevant activities in their plans as well.

In order for the LPP to be manageable, FPMD's experience has taught, the number of benchmarks must be small. In addition, there are certain conditions that must exist before a benchmark can be effective, and sometimes the national services or CAs have not seemed aware of or perhaps ready to accept the burden of the preparation they need to undertake. For example, it is not possible to require LGUs to meet a "service access" benchmark until the national level has set standards for what types of services are expected to be delivered in what types of facilities, and until a viable facility accreditation process is operational throughout the country. These are pre-conditions that are not the responsibility of the LGUs, but of the national and regional levels.

Not every management objective can be a benchmark. FPMD showed how planning standards themselves can be used successfully to promote national goals, without creating the administrative and legal burden of a benchmark.

6. Benchmarks Can Provide Management Incentives that Work.

Evidence from the Contraceptives Distribution benchmark shows this most clearly. Baseline evaluation prior to the LPP setting a contraceptives deliveries benchmark showed that only 75% of service delivery outlets in the LGUs had at least one month of stock of pills and condoms on hand at time of supplies delivery, while benchmark performance six months later measured that this percentage had increased to 95%. Over half of the LGUs (13 out of 20, or 65%) saw an increase in performance of 10% or more over baseline. Seven LGUs (35%) improved by 20% or more. The benchmark provided the LGUs with the management incentive to make existing systems work, in most cases even without additional resources (since many LGUs had not yet been able to procure requested delivery vans with their LPP grant funds before the benchmark performance report was due).

Qualitative impressions from FPMD/PMO and regional staff indicate that significant improvements in information systems management and reporting were also seen this year, due mainly to LPP incentives. There was no baseline measurement, however, to document this improvement.

Finally, in some LGUs there was improvement in the management of procurement systems in general, as a result of the LPP benchmark. For example, in Baguio City the staff decided to apply the LPP-required procurement tracking logbook to all health and population procurements, not just those funded through the LPP. And in South Cotabato, though the procurement benchmark only required LGUs to track procurement, information from the tracking system was used to identify bottlenecks and encourage the General Services Office staff to speed up the system.

7. LGUs Which do Not Perform Must Be Held Accountable.

After the elections in May, political leadership in many local governments changed. Several of these new leaders were not eager to endorse family planning, and expressed an unwillingness to support delivery systems for any artificial methods. One LGU executive readily admitted that he was opposed to a certain benchmark contained in the LPP Memorandum of Agreement. Yet, thusfar the DOH has attempted but not succeeded in holding these LGUs accountable, and enforcing MOA compliance. It is admirable that the DOH is eager to attempt to accommodate where possible, in order to maintain services to the population even where a LCE is unsupportive. However, beyond a certain point this accommodation is compromising the purpose of the program, and sends a message that LGUs do not have to deliver on the commitments that helped them win their grant.

On how LPP can become truly sustainable.

1. Regional Offices Must Adopt Greater Responsibilities for LPP Implementation and Management.

Early in the LPP implementation, it became clear to FPMD that the regional health and population offices needed to assume a greater role in LPP than had been anticipated in the project design. This was necessary for two reasons: first, it was simply not possible or efficient for the national level to provide all the technical assistance, monitoring and trouble-shooting directly. Many regional staff are competent and qualified to perform these tasks, and more importantly, they have ongoing relationships with LGU technical, administrative and political/legislative staff as well. Secondly, the regions were very eager to be more involved in LPP. This is in part because the LGU Performance Program, assisted by USAID, is the first program of the Department of Health and POPCOM to begin working very closely with the LGUs post-devolution. As such, the LPP has helped the Regions to clarify and begin operationalizing new roles and responsibilities vis-a-vis the LGUs.

In order for regional staff participation in the LPP to be effective, FPMD learned that selection of the appropriate regional LPP coordinators is essential. Selection need not be limited to just the Family Planning Coordinator, but should consider CSP coordinators or other regional staff according to competency, skills, enthusiasm, and the problems at hand. FPMD also learned that "legislating" regional roles (e.g. formally requiring the regional staff to be involved in trainings, or to attest to certain activities or outputs) is the least productive manner for encouraging effective collaboration, though at times it may serve a limited function. The LGUs must first see the benefits which regions have to offer, and must learn to appreciate the talents, knowledge and technical assistance which regional staff may bring to bear on LGU problems. The involvement of regions in the LGUs must be demand-driven in order for it to have the greatest impact on performance.

A key decision which must be made for full sustainability of the LPP is whether the "case managers" of LGUs should be regional or national staff. These case managers or LPP coordinators are now situated at the national level, as mentioned earlier. They provide comprehensive assistance to LGUs in planning and implementing their programs, as well as monitoring LGU progress in meeting benchmarks. If LPP case managers were situated at the regional level it would mean that less staff would be needed to manage at the national level, a situation which might be desirable given the current dearth in staffing at DOH central office. Issues related to the documentation of benchmarks would also need to be addressed, since currently the benchmarks are a requirement for LGUs and the national level, but not the regions. A more substantial program of on-the-job training for regional case managers would also need to be carried out.

2. LPP Must Be Perceived as Owned by the Philippines, and Not Donor-Driven.

Focus groups designed as part of the FPMD Evaluation revealed that despite the best efforts at publicity and education by DOH and FPMD, the LPP is still perceived as a "special, donor-financed" program of the Department of Health. FPMD found that this perception is damaging, in that it allows LPP to be pigeon-holed as a special requirement of DOH, imposed by USAID, rather than being perceived as the DOH's response to devolution, and a new way of relating to the LGUs within a decentralized health care system.

Several actions have seemed to sustain the idea of LPP being donor-driven. One is that USAID has at times tried to tie national services support too closely to LPP support, favoring the selection of LPP LGUs for assistance. Because coordination of the national services component and the LPP component of the Integrated Family Planning and Maternal Health Program has essentially meant asking the national services collaborating agencies to prioritize the LPP LGUs when giving direct assistance to the local level, other aspects of coordination which could lessen the perception of LPP as a donor-driven project have been neglected. For example, coordination is also needed between the national services and LPP components in the documentation of DOH policies, standards and strategies in the area of MCH/FP, and preparation of guidance for LGUs on how to implement and use these policies, standards and strategies. The national services component should also be helping to give more complete advice to LGUs on resources and information available from DOH, other government agencies, donors, NGOs, and outside organizations, on all aspects of FP, CSP, and Population Management.

FPMD has also noted the need to respect DOH decision making and the participatory, consensus building processes followed in selection of LGUs and benchmarks. At times, it is perceived by the DOH that USAID has participated in the consensus building process, but in the end simply wants to have its own way and to disregard the outcome of that process if it is not exactly what USAID wants. This perceived disregard for the DOH decision making process, even while taking part in that process, is a source of discouragement for DOH decision-makers, who themselves then tend to think of LPP as a donor-financed and managed project.

The fact that the LPP is part of the Integrated Family Planning Maternal Health package of USAID assistance and is released by the GOP through a special account is another reason why the LPP is perceived as a donor-driven project, even though the funds are actually from the Government of the Philippines. If the DOH begins to use performance-based disbursements for other government and donor resources, as well, this will serve to expand the overall resource base for the LPP and thus improve program sustainability.

3. DOH Should Harmonize Approaches for Donor Assistance to LGUs in FP, CSP and Population.

If the LPP is to truly define a new, post-devolution relationship between the Office of Public Health Services and the LGUs, then the DOH needs to make more efforts to coordinate and integrate the LPP with other donor assistance to LGUs for FP, CSP, and Population. For example, the Situation Analysis tool and LPP planning standards should be edited for full women's health and reproductive autonomy/safe motherhood, not just family planning, child survival and population management. This means coordinating with protocols for the Women's Health Safe Motherhood project. Also, UNFPA assistance to LGUs needs to be compatible with the LPP approach, since the "LPP approach" is the DOH approach and not just a special project approach. As currently designed, UNFPA assistance is geographically limited to only five municipalities per province, rather than following the regular LPP planning process of determining priorities based on needs. Other donor assistance which should be coordinated with the LPP approach includes JICA assistance in the area of population and FP, and UNICEF assistance for child survival programs. Only in this way will the Philippines be able to define the Department of Health's approach to LGU assistance, and ask all donors to adapt their projects and resources to support this DOH approach.

4. POPCOM and Regional/Local Population Offices Need to be Further Integrated into LPP Processes.

Unlike CSP program, the LPP has had to implement a performance-based disbursement system in coordination with an agency outside DOH, i.e. the Commission on Population (POPCOM). Cross-agency cooperation is never easy, and there have been many bureaucratic challenges from trying to keep everyone informed and involved in decision-making, and comfortable in their roles. At the start, certain actions implied that POPCOM's role was less important than DOH, and POPCOM did not feel their potential contributions were adequately appreciated. This concern has been addressed to a large degree. For example, the Executive Director of POPCOM is now a member of the LPP Advisory Committee and participates in policy and programmatic decision-making. In addition, POPCOM regional offices are provided with frequent updates regarding program activities and directions, and are more involved in the plan development and review process, monitoring of performance, and provision of technical assistance. On the other hand, POPCOM also needs to provide clearer guidance to the DOH and LGUs regarding the types of activities and interventions it would like to support. Overall, the LPP has required more complicated planning standards, monitoring systems and MOA compliance procedures due to the

involvement of POPCOM in the program; but the advantage is that program implementors in the field are able to draw on more of the resources of the regional and local population offices, and to coordinate interventions more closely to avoid overlap and to fill gaps and assure better coverage.

5. Implementation Must Go Forward at a Pace that Permits Adequate Monitoring of MOA and Benchmark Compliance.

The initial project design and grant agreement allowed for progress to go forward at a pace slower or faster than 20 LGUs per year, depending on experience and commitment of LGUs. However, since that time the interpretation of the program by both DOH and USAID has focused on the importance of achieving the numerical target of 100 LGUs, thus requiring fast program expansion. What FPMD has learned over the past two years is that expanding the LPP at a pace of 20 or more LGUs per year is likely to endanger the desired outcomes of the program. The success to date in providing support to LGUs under devolution has been achieved because USAID and DOH were not afraid to "learn by doing." Yet, time is needed to systematize what we "learn as we do." The DOH's first attempt to work with LGUs under devolution was through the Comprehensive Health Care Agreements (CHCAs). Essentially, these failed through lack of monitoring: the agreements were not enforced, and LGUs were not held accountable. The failure to monitor and enforce compliance was in turn due to lack of time, systems, staff and other resources to trouble-shoot and diagnose problems, and to respond adequately. The LPP could expand quickly, and most probably benchmarks would be met (at least on paper) and the funds would flow. However, the real effects of the LPP in reviewing and improving the content of local plans, increasing local management capacity, and enhancing accountability within a decentralized health care system might be sacrificed.

Additionally, there are real dangers in promoting program expansion faster than the DOH is able and committed to providing staff and time to manage the program--and not just through contractually hired using performance-based disbursement funds. For example, "special cases" take much of the time of the program staff, i.e. assessing an LGU's capacity to implement given current staffing and/or difficult relationships among personnel, determining when DOH standards and guidelines are being violated and what should be done in these cases, and managing conflicts. In most special cases, TAs and PMO staff must involve senior DOH management in making decisions and managing conflict, often including site visits to LGUs. This creates problems due to conflicting demands on the time of DOH management, resulting in trips being postponed indefinitely, and problems continuing on unresolved. Also, as new PMO contractual staff are added, program expansion must be timed so as to allow these staff to be adequately oriented and trained prior to assigning them their own "LGU case load." In FPMD's experience, staff need 3-4 months to learn their jobs, and additional close supervision for at least the first year.

Accelerating expansion too quickly threatens to absorb staff entirely in the tasks of implementation at the LGU level, neglecting needed technical assistance for the national level in

adapting to their post-devolution roles and responsibilities. Balanced progress at both levels is a prerequisite for measured and sustainable expansion.

6. DOH Services Must Assume Greater Responsibilities for Technical Assistance, Plan Review, and Monitoring of Program/Plan Implementation at LGU Level.

The LPP as currently implemented uses only contractual staff, technical advisors paid through a USAID contract, and part-time DOH national services and POPCOM counterparts. Again, if the DOH is really to adopt a new, post-devolution role vis-a-vis the LGUs, there is a need for the DOH services to assume greater responsibility for LPP planning and implementation. This cannot be a part-time activity, or else the LGU performance program will only be perceived as a vertical program that is independent of regular DOH services and operations. In fact, the planning and monitoring aspects of the LPP were meant to be, and must become, integral functions of the DOH services. For this to occur, DOH and perhaps also POPCOM staff at national and regional levels will need new job assignments and training as "case managers" of LGUs.

D. Recommendations

1. There is a need for immediate and realistic dialogue between DOH and USAID to consider expanding the LPP at a pace so that what assistance is provided is done well and lessons are internalized by both the LGUs and the DOH and POPCOM. DOH and USAID should **re-visit the requirement of 20 LGUs per year**, since this level of expansion seems too rapid for sustainable maintenance by the DOH. Ten LGUs per year is more likely to be manageable, but in any case the expansion plan should be set to ensure complete DOH and POPCOM participation in the implementation and management of the LPP. This change need not dictate a decrease in the grant tranches of non-project assistance; rather, additional financial assistance should be given to each participating LGU and to the national services to build capacity to manage programs effectively in the post-devolution environment.
2. DOH and the PMTACT should **study ways in which an LGU's commitment and capacity to implement the LPP can be measured with a greater degree of reliability**. The DOH and USAID should confirm the voluntary nature of the LPP by not selecting or orienting during the start-up year any LGUs that have questionable commitment, even if this means that the program does not attain national coverage.
3. The new project should **continue the process-oriented approach to LGU management development** by assigning case managers to handle all technical assistance, monitoring, and on-the-job management training for LGUs. Each manager should not be assigned more than five LGUs during the first two years of LPP participation. It is possible that

case managers can handle a larger case load of "experienced" LGUs, though this must be tested. Case managers should continue to reinforce accountability of LGU managers by requiring LGUs to justify the content of plans, and monitoring implementation to assure that the LGUs follow through on their proposals. Regular DOH and POPCOM staff at national and regional levels should also be assigned and trained as case managers.

4. DOH and the collaborating agencies providing support to the national services component of the IFPMHP should **focus on documentation of national policies, strategies and standards for dissemination to LGUs**. DOH must also begin preparations at the national level for the service access and performance LPP benchmarks. These should not be seen as the sole responsibility of LPP managers and the LGUs. This particularly concerns the re-vitalization of a system for accreditation of service delivery outlets, and systems to measure and report on quality of care and other performance indicators.
5. **USAID collaborating agencies should closely coordinate strategies and activities regarding LGUs**, and should provide information to the LPP which will enable LPP case managers to advise LGUs properly. For example, the timing of the assessment of LGU hospitals by AVSC staff should be modified so that LGUs have a clear understanding of the level of expected AVSC support before they finalize their LPP plan for that year. IEC training and plan development activities targeted to LGUs through JHU/PCS should be identified for inclusion in LPP training and orientation materials. The Population Council's proposed support for operations research in LGUs through staff development and actual funding for selected research projects can also be conveyed through LPP. If LPP staff are involved early enough, there are many ways that information needs or planning exercises required of LGUs by CAs may be incorporated into the regular LPP situation analysis, planning and benchmark monitoring process, thus making things easier for everyone.
6. **The total number of benchmarks per year must be kept to a minimum (no more than five)**, to allow adequate monitoring and documentation of compliance. The DOH should strictly enforce this so that all collaborating organizations understand that programs or program components which do not have their own benchmark are no less important than those programs/components where benchmarks are set.
7. The DOH, through the Local Government Advisory and Monitoring Service, should **provide clarification on provisions in the Local Government Code that relate to the provincial role for management of public health services**, especially national programs, post-devolution. Specific guidance should be given to provinces on how to clarify roles and re-establish appropriate provincial-municipal working relationships within the newly devolved health care system.

8. DOH should begin designing **procedures to provide rewards or incentives to LGUs with outstanding program performance**. These incentives can be non-financial, but also the DOH could use some of the LPP performance-based disbursement funds each year to provide special financial awards to LGUs with outstanding performance. The emphasis of the LPP should be changed from merely encouraging LGUs to meet their common benchmarks, to stimulating LGUs to reach higher by giving special recognition for excellence in surpassing the minimum standards set by the DOH.
9. DOH should **take active charge of funds management** for the LPP, including close monitoring of the flow of funds from USAID through the Departments of Treasury, Budget and Management, and Health, and down to the LGUs. Without this active attention, initially provided by FPMD, the program risks failure. DOH should also provide opportunities for LGU-to-LGU technical assistance and sharing of lessons learned about how to disburse funds quickly. This can be encouraged through exchange programs and national conferences.
10. DOH needs to **define and operationalize specific procedures and conditions which will result in exclusion from the LPP** (e.g. failure to achieve benchmarks, failure to uphold MOA, or lack of sufficient evidence of commitment and capacity to implement the FP/Pop/CS programs). Also, procedures under which LGUs may be entitled to extensions of time required to meet benchmarks should be well-defined.
11. Regional health and population offices, and other regional structures such as Regional Population Commissions, should be given increasing advisory and management roles in the LPP, especially in the areas of situational analysis, plan development and review, training, technical assistance and monitoring. The DOH Project Management Team should **decide whether LGU case managers should be situated at the regional level**, and should discuss with the project management technical assistance contract team possible strategies for building the capacity of regions to assume greater responsibilities in these areas. The regions themselves should develop management plans to deal with the LGUs so that they would know exactly the tasks to carry out.
12. DOH and USAID should **develop and agree upon procedures for developing consensus decisions on the selection of LGUs and benchmarks**. Both parties should then respect these procedures as a democratic process.
13. DOH and USAID should **consider ways to channel more funds to LGUs through performance-based disbursements**--for example, from AVSC, or from the Japanese. In addition, DOH should request and budget for more funds from the GOP, and lobby DBM to provide it through the regular health budget.
14. DOH and POPCOM should **coordinate and integrate the LPP with other donor assistance to LGUs for FP, CSP, and Population** by updating situation analysis and

planning norms and standards to include aspects of women's health and safe motherhood, and by coordinating approaches being implemented by donors such as UNICEF and UNFPA with those of the LPP. USAID should also initiate high-level meetings with UNFPA and other donors, to assure coordination of approaches. On the implementation level, LPP staff and technical assistance contractors should meet on a regular basis with DOH staff and contractors from the UNFPA project and other donor-assisted projects, to assure coordinated implementation.

15. DOH and USAID should **study alternative structures for the Family Planning, MCH, and Nutrition Services, as well as the LPP**, to recommend options which can reinforce the new roles and responsibilities of the DOH post-devolution--many of which are being "pilot-tested" in a sense by the LPP case managers. Concurrently, DOH should revise current job descriptions and work plans of national services and staff to incorporate the new functions of technical assistance and monitoring that the LPP case managers are now performing. DOH should dedicate not only contractual project management staff, but full-time managers to the LPP as well. These steps will help to mainstream the management development and "consulting" approaches to LGUs that have been initiated by the LPP, so that it is no longer perceived as a special, donor-financed initiative, but can truly become the DOH's approach to operating under devolution.
16. **LPP roles and responsibilities need to be clarified** among the national services, regional offices, IFPMHP Project Management Office (PMO), and Project Management Technical Assistance Contract Team (PMTACT). Steps which FPMD has already taken in this direction (i.e. the March 1995 "Sustainability Plan") need to be reviewed, updated, and acted upon as soon as possible.