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PROGRAM ASSISTANCE COMPLETION REPORT

CHILD SURVIVAL PROGRAM

492-0406

*USAID/PHILIPPINES*

March 1996

This Program Assistance Completion Report (PACR) consists of two parts: Interim PACR covering the period October 1989 to December 1993 and Supplemental PACR covering the period January 1994 to March 1995.

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UNITED STATES GOVERNMENT

# Memorandum

TO : THE FILES

DATE: January 21, 1994

FROM : Rosendo R. Capul, OPHN

*Report*

SUBJECT : Child Survival Program (492-0406): Interim Project Assistance Completion Report

The Child Survival Program (CSP) Grant Agreement was signed on September 29, 1989 and was planned to end on March 31, 1994. The project was granted a one-year, no-cost extension and the new Project Assistance Completion Date (PACD) is March 31, 1995. This interim Project Assistance Completion Report (PACR) describes the status of CSP as of December 15, 1993 and was prepared in accordance with USAID Mission Order No. 1026.9 dated January 26, 1988.

## I. Project Background

CSP was conceived in 1987 to assist the Department of Health achieve the child survival goals set in the 1988-1992 Philippine Development Plan. A joint USAID and DOH analysis at that time identified five sectoral constraints that would impede the attainment of such goals: a) inadequate budgetary resources; b) lack of effective targetting of services; c) low client demand; d) centralized administration of services; and e) fragmentation of services.

A performance-based sector assistance program was decided to be the most appropriate strategy for effectively addressing these constraints. Under this concept, annual tranches of AID assistance to the GOP will be conditioned upon GOP agreement to specified policy objectives and implementation of those objectives as measured against performance benchmarks. The policy agenda focuses on changes to foster the efficient delivery, increased availability and utilization of services through the targetting of services to high-risk groups and underserved areas; decentralization of planning and budgetting; and the integration of child survival-related services. The policy agenda also includes measures to ensure sustained commitment to, demand for and financing of child survival services through both the public and private sectors.

A \$50 million grant was authorized to implement CSP, consisting of \$45 million in performance disbursements and \$5 million in technical assistance. The goal of CSP is to "contribute to a reduction in the variance in infant and child mortality and morbidity rates among and within provinces and regions while

purpose is to "increase the availability, utilization, and sustainability of child survival-related services, including child spacing".

In order to achieve its goal and purpose, CSP pursued two principal strategies:

- 1) to create conditions that foster the efficient delivery, increased availability and utilization of child survival-related services, particularly to underserved and high-risk groups; and
- 2) to ensure the sustained commitment to, demand for, and financing of child survival services through both the private and public sectors.

Performance Disbursement Component. Prior to the first disbursement of the grant USAID and the GOP agreed on the policy matrix that formed the basis for the GOP's program of policy changes. This consisted of the two policy reform strategies, eight categories of policy reform, and annual policy objectives. The policy objectives address the various categories of reform needed to carry out the two program strategies, and they were designed, sequenced and interwoven in such a manner that their achievement will insure the attainment of the program's service delivery targets, which serve as indicators for the program's purpose-level objectives.

Implementation of CSP, therefore, centered on the accomplishment by the DOH of the policy objectives contained in the policy matrix. Each policy objective is assigned an indicator or benchmark, and they are grouped into sets according to the year that their completion are due. Progress in meeting the policy objectives is jointly reviewed by USAID and DOH towards the end of each year of the program. Presentation by the DOH and acceptance by USAID of adequate documentation to evidence completion of performance benchmarks that are due, and agreement by the DOH to the succeeding year's set of benchmarks trigger the release of a pre-determined and pre-agreed portion of the dollar grant. The GOP uses the dollar grant proceeds to service a portion of the foreign debt according to a schedule pre-agreed with USAID. CSP's planned schedule of tranching the \$45 million performance-based disbursement component of the grant is as follows:

CY 1989	-	\$ 9 million
CY 1990	-	11 million
CY 1991	-	13 million
CY 1992	-	12 million

Technical Assistance Component. CSP has a \$5 million technical assistance component, which includes funds for monitoring, evaluation and audit. Disbursement of this component follows the standard project assistance mode.

The types of technical assistance (TA) needed in CSP were determined during the design stage by the analysis of constraints and through consideration of on-going and planned TA provided by USAID and other donors. Four areas of technical assistance were emphasized: health information system development; epidemiology-based planning; social marketing and IEC; and health care financing. Technical assistance for CSP was planned to contribute to the program's specific objectives, and directed at improving sustainability of child survival services, improving efficiency in service delivery; institutionalizing health care technologies and management practices in the DOH; and achieving specific policy objectives.

## II. Implementation of CSP

The CSP grant agreement was signed on September 29, 1989. The DOH Undersecretary and Chief of Staff serves as Project Director, while the Program Coordinating Unit (PCU) provides staff support to manage the implementation of the project. The PCU at the same time coordinates the implementation of the World Bank-financed Philippine Health Development Project.

The Conditions Precedent (CPs) for the first disbursement of the grant, which included agreement by the DOH to the Policy Implementation Matrix and the performance benchmarks for the first year of the project, were met on December 19, 1989. Acceptance by USAID of these CPs triggered the release to the GOP of the first performance-based disbursement in the amount of \$9 million.

By July 1990 a technical assistance team (TAT) composed of five resident advisors was in place at the DOH to provide technical support in meeting the benchmarks, through a three-year contract with the Management Sciences for Health. The TAT provided technical advice in the areas of epidemiology-based planning, health care financing, social marketing, health information systems and program evaluation.

An elaborate tracking system to monitor and review periodically DOH progress in meeting the performance benchmarks was installed. It consisted of quarterly joint DOH, USAID and NEDA review meetings, and monthly progress monitoring meetings among DOH managers with benchmark completion responsibilities. USAID participation in the quarterly meetings included the CSP Project team. The monthly progress review meetings involved only the PCU, the USAID Project Manager and the DOH program and service managers.

The first joint quarterly meeting during an implementation year was a performance benchmarks clarification and planning workshop. During this meeting USAID technical staff and DOH program and service managers agreed on a common interpretation of all performance benchmarks, and the documentation required to prove satisfactory completion. Timeliness for benchmark completion, with corresponding progress milestones, were then set, responsibilities established, and logistic requirements determined. The second quarterly joint workshop was a review of progress after six months of implementation. Outstanding issues that constrained the completion of benchmarks were identified and discussed, and agreement was reached regarding actions that needed to be taken to resolve them. The third workshop was a preliminary review of the documentation that DOH would be submitting to USAID to prove benchmark completion, and was actually a dry-run of the formal review. Each document submission was presented, discussed and critiqued. Additional information and implementation actions that were needed to fully satisfy benchmark completion requirements were identified. At the fourth and final workshop, the DOH formally presented to USAID the documents that evidence completion of the benchmarks due for that year. During the presentation USAID sought whatever clarification it deemed needed on the material being presented, and pointed out deficiencies in the documentation if any were noted.

The CSP Project Team met shortly after the joint review to go over once more the documentation submitted by the DOH. If no major issues were identified the team recommended to the Mission Director that a Mission Review Committee (MRC) meeting be convened to review the DOH submissions. If no major issues were found during the review, the MRC recommended that the Mission Director accept the performance benchmarks as having been met and approve the release of the scheduled tranche.

III. Status as of December 31, 1993. By December 1992 and as scheduled, the DOH had completed and USAID had accepted all the performance benchmarks in the project's policy implementation matrix. Consequently, the entire performance disbursement component of CSP has been disbursed. Three benchmarks could not be met during the first year of implementation because they were improperly formulated. With the approval of the Mission Review Committee, they were modified without affecting the essence of the policy matrix and were subsequently met. No other problems were encountered in meeting the rest of the benchmarks.

Achievement of Project Outputs. The CSP midterm evaluation that was done in late 1991 concluded that the DOH performance in implementing the project's policy implementation matrix has been remarkable. The DOH effectively wielded the benchmarks as management tools so that important programmatic and management policy reforms within the system were successfully instituted,

among which are: the adoption of decentralized planning and program-based budgeting systems; integration of child survival-related services; application of social marketing strategies to internalize demand for health promotion and disease prevention strategies; and increased private sector participation in the planning and provision of services.

The evaluation also noted that at mid-project, most of CSP's health care financing and private sector involvement benchmarks were already achieved. It, therefore, recommended that support in these areas be transferred to the Health Finance Development Project which was then coming on stream. The implementation of this recommendation involved the abolition of the health care financing advisor position from the TAT.

The reforms that were brought about by meeting the performance benchmarks under CSP almost immediately resulted in improvements in the service delivery performance of the DOH. A coverage survey done in mid-1991 showed that the DOH was well on its way to meeting the 1993 service delivery benchmarks. For example, tremendous improvements were noted in the percentage of fully immunized infants, use of oral rehydration therapy in diarrhea, percentage of pregnant women presenting for prenatal care, and percentage of women with tetanus toxoid immunization. By July 1993 data were available on four of the nine end-of-program service delivery targets, which showed that these targets had been exceeded. Data for the rest of the service delivery indicators were collected during the September, 1993 Demographic and Health Survey and will be available for analysis during the end-of-program evaluation in early 1994. (Please see Annex 1 for a summary report on the status of the CSP service delivery targets as of July 1993).

**Attainment of Project Purpose.** The accomplishment of the project outputs, which essentially consist of meeting all the policy objectives and performance benchmarks in the policy implementation matrix as well as the project's service delivery targets, has enabled CSP to attain its purpose which is to "increase the availability, utilization and sustainability of child survival-related services, including child spacing, particularly to underserved and high-risk groups".

**Continuing AID Actions.** In 1991 the Local Government Code was enacted, which devolved the responsibility of planning, organizing, financing and delivering basic health services to local government units. Thus, although the performance disbursement component of CSP has been completed, the PACD was extended by one year to enable the DOH, through the project's technical assistance component, to address issues affecting the sustainability of CSP under the devolution. These continuing activities are being carried out through: 1) a buy-in to the Family Planning Management Development Project (FPMD) to develop

the strategies and mechanisms for strengthening capabilities of local government units under the Integrated Family Planning and Maternal Care Project; 2) a buy-in to the Data for Decision Making (DDM) Project to assist the DOH develop and install a health information system that can continue to operate under the devolution; and 3) through an extension of the services of one resident advisor under the MSH technical assistance contract to provide advice to the DOH Office of Special Concerns on developing plans to insure that CSP services continue to be delivered even with the devolution.

The DOH has likewise developed a plan (see Annex 2) that will ensure that the gains achieved by the Child Survival Program will be maintained under the devolution.

**Other Accomplishments.** Significant accomplishments were also made under the technical assistance component of the project. The largest portion (67%) of the projectized technical assistance component was implemented through a \$3.365 million technical assistance contract with the Management Sciences for Health (MSH). Under the MSH contract, 14 person-years of consultancy services were provided to the DOH by resident advisors. The contract had also been able to respond to immediate technical assistance needs of the DOH through the provision of short term local and foreign consultants. Research and evaluative studies, preparation of manuals and other activities that were undertaken to meet benchmarks completion requirements were funded through this mechanism, in addition to supporting limited participant training abroad. A series of seven monographs were written, published and distributed, and a fifteen-minute video documentary on the program was produced. (Please see Annex 3 for a full listing of extra-TA activities accomplished under the MSH Technical Assistance Contract).

Other major technical assistance activities included support for the Field Epidemiology Training Program resident advisor, a sub-grant to the Nutrition Center of the Philippines to assist the DOH develop its comprehensive nutrition program, a buy-in to the REACH project for technical assistance to the Program for Acute Respiratory Infections, a subgrant to the Office of Population Studies to analyze CSP field data in Cebu, and buy-ins to FPMD and DDM.

#### IV. Financial Summary and Status

The total amount obligated under CSP was \$49,998,148.80 consisting of \$45,000,000 in performance disbursements and \$4,998,448.80 in technical assistance.

Performance Disbursement Component. As of July 1993, the performance disbursement component was fully earmarked, committed and expended, as based on the following disbursement record:

December 26, 1989	-	\$ 9,000,000
December 21, 1990	-	11,000,000
December 20, 1991	-	13,000,000
December 23, 1992	-	8,750,300
June 28, 1993	-	3,249,700

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Total - \$45,000,000

Technical Assistance Component. As of December 31, 1993 the obligated amount under this component was fully earmarked, 82% committed and 76% expended (see Annex 4 for breakdown).

Overall, CSP is 100% obligated and earmarked, 98% committed and 96% disbursed as of December 31, 1993.

There were no problems identified when the status of active AID-financed contracts under CSP as of December 30, 1993 was reviewed. Consequently no disputes are being anticipated and no consultations will be required with EO/CSO to obtain contractor release. A review of commitments and disbursements under individual commitment documents likewise ascertain that all disbursements can be made under existing documents within the Terminal Date for Disbursements, and no deobligation of funds under CSP is to be expected.

Host Country Contribution. A summary of the host country contributions to CSP will be available on April, 1994.

#### IV. End-of Program Evaluation Plans

Although the PACD of the Child Survival program was extended to March 31, 1995, the end-of program evaluation will be undertaken in March 1994 as planned. It will be both process and impact oriented, and its major purposes will be:

1. To determine the extent to which the DOH accomplished the performance benchmarks agreed to at the time of the grant agreement (including subsequent amendments), and to assess whether the benchmarks were accurate indicators of the program's policy objectives.

2. To measure the achievement of the end-of-program service delivery targets, and assess the impact of meeting the policy objectives on their achievement.

3. To assess the process of program design and implementation management and monitoring (including

implementation arrangements that have been adopted by DOH and USAID), and identify factors responsible for project success or failure.

4. To do an overall analysis of CSP's implementation experience in order to define the conditions under which the performance-based mode of assistance that was employed by the Philippines CSP was successfully implemented, and determine its suitability as a funding mode for similar programs that USAID and other donors will be assisting in the future.

5. To identify the issues that need to be addressed and strategies that need to be employed in order to sustain the gains of CSP under the devolution.

The end-of-program evaluation will cover the design phase and the implementation period starting from the signing of the grant agreement (September 29, 1989) to December 31, 1993. In terms of the technical subject scope, it will include all elements and components of the program, including aspects related to the DOH, USAID and the Technical Assistance Team. (Please see Annex 5 for the evaluation scope of work).

#### V. Conclusions and Lessons Learned.

Using a variety of measures, the Child Survival program can be rated an outstanding success. All the performance benchmarks of the program have been met, causing the institutionalization of needed organizational, management and policy reforms that increased the availability and utilization of child survival services. This in turn enabled the program to attain its stated purpose. Because of the completion of all the benchmarks in the policy implementation matrix, the performance disbursement component of the grant was fully disbursed, giving CSP a very high expenditure rate. A high point in the implementation of CSP was the highly professional, mature and cordial relationship that developed between USAID and the DOH. The employment of the program mode or the performance-based approach for CSP was responsible for this, and kept discussions and interactions between the donor and beneficiary agencies at the policy level.

Following are some of the lessons learned from implementing CSP:

1. A project's chances to succeed become very high if the analyses of the development problem to be addressed and the prescription of interventions that go into project design are shared between the donor and the beneficiary agency.

2. The extremely collaborative manner that CSP was designed caused the DOH to develop a proprietary interest in the project, and this bound them to see to its successful implementation.

3. The program mode of assistance can be effective in meeting developmental goals and targets such as those of CSP. However, it requires that the counterpart host country institution must have attained a certain degree of maturity with a strong and solid leadership that has a clear vision of where the institution is going and what it wants to accomplish. If this condition is met, the program mode of assistance has distinct advantages over the project mode.

4. Another important element that contributed to the success of CSP was the elaborate and comprehensive progress tracking system that was closely and carefully followed. The system enabled the DOH to do proactive planning, assign responsibilities and accountability, flag problems early on to allow timely resolution, and allow a good review of the quality of implementation activities.

5. The notion that the program mode of assistance lessens management requirements from the responsible USAID technical office is a myth. While such project management responsibilities as the preparation of commitment documents, writing PIO/Ts, etc. are minimal, the need to constantly monitor the pace and quality of the various activities to meet the performance benchmarks demands an inordinate amount of time and skill from the project manager.

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SUMMARY OF CHILD SURVIVAL PROGRAM  
SERVICE DELIVERY TARGETS 1988-1993

July 1993

- 1) Percent of all children at age one who are fully immunized increases from 65% (1988) to 85% (1993).

STATUS: Target was accomplished! FHSIS indicates that FIC was 90% in 1992. Data from post NID coverage survey (fig. #1) shows that measles coverage has been consistently high (85%) over the last 4 years.

- 2) Percentage of pregnant women with at least 2 doses of tetanus toxoid increases from 50% (1991 household survey) to 80% (1993).

STATUS: Post NID survey indicates that TT2+ is now 72.5% (fig. #2). The target may be accomplished by the end of 1993.

- 3) Percent of all midwives, nurses, and doctors working at, or below, the level of the district hospital trained in new ARI case management, increases from 0% (1989) to 40% in 1993.

STATUS: Target was accomplished! Health facility survey done by HIS in July 1993 shows that 72% of midwives have already been trained as have 84% of PHNs (fig. #3).

- 4) Percent of DOH outreach workers trained to deliver a wide range of FP services increases from 59.5% (1990 FPS survey analyzed by UPPI) to 75% by 1993.

STATUS: Target was accomplished! Health facility survey done by HIS in July 1993 shows that 75% of midwives have already been trained (50% since 1990!). 84% of RHUs have staff trained in IUD insertion (fig. #4).

- 5) Percent of DOH health facilities delivering a broad range of FP services appropriate to the type of facility increases: BHS: from 1.9% (1990) to 40% in 1993. RHU from 0.5% (1990) to 50% in 1993. District Hospitals from 0% (1990) to 25% (1993)

STATUS: Target was accomplished! Health facility survey done by HIS in July 1993 indicates that 44% of BHSS are providing a broad range of services (fig. #5). 70% of RHUs are able to provide broad range of services (fig. #6).

6. Total Contraceptive Prevalence Rate for all program methods whether provided by the public or private sector, increases from 22% (1988 Contraceptive Prevalence Survey, UPPI) to 35%.

STATUS: Actual CPR won't be known until DHS results in Sept. 1993. Much progress has been made in terms of IUDs and pills but VSC has not improved (fig. #7). The latter is a critical problem because VSC makes up more than 50% of contraceptive prevalence (fig. #8).

7. Percent of all pregnant women served by DOH at least three prenatal visits increases from 48% (1991 household survey) to 80% by 1993.

STATUS: Data not currently available. Available from 1993 DHS.

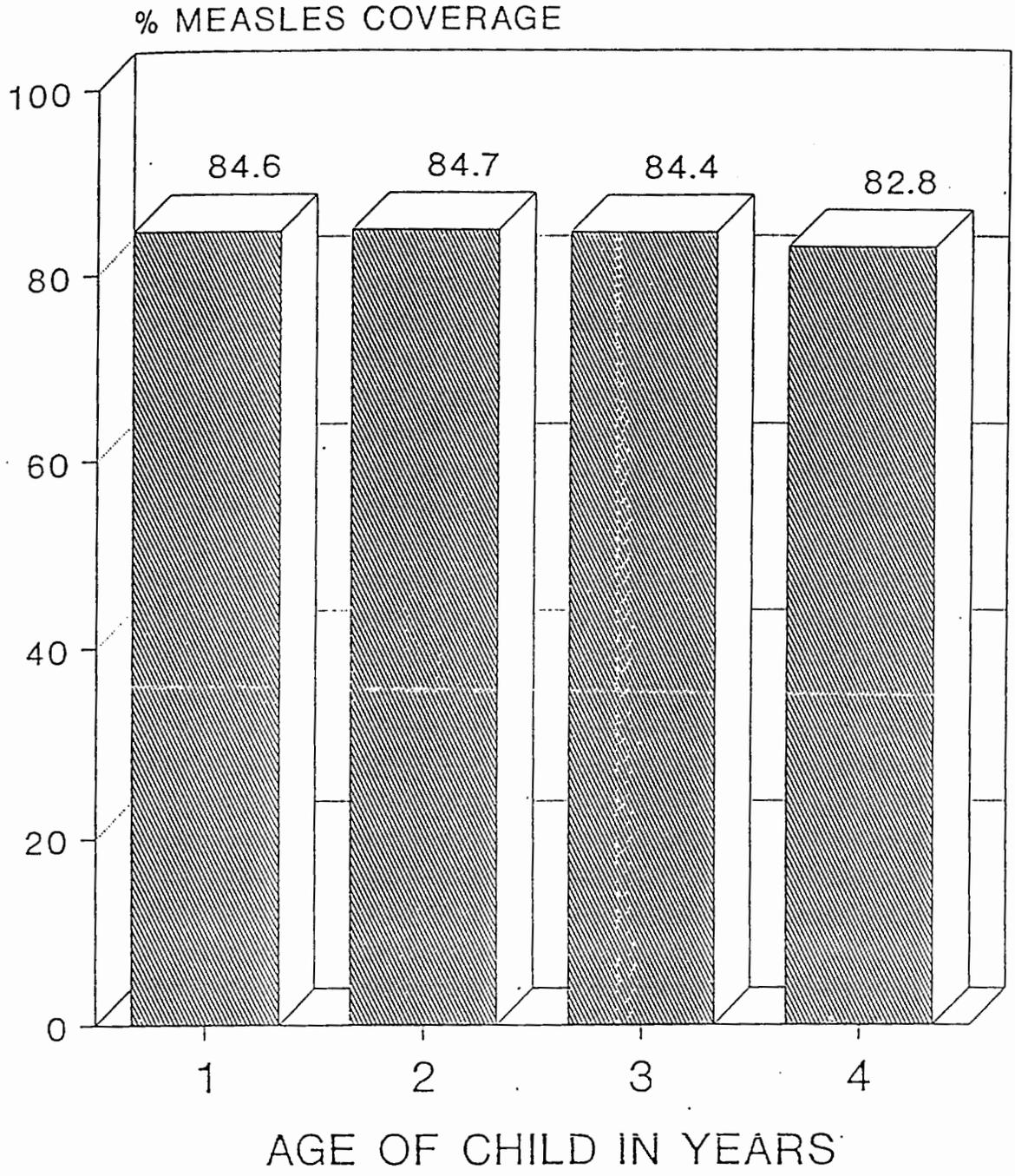
8. Percent of all births attended by trained personnel, including trained TBAs, increases from 76% (1991) to 85% in 1993.

STATUS: Data not currently available. Available from 1993 DHS.

9. ORT use rate in all cases of diarrhea among children under five years of age, increases from 25% (1991 household survey) to 60% in 1993.

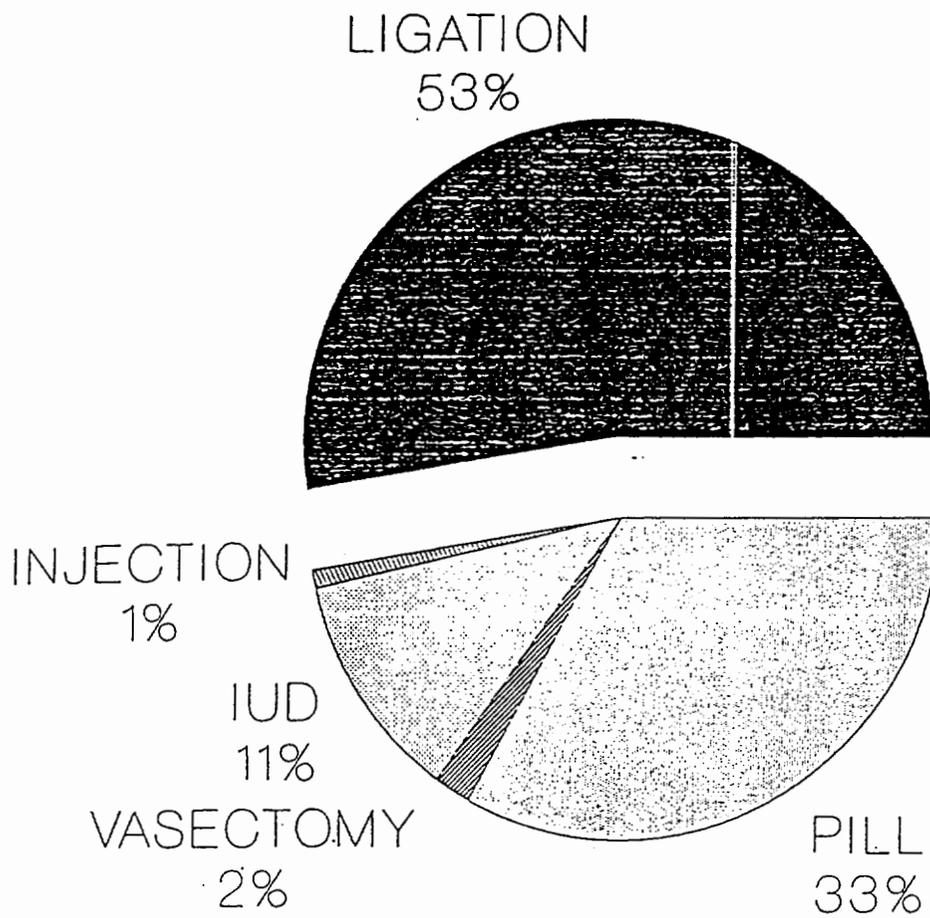
STATUS: Data not currently available. Available from 1993 DHS.

# MEASLES VACCINATION COVERAGE BY AGE OF CHILD IN YEARS



SOURCE: 1993 POST-NID SURVEY (N=2,511)

# METHOD MIX AMONG MCRA's USING MODERN, PROGRAM METHODS 1988 NDS



DOH PLAN TO MAINTAIN THE GAINS  
ACHIEVED BY THE CHILD SURVIVAL PROGRAM  
AFTER IMPLEMENTATION OF THE LOCAL GOVERNMENT CODE

I. INTRODUCTION

The DOH is concerned that the gains achieved through the Child Survival Program (CSP) are maintained after health services are devolved to local government units. The DOH plan consists of three main strategies:

- A. The creation of a "Task Force on Child Survival, Development, and Protection."
- B. Continued strong DOH support, using both GOP and donor funding, to achieve long-term, sustainable child survival activities and services.
- C. Active and continuing collaboration between the DOH and governors, mayors, and their health staff to assure effective and efficient child survival services, focusing on the needs of the mother and her child rather than on "programs" per se.

II. WHAT ARE THE MAJOR GAINS OF THE CSP THAT NEED TO BE MAINTAINED?

A number of important innovations and programs have been strongly supported by the CSP. These include Area Program-Based Health Planning, the integration of services for mothers and children, the Field Health Services Information System, augmentation funding for provinces and cities, social marketing campaigns, child survival service delivery targets as DOH priority goals, and so forth. In addition, the CSP has helped to strengthen such programs as EPI, CDD, and ARI.

Once the Local Government Code is fully implemented and health services have been devolved, it will be up to governors, mayors, and their health staff whether to continue, expand, or reduce these programs at the local level. The DOH is committed to maintain the important gains of the CSP.

III. WHAT DOES THE DOH PROPOSE TO DO?

The DOH has issued a Department Order which creates a Task Force for "Child Survival, Development, and Protection." This Task Force has several important

objectives:

1. To determine what should be the program framework for child survival, development, and protection for the years 1994-2000 (e.g., for the seven-year period following the end of the CSP -- note that the mandate of the Task Force goes beyond survival to include the development and protection of children).
2. To develop a Plan of Action (for 1994-2000) using the life-cycle approach.
3. To develop a financial plan (using GOP and donor resources) aimed at developing long-term sustainable programs.

Our goal here is to combine GOP and donor funds in such a way that by the time CSP funds are exhausted (e.g., by 1994) we will have in place a clear plan, with well thought out strategies and a funding base to maintain the gains of the CSP into the next century.

In addition to the Task Force, the DOH plans specific steps to ensure continuity and even expansion of key programs. One example is that of Area Program-Based Health Planning (APBHP), developed by the DOH in 1989 as a new approach to decentralized planning. The main features of APBHP include the following:

- o It is decentralized in that midwives and nurses from Barangay Health Stations and Rural Health Units actively participate in the planning process.
- o APBHP is data-based, relying on the FHSIS to provide the most important inputs.
- o It is epidemiology-based in that the most important preventable causes of mortality and morbidity are given top priority, based on prevalence and incidence rates using the "risk approach"
- o APBHP targets particular geographic units (such as barangays) which have low levels of coverage for key programs.
- o It also targets particular programs which are performing poorly in a number of barangays.

It can be said without exaggeration that APBHP revolutionized health planning in the Philippines. An APBHP Manual (now in its 4th edition) has been widely disseminated and health workers at all levels have been trained in the APBHP approach. Annual plans meeting quality standards are produced by all 75 provinces and 60 chartered cities.

The APBHP methodology anticipated the fact that health services in the Philippines would be devolved to LGUs. In addition, augmentation funding (MOOE) is made available to provinces and cities to implement their health plans on a decentralized basis.

The DOH is aware of the possibility that under the LGC governors and mayors will be responsible for health matters and may choose not to continue using the APBHP approach. What can the DOH do to ensure continuation of decentralized planning? The DOH has already taken or is about to take several positive steps to support APBHP at the local level once devolution takes full effect in 1993:

- (1) Health staff from every province and most municipalities have received training in APBHP and virtually all of them are committed to this approach. The DOH plans to intensify its efforts to "market" APBHP to LGUs. An operations research study, with the collaboration of the UP College of Public Health, will begin very soon and will determine how the DOH can most effectively support APBHP in provinces and cities.
- (2) DOH field offices (formerly region offices) will also vigorously promote APBHP in provinces, cities, and municipalities. DOH field office staff can support DOH representatives on the Local Health Boards to make sure APBHP is understood and its value appreciated.
- (3) The proposed "Guidelines for the Management by LGUs of a Health Care Delivery System After Devolution" (Chapter 7, Section 22 "Directions for Health Planning") states that municipal and provincial health units "shall submit their operational health plans by the second week of January prior to the year of implementation of the plan, following the standard set in the Area Program-Based Health Planning Manual of the DOH" (underline added). These guidelines require that the APBHP approach be followed by all provinces and municipalities.
- (4) MOOE augmentation funds can be made available to provinces, cities, and municipalities contingent upon submission of decentralized health plans. This can be a useful means of ensuring continuation of APBHP.
- (5) The Core Group (managed by the Internal Planning Service) consists of about 25 DOH Central Office staff who have been trained in APBHP and in process consulting skills. The members of the Core Group frequently provide technical assistance in health planning to local health officials and LGUs

The DOH is confident that these measures will assure a

sustainable process of decentralized health planning (using the APBHP approach) for the foreseeable future.

The DOH chose nine CSP service delivery targets to be achieved by the end of 1993. What can the DOH do to support local government officials in their efforts to achieve and maintain these targets?

The nine (9) service delivery targets were selected because they were clearly measurable, were feasible, and if accomplished would have a considerable impact upon morbidity, mortality, and fertility.

Beginning in 1990, provinces have set annual targets for these nine indicators (two involve immunization, two involve maternal care, three involve family planning, and one each concerns CDD and ARI). Most recently, in June 1992, all 75 provinces established province-level targets for all nine, to be achieved by the end of 1993. Program managers from the DOH central office in Manila negotiated in June with each of the provinces regarding their nine targets to make sure that the targets selected were feasible and also to make sure that when added all together the 75 provincial targets would equal or exceed the 1993 national targets. Similar negotiations have taken place each year since 1990.

For seven of the service delivery targets the provincial health officials can monitor their performance on a regular basis by using routinely reported data. For two (ORT use rate and contraceptive prevalence rate) special household surveys are required in order for the province to know whether they are meeting their target or not. These special surveys normally require assistance from outside the province (especially from DOH central and regional offices).

A concern of the DOH is the possible effect of the LGC on province-level commitment to achieve the nine CSP service delivery targets in 1993. The DOH feels, however, that the LGC will have only a minimal impact on service levels. Their main reasons for this confidence are as follows:

- (1) During the June 1992 negotiations between the DOH central office program managers and provincial health staff, the effect of the LGC was raised as an important issue for discussion. Most Provincial Health Officers (PHOs) were quite confident that there would be no loss of commitment to achieving CSP targets despite implementation of the LGC. They felt this way because of their own personal commitment to reach their targets, their confidence in the doctors, nurses, and midwives of their provinces to likewise place CSP goals as a high priority, and because of the support they expect from the newly elected governors and mayors of

their provinces. Almost all the PHOs insisted that there was no need to lower the targets because of the LGC.

- (2) In the proposed "Guidelines for the Management by LGUs of a Health Care Delivery System after Devolution" (Chapter 7, Sections 21 and 22), it is required that all provinces prepare annual health plans in accordance with national directional health plans and follow the Area Program-Based Health Planning Manual. Both the national directional health plans of the different MCH and Family Planning programs as well as the APBHP manual mandate that the nine CSP service delivery targets be a top priority and be achieved by 1993.
- (3) The DOH can use the 1993 Provincial MOOE Augmentation funds (from the CSP) in such a way as to strongly encourage provinces to meet their 1993 targets. Any provincial lack of commitment can be countered by withholding 1993 MOOE Augmentation funds (which are intended to support CSP objectives, especially the nine service delivery targets).

For these three reasons the DOH is convinced that the provinces will make every efforts to reach their targets in 1993. Devolution may in fact help them in reaching their targets if mayors and governors are convinced of their importance.

Another important gain of the CSP has been the increased attention given to integrating services for mothers and children at all levels of the health care system. A manual has been prepared focusing on this issue and what can be done to improve the integration of services. In addition, large numbers of physicians, nurses, and midwives have been trained in applying this manual to actual service delivery. What can be done by the DOH to ensure that fully integrated services for mothers and children continue after devolution?

One recent step the DOH taken is to put the Family Planning Service, Nutrition Service, and the MCH Service (the three most important services for child survival service delivery) under one Assistant Secretary. This should help integration at the national and regional levels and should strengthen integration at lower levels as well. In addition, the widespread training in integration that has occurred throughout the country is likely to lead to sustained improvements for mothers and children even after devolution has taken place and CSP funds have all been spent.

#### IV. CONCLUSION

The DOH is totally committed to child survival and to maintaining the gains of the CSP into the 21st century. Devolution should eventually strengthen child survival, as local government officials and their health staff make decisions based on their local situation which they, of course, know best. When CSP funds are no longer available, beginning in 1994, the DOH will be ready with a long-term strategy, with concrete plans, and with appropriate and sustainable funding.

CHILD SURVIVAL PROGRAM  
PROJECTS AND ACTIVITIES FUNDED UNDER PARTICIPANT TRAINING,  
ANALYTICAL RESEARCH AND PUBLICATIONS LINE ITEM OF THE MSH  
TECHNICAL ASSISTANCE CONTRACT

1. Evaluation of Module B Campaign in the Control of Diarrheal Diseases communications pilot area.
2. Health care financing Benchmark Studies
  - o An Evaluation of the Philippine Medical Care Commission/Health Maintenance Organization (PMCC/HMO) Tie-Up Project
  - o Strengthening the HMO Industry through Regulation
  - o Policy, Regulator, and Political Framework for Health Services Privatization
  - o A Study on Cost Containment in Department of Health (DOH) Hospitals
  - o National and Local Government Shares in Health Care Financing
  - o Uses and Sources of Funds for Child Survival Interventions
  - o The Role of the Community Health Service in Public-Private Sector Collaboration
  - o Development of an Agenda for Public-Private Sector Collaboration
  - o PMCC/HMO Tie-up: Second Evaluation
3. Data gathering and documentation for the CSP mid-term evaluation
4. Dr. Mariquita J. Mantala as consultant and liaison between the DOH Project Coordinating Unit and CSP
5. Integrated Supervisory Checklist Project
  - o Printing of the Health Facility and Supervisory Checklist Manuals
  - o Training on the use of the checklists
  - o Evaluation of the checklists

6. Preparation of the Implementation Guidelines/Briefer/Manual
7. National Immunization Days (NID)
  - o Printing and distribution of materials for NID
  - o Conferences and caucuses for broadcasters and NGOs
  - o Communications
8. Institutionalization of CSP through Devolution
9. Midwives Integrated Communications Aid for Child Survival
10. Invitational travel to conferences and seminars of
  - o USec. Tomas Maramba
  - o USec. Jaime Galvez-Tan
  - o ASec. Linda Milan
  - o Dr. Lourdes Casimiro
  - o Dr. Wilfredo Asoy
  - o Dr. Jose Miguel Vergara
11. CSP Publications
  - o Area Program-Based Health Planning Manual
  - o Clinical Manual
  - o CSP Monograph Series
    - Monograph No. 1      Implementing the Philippine Child Survival Strategy
    - Monograph No. 2      Area Program-Based Health Planning in the Philippines
    - Monograph No. 3      Setting Quantitative Objectives in Health Sector Programs: Lessons Learned from the Philippine Child Survival Program
    - Monograph No. 4      The Field Health Services Information System: Its Role in Decentralizing Health Services in the Philippines
    - Monograph No. 5      Social Marketing Communications: Its Contribution to the Philippine Child Survival Program
    - Monograph No. 6      Paying for Performance: An Approach to Donor Funding in the Philippines

Monograph No. 7

The Field Health Services  
Information system: A Case Study

12. CSP Documentary Video

## Annex 4

Child Survival Program  
 Technical Assistance & Monitoring/Evaluation/Audit Component  
 (In US Dollars) As of Dec. 31, 1994

CONTRACT/DOCUMENT NO.	DESCRIPTION	EARMARK	COMMITMENT	EXPENDITURE	AMOUNT OBLIGATED	% EARMARKED	% COMMITTED	% EXPENDED
1. AID 492-0406-C-0000-7900	MSH/TECH Asst.	3,365,630.00	3,365,630.00	3,070,682.00		67%	67%	61%
2. PASA-ANE-0371-PHH-7030	White/Cont Ext.	509,417.00	509,417.00	461,842.73		10%	10%	9%
3. DPE-5982-Z0090-34000DO#5	John Snow/TA/ARI Program	75,947.00	75,947.00	75,733.32		2%	2%	2%
4. AID-492-0406-G-SS-111500	OPS/TIER 3 Evaluation	33,372.60	33,372.60	33,372.60		1%	1%	1%
5. AID 492-0406-G-SS-107900	NCP/TA/National Nutrition Plan	58,423.00	58,423.00	58,423.00		1%	1%	1%
6. AID 492-0406-G-SS-107900	NCP/TA/National Nutrition Plan	47,481.00	47,481.00	47,481.00		1%	1%	1%
7. TA-AID-MA-91-330	Ongcoy/TRVL/San Francisco	2,240.27	2,240.27	2,240.27		0%	0%	0%
8. TA-AID-MA-91-329	DeLeon/Trvl/San Francisco	2,414.89	2,414.89	2,414.89		0%	0%	0%
9. AID 492-0406-C-00-200900	Abelia/TA/Support DOH	7,616.65	7,616.65	7,616.65		0%	0%	0%
10. AID 492-0406-C-00-200200	John Snow/TA/Mid. Evaluation	15,816.00	15,816.00	15,816.00		0%	0%	0%
11. AID 492-0406-C-00-207200	Detels/TA/Epidemiology	5,361.50	5,361.50	5,361.50		7%	0%	0%
12. PIO/T 492-0406-3-2-20229	MSH/FPMD/Buy-in	625,000.00				13%	0%	0%
13. PIO/T 492-0406-3-20232	Data Decision Making	249,728.89				5%	0%	0%
<b>TOTAL</b>		<b>4,998,448.80</b>	<b>4,123,719.91</b>	<b>3,780,983.96</b>	<b>4,998,448.80</b>	<b>100%</b>	<b>82%</b>	<b>76%</b>

The Child Survival Program  
End-of-Program Evaluation

SCOPE OF WORK

A. Project Background

The Child Survival Program (CSP) is a \$50 million sectoral support grant to the Government of the Philippines that was intended to assist the Department of Health implement organizational and policy reforms to improve the delivery and utilization of health services for mothers and children. The grant agreement was signed in September, 1989 and consists of \$45 million in performance disbursements and \$5 million in technical assistance. The grant's Project Assistance Completion Date (PACD) is March 31, 1994. However, this has been extended by one year to allow the project to address issues brought about by the devolution of health services planning, delivery and financing to provinces, cities and municipalities. The PACD extension notwithstanding, it was deemed propitious that the end-of-program evaluation be undertaken as originally scheduled.

The goal of CSP is "to contribute to a reduction in the variance in infant and child mortality and morbidity rates among and within regions and provinces while simultaneously lowering the corresponding national rate". Its stated purpose is "to increase the availability, utilization and sustainability of child survival-related services, including child spacing". In order to achieve its goal and purpose, CSP pursued two principal strategies:

- 1) To create conditions that foster the efficient delivery, increased availability and utilization of child survival-related services, particularly to underserved and high-risk groups; and
- 2) To ensure the sustained commitment to, demand for, and financing of child survival services through both the private and public sectors.

Implementation of CSP centered on the accomplishment by the DOH of pre-agreed policy objectives contained in the project's policy implementation matrix. The policy objectives address the various categories of reform that need to be enacted to carry out the project's two major strategies. They were designed, sequenced and interwoven in such a manner that the attainment of these objectives would insure the achievement of the end-of-program service delivery targets, which are the markers for the project's purpose-level objectives.

Each of the policy objectives are assigned an indicator or benchmark, and they are grouped into sets according to the year that their accomplishments are due. Benchmarks that are due in a given year are reviewed jointly by DOH and USAID in early November. Presentation by the DOH and acceptance by USAID of adequate documentation to evidence satisfactory completion of the benchmarks

triggers the release of a pre-determined and pre-agreed portion of the dollar grant, which the GOP in turn uses to pay a part of the foreign debt. (This applies to the \$45 million performance disbursement component of the grant. The \$5 million TA component is disbursed according to the conventional project assistance mode).

To support this process, the Program Coordinating Unit under the Office of the Chief of Staff was designated as the DOH staff office to coordinate the implementation of CSP. In addition, a technical assistance team (TAT) of five long-term advisors provided support to the DOH in the areas of management information systems, health finance, social marketing, health planning and evaluation.

#### B. Purpose of the Evaluation

The end-of-program evaluation will be both process and impact-oriented. Its major purposes are:

1. To determine the extent to which the DOH accomplished the performance benchmarks agreed to at the time of the grant agreement (including subsequent amendments), and to assess whether the benchmarks were accurate indicators of the program's policy objectives.

2. To measure the achievement of the end-of-program service delivery targets, and assess the impact of meeting the policy objectives on their achievement.

3. To assess the process of program design and implementation management and monitoring (including implementation arrangements that have been adopted by DOH and USAID), and identify factors responsible for project success or failure.

4. To do an overall analysis of CSP's implementation experience in order to define the conditions under which the performance-based mode of assistance that was employed by the Philippines CSP was successfully implemented, and determine its suitability as a funding mode for similar programs that USAID and other donors will be assisting in the future.

5. To identify the issues that need to be addressed and strategies that need to be employed in order to sustain the gains of CSP under the devolution.

#### C. Scope of the Review

The CSP end-of-program evaluation will cover the design phase and the implementation period starting from the signing of the grant agreement (September 29, 1989) to December 31, 1993). In terms of the technical subject scope, it will include all elements and components of the program, including aspects related to the DOH, USAID and the TAT.

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#### D. Key Evaluation Issues/Objectives

1. To measure the extent to which CSP has achieved its purpose-level objectives. Were the nine end-of-1993 service delivery targets met? Were the targets realistic given intervening factors beyond the influence of the program and of the DOH? Can an estimate be made of the impact that the achievement of the service delivery benchmarks have on infant, child and maternal morbidity and mortality reduction?

2. To assess the extent to which the DOH has met the program's policy objectives and whether the planned reforms were realized. Are the policy objectives in the policy implementation matrix the most critical to achieving overall goals of CSP? Were the performance benchmarks accurate indicators to measure achievement of the policy objectives? As a result of meeting the policy objectives what reforms were successfully enacted in the DOH management and organizational structure and programs? How did these reforms impact on the achievement of the service delivery targets? Was the DOH successful in obtaining extrabudgetary funding to support CSP implementation? How were these funds invested?

3. To assess the CSP design and implementation process. What was the process that USAID and DOH followed in designing the program and how did this influence the way the program was implemented and its eventual outcome? How did the DOH manage the implementation of the program, and how effective was this management process? How did USAID manage the process from its end, how did this influence program implementation and outcome, and what lessons can be learned for future programs of a similar nature?

4. To assess the appropriateness and utilization effectiveness of the technical assistance component of the program. What process or system was used to identify the technical assistance requirements of the program? How clearly were the workscopes of the technical assistance team as a whole and of the individual members defined? On the whole, what was the impact of the technical assistance component (particularly the TAT) on the outcome of the program? From the CSP experience, what lessons can be learned regarding the provision of technical assistance teams for similar programs in the future?

5. To assess the effectiveness of the performance-disbursement mode of assistance for CSP-type projects in meeting developmental goals of donors and host counterpart agencies. Overall, can CSP be rated a success? On what measures? If the program has been successful, what conditions were present and what were done right that made success possible? Is USAID satisfied and happy with the manner by which the disbursement of the CSP grant was designed and implemented? Given similar conditions will USAID (particularly OD, OFM, OLA, PDIS and PRM) recommend the use by USAID and other donors of the program mode of assistance for CSP-type projects in the future?

6. To examine post-CSP sustainability issues. What are the plans of the DOH for sustaining CSP upon termination of USAID assistance? How did the DOH sustain CSP in 1993 which marks the first year of the full implementation of the Local Government Code? By looking at the current behavior of LGUs in the way that they are dealing with health service delivery concerns, what issues need to be addressed in order to conserve and sustain the gains of CSP? What strategies can be employed to effectively deal with these issues?

#### E. Data Sources and Report Format

The evaluation will rely on three main sources of information: 1) secondary data sources such as CSP implementation monitoring data and various program documents; 2) interviews with key officials and staff knowledgeable about the program; and 3) selected field site visits.

Key documents to review will include the Project Assistance Approval Document (PAAD), the Mid-term Evaluation Report, documentation submitted by the DOH in meeting the performance benchmarks, various monographs written by TAT, the Demographic and Health Survey Reports for 1983 and 1993, the Family Planning Service/University of the Philippines Health Facility Survey (1990), FETP documents relevant to vaccine-preventable diseases, the 1993 WHO Evaluation Report on the CDD Program, REACH's ARI Training Program, FHSIS reports, post-NID coverage survey reports, the HIS Health Facility Survey (July, 1993), and the various reports documenting the progress and issues surrounding the implementation of the Local Government Code as they affect the planning, organization, delivery and financing of health services. Correspondence files between USAID, DOH and TAT will also be of value in the evaluation.

The team will select a representative set of provinces and municipalities for site visits to assess the policy, organizational and budgetary changes supported by CSP. Focus group interviews may be used to obtain information from staff of provincial and municipal health offices about operational changes affecting child survival-related services.

Interviews will include current and previous DOH managers, USAID/Manila and USAID/Washington staff, other donor staff, and key health sector personalities who have knowledge about CSP.

The evaluation report format should include: 1) the major findings of the team, noting where information was adequate or lacking; 2) the conclusions interpreting the findings of the topics studied; 3) recommendations for the DOH and USAID on sustainability concerns; and 4) recommendations to USAID on the application of the program mode of assistance in other settings.

The evaluation will be conducted over a four-week period. The first two days will be devoted to team planning, consisting largely

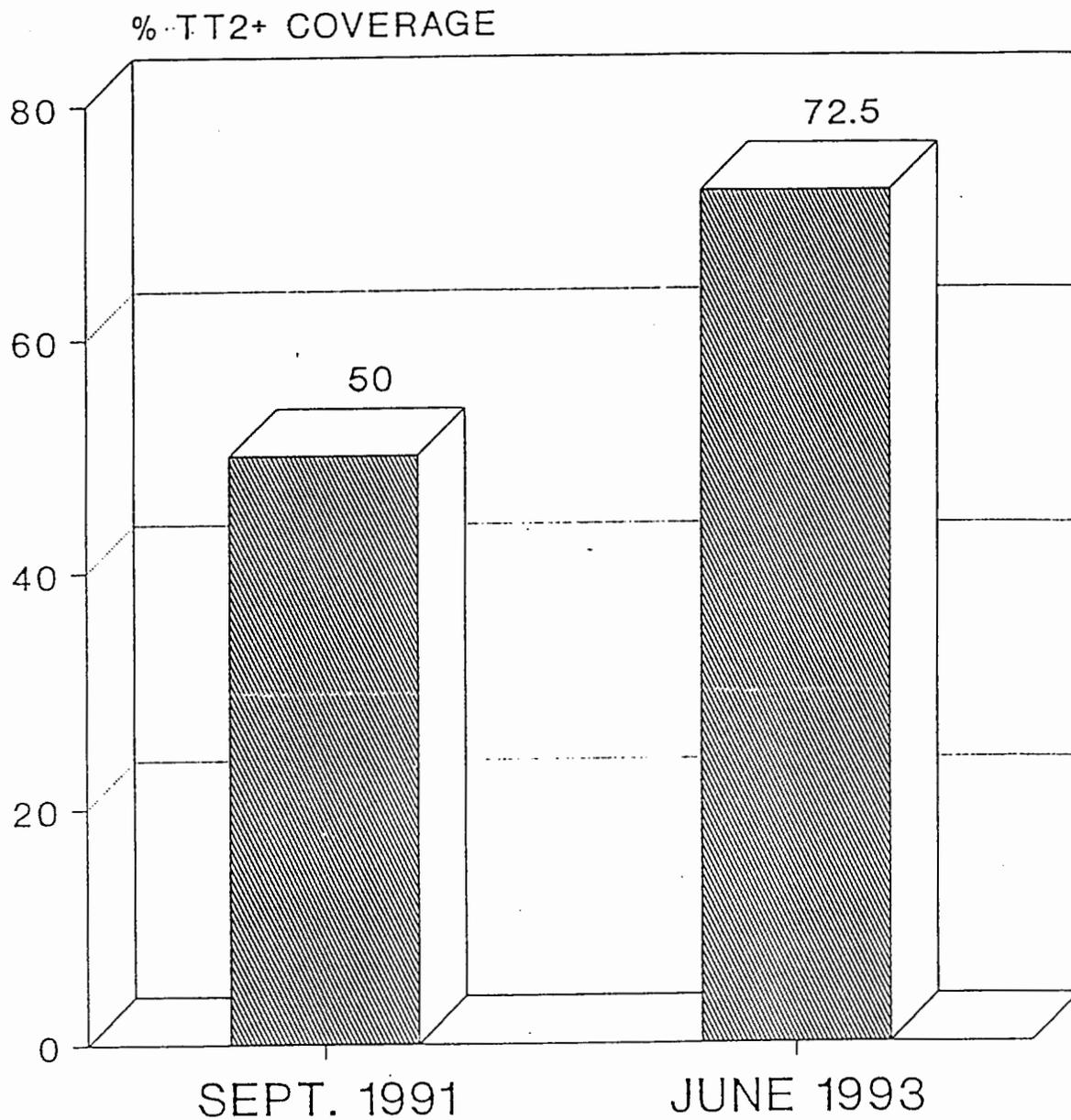
of briefings from easily accessible key staff in order to: a) arrive at a common understanding of tasks specified by the scope of work; b) identify types of information needed and how they will be obtained; c) organize activities to carry out the work, both as a team and individually; and d) develop schedules for interviews and site visits.

Data collection and analysis will be carried out over the following three weeks with a draft report submitted for review by the beginning of the fourth week. The team will revise the report based on comments from reviewers by the end of the fourth. Any further revisions will be made by the team leader. The team is required to make all factual corrections identified by the reviewers. However, the team will use its own professional judgement concerning matters of interpretation and analysis of findings.

#### F. Team Composition

- Program Analyst/Team Leader
- Public Health/Child Survival Specialist
- Public Health/Service Delivery Specialist
- Organization and Management Development Analyst

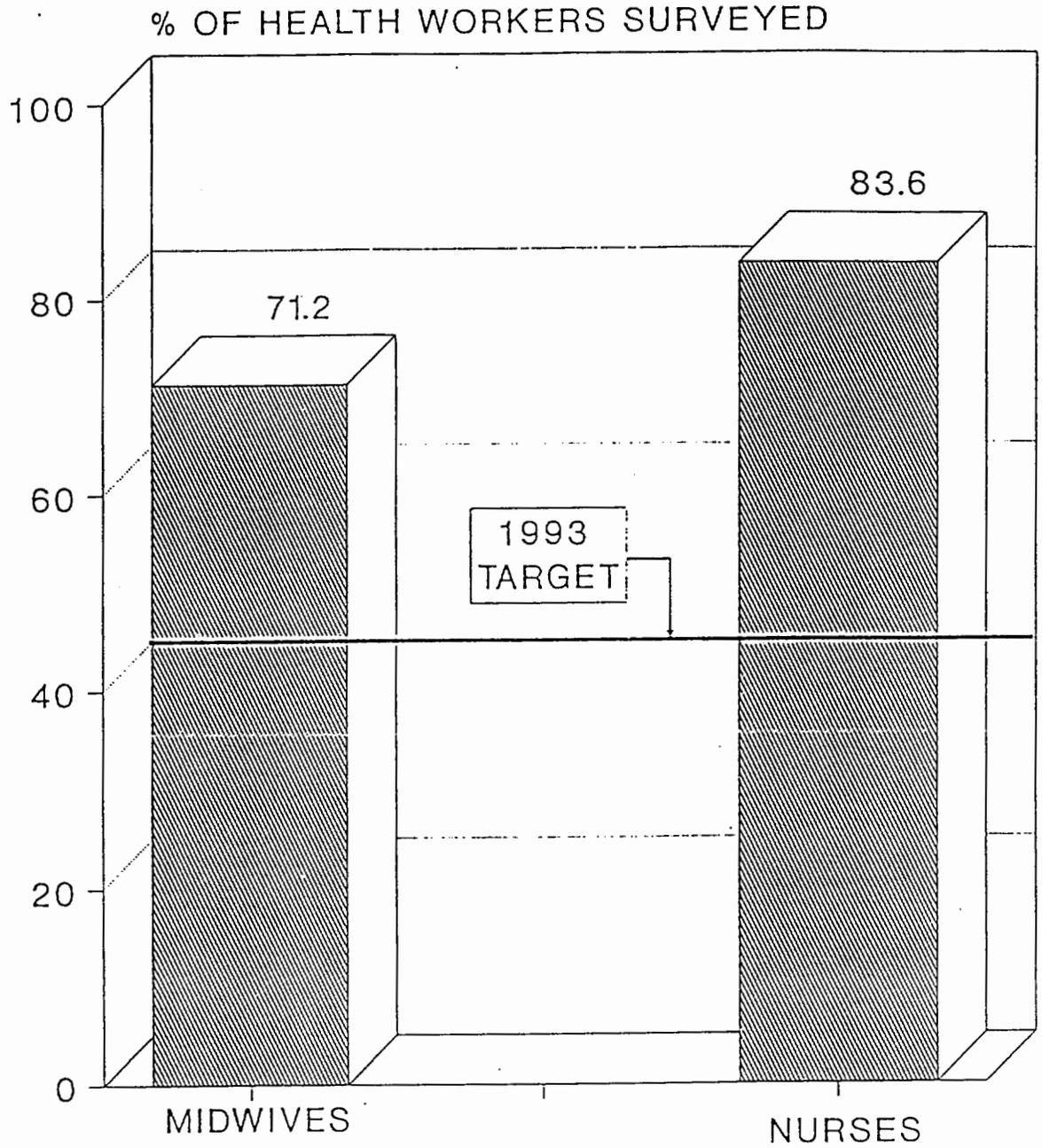
# TETANUS TOXOID (TT2+) COVERAGE AMONG MOTHERS OF INFANTS ACCORDING TO HOUSEHOLD SURVEYS



SOURCES: 1993 POST-NID SURVEY  
1991 "TRENDS" SURVEY

*note: problem w/ quality  
of vaccine -*

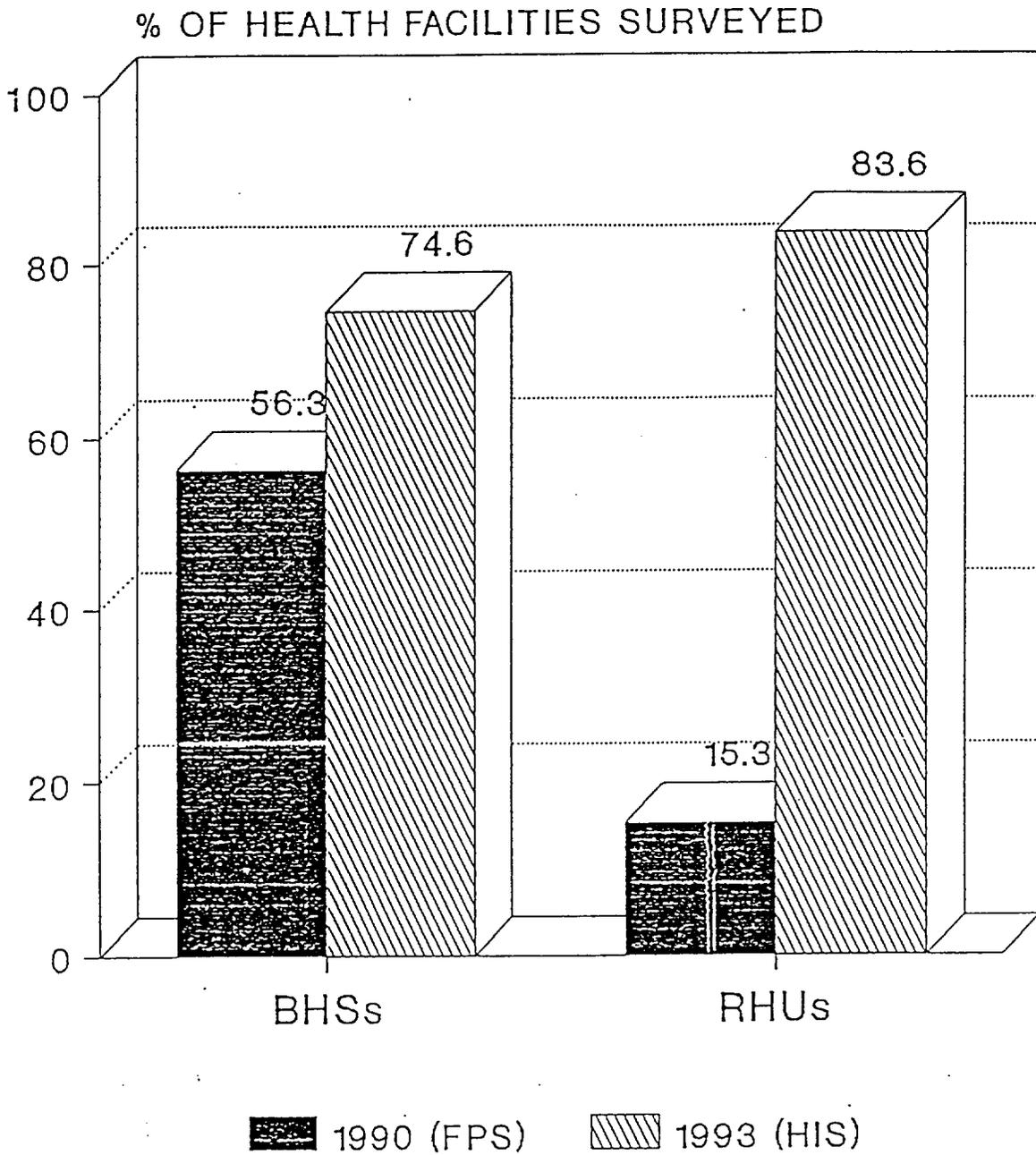
# MIDWIVES AND NURSES TRAINED IN MANAGEMENT OF ARI BY JUNE 1993



SOURCE: HEALTH INTELLIGENCE SERVICE  
HEALTH FACILITY SURVEY (N=146)

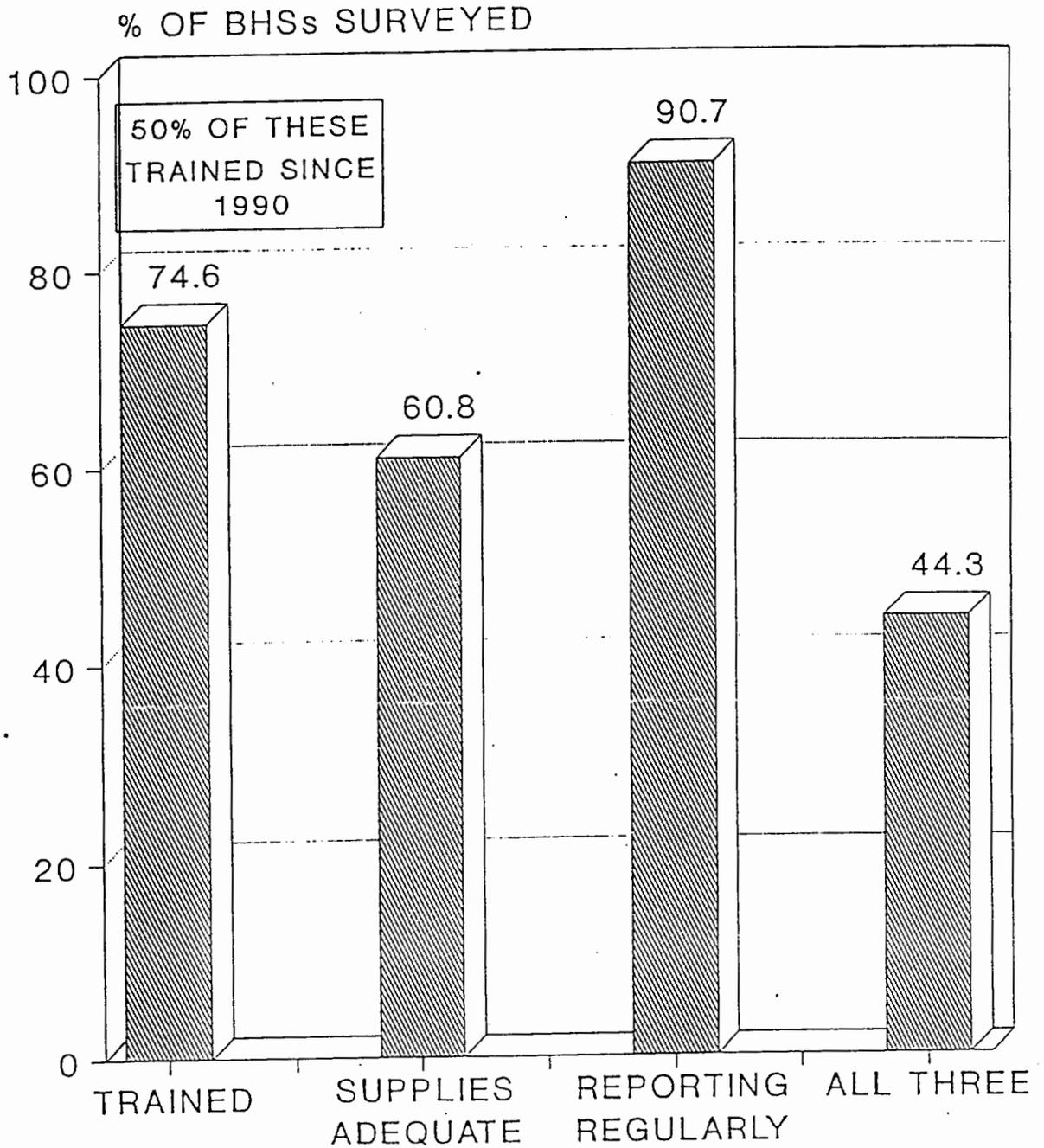
30

### BHSs AND RHUs WITH APPROPRIATE LEVEL OF FP TRAINING 1993 and 1990



SOURCES: HIS HEALTH FACILITY SURVEY,  
FPS SURVEY ANALYSED BY UPPI

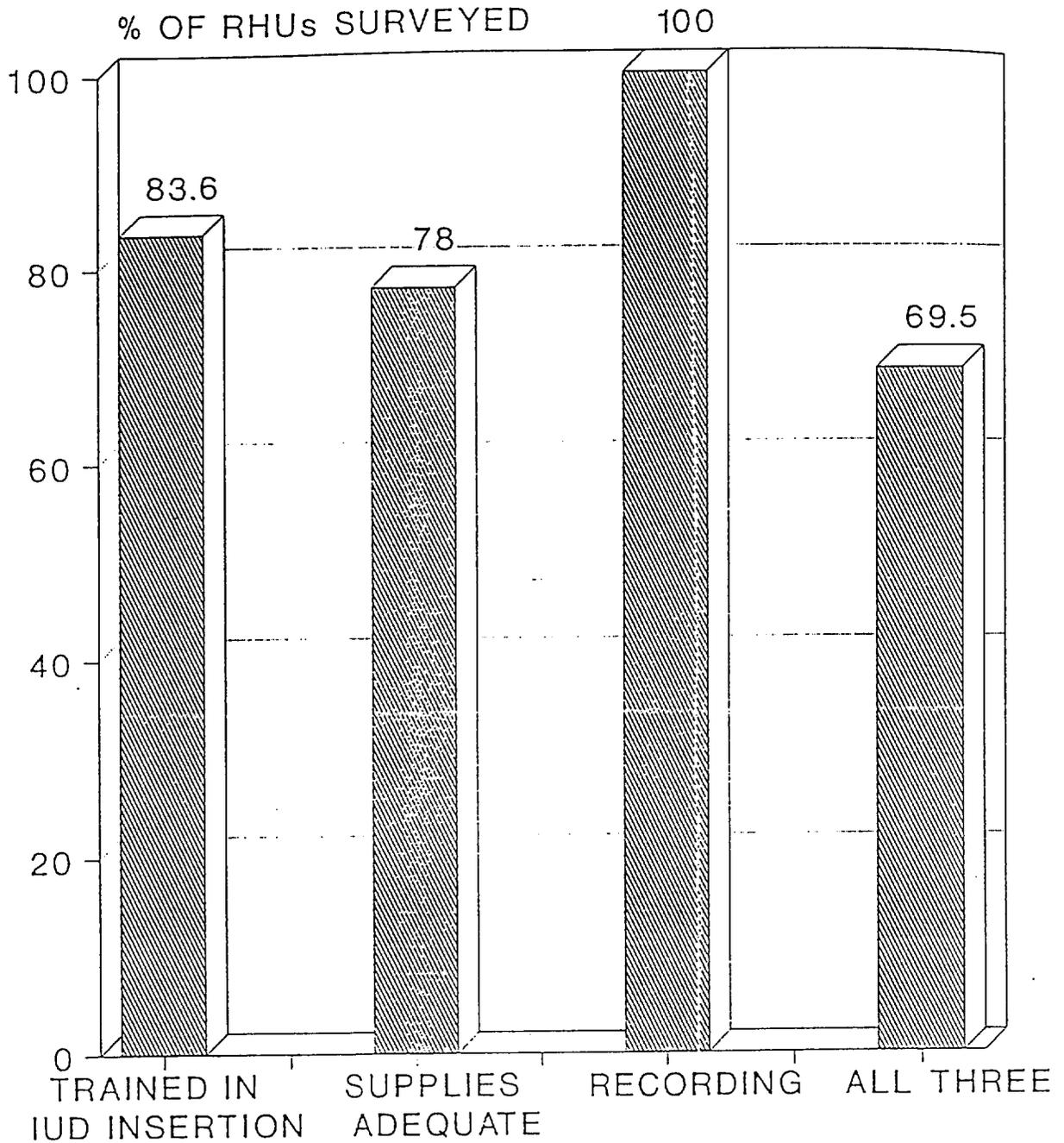
### BHSs ABLE TO DELIVER BROAD RANGE OF FAMILY PLANNING SERVICES, JUNE 1993



SOURCE: HEALTH INTELLIGENCE SERVICE  
HEALTH FACILITY SURVEY (N=118)

27

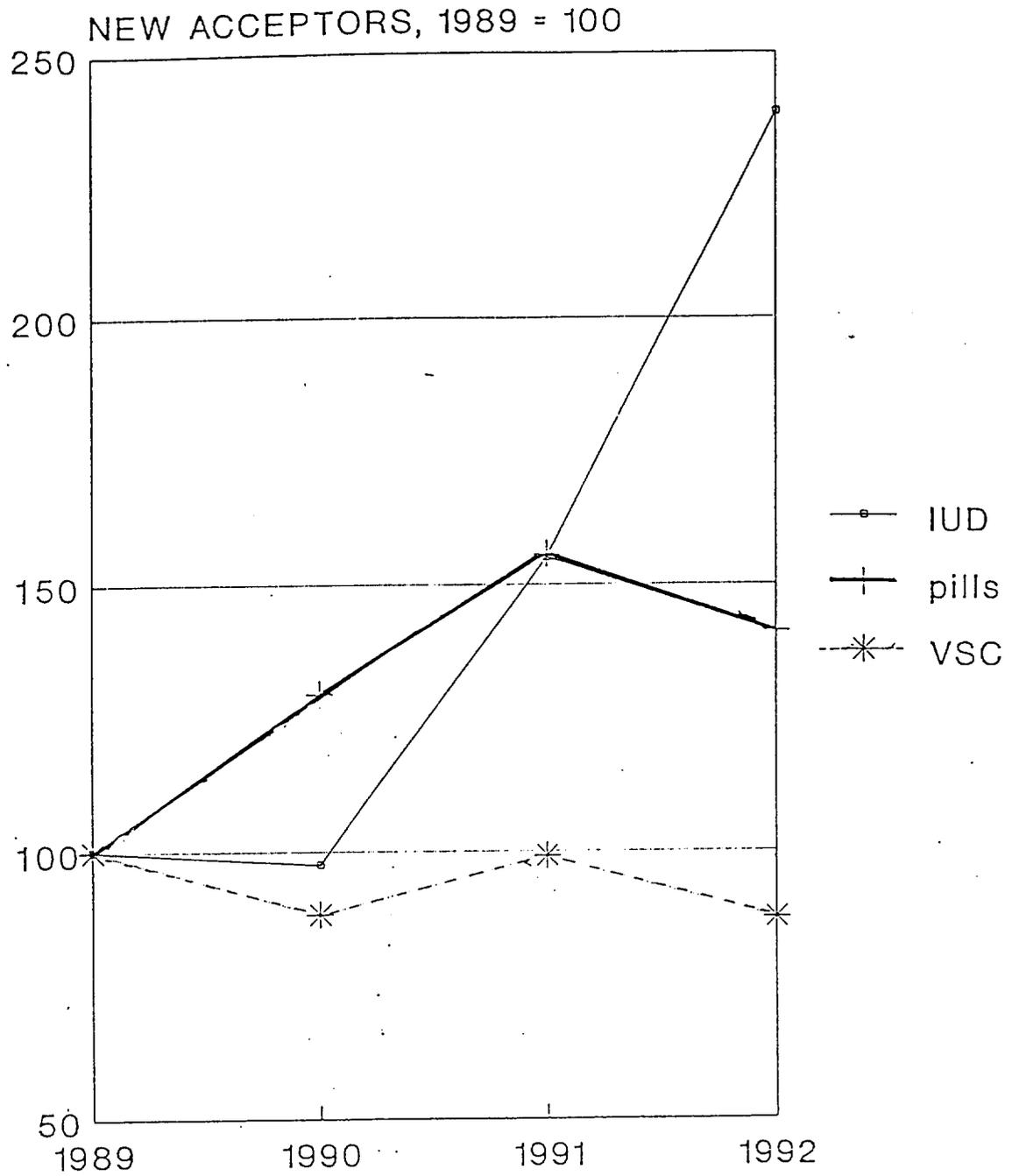
# RHUs ABLE TO DELIVER BROAD RANGE OF FAMILY PLANNING SERVICES, JUNE 1993



SOURCE: HEALTH INTELLIGENCE SERVICE  
HEALTH FACILITY SURVEY (N=61)

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# NEW ACCEPTORS OF FAMILY PLANNING BY METHOD (1989 = 100)



**CHILD SURVIVAL PROGRAM (492-0406)**  
**SUPPLEMENTAL PROGRAM ASSISTANCE COMPLETION REPORT**  
**DECEMBER 16, 1993 TO MARCH 31, 1995**

The Child Survival Program (CSP) Grant Agreement was signed on September 29, 1989 with a completion date of March 31, 1994. CSP was extended until March 31, 1995 to assist the Department of Health (DOH) in strengthening the capabilities of local government units (LGUs) in planning, organizing, delivering and financing child survival related activities. An Interim PACR covering the period 1990 to 1993 was prepared in early 1994. This supplemental PACR covers the period January 1994 to March 1995.

**I. Background**

The final year of CSP was devoted to assisting the DOH strengthen the systems for maintaining the achievements of the Child Survival Program. Specifically, the following major activities were undertaken: (1) development of a plan for the re-introduction of Depo-Provera (DMPA), an injectable contraceptive which includes medical, training, logistics and IEC components; (2) technical assistance in the planning and conduct of the annual National Micronutrient Day; (3) technical assistance in the planning of the Women's Health and Safe Motherhood Project; (4) technical assistance in managing the LGU Performance Program; (5) technical assistance in developing and testing methods for increasing the availability and use of information for decision making under a devolved setting; and (6) conduct of the CSP final evaluation.

**II. Highlights of Accomplishment during the Period**

In November 1993, the Philippine Bureau of Food and Drugs approved DMPA as contraceptive for use in the Philippines. With technical assistance under CSP, the DOH organized a DMPA Task Force that developed and implemented a plan to effectively introduce DMPA throughout the country. National Service Delivery Guidelines for DMPA and Basic Guidelines for Introducing DMPA were developed, through a collaborative effort among DOH, various consultants and local NGOs. Sufficient quantities of DMPA for the first year of DMPA use were obtained by the DOH with assistance of UNFPA. DMPA was included in the contraceptive social marketing project (Couple's Choice) as part of the IEC campaign to promote DMPA. A total of 5,027 doctors, nurses and midwives were trained in DMPA use by March 1995 using a 2-day training module developed by the Family Planning Service of the DOH. Mechanisms for ensuring the availability of DMPA as well as of trained personnel to administer/deliver this service at the LGUs are now in place.

In 1993, the DOH launched an annual massive campaign to bring an end to hidden hunger: vitamin A deficiency, iodine deficiency, and iron deficiency anemia. Known as "Araw ng Sangkap Pinoy" (ASAP) or National Micronutrient Day, one day in mid-October is devoted to the distribution of vitamin A capsules to children 12-59 months of age, iodine capsules or iodized oil to mothers, and vegetable seed packets and malunggay cuttings to families. Much of the technical preparation and planning of this program was undertaken through CSP. By the time the program was launched, an active surveillance system to monitor the occurrence of any adverse reactions to the high dose vitamin A capsules had been designed and implemented. Informational booklets for health

workers and community volunteers were designed, produced and disseminated. Through this program, not less than 90% of target children are being reached with vitamin A capsule (VAC) supplementation. In October 1995, after the third ASAP or National Micronutrient Day was conducted, it was decided by the interagency National Micronutrient Action Team (NMAT) to continue with the program for another three years.

At about the time that CSP was completing its assistance, the DOH was designing a Women's Health and Safe Motherhood Project with support from five separate donors (World Bank, Asian Development Bank, the European Community, the German Bank, KFW, and AusAID). Technical support in determining appropriate commodities for the project, as well as in analyzing data and reports regarding the different components of the project in order to minimize overlapping and duplication of activities, were rendered by a CSP Advisor.

The enactment of the 1991 Local Government Code (LGC) devolved the responsibility for health service delivery to LGUs, including personnel and facilities, from the provincial level and below. The DOH, while still mandated "to be the primary national government agency responsible for the protection and promotion of the people's health," must, under the LGC, fulfill this role through means other than direct implementation of health services - a major shift in orientation for a large bureaucracy heavily focused on service delivery. For the DOH, this meant a fundamental change in its functions and operations vis-a-vis the LGUs. With the LGC, the DOH has become a "servicer of service providers" and the need to develop its capacity to assist and support LGUs which are now the actual providers of services had to be addressed. In earlier years, CSP introduced the concept of area program-based health planning (APBHP) which, in a sense, anticipated the fact that health services in the Philippines would be devolved to LGUs. This planning methodology was revised and updated to focus on FP/MCH services in 1993 under the LGU Performance Program (LPP) of the DOH. The LPP start-up phase began in late 1993 through a buy-in to the Family Planning Management Development (FPMD) Project to develop the strategies and mechanisms for strengthening capabilities of LGUs under a subsequent USAID-assisted activity, the Integrated Family Planning Maternal health Program (IFPMHP). Twenty LGUs were initially selected to participate in LPP and were assisted in the development of their FP/MCH plans. These 20 LGUs received a grant from the DOH to help them implement these plans in 1995.

Devolution also created the need to develop sustainable strategies for collecting, analyzing, interpreting and disseminating accurate and timely health information to decision makers at the various geo-political levels. Through a buy-in to the Data for Decision Making (DDM) Project, technical assistance was provided to the DOH in developing and pilot testing methods for increasing the availability and use of reliable information in making rational public health decision during a period of rapid devolution. A system for Rapid Appraisal for Priority Setting and Informed Decision Making (RAPID) was established in two regions (Cordillera Autonomous Region and Bicol Region) to improve access to information and facilitate communication at different levels of the health system. Under this system, a set of consensus health indicators was developed; computer workstations for analyzing and interpreting the selected indicators were set up; communication tools to enhance dissemination of information to key decision makers were developed; and local government officials and staff were

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trained on the use of management tools that will help them perform their new functions under devolution.

The final evaluation of CSP conducted in March 1995 found the CSP design to be an appropriate response to the constraints in the effective delivery of child survival services. The policy reforms and objectives reflected accurate analyses of the problems as well as the measures required to overcome them in a sustainable manner. The performance benchmarks were accurate measures of achievement of policy reform. The evaluation also pointed out the appropriateness of using a performance based program mode of disbursement rather than project assistance due to the following factors: mutual agreement between DOH and USAID as to what should be done and the presence of technical and managerial capacity at the DOH, given adequate resources and leverage to do it. This led to an effective, well coordinated and highly accountable implementation resulting in tangible policy reforms and program outcomes. The following high impact changes were noted:

- increased prioritization of child survival
- identification of underserved areas and effective, decentralized health planning from the bottom up
- definition/implementation of a well-chosen core package of MCH interventions, including control of acute respiratory infection, which was new to the Philippines, and family planning, which was revised after a period of stagnant implementation
- a comprehensive IEC strategy utilizing various media to increase consumer demand and promote improved health behaviors
- strengthening of supervision through integrated, criteria based supervisory systems and health information systems.

### III. Update on Status of Achievement of Service Delivery Targets

Significant, measurable gains in child survival delivery occurred during the course of CSP, as reported in the interim PACR. In addition, the following data complete the summary of CSP Service Delivery Targets for 1988-1993 (Annex 1 of Interim PACR):

1. Percentage of pregnant women with at least 2 doses of tetanus toxoid increases from 50% (1991) to 80%.

Status: By the end of 1993, 73% (1993 household survey) of pregnant women had at least 2 doses of tetanus toxoid. There is concern about TT immunization not being given routinely during pre natal visits as well as the false rumor of tetanus toxoid being an abortifacient which caused a lot of adverse publicity and the acceleration of TT immunization coverage to slow down.

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2. Total Contraceptive Prevalence Rate (CPR) for all program methods whether provided by the public or private sector, increases from 22% (1988) to 35% (1993).

Status: The 1993 Demographic Health Survey/National Demographic Survey (DHS/NDS) puts CPR for all methods at 40%. Modern method use was 25% in 1995. With the program supported modern natural family planning methods included, the CPR rose to 32%.

3. Percent of all pregnant women served by DOH at least three prenatal visits increases from 48% (1991) to 80% by 1993.

Status: Per the 1993 DHS/NDS, 83% of mothers received prenatal care services from a health professional.

4. Percent of all births attended by trained personnel, including TBAs increases from 75% (1991) to 85% in 1993.

Status: In 1993, DHS/NDS reports that 98% of births were delivered by a doctor, nurse, midwife or TBA.

5. ORT use rate in all cases of diarrhea among children under five years of age, increases from 25% (1991) to 60% (1993).

Status: ORT use rate per the 1993 DHS/NDS was 63% in 1993.

#### IV. Financial Summary

The total amount obligated under CSP was \$49,983,110.87 consisting of \$45,000,000 in performance based disbursements and \$4,983,110.87 in technical assistance. Total host country counterpart contribution (CC) amounted to \$72,603,365.95 or 100.84% of the required CC of \$72 million.

Table 1 below summarizes the financial status at program closeout.

Table 1: Financial Status  
Child Survival Program

	USAID	GOP	TOTAL
Performance Disbursements	\$45,000,000.00	72,603,365.95	\$117,603,365.95
Technical Assistance, Evaluation, Monitoring and Audit	4,983,110.87	-	4,983,110.87
<b>TOTAL</b>	<b>\$ 49,983,110.87</b>	<b>72,603,365.95</b>	<b>122,586,476.82</b>

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## V. Evaluation Findings/Lessons Learned and Sustaining Gains of CSP

The final evaluation conducted in March 1995 confirms the success of and lessons learned from CSP initially identified in the Interim PACD.

In summary, these lessons are:

1. The use of a performance-based program mode of assistance, rather than project assistance, can be a highly appropriate and effective instrument for achievement of health sector goals in settings such as the Philippines where there is:
  - a broad consensus between the donor and the host government on the needed policy reforms;
  - a sincere commitment on the part of the host government agency to the implementation of these reforms; and,
  - \* a high caliber of personnel within the host government implementing agency with the training, experience and skills necessary at all levels to enable it to independently identify and implement appropriate means of achieving policy objectives and performance benchmarks.
2. Implementation of a few well-chosen policy reforms in the health sector can contribute to tangible reductions in mortality in as little as five years.
3. Decentralization of health services, particularly when carried outside the administrative confines of the Department or Ministry of Health, requires major conceptual, operational and structural readjustments on the part of those institutions.
4. When lines of administrative control are changed or removed, needed technical linkages may also vanish unless a conscious effort is made to re-define them in the new context.
5. Service delivery indicators (purpose-level indicators) need to be selected with care and investments made to the maximum extent possible in obtaining accurate baseline measurements at the onset of any program expected to impact on health services. Care must be taken to ensure that baseline and end of project measurements will be comparable and reliable.

In recognition of CSP's effectiveness, the Integrated Family Planning Maternal Health Program (IFPMHP), which is the centerpiece of the Mission's Strategic Objective on population and health, adopts the performance-based disbursement method and most of the implementation mechanisms employed under CSP.

Recognizing that sustaining and expanding on the impressive achievements of CSP will be heavily contingent on the successful management of the devolution process both by the LGUs and the DOH, activities under SO 3 respond to the transition in the changed roles of LGUs and the DOH. Specifically, USAID assistance is being utilized to address the following policy and programmatic issues: re-definition and clarification of the roles and relationships of the DOH central and regional offices, re-introduction, as appropriate, of a decentralized health planning process used under the CSP to create municipal-provincial linkages, assistance to the DOH in facilitating its role as a "servicer of service providers," putting an LGU focus in the FP/MCH training, research, monitoring and IEC activities of IFPMHP, and strengthening the system for collecting and analyzing service statistics that will help LGU program managers and central office policy makers in sustaining responsive FP/MCH programs.

Clearance:           OPHN: (see attached)  
                          OFM: (see attached)  
                          ORP: (see attached)  
                          PRM: (see attached)  
                          OLA: (see attached)

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Doc. Name: WP5.2 CSP 4/2/96

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\* a high caliber of personnel within the host government implementing agency with the training, experience and skills necessary at all levels to enable it to independently identify and implement appropriate means of achieving policy objectives and performance benchmarks.

- 2. Implementation of a few well-chosen policy reforms in the health sector can contribute to tangible reductions in mortality in as little as five years.
- 3. Decentralization of health services, particularly when carried outside the administrative confines of the Department or Ministry of Health, requires major conceptual, operational and structural readjustments on the part of those institutions.
- 4. When lines of administrative control are changed or removed, needed technical linkages may also vanish unless a conscious effort is made to re-define them in the new context.
- 5. Service delivery indicators (purpose-level indicators) need to be selected with care and investments made to the maximum extent possible in obtaining accurate baseline measurements at the onset of any program expected to impact on health services. Care must be taken to ensure that baseline and end of project measurements will be comparable and reliable.

Clearance:

OPHN: CCY 3/4/96  
 OFM: cleared on p. 10 - page 12  
 ORP: Administrative 3/16 R.S.  
 PRM: \_\_\_\_\_  
 OLA: TP

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agency to the implementation of these reforms; and,

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Clearance: OPHN: see attached  
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