

Project Performance Monitoring Unit

Performance Monitoring & Evaluation Plan

Deliverable No. 14

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I. Project Summary and Deliverables

The United States Agency for International Development (USAID) awarded Contract No. 492-C-00-03-00024-00, a cost-reimbursable contract, to Management Sciences for Health (MSH) to provide the required technical and logistical assistance for implementing the Local Enhancement and Development (LEAD) for Health Project.

The project aims to support the priority programs of the Department of Health (DOH), primarily family planning, TB-DOTS, Vitamin A, HIV-AIDS, and MCH. It will provide this support by strengthening the service provision capacities of municipalities and cities, to which the responsibility of delivering and financing these services was devolved under the Local Government Code of 1991. Improving LGU capacities will involve: a) strengthening the financial, managerial, and technical capacity to provide FP and selected health services; and b) improving the policy and legislative framework at both national and local levels to finance and support these programs.

LEAD will also work towards developing commitment to and ownership of the project by LGUs. Because of LEAD's focus on service improvement by LGUs, as well as on increased role for private sector services, the project is structured in such a manner as to make the target LGUs (selected municipalities and cities) as the primary clients, with the DOH, PHIC, and Leagues of Cities and Municipalities as collaborating agencies.

Scope and End-of-Project Deliverables. The LEAD for Health Project has an initial life of three years beginning October 1, 2003, and ending on September 30, 2006. At the end of the initial contract period of three years, the project should have achieved significant progress towards achieving the following national targets:

1. Total Fertility Rate (2006) – 2.7
2. Contraceptive Prevalence Rate (modern, 2006) – 40 %
3. TB Treatment Success Rate (2006) – at least 70 %
4. HIV seroprevalence among Registered Female Sex Workers - <3 % annually
5. Vitamin A supplementation coverage – 85 % annually

Project Components. The LEAD for Health Project has the following two major components with their corresponding tasks:

Component 1: Strengthen the local level support for, and the management and provision of FP, TB and other selected health services. Building the capacity of target LGUs to sustain the provision of quality FP and the other selected health services is the core of the LEAD for Health project. Activities under this component will expend around 70 % of the level of effort and 65 % of the project budget. There are four tasks under this component:

Task A. Increase local level support for FP and other health services. The task mainly involves recruiting and enrolling a critical number of LGUs under the project, so that their collective successful participation will impact positively on increasing CPR and lowering TFR, improve TB treatment success rate and Vitamin A supplementation

coverage, and maintain the low HIV seroprevalence. The project will target those LGUs that contribute most to population growth, have low contraceptive prevalence rates, low capacity for quality service provision, but are potentially receptive to LEAD technical assistance.

Task B. Improve Management and Information Systems for LGUs. Under this task, LEAD will provide assistance in improving management systems that LGUs can use for FP and health program management, financial management and control, quality assurance, and procurement. Health information systems used in previous projects, such as the community-based MIS, will be assessed for their potential for scaled up application. Local officials will be trained on the use of these management and information systems as tools for planning, policy development, and resource allocation decision-making.

Task C. Increase the availability of LGU financial resources for health services. LEAD will explore alternative strategies, and develop new systems and innovative schemes for resource mobilization so that LGUs can increase their financial resources, allocate more funds, and ensure the sustained provision of quality FP and selected health services. The project will particularly explore the operational feasibility of client segmentation strategies, whereby scarce public program resources will be used exclusively to service the needy who cannot afford to pay for essential services, and those with means will be directed to private sector providers, or be made to pay for services availed at public facilities. LEAD will also support interventions that will strengthen health insurance coverage and utilization of benefits, particularly among the indigent segment of the population.

Task D. Improve the quality of FP, TB, and other selected health services, and the performance of service providers. LEAD will strengthen the delivery of FP services in target LGUs, and improve contraceptive prevalence rates by effectively responding to unmet demand. Major interventions will include: a) ensuring access to a complete selection of contraceptive methods in key service points; b) improving post-partum counseling and provision of FP services in conjunction with post abortion care; c) promotion of community-based contraceptives distribution systems to expand access and availability; and d) identification and removal of barriers to quality family planning service provision.

LEAD will work with LGUs to strengthen their capacities to implement the DOTS modality of diagnosing and managing TB cases. It will support the implementation of strategies and activities already identified in the National TB Program, and assist in developing and implementing policies to incorporate TB in the National Health Insurance Program (NHIP) benefit package. Technical and logistical assistance will be tailored to the needs of individual target LGUs, to be based on the results of a thorough assessment that the project will undertake after the LGU enrolls in the project.

LEAD will build on the experiences and lessons learned from the eight HIV/AIDS sentinel sites, and examine and apply other effective approaches in order to expand the

number of LGUs that are actively implementing HIV/AIDS education and surveillance activities. It will strengthen the distribution and administration of Vitamin A supplementation capsules.

Component 2: Improve national level policies to facilitate efficient delivery of quality FP and selected health services by LGUs. LEAD will work closely with national and local policy makers to create and promote a policy environment and obtain a level of financing that would favor the sustained provision of quality FP and selected health services. A major agenda of this project component is to review existing policies and regulations, and study how they can be modified so that the government can formulate and enunciate a realistic national contraceptive self-reliance policy, along with the appropriate implementing strategies.

Task A. Improve national and local policies for increased financing of FP. Under this task, LEAD will undertake studies, make recommendations, build consensus on how contraceptive security should be attained, and assist partners in developing and implementing strategies to reduce GRP's reliance on external contraceptive commodity donations. In addition to promoting measures that would lessen government's burden of service provision through client segmentation, the project will explore alternative modes of financing contraceptives. An example of this would be to continue the efforts to include contraceptives and services, in addition to surgical sterilization, in the NHIP benefit package. To entice target LGUs to use their own resources to procure commodities for FP and the other selected health services, the project will assist them develop and operationalize their own drug management systems, which include drug selection, procurement, distribution, and drug use monitoring.

Task B. Develop policies for mobilizing financing resources for services. Project activities under this task will be directed towards strengthening national policies for increased spending for FP, TB, HIV/AIDS, and Vitamin A supplementation. LEAD will undertake studies to review legal provisions for internal revenue allocations for health, and user fees in public health facilities, and identify policy constraints that impede expansion of private health insurance.

Task C. Improve legal and regulatory policies for health service delivery. Project activities under this task are primarily to review existing legal and regulatory policies, and make recommendations on how they can be modified so that they will be supportive to the provision and financing of FP and other selected health services by LGUs. An example of legal and regulatory policies to be reviewed (which the project needs to carefully validate before it actually begins work) are: a) possible reclassification of oral contraceptives from a prescription drug to over-the-counter; b) lowering of duties and tariffs for contraceptive products; c) improving rules and regulations concerning distribution and advertising of contraceptives; d) expanding the role of trained volunteer workers in dispensing oral contraceptives and other essential services and products. In addition, LEAD will assist in the formulation of legal and regulatory policies affecting the implementation of HIV/AIDS and TB control and prevention activities at the LGU level.

Life of Project Goals and Targets. In order to bring about national impact and achieve the project's end-of-project deliverables, the LEAD Project should cover 40% of the total Philippine population. The project has identified 530 municipalities and cities in 45 provinces that it will target or engage, at the very least, over the course of its three-year project life. The aggregate population of these LGUs is projected to reach 34.2 M in 2005, which will be close to 40 % of the projected total Philippine population of 86.2 M in that year. Technical and logistical assistance will be provided to these target LGUs so that each of them will achieve the following goals or ends:

Governance

- a. Increased share of FP/TB/HIV/AIDS/MCH in the total municipal/city budget, especially for contraceptive procurement;
- b. Ordinances enacted, such as a local health code, that articulates official support and provides adequate financing for FP and selected health services;
- c. Formulation and adoption as an official policy of a local **CSR+**¹ plan (that covers FP, TB-DOTS, HIV/AIDS, and Vitamin A supplementation);
- d. Enrolment of indigents under the National Health Insurance Program; and
- e. Adoption, as official policy, and implementation of an LGU plan for strengthening services and improving quality of FP, TB-DOTS, HIV/AIDS, and Vitamin A supplementation, including private sector services, to meet community needs.

Family Planning and Health Systems

- a. A functional health information system;
- b. Increased access to quality modern contraceptive supplies and services, including voluntary surgical sterilization and IUD
- c. Reduce rate of drop-outs among pill and DMPA users;
- d. The RHU is providing routine Vitamin A supplementation to sick children;
- e. The Rural Health Unit (RHU) is Sentrong Sigla Level 1 certified, and accredited by PHIC as provider of TB-DOTS and outpatient benefit packages;
- f. All HIV/AIDS sites are implementing interventions and improved surveillance and education activities, especially for high-risk groups such as injecting drug users and men having sex with men;
- g. An expanded health volunteer network; and
- h. Increased collaboration with the private sector.

LEAD is aiming at the adoption and implementation of a Contraceptive Self-Reliance Initiative nationally and in the target LGUs, by the end of the project. Another end-of-project goal is the sufficient improvement of national and local policies and regulations to enable LGUs to increase support, including financing, for FP and selected health services.

¹ **CSR+ plan and strategies** cover implementation strategies, guidelines and plans that aim to establish sustainable programs not only for contraceptive self-reliance, but also for TB-DOTS, HIV/AIDS, and selected MCH services

Phases of Project Implementation. The MSH implementing strategy for the LEAD for Health Project technical assistance contract divides the contract period into five phases:

1. Start-up Phase (October 1, 2003 – January 31, 2004)
2. Test Phase (January – July, 2004)
3. Initial Roll-out Phase (August – December, 2004)
4. Peak Performance Phase (January – December, 2005)
5. Project Assessment Phase (January – September, 2006)

The start-up phase includes all activities that have to be undertaken in order to organize and staff the project office for it to function immediately and begin to carry out its technical work. During the test phase, the project will complete the development of all assessment tools, technical assistance instruments, including the LGU engagement process, and actually test them in at least 20 LGUs in Visayas and Mindanao. This phase will be capped by an assessment of the effectiveness of the tools, instruments, and processes that were initially used. Appropriate modifications and refinements will be made in preparation for the initial rollout phase, where 90 additional LGUs will be engaged. The second year of the project is its peak performance phase, when an additional 375 LGUs will be enrolled. In its third year, LEAD will enroll an additional 45 LGUs and sustain those enrolled in prior years, but a major part of its time will be devoted to the collection and analysis of data and information to be used as bases for formulating recommendations for sustaining initiatives when the three-year contract ends.

Strategies and Approaches. Fig. 1 shows the general flow of events or activities that will guide the LEAD Project towards attaining its end-of-project deliverables. The central focus is to capacitate every target municipality or city to sustainably provide quality FP, TB, HIV/AIDS and MCH services through public-private partnerships. This project intervention will be achieved at the national and local government levels. The project will be developing the abilities of target LGUs to provide stronger policy, regulatory, and financing support to these programs, as well as their capacities for program service provision in partnership with the private sector.

The project prepared a list of target LGUs to be invited to participate in the project. The list was submitted to, reviewed and approved by USAID. The LGUs in the list come from areas with the following characteristics: a) low CPR, b) socio-economically disadvantaged, c) high percentage of urban poor, d) strong program support by local chief executives and other local officials, e) the eight sentinel sites of the AIDS Surveillance and Education Project, f) cities and municipalities in ARMM, g) organized LGU clusters, and h) strong support from regional offices of DOH and POPCOM.

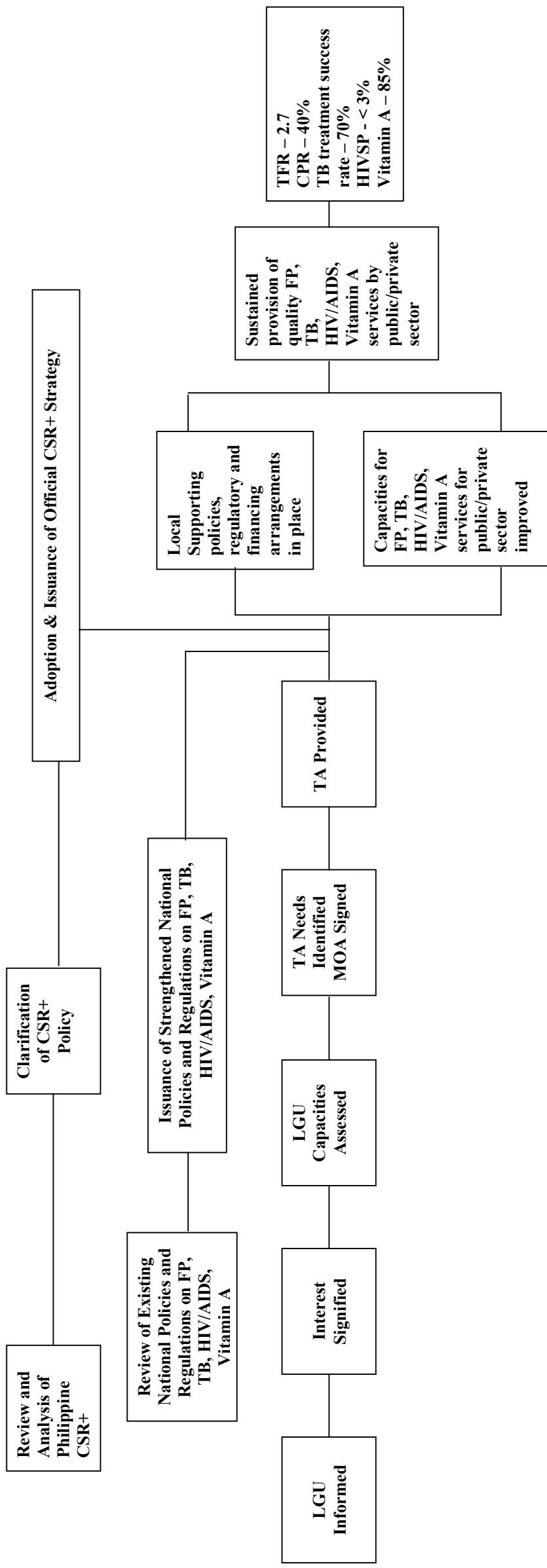
After the targeted LGUs have responded positively to the invitation and have signified their intention to participate in the project by submitting the accomplished self-assessment forms, LEAD will organize a participatory workshop to review the results of the self-assessments and determine the individual priorities of the target LGUs. The LGUs will do a more detailed follow-on assessment after the initial workshop, the

outcomes of which are: a) the governance and FP/health service capacity development plans, and b) detailed specifications of the LGUs' TA and logistical requirements to support their respective plans. Each LGU will subsequently sign a Memorandum of Agreement with LEAD, and the MOA will stipulate the technical and logistical assistance that the project will provide, and the governance and FP/health service capacity improvements that the LGU will commit to achieve.

The main tools that LEAD will employ to achieve the objectives of Component 1 of the project are the provision of technical assistance to all target LGUs, and cash grants to selected LGUs. The TA that will be provided will be in the areas of governance and FP and selected health service capacity development. LGUs that meet the eligibility criteria that the project will set and agree with USAID, will receive cash grants that will be disbursed upon meeting pre-agreed performance benchmarks. Although the system and procedures for administering the performance-based grants, including the benchmarks that will be used and how they will be measured, will be negotiated and developed collaboratively with USAID, the entire grants concept, system, process and procedures are still subject to USAID review and approval. The central objective of the cash grants and TA is to strengthen governance and service provision capacities in all target LGUs, and achieve the LGU goals that are listed on page 4.

Under Component 2, LEAD will assist the government prepare a national self-reliance initiative, including clarification of policy statements and formulation of implementation strategies and guidelines, that covers not only contraceptives but also TB-DOTS, HIV/AIDS, and MCH services. (The expanded initiative is termed as Contraceptive Self-Reliance Plus or CSR+). The project will likewise assist in reviewing legal and regulatory policies, and make the appropriate recommendations for modification, in order to gain policy and financing support for FP and selected health services. These policies, including the CSR+ initiative and implementing guidelines, will be clearly articulated and enunciated to provide support to the work that will be going on at the LGU level.

Figure 1: Project Activity Flow



II. Rationale for the PMEP

The project's Performance Monitoring and Evaluation Plan (PMEP) is the main guide that the LEAD Project will follow to ensure the systematic and timely data collection, monitoring, analysis and reporting of all performance data. It provides the detailed information needed for establishing and operating a functional monitoring and evaluation system that would ensure continuous assessment and evaluation of project implementation and LGU performance in relation to agreed deliverables, targeted results, timelines and resources. It is designed to provide the LEAD Project with feedback mechanisms that can help the implementing teams anticipate and identify potential problems and obstacles, as well as opportunities and threats, to allow for timely adjustments in project operations. Integral parts of this system are the periodic assessment of project-level and LGU-level performance as well as the measurement of project impact, both expected and unexpected. The PMEP is a major resource document that will serve as the official guide for all monitoring and evaluation activities that the LEAD Project will undertake. A companion document to the PMEP is the LEAD Indicator Monitoring System, which is the project's guidebook for tracking LGU performance.

A. Monitoring Project Performance

Regular monitoring of LEAD project deliverables is important as it allows the project to examine the quality, timeliness and usefulness of project outputs and outcomes, which are expected to impact on LGUs' overall performance, which in turn, will lead towards achieving end-of-project deliverables.

Tracking project performance ensures that quality outputs are delivered on time and that important outputs such as effective processes, tools, TA instruments and implementing mechanisms, through which stated objectives are to be realized, are all generated for successful project implementation.

Timely identification of problems and implementation issues, through a good project monitoring process, will allow for timely application of corrective measures. Hence, one effective way of tracking project performance is the holding of quarterly, semi-annual and annual reviews of dynamically pre-set performance benchmarks.

B. Monitoring LGU Performance

The LGU is the main client of the project. Technical assistance and grants will be provided to the target LGUs so that they can achieve the governance and health service capacity development goals and be able to provide local support and commitment to the sustained provision of quality FP, TB and other selected health services. It is therefore important for the project to examine how well the LGUs perform and to make comparison between actual results accomplished over time versus the targets. LGU performance data will likewise guide the project towards developing future technical assistance support and other interventions for target LGUs. Information on LGU

performance will also serve as important inputs to the project's performance-based granting system, which the project is discussing and negotiating with USAID.

Knowing how the LGUs perform will not only provide the necessary information for effective project implementation, but more importantly, will benefit the LGUs themselves, both in its planning, decision-making, particularly regarding investments in family planning and in advocating for FP and health-related programs at the local level. Performance information will enable LGUs to identify their strong and weak points, learn important lessons and capitalize on best practices. It is therefore critical that the LGUs find the monitoring approach useful, sustain the process of tracking performance, and make use of the information generated to support policy development, planning and decision-making.

C. Monitoring Policy Support

Monitoring policy support, from the development process to its actual implementation is essential for LEAD. It will allow the project to assess how effectively (or ineffectively) national level policies and regulations are able to support and facilitate increased financing and mobilization of resources for effective delivery of quality services in family planning, TB, HIV/AIDS and Vitamin A supplementation at the LGU level. Valid information on the strength of these policies will give the local government unit a strong basis and foundation for developing and implementing its governance and health service capacity strategies and plans.

The extent of policy implementation, particularly at the LGU level, should likewise be monitored (a) to evaluate whether the project is able to provide the necessary inputs and appropriate technical assistance both to the national government and to the local government units; (b) to provide the necessary corrective measures and address impediments to effectively implementing these policies. Support activities such as the conduct of studies and evaluation of existing policies and practices, for example, should also be monitored and evaluated to assess whether they are able to establish the necessary empirical evidence and basis for policy revision or initiation of policies that will enhance LGU's capacity to increase financing, and mobilize more resources to deliver quality services.

D. Monitoring Project Impact

The ultimate goal of the LEAD Project is to make significant impact on total fertility rate, contraceptive prevalence rate, TB treatment success rate, HIV seroprevalence and Vitamin A supplementation coverage. Assessing the impact of LEAD interventions would allow the project to determine the extent to which these project efforts have caused changes in the well-being of the population in target LGUs, whether it be in the form of changes in behavior (increased use of modern contraceptives) or changes in the success levels in the provision and coverage of FP/PHS services (TB treatment success rate and Vitamin A supplementation coverage).

Information generated from impact evaluation will help the LEAD Project make informed decisions on whether to extend, expand, modify or eliminate a particular project intervention. If the LEAD Project is extended, results of impact evaluation will likewise be expected to improve efficiency and effectiveness of approaches, tools and instruments used. Impact evaluation tries to answer the following key questions:

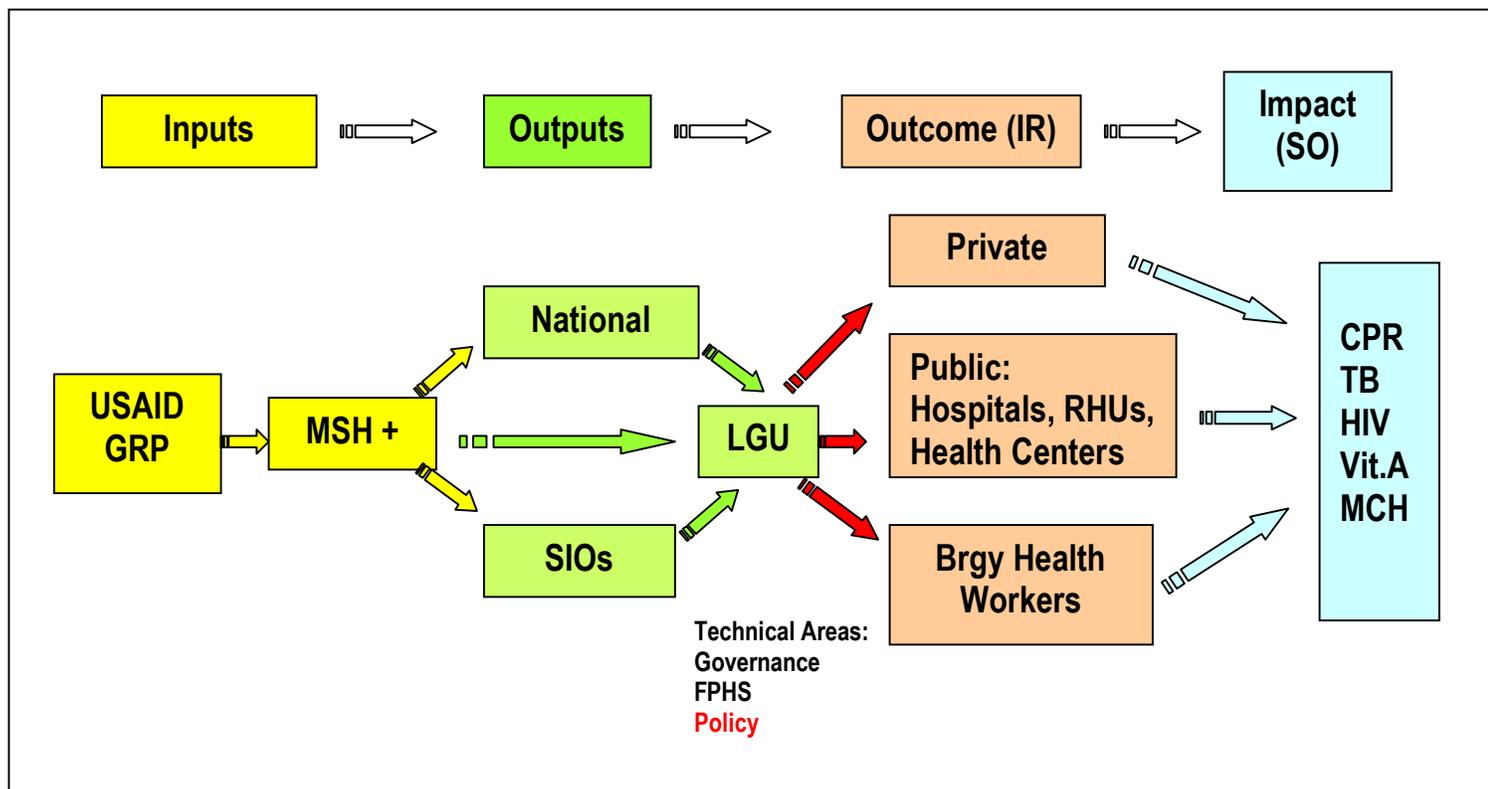
- a. Did the LEAD Project achieve its intended goal?
- b. Are these changes the direct results of LEAD project interventions or a result of some other factors occurring simultaneously?
- c. Does the project have any unintended effects (positive and negative)?

III. The Monitoring and Evaluation Framework

A. What Do We Want to Know

The LEAD Project is a highly complex project with activities and expected outcomes at different levels: national, project, LGU and population levels. Further, its size in terms of scope of activities, number of partner organizations, and number of participating LGUs make it imperative that we be selective in the numbers and types of indicators that are collected for tracking and monitoring performance and in the frequency of collection, to avoid overwhelming the project staff with the data management requirements. Toward this end, the starting point of the PMEP is a clear definition of what it is we want to know in order to manage and evaluate the project and its multiple components. To guide this, a schematic representation of the project “logic model” was developed. The model highlights how the LEAD Project will proceed from inputs to outputs to outcomes to impact. (Please see Figure 2 below).

Figure 2: The LEAD Project Logic Model



This diagram clarifies three important points. One is that there are 4 different types of data that will be required to properly monitor and evaluate this project. These are:

- data about project inputs and outputs that will come from internal project reporting mechanisms about project deliverables and benchmarks, products such as tools, strategies, TA instruments and other reporting requirements;
- data about LGU performance that will be a combination of output and outcome measures, covering the extent of LGU achievement of the governance and FPHS goals;
- data on national-level policy support. These data will also be a combination of output and outcome measures, such as: (a) existing national policies on FP, TB, HIV AIDS and Vitamin A supplementation reviewed, clarified and modified; (b) new policies formulated and adopted; (c) relevant policies implemented at the national and local levels, (d) national policies on social insurance that provide additional resources for this set of health services formulated; and (e) changes in policies effected to improve current policy context towards minimizing barriers to the provision of services for FP, TB, HIV-AIDS and Vitamin A supplementation; and
- data for measuring impact on the health and demographics of the population, such as total fertility rate, contraceptive prevalence rate, TB treatment success rate, HIV seroprevalence, and Vitamin A supplementation coverage.

A second conclusion that comes from this project logic model is that the performance of the LGU will be the central focus of the project and will therefore be the focal point for tracking and evaluation efforts. If the LEAD Project is to be successful, it will be through the improvement of the performance of the LGUs.

A third conclusion from this diagram is that measures will need to be taken at various points during the life of the project including a set of baseline measures taken before the introduction of interventions in an LGU and results measures taken after the interventions have had time to achieve some success. For many of the indicators, it will also be desirable to collect data at regular intervals during the project period in order to track whether project interventions are having the desired effects on LGU performance.

After having defined the logic model of the LEAD project, it is now possible to define the questions that we anticipate to be answered through the PMEP.

1. Is the project delivering on its contractual outputs?

Because of the contractual nature of this project, many of the outputs and results are specified in the project contract, and these include the Strategic Objectives of USAID, and specific deliverables. In addition, many partners including the Department of Health,

the Population Commission (POPCOM), the Philippine Health Insurance Corporation (PHIC) and the cities and municipalities participating in this project will also have use for information about project outputs.

The data needed to answer this question will be drawn from a variety of sources including an internal project monitoring system of outputs, data that is collected by the DOH, data collected from LGUs and health facilities, and information from the SIOs who work with LEAD and provide technical assistance to the LGUs.

The formats for reporting on this particular question are varied and are largely defined by the specifications of the contract documents. This will include quarterly, semi-annual, and annual reports, and end-of-contract report and are described more fully in another section of the PMEP. These reports will include discussions on whether the project achieved the benchmarks it has set for each quarter, and analyses of the mid-year and annual assessment to be conducted to evaluate project tools, processes, mechanisms and instruments used.

2. Are LGUs able to deliver on their expected outputs and results? Are the LGUs showing improvements in the key areas of governance and FP health services?

The primary focus of the LEAD Project is the development of the capacity of LGUs to plan and deliver effective health services in the priority areas of family planning, TB, HIV/AIDS, and Vitamin A. For this reason, it is critical for the project to monitor the performance of LGUs as they participate in project activities and to track on an individual as well as on an aggregate level, the ways in which LGUs have improved and the areas where improvement is still needed. Mainly, the basis is the achievement of governance and FP/ health service capacity development targets listed on page 4.

As with the first question, data needed for the assessment of LGU performance will come from a variety of sources. Substantial information will come from the initial LGU assessments that look at questions of adequacy of staffing, management systems, and political commitment. These initial assessments will also include information about the family planning and health program activities carried out at the LGU level. It is anticipated that these LGU assessments will be done on an annual basis yielding longitudinal as well as baseline data about LGU capacity. Other data will also be collected from each LGU; some will be facility-based data such as TB treatment success rates and Sentrong Sigla certification, while some will be population-based data such as contraceptive use and source (private or public). It is anticipated that the latter data will be collected through the Community-Based Management Information System (CBMIS).

3. Has the project had a significant impact on the population?

The ultimate goal of health projects is to improve the health of the population, and for LEAD, the contract is very explicit about this expectation in defining the strategic objectives for the project. There are many reasons why this type of information is important. First, is that this is the ultimate measure of whether the investments that have gone into the project were worthwhile and whether the population has benefited as a

result. Second, impact data allows us to measure changes in the population over time, an important consideration in areas such as population programs or disease control. Finally, impact data allows us to compare the ultimate results of alternative approaches to health improvement and identify those approaches that have the greatest impact on health.

There are a number of ways of collecting impact data, but ultimately all such data must be population-based. This is the rationale for the Demographic and Health Surveys that are conducted every 5 years in the Philippines as well as the annual national family planning surveys. However, these surveys are national and do not provide data that can be traced to the individual LGU which is the focus of this project. Thus, if we want to collect data that shows the impact of this project at the LGU level, additional population-based data need to be collected, either through small scale surveys, or through the use of a population-based information system such as the CBMIS, which collects these data from the community through a household survey. Each of these methodologies has costs and benefits.

While these first three questions capture much of what is needed for the formal monitoring and evaluation of the LEAD Project, two other important questions need to be settled to determine future courses of action. The first of these two will help the project better understand the characteristics of those LGUs that can most effectively benefit from project investments.

4. What conditions and what types of inputs have the highest likelihood of success at the LGU level?

As the project expands, it is important to focus on the areas with the highest likelihood of success to be able to maximize the use of its limited resources. We have good evidence that those LGUs that demonstrate strong political commitment to health, and particularly to family planning, can most effectively use project inputs to reach population health goals. There are other factors affecting health outcomes that we still do not fully understand, and the design of this project offers a unique opportunity to enhance our understanding of these factors and to use this new knowledge to better target project investments in the future.

5. To what extent can we attribute service improvements to project activities?

The LEAD Project is ambitious in terms of the scope of activities and the level of impact it strives to achieve in the Philippines. Given its size, many of its goals will be achieved. However, like other projects, this one does not operate in a vacuum. It is operating in the context of a very rapidly changing environment characterized by:

- an active and changing political environment, including elections at the national and local levels. This year (2004), the issues of population and health have become major points of discussion and figure prominently in the election process.
- an active and changing political environment in the U.S. where both overseas assistance and population have been major points of discussion;

- changes in USAID policy regarding the supply of contraceptive commodities to the Philippines have meant that a significant share of the costs of these commodities will be paid for at the local level;
- an increased focus on the use of the private sector in the delivery of all health services especially family planning; and
- continuing and active devolution of power from the central government to the LGUs, especially in the areas of social services, putting increased responsibility and management requirements on the local government structures.

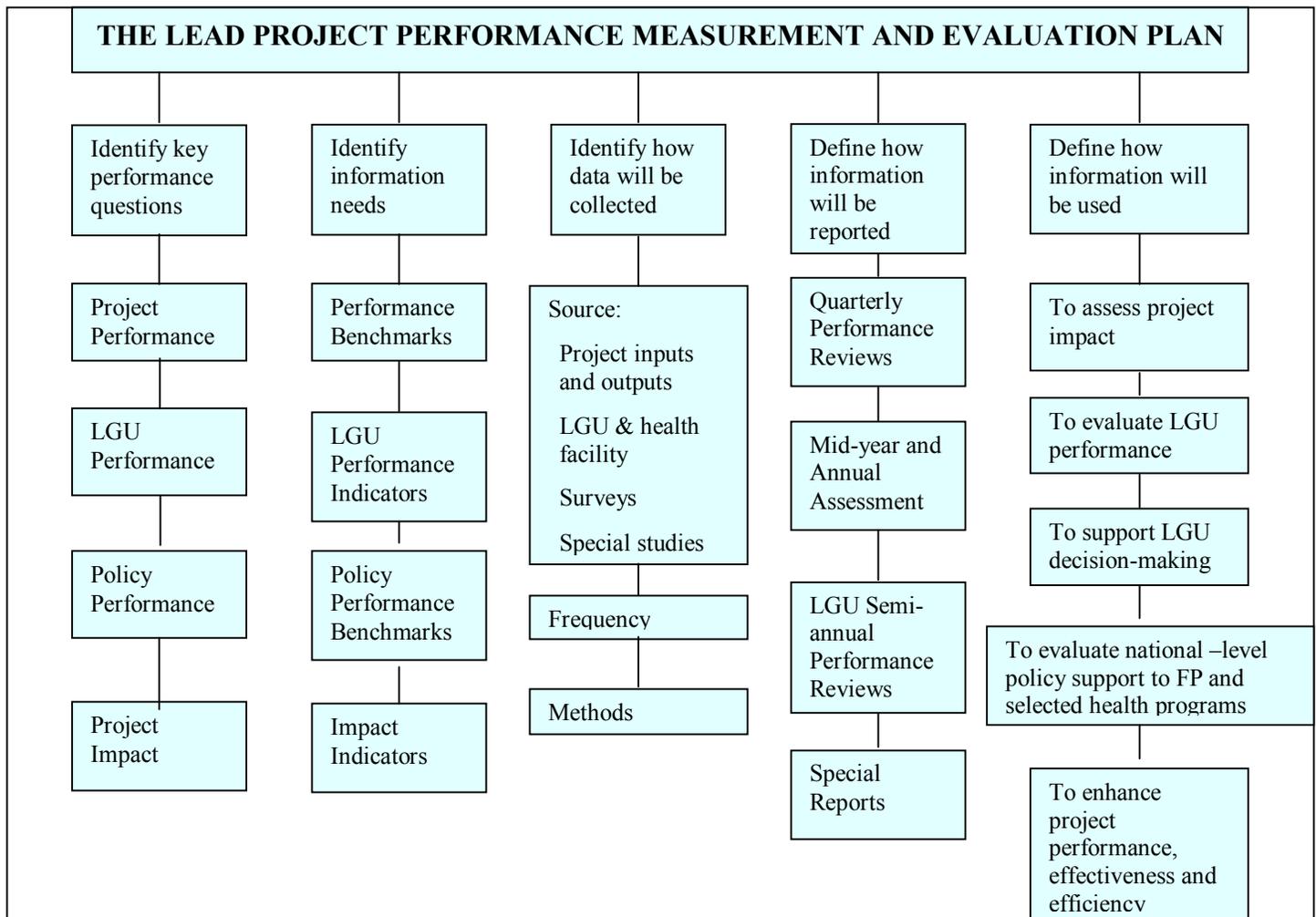
In the face of these changes, it is essential that the performance of the LEAD Project be evaluated in the context of changes that are happening throughout the country so that positive changes in LEAD LGUs can be directly attributed to project activities rather than to macro social and economic changes in the country. This way, the project and USAID will be able to demonstrate the importance and impact of large-scale projects such as LEAD to a sometimes skeptical audience.

B. Development Process of PMEP

Taking off from the PMEP Logic Model, the project underwent five important steps in the process of developing the plan. First was the identification of key performance questions. What is it that the project wants to know regarding overall project performance? These questions served as a starting point in the design of the LEAD Project monitoring and evaluation system. Specifically, LEAD would like to monitor and evaluate project performance, which includes its ability to effect stronger policy support for FP and selected health programs, LGU performance, policy performance, and project impact.

The process continued with the identification of the specific information required to measure progress. At the project level, LEAD has a list of performance benchmarks, which will be reviewed every quarter. At the LGU level, the project has a roster of LGU performance indicators that will be used to measure progress in the accomplishment of its governance and service capacity goals. And finally, it has a list of impact indicators to determine whether the project is making an impact or not at the national level.

This was followed by the development and definition of indicators. The LEAD Project took an effort to ensure that the definitions for indicators are detailed enough to ensure that different people given the task of collecting data for a given indicator, at different times, would collect identical types of data. Then, the project proceeded with identifying the source, the methods, and the frequency of collection. Finally, it defined how the information will be reported and used by the project. A summary of the process is shown in the diagram illustrated in the next page:



C. Principles of the Development Process

PMEP should guide tracking of overall project performance. The first principle in the design of the PME system is that it should serve as a useful guide in measuring and evaluating project performance and progress, particularly in assessing the extent of project achievement towards attaining its end-of-project results and deliverables. This will be especially important during the second and third year of project implementation, during which results and lessons learned from the PME system will be used to refine the approaches and interventions that are described in the project work plan. The types of results and deliverables for LEAD range from output measures such as numbers of trainees to impact measures, such as CPR, and this poses some special challenges to the LEAD Project. It is for this reason that the design of the PMEP includes three separate data bases: one based on project performance, the other based on LGU performance and the last one, showing project impact. Data on policy performance will be included in the project-level and LGU-level performance databases. For LGU performance to be useful

both in project management and in measuring project results, the analysis will include the following:

- Documentation of key impact variables such as CPR, use of private sector, TB success rates, etc. by the LGU. This information, including changes over time can be tracked against the characteristics of the LGU as well as against project activities in that LGU. This way, positive impact can be linked to project inputs.
- Analysis of the critical characteristics of LGUs that predict the greatest benefit from project inputs in terms of positive changes in the population health status, we should be able to predict which LGUs are likely to be included in subsequent rounds of project activities, thus improving the ability of the project to achieve their performance targets.
- The combination of data to be collected will put the project in a good position to document what constitutes “best practices” for specific constellations of LGU organizational characteristics and demographics. Pockets of best practices have been identified but these have been mostly anecdotal and, therefore, could not be used for making generalizations. The more rigorous type of analysis being developed for this project will facilitate better documentation of these best practices and allow for generalization of these findings for application in future work with LGUs in the Philippines.

Simplicity. The second principle in the PME design is simplicity. The LEAD Project is a very complex one, working in a large number of LGUs in a wide variety of technical areas using a vast array of partners for implementation. Consistency in data measurement will, therefore, be a particular problem. For this reason, it is imperative that indicators and data collection methods be simple and clear, and the number of indicators to be collected be kept to an absolute minimum. It is much better to have complete and accurate data on a small number of useful measures than to have a comprehensive set of measures for which the quality and completeness of the data is uncertain.

Minimized data needs. The third principle in the design process is minimizing data needs. Given the scope of activities included in this project, it is critical that data collected for monitoring purposes should, to the greatest extent possible, utilize data that is being collected for other purposes. Thus, for example, the data that is being collected for use in initial assessments of LGU capacity must be consistent with the data that will be used for monitoring. In the same way, data that is collected for the performance based contracting mechanism should form the basis of data that is used for other monitoring purposes in the project. Not only will this reduce the amount of data that is required from each LGU, it will also simplify data interpretation as the project activities increase.

Performance data should be useful to LGUs. The fifth principle of the design is ensuring that performance data proposed to be generated from the PMEP are useful to LGUs. In meeting the challenges of improving governance and health service capacities, the LGUs should find the performance indicators useful in establishing objective and reasonable bases for its policy decisions and actions.

IV. Monitoring and Evaluation of Data on Project Performance, LGU Performance and Impact

A. Project Performance Benchmarks

Monitoring project deliverables, using performance benchmarks is important as it ensures that inputs and outputs of the LEAD Project are delivered in a timely fashion and that the processes, instruments, and mechanisms, through which the stated objectives are to be realized, are all in place for effective project implementation.

The project performance benchmarks, which were derived from LEAD's overall work plan, are reviewed quarterly. To successfully achieve the first year targets, each implementing and support unit determined what it needs to accomplish every quarter. The project uses these deliverables as the performance benchmarks that serve as the project's yardstick to measure performance at a particular period of time. It clearly indicates where the project is in terms of implementing its work plan. Listed in **Annex A** are the LEAD Project's First Year Benchmarks classified by quarter and by unit.

Quarterly performance reviews and benchmarking meetings are held to evaluate status of implementation and to seek comments from, and discuss concerns of project clients, namely, the DOH, POPCOM, PhilHealth, the Leagues of Cities and Municipalities and USAID. They are represented in the Project Advisory Group (PAG), which provides advice and guidance on project strategy and help assess implementation progress periodically. During the quarterly benchmarking meeting, accomplishments and benchmark status are presented and are reviewed against the benchmarks set for that quarter. Comments, suggestions and implementation concerns are raised by the participants, including other matters related to project implementation. Performance benchmarks for the next quarter are revised, adjusted and agreed upon by the participants based on the comments raised during the benchmarking meeting and the actual project accomplishments for the quarter under review.

B. LGU Performance Indicators

The LEAD Project's LGU performance indicators define the data to be collected at the LGU level which allow the project to measure output and outcome. The data are expected to measure definite progress and compare actual project results achieved over time against planned results. Simply put, these performance indicators are measures that describe how well the LEAD Project LGUs are achieving governance and FP/health service capacity development objectives and targets.

The LGU performance indicators lie at the heart of the project's performance monitoring system. This set of indicators is an important management tool to guide decisions about project strategies and activities. The information that the LGU performance indicators will yield will be very useful in evaluating whether the target LGU has improved and has

achieved its governance and health service capacity goals, or whether the LGU still needs further technical assistance, support, and other interventions.

At the project level, the information that will be generated will be used to:

- define how LGU performance will be measured
- allow comparison between actual results accomplished over time versus project targets
- guide the project towards developing future technical assistance interventions for target LGUs
- orient and motivate project staff towards achieving results
- help communicate project achievements to its clients (USAID, DOH/CHDs, POPCOM, PhilHealth, LGUs/Leagues of Cities and Municipalities)

At the LGU level, these indicators are expected to:

- guide LGU decision-making in terms of its own investments for family planning and health services
- help identify LGU best practices
- support advocacy at the local level

The indicators that are presented below, which will be used to monitor LGU performance, are the results of extensive discussions within the LEAD Project. In developing the indicators, the starting point was the intermediate results (IRs) as well as the end of project targets that were written into the contract for the LEAD Project. Following discussions with USAID, modifications to these indicators were made to make them more representative of the governance and FP/health systems development targets. Feasibility of data collection was likewise considered in revising the set of indicators.

Governance:

1. LGU providing for funds needed for the cost of its net commodity requirements for FP, TB, Vit. A and HIV/AIDS* (*- sentinel sites)
2. Health ordinance/s enacted, resolution/s passed, or executive order/s issued that promote FP, TB-DOTS, HIV/AIDS* prevention and Vitamin A supplementation
3. Health boards and other similar participatory bodies functional
4. CSR+ plan developed and implemented
5. % of indigent families enrolled in PhilHealth (NHIP enrollees)
6. LGU governance and service capacity plan document with TA specifications, signed and approved by the LCE for implementation
7. Availment of the TA specified in the governance and health service capacity development plan as reflected in the SIO work orders

Family Planning and Health Systems:

8. LGU able to generate on a regular basis, using CBMIS, FHSIS or other information systems, relevant data on FP, TB and Vit. A
9. RHU/ HC/ BHS providing clients with: access to pills, IUD, condom, DMPA, SDM and NFP; referral services for surgical sterilization; and counseling on FP
10. A health facility should have the minimum level of contraceptives, and TB & Vit. A supplies as defined by the Sentrong Sigla Standards
11. Rural Health Unit (RHU)/ Health Center (HC) is Sentrong Sigla Level 1 certified
12. Rural Health Unit (RHU)/ Health Center (HC) is accredited by PHIC as provider of TB-DOTS and out-patient benefit packages
13. % reduction in the proportion of high-risk groups who report high -risk behaviors (inconsistent condom use, sharing of needles)
14. % of barangay health workers trained for specific services
15. % of FP clients obtaining supplies and services for FP from private sector
16. % reduction in unmet need for FP

Annex B is the Performance Indicator Matrix, which provides complete information on the above indicators list, including the particular target that an indicator tries to measure, the indicator definition, the sources of performance data, and the frequency of data collection.

C. Policy Performance Benchmarks and Indicators

At the national level, the project must determine whether it has established a sound basis for proposing: (a) revisions to existing policies that are required to achieve the LGU goals and targets; (b) adoption of policies, where no such policies exist. This will require a series of steps, as follows: a) conduct studies to provide the bases for the policy proposals or review, b) provide technical assistance to the appropriate national government agencies such as the DOH, PhilHealth, POPCOM, in their efforts to formulate these policies, c) provide assistance in disseminating the corresponding policies to LGUs and other appropriate government agencies, d) provide support in ensuring that appropriate mechanisms are in place for the implementation of these policies, and e) assist, as necessary, in monitoring policy implementation and in evaluating the outputs and outcomes.

Performance data will also be needed to: a) determine to what extent the project will have assisted in creating a multi-level and multi-sectoral policy environment necessary to achieve contraceptive self-reliance, b) document/substantiate lessons learned from the experience of Pangasinan as a pioneer province with a relatively longer experience in adopting and implementing its own contraceptive self-reliance policy and program, and share with other LGUs, c) develop local and national policies for increasing and mobilizing additional resources for family planning, TB, HIV-AIDS, and Vitamin A supplementation, and d) conduct studies in support of client segmentation, and e) undertake policy advocacy activities at the national and local levels.

Policy Indicators:

Target: Adoption, issuance and implementation of National CSR Policy and Strategy
Indicator: DOH administrative order on CSR issued and implemented

Target: Passage of Local Ordinances adopting a local CSR strategy and setting specific targets under the local CSR Plan.

Indicator: Number of LGUs with Local CSR Strategy and formulation of local CSR+ plan with specific local targets (listed in the indicator matrix)

Target: Increased financing made available for FP through enhanced Social Insurance benefit package

Indicator: Inclusion of FP benefits in PhilHealth benefit package as a long term goal (listed in the indicator matrix)

Target: More RHUs of LGUs will be accredited under the PhilHealth Indigent Program

Indicator: Increase in number of LGUs participating in the PhilHealth Indigent Program and increase in the number of PhilHealth-accredited RHUs receiving capitation funds (listed in the indicator matrix)

Target: Pangasinan's experience in adopting and implementing CSR documented shared with other LGUs

Indicators: (1) Documentation of best practices and lessons learned on CSR implementation; (2) A guidebook on Local CSR implementation developed and copies provided to target LGUs

D. Impact Indicators

The LEAD Project is expected to contribute significantly to the achievement of the end-of-project goals, which will be measured using the following impact indicators:

1. Contraceptive Prevalence Rate – Modern Methods
2. TB Case Detection Rate and Treatment Success Rate
3. HIV Sero-prevalence rate and new case rates among high risk groups
4. % of children (6 months – 71 months) who received Vitamin A supplement within the past 12 months

The first impact indicator, the contraceptive prevalence rate (CPR), is an indicator of family planning use and a major factor affecting fertility rate. Modern CPR is the number of currently married women (15-49 years old) using modern methods of contraception (i.e. oral pill, IUD, condom, injectible, male and female sterilization and natural family planning) over the total number of currently married women (15-49 years old).

To measure the impact of project interventions on TB, LEAD will monitor the TB case detection rate and treatment success rate. The *tuberculosis case detection rate* is the ratio of smear-positive case notifications in a given year to the estimated number of new

smear-positive cases arising in that year. The *treatment success rate*, on the other hand, is the ratio of registered cases that have completed treatment and were cured over the total registered cases (as defined in the National TB Program register). The *cure rate* is the number of smear-positive cases that were cured over the total number of smear-positive cases registered, while a *tuberculosis case* is defined as a patient in whom tuberculosis has been bacteriologically confirmed or diagnosed by a clinician.

Since the ultimate measure of success of an HIV prevention program would be a decline in new HIV infections, experts recommend HIV incidence as the most appropriate indicator of program impact at the highest level. Unfortunately, adequate methodologies to measure incidence are still lacking. Recent joint guidance by UNAIDS, USAID, and WHO recommend monitoring HIV seroprevalence trends among targeted population groups. Therefore, to measure success in the LEAD Project HIV/AIDS interventions, it will monitor HIV sero-prevalence rate and new case rates among high-risk groups.

HIV seroprevalence is obtained by blood sample testing for HIV antibody using methodologies established by the CDC and WHO. Samples are taken at sentinel surveillance sites using established sampling techniques. New cases are HIV positive sero conversions during the previous year taken from the same sample.

Finally, the project will also measure effectiveness of interventions in expanding Vitamin A coverage using the percentage of children (6 months – 71 months) who received Vitamin A supplement within the past 12 months. To more fully reflect Vitamin A coverage, this indicator may be used in conjunction with facility-based indicators relating to IMCI Vitamin A protocols (e.g. proportion of children presenting at health facility with measles, prolonged diarrhea, etc. who receive Vitamin A).

V. Methodology

A. Data Collection: LGU baseline data and follow up

Because the central focus and client of LEAD project activities is the LGU, it will also be the central focus of the data collection efforts and analysis. This means that various types of data, including population-based, facility-based and administrative data as well as project interventions will all be identified by the LGU, and maintained in an LGU data base. This will enable project staff and others to track the progress of each LGU with which they are working vis a vis the types and volume of technical interventions that have been introduced to the associated LGU. Schematically, the structure of the data base will be as shown below. Note that this diagram does not show all the types of data that will be collected from each LGU, but rather the underlying structure of the database into which it will be stored. The key point is that all data, regardless of whether it is population-based, facility-based or project-based, will be identified to allow analysis of the impact of various types of interventions and LGU characteristics on program performance.

Name of LGU	population	date of data collection	CPR pub/priv.	TB success rate	HIV sero prev.	LGU capacity	governance measures	facility quality measures	interventions by type
Pangasinan									
Iloilo 1									
Davao City									

The first step in this process will be the LGU in-depth assessment. Tools are currently being developed for use by each LGU. This tool will ask LGUs about baseline data in the following areas:

- population and poverty levels
- budgets: total, and total health and FP related, total contraceptive commodities
- PhilHealth enrollment figures and cost
- Local Health Board activities and health ordinances enacted
- role and size of private sector in LGU
- measures of health service availability and quality including Sentrong Sigla certification
- Vitamin A supplementation, tuberculosis control, and family planning program performance
- information systems performance
- LGU policy support
- other data to support LGU performance indicators
- others

For most of the indicators, data can be collected during the initial assessment of the LGU, with annual follow-up data to be provided by the participating LGU. However, because of the importance of these data to track the progress of the project goals, it is necessary that all data either be collected or be verified by personnel who are not working for the LGU. This might include LEAD project staff, SIOs and other groups such as the regional health offices.

Although the in-depth assessment tool will provide valuable data on many variables, it will need to be augmented by other data sources to provide a more complete picture of LGU capacity and performance. These additional sources will include:

- population-based data on HIV seroprevalence among the most-at-risk-groups conducted through special surveys;
- health facility output data on TB treatment success rates and other priority health outputs;
- health facility data on Sentrong Sigla certification;
- non-LEAD activities (by category) in the LGU and the implementing agency (to the extent possible).

Further, as the project team or SIOs work with each LGU, the data that have been collected will be verified and updated.

Following the in-depth assessment of each LGU, indicators will be tracked on a regular basis with the timing and source of data indicated for each indicator.

Indicator Monitoring System. The project will also establish its indicator monitoring system where data on LGU performance indicators will be updated quarterly, semi-annually or annually, depending on the agreed frequency of data collection. The system will allow the project to track, evaluate, analyze and report status of LGU performance with respect to the governance and health service capacity development targets. These performance data will be consolidated at the central LEAD office through the database maintained by the PPMU. PPMU will prepare a summary report on the status of indicators indicating the total number of LGUs achieving the governance and FPMS targets using data on performance indicators. Under this system, a semestral reports will likewise be prepared by the PPMU, together with the performance coordinators and the LGU Performance Specialist, to show how the LGU achieved/ or did not achieve expected targets. It will include a discussion of issues and concerns affecting LGU performance. The report will be based on the following summary table that the PPMU database will generate quarterly:

Performance Indicators	Number of LGUs Achieving Governance and Service Capacity Targets as Measured by the LGU Performance Indicators									
	Baseline		Quarter 1				Quarter 2 ...			
	# of LGUs	Date Collected	Target # of LGUs	Actual # of LGUs for Qtr-1	Date Collected	Cumulative as of Qtr-1	Target # of LGUs	Actual # of LGUs for Qtr-2	Date Collected	Cumulative as of Qtr-2
Indicator # 1										
Indicator # 2										
Indicator # 3										
Indicator #...										

Data collected during the in-depth assessment period will be entered in the baseline data column. The baseline data will reflect the status of the LGU performance indicators at the time of initial LGU engagement. The target number of LGUs for each performance indicator will be determined once the TA requirements are identified and agreed upon. TA interventions will then be introduced by the project through the SIOs, and actual accomplishments every quarter will be measured, compared, and analyzed against the baseline data. Cumulative data as of the end of each quarter will likewise be provided by this database. Using quarterly data, a semi-annual assessment of LGU performance indicators will be conducted to evaluate LGU performance for two quarters and assess the effectiveness of the project’s TA interventions.

B. Data Collection: Population-based Data

Like most USAID health and population projects, LEAD aims to contribute to the achievement of national targets in health and population as defined by the Strategic Objectives and Intermediate Results. Many of these targets are population-based, including CPR, CPR among the poor, and HIV sero-prevalence among at-risk groups. While the goals that are stipulated are national, and will ultimately be verified through national surveys, it is important that the project also monitors some population-based indicators at the local level to compare changes in these impact variables with the characteristics and inputs of each LGU. A significant component of the PMEP is therefore, the development of a population-based data collection system that will provide impact data for each LGU.

Using the Community-Based Monitoring and Information System (CBMIS). The CBMIS is one of the methods for data collection that can be employed. This type of system utilizes health workers at the barangay level (BHWs) in gathering family planning and other health-related data. This type of system requires that the BHW goes to each household on a regular basis, asks about a variety of health indices and correctly enters the data. There has been a considerable investment in this system in some of the barangays covered by the LEAD Project. All it takes would be to build on the work that was previously done. Further, there is some evidence that the use of this type of system has a positive impact on health outcomes and therefore, is a good investment for the project. In addition, the approach has the significant appeal that its primary purpose is to collect data for use by the health worker, with the collection of evaluation data as a by-product. Thus, the BHW has an incentive to collect the data since these will be valuable in the performance of his/her job.

However, there are also many concerns about the use of the CBMIS as the primary tool for population-based measurement. One of these is the considerable effort needed to implement the system in LGUs where it does not exist. There is substantial training required and there is a need to continually supervise and motivate the BHW to go to each household on a regular basis and collect and enter data. There are examples in other countries such as Indonesia and Bangladesh where this has been achieved and provided a sound basis for both program planning and evaluation. However, there are also many countries, such as India, that have tried this approach with little success due to the considerable effort needed for the BHW to visit each household.

A second concern about the use of the CBMIS is the potential for bias in the data that is entered, and therefore invalidating its use as an evaluation tool. Since the data is entered by the same individual who provides services, and since there may be considerable motivation by this individual to look like they are performing well under the program, there may be a tendency to exaggerate the success of the program through the manipulation of the data. In the same way, a BHW may simply make up data as an easier alternative to visiting each household on a regular basis. In either case, the data may not be completely reliable to be used for evaluation purposes. Another type of bias that is unintentional is the difficulty in enumerating all the potential beneficiaries of a service thereby underestimating the denominator for coverage rates such as CPR or Vitamin A supplementation. This can come about by undercounting households (for example, not

including those that are very far from the center of the barangay) or systematically undercounting households of indigenous or very poor populations. In these cases, the bias will again be to overestimate the impact of the program.

Using National Surveys and Cluster Surveys. An alternative to the use of a CBMIS is the use of surveys to collect population-based data. At the national level, annual FP surveys and 5-year Demographic and Health Surveys will be used to measure contraceptive prevalence and other population-based indicators. However, these surveys will not provide impact data at the LGU-level. It will therefore, not be possible to use these national data to establish the relationship among project inputs, LGU performance, and impact. One method that has been used successfully for the collection of this type of locally-based data is the use of mini-surveys using cluster sampling techniques, and employing local data collectors such as school teachers. This type of approach has been very successful in the childhood immunization programs, and have also been implemented in earlier projects in The Philippines including the LPP project funded by USAID and implemented by MSH. The advantage of this type of survey is that it is relatively low-cost (although still expensive when implemented in more than 500 LGUs) and because of the small sampling frame, the margin of error may be too large to capture small changes in population. This latter point is of particular concern since the LEAD Project only has a three-year time horizon, and because many of the LGUs will not come on board until the second or third year of the project, there will be too little time to see significant changes in measures such as CPR if a small sample size is used. One advantage of the use of small-scale surveys is that they could be contracted out to SIOs that are familiar with the technique, provided the project does not use the same SIOs that are providing technical assistance to the LGUs.

Because of the concerns raised about the feasibility and bias of using the CBMIS approach and the cost, logistic and statistical concerns about the use of small-scale surveys, the following approach is being considered:

- LEAD will continue to use the CBMIS in LGUs where it is already operational and will attempt to introduce it to as many other LGUs as possible on the basis of its positive impact on program performance. In those LGUs with an operational CBMIS, the data will be regularly collected by the project for review.
- LEAD will implement small-scale surveys in a limited number of LGUs, particularly in those LGUs that were engaged by the project during its first year, to allow for a reasonable time period during which to measure changes in the population.
- Between now and July 2004, LEAD will assess, the sample size and administrative requirements to implement small-scale surveys in this limited number of LGUs and, if feasible, will contract with appropriate SIOs for their implementation.
- During the second year of the project, data from each LGUs where both small scale surveys and the CBMIS are being implemented, will be compared for accuracy and cost. Based on this analysis, decisions will be made about using each of these approaches in the collection of population-based data.

There are several questions important to the LEAD Project that can only be answered through the use of population-based data. In particular, the project would like to know the following:

- Do LEAD project interventions lead to demonstrable changes in the population?
- Are there some interventions that are particularly important?

Two methodologies have been discussed as potential sources for this type of data – the CBMIS and cluster surveys. Although there is great potential in the use of the CBMIS as a support tool for BHWs and their supervisors, there are limitations to this methodology, which include potential bias in data collection, exclusion of some households that skews the sample and underestimates the size of the denominator, and the need to continually update the information for it to be useful as a monitoring tool. The following were noted based on the experience of past projects that utilized the CBMIS indicates that

- While the CBMIS is a good tool for planning, it is generally not sufficiently updated for continuing use in monitoring and evaluation.
- The CBMIS is very good tool in estimating unmet demand, but not so good in estimating the CPR since it does not cover all households.
- If the performance on key indicators is used as the basis for payment, there is likely to be a significant overreporting of utilization of services and impact.

While the CBMIS is useful for planning and monitoring, it will need to be augmented by some survey methodology to be able to collect population-based data on indicators such as CPR and source of contraceptives, as well as Vitamin A coverage and TB treatment. By doing both types of data collection in some LGUs and barangays, a further outcome of the project will be to report on the data validity and impact of having a functioning CBMIS which is itself an important question for the project to address given the substantial resources that will be invested in this single intervention.

Timing of Data Collection

Ideally, the project would like to collect data at three points

- Baseline, before activities begin
- End of project, to measure the impact of project interventions, and
- Mid-point, to see the direction at which the impact indicators are moving in time to make mid-course corrections to project activities.

However, this model is complicated by two factors. One is that LGUs will be entering the program at different points in time so a measurement at the midpoint of the project will not necessarily be the midpoint of project activities for any given LGU. The second factor is that while the LEAD Project is currently contracted for 3 years, it is possible that the project will be extended for another 4 years, leaving open the question of when to carry out the EOP assessment. This is further complicated by the fact that the majority of the LGUs will not enter the project until its final year, so that if the project were in fact to end after only 3 years, there would be not enough time to measure both baseline and impact, and the project will not be able to see a significant change in impact measures.

Based on the foregoing, it is suggested that data collection be made to coincide with the LGU's participation in the LEAD Project rather than with the beginning and ending of the project itself. Further it is suggested that impact indicators be collected from LGUs every two years, starting from the entry of the LGU into the LEAD Project. This means that the project will collect population-based data on a rolling basis rather than at fixed intervals of the project life. There are several reasons for this recommendation.

- By timing the data collection with the LGU cycle, the project will be able to collect data that are comparable across LGUs.
- This approach will generate data on those LGUs that have had at least a 2-year window of activities. This seems like a reasonable amount of time in which to expect any measurable change in impact. Note that if the project is only for 3 years, we will have only two measurements for each LGU since there is not enough time for more.
- If the project is extended for 2 or 4 years, the data collection can continue, providing the project data at 2-year intervals and tracking changes in impact in each LGU. In this case, the LGUs that enter the project early will have a midpoint and EOP survey as well as a baseline.
- The logistics of doing these surveys on an ongoing basis will mean less disruption of activities for the project once the general methodology is developed. This approach also means that a smaller number of organizations which are actually doing the data collection can be used since the work is spread out over the year.

Sampling Framework

Several questions arise regarding the sampling framework for the surveys being proposed. These include the number and selection of LGU for participation, whether all barangays in an LGU are included or only those that are included in intensive project activities, whether follow-up surveys include the same households in the sample or a new random array, the number of clusters and number of households in each cluster, and the use of control groups.

- Selection of LGU – It is neither necessary nor feasible to include all LGUs in the sample. A subset of LGUs should be included that would be stratified for region, year of initiation of project activities, urban vs. rural, and other important characteristics that are likely to influence the outcomes. The total number of LGUs to be included can depend on the number of these factors on which the project is stratifying since the project wants enough LGUs in each category to have a valid sample. The project may also choose to oversample from the LGUs that enter in year 1 of the project since if the project lasts only 3 years, these will be the only LGUs from which LEAD could have follow-up data. Once the stratification criteria are developed, the project can select randomly, although in the first year, this will include a large percentage of the total number of participating LGUs.

- Which barangays – Since not all barangays in an LGU are participating in the LEAD Project, the project may include both and have a marker to indicate whether they are included or not. There are several reasons for this. One is to see whether some critical inputs at the barangay level (i.e. presence of BHW, CBMIS) have a substantial effect on impact, and this would be a straightforward way to do this analysis. This would also enable the project to generate information on the relative impact of the work done at the LGU level (health boards, etc.). A second reason is that, ultimately, the project is accountable for impact at the LGU and national levels, and indeed one of the criticisms of the last project was the need for broader impact beyond a few test barangays. For this reason, it would be important to show impact at the LGU level, not just at the barangay level.
- Follow-up survey households – Once the first round of surveys is done, there are two possible approaches to the selection of households to include in the follow-up survey. The first is to try to identify the same households two years later and resurvey them. This methodology is a true longitudinal survey, but will be very difficult to do, and for the purposes of this project, not worth the added investment to re-find the same households. Rather, it is suggested that the second (and potentially third) rounds of survey be done on a different sample of households but from the same LGUs that are included in the first sample. This will greatly simplify the data collection.
- Number of clusters and households – The number of clusters and households needed is determined by the prevalence rates of the indicator, the expected change over the period of time (2 years) in this indicator and the desired confidence intervals. However, as a general rule of thumb, this usually comes to about 30 clusters with about 7-10 households per cluster to achieve 95% confidence intervals, but these numbers should be calculated based on the available data on the indicators in question. There are many experts in the Philippines who can do this calculation, or software such as *RightSize* from CDC could be used. Note also that the indicators include information about different groups. CPR is about adults of reproductive age, TB is about adults and children, while Vitamin A is about children ≤ 60 months.
- Control groups – Although LEAD is not a research project, there is a strong argument for use of a small number of control LGUs in order to show that project interventions have some impact on relevant indicators of population health. The reason for this is that demonstrating change in the target LGUs that result from project intervention is only significant if the project can also demonstrate that there is no change in the population as a whole. To do this, some comparator group that did not participate in the project activities is necessary. This does not need to be a large sample of LGUs, but again, an assessment of the necessary sample size is necessary. Note that the control LGUs need to be surveyed every 2 years.

Data Collection

If the LEAD Project is to collect population data, it is important that the data that is collected be both accurate and unbiased. To achieve this, it is important that the data collectors are not those who are responsible for the implementation of the project activities. Universities and other institutions can be contracted to collect the data. Alternatively, the SIOs could collect data, provided they are not from the LGUs where they were working. In either case, the past experience with this form of data collection should guide the decisions.

Substantial work has been done on the development of the Multi-Indicator Cluster Survey Methodology both in the Philippines and throughout the world. Both WHO and UNICEF have led this effort initially for EPI and, increasingly, for other interventions including FP and HIV. Several projects have used the methodology and experts in the Philippines could assist in the technical design and implementation of the surveys.

C. Data Collection: Special Studies

In addition to the routine data that is collected through the project, there are a number of special studies that will be considered. Some of these will be operational research type of studies and will be developed on the basis of identified barriers to improvements and expansion of service delivery. Some special studies are planned to be implemented in the first year of the project for the purpose of consolidating the current information about the population, service providers, and existing regulation and laws. Another set of special studies that will be done in the first year of the project is for the purpose of refining instruments and procedures used by the project. The studies include:

- Demographic analysis of existing data from national DHS and FP surveys;
- Review of behavior, job satisfaction, motivations, aspirations, and barriers to quality service and interventions for improvement;
- Identification of mechanisms for defining and identifying market segments;
- Analysis of existing policies, laws, and regulatory constraints affecting the provision of family planning services, TB-DOTS, and HIV-AIDS;
- Market transformation study of the impact of interventions to motivate the private sector and increase the private provision of contraceptives and family planning services;
- Develop, test, and provide a preliminary rollout of an assessment methodology on the size and composition of ambulatory service markets in the Philippines, focusing on the services prioritized by the LEAD Project. This information would

be used for advocacy and LGU planning, and to create a market typology that could guide future LEAD interventions and strategies;

- Analyze the Indigent Program of PhilHealth from the perspective of the LGU and assess the financial and administrative costs and benefits of significant LGU participation in the program;
- Mid-Year and Year-End assessment of tools, guides, TA instruments and delivery mechanism, and LGU engagement process; and
- Utilization of FP, TB, HIV/AIDS services and Vitamin A supplementation by the poor.

VI. Data Analysis and Reporting

A. Performance Reviews, Assessment, and Reporting

1. Conduct of Quarterly Benchmark Setting/ Quarterly Performance Reviews.

At the end of each quarter, actual project performance will be reviewed against benchmarks and deliverables set for that period. The main audience of the quarterly performance reviews are the members of the Project Advisory Group (PAG) and the Technical Advisory Group (TAG) coming from the Leagues of Cities and Municipalities, DOH, POPCOM, PhilHealth, USAID, ARMM, the academe and the private sector. During the quarterly performance review, benchmarks and activities for the next quarter will be validated or revised as necessary.

Customer satisfaction. The LEAD Project will use the quarterly performance review as the venue to assess client satisfaction. From the resulting project efforts, LEAD will seek client comments and recommendations and will gather information to assess the degree of client satisfaction with respect to meeting their interests and priorities. Implementation issues and concerns will be discussed with the clients and recommendations on how to address them will be formulated and implemented by the project upon the advice of the clients.

The Quarterly Performance Reviews are designed to be the process for measuring and responding to the interests and concerns of the main customers of the project in an organized regular review process. The PAG and TAG represent the main clients (customers) of the project. Through the conduct of the Quarterly Performance Reviews, the key clients have a regular opportunity to establish and review the project's deliverables, and determine their satisfactory completion, and to discuss with the LEAD project team leaders the key issues or concerns and other interests they might have. The LEAD Project has the opportunity to describe the project's activities, present accomplishments, discuss implementation issues, and to hear and respond to suggestions from the clients.

The PAG is the most senior oversight body for the project. It exercises overall oversight, provides strategic advice, and ultimately judges the progress and achievements of the Project. The PAG represents the major customers of the project. The LEAD customers often have dual roles as customers (clients) and as

collaborating organizations. For example, the DOH is a collaborating agency in implementing improved services by LGUs. At the same time, the DOH is a major client since it must be satisfied with the performance of the project. The DOH Undersecretary for Mindanao Health Development serves as the Chairperson of the PAG.

The TAG, composed of senior technical managers in the health sector, primarily from the DOH and PhilHealth, are also major counterparts of the LEAD team on programmatic and strategic issues. Their input to the quarterly reviews is to exercise their professional judgment over the work of the project, and to suggest ways to improve operations, coordination with major government health and financing initiatives, as well as judge the work of the project.

The PAG and TAG likewise provide inputs in the formulation and review of the LEAD First Annual Work Plan. During the quarterly reviews, the PAG and TAG members comment on LEAD's activities, approve or disapprove project deliverables, and make suggestions. The LEAD team responds by making necessary adjustments to deliverables for subsequent quarters. Thus, the LEAD activities are designed to respond to the major clients' directions, and are monitored by the major clients on a quarterly basis.

LEAD for Health will develop other approaches to gauge the satisfaction of LGUs with the project intervention. One approach is likely to focus on measuring satisfaction of LGUs about the quality, timeliness, and effectiveness of technical assistance received through the Service Institutions and Organizations (SIOs). These SIOs are local organizations contracted by the LEAD Project to provide technical assistance in governance and FP/health service capacity development. LEAD staff will measure LGU satisfaction with this work as part of monitoring the performance of the SIOs.

The ultimate beneficiaries of the LGU initiatives, supported by LEAD, are the people receiving the services. Admittedly, measurement of beneficiary satisfaction is often overlooked by existing programs. This feedback is an essential input for performance improvement. LEAD cannot, at this time, commit to a measurement of beneficiary satisfaction because of the many uncertainties about the engagement and support processes for the LGUs such as questions on which client services and which clients will be selected for primary technical support, and the known cost and complexity of many survey methods. However, the LEAD Project will continue to explore cost-effective methods for measuring client satisfaction through existing survey findings, possible additional "rider" questions on existing surveys, adapting existing LGU formal and informal information channels, etc. This measurement of beneficiary satisfaction is fully supported in concept by the LEAD project.

2. **Conduct of Semi-Annual Reviews.** LEAD will document the assessment of project implementation processes and approaches, including the assessment of the LGU engagement process (and the validity of the assumptions made), TA

instruments and mechanisms, assessment tools and strategies, at the end of the test phase in July 2004. After that, the project will determine whether further mid-term reviews will still be necessary.

3. **Preparation of Quarterly/ Annual Reports.** At the end of each quarter/year, implementing units will submit their quarterly/annual accomplishment reports for consolidation by the PPMU. These reports are keyed to the activities and benchmarks set at the beginning of each quarter/year, containing information on accomplishments, major problems encountered, and recommendations on how these problems are to be resolved. The quarterly reports will likewise contain the performance objectives of each implementing unit for the subsequent quarter, which illustrate what the project commits to accomplish for the next quarter. These reports are submitted to USAID and copies are provided to its clients, namely, the DOH, POPCOM, PhilHealth, and the Leagues of Cities and Municipalities.

B. Regular Updating of LGU Performance Data

Having defined the data to be collected on LGU performance, project outputs and population impact, systems will be developed to store and analyze the data. Storage will be done using two project databases. The first one, which was described earlier in the section on *Data Collection: LGU Baseline Data and Follow-Up*, will be developed to capture data from the indicators in this document and will be maintained for each LGU. This database will be developed during the next several months so that it is ready for use when the collection of data from the intensive assessments of the first batch of LGUs. Data will be entered into the database by project or contracted staff as it is received from each LGU or SIO and will be entered into a new record identified by LGU name and date. In this way, data can be updated as often as it is received, and at the same time, will allow the analysis of data as it changes over time. The data base will use commercially available software that is customized for use by the LEAD Project and will be housed on a computer at the LEAD project office.

The analysis of the data that is stored in this database will include some standard products and the ability to query the database on an ad hoc basis as the project progresses. The types of standard analysis that will be done include the following:

- **Aggregate LGU performance** – this will include aggregate data reporting on the numbers and % of LGUs that are satisfactorily performing according to the indicators as defined. An example would be the total number of LGUs and the percentage that *achieved national targets for tuberculosis case detection rate and treatment success rate*.
- **Trends in LGU performance compared to targets** — this would be a measure over time of aggregate LGU performance compared to the governance and service capacity targets.

- **LGU performance, by province and region** – this would be a report generated for project and DOH staff who are interested in the relative performance of individual LGUs.
- **SIO performance** – this would be a report generated for project staff to assess the relative performance of the SIOs working with the LEAD Project. This type of information will be helpful in determining which SIOs are most successful in this work, and which SIOs may need to be either strengthened or replaced. In instances where LGUs are working with multiple SIOs the information will be reported according to those areas (by indicator) where the SIO is working with that particular LGU.

The other set of database that will be maintained by the project is the one which contains the impact data. The design of this database will depend on what type of impact evaluation plan will be agreed on. This impact evaluation plan will include an analysis of the impact of Component 2 of the project.

C. Special Reports

This project will generate a large number of special reports. Some of these will come as a result of special studies being done by the project wherein specific questions of importance to project success are being assessed. Other special studies will be done to look at the relationships between project inputs and LGU performance in an effort to answer the questions posed earlier in the report:

Can we identify what conditions and what types of inputs have the highest likelihood of success at the LGU level?

To what extent can we attribute service improvements to project activities?

The methodologies that will be used to attempt to answer these questions have not been fully determined but several approaches may be considered. One requirement for answering the first question is to define the types of assistance being provided to LGUs by the project staff, SIOs, or through some other mechanism such as performance-based contracting. A starting point for this might be to use categories consistent with those used for indicators such as governance, management, etc. Within these categories (or for some types of interventions that do not fit into these categories) further classifications will be needed such as specific training being offered, development of specific management systems, material and commodities, or some other categories depending on what types of interventions are done. This is necessary in order that specific types of interventions may be linked to changes in LGU performance or even to impact changes. These data will be entered in the LGU data base described above including the dates during which the intervention is undertaken. This will be enable the project to analyze the relationships between these interventions and performance.

Having entered this type of data, the project will be in a position to look at specific questions of interest to the LEAD Project. An example of such a question would be:

Does the use of CBMIS lead to better performance in LGU capacity and population impact?

To answer this question, we will need to look at those LGUs that are using a CBMIS and those that do not and compare the changes in performance indicators in these two groups. The same could be done for questions about other types of project inputs such as market segmentation, governance, etc. These possible questions will be identified later in the project as we gain more experience in program implementation.

VII. Use of Information

Like all evaluation systems, the PMP is of little value if it is not used. For this reason, attention to how the performance information generated from the LEAD Project is used is an important consideration. To some extent, this has already been done in the project design through the use of strategic objectives (SOs) that will assess project impact and intermediate results (IRs) which will evaluate project and LGU performance.

Beyond this, the data generated also have other uses. One of these is to guide project activities toward those LGUs and those types of interventions that have the highest likelihood of success. As the project unfolds, relevant data will be increasingly available for use in this analysis and the selection of LGUs will then be made on this basis.

Another use is to help guide LGU decision making in terms of their own investments in health programs and the approaches they use. One way to achieve this is through the use of data collected using CBMIS. Training and follow up on the use of this system to collect data will be an important component of the project and should lay the foundation for a sustainable data collection system at the LGU level. Another way in which the evaluation system will be used to guide LGU decision making is through the more sophisticated analysis of selected items being made available to the LGUs and the use of this data for decision making.

Information from these indicators can help an LGU to understand the financial implications of increased enrollment of their indigent population. Since poor LGUs are subsidized and pay only 10% of the total premium for their population and receive capitation payments of P300 for primary health care, they should benefit financially from the system. One LGU in Davao del Norte used this strategy to generate funds to subsidize its TB program.

A third way in which the evaluation system will be used to support LGU decision making is through the identification and publication of best practices that have been learned in the course of project implementation. Because of the way the LEAD Project is being

implemented and given the large number of LGUs that are participating, there is a kind of natural experiment underway in which different LGUs and different SIOs will address the challenges of improving health in a wide variety of ways but each with the same set of outcomes and impact indicators. Good analysis of which approaches work well will lead to a set of best practices that can then be documented and shared with other LGUs for this benefit.

Another use of the information generated from the PME system will be for advocacy, especially at the local levels. Comparative data on LGU performance can encourage underperformers to invest in family planning and selected health services. Politicians naturally like to be seen as leaders of well-managed LGUs and this type of approach can be successful in influencing these leaders to support health programs.

Finally, there is an opportunity for the LEAD Project to learn new knowledge about the relationships between the types of project interventions and their impact on the population. It is hoped that some of the lessons learned from the LEAD Project will have positive implications on the provision of future technical assistance and these lessons can be used not only throughout the Philippines, but perhaps in other countries as well.

One interest of the LEAD Project is to document its work for use either in the form of published articles or teaching cases that can be used both in the Philippines and in other countries including the U.S. The LEAD Project is an innovative and complex project with clear measures of success. Students from the Philippines who intend to work in the country can benefit from the lessons of this project as many of them will be applicable to their work in other parts of the country. Published articles and teaching cases leave a written record of the lessons of the project making them more widely available than project documents which are typically not widely circulated beyond those who are involved in the project.

VIII. Implementation of the PMEP

The PMEP will be implemented in accordance with the overall project phasing as mentioned in page 5. The LEAD work plan was developed and the project deliverables were identified during the start-up phase (October 1, 2003 – January 2004). It was also during the start-up phase when the PMEP was conceptualized and work on indicators was initiated. The PMEP Technical Working Group and Unit Performance Coordinators Group were organized, both to support the development of the PMEP and to participate in collection and analysis of LEAD performance data.

On or about two weeks after the end of every quarter, performance reviews/benchmarking meetings will be held to discuss the accomplishments of each implementing unit for the quarter, and to review whether the benchmarks they have committed to achieve were met on time or not. Each unit will be expected to discuss implementation issues and concerns affecting performance. This meeting will culminate at examining the benchmarks for the subsequent quarter, in the light of the results of the performance review and the comments made by the PAG. Finally, the benchmarks will

be adjusted and revised and the quarterly performance report will be written and submitted to USAID. This report includes a documentation for each deliverable committed by the LEAD Project. Once the quarterly performance report is officially accepted by USAID, the project will provide the PAG/TAG members copies of the report.

Sometime in July 2004, a mid-year review will be conducted to initially assess and evaluate the tools, processes, approaches, and TA instruments and mechanisms developed by the project. Then, sometime in September 2004, the effectiveness of these tools, instruments and mechanisms will be evaluated and may be refined, improved or changed, depending on the results of the review. The mid-year review will also serve as a venue to address implementation problems and issues encountered by the project, particularly in implementing the project in the first 46 LGUs that were engaged in the test phase.

An Annual Review by the end of the initial roll-out phase (December 2004) will be conducted by the LEAD Project to evaluate overall project performance for the first year of implementation. In this activity, the first year accomplishments will be assessed vis-a-vis the first year targets that were committed in the work plan. A review of the status of LGU engagement, both covering the first 46 LGUs (under the test phase) and the next 100 LGUs (under the initial roll-out phase) will also be conducted to evaluate progress in terms of achieving the governance and health service capacity development goals. PPMU will then prepare the annual report on the basis of this review. The annual report will be submitted to USAID and after acceptance of the report, copies will be provided to the members of the PAG.

To monitor LGU performance, LEAD developed a list of LGU performance indicators for each of the governance and health service capacity development targets. The indicator matrix clearly defines the indicator, the data sources and the frequency of data collection. The set of indicators developed will be used consistently by the project in many of its major activities such as the development of assessment tools, MOA development, design and administration of performance-based grants, TA planning, evaluation activities and other related activities. PPMU will also coordinate the development of the indicator monitoring system and database and manage overall collection, tracking, and monitoring of performance data, which will be done quarterly, semi-annually or annually, depending on the frequency of data collection that was agreed upon for each performance indicator.

Indicator monitoring results will be used by the project to enhance field implementation, validate effectiveness of TA interventions introduced in the target LGUs, and develop special TA if necessary. The status of indicators will likewise be reported during the mid-year and annual reviews, and will input into the project's quarterly and annual performance reports.

To monitor results of the project's policy interventions, the LEAD Project, through its Policy Unit, will clearly (1) define specific results that it intends to achieve during the performance period; and (2) show how achieving these specific results leads to specific changes in policies and regulations to support the attainment of the project's objectives.

Policy activities shall be included in the annual workplan with specific targets identified for each activity. Detailed results of these activities will be defined for each quarter. The progress of the policy interventions will be tracked through the quarterly project performance reviews. Measurement of the impact of policy support on strengthening the provision and financing of FP and the selected health services will be included in the design of the LEAD impact evaluation plan.

To support the monitoring of impact data, the project, through PPMU, will also establish links with different data sources, such as the National Statistical Coordination Board (NSCB), the National Statistics Office (NSO), the National Economic and Development Authority (NEDA), and other institutions. Access to and utilization of national surveys and related reports, such as the FPS, DHS, NSO Surveys, etc., will also be maximized. Possible cluster surveys and special studies may also be conducted by the project to support gathering of impact data.

LEAD will also develop the end-of-project (EOP) Evaluation Plan that will demonstrate how the project will analyze and evaluate project performance vis-a-vis EOP targets. The EOP evaluation results will serve as important inputs in the determination of whether the project has made significant progress in achieving its end-goals and whether it deserves an extension or not.

Finally, the project will also conduct an analysis of the project's cost-effectiveness and cost-efficiency by the end of the first year. This analysis is critical in evaluating whether interventions introduced and investments spent for this project are worth the cost or not.

The project will finalize plans for measuring project impact by July 2004.

Activity Matrix

**PMEP Activity Matrix
First Year (Oct 2003 – Dec. 2004)**

GOAL: I. Monitor, evaluate and improve over-all project progress and performance, including LGU performance

STRATEGIES 1. Develop the Performance Monitoring and Evaluation Plan (PMEP)

- 2. Establish and implement systems and mechanisms for collecting, monitoring, evaluating and analyzing performance data:**
 - a. Performance benchmarks
 - b. LGU performance indicators
 - c. Impact Indicators

Strategy/Activities	Deliverable	Budget	Start Date	Completion Date	Unit Responsible
<p><u>Strategy 1: Develop the Performance Monitoring and Evaluation Plan</u></p> <ol style="list-style-type: none"> 1. Facilitate and coordinate the preparation of the LEAD Performance Monitoring and Evaluation Plan (PMEP) <ol style="list-style-type: none"> a. Develop the PMEP conceptual framework b. Organize the PMEP technical working group c. Develop the SOW for the Harvard STTA to seek expert support in developing the PMEP d. Conduct meetings/ consultations/ workshops e. Consolidate Implementing Units' inputs f. Prepare/Write Over-all PMEP <ol style="list-style-type: none"> i. draft narrative ii. indicator matrix 	<p>Conceptual Framework developed</p> <p>PMEP Technical Working Group Organized</p> <p>SOW for Harvard STTA finalized</p> <p>Consultation meetings/ workshops conducted</p> <p>Implementing unit inputs consolidated</p> <p>Draft PMEP and Indicator Matrix developed</p>		<p>January 2004</p> <p>February 2004</p> <p>February 2004</p> <p>March 2004</p> <p>March 2004</p>	<p>February 2004</p> <p>February 2004</p> <p>February 2004</p> <p>March 2004</p> <p>March 2004</p>	<p>PPMU</p> <p>PPMU/ Other Units</p> <p>PPMU/ Other Units</p> <p>PPMU</p> <p>PPMU</p>

<p><u>Strategy 2: Establish and implement systems and mechanisms for collecting, monitoring, evaluating and analyzing performance data</u></p> <ol style="list-style-type: none"> 1. Conduct Quarterly Performance Reviews/ Benchmarking Meeting 2. Conduct the Mid-Year and Annual Assessment to review assessment tools, processes, systems, TA instruments and mechanisms, assumptions and approaches used by the project 3. Develop the Indicator Monitoring System, including e-based indicator monitor 4. Develop the project's database system for LGU data 5. Compile LGU baseline data 	<p>Quarterly Performance Review/ Benchmarking Meeting conducted:</p> <ul style="list-style-type: none"> - 1st Quarter (Oct 03 - Dec 04) - 2nd Quarter (Jan 04 – Mar 04) - 3rd Quarter (Apr 04 – Jun 04) - 4th Quarter (Jul 04 – Sept 04) - 5th Quarter (Oct 04 – Dec 04) <p>Mid-Year and Annual Assessment Conducted</p> <ul style="list-style-type: none"> - Mid Year - Annual <p>Revised/Improved tools, processes, instruments and mechanisms based on lessons learned</p> <p>Indicator Monitoring Systems established</p> <p>Over-all LGU Database system developed</p> <p>LGU baseline data compiled</p>		<p>February 2004 April 2004 July 2004 Oct. 2004 Jan 2005</p> <p>July 2004 Sept 2004 Jan 2004</p> <p>March 2004</p> <p>May 2004</p> <p>July 2004</p>	<p>February 2004 April 2004 July 2004 Oct. 2004 Jan 2005</p> <p>July 2004 Sept 2004 Jan 2004</p> <p>June 2004</p> <p>September 2004</p> <p>Dec 2004</p> <p>PPMU PPMU PPMU PPMU PPMU</p> <p>PPMU and other Units</p> <p>PPMU/ Other Units</p> <p>PPMU/ LGU Unit/ Other Units</p> <p>PPMU</p>
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<p>6. Conduct a semi-annual review of the status of LGU performance indicators</p>	<p>Review of LGU Performance Indicators - for the first batch of LGUs engaged (46)</p>	<p>Dec 2004</p>	<p>Dec 2004</p>	<p>PPMU/Other Units</p>
<p>7. Establish links with different data sources (NSCB, NSO, NEDA, etc)</p>	<p>Links established with different data sources</p>	<p>April 2004</p>	<p>June 2004</p>	<p>PPMU</p>
<p>8. Develop the End-of-Project (EOP) Evaluation Plan</p>	<p>EOP Evaluation Plan developed</p>	<p>July 2004</p>	<p>Dec 2004</p>	<p>PPMU</p>
<p>9. Finalize plans for measuring project impact</p>	<p>Plans for measuring national TFR, CPR, TB Treatment Success Rate, HIV/AIDS Seroprevalence and Vitamin A Supplementation Coverage Rates in 2006</p>	<p>June 2004</p>	<p>July 2004</p>	<p>PPMU</p>
<p>10. Organize baseline data for impact measurement</p>	<p>Baseline data for impact measurement organized</p>	<p>July 2004</p>	<p>August 2004</p>	<p>PPMU</p>

Performance Benchmarks

ANNEX 1

SECOND QUARTER (Jan-Mar 2004) BENCHMARKS:

Family Planning and Health Systems Unit:

1. Assessment tools, instruments and guides developed for LGU engagement
2. Specifications, guidelines and alternative models of LGU level health information systems development initiated
3. Initial review of training modules on NSV, mini-lap and IUD insertion, itinerant NSV services conducted
4. Guide on setting up IUD services developed
5. Training modules on FP group counseling techniques drafted
6. LGU procurement models and FP supplies management guidelines reviewed/ improved

LGU Unit:

7. The first batch of 20 LGUs with signified intent to participate in the program
8. Completed self-assessment forms from 20 LGUs reviewed and evaluated
9. One (1) participatory workshop conducted to assess LGU needs, capacities and priorities

POLICY Unit:

10. Inventory, review and analysis of and recommendations on existing policies, laws, and regulatory constraints affecting the provision of family planning services, TB-DOTS, HIV-AIDS - initiated
11. Workable systems/mechanisms for defining and identifying market segments developed
12. Operations research (OR) Plan / TA plan for Pangasinan developed

Project Performance Monitoring Unit:

13. Project's First Year Workplan (Oct. 2003 - Dec. 2004) submitted to and approved by USAID
14. Performance Monitoring and Evaluation Plan (PMEP) developed and submitted to USAID
15. Functional Indicator Monitoring System established
16. 1st Quarter (Oct. -Dec. 2003) Performance Report submitted to USAID
17. First Benchmarking and TAG Meeting held
18. Draft Communication Plan Framework developed

Performance-Based LGU Grants and TA Contracting Unit:

19. Development of the manual on the guidelines and procedures for contracting SIOs initiated
20. Contracting process for the engagement of 9 NGOs (that provide technical assistance support to HIV-AIDS high -risk groups in 8 sites) initiated

Administrative and Finance Unit:

21. All technical and administrative staff for central and field offices officially hired
22. Permanent and functional project offices (central & field) established
23. All needed financial and administrative systems, policies and procedures established
24. First quarter financial status report submitted as part of the first quarter performance report
25. Employee handbook drafted
26. All needed office equipment procured

THIRD QUARTER (April-June 2004) BENCHMARKS:

Family Planning and Health Systems Unit:

1. Specifications, guidelines and alternative models of LGU level health information systems fully developed/completed; catalog of successful information system interventions developed
2. Training modules on NSV, mini-lap and IUD insertion services improved and currently available
3. Provider perspective tool to assess barriers to quality care developed
4. Guidelines for addressing missed opportunities for FP developed
5. Tool for assessing community mobilization and ability to identify and manage more TB symptomatics and cases reviewed, modified and tested
6. 9 NGOs engaged in capacity building in identifying and reducing threat to HIV/AIDS
7. LEAD Strategies developed for:
 - Family Planning
 - TB-DOTS
 - HIV-AIDS
 - MCH

LGU Unit:

8. PHN Strategy / LEAD Strategy for ARMM developed and submitted to USAID, including an assessment of the applicability of the LGU performance indicators in ARMM
9. At least one (1) additional participatory workshops conducted
10. Draft advocacy plan developed
11. Detailed LGU performance monitoring plan developed and integrated into the over-all project performance monitoring plan
12. Field operations plan for Luzon, Visayas and Mindanao developed
13. Training of field coordinators on ToP conducted
14. Inventory of management and leadership courses
15. Health management capacity development needs analysis conducted (for the first 46 Project sites)

POLICY Unit:

16. Inventory, review and analysis of and recommendations on existing policies, laws, and regulatory constraints affecting the provision of family planning services, TB-DOTS, HIV-AIDS - completed
17. Review and analysis of demographic data and results of regular national health demographic and FP surveys completed
18. CSR distribution plan and allocation formula approved and implemented by the DOH TWG on CSR
19. Technical report on lessons learned from Pangasinan CSR experience completed
20. Research objectives, coverage, methodology and framework for the analysis of current PhilHealth benefits for FP and existing indigents formulated;

- Related data gathering initiated
21. Technical report on the policy framework for increased financing for health and family planning in LGUs completed
 22. Research objectives, coverage, methodology and framework for the analysis of national policies that can facilitate or block allocation of funds for local government's health and FP programs formulated; Related data gathering initiated
 23. Quarterly market survey on buying behavior of consumers for pharmaceutical products, especially FP products conducted
 24. Mapping and identification of potential allies and partners in advocacy work completed
 25. PR outfit to cover advocacy events selected and mobilized
 26. Initial report on pharmaceutical sales in the 20 LGUs prepared

Project Performance Monitoring Unit:

27. Second Benchmarking Meeting and TAG meeting conducted
28. 2nd Quarter (Jan. -Mar. 2004) Performance Report submitted to USAID
29. LGU baseline data compiled for project monitoring
30. Communication Plan developed and initially implemented
31. Information Resource Center established
32. Performance Monitoring TWG/ Coordinators organized
33. Systems for identifying and servicing data needs of implementing units functional
34. Links established with different data sources (NSCB, NSO, NEDA, etc)
35. LEAD Website concept fully developed

Performance-Based LGU Grants and TA Contracting Unit:

36. SIOs providing TA on HIV activities on all engaged HIV sentinel sites
37. Development of grants and subcontracts database system initiated
38. At least 3 SIOs contracted
39. Manual on the guidelines and procedures for contracting SIOs finalized
40. Manual on the guidelines and procedures for performance-based grants to LGUs finalized (contingent on the approval of the PBC performance based grants concept)
41. Potential SIO Bidders identified/ RFP for SIO engagement (for the first 20 LGUs) issued

Administrative and Finance Unit:

42. Financial and administrative systems, policies and procedures reviewed, improved and revised if necessary
43. Employee handbook finalized
44. Second quarter financial status report finalized and submitted as part of the second quarter performance report
45. All technical and administrative staff for central and field offices officially hired

FOURTH QUARTER (July - September 2004) BENCHMARKS:

Family Planning and Health Systems Unit:

1. FP performance improvement guide available
2. Fifty (50) LGUs (first 20 + 30-A) engaged in detailed health need assessments and implementation planning
3. Additional 5 NGOs engaged in capacity building in identifying and reducing threat to HIV/AIDS
4. Guide for incorporating the expanded HSS in HIV/AIDS prevention activities developed
5. Guide for incorporating the revised BSS in HIV/AIDS prevention activities developed
6. Two trainings of NGOs in the design, implementation and assessment of community HIV/AIDS outreach and prevention education to most at risk groups conducted
7. Quarterly reports from HIV/AIDS NGOs review and feedback completed
8. Monitoring and evaluation of TA provision conducted
9. SIOs oriented, trained and prepared to provide TAs to LGUs

LGU Unit:

10. Supplemental Work plan and TA Plan for ARMM developed
11. Summary report on past/ current programs for LGUs
12. At least 20 LGUs have signed MOAs with the LEAD Project
13. Additional sixty (60- A & B) LGUs signifying intent to participate in the program
14. TA needs of fifty (50) LGUs [first 20 + 30 (A)] identified
15. Participatory planning workshops for the 30 (A) LGUs to assess needs, capacities and priorities conducted
16. Management development training program strategy implemented
17. Ten (10) LGUs implementing local FP/health policies, upon local health board (LHB) recommendation; and such policies are enabled through resolutions, ordinances and executive orders with approved resolutions
18. Two (2) new advocacy groups actively supporting local FP initiative in three regions

POLICY Unit:

19. Tools, template, procedures and model ordinances for LGU financing developed
20. Policy on assistance to LGUs regarding phase-out of contraceptives drafted by the DOH Task Force on CSR
21. 20 LGUs have approved the local CSR+ Plan for implementation
22. Study on the analysis of current PhilHealth benefits for family planning and existing benefits for indigents - on going and about 60%-completed
23. Study on the analysis of national policies that can facilitate or block allocation of funds for local government's health and FP programs- on-going and about 70%-completed
24. Quarterly report on pharmaceutical sales in 110 LGUs (including the first 20) prepared

25. Quarterly market survey on buying behavior of consumers for pharmaceutical products, especially FP products conducted
26. Advocacy work on potential allies and partners initiated
27. One (1) national health forum conducted

Project Performance Monitoring Unit:

29. Third Benchmarking Meeting and TAG meeting conducted
30. Mid-year review of the LGU engagement process and assessment tools conducted
31. 3rd Quarter (Apr. -Jun. 2004) Performance Report submitted to USAID
32. LGU baseline data continuously compiled for project monitoring
33. E-based indicator monitor developed and updated
34. Reports on project successes and lessons learned documented
35. Information Resource Center functional

Performance-Based LGU Grants and TA Contracting Unit:

36. Grant mechanisms operational for the first 20 LGUs
37. Technical and cost proposals from additional SIOs reviewed
38. Work orders issued to the first 3 SIO subcontracts
39. Subcontracts and grants monitored for performance

Administrative and Finance Unit:

40. Third quarter financial status report finalized and submitted as part of the third quarter performance report
41. Employee performance review and evaluation conducted

FIFTH QUARTER (October - December 2004) BENCHMARKS:

Family Planning and Health Systems Unit:

1. Additional 60 (B & C) LGUs engaged in detailed health need assessments and implementation planning
2. Integrated intervention model for MSMs developed
3. Integrated intervention model for IDUs developed
4. Improved HIV/AIDS rapid response plan finalized
5. Quarterly reports from HIV/AIDS NGOs review and feedback completed
6. Monitoring of all engaged LGU in their project implementation completed

LGU Unit:

7. The next thirty (30-C) LGUs signifying intent to participate in the program
8. Participatory planning workshops for the next 60 (B & C) LGUs to assess needs, capacities and priorities conducted
9. TA needs of next 60 (B & C) LGUs identified
10. Additional ten (10) LGUs implementing local FP/health policies, upon local health board (LHB) recommendation; and such policies are enabled through resolutions, ordinances and executive orders with approved resolution
11. Additional three (3) new advocacy groups actively supporting local FP initiative in four regions
12. Twenty (20) LGUs have initiated implementation of the local CSR + Plan
13. Additional 30 LGUs have signed MOAs with the LEAD Project
14. Stakeholders analysis and political mapping report

POLICY Unit:

15. Policy on assistance to LGUs regarding phase-out of contraceptives approved by DOH TWG on CSR
16. Study on the analysis of current PhilHealth benefits for family planning and existing benefits for indigents completed including recommendations on expansion of benefit coverage and provider payment for family planning
17. Study on the analysis of national policies that can facilitate or block allocation of funds for local government's health and FP programs completed
18. Report on the 2004 pharmaceutical annual sales in 110 LGUs completed
19. Established partnership, i.e. signed MOA, with private sector to provide health services and products to those steered out of the public sector's health services in the 110 LGUs
20. Policy guidelines for drugs and contraceptives defined and elaborated for implementation in twenty (20) participating LGUs
21. Quarterly market and consolidated annual survey reports on the buying behavior of consumers for pharmaceutical products, specially FP products
22. 1 regional health forum conducted
23. Media coverage of advocacy events by PR outfit managed

Project Performance Monitoring Unit:

24. Fourth Benchmarking Meeting and TAG meeting conducted
25. 4th Quarter (July. -.September 2004) Performance Report submitted to USAID
26. LGU baseline data continuously compiled for project monitoring
27. E-based indicator monitor updated
28. Reports on project successes/documentaries and lessons learned developed
29. Data needs of implementing units continuously provided
30. Inputs for the First Year Annual report drafted

Performance-Based LGU Grants and TA Contracting Unit:

31. Grants and subcontracts systems evaluated for performance efficiency
32. Additional SIOs subcontracted

Administrative and Finance Unit:

33. Fourth quarter financial status report finalized and submitted as part of the fourth quarter performance report

Performance Indicator Matrix

ANNEX 2

**LOCAL ENHANCEMENT & DEVELOPMENT
(LEAD) FOR HEALTH
PERFORMANCE INDICATOR MATRIX**

LGU PERFORMANCE INDICATORS:

GOVERNANCE	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
<p>a. Increased share of FP/TB/HIV/AIDS/MCH in the total municipal/ city budget, especially for contraceptive procurement</p>	<p>1.) LGU providing for funds needed for the cost of its net commodity requirements for FP, TB, Vit. A and HIV/AIDS*</p> <p>* - for HIV/AIDS sentinel Sites</p>	<p>This indicator shows whether the LGU allocated full funding for the total cost of net commodity requirements (total commodity requirements less those funded by external sources such as DOH and donor agencies). The commodity requirements cover FP, TB, HIV/AIDS and Vit. A supplementation.</p> <p>An LGU has met this target if it provides 100% of the total commodity requirements less those funded by the external sources such as the DOH and other donor agencies, and out-of-pocket sources</p>	<p>LGU – CSR+ Plan, RAAO – Status of Appropriations, Allotment and Obligations</p>	<p>Baseline at in-depth LGU assessment</p> <p>Quarterly thereafter</p>

GOVERNANCE	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
<p>b. Ordinances enacted, such as a local health code, that articulates official support and provides adequate financing for FP and selected health services</p>	<p>2.) Health ordinance/s enacted, resolution/s passed, or executive order/s issued that promote FP, TB-DOTS, HIV/AIDS* prevention and Vit.-A supplementation. * for HIV sentinel sites</p>	<p>This indicator covers new ordinance/s or existing ordinance/s that are improved to address the following: FP, TB-DOTS, HIV/AIDS and Vit.A. Ordinances and resolutions come from the local governing council while executive orders are issued by the mayor. This indicator is critical as it shows the degree to which policy environment in a given LGU supports efforts to promote FP, TB-DOTS, HIV/AIDS* and Vit. A.</p> <p>Baseline at the time of engagement can be:</p> <ul style="list-style-type: none"> - an existing ordinance but needs improvement or non-existent at all <p>An LGU is considered to have met the target if it has enacted ordinance/s, EO/s or resolution/s that between them contain the following elements:</p> <ul style="list-style-type: none"> - statement of policy support - objectives of the program - management systems support - financing including personnel and other resources 	<p>LGU – Office of Sanggunian Office of the LCE</p> <p>LGUs will report on the enactment or issuance of resolutions or executive orders with the precise language that is used. LGUs will be expected to keep public records of these for inspection and data verification</p>	<p>Baseline at in-depth LGU assessment Quarterly thereafter</p>

GOVERNANCE				
TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
<p>b. Ordinances enacted, such as a local health code, that articulates official support and provides adequate financing for FP and selected health services</p>	<p>3.) Health boards and other similar participatory bodies functional</p>	<p>This measure allows us to see whether the health board is functioning appropriately. Functional is defined here as being able to:</p> <ul style="list-style-type: none"> - propose annual budgetary allocation for health - serve as advisory committee to the Sanggunian - create committee which shall advise local health agencies <p>In addition to reporting on whether board members are meeting regularly, LGUs should also provide copies of the agenda and minutes for each meeting to indicate that the meeting actually took place and business was conducted.</p> <p>An LGU is considered to have met this target if the definition of functionality were met by the LGU health boards or other similar bodies</p>	<p>LGU – Office of the LCE Records of LGU Health Boards</p> <p>Reports on the meetings of the health boards as verification</p> <p>Evidences of actions done such as LHB resolutions, reports and endorsement</p>	<p>Baseline at in-depth LGU assessment</p> <p>Quarterly thereafter</p>

GOVERNANCE TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
<p>c. Formulation and adoption as an official policy of a local CSR+ plan (that covers FP, TB-DOTS, HIV/AIDS, and Vitamin A supplementation)</p>	<p>4.) CSR+ plan developed and implemented</p>	<p>The local CSR+ plan is a manifestation of the commitment of the LGU to allocate resources for FP, TB, HIV/AIDS and Vit. A that would ensure commodity supply security. The plan covers forecasting commodity requirements, possible sources of financing, LGU acquisition and distribution scheme and defining the role of the private sector (client segmentation).</p> <p>An LGU has met this target if is has a Local CSR+ Plan that contains the following components:</p> <p>1) For Family Planning (CSR –<i>contraceptive self reliance</i>):</p> <ul style="list-style-type: none"> - forecasting commodity requirements for contraceptives - financing - procurement and distribution - client segmentation (as necessary) <p>2) For TB, Vit. A and HIV/ AIDS (selected sites only) (CSS-commodity supply security)</p> <ul style="list-style-type: none"> - forecasting commodity requirements for TB drugs, Vitamin-A capsules and STI- drugs and condoms for HIV/AIDS - financing - procurement and distribution <p>An LGU has met this target if the LGU has:</p> <ul style="list-style-type: none"> • Developed and initially implemented the CSR component for the first year • Introduction and implementation of the “plus” (+) component for the succeeding years 	<p>LGU – team (LCE, GSO, Treasurer, Budget Officer, CHO/ MHO, others)</p>	<p>Baseline at in-depth LGU assessment</p> <p>Quarterly thereafter</p>

GOVERNANCE				
TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
<p>d. Enrolment of indigents under the National Health Insurance Program</p>	<p>5.) % of indigent families enrolled in PhilHealth (NHIP enrollees)</p>	<p>This indicator gives us a picture of the level of insurance coverage by NHIP for the indigent families in each LGU</p> <p>This indicator is equivalent to the total number of indigent families enrolled in PHIC over the total number of indigent families in an LGU</p> <p>The project will use PhilHealth definition for "indigent"</p> <p>An LGU has met this target if it has enrolled 100 % of its indigent families</p>	<p>MHO / NHIP records/ Mayor's Office</p>	<p>Baseline at in-depth LGU assessment</p> <p>Quarterly thereafter</p>
<p>e. Adoption, as official policy, and implementation of an LGU plan for strengthening services and improving quality of FP, TB-DOTS, HIV/AIDS, and Vitamin A supplementation, including private sector services, to meet community needs</p>	<p>6.) LGU governance and health service capacity development plan document with TA specifications, signed and approved by the LCE for implementation</p>	<p>This indicator shows LGU commitment to implement governance and service capacity activities, reflecting the technical assistance needed by the LGU. This indicator refers to the plan for enhancing governance capacity and for strengthening services and improving quality of FP, TB-DOTS, HIV/AIDS and Vit. A supplementation. The TAs are expected to be provided by the service institutions/ organizations (SIOs)</p> <p>An LGU is said to have met this target if it has developed a plan that clearly articulates activities with definite timeline, and expected outputs and deliverables that lead towards governance and service capacity goals set by the LGU. The plan should likewise include a monitoring</p>	<p>LGU and SIO</p> <p>LGUs will provide this data as part of their agreement with the LEAD Project. Verification will come from the SIOs that are working with the LGU</p>	<p>Baseline at in-depth LGU assessment</p> <p>Quarterly thereafter</p>

<p>e. Adoption, as official policy, and implementation of an LGU plan for strengthening services and improving quality of FP, TB-DOTS, HIV/AIDS, and Vitamin A supplementation, including private sector services, to meet community needs</p>	<p>7.) Option 1: Availment of the TA specified in the governance and health service capacity development plan as reflected in the SIO work orders</p>	<p>component:</p>	<p>The availment of TA refers to the extent of utilization of the TA provided by the SIO over the total TA needs identified in the work plan. This would show whether critical activities in the work plan are being implemented or not</p> <p>An LGU is said to have met this target if it has availed all the TA stipulated in the LGU TA requirements</p> <p>= Number of TAs provided over the total number TA needs identified</p>	<p>LGU and SIO</p> <p>LGUs will provide this data as part of their agreement with the LEAD Project. Verification will come from the SIOs that are working with the LGU</p>	<p>Baseline at in-depth LGU assessment</p> <p>Quarterly thereafter</p>
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FAMILY PLANNING AND HEALTH SYSTEMS					FREQUENCY OF DATA COLLECTION (including development status)
TARGET	INDICATOR	DEFINITION	SOURCE		
<p>a. A functional health information system</p>	<p>8.) LGU able to generate on a regular basis, using CBMIS, FHSIS or other information systems, → relevant data on FP, TB and Vit. A</p>	<p>This indicator is critical as it shows whether or not a reliable information system exist in an LGU which could serve as a basis for objective planning and decision making, particularly in the areas of FP, TB and Vit. A.</p> <p>An LGU has met this target if it has an existing information system that:</p> <p>a) is able to generate on a regular basis the following info:</p> <ul style="list-style-type: none"> - Unmet needs for FP and Vit. A - Contraceptive clients by method - TB case detection rate, TB cure rate - SS facility self-assessment checklist (SSFSAC) results - Supplemental questions for health facility assessment (SQA) results <p>b) contains information that is being used for:</p> <ul style="list-style-type: none"> - planning, reporting, resource allocation, advocacy - adequate public health monitoring and evaluation - making management decisions/ action for service provision <p><i>regular</i> – may be quarterly, semi-annually or annually depending on the system</p>	<p>CBMIS, FHSIS, NTP Report or other health information system</p> <p>CBMIS – for unmet needs for FP, Vit. A</p> <p>FHSIS – for contraceptive clients by method</p> <p>NTP Register - NTP quarterly report on the Treatment Outcome of Pulmonary TB Cases</p> <p>SSFSAC</p> <p>LEAD Supplemental Questions for Health Facility Assessment (LEAD-SQA)</p> <p>Sentrong Sigla Supervisory Plan → to know whether we are using the data in (a) in conducting (b)</p> <p>RHU Work and Financial Plan → using the data gathered from the CBMIS, FHSIS, SSFSAC, NTP as basis for the targets</p>	<p>Baseline during in-depth assessment, and</p> <p>CBMIS – quarterly</p> <p>FHSIS –quarterly</p> <p>NTP - quarterly</p>	

FAMILY PLANNING AND HEALTH SYSTEMS				
TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
<p>b. Increased access to quality modern contraceptive supplies and services, including voluntary surgical sterilization and IUDs</p> <p>c. Reduce rate of drop-outs</p>	<p>9.) RHU/ HC providing clients with: access to pills, IUD, condom, DMPA, SDM and NFP; referral services for surgical sterilization; and counseling on FP</p>	<p>This measure tells whether clients who wish to use family planning have access to a full complement of FP methods. A complete array of FP methods includes pills, IUD, condom, DMPA, SDM, NFP and surgical sterilization.</p> <p>This indicator also shows whether health workers are trained on, and providing FP counseling to improve continuity of use and reduce drop-out rates</p> <p>An LGU is said to have met this target if its RHU [in the case of municipalities], or at least 1 HC in each district, [in the case of cities]:</p> <p>(a) offers FP users and potential users with counseling on all modern FP methods;</p> <p>(b) offers the following modern FP services and supplies: pills, IUD, condom, DMPA, SDM, and NFP;</p> <p>(c) has an established system for referring clients to other health facilities for voluntary surgical sterilization; and</p> <p>(d) has at least one health staff trained on FP counseling</p>	<p>LGU – MHO</p> <p>FP counseling log book or similar records</p> <p>FP target client list</p> <p>FP referral logbook or similar records</p>	<p>Baseline at in-depth LGU assessment</p> <p>Quarterly thereafter</p>

FAMILY PLANNING AND HEALTH SYSTEMS				
TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
d. The RHU is providing routine Vitamin A supplementation to sick children	10.) A health facility should have the minimum level of contraceptives, and TB & Vit. A supplies as defined by the Senstrong Sigla Standards [Note: #10 is also an indicator for FPMS target (b)]	A facility is said to function effectively, if, at any given day, during a facility visit, the rural health unit or the health center has the following at a minimum: - Pills – 5 cycle packs - DMPA – 5 vials - IUD – 1 piece - Condoms – 10 pieces - TB Drugs: → 100% of drugs for all registered patients: the quantity should match with the number of blister packs/ tablets for the remaining duration of treatment of patients being treated at the RHU - Vitamin A Capsules (VAC): → 40 capsules of Vitamin A gel capsules (10,000 IU) → 5 capsules of Vitamin A gel capsules (200,000 IU) An LGU is said to have met this target if all of its health facilities meet the SS standards for the minimum level of commodities (as mentioned above)	RHU/ MHO in each LGU RHU -stock monitoring record The data needed to report on this indicator must come from a physical inventory of contraceptives and other commodities as identified in the definition, from each health facility and reported through the LGU to LEAD.	Baseline during in-depth assessment Quarterly thereafter

FAMILY PLANNING AND HEALTH SYSTEMS				
TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
<p>e. The Rural Health Unit (RHU) is Sentrong Sigla Level 1 certified, and accredited by PHIC as provider of TB-DOTS and out-patient benefit packages</p>	<p>11.) Rural Health Unit (RHU)/ Health Center (HC) is Sentrong Sigla Level 1 certified</p>	<p>This measure requires that RHU/ HC be :</p> <ul style="list-style-type: none"> - Sentrong Sigla level 1 certified which means it meets the quality standards set by the DOH and certified by the CHD as such <p>An LGU has met this target if its RHU/ HC obtained Sentrong Sigla 1 certification</p>	<p>LGU, RHU; verified by DOH CHD</p>	<p>Baseline at in-depth LGU assessment Quarterly thereafter</p>
	<p>12.) Rural Health Unit (RHU)/ Health Center (HC) is accredited by PHIC as provider of TB-DOTS and out-patient benefit packages</p>	<p>This measure requires that RHU be:</p> <ul style="list-style-type: none"> - Certified by PhilCAT and accredited by PHIC as provider of TB-DOTS - Accredited for out-patient benefit packages (OPB) provider <p>An LGU has met this target if it does obtain PHIC accreditation for TB-DOTS and out-patient benefit package</p>	<p>LGU/ RHU verified by PHIC</p>	<p>Baseline at in-depth LGU assessment Quarterly thereafter</p>

FAMILY PLANNING AND HEALTH SYSTEMS				
TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
<p>f. All HIV/AIDS sentinel sites are implementing surveillance and prevention education interventions for the most-at-risk groups, [i.e. sex workers, Men having Sex with Men (MSMs) and Injecting Drug Users (IDUs)]</p>	<p>13) %-reduction in the proportion of high risk groups who report high -risk behaviors (inconsistent condom use, sharing of needles)</p>	<p>This indicator tracks the effectiveness of surveillance and prevention education interventions for most-at-risk groups</p> <p>Percentage Reduction refers to the %-points decrease in high risk behaviors, from the time intervention was introduced to the time the project ends.</p> <p>High risk behaviors include such practices as:</p> <ul style="list-style-type: none"> - inconsistent condom use - sharing of needles <p>equivalent to = A:</p> <p>Number of sex workers practicing high risk behaviors</p> <p>-----</p> <p>Total number of sex workers surveyed</p> <p>%-points reduction will be computed by</p> <p>A (baseline) – less A (end of project)</p> <p>An LGU is said to have met this target if it achieves 10 % reduction by the end of the project</p>	<p>LGU sentinel sites CHO</p> <p>LGU Sentinel sites CHO</p>	<p>Baseline at in-depth LGU assessment</p> <p>Quarterly thereafter</p>

FAMILY PLANNING AND HEALTH SYSTEMS				
TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
g. An expanded health volunteer network	14.) % of barangay health workers trained for specific services	<p>Barangay health workers play a critical role in an LGU, particularly in the areas of a) community organizing; b) service provision; and c) community education. As community organizer, the BHW mobilizes the families in his or her area of coverage to collectively act on specific health concerns. As community educator, the BHW conducts information campaigns, small group or one-on-one instructional sessions with mothers and other household members or caregivers. As service provider, the BHW provide a range of health services, which include: growth monitoring, micronutrient supplementation, household care for control of diarrhea diseases, follow-up of compliance to medication, and referral of cases to the health center, including FP, TB and other services</p> <p>Trained barangay health workers are those that are trained in all of the following areas:</p> <ul style="list-style-type: none"> - FP - TB-DOTS - Vitamin-A - CBMIS <p>This is the ratio of health workers trained over the total number of health workers</p> <p>An LGU has met this target if it has trained 100% of its barangay health workers in barangays covered by LEAD target LGUs</p>	LGU/ MHO validated by the SIO	Baseline at in-depth LGU assessment Quarterly thereafter

FAMILY PLANNING AND HEALTH SYSTEMS	TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION (including development status)
h. Increased collaboration with the private sector	15.) % of FP clients obtaining supplies and services for FP from private sector	<p>This indicator refers to the number of FP clients who avail services and/or obtain FP supplies from the private sector.</p> <p>Private sources include any of the following:</p> <ul style="list-style-type: none"> - private hospitals or clinics - pharmacies - private doctors - private nurses/ midwives - NGOs - industry-based clinics <p>An LGU has met this target if it is able to meet the level of percentage-increase it has set in its local CSR+ Plan</p>	CBMIS data	Baseline CBMIS during in-depth assessment Quarterly thereafter	
i. Reduced unmet need for FP	16.) % reduction in unmet need for FP	<p>Unmet need - is the number of women who expressed desire to limit or space their births but are not using any form of modern FP methods</p> <p>% reduction - is the ratio of women who have availed those services over the total number of women who expressed desire to limit or space their births but are not using any form of modern FP methods</p> <p>An LGU is said to have met this target if it has achieved 50% reduction in unmet need</p>	CBMIS	Baseline at in-depth LGU assessment Quarterly thereafter	

IMPACT INDICATORS:

TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION
Total Fertility Rate (2006) – 2.7 Contraceptive Prevalence Rate (modern, 2006) – 40 %	1) Contraceptive Prevalence Rate (CPR)- Modern Methods	CPR is an indicator of family planning use and a prominent factor affecting fertility rate. Modern CPR is the number of currently married women (15-49 years old) using modern methods of contraception (i.e. oral pill, IUD, condom, injectible, male and female sterilization and natural family planning) over the total number of currently married women (15-49 years old)	LGU level -CBMIS or small scale cluster survey National level – FPS and DHS	LGU – baseline & end-of-project National level – annual
TB treatment success rate: 70%	2) LGU achieving national targets for: TB case detection rate; Treatment success rate	The <i>tuberculosis case detection rate</i> is the ratio of smear-positive case notifications in a given year to the estimated number of new smear-positive cases arising in that year. The <i>treatment success rate</i> is the ratio of registered cases that have completed treatment and were cured over the total registered cases. (as defined in the NTP) The <i>cure rate</i> is the number of smear-positive cases that were cured over total number of smear-positive cases registered. A <i>tuberculosis case</i> is defined as a patient in whom tuberculosis has been bacteriologically confirmed or diagnosed by a clinician.	LGU - NTP reporting and recording forms (TB-register) LGU - NTP reporting and recording forms (TB-register)	Baseline Annual

TARGET	INDICATOR	DEFINITION	SOURCE	FREQUENCY OF DATA COLLECTION
HIV seroprevalence among Registered Female Sex Workers - <3 % annually	3) HIV Sero-prevalence rate and new case rates among high risk groups	HIV seroprevalence is obtained by blood sample testing for HIV antibody using methodologies established by the CDC and WHO. Samples are taken as sentinel surveillance sites using established sampling techniques. New cases are HIV positive sero conversions during the previous year taken from the same sample.	sentinel surveillance sites	Baseline Annual
Vitamin A supplementation coverage – 85 % annually	4) % children (6 months– 71 months) who received Vat. A supplement within past 12 months.	This is the measure of the number of children (6 months– 71 months) who have received Vat. A supplementation at some time during the past 12 months divided by the total number of children (6 months– 71 months)	Cluster surveys?	Baseline Annual