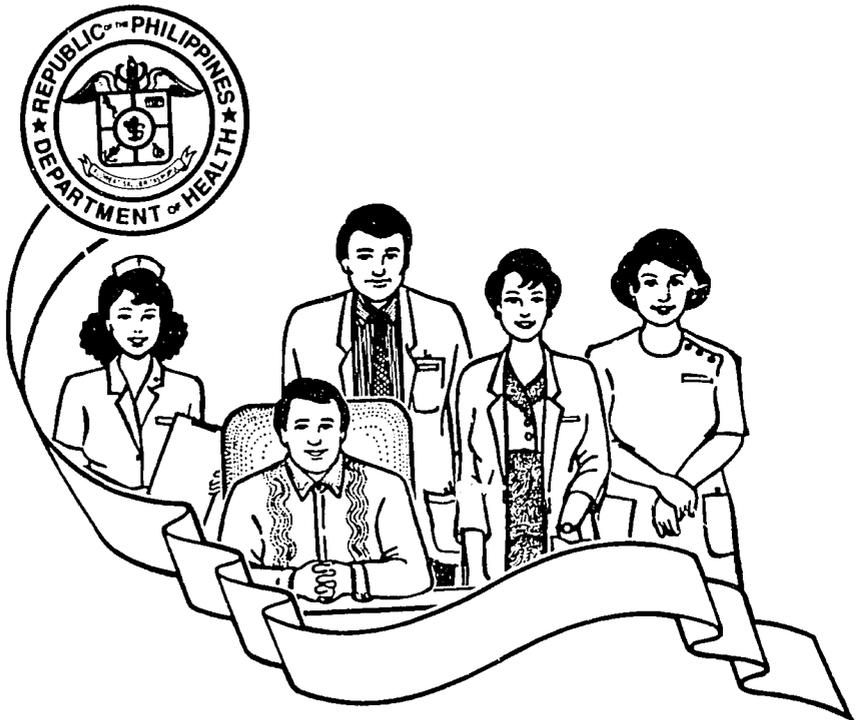


Monograph No. 1

Implementing the Philippine Child Survival Strategy



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Implementing the Philippine Child Survival Strategy

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This paper was derived from a speech delivered in late 1990 about the Department of Health's strategy for child survival. While the speech originally dealt with the issues of implementation in 1991, the present paper attempts to extend the discussion of implementation issues over a longer period beyond one or two years. This treatment is appropriate because the improvement of child survival prospects obviously requires sustained effort over a long period.

Contents

- 7 **Chapter 1**
The Goal
- 8 **Chapter 2**
The DOH Role in Child Survival
- 11 **Chapter 3**
The DOH Strategy for Child Survival
 - 11 On Component Programs
 - 14 On Critical Processes
 - 17 Two Important Related Concerns
 - 18 On the Level of Broader Public Policy
- 19 **Chapter 4**
*The USAID Child Survival Program
In the DOH Strategy*
 - 20 Setting and Meeting the Benchmarks
 - 22 Use of the Resources from Performance Grant Disbursements
 - 23 Organizing and Managing CSP Activities

Chapter 1

The Goal

Child survival means assuring that Filipino children who are conceived are carried full term, delivered safely, develop as healthy children through their first, second and succeeding years of life, then reach the age of six ready to begin their schooling in the formal educational system. This means reducing infant mortality, currently at around 32 per 1,000 live births, and reducing child mortality from the three most common childhood diseases, namely pneumonia, diarrhea and measles.

A goal as fundamental as child survival demands broad social action in the fields of education, nutrition, housing, sanitation, welfare, employment, and health care. The Department of Health's contribution revolves principally around health care: prevention, treatment,

rehabilitation and promotion.

In the field of health care, research and operational experience has identified the provision of a set of health services as an important intervention that reduces morbidity and mortality. Services to care for the mother are essential since the survival of infants begins in healthy pregnancies and safe deliveries. Services for child care are also necessary since the survival of children involves more than just episodic treatment during acute illnesses.

From the standpoint of health, the goal of assuring the survival of 7 million Filipino children under the age of 5 years involves providing care for them as well as the 9 million married women of reproductive age who mother them.

Chapter 2

The DOH Role In Child Survival

Child survival cannot be the concern of the DOH alone. The DOH cannot be the sole guarantor of child survival; it cannot be solely responsible for children to be born, delivered and raised safely so that they survive.

Child survival is, above all, the concern of parents. Families are the true guardians of children's health. If large numbers of parents do not care that their children reach school age with a sound mind in a sound body, the task is virtually impossible on a social scale. The resources, knowledge and behaviors that are essential to child survival are available in individual families in individual households; these must be viewed as the first-line provisions needed to meet the goal.

Beyond the family, individual

communities assume a layer of responsibility for child survival; these communities include neighborhoods, barangays, towns, cities, provinces and regions. There are threats to child health that are beyond the capabilities of individual families to contain, and the immediate community acts to reduce or eliminate these threats. Public hygiene, public safety and order, environmental protection, public education, control of epidemics – these are social actions that communities take to respond to concerns shared by many families.

As an expression of a community desire to take organized action, the government exercises leadership in beneficial initiatives. Child survival is one such initiative where government leads in mobilizing com-

munities, as well as in institutionally providing basic services. It is this role as a government agency that the DOH is elaborating with its strategy for child survival.

The DOH contributes to political leadership towards community action by raising awareness, educating people about the problems, promoting technically sound policies and public choices, mobilizing resources, clarifying priorities, and in general encouraging communities to take responsibility for child survival needs outside the home. In addition, the DOH also acts as an institution producing and delivering services necessary for families, communities and other government agencies to effectively protect and promote the health of children. People tend to confuse these two functions. For instance, there is a tendency to think that whatever the DOH advocates should be undertaken only by DOH clinics and hospitals without considering that a large portion of health advocacy concerns matters that parents in their homes could more effectively do something about. On the other hand, DOH health workers tend to think that they are the only providers of child survival services, forgetting the important contributions of other groups in the community.

Let us consider in more detail these two major roles of the DOH in child survival. First, the DOH supports political actions in the appropriate directions. Examples of these are the passage of a Breastfeeding Code; public declarations committing society to universal immunization and polio eradication; and the creation of organized struc-

tures for dealing with issues that impact on child survival such as hospitals for mothers and children, a Maternal and Child Health Service, and similar agencies. Second, the DOH, using its own service delivery network, undertakes to reach the population with services consistent with these political actions. By launching programs like EPI, CDD, ARI, FP, MC and other health programs, the DOH declares that government and society have decided to adopt a set of policies and standards, deploy a level of resources and commit a range of capabilities necessary to respond to a specific range of problems such as immunizable diseases, dehydration due to diarrhea, delayed and inappropriate care of pneumonias, lack and poor quality of information and services on family planning methods preferred by couples, lack of adequate maternal care, etc.

In addition to these two major roles, the DOH serves in two other ways. The DOH also performs the crucial function of health assessment and evaluation – the task of gathering and analyzing data that would identify, describe, estimate and characterize the problems of child

“... the DOH plays four key roles in Child Survival and provides four important contributions – advocacy, service, information, and technical advice.”

health, and that would evaluate the effectiveness of the solutions being applied by families, communities and organized agencies. A factual basis for policies and programs is undeniably an essential requirement for sound decisions and actions, and the DOH performs the function of providing the basis for child survival directions in health.

Flowing directly from the assessment and evaluation function is the DOH's role as technical expert, advising political advocates and service providers on the technical correctness of their directions. By virtue of its links with other technical agencies, and using its professional and scientific personnel, the DOH serves as a technical advisor for government, communities and families on scientifically proven ways to enhance child survival. The value of breastfeeding, child spacing, proper nutrition, and many other practices and behaviors are insights gained from world-wide research which the DOH "prescribes" to society for adoption as beneficial to health and child survival. In this respect, the DOH performs the function of advisor.

Thus, the DOH plays four key roles in Child Survival and provides four important contributions - advocacy, service, information, and technical advice.

While these roles of the DOH are substantial and important, the crucial role remains that of mothers and fathers in the family. Everything that the DOH does is geared towards assisting mothers and fathers in recognizing and understanding the individual and collective causes of each child death, and

the individual and collective character of the actions necessary to prevent such deaths.

Every single child death resulting from a preventable or treatable cause is a tragic and avoidable failure. It is a failure of individual actions that could have prevented that death. It is also a failure of family conditions that could have made such actions more effective. It is also a community failure to prevent its causes or to provide better means for effective actions. It is a national failure as well. Every child death is a result of the confluence of a lack of critical knowledge, critical resources, and critical behaviors that could have prevented that death.

In the face of an unacceptably high level of infant and child death in Philippine society, what can be concluded about the social capacity to assure child survival? Families and communities are not yet well organized for effective individual health actions, are not yet well educated about causes of child death and about their prevention, and are not yet well situated to take effective social actions for better health. In these circumstances, the DOH, as a professionally staffed, formally organized, and historically dedicated agency for people's health, assumes strategic importance. The DOH could catalyze the actions of families and communities, the only real source of decisive and sustained actions for child survival over the long run. The DOH must not only play its roles in eliciting family and community response, the DOH must also ensure that this response is sustained.

Chapter 3

The DOH Strategy For Child Survival

At this point, it is clear that child survival requires broad participation from many groups and agencies. The following section will discuss the plans and intentions of the Department of Health, within its administrative and institutional boundaries. While many partners and collaborators may share these plans, it is useful to focus on what the DOH on its own initiative and within its authority will do to achieve the goal of child survival.

On Component Programs

The DOH has put forward 10 component programs in child survival. These programs contain the substantive knowledge and actions deemed essential for reducing morbidity and

mortality in the household and the community.

What is a "program"?

First of all, it is an operationally worked out concept of intervention, a way of sorting out factors and circumstances leading to an insight on what things need to be done and how they are to be done so that the identified problem is reduced or solved. A program, in this sense, is a way of thinking among program managers, planners and experts. It is a deliberate recognition of important issues and an equally deliberate setting aside of less important issues. A program is a selection of ideas that emerged out of an analytical process and a factual evaluation.

Then, a program is a plan containing a set of outcomes necessary to

reduce or alleviate a health problem, a set of activities known to create such outcomes, and a set of inputs deemed sufficient to undertake the required activities. In this sense, a program is a document, formally considered and approved.

Finally, a program is a reality in the field. It is a level of financing, a degree of mobilization, an extent of coverage, a range of action and a quality of impact. In this sense, a program is embodied in implementation that occurs in communities, clinics and hospitals.

The process of program development is a cycle of design, formalization and implementation that never stops and constantly progresses.

Ten Programs

The ten component programs of Child Survival cover areas regarded by DOH professionals as the most critical for reducing morbidity and mortality among infants and children. These are:

1. **EPI** (Expanded Program For Immunization) for immunizable diseases of children and tetanus in mothers and newborns.

2. **CDD** (Control of Diarrheal Diseases) for diarrhea.

3. **CARI** (Control of Acute Respiratory Infections) for pneumonia and other acute respiratory diseases.

4. **UFC** (Under-Five Clinics) for comprehensive child care.

5. **MC** (Maternal Care) for prenatal care, deliveries and post-natal care.

6. **BF** (Breastfeeding) for promotion of this key health practice.

7. **MRP** (Malnutrition Rehabilitation Program) for rehabilitation of

second and third degree malnourished children and malnourished pregnant and lactating mothers.

8. **VAD** (Vitamin A Deficiency) for prevention and treatment of Vitamin A deficiency in mothers and children.

9. **IDD / IDA** (Iodine Deficiency Disorders / Iron Deficiency Anemia) for prevention and treatment of iron and iodine deficiencies in mothers and children.

10. **FP** (Family Planning) for child spacing and fertility management by couples.

Five Issues

In each of the above programs, the DOH management is grappling with five main issues.

1. **Design.** The program design has to be sound, technically and administratively. The review of the program document serves to flush out issues about conceptual clarity, technical basis of intervention, reasonableness of resource demands, and feasibility of organizational arrangements.

2. **Installation.** Installation of the approved program in the field has to be undertaken effectively. Field managers and implementors have to understand and accept the program policies, both in its substance as well as spirit. The training and orientation for the program usually serves as the vehicle for installation. Thus management seeks to assure the quality and speed of these initial training efforts.

3. **Financing.** Then the financing of the program requirements needs to be assured. Some programs never progress because of a mistaken no-

tion that resources are hopelessly unavailable, not realizing that good program designs may in fact attract the resources needed. In most cases, the issue concerns the balance between ambitious scope and targets on one hand, and limited resources on the other. This balance is resolved in the approval and implementation process. In other cases, the financing issue deals with initial start-up requirements versus maintenance requirements. In all these cases, a more deliberate approach to financing problems introduces more realistic planning.

4. Implementation. The main issue remains that of program implementation. What happens at the front lines of service delivery? This is the central question which the DOH management constantly seeks to answer. Training, logistics support, supervision, reporting, targeting, equipment support, IEC support – all these activities need to be planned and executed so that service becomes available and is utilized. All design, installation and financing decisions are eventually reconsidered in the light of the unfolding results of implementation.

5. Leadership. Finally, the DOH management is concerned about program leadership and organization. No program executes itself. No budget gets realized and utilized automatically. All plans are implemented by people in structured relationships. The first concern is the role of central staff relative to regional staff, and the second, more important concern is the relationship between managers and supervisors on one hand and field implementors on the other. From the

start of the program development process, the role of program leadership and organization is emphasized because the tasks of planning and resource mobilization become the first challenges of managerial effectiveness and competence.

The Child Survival Strategy gives priority to the proper and adequate development of the 10 component programs. By allocating managerial talent, providing high level sponsorship, extending technical assistance and contributing initial program

Ten Programs

1. *EPI* (Expanded Program For Immunization)
2. *CDD* (Control of Diarrheal Diseases)
3. *CARI* (Control of Acute Respiratory Infections)
4. *UFC* (Under-Five Clinics)
5. *MC* (Maternal Care)
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9. *IDD / IDA* (Iodine Deficiency Disorders / Iron Deficiency Anemia)
10. *FP* (Family Planning)

Five Issues

- 1. Design***
- 2. Installation***
- 3. Financing***
- 4. Implementation***
- 5. Leadership***

development funding, DOH management expects the Child Survival programs to develop better and reach operational maturity sooner.

The expectation is that well designed, effectively led, and adequately financed programs would gain the support and enthusiastic backing of field managers so that among the competing concerns of the DOH field units, the Child Survival programs become the real and not merely the avowed priorities.

Program development tends to emphasize the substantive content of programs (e.g. policies on how and when and who to immunize, policies on proper oral rehydration treatment, policies on drug therapy for pneumonia, etc.). Yet all programs depend on common processes which are somehow not adequately tackled within any single program. Thus, part of the Child Survival Strategy consists of yet another category of action, in the area of critical institutional processes.

On Critical Processes

The DOI is a large organization with a long history, a complex culture, and many competing concerns.

In order to properly deliver programmed services, the DOH management recognizes that its organizational processes have to be reformed. These processes have to do with how ideas are generated, debated and agreed upon; how agenda for actions are determined; how decisions are made; how actions are taken; how learning is acquired; how resources are allocated; how "good" things are recognized and rewarded; how "bad" things are identified and handled; and many other issues of day to day importance. These processes need to be made more efficient, more tailored to program needs, less diverting from program priorities, and more responsive to the conditions under which DOH field units operate. The Child Survival Strategy has taken these processes head on and has allocated necessary resources to improve them for the benefit of Child Survival programs, as well as other health programs.

Ten Processes

Ten distinct groups of processes are given importance because of their contribution to effective program implementation by a decentralized network of service providers. These are:

1. Planning. The challenge is how to develop a planning methodology which can be applied by field managers, adequately account for various programs, and yet be understood by regional and national managers. The strategy is the adoption of area/program-based decentralized planning.

2. Budgeting. The challenge is

how to develop a budgeting method that translates plans into resource requirements, allow for program accounting, fits into general government budgeting procedures, and simple and easy for field implementors to use. The strategy is the adoption of a program budgeting module closely linked to the planning module.

3. Integration. The challenge is how to integrate the information, logistics and services defined by various programs into an operationally feasible whole, for implementation by the DOH network to benefit mothers and children. The strategy is the planned and managed integration of services for mothers and children, side by side with individual program development.

4. Information Use. The challenge is how to gather, process, and distribute regular operation reports so that they support operational decision-making and guide policy formulation. The strategy is the adoption of a field health services information system, the sentinel surveillance system, and the emerging line-up of surveys and field studies to supplement administrative reporting systems.

5. IEC Support. The challenge is how to maximize service utilization and effectiveness through IEC support. The strategy is the adoption of social marketing approaches in the design, planning and execution of IEC campaigns.

6. Logistics. The challenge is how to provide the right goods at the right place at the right time consistently for all programs.

There is no coherent strategy but rather a variety of approaches, in-

Ten Processes

- 1. Planning**
- 2. Budgeting**
- 3. Integration**
- 4. Information Use**
- 5. IEC Support**
- 6. Logistics**
- 7. Technical Assistance**
- 8. Training**
- 9. Coordination**
- 10. Linkages**

cluding the combination of central and regional procurement, a national distribution system for vaccines and contraceptives, local distribution systems for various consumables, and a number of other separate responses.

7. Technical Assistance. The challenge is how to optimally utilize available expertise in order to assist central managers, regional managers, and field managers. The strategy is the adoption of a method for planning and specifying externally provided technical assistance for programs, and a method of process-oriented supervision of field operations as a way of structuring internally provided technical assistance.

8. Training. The challenge is how to design and implement training programs that increase acceptance and retention, improve skills relevant to field requirements, and maintain quality despite widespread and rapid execution. A coherent strategy has not yet emerged, but a number of developments offer some leads. These include development of profession-based training in addi-

tion to program-focused training, and the adaptation of new technologies within a rationalized training program management system.

9. Coordination. The challenge is how to improve coordination among various programs, and among hierarchical levels of the DOH organization. The strategy is the adoption of multi-program meetings and conferences, and a system of staff meetings that involve various levels of the organization. Program coordination conferences have also been regularized and improved.

10. Linkages. The challenge is how to expand and sustain linkages of the DOH with potential partners in NGOs, LGUs and other GOs. The strategy is the adoption of consultative and partnership approaches, applied at the provincial level using various mechanisms and structures.

These processes involve the very stuff of DOH institutional life. The fact that these processes are being addressed explicitly, and not only in the context of each service program, means that the DOH has recognized that it cannot attain program improvement across the board without reforming the very way it performs every important function, from planning, to budgeting, to IEC, to logistics, to coordination, to linkages with other groups.

A critical insight of the Child Survival Strategy is that the very rationale for the way DOH operates needs to be altered. DOH is a hierarchical organization where the lower level works for the higher one. Yet the reality faced by the lower level is always more urgent, more varied,

more challenging and more complex than what the higher level recognizes. The organization is thus faced with a dilemma where the higher level has the resources and authority necessary to respond to the demands of reality while the lower level has the actual experience, the day-to-day stake, and the current feel for that reality.

The Child Survival Strategy, therefore, calls for an approach that dedicates the whole organization to the cause of making the front-line field unit as effective and as efficient as possible. Thus, it is everyone's business, including the highest levels of management, to ensure that all field implementors have the knowledge, skills, information, tools and supplies necessary to do the best job appropriate to the real circumstances. In other words, the hierarchy is placed at the service of field implementation.

Organizational Vision

What is the vision of a DOH organization that is capable of effectively implementing Child Survival as well as other health programs? It is composed of area units (MHO's, CIO's, DHO's, IPIO's, RHO's) where managers and personnel grapple with the health issues of their areas, applying all the technological and scientific tools available to them and using the managerial and administrative systems established to support them. In their work, managers and implementors benefit from program guidelines, national plans, and technical assistance from experienced and supportive experts coming from national, regional and provincial

14

levels. These area units obtain IEC support, logistical assistance, training services and other support as they need, and as their technical superiors prescribe. They plan and budget according to local priorities, national standards, and specific conditions.

The area health units generate and use information to guide their decisions, not just to render an accounting of their work. They link with partners in their area and coordinate with all relevant authorities, yet they maintain initiative in their operations and sustain their autonomous effectiveness. As the area health units become more mature and more deeply rooted in their communities, they become more self-sufficient in the things they need most. In turn, the central and regional levels move away from micro-managing the area units and become more focused on anticipating and responding to the changing demands in the technical, organizational and financial capabilities of the whole DOH.

Instead of a centrally organized DOH whose greatest assets are discipline, stability, predictability and uniformity, the strategy calls for a different organization. It would be an organization characterized by a broad base of technical and administrative competence; unified by reliable and robust institutional communication links that operate outside of power or authority lines; technically disciplined (i.e., everyone adopts the technically proven way); administratively decentralized (i.e., guidelines are followed without prior action of a higher authority). It would be an or-

ganization where the highest value is placed on using the assets of discipline, stability, predictability and uniformity on the transcendent challenge of responding to local health conditions with the most appropriate science and technology.

It is a DOH where everyone is empowered to decide and act on the basis of each one's capabilities and circumstances, yet instead of becoming fragmented, it becomes more cohesive, as people share the same values, practice the same science, and learn to appreciate and respect each one's contributions.

Such is the organization capable of carrying through the Child Survival Strategy, and such is the organization which the strategy seeks to create.

Two Important Related Concerns

Nutrition and family planning are two areas of concern which are closely related to child survival. By themselves, they are sprawling concerns, involving many issues aside from health. The Child Survival Strategy calls for their better articulation as DOH priorities, particularly from the standpoint of their contributions towards lowering infant and child mortality.

In the area of nutrition, the Child Survival Strategy involves the development of a framework for DOH action that would mobilize the clinic and hospital network of the public health system as local resources for community action to reduce malnutrition. While linkage with the broader field of nutrition via the Na-

tional Nutrition Council would be strengthened, the framework would seek to specify initiatives that DOH would take in nutrition assessment and surveillance, nutrition education, and nutrition interventions. The premise of these DOH initiatives is that nutrition is principally a family and community concern and the formal health network simply provides technical and service support to the basic efforts of individuals, households, and localities.

In the area of family planning, the Child Survival Strategy involves the support and encouragement of actions within the Philippine Family Planning Program. With the DOH's assumption of program leadership in inter-agency efforts for family planning, the institutional burden consequent with being both program implementor and program coordinator weighs heavily on the DOH organization. The Strategy therefore would support two particular tracks, namely, (a) the effort to expand availability and improve quality of a range of family planning information and services in the DOH service network; and (b) the effort to strengthen the coordinative and technical support mechanisms that would allow the other participating agencies such as NGO's, LGU's and other GO's to respond to the family planning needs of the community. In both these tracks, the health benefits of family planning, particularly its impact on reducing maternal, infant and child mortality, would be emphasized.

In these two concerns, there are separate and identified inter-agency fora for setting policy and program directions. The Child Survival

Strategy calls for strengthening these fora as well as for facilitating the improvement of the DOH's own participation in these fora.

On the Level of Broader Public Policy

Child survival is one of the initiatives in the health sector. Health in turn is one of the sectors of social development. Social development is one of the concerns of public policy. The magnitude and importance of child survival as well as the broad scope of actions necessary to achieve it require the examination of the public policy environment within which it is tackled. One of the key elements of public policy that has a direct and traceable impact on the level and vigor of child survival interventions is the matter of financing. The Child Survival Strategy, therefore, calls for the initiation of analytical work towards a more coherent and policy-oriented understanding of health financing issues.

It is clear to DOH management that the matter of health financing has to be tackled separately and comprehensively via a dedicated effort. And such an effort will be undertaken. Suffice it to say here that the Child Survival Program would seek to articulate the view that policy reform in health financing should maximize the effectiveness of health interventions affecting infant, child and maternal mortality as a matter of priority. The adequate financing of cost-effective Child Survival activities should be a central goal of health financing policy.

Chapter 4

The USAID Child Survival Program In The DOH Strategy

Elements of the DOH Child Survival Strategy have been included in DOH policies and programs for some time. But the clarification and elaboration of the strategy, as a comprehensive and explicit strategy, was facilitated by the Philippine government's agreement to undertake a USAID grant funded project in child survival in late 1989. This section describes how the implementation of the Child Survival Strategy is proceeding in the context of the DOH's work to carry out the USAID-assisted project.

The Child Survival Program (CSP), as the USAID-assisted project is formally called, is a sector assis-

tance project supporting policy and institutional reforms to develop child survival related health services. It provides \$45 million in performance-based disbursements and \$4.25 million in technical assistance over four years (1989 - 1994). The technical assistance component is programmed to provide inputs to address managerial, technical and organizational problems in the areas of planning, information systems, social marketing and financing, particularly to strengthen the 10 service programs included in the DOH Child Survival Strategy.

The performance-based disbursements are annual releases made on

the basis of achieving agreed performance benchmarks covering policy and institutional reforms designed to increase the availability, utilization and sustainability of child survival related health services.

The Child Survival Program is a catalyzing activity in the implementation of the DOH Child Survival Strategy. The manner with which DOH implements the CSP serves to organize and drive the whole process of implementing the strategy described in previous sections. Of particular importance in this respect, are three issues, namely: setting and meeting the performance benchmarks; allocating and utilizing the GOP equivalent of the performance grant proceeds; or organizing and managing the CSP activities.

Setting And Meeting The Benchmarks

At the start of the CSP, and before every year during its effectivity, the DOH and USAID negotiate and agree on performance benchmarks which should be met at the end of every implementation year. At the core of these benchmarks is the agreement that by the end of the project life, a set of quantified service delivery utilization or availability coverage targets in the 10 child survival programs would be met. In order to achieve this, the DOH lays out an annual policy and institutional reform program intended to facilitate, attain, and sustain such service delivery targets. Specific elements of this reform program are incorporated in the annual

performance benchmarks that are agreed and reviewed with USAID. Whenever the benchmarks are met, the performance-based disbursements are made.

The benchmarks that have been established and met, as well as those that remain to be met within a given year concern essentially three sets of milestones. One set has to do with national service delivery targets to be met by field performance. This is the central rationale for all other inputs and activities. In order to meet these benchmarks, DOH managers establish provincial, district and municipal targets; plan, budget, organize and lead to reach these targets; generate and allocate the necessary resources; monitor, evaluate and document how each unit is performing.

Another set of benchmarks concerns the improvement of the processes essential to service delivery performance. Planning, budgeting, service integration, IEC support, public-private collaboration, information systems, epidemiological support and private sector mobilization have been identified as important processes supportive of improved delivery of child survival related health services. Benchmarks in these concerns have served to focus efforts towards more decisive support to field units struggling to achieve the service delivery targets.

A final set of benchmarks is specified as the preparation, discussion or approval of documents containing plans or policies deemed useful to further accelerate service delivery performance. These documents serve as basis for future commitments to action which can then

be translated into future benchmarks. Some of the plans and policies completed thus far include a nutrition plan, a proposed user fee policy, studies on privatization, program cost projections, central-local government shares in health service financing. These benchmarks facilitate the formulation of formal policies and plans required to organize broader actions in the DOH organization.

Identifying and setting benchmarks is a key managerial task in the DOH. The process involves the development of a consensus regarding what aspects of DOH operations can significantly impact on field performance in service delivery. Then a strategy for enhancing or altering those aspects that facilitate field improvements is developed. With a strategy, decisions and actions are then structured into activities that carry out its implementation. Finally, a measurable or verifiable indicator of annual progress in pursuing that strategy is defined. This becomes a benchmark that will be negotiated and agreed with USAID.

Setting appropriate benchmarks is essential so that the effort to meet the benchmarks do not detract from the underlying purpose of implementing the Child Survival Strategy. Benchmarks should be such that when DOH meets them, then it implements its Child Survival Strategy. The close correspondence between CSP benchmarks and the substantive goals of the Child Survival Strategy should result from benchmark setting.

Once DOH management is satisfied that the character and design of the benchmarks are consistent with

and contributory to the underlying CS Strategy, the effort to achieve the benchmarks can properly be regarded as efforts to implement the strategy. In the CSP, benchmarks are taken as objectives of a planning, organizing, mobilizing and monitoring cycle. Program and field managers take these benchmarks and incorporate them as targets in their management of their operations. This ownership of the project goals is the key to successful implementation of the CS Strategy.

The DOH regards the performance benchmarks incorporated in the annual targets and evaluation of the CSP as milestones that mark the progress in the implementation of the DOH Child Survival Strategy. Every year, the CSP provides an opportunity for DOH to re-state the directions it intends to move in implementing its Child Survival Strategy, establish specific points to be reached along that direction for that year, manage its affairs and resources to reach those points, assess the extent and consequence of reaching (or not reaching) those points, and link a substantial additional resource flow to the outcome of that annual exercise.

“ Benchmarks should be such that when DOH meets them, then it implements its Child Survival Strategy. ”

Use Of The Resources From Performance Grant Disbursements

Each annual tranche of performance-based disbursement from the Child Survival Program generates a peso equivalent provided by the national treasury to the DOH. This is not technically the simple peso proceeds of the dollar grant, so for purposes of this discussion, we shall call this the performance grant peso equivalent.

Under the terms of the agreement with USAID and the understanding between DOH and DBM, the allocation and use of the performance grant peso equivalent is the prerogative of DOH management. In exercising this prerogative, the DOH is guided by general rules and regula-

“ The management of CSP activities is integrated into regular DOH management structures and processes. There are no structures purely dedicated to CSP management yet CSP priority decisions and actions are taken promptly and adequately ... ”

tions regarding use of public funds and the policy and program goals of the Child Survival Program.

In the allocation of the CSP performance grant peso equivalent, the program management has adopted 4 categories of use. The priority use is allocated to two categories, namely, (a) the budget augmentation requirements of the 10 child survival service delivery programs and (b) the budget augmentation requirements of the field units (provincial, district and city health offices) implementing the programs. In evaluating the requirements for these categories, consideration is given to their needs in order to meet the benchmarks. For the field units, priority support is given to the needs identified by the area-based plans.

The remaining two categories of use include (c) the activities that support programs for child survival health services, and (d) related priority concerns of the DOH which are not being adequately met by its regular budget.

The process of allocation begins with proposals being put forward by various responsible units. These proposals are reviewed, clarified and evaluated. A consolidated allocation is prepared and the CSP management makes a recommendation that is finally acted upon by the Secretary of Health.

In the course of reviewing and approving funding proposals, certain policies have been adopted to guide the use of the performance grant peso equivalent.

1. As far as the child survival programs are concerned, the guiding consideration for determining

the level of funding support of their proposals is implementing capacity consistent with their approved plans.

2. As far as the augmentation of field unit budgets is concerned, the guiding consideration is the priority needs identified by their area based plans that can be accommodated within the standard level of funding support set for each field unit. Augmentation has been a key factor encouraging the improvement of planning and budgeting skills in field units.

3. Flexibility in the use of augmentation funds has been a key factor in the effectiveness of field units in utilizing these resources to meet child survival goals.

4. In general, the funding provided by CSP may only be used to support programs and plans that have been formally reviewed and approved by top DOH management. But modest amounts have been provided for program development or plan preparation activities for thrusts identified as DOH priorities but which require further analytical and testing work.

5. Timing of releases has become at least as important as level of allocation in the utility and impact of the CSP resources. Efforts have been focused to speed up the review, approval and request for release of funding proposals.

6. Linkage of funding and technical assistance inputs require further work in order to improve impact on CS priorities. The role of program managers in coordinating technical inputs and budget augmentation needs to be strengthened as the key mechanism for such linkage.

Organizing And Managing CSP Activities

The management of CSP activities is integrated into regular DOH management structures and processes. There are no structures purely dedicated to CSP management yet CSP priority decisions and actions are taken promptly and adequately as evidenced by the progress in program accomplishments and the meeting of the annual performance benchmarks.

There are four spheres of decisions and actions that operate to manage CSP and the larger Child Survival Strategy. The top DOH management consisting of its most senior managers provide the vision and the strategic direction as well as arrange for the structural mechanisms that mediate competing priorities into coherent plans and policies. This function is largely coordinated by the Undersecretary and Chief of Staff designated as CSP director under whose initiative and direction the strategies of the program are passed upon by the DOH Executive Committee and the Secretary of Health. The interactions among the top decision makers of DOH are reflected in the frameworks that guide resource allocation, benchmark definition, and task assignments of key managers.

In order to provide comprehensive and timely support to top management decision making, the CSP has developed a system of staff coordination largely run by the Project Coordination Unit under the Office of the Chief of Staff. Top management, program manage-

ment, field management and USAID mission management are plugged into this staff coordination system so that all parties involved in CSP give and take the information, decisions, and actions required to move the strategy forward.

The third sphere of management involve individual management groups within the programs included in the CSP. This is really the primary source of technical and policy ideas and the primary source of implementation initiatives. While the maturity and effectiveness of various program management staff are uneven, the CSP mechanisms have provided most program managers with the conditions for developing their programs with due regard to their technical standards, the real conditions of the field, and the competing concerns of DOH.

The final sphere of management involve individual field unit management. CSP has succeeded more than most initiatives in provid-

ing the field managers with the purpose and means to strengthen their ownership of child survival programs. While the degree of response has been varied, the general direction has been towards improved managerial processes in the field units.

The Child Survival Strategy will continue to require re-statements, further articulation, constant adjustments and new elaborations. This will continue to be a responsibility of DOH's top management. But policy and vision must be reflected in plans, instructions, assignments, budgets and routines which shape thinking and behavior within organizations. The successful implementation of the Child Survival Strategy would require the constant attention and continued effort to acculturate purposes and processes in the DOH organizational life. This is the challenge of managing the strategy over the long term.

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