PD-AAZ-512

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AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D. C. 20523

PROGRAM ASSISTANCE

APPROVAL DOCUMENT

(PAAD)

Philippines: The Child Survival Program
(492-0406)

September 28, 1989

UNCLASSIFIED

THE CHILD SURVIVAL PROGRAM
(492-0406)

PROGRAM ASSISTANCE APPROVAL DOCUMENT

USAID/Philippines
September 1989

CLASSIFICATION: UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROGRAM ASSISTANCE APPROVAL DOCUMENT (PAAD)

1. PAAD Number: 492-0406
2. Country: Philippines
3. Category: Sector Assistance
4. Date: September 28, 1989
5. To: Malcolm Butler, Director, USAID/Philippines
6. OYB Change Number: N/A
7. From: Gary M. Imhoff, Chief, DRM/PDID
8. OYB Increase: N/A
To be taken from:
9. Approval Requested for Commitment of: $ 50,000,000
10. Appropriation Budget Plan Code: HE: $44,000,000 PN:$6,000,000
11. Type Funding: ☐ Loan ☒ Grant
12. Local Currency Arrangement: ☐ Informal ☐ Formal ☒ None
13. Estimated Delivery Period: Sept. 1989-March 1994
14. Transaction Eligibility Date: September 28, 1989
15. Commodities Financed: N/A

16. Permitted Source		17. Estimated Source	
U.S. only	-	U.S.	$ 3,400,000
Limited F.W.	-	Industrialized Countries	-
Free World	$ 5,000,000	Local	$46,600,000
Cash	$45,000,000	Other	-

18. Summary Description

The Child Survival Program will provide $50 million in grant assistance to the Government of the Philippines. Of this total, approximately $45 million will be disbursed in exchange for agreed policy changes and the expansion of child survival-related services. The remaining $5 million will finance the anticipated technical assistance, monitoring and evaluation needs of the program, with any unused amount reallocated to the program assistance line item. The $45 million in sector assistance will be disbursed in four annual tranches beginning in early FY 90. The planned technical assistance, monitoring, evaluation and audit services will be provided through AID-direct contracts.

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

J.C.Stanford, Controller

19. Clearances	Date
OPHN:WHJohnson	9/26/89
OD/PE:PRDeuster	9/27/89
CO:JCStanford	9/27/89
DRM:GMImhoff	9/27/89
OLA:LChiles	9/27/89
OD:RAJohnson	9/27/89

20. Action: ☒ APPROVED ☐ DISAPPROVED

Authorized Signature: Malcolm Butler — Date: Sept. 28, 1989

Title: Director

AID 1120-1 (5-82) CLASSIFICATION:

ACTION MEMORANDUM FOR THE DIRECTOR

THROUGH: Mr. Richard A. Johnson
Deputy Director

DATE: September 27, 1989

FROM: Gary M. Imhoff
Acting Associate Director
Office of Development Resources Management

SUBJECT: CHILD SURVIVAL PROGRAM (492-0406) -- Program Assistance Approval Document (PAAD) Authorization and Approval of Grant Agreement

ACTION REQUESTED: Your approval is sought to authorize the attached PAAD for the subject program and to approve the transmittal of the final Grant Agreement to the National Economic and Development Authority (NEDA) for signature.

BACKGROUND: The purpose of the Child Survival Program is to assist the Government of the Philippines (GOP) to increase the availability and utilization of child survival-related services, including child spacing, particularly to underserved and high-risk groups. The Child Survival Program is designed as sector assistance, with performance measured against specific policy objectives and performance benchmarks used as the basis for program disbursements.

The Child Survival Program will provide $50 million in grant assistance over the four-year life of program. Of this total, approximately $45 million will be in performance-based program disbursements; the remaining $5 million will finance technical assistance services and the program's monitoring and evaluation requirements.

The program assistance will be disbursed in four annual dollar tranches. The tranching decision each year will be based on the program's annual progress review. Dollars and any interest earned will be used for payment of official debt (excluding obligations incurred by public corporations) to multilateral lending institutions such as the International Monetary Fund, the International Bank for Reconstruction and Development and the Asian Development Bank. There will be no peso generations under the program.

DISCUSSION: The PAAD for the subject program was reviewed by the Mission Review Committee on September 11, 1989. Two issues were raised at the review: tranching decisions and the specificity of the performance benchmarks.

1. Tranching Decisions: The Mission Review Committee recommended utilizing an "all or nothing" tranching scheme the first year of the program, with the GOP responsible for achieving all of the agreed performance benchmarks, but incorporating into the Grant Agreement language that would permit AID, at its discretion, to disburse the planned tranche amount in circumstances where the benchmarks were not met but the policy objectives were achieved. This tranching arrangement will be reviewed at the end of the first year of the program to determine its continued appropriateness.

2. Performance Indicators: The Mission Review Committee recommended the rewording of two policy objectives and performance benchmarks related to ensuring appropriate funding for child survival services. The Committee specified language for one objective and benchmark, and asked the Controller's Office to research Department of Health budget information in order to revise the second. One objective/benchmark set was accepted by the GOP during negotiations; however, the other was deleted, with the substance incorporated into another performance benchmark.

In relation to the policy matrix, the Mission Review Committee recommended omitting the subheadings of the end-of-program service delivery indicators indicating the degree of DOH control over the indicators. In addition, the Committee recommended eliminating the "malnutrition" service delivery indicator and replacing it with a policy objective requiring the development of a comprehensive national strategy for addressing malnutrition problems. These changes have been made in the matrix and were accepted by the GOP during negotiations.

Subsequent to the Mission Review, during the preparation of the Grant Agreement, OPHN, OLA, DRM/PDID and CO representatives agreed that the distinctions between "core" and "non-core" policy matrix items would be eliminated; for each year of the program, all policy items agreed to would be required to be completed. This change is consistent with the revised tranching procedure. Consequently, some proposed first-year policy changes were rescheduled for the second year of the program. In addition, for reasons of clarity, the policy matrix headings have been changed; instead of "policy objectives," "implementation actions" and "performance indicators," the new headings are "categories of policy reform," "policy objectives" and "performance benchmarks," respectively.

The end-of-program service delivery indicators have been included in Annex 1 to the Grant Agreement. However, the policy implementation matrix does not form part of the Grant Agreement; instead, the matrix as agreed to during program negotiations has been forwarded to NEDA. NEDA will formally submit the matrix to A.I.D. at the time of grant signing. For your reference, the final matrix appears on pages 25 - 29 of the PAAD.

AUTHORITY: In STATE 245039, the ANE Bureau approved the Mission's request to authorize the Child Survival Program in the field. The Mission was advised in STATE 266046 dated August 19, 1989 that the Congressional Notification waiting period had expired without objection. The Mission received budget allowances of $8 million in population and health funds (new obligating authority) for the program per STATE 265946, dated August 19, 1989, and $3,121,300 in health funds (reobligation) per STATE 285807, dated September 7, 1989. The statutory checklist has been reviewed by ANE (country portion) and the Mission, and there are no legal impediments to the obligation of funds.

WAIVERS: There are no waivers required at this time under the Child Survival Program.

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RECOMMENDATION: Based on the above, that you indicate your approval of this request by signing in the space provided below, and authorize the subject program by signing the PAAD facesheet (TAB A). You are also requested to sign the Gray Amendment Certification (TAB B) and approve transmittal of the Project Agreement to NEDA by signing the clearance sheet.(TAB C) and the transmittal letter to NEDA (TAB D). Upon receipt of signed copies of the Agreement, the documents will be returned to you for your signature and obligation of funds.

APPROVED: MB

DATE: SEP 27 1989

Attachments:

A. PAAD Facesheet
B. Child Survival PAAD
C. Clearance Sheet for Grant Agreement
D. Transmittal Letter to NEDA
E. Program Grant Agreement
F. STATE 245039
G. STATE 266046
H. STATE 265946
I. STATE 285807

Clearances:

OPHN:WHJohnson	(draft)
DRM/PT:DAD'Antonio	(draft)
OD/PE:PRDeuster	
CO:JCStanford	
OLA:LChiles	

SEP 2 7 1989

Dr. Florian A. Alburo
Acting Director General
National Economic and Development
Authority
Amber Avenue, Pasig, Metro Manila

Subject: Child Survival Program
Program No. 492-0406
Program Grant Agreement

Dear Dr. Alburo:

Enclosed for your review are four copies of the Program Grant Agreement for the Child Survival Program. The Agreement provides grant funding of $11,121,300.

If the documents are satisfactory to you, please sign and return all four copies to us for signature and obligation of funds. We shall return two executed original copies and two conformed copies to you for your records.

We look forward to the initiation of program implementation.

Sincerely,

/s/ MALCOLM BUTLER

Malcolm Butler
Director

Enclosure: a/s

CLEARANCES:
DRM:GHImhoff
OPHN:WHJohnson (draft)
DRM/PT:DAD'Antonio (draft)
CO:JCStanford
OLA:LChiles
OD:RAJohnson

bcc: DRM/PT, OPHN, CO, OD, OLA, C&R

DRM/PDI:PJordan/lla:2264b:9/27/89

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J. Institutional Analysis
K. USAID Child Survival Strategy

4'

ABBREVIATIONS AND ACRONYMS

ABCSD	Area-Based Child Survival and Development Project
ADB	Asian Development Bank
AIDAB	Australian International Development Assistance Bureau
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
ASEAN	Association of Southeast Asian Nations
BHS	Barangay Health Station
BIHNP	Bicol Integrated Health, Nutrition and Population Project
CDD	Control of Diarrheal Diseases
CHS	Community Health Service
CIDA	Canadian International Development Agency
CP	Condition Precedent to Disbursement
CPR	Contraceptive Prevalence Rate
DBM	Department of Budget and Management
DOH	Department of Health
EFT	Electronic Funds Transfer
EPI	Expanded Program for Immunization
FETP	Field Epidemiology Training Program
FIES	Family Income and Expenditure Survey
FP	Family Planning
GOP	Government of the Philippines
GTZ	West German Agency for Technical Cooperation
HealthCom	Health Communications Project
HMO	Health Maintenance Organization
IBRD	International Bank for Reconstruction and Development
IE&C	Information, Education and Communication
IMR	Infant Mortality Rate
IPHO	Integrated Provincial Health Office
IQC	Indefinite Quantity Contract
JICA	Japanese International Cooperation Agency
MCH	Maternal and Child Health
NCR	National Capital Region
NEDA	National Economic and Development Authority
NGO	Nongovernmental Organization
NOA	New Obligation Authority
OPHN	Office of Population, Health and Nutrition

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ORT	Oral Rehydration Therapy
PAAD	Program Assistance Approval Document
PAIP	Program Assistance Initial Proposal
PHCF	Primary Health Care Financing Project
PHDP	Philippine Health Development Project
PIHES	Public Information and Health Education Service
PIO/T	Project Implementation Order for Technical Services
PUSH	Panay Unified Services for Health Project
PVO	Private Voluntary Organization
RHU	Rural Health Unit
RIG/A	Regional Inspector General for Audit
TA	Technical Assistance
TFR	Total Fertility Rate
UNICEF	United Nations Children's Fund
WHO	World Health Organization

SUMMARY AND RECOMMENDATIONS

1. PROGRAM TITLE AND NUMBER: Child Survival (492-0406).

2. GRANTEE: The Government of the Philippines (GOP).

3. IMPLEMENTING AGENCY: The Department of Health (DOH).

4. FUNDING LEVEL AND TERMS: U.S. $50 million grant from Development Assistance funds.

5. LIFE OF PROGRAM: September 28, 1989 to March 31, 1994.

6. PROGRAM PURPOSE: To increase the availability and utilization of child survival-related services, including child spacing, particularly to underserved and high-risk groups.

7. SUMMARY PROGRAM DESCRIPTION: The program will provide $45 million to support policy changes, including the expanded delivery of child survival-related services, and $5 million to finance technical assistance, monitoring, evaluation and audit services.

8. GRANTEE CONTRIBUTION: The GOP plans to provide approximately $72 million of GOP funds for child survival-related services over the four-year life of the program.

9. STATUTORY REQUIREMENTS: All statutory requirements have been met. (See Annex D.)

10. RESOLUTION OF PROGRAM ISSUES: All program issues have been satisfactorily resolved; these are detailed in the Action Memorandum requesting Program Authorization.

11. RECOMMENDATION: Authorization of a grant of U.S. $50 million, if negotiations do not significantly alter the Program in form or substance.

12. PROGRAM COMMITTEE: The USAID Program Committee members are:

OPHN:WHJohnson	OPHN:KRFarr
OPHN:RRCapul	OFFPVC:ADavis
DRM/PRO:SBlevins	DRM/PDID:PJordan
OD/PE:MLPanlilio	CO/FMSD:MAFrancisco
EO/CSD:WEReynolds	RLA:LChiles

I. BACKGROUND

A. STATE OF THE PHILIPPINE ECONOMY

The early and mid-eighties were a lost period of development for the Philippines. The lack of economic progress, particularly from 1984 - 1985 when the economy suffered its worst recession since World War II, has deepened Philippine poverty and unemployment problems. The Philippine economy has recovered since 1986 as a result of the restoration of political legitimacy and implementation of policy reforms. The economy grew by 1.5 percent in 1986, 5.91 percent in 1987, 6.74 percent in 1988 and 4.10 percent in 1989 (first quarter). Despite economic recovery, fundamental problems remain in the areas of poverty, unemployment, rapid population growth, the inefficient industrial sector, underdeveloped export and agricultural sectors, a large foreign debt, equally large domestic debt of the public sector, and weak financial institutions.

Coupled with rapid population growth, the slow growth and actual 1984 - 1985 declines in output caused per capita income to fall to $536 from the pre-crisis level of $720. The economic recovery that started in 1986 has not yet raised per capita income to its pre-crisis level. Although the incidence of poverty was reduced from 58 percent in 1985 to 49.5 percent in 1988, at least 30 million of the country's estimated 56 million people are still poor. Rural incomes are only half of urban incomes. In a situation of few employment opportunities, rapid growth of labor supply aggravates the poverty situation. The unemployment rate remained high at 9.6 percent in 1988, although reflecting an improvement from the 1986 rate of 11.8 percent. Underemployment is estimated at about 32 percent. The urban unemployment rate of 15 percent in 1988 was around twice that of rural areas.

High population growth, currently at approximately 2.4 percent annually -- the highest of the Association of Southeast Asian Nations (ASEAN) countries -- and the continued expansion of the labor supply, which brings 700,000 new entrants yearly to the labor force, created a labor surplus condition that depressed real wages and imposed pressures on the utilization of the country's natural resources. A rapidly growing population also exerts pressures for increased government resources to be devoted to basic social services. Severe constraints on the availability of public sector resources, as indicated by the national budget deficit of P23.2 billion in 1988 ($1.09 billion using the end-of-year exchange rate of P21.335:$1.00), limits the ability of the government to respond.

Productivity declines in manufacturing over the past two decades have made the situation worse. These declines may be attributed to the Philippines' long history of trade protectionism resulting in inefficiency in manufacturing industries.

The serious poverty situation in the country has bred malnutrition and poor health status. Chronic malnutrition ("wasting"), as indicated by the proportion of children below the weight-for-height standards, increased from 10 percent in 1982 to 16.6 percent in 1987. Despite a relatively high per capita income in comparison with other countries in the region, the Philippines lags behind in improvements in the quality of life. Among ASEAN countries, the Philippines has the lowest calorie supply per capita and the second highest infant mortality rate.

B. CURRENT POLITICAL SITUATION

On February 25, 1986, a popular, civilian-backed and relatively bloodless revolution brought Corazon Aquino into power. Fundamental political changes characterized the first two years of the Aquino administration. President Aquino's popularity created a climate conducive to reform, including the replacement of senior members of the judiciary as well as military reforms. A new Constitution was ratified in February 1987; elections of Congressional members were conducted in May 1987; and the convening of Congress in July 1987 re-established a system of checks and balances. The conduct of provincial and municipal elections in January 1988 and barangay elections in March 1989 completed the restoration of democratic political institutions in the country.

The Aquino administration also launched a major economic reform program that greatly contributed to the economic recovery starting in 1986. A major redistributive thrust of the economic program, the Comprehensive Agrarian Reform Program, was signed into law in June 1988.

The restoration of democratic political institutions has stimulated the rebirth of traditional Filipino politics characterized by rhetoric rather than action and personal interest rather than public service. These developments, together with the leftist and Muslim insurgencies, have complicated consensus building for reform. In addition, the 20-year rule of Ferdinand Marcos left a legacy of overcentralized decision-making and administrative difficulties in getting resources to rural areas. All these, together with charges of serious graft and corruption in government (which may be undermining the popularity of President Aquino), challenge the Aquino administration to sustain the momentum for reform and to prove its good intentions by translating pronouncements into concrete actions. This largely depends on its ability to manage interest group pressures without undermining national interest, economic stability and confidence in government, as well as on its ability to reduce red tape and remove graft in the government bureaucracy.

C. THE PHILIPPINE HEALTH SECTOR

1. Health Status

The health of the Philippine population improved significantly during the 1970s, although reduction in mortality rates in the 1980s has slowed considerably. The crude death rate declined from 12 per 1,000 in 1970 to 9 per 1,000 in 1980; life expectancy at birth increased from 58 years in 1970 to 62 years in 1980; and the infant mortality rate declined from 75 per 1,000 live births in 1975 to 63 per 1,000 in 1980, and further to 52.9 per 1,000 by 1988.

At the same time, significant regional differences in mortality rates exist, with higher rates in the less developed regions. In 1980, life expectancy at birth was 66 years in the National Capital Region (NCR), compared to 52 years in Western Mindanao. Infant mortality rates (IMRs) ranged from 44 per 1,000 live births in the NCR to 113 per 1,000 live births in Western and Central Mindanao.

The leading causes of death for all ages continue to be infectious and communicable illnesses, although degenerative diseases appear to be slowly gaining prominence. Altogether, easily preventable illnesses and diseases

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such as pneumonia, tuberculosis, diarrhea, nutritional deficiencies and measles accounted for 41 percent of all reported deaths in 1984, while degenerative diseases accounted for 28 percent of reported deaths.

Infant deaths comprise at least one fifth of all reported deaths, with pneumonia the single most important cause of infant mortality. The incidence of pneumonia has not declined since 1978. In 1984, 24 percent of all infant deaths were due to pneumonia, and 16 percent were due to other respiratory illnesses. Diarrhea, nutritional deficiencies and measles accounted for an additional 17 percent. Together, these illnesses accounted for more than half of all infant deaths.

Respiratory infections (bronchitis, influenza, pneumonia and tuberculosis) and diarrhea are the most frequent causes of illnesses. Infants and children under five years of age account for a large majority of morbidity cases from specific causes. In 1983, 66 percent of pneumonia cases, 59 percent of bronchitis, 57 percent of diarrhea and 64 percent of measles cases occurred in infants and children under five.

Mortality rates for all ages and for infants are higher in regions with a very high incidence of poverty. IMRs are higher in rural areas, where the majority of the poor reside. The infant mortality rate among mothers in farm occupations was three times that among mothers in professional, administrative or managerial occupations. Infant mortality rates also vary significantly according to level of mother's education. Women with three to four children experienced 30 percent higher infant mortality rates in both urban and rural areas than women with one to two children.

The major causes of morbidity and mortality -- particularly of infants -- are generally associated with poor environmental sanitation, crowding and congestion arising from inadequate housing, and poor quality child care resulting from the low education of mothers and child caretakers. All these characteristics are commonly found in low income households.

2. Determinants of Health Status

Current trends do not favor rapid improvements in health status unless major, highly focused interventions are implemented. Other than income, a major determinant is the education level of mothers. The proximate determinants of health status include reproductive factors such as parity and birth interval; environmental risk factors; nutrient intake; and health care. High infant mortality risk is associated with increasing parity and shorter birth intervals. In 1985, one-third of all households did not have sanitary toilet facilities, and 23 percent did not have ready access to safe water supply. Moreover, poor environmental sanitation is suggested by the very high prevalence of infectious parasitism among preschoolers. The acute malnutrition rate of preschoolers (underweight for age -- below 76 percent of Philippine standards) in 1987 was about 19 percent, about the same as in 1982, but down from about 21.6 percent in 1985.

The incidence of breastfeeding is a major determinant of the nutritional status of infants and a major factor in infant mortality risk. Between 1973 and 1983, the incidence of breastfeeding declined, primarily among younger mothers, among women with a primary education or less, and in all regions except the NCR. Another important preventive measure,

immunization, shows rapidly increasing rates. The Medium-Term Philippine Development Plan (1987-1992) estimated that only 30 percent of infants were fully immunized in 1986, but by the end of 1988 coverage had reached nearly 70 percent. The goal is to achieve 90 percent immunization coverage by 1990, a task that will entail targeting the hard-to-reach population groups.

The utilization of health care services is another important factor affecting survival. The proportion of medically attended births rose steadily to 57 percent in 1980, with no progress since then. In 1983, 93 percent of births in the NCR had medical attention, compared with 34 percent in the Bicol region. Access to medical facilities and personnel is clearly more limited in rural areas. Utilization of prenatal services is also low; the DOH estimates that only 40 percent of pregnant women visit DOH facilities for full prenatal care, and even less receive the tetanus toxoid immunization critical to reducing neonatal tetanus deaths among newborns.

Although there are no available national data on the use of oral rehydration therapy (ORT) by mothers for the treatment of diarrhea, surveys done in Region VII show that the utilization rate is still low but improving. In 1987 ORT use was below 10 percent in Region VII; it rose to almost 25 percent in early 1989 after an intensive training program for rural health unit (RHU) staff and barangay health station (BHS) midwives was implemented, and the use of oral rehydration salts (ORS) for diarrhea cases presenting at DOH facilities is now approaching 100 percent.

3. Access to Health Services

The existing health care system has not adequately dealt with the health needs of the population, particularly of the poor majority. The persisting disease pattern calls for greater efforts in promotive and preventive health care services, including family planning, immunization, environmental sanitation and hygiene, nutrition, breastfeeding and maternal care. It also calls for wider coverage of basic curative services in the rural areas, and stronger efforts to counteract the inaccurate beliefs and attitudes about health care associated with low educational levels among the poor.

Health care services are provided through public and private hospitals, RHUs, BHSs, private physicians, various nongovernmental organizations (NGOs) and traditional health practitioners. In 1986, there were 1,949 hospitals, about two-thirds of them privately owned. More than half -- small hospitals with limited diagnostic and treatment capabilities -- were for primary care. In 1985, there was one hospital bed for every 600 persons, although these beds were unevenly distributed across the country. The hospital bed ratio was 1:300 in the NCR, while in the rest of the regions the rate ranged from 1:600 to 1:1,000.

Physical access to public health facilities and personnel varies widely. Both RHUs and BHSs are relatively more evenly distributed across the country than hospital beds, but are close to major transportation networks and to towns, while a large part of the population resides in remote areas. Nutritionists are the least accessible government health workers, with a ratio of 1:86,000 population in 1986. Dentists have a ratio of 1:48,000 population; sanitary inspectors 1:28,000; and physicians, nurses and midwives, 1:6,000

population. Again, there are significant regional differences in health manpower distribution.

Although various NGOs provide maternal and child health, family planning and nutrition services, their operations are relatively small. A large majority of the rural population continues to rely on the services of traditional health practitioners.

4. Health Care Expenditures

Serious problems have been noted regarding the quality of services in public health facilities as a result of insufficient funding, inadequate financial management and planning capabilities, as well as supervision and monitoring. Public health expenditures account for only a relatively small proportion of total spending, in comparison to private health expenditures. In 1985, formal health care expenditures totalled approximately P14.5 billion, with the GOP accounting for 26 percent and the private sector for 74 percent. On a per capita basis, real health care expenditures dropped to P40 in 1985, down from P49 in 1981.

Data on household health expenditures indicate that about 70 percent of total expenditures are for curative care such as hospital charges, physician's fees and medicines. Low income groups, which spend a smaller absolute amount on health care than higher income groups, spend a relatively larger amount of their total health expenditures on curative care. Low income households may have to spend their incomes on other, more pressing needs than preventive care.

5. DOH Approach

The diseases most commonly found among the poor are easily preventable and controllable, at low cost per beneficiary, through immunization, proper hygiene, early detection and simple cure. Yet the health sector in the past has allocated a substantial part of its scarce resources to expensive urban-based curative care based in hospitals and using highly-trained health professionals, to which the poor have had limited physical and financial access. Moreover, in times of severe budgetary cutbacks, expenditures on curative care were maintained at the expense of preventive and promotive health care.

The GOP recognizes this problem and has adopted policies and strategies for the 1987 - 1992 planning period to address it. The major features of the GOP health strategy are: the provision of basic health services to the poor; vigorous implementation of preventive and promotive health measures; and increased budgetary resources to the health sector. In addition, policies call for greater integration of efforts among sectoral agencies involved in the delivery of health services and greater collaboration with the private sector.

DOH programs include implementation of an integrated maternal and child health (MCH) program; strengthening of the primary health care approach; sustained support for existing programs for tuberculosis, malaria and schistosomiasis; and the development of new programs for cancer, cardiovascular disease and acquired immune deficiency syndrome (AIDS).

The integrated MCH program, considered central to DOH child survival efforts, is composed of (a) the expanded program for immunization (EPI); (b) control of diarrheal diseases (CDD); (c) treatment of acute respiratory infections (ARIs); (d) nutrition services; and (e) maternal health care, which includes child spacing. These components are briefly described below.

a. EPI: The EPI component aims to increase the percentage of fully immunized children in the under one year age group from 70 percent in 1988 to 90 percent by 1992, and tetanus toxoid immunization of pregnant women from 37 percent in 1988 to 90 percent by 1992. To accomplish this, DOH activities include the procurement of cold chain equipment; the training and retraining of personnel; vaccine production, importation and distribution; education of mothers combined with the social mobilization of communities; and improved monitoring and evaluation services. Areas with low coverage and high drop out rates are specific EPI targets.

b. CDD: The CDD program has two major components: effective case management and diarrhea prevention. The case management component includes the training of DOH personnel on the use of ORT for diarrhea management; development of public information, education and communication (IE&C) campaigns to promote ORT use; the involvement of private sector groups and professional societies to promote ORT; and the implementation of strategies to assure a continuous, readily accessible supply of ORS.

There are seven diarrhea prevention interventions that are to be promoted under the CDD program. These include the promotion of breastfeeding and proper weaning foods; measles immunization; and such environmental sanitation measures as handwashing, proper excreta disposal, use of clean water and proper food storage. Program emphasis, however, has been on effective case management. Program resources allocated for the implementation of the diarrhea prevention strategies have been minimal.

c. ARI: ARIs, chiefly pneumonias, are the number one killer of infants and children in the Philippines. Although there is currently no national program to reduce infant and child deaths due to ARIs, an ARI control plan has been drafted, with a promising demonstration project underway in Bohol Province.

d. Nutrition: The DOH nutrition activities are aimed at improving the major nutritional problems in the Philippines: protein energy malnutrition and deficiencies in Vitamin A, iron and iodine. The nutrition component includes the promotion of appropriate weaning practices, the provision of micronutrients to mothers and children, nutrition education and growth monitoring. A new comprehensive breastfeeding initiative is also being planned within the overall MCH program.

e. Maternal Health Care and Family Planning: This program provides comprehensive maternal health services, including family planning. These services include counseling to avoid high-risk pregnancies, provision of contraceptive information and services, pre- and postnatal care, tetanus toxoid vaccination, promotion of breastfeeding and education to promote weaning practices. The program is designed to reach the estimated two million women between the ages of 15 and 44 who become pregnant each year, with special emphasis on the estimated 20 percent of these women who will fall in the high risk category.

Building on the theme of the health benefits of family planning and recognizing the linkages between population growth and development, the DOH's integrated MCH/family planning program also has fertility reduction as an objective. To reach this objective, the DOH has developed a plan to expand the service delivery network so that 97 percent of all existing DOH facilities will deliver at least some contraceptive information and methods by the end of 1993. Currently, the DOH provides family planning services in about 82 percent of its facilities.

6. USAID Assistance to the Sector

Since 1978, USAID has provided approximately $30 million for health activities through the Panay Unified Services for Health (PUSH) Project, Bicol Integrated Health, Nutrition and Population (BIHNP) Project and the Primary Health Care Financing (PHCF) Project. The USAID health priorities have been to strengthen primary health care services; improve child survival; improve cost effectiveness and service delivery efficiency; examine health care financing alternatives; and increase the role of the private sector in delivering health services. All of these projects have aimed at shifting the focus of DOH from curative to preventive services.

The goal of the 1978-84 PUSH Project was to demonstrate an effective local government-managed and operated primary health care service delivery system. The project, with AID funding of $5.7 million, was designed to serve communities that are difficult to reach through the conventional DOH service delivery system. Project implementation emphasis was on environmental sanitation infrastructure development, such as household water and toilet facility construction. The GOP implementing agencies were the Region VI Regional Development Council and the respective provincial and municipal government units in project areas. The project's geographical coverage was 400 barangays selected from the four provinces comprising Panay Island.

The BIHNP Project was implemented in the provinces of Albay, Camarines Sur and Sorsogon during the period 1979 to 1984. The project's focus was similar to that of the PUSH project; however, the BIHNP Project's GOP implementing agency was the Region V Health Office.

The PHCF Project, launched in 1983, originally provided funding for financing schemes, special studies and selective primary health care service delivery systems. By 1985, USAID and DOH began to shift the project's focus to planning for higher-impact child survival activities. In 1985, 1986 and 1987, amendments to the project were made to add the ORT, Field Epidemiology Training Program (FETP), EPI and IE&C components, so that most of the current PHCF Project assistance of $17.5 million is being utilized in support of child survival-related activities. In addition, PCHF has provided technical assistance in program management and support to the DOH to develop and implement a totally new Health Information System, a crucial ingredient in measuring program impact.

USAID has also helped support planned GOP health expenditures through its Budget Support and Food Assistance programs. In 1986, under the Budget Support Program, USAID provided approximately $39.7 million in support of such items as the operation and maintenance of health care facilities, the purchase of drugs and medicines, intensification of the DOH primary health care program and regional health administration and support services. In 1987, under the

PL 480 Title II Section 206 food program, USAID provided approximately $13.6 million in support of DOH budget items including the purchase of drugs and medicines, field health services, the primary health care program, and the extension of medical and health services in regional hospitals. In 1988, under the PL 480 Title II Section 206 food program, about $10.3 million of USAID support was attributed to the DOH budget item for regional operations and services. Through the Budget Support Program II, an estimated $30 million of USAID support was attributed to malaria eradication, schistosomiasis control and provincial medical and health services.

The PL 480 Title II Food Assistance program supports the DOH's child survival-related activities. In FY 1990, the U.S.-based private voluntary organization (PVO) CARE and the DOH will implement a Title II MCH supplementary feeding program, which will reach an estimated 386,400 preschool children and 257,600 pregnant or lactating women. Also in FY 1990, the U.S. PVO Catholic Relief Services will assist approximately 730,000 preschool children and 110,000 pregnant or lactating women through their Title II MCH and day care feeding center programs, in collaboration with the Roman Catholic Church and the Department of Social Welfare and Development.

In addition, a $1 million AID-funded Vitamin A project is being implemented jointly by DOH and Helen Keller International. The purposes of the project are to reduce Vitamin A deficiency through the integration of Vitamin A supplementation into existing primary health care activities, and to develop an effective low cost method of achieving adequate long-term Vitamin A status among preschool children.

II. PROGRAM RATIONALE

A. CHILD SURVIVAL SECTOR GOALS

More than half of the country's estimated 59.7 million persons are under 20 years old, with 20 percent (11.9 million) of the population under seven years of age. The Philippines' child survival rate is significantly lower than in other ASEAN countries, and mortality rates for all ages, including infants, are higher in regions with a high incidence of poverty and in rural areas, where the majority of the poor reside.

Although the DOH has recently increased both its overall health budget and the proportion devoted to preventive health care, in the past the GOP allotted only a relatively small proportion of its budget to public health expenditures. Between 1981 and 1985, health care expenditures actually declined by nine percent in real terms. As a result, the quality of services in public health facilities was adversely affected.

Recognizing these problems, the GOP's Updated Philippine Development Plan for 1988 - 1992 sets the following health priorities: the provision of basic health services to the poor; vigorous implementation of preventive and promotive health measures; and increased budgetary resources for the health sector. Included among their specific health objectives are:

-- A decrease in the total fertility rate (TFR), from 4.0 children in 1988 to 3.7 in 1992, and an increase in contraceptive use from 39.6 to 45.6 percent of married couples of reproductive age over the same period.1/

-- A reduction in the nationwide infant mortality rate, from 52.9 in 1988 to 47.8 per 1,000 live births by 1992.

-- A decrease in the percentage of pre-schoolers who are moderately or severely malnourished, from 18.5 in 1988 to 14.2 percent by 1992.

B. SECTOR CONSTRAINTS

1. Budgetary Resources

Because of the ever-growing numbers of mothers and children in need and the increased awareness of the importance of preventive services, budgetary resources remain a current and projected constraint to the achievement of the program purpose. The roots of the problem are found in revenue limitations, budget allocations, population growth and the inefficient utilization of funds. The solution to this problem will not be found in an ever-increasing GOP budget for health. Rather, the solution will be found in limited budget growth, reallocation of the available budget resources,

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1/ A more recent target established in the Philippine Population Program Five Year Directional Plan is a contraceptive prevalence rate of 55.4 percent in 1993. Also, the 1988 baseline TFR of 4.0 is suspected to be too low. A more realistic figure is 4.4.

improved efficiencies of utilization, and the shifting of demand -- where possible -- to the private sector. Some of these steps have already begun.

As previously noted, health care expenditures declined 9 percent in real terms between 1981 and 1985. Since then, largely as a result of the strengthened political commitment to health, GOP budget allocations for health have significantly outpaced overall GOP budget growth. GOP health allocations have increased from 3.6 billion pesos in 1986 to 6.8 billion pesos in 1989, a nominal increase of 89 percent in three years. At the same time, attention has been given to proportionately increasing the allocations to preventive services, from about 14 percent of the DOH budget in the early 1980s to roughly 34 percent at present. Obviously, these trends cannot be sustained solely through increased public sector funding.

The extent to which public sector funding for health needs to increase is a matter of debate. The 1988 International Bank for Reconstruction and Development (IBRD) poverty study recommended a doubling of the DOH health budget to allow growth in preventive care while resource efficiencies and financing alternatives are introduced. The doubling of resources will be difficult. At the macroeconomic level, the GOP faces formidable revenue constraints. Forty-five percent of export earnings are consumed by debt servicing. In addition, the Philippines has a low revenue base relative to other Asian countries, due in part to low tax collection efficiency. Sustainable improvements in resources for preventive services must principally come from greater efficiency in the use of existing resources, various cost recovery and cost containment measures, especially in the hospital subsector, and better utilization of community, commercial and non-profit private resources to finance cost-effective services. However, it will take several years for the full impact of these reforms and new initiatives to be achieved. In the interim, additional external resources are needed to expand the delivery of child survival-related services and, at the same time, accelerate the adoption of measures aimed at achieving a more sustainable financial future for preventive care.

2. Targeting

The national IMR masks significant variance in child survival status, with the highest infant mortality rates in the less developed regions and the underserved populations within all regions. Infant mortality rates from the 1980 Census ranged from 44 in the NCR to 113 in Western and Central Mindanao; six regions (Regions II, VIII, IX, X, XI and XII) had IMRs over 75. Improved targeting is necessary to reduce the variance in child survival rates both among and within regions as well as to lower the overall national rate in a cost efficient manner. The GOP is very conscious of the need for improved targeting and has launched several efforts in this direction over the past few years, including the establishment of the DOH Community Health Service (CHS) Division.

Continued progress in targeting will require addressing the need for improved, epidemiology-based provincial health planning as well as the need for a cost-efficient and sustainable preventive care delivery system in the underserved areas. In essence, this constraint centers on the need for improving the epidemiological and economic soundness of plans to deliver child survival-related services to high risk groups. A related constraint is local absorptive capacity, i.e., the most underserved areas will likely have the

least skilled DOH planners, the weakest infrastructure, and the most difficult terrain. The marginal cost of incremental child survival related gains in these areas will be considerably higher than the marginal cost of child survival gains in the more advanced areas. For this reason, the program envisions a nationwide focus to improve targeting both within and among regions and to ensure national as well as local improvements in child survival status at acceptable marginal costs. Service expansion into the most difficult areas will be phased. Complete coverage of the underserved would not be economically feasible and is not an objective of this program.

3. Low Client Demand

Even in areas of the country where health facilities and services are relatively accessible, utilization is sometimes poor. The low demand for these services often results from incomplete knowledge about the need for and benefits of preventive health care or from insufficient motivation to obtain services. For example, studies show that the majority of mothers do not perceive severe cases of acute respiratory illnesses or diarrhea as life threatening. Furthermore, while there is a high level of ORT use among mothers who visit DOH health centers, the large majority never visit a health center for this service. Access to immunization services seems less a problem than the incompletion of the EPI series. While low demand and utilization are the result of many factors (e.g., low income, poor quality of service, literacy difficulties), the problem of incomplete demand can largely be addressed through IE&C campaigns and social marketing efforts.

In the past two years the DOH has launched a major social marketing effort to generate consumer demand for child survival services. National implementation of the EPI and CDD portions of this program will begin in late 1989. To internalize client demand for child survival services, build DOH's capability to develop and manage them, and sustain these efforts will require additional social marketing and technical assistance efforts during the early 1990s.

4. Centralization

The centralized planning and administration of the DOH are major constraints to improving the access to and efficient delivery of child survival-related services. These constraints include the DOH's limited capacity to effectively utilize additional program or project funding at the central level; cumbersome bureaucratic/multidepartmental central decision-making processes, which lead to slow commitment of funds; and delays in the disbursement of centrally-held funds to the regional and provincial levels. In addition, there is poor coordination among the national-level service offices for family planning, MCH and nutrition, while at the provincial and local levels, due to the delivery of all child survival-related services by midwives, these functions are more closely coordinated or are largely integrated. Progress in achieving decentralization is often correlated with the amount of financial and material resources available at the local government level. Because health conditions among and within provinces, cities and municipalities vary significantly, planning for child survival activities must begin at the local level to be responsive to local conditions.

5. Fragmentation of Services

The causes of infant mortality and morbidity are usually multiple and interrelated, so the success of child survival programs often depends on integrating the delivery of child survival-related services. Integrated training, supervision and administration of programs at the local level also contribute to efficiencies in resource utilization. However, the integrated delivery of services has been problematic. First, the administration of child survival-related activities at the DOH national level has been service- or activity-specific, with little coordination among the family planning, MCH and nutrition programs. Second, there has not been an operational manual or policy guidance on the integrated delivery of services to direct the actions of personnel at all levels. A third contributing factor has been the practice of each of the various donor-assisted projects to have its own development, implementation and monitoring requirements, which has resulted in time-consuming administrative procedures, fragmentation and/or duplication of efforts. The DOH has recently begun to implement new policies and strategies for the greater integration of programs within the DOH, better integration of efforts among other government agencies involved in the delivery of social services, and closer collaboration with private sector health providers.

C. STRATEGY FOR ADDRESSING CONSTRAINTS

1. Program Concept

The Child Survival Program is a performance-based sector assistance program. Annual tranches of AID assistance to the GOP will be conditioned upon GOP agreement to specified policy objectives and implementation of those objectives as measured against performance benchmarks.

The policy agenda focuses on changes to foster the efficient delivery, increased availability and utilization of services through the targeting of services to high-risk groups and underserved areas; decentralization of planning and budgeting; and the integration of child survival-related services. The policy agenda also includes measures to ensure sustained commitment to, demand for and financing of child survival services through both the public and private sectors. End-of-program service delivery targets focus on increases in the levels of specific child survival-related interventions, primarily in priority provinces.

The policy matrix, which forms the basis for the GOP's program of policy changes, consists of two policy reform strategies, eight categories of policy reform, and annual policy objectives and performance benchmarks. The strategies and categories of policy reform will remain unchanged over the life of the program. The policy matrix, which will be agreed to prior to the program's first performance-based disbursement, presents recommended policy objectives and performance benchmarks for the first year of the program. In addition, proposed policy changes for the second, third and fourth years of the program, which will be further developed during the program's yearly progress reviews, are presented in the matrix.

Approximately at the end of each year of the program, there will be a review of progress achieved as measured against the agreed plan for that year. Revised policy objectives and performance benchmarks for the following year will be agreed to prior to the disbursement of that year's tranche. Over

the four-year life of the program, the basis for AID fund disbursement gradually shifts from achievement of policy measures to achievement of service delivery impact.

2. Addressing the Constraints

Five constraints to development were identified in the Program Assistance Initial Proposal (PAIP): budgetary resources; targeting; low client demand; centralization; and fragmentation of services. Two additional concerns -- the need for increasing efficiency in the delivery of services and ensuring the sustained commitment to and financing of child survival services -- are overriding themes that are addressed throughout the Program Assistance Approval Document (PAAD). The USAID strategy for addressing the constraints follows.

a. Budgetary resources: One policy objective that must be met prior to disbursement of the second, third and fourth program tranches is the GOP's allocation of adequate funding for child survival-related services. In addition, the GOP has agreed to a broad policy review in order to sustain the expanded service delivery levels that are expected to be achieved during the life of the program. The GOP will consider the use of private providers for various goods and services as well as considering other health care financing measures such as cost containment, greater efficiency in providing services, insurance schemes, etc. Section III of the PAAD provides more information on proposed sustainability measures.

b. Targeting: The GOP's agreement to target increased child survival services to high risk groups and underserved areas is a key component of the program. Prior to the release of the first program tranche, the GOP will have developed criteria for determining high-risk and underserved areas and will have identified the program's priority provinces. Illustrative criteria are set forth in the section on policy agenda.

c. Low client demand: The program will provide technical assistance in the areas of social marketing and IE&C, in order to educate families on the advantages and importance of preventive care, and to motivate them to seek preventive health services.

d. Centralization: With the encouragement and support of USAID, the IBRD and the United Nations Children's Fund (UNICEF), the DOH is moving to a decentralized planning process. Using the epidemiological data provided through the Health Information System, health workers at the provincial and regional levels will be trained to identify and direct resources toward the child survival problems in their own areas. The Integrated Provincial Health Offices (IPHOs) will be able to carry out provincial-level epidemiology-based planning for their own provinces. Provincial plans will be consolidated at the regional level, with the Regional Health Office adding region-specific resource requirements.

Once the plans are approved at the DOH national level, the regions and provinces will receive direct allotments of funds from the Department of Budget and Management (DBM). Only those funds supporting national-level child survival services will go to the central DOH offices. The provincial health offices will make the plans, receive funds directly, and will have the responsibility and the authority to carry out their respective plans.

e. Fragmentation of services: Both the DOH administration of child survival-related services and the administration of the major donor projects (primarily IBRD and USAID) will be integrated. Support services are also being focused; bulk procurement, logistics, training, IE&C and information strategies will be coordinated to focus on child survival, including family planning, MCH and nutrition. It is expected that a DOH Assistant Secretary will become the coordinator of donor assistance in order to avoid duplicative and fragmented efforts.

3. Role of Technical Assistance

The types of technical assistance (TA) needed in the Child Survival Program have been defined by the analysis of constraints as well as through consideration of on-going and planned TA provided by USAID and other donors. Four areas of technical assistance will be emphasized: health information system development; epidemiology-based planning; social marketing/IE&C; and health care financing.

Although USAID-funded assistance is already being provided in social marketing and HIS, development is far from complete. Epidemiology-based planning is essential for targeting high-risk and underserved areas. Such planning within the DOH is minimal at present, and AID-funded TA is limited to training a small number of field epidemiologists for outbreak investigations. Finally, the critical area of financial sustainability of child survival services must be addressed; hence, the inclusion of TA in health care financing.

Current PHCF Project-funded TA in the child survival-related areas of EPI and CDD will continue through the end of 1990, assuring continuity of these programs as the Child Survival Program gets underway. Meanwhile, the new IBRD project will finance extensive provincial and regional level TA in the areas of program planning, budgeting and communications.

While each element of the technical assistance planned under the Child Survival Program will contribute to the program's specific objectives, all of the TA will be directed at improving sustainability of child survival services, improving efficiency in service delivery; institutionalizing health care technologies and management practices in the DOH; and achieving specific policy objectives.

D. EXPECTED PROGRAM IMPACT

The impact of the Child Survival Program will be felt in terms of the expanded provision of supplies and services as well as through the programmed changes in policy with respect to the delivery, management and financing of preventive health care activities in general and child survival activities in particular. The cumulative effect of these policy changes is expected to be significant in three respects: more efficient use of resources; greater equity; and financial sustainability.

Proposed policy reforms to ensure more efficient use of resources will have a lasting impact. Targeting of services to high-risk population groups and underserved areas will guarantee that resources will go to the groups most in need of care; the equity dimension of this strategy is incalculable. Decentralization and integration also have a direct bearing on resource

allocation; provincial planning and budgeting will provide a more accurate assessment of local needs, thus reducing or possibly eliminating resource misuse. The integration of services, resting on the principles of the economies of scale and scope, will prevent duplication of services and encourage easier program management. Integration of activities such as IE&C, training and logistics will result in a more cost-effective program.

The impact of the expanded child survival services on program beneficiaries can be estimated using current service delivery coverage data. During the 1990 -1995 period, the DOH's MCH/family planning (FP) program is expected to provide prenatal care to not less than 7.5 million pregnant women, of whom 20 percent are expected to be anemic or have high-risk pregnancies. During the same period, DOH natal care and under-six clinics will provide services to an estimated 7.5 million newborns, a significant proportion of whom will likely have complicated deliveries, as well as more than 500,000 pediatric cases.

The EPI component is targeted to immunize 1.76 million infants and 1.64 million school entrants annually. The CDD component calls for the annual distribution of some 2.8 to 2.9 million packets of oral rehydration salts to children ages 0 to 4 and for the treatment of severe diarrheal cases. Within the next five years, the nutrition component of the MCH/FP is expected to cover an estimated 5.76 million malnourished or anemic infants and children, and will also provide deworming services for approximately 7 million children. The following end-of-program service delivery targets have been established for the Child Survival Program. (Policy dialogue indicators are discussed in Section III.)

1. Increase the percentage of fully immunized children from 70 percent of all children under age one in 1988 to 90 percent by the end of 1993.

2. Increase the percentage of pregnant women with tetanus toxoid immunization from 37 percent in 1988 to 80 percent by the end of 1993.

3. Increase the percentage of births attended by trained health personnel, including trained traditional birth attendants, from 62 percent of all births in 1988 to 80 percent by the end of 1993.

4. Increase the percentage of pregnant women with at least three prenatal visits from 40 percent[2/] of all pregnant women served by DOH in 1989 to 80 percent by the end of 1993.

5. Increase the percentage of DOH outreach workers trained to deliver a wide range of family planning services from 24 percent in 1989 to 75 percent by the end of 1993.

6. Increase the percentage of DOH health centers delivering a broad range of family planning services from 82 percent in 1989 to 97 percent by the end of 1993.

2/ This baseline figure will be confirmed in early 1990 when HIS becomes operational nationwide.

7. Increase the percentage of midwives and District Hospital doctors and nurses with DOH training in new ARI case management and provided with adequate ARI management drugs and supplies from 0 percent in 1989 (excluding the Bohol Province demonstration program) to 40 percent (midwives) and 70 percent (hospital doctors and nurses), respectively, by the end of 1993.

8. Increase public- and private-supplied oral rehydration therapy (ORT) usage rate from 22 percent of all diarrhea cases in children aged 0-5 in 1989 to 60 percent by the end of 1993.3/

9. Increase total public- and private-supplied contraceptive prevalence rate (CPR) from 47 percent of all married women of reproductive age (15-44) in 1988 to 55 percent by the end of 1993.4/

E. SELECTION OF PROGRAM ASSISTANCE

USAID has carefully analyzed the factors identified earlier as constraints to development in the child survival sector. These constraints can not be eradicated by simply providing additional goods and services to the DOH, because the constraints relate to the basic way the health sector plans for and provides preventive child survival-focused health services.

While there is a need for more analysis regarding the expansion of the role of non-governmental health providers in the Philippines (which is built into this program), USAID and DOH have agreed that a strategic approach to the identified constraints must be undertaken. In exchange for the disbursement of tranches to the GOP and the technical assistance to be provided to the DOH, the DOH has agreed to reformulate its methods of planning, implementing and monitoring child survival services. The AID performance-based program will be a catalyst to development and implementation of an integrated national child survival approach. AID assistance will encourage a process to directly impact health and demographic status, create more efficient, effective utilization of GOP and donor resources, and focus on sustaining this effort after the completion of the program.

The ability of the DOH to maintain the momentum of its program will be affected by the intensity of its initial efforts. The budgetary increases in preventive services required as part of the AID policy agenda will enable the DOH to move faster and more comprehensively than it could otherwise. The program supports the GOP political commitment to the people of the Philippines to bring basic health services to those most in need, particularly children.

3/ To be measured by special population-based surveys.

4/ Total contraceptive prevalence includes program and non-program methods. DOH-HIS reports program method acceptance only. Total CPR will be measured by 1988 National Demographic Survey, 1990 Contraceptive Prevalence Survey, and 1993 National Demographic Survey.

F. AID, GOP AND OTHER DONOR STRATEGIES

1. AID Strategy

The goal of the USAID program in the Philippines as outlined in the Action Plan and AID/W's program week response cable (State 203872) is to support Philippine government efforts to achieve broadly-based, sustainable economic growth through the active partnership of public and private interests in establishing and managing efficient private sector markets. The strategy contains five programmatic objectives: addressing policy and institutional constraints that distort or impede growth; achievement of more efficient and competitive private markets; infrastructure improvement; more efficient provision of social services; and improved natural resource management. Policy dialogue, decentralization and the private sector are cross-cutting themes that apply to each of the programmatic objectives.

The Child Survival Program includes a policy dialogue agenda to encourage the implementation of reforms to increase the efficiency and effectiveness of child survival-related service delivery, including policy changes emphasizing the role of the private sector and to decentralize the planning and administration of child survival- related services. The proposed program will complement USAID's development efforts by increasing the efficiency, availability and utilization of child survival interventions, including improved nutrition and child spacing.

The Child Survival Program supports the USAID/GOP policy agenda, which includes broadening the awareness of government officials about the implications of rapid population growth on the development objectives of the Philippines. In addition, the program complements USAID's emphasis on private sector involvement in development by supporting the DOH's efforts to collaborate more fully with the private commercial sector and with PVOs. The Child Survival Program also supports USAID and GOP efforts to decentralize the responsibility and authority for program implementation.

USAID/Philippines has supported a full array of child survival interventions under the PHCF Project, and plans to continue assistance in this sector. For this reason, USAID finalized a Child Survival Strategy in January 1989, which is presented as Annex K to this PAAD.

2. GOP Health Sector Strategy

The health-related development goals of the GOP in the areas of population planning, infant survival and malnutrition were discussed earlier. The DOH health strategy and programs are briefly discussed below.

Although the health problems of women and children are largely preventable and controllable, maternal and child health care activities were not intensified until 1986. At that time, the reorganization of the Ministry of Health into the DOH emphasized the integration of program planning at the central level with the decentralization of program implementation at the regional, provincial and district levels. The reorganization has expanded the physical coverage of public health care facilities, including the creation of integrated district health offices in 1986.

Since then, total GOP budget allocations for health have progressively increased, from pesos 3.6 billion in 1986 to pesos 6.8 billion in 1989, representing a nominal increase of almost 90 percent in the three year period. At the same time, attention has been given to proportionately increasing the allocations for preventive services, from about 14 percent in the early 1980s to roughly 34 percent of the regional and provincial health budgets targeted for these services in 1989. The allotment of funds is being decentralized to the regional and provincial levels as well. In the GOP Fiscal Year (FY) 1990, which begins January 1, 1990, it is expected that DOH will directly allot approximately two-thirds of its total budget of 6.7 billion pesos to the regions and provinces.

In addition to the GOP policies emphasizing more vigorous implementation of preventive and promotive health services and the decentralization of funding resources, new strategies call for greater integration of programs within the DOH; better integration of efforts among other agencies involved in the delivery of health-related services; better targeting; greater sustainability of services; closer collaboration with the private sector; and the increased use of the media for public education on child health.

3. Other Donors

A number of bilateral donors, international organizations and NGOs support the DOH's child survival-related services. Principal among these are (a) IBRD; (b) UNICEF; (c) the Canadian International Development Agency (CIDA); (d) the Australian International Development Assistance Bureau (AIDAB); (e) the World Health Organization (WHO); and (f) Rotary International. Other donors involved in the broader health sector are the Asian Development Bank (ADB), the Japanese International Cooperation Agency (JICA) and the West German Agency for Technical Cooperation (GTZ).

a. IBRD. In June 1989 the IBRD and GOP completed negotiations for the approval of a $108 million project entitled Philippines Health Development Project (PHDP). IBRD will provide loan funds of approximately $40 million with parallel financing of another $40 million in grant funds expected from other donors (primarily Japan, Italy and the U.S.); the balance will come from the GOP.

The Health Development Project has four major implementation components: (1) support to DOH impact programs (MCH, malaria, schistosomiasis and tuberculosis); (2) strengthening of DOH's institutional capability to deliver services; (3) support to community-based health programs through NGOs; and (4) health policy development.

PHDP objectives include: (a) reducing the mortality risks to women and children in high-risk communities; (b) assistance in lowering fertility rates; (c) improving DOH's capacity to identify and monitor specific high-risk households within communities, to increase the equity and efficiency of service use; (d) mobilizing community resources through local government/NGO/DOH partnerships, to address critical community health needs; and (e) improving the institutional capacity of DOH in planning, management, communication, support and evaluation services, leading to more effective and efficient service delivery.

The IBRD Project and the Child Survival Program share many health development objectives. Recognizing the complementarity of the two donors' health development plans, USAID and the IBRD have jointly planned their assistance in consultation with the DOH, and have held several coordination meetings. Both donors plan to encourage decentralization of budget authority, improve child survival-related service delivery, encourage DOH to target resources at high-risk and underserved population groups, and to strengthen the DOH capacity to utilize and sustain additional program funds.

b. UNICEF: UNICEF's Strengthening Health Services for Child Survival and Maternal Care Program is a $5.83 million activity currently being implemented by the DOH. The program has three main components: EPI; care of mothers and under-six children; and CDD through the promotion of breastfeeding. UNICEF is also assisting the DOH through its Area Based Child Survival and Development (ABCSD) Program aimed at improving the health and nutritional status of women and children. The ABCSD program works directly with line agencies of seven provincial governments and, through these line agencies, with NGOs, to provide child survival services, equipment and training. The total cost of the five-year ABCSD program is $20 million, of which UNICEF will provide $3.41 million. The balance will be sought from other donors.

c. CIDA: In 1987, the Canadian Government financed a Can $5 million (US $3.12 million), five-year assistance package for the purchase of the DOH's total diphtheria, pertussis and tetanus and measles vaccine requirements. In September 1988, CIDA granted an additional Can $5 million to UNICEF's ABCSD Program for support to three provinces.

d. AIDAB: Since 1983, AIDAB has provided assistance to the DOH for the implementation of an ARI pilot project in the province of Bohol. This grant of As $2.10 million (US $1.69 million) has provided technical assistance, training, education materials and operations research. The project, scheduled to end in 1991, has already demonstrated that midwives can successfully identify and treat ARIs with antibiotics as well as teach mothers how to identify ARIs and to properly manage their children's illnesses. AIDAB has also provided As $4.5 million (US $3.62 million) through UNICEF for the purchase of syringes and needles for the EPI program.

e. WHO: WHO primarily provides extensive technical assistance to child survival-related programs as well as financial support to DOH mid-level training and workshops in support of child survival activities. Significant technical support is also being given for the development of DOH's health information system. A long-term WHO CDD/ARI adviser is now working with the DOH on the CDD program and in launching a national ARI program. WHO has also provided technical assistance to integrate state-of-the-art information on CDD and EPI into the curricula of medical and nursing schools.

f. Rotary International: Since 1980, Rotary has provided the entire polio vaccine supply of the DOH. They have made an informal commitment to continue this arrangement through 1990, after which they will phase out their contribution at the rate of 20 percent per year. Intensive routine nationwide EPI campaigns in most major cities are now carried out jointly with the DOH, with Rotary Clubs providing major support for social mobilization.

g. Asian Development Bank. ADB has only recently become involved in the Philippine health sector, with the approval of a $470,000 grant to provide technical assistance for the preparation of a national hospital services development plan. Implementation of the plan over the long term may also be partially financed by ADB, which has reserved $30 million for financing a future hospital construction/equipment project.

h. JICA. Japanese assistance has been extensive in recent years, but largely for turnkey construction projects, including the provision of hospital equipment and laboratory construction. Most notably, JICA has financed major laboratory and training facilities for the Bureau of Food and Drugs and the Research Institute for Tropical Medicine, as well as for research and advanced training in ARI. A planning grant for development and pre-implementation of the IBRD Health Development Project is also an important resource for DOH development. JICA is expected to co-finance the malaria impact program portion of the IBRD Project. Large-scale financing of the DOH's Alabang Vaccine Labs development is also under study by JICA.

i. GTZ. The Government of West Germany has been involved in funding small projects with the U.P. College of Public Health, especially in schistosomiasis. In 1988 a $1.6 million project was approved to support DOH's management information system, especially at the District level. The grant provides for two long-term advisers on information systems and epidemiology, various short-term advisers, vehicles, computer equipment, and funds for studies and research. There will be a need for close coordination of efforts between the GTZ and USAID technical advisers on HIS. A second project, begun in 1989 with a funding level of $3.2 million, provides for the maintenance of hospital equipment, including related technical advisory services.

III. POLICY AGENDA

The Child Survival Program focuses on targeting high-risk populations and underserved geographical areas for the expanded delivery of services in order to impact on the higher than average infant and child morbidity and mortality rates in some parts of the country. In exchange for AID program assistance, the GOP is committed to implement those policy changes that the GOP and USAID have agreed should have the most significant impact on the identified target areas.

The commitment of the GOP to set agreed child survival performance targets and the additional resources the GOP will make available to implement expanded service delivery are crucial to achieving the program purpose. Through the Policy Implementation Matrix, USAID and the GOP have agreed on two basic strategies: (a) to create conditions that foster the efficient delivery, increased availability and utilization of child survival-related services, particularly to underserved areas and high-risk groups; and (b) to ensure the sustained commitment to, demand for and financing of child survival-related services through both the public and private sectors.

The required first-year policy objectives and performance benchmarks for each strategy are briefly discussed below. Other policy objectives proposed for implementation in subsequent years of the program are presented in the policy matrix.

A. EFFICIENT DELIVERY, INCREASED AVAILABILITY AND UTILIZATION OF SERVICES

Four categories of policy reform have been established as part of this strategy: the targeting of child survival-related services; the increased delivery of services; decentralization; and integration of child survival-related services.

There are three required implementation actions under the "targeting" policy reform category: the determination of priority underserved geographic areas; the linkage of budget allocations to program and geographic targeting; and the determination of functional (programmatic) priorities for additional services and programs.

Based on DOH's classification of high-risk and geographically inaccessible provinces and cities, DOH will produce a prioritized list of provinces and cities where additional resources will be concentrated over the life of the program. Geographical targeting will be based on a set of criteria, primarily using epidemiologic data, that demonstrate the higher risk of infant, child and maternal morbidity and mortality in certain geographic areas; an additional criterion could be the physical inaccessibility of a service area. Functional targeting, i.e., focusing on those child survival-related services for which the demonstrated need is the greatest, will also be a part of the targeting exercise. Nutrition, family planning services and ARI intervention are examples of program areas that may be emphasized. The prioritized list of provinces and cities is to be completed prior to the release of the first tranche of program assistance. (Illustrative selection criteria are included in Annex I to this PAAD.)

During the first year of the program, programmatic and geographic targeting will be linked with budgetary targeting by providing increased budget appropriations to the identified priority provinces and cities. This action is to be completed by October 1990, prior to the program's first progress review.

Functional priorities for additional child survival programs and services in priority provinces will also be determined during the first year of the program. This will be accomplished through the development of DOH provincial plans that address priority programs, including family planning and nutrition.

The second category of policy reform is the increased delivery of child survival-related services. The policy objective -- increases in the public and private sector provision of services in accordance with prioritized provincial plans -- has two essential performance benchmarks. The first is the set of national level end-of-program service delivery coverage indicators, which will form part of the Program Grant Agreement. These indicators will remain constant over the life of the program and will be measured after the program ends in December 1993. (The end-of-program indicators are listed in Section II.D. and in the Policy Implementation Matrix in Section III.C.)

In addition, beginning in the first program year, USAID and the DOH will agree on annual service delivery performance targets for the priority provinces for the next year of program implementation. To the extent possible, these performance targets will be based on the national end-of-program service delivery indicators; however, it may be necessary in some cases to establish separate indicators, e.g., in areas of high malaria incidence.

The "decentralization" policy reform category contains one policy objective, the decentralization of health planning to the regional and provincial levels. Expanded local planning will allow each local area to determine its service levels, develop service delivery priorities and performance targets, and allocate resources to meet its unique health needs. Comprehensive epidemiology-based health plans will be developed by the priority provinces in the first year of the program, with provincial plans instituted for all provinces by the end of the third year.

The fourth category of policy reform, "integration of child survival services," has five policy objectives slated for first-year implementation. The first is, as the government's lead agency for population services, DOH's development of implementation arrangements for the population activities outlined in the June 1989 "Integrated Population and Development Program Plan."

The second policy objective calls for the development of a national strategy to address malnutrition problems. The strategy will include a prioritized work plan for providing comprehensive nutrition services. Needed implementation actions, the time frame for completion of actions, the identification of responsible agencies and the concurrence of these agencies with planned nutrition activities will be elements of the work plan.

The integrated provincial delivery of child survival services is the third "integration" policy objective; the performance benchmark is the completion of an integrated MCH operations guide by October 1990. The MCH operations guide, as the core implementing document for addressing child survival problems, will

emphasize using a family context for addressing child survival problems in order to encourage the integration of services.

The integration of health information reporting at local and national levels is the fourth policy objective. There are two performance benchmarks: the operation of a revised, reliable HIS in all provinces by October 1990; and the development of a plan for the reorganization of DOH's Health Intelligence Service. The HIS will be used by DOH to provide an epidemiologic information base upon which program planning and implementation revisions can be meaningfully based. As the DOH's information base expands, it can better target its attention, prioritize its resources and adjust its strategy to respond to identified problems.

The last policy objective for 1990 under the "integration" policy reform is the coordination of child survival-related programs at the national level. The performance benchmark is the designation of a DOH Assistant Secretary or DOH official at a comparable level for the coordination of all GOP and foreign- assisted child survival-related activities.

B. SUSTAINABILITY OF CHILD SURVIVAL-RELATED SERVICES

Efforts to ensure sustainability are a special program concern, and other health activities will complement sustainability efforts. The second program strategy -- to ensure the sustained commitment to, demand for and financing of child survival services -- contains four categories of policy reform: government commitment; internalizing the demand for preventive health services; financial sustainability; and increased private sector involvement.

The "government commitment" category includes two first-year policy objectives. The first is the demonstrated commitment of the GOP to increase DOH's technical capability in HIS, epidemiology-based planning, IE&C and health care financing. The performance indicator for this objective is the appropriate GOP signature on the Project Implementation Order for Technical Services (PIO/T) for the AID-direct financing of long-term technical advisory services, which is to be completed prior to the release of the first program tranche.

Program budgeting of DOH activities is the second policy objective related to government commitment. The performance benchmark is the funding of activities planned by DOH to achieve their performance targets, as evidenced by advices of allotment. This performance benchmark will be measured prior to the release of the second, third and fourth tranches.

The policy objective for the second "sustainability" policy reform category -- internalizing the demand for preventive services -- is the development and implementation of a plan to increase consumer demand for preventive health services, in order to sustain high utilization rates and encourage the transitional movement of service delivery from the public to the private sector. The performance benchmark to be measured is the issuance by DOH of a national IE&C plan by October 1990.

Because financial sustainability is essential to the long-term success of child survival efforts, development of a health care financing strategy and a plan for an enhanced Medicare system are policy objectives under the "financial sustainability" category. USAID and DOH will complete a concept

paper for a bilateral National Health Insurance Development project for the expansion of the Medicare system by October 1990. Project development will include the services of a resident adviser experienced in public-funded health insurance development, and may also include the development of a software system to track service utilization as the first step toward cost containment. The technical adviser will develop the framework for a three-phase development of the Medicare Program, which presently covers 43 percent of the population.

In addition, by March 1991, DOH will complete a research agenda and prioritized work plan for the development of a comprehensive health care financing strategy, which will address resource generation, cost containment, private sector delivery of appropriate services, and the shifting role of the GOP to regulatory and quality assurance.

"Sustainability" has a broader meaning than sustaining the level of GOP health resources -- it is important to find viable alternatives to the public provision and financing of health care. Although the GOP is committed to providing increased levels of health resources, both the donor community and the GOP are aware that the need for resources in the health sector will continually outpace the likely budgetary resources of the GOP for health. Long-range solutions will depend upon the increased involvement of the private sector in the provision of health services. Thus, two key policy objectives for the fourth "sustainability" category -- increased private sector involvement -- are the development of plans for the privatization of four key national health facilities and for increasing the role of the private sector in the provision of health services.

By the end of the first year of the program, the DOH will have completed privatization plans for the Philippine Heart Center, the Philippine Children's Medical Center, the National Kidney Institute and the Lung Center of the Philippines, and, in consultation with the Committee on Privatization, will make decisions on the implementation of the plans.

In addition, during the second year of the program, the DOH will develop a prioritized work plan for increasing the private sector's role. Areas that will be included in the plan are a strategy for the privatization of health facilities, direct service provision by the private sector; the use of contractors; and policy incentives to make the provision of health services more attractive to the private sector. Other ideas to be considered for inclusion in the plan are franchising a network of rural health clinics; the establishment of community-based health maintenance organizations (HMOs); setting up provincial level "partnerships" between the government and local private organizations to facilitate community sponsorship of health activities; investigating the capabilities of local companies to provide a greater percentage of needed medical equipment, supplies and medicines; and contracting-out ancillary services at DOH hospitals and for its preventive care program, such as for the procurement of drugs and medical supplies or for providing services due to unfilled DOH positions.

Revised 9/25/89

CHILD SURVIVAL PROGRAM
POLICY IMPLEMENTATION MATRIX

Goal: To contribute to a reduction in the variance in infant and child mortality and morbidity rates among and within provinces and regions while simultaneously lowering the corresponding national rate.

Purpose: To increase the availability, utilization and sustainability of child survival-related services, including child spacing, particularly to underserved and high risk groups.

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	TARGET DATE
STRATEGY I: TO CREATE CONDITIONS THAT FOSTER THE EFFICIENT DELIVERY, INCREASED AVAILABILITY AND UTILIZATION OF CHILD SURVIVAL-RELATED SERVICES, PARTICULARLY TO UNDERSERVED AREAS AND HIGH-RISK GROUPS.			
A. Targeting of Child Survival Services	Determination of priority underserved geographic areas.	-- Priority-ranked list of provinces and cities, based on classification of provinces and cities using DOH-established high-risk and geographical access criteria.	Prior to release of first tranche.
	Budget allocations linked to program and geographic targeting.	-- Increased budget appropriations given to priority high-risk and underserved provinces and cities.	Oct. 1990
	Determination of functional (programmatic) priorities for additional services and programs.	-- DOH provincial plans address priority child survival-related programs, including family planning and nutrition. a. Priority provinces b. 50 percent of total provinces c. 100 percent of provinces	 Oct. 1990 Oct. 1991 Oct. 1992
B. Increased Delivery of Child Survival Services	Supply of services from DOH, NGOs and private commercial sector increases in accordance with prioritized provincial plans.	-- Annual service delivery performance targets for priority provinces, based on national end-of-program indicators, set by DOH.	Prior to release of tranches 2, 3 and 4.
		-- Achievement of national end-of-program service delivery coverage indicators. a. Percent of all children under age one who are fully immunized increases from 70% (1988) to 90%. b. Percent of pregnant women with tetanus toxoid immunization increases from 37% (1988) o 80%. c. Percent of all births attended by trained health personnel, including trained traditional health personnel, increases from 62% (1988) to 80%.	Dec. 1993

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	TARGET DATE
		d. Percent of all pregnant women served by DOH with at least three prenatal visits increases from 40% (1989) 1/ to 80%.	
		e. Percent of DOH outreach workers trained to deliver a wide range of family planning services increases from 24% (1989) to 75%.	
		f. Percent of DOH health centers delivering a broad range of family planning services increases from 82% (1989) to 97%.	
		g. Percent of all midwives and District Hospital doctors and nurses with DOH training in new ARI case management and provided with adequate ARI management drugs/supplies increases from 0% (1989) (excluding Bohol Province demonstration program) to 40% (midwives) and 70% (doctors and nurses) respectively.	
		h. Use of public- and private-supplied ORT in all diarrhea cases in children aged 0-5 increases from 22% (1989) to 60%. 2/	
		i. Total public- and private-supplied contraceptive prevalence rate for all married women ages 15-44 increases from 47% (1988) to 55.4%. 3/	
C. Decentralization	Decentralization of health planning to the regional and provincial levels.	-- Provincial health plans that specify service priorities, service levels, commodities required, annual performance targets and required resources, including staff.	
		a. Priority provinces	Oct. 1990
		b. 50 percent of total provinces	Oct. 1991
		c. 100 percent of provinces	Oct. 1992
		-- Provision of needed health planning technical and managerial personnel to priority provinces (e.g., through transfer of existing personnel, establishment of incentives for relocation of personnel, hiring of short-term contractors).	Oct. 1991
		-- Regional and provincial health managers trained in health planning.	
		a. Priority provinces	Oct. 1991
		b. 50% of total provinces	Oct. 1992
		c. 100% of provinces	Oct. 1993

1/ Baseline figure to be confirmed in early 1990 when HIS becomes operational nationwide.
2/ To be measured using special population-based surveys.
3/ Total contraceptive prevalence includes program and non-program methods. (DOH HIS reports program method acceptance only.) Total CPR will be measured by 1988 National Demographic Survey, 1990 Contraceptive Prevalence Survey and 1993 National Demographic Survey.

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	TARGET DATE
D. Integration of Child Survival Services	Development of implementation arrangements for population activities outlined in the June 1989 "Integrated Population and Development Program Plan."	-- Completed implementation plan, which considers the administrative and financial feasibility of proposed actions, availability of human and financial resources, and commitment to proposed activities by all implementing agencies.	Oct. 1990
	Development of a national strategy to address malnutrition problems.	-- Completion of a prioritized work plan for the provision of comprehensive nutrition services, including implementation actions needed, time frame for completion and responsible agencies, including responsible agency concurrence.	Oct. 1990
	Integrated delivery of child survival-related services at the provincial level.	-- Completion and distribution of integrated MCH operations guide (including child spacing and nutrition activities).	Oct. 1990
		-- Training of provincial health workers in the integrated service approach.	
		a. Priority provinces	Oct. 1991
		b. 50 percent of total provinces	Oct. 1992
		c. 100 percent of provinces	Oct. 1993
	Integrated health information reporting at the local and national levels.	-- New Field Health Information System (FHIS) operational in all provinces, including an approved management policy statement identifying central, regional and provincial level staff responsible for FHIS operations and monitoring.	Oct. 1990
		-- Plan for the reorganization of the Health Intelligence Service approved, including the identification and training of staff to manage the Health Information System; strengthening of DOH central Health Intelligence Service staff (e.g., upgrade statistical, analytical skills); provide required staff at RHO and PHO levels for FHIS.	Oct. 1990
	Coordination of child survival-related programs at the national level.	-- Designation of DOH Assistant Secretary or DOH official at comparable level for coordination of all GOP and foreign-assisted child survival-related activities.	Oct. 1990
	Full implementation of program-based budgeting system at provincial, regional and national levels.	-- Program plan-based budgeting system (PPBS) in place and fully operational, including trained DOH staff.	Oct. 1991
	Participation of other GOP agencies providing child survival-related services in the development of integrated provincial health plans.	-- Integrated provincial health plans that include input from provincial representatives of other GOP agencies, e.g., PopCom, National Nutrition Council.	
		a. Priority provinces	Oct. 1991
		b. 50 percent of total provinces	Oct. 1992
		c. 100 percent of provinces	Oct. 1993

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	TARGET DATE
STRATEGY II: TO ENSURE THE SUSTAINED COMMITMENT TO, DEMAND FOR AND FINANCING OF CHILD SURVIVAL SERVICES THROUGH BOTH THE PRIVATE AND PUBLIC SECTORS.			
A. Government Commitment	Demonstrated commitment to increase DOH technical capability in HIS, epidemiology-based planning, IE&C and health care financing.	-- DOH-signed PIO/T for AID-direct financing of technical services in HIS, epid.-based planning, IE&C and HCF.	Prior to release of first tranche.
	Program budgeting of DOH demonstrates funding for child survival activities.	-- Activities planned by DOH to achieve performance targets are fully funded, as evidenced by advices of allotment. a. Priority provinces b. 50 percent of total provinces c. 100 percent of provinces	Prior to release of: a. 2nd tranche b. 3rd tranche c. 4th tranche
	AID-funded Field Epidemiology Training Program (FETP) institutionalized in DOH and used as a resource for targeted, epidemiological-based planning.	-- DOH organizational structure formally revised to incorporate FETP as a division or service, with permanent positions and budget established.	Oct. 1992
B. Internalizing the Demand for Preventive Health Services	Development and implementation of a plan to increase consumer demand for preventive health services.	-- IE&C plan for child survival is issued.	Oct. 1990
		-- IE&C plan is operational.	Oct. 1991
	Development of a strategy for internalizing promotive/preventive health behaviors.	-- Adoption and execution of a strategy promoting smaller family size, delayed marriages, complete immunizations, smoking cessation, early illness/disease intervention, etc.	Oct. 1992
C. Financial Sustainability	Development of a plan for an enhanced Medicare system.	-- Completion of a concept paper for a bilateral National Health Insurance Development project.	Oct. 1990
	Development of a health care financing strategy.	-- Completion of the research agenda and prioritized work plan for development of a comprehensive national HCF strategy. Strategy to include analysis to determine resources needed to sustain child survival-related services; resource generation, cost containment, private sector delivery of appropriate services, shifting role of GOP to regulatory/quality assurance.	Mar. 1991
	Development of a cost containment strategy for DOH services.	-- Completed study identifying potential cost containment actions, including contracting for clinical/support svcs. with private sector; procurement, distribution, storage of supplies; preventive maintenance; hospital shared svcs.	Oct. 1991
	Development of an improved cost recovery scheme for DOH facilities and services.	-- Completed analysis of user fees for DOH hosps., clinics, pharmaceuticals, with recommendations for strengthening user fee retention system.	Oct. 1991

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	TARGET DATE
D. Increased Private Sector Involvement	Development of plans for the privatization of the Philippine Heart Center, Philippine Children's Medical Center, the National Kidney Institute and the Lung Center of the Philippines.	-- Completion of the privatization plans for these four institutions and, in consultation with the Committee on Privatization, decisions made re: implementation of the plans.	Oct. 1990
	Establishment of partnerships for the provision of basic health services.	-- Implementation of a grant partnership program, including management arrangements, for provision of child survival-related services in geographically inaccessible areas by provincial-based NGOs.	Oct. 1990
	Expansion of private sector participation in health planning.	-- Consumer and private sector health provider representation on Provincial Health Councils in priority provinces.	Oct. 1990
	Development of a strategy for increased role of the private sector in the provision of health services.	-- Completion of a prioritized work plan for the increased role of the private sector, including a strategy for the privatization of health facilities, the areas of direct service provision; local provision of equipment, medicine and supplies; contract services; policy incentives to make provision of health svcs. more attractive to the private sector.	Oct. 1991
	Stimulation and facilitation of HMO development.	-- Proposed regulations and quality control guidelines for HMO operations.	Oct. 1991
		-- Develop a government/private sector risk-sharing program for HMO development.	Oct. 1992

IV. FUNDING REQUIREMENTS AND FINANCIAL PLAN

A. COST ESTIMATES AND FINANCIAL PLAN

The program will provide approximately $50 million in grant funds to the GOP over the four-year life of the program, subject to the availability of funds and to the tranching requirements set forth later in this section. Of this $50 million, approximately $45 million will be made available for performance-based disbursements directly to the GOP; an additional $5 million will be reserved to cover the technical assistance, monitoring, evaluation and audit requirements of the program. Table IV-1 shows the summary cost estimates for the various program components.

As shown in Table IV-2, approximately $4.25 million of the total grant funds will be used to finance an AID-direct contract with a U.S. or Philippine organization to provide the comprehensive long- and short-term advisory services outlined in this PAAD. This will fund some 184 person months of long- and short-term TA and provide $850,000 for subcontracting of local TA to be administered by the contractor. The local subcontracts will draw upon and strengthen local institutional capabilities to assist the DOH. Contract signing is projected to occur in late CY 89 (first quarter FY 90), after meeting the Condition Precedent on the Program Agreement's legal status. Approximately $2.0 million for TA will be obligated during the initial year of the program, with the balance to be obligated in year two.

In addition to the master TA contract, USAID will annually contract for progress review and/or evaluation services, as outlined in Section VI, probably with an 8(a) firm. Some $750,000 will be set aside for program monitoring; annual progress evaluations related to release of subsequent tranches; final impact evaluation at the end of the program; and possible audit requirements. Of this $750,000, the amount of $150,000 will be reserved for non-federal audits. Any unused monies for TA, monitoring, evaluation and audit will revert to sector assistance for disbursement to the GOP.

Table IV-1

SUMMARY COST ESTIMATES AND FINANCIAL PLAN
(Amounts in US$ 000)

	Component	FX	LC	Total
1.	Sector assistance	$45,000	$ -	$45,000
2.	Technical assistance	3,050	1,200	4,250
3.	Evaluation, monitoring and audit	350	400	750
	TOTAL	$48,400	$ 1,600	$50,000

Table IV-2

TECHNICAL ASSISTANCE, MONITORING, EVALUATION AND AUDIT BUDGET
(Amounts in US$ 000)

Component	FX	LC	Total
A. **Technical Assistance**			
1. Long-term Consultants:			
-- Compensation of 4 long-term advisers	$2,400	-	$2,400
-- Housing (rent, utilities, etc.)	-	$ 225	225
-- Transportation and per diem for four advisers)	50	125	175
SUBTOTAL - Long-term advisers	$2,450	$ 350	$2,800
2. Short-term consultants:			
-- 40 person-months	600	-	600
3. Subcontract for local technical and administrative support	-	850	850
Total Technical Assistance	3,050	1,200	4,250
B. **Monitoring, Evaluation and Audit**			
1. Program monitoring	-	250	250
2. Annual progress review			
-- Contract with 8(a) firm at $50,000 per review for 3 reviews	150	-	150
3. Midterm evaluation	100	-	100
4. Final evaluation	100	-	100
5. Non-federal audit	-	150	150
Total Monitoring, Evaluation & Audit	350	400	750
TOTAL TA, MONITORING, EVALUATION & AUDIT	$ 3,400	$1,600	$5,000

B. METHOD OF IMPLEMENTATION AND FINANCING

	Component	Method of Implementation	Method of Financing	Approximate Amount ($000)
1.	Sector assistance	Tranche release	Direct payment (dollar disbursement through EFT)	$45,000
2.	Technical assistance	AID-dir. contract	Direct payment	4,250
3.	Evaluation, monitoring and audit	AID-dir. contract	Direct payment	750
	TOTAL			$50,000

C. PLANNED YEARLY OBLIGATIONS BY FUNCTIONAL ACCOUNT AND PROGRAM COMPONENT ($000)

1. FUNCTIONAL ACCOUNT	FY 89	FY 90	FY 91	FY 92	TOTAL
Health -- NOA	$ 2,000	$12,879	$14,000	$12,000	$40,879
-- Reob	3,121	-0-	-0-	-0-	3,121
Population	6,000	-0-	-0-	-0-	6,000
TOTAL	$11,121	$12,879	$14,000	$12,000	$50,000

2. PROGRAM COMPONENT	FY 89	FY 90	FY 91	FY 92	TOTAL
Sector Assistance	$ 9,000	$11,000	$13,000	$12,000	$45,000
TA, Monitoring, Evaluation, Audit	2,121	1,879	1,000	-0-	5,000
TOTAL	$11,121	$12,879	$14,000	$12,000	$50,000

Approximately $6.0 million or twelve percent of the total of $50.0 million proposed for authorization for the Child Survival Program will be from the population account. The $6.0 in population funds are scheduled for obligation in the first year of the program, with no population funds obligated in the subsequent years of the program. This decision is influenced by functional account funding availabilities, and does not reflect the emphasis on population-related policy changes and service delivery coverage throughout the life of the program.

D. PROGRAM DISBURSEMENTS AND CONTROLS

1. Program Disbursements

USAID will disburse grant funds of approximately $45 million based on the GOP's performance as measured against the agreed upon policy changes and related performance indicators. Dollar disbursements, which will be effected through the electronic funds transfer (EFT) system, will be made by AID on behalf of the GOP and will be deposited into the bank account(s) specified by the GOP. Funds provided under the program may be used by the GOP for debt servicing or for such other purposes as AID may agree to in writing. These funds may not be commingled with other funds owned by the GOP.

Tranche releases will be made based on the following arrangements:

a. First Tranche: The criteria against which the initial disbursement will be made are: the GOP's acceptance of the Policy Matrix shown in Section III.C. of the PAAD, subject to minor revisions or clarifications as necessary; the GOP's determination of priority underserved geographic areas (the performance indicator is a priority-ranked list of provinces and cities, based on classification of provinces and cities using DOH-established high-risk and geographical access criteria); and the appropriate GOP signature on the PIO/T for program-funded advisory services.

b. Second, Third and Fourth Tranches: Near the end of the first, second and third years of the program, there will be an external review of progress achieved as measured against that year's policy objectives and performance benchmarks. Based on the results of each review, revised policy objectives and performance benchmarks for the subsequent year will be developed.

The expected tranche levels over the life of the program have been developed as shown in the Financial Plan based on agreement between the GOP and AID on the relative "value" of the policy and service delivery coverage changes proposed for implementation each year of the program. The tranching decision for the first year will be "go" or "no go;" i.e., the GOP will either receive 100 percent of the planned tranche amount or no tranche release at all. This tranching method will be reviewed and revised, if necessary, during the first annual program review.

Funds for TA, monitoring, evaluation and audit will be disbursed directly by USAID to the contractors. It is estimated that about $3.4 million will be paid in dollars while $1.6 million will be paid in local currency.

2. Financial Controls

Prior to any disbursement of dollars, the GOP will provide the following to AID:

a. An implementation plan specifying: (1) the responsibilities and interrelationships of the entities involved in the disbursement of the funds; (2) a schedule of payments, identifying payees, amounts and due dates of the loans proposed to be paid by the GOP using dollars provided in the tranche releases and any interest earned thereon; and (3) the type of

documentation to be obtained and maintained by the GOP evidencing use of dollars disbursed from funds provided through the Program; and

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

The submission of the schedule of payments and the implementation plan is a Condition Precedent (CP) to each tranche release. This will ensure that agreed-upon uses of the dollars are identified before tranche releases are made. The GOP may disburse the dollars upon written notification from AID that the CPs to the disbursement of dollars by the GOP have been satisfied. Within five working days after payments are made, the GOP will provide documents satisfactory to AID that the funds from the dollar accounts were utilized for the agreed-upon purposes.

E. GOP FINANCING

During the life of the program, the GOP will continue to provide funds to the DOH, through its regular cycle of budgetary appropriations, at the levels consistent with the priority given to the health sector. Since AID disbursements are performance-based, the GOP will not be required to put up the equivalent amount of pesos; however, as part of the policy agenda, the GOP will ensure that the required level of resources will be provided to the DOH, particularly those needed for the delivery of non-hospital field health (preventive) services, in order to achieve the program targets.

V. IMPLEMENTATION PLAN

The Child Survival Program will be managed by the USAID Office of Population, Health and Nutrition (OPHN). The Program Officer will be the Health Development Officer, who will be assisted by two Foreign Service National Program Specialists. Other USAID offices will be called upon to assist as needed with implementation issues specific to their areas of responsibility.

The principal GOP implementing agency will be the Department of Health, although the National Economic and Development Authority (NEDA), Department of Finance and Department of Budget and Management will be involved in implementation actions specific to their areas of responsibility.

A. PROGRAM PERFORMANCE INDICATORS

Implementation of the Child Survival Program involves GOP agreement to policy objectives; implementation of the policy objectives; and progress toward the end-of-program service delivery coverage indicators. Target achievement dates for performance benchmarks are outlined in the Policy Implementation Matrix.

The policy matrix includes two strategies for achieving policy change, with four categories of policy reform under each strategy. Policy objectives and performance benchmarks for the first year of the program have been developed and agreed to; proposed policy objectives and benchmarks for subsequent program years have been developed and are included in the matrix. The policy strategies and categories of reform will remain fixed for the life of the program, but the policy objectives and performance benchmarks will be updated annually on the basis of lessons learned from monitoring, annual reviews and the midterm evaluation.

Similarly, the end-of-program national service delivery coverage targets will remain fixed over the life of the program. However, beginning in year two, interim service delivery targets for the priority provinces and cities will be established annually by the DOH and reviewed at the annual progress review. This approach establishes AID/GOP consensus on both long- and short-term performance objectives and provides a system for annually reviewing and updating tactical action plans.

Over the four-year life of the program, the focus of program performance gradually shifts from policy changes to service delivery targets. Progress in the first year will be measured in the fall of 1990 solely against the agreed policy agenda. Progress achieved in the second and third years will be measured in the falls of 1991 and 1992, respectively, against a mix of policy changes and service delivery targets. Progress in the fourth year will be measured in the final program evaluation solely against the end-of-program service delivery coverage indicators. The policy change/service delivery indicators chart below shows the relative weights that will be given to policy changes and service delivery indicators in the development of each year's program performance plan.

PROGRAM YEAR	POLICY CHANGE INDICATORS	SERVICE DELIVERY COVERAGE INDICATORS
One (1990)	100 %	0 %
Two (1991)	75 %	25 %
Three (1992)	40 %	60 %
Four (1993)	0 %	100 %

Child survival service delivery coverage will be measured annually, primarily through DOH's Health Information System, beginning with the second year of the program. It is critical to the success of performance-based sector support for AID and the GOP to share a common understanding of outcome, stated in measurable terms. Accordingly, we have agreed upon the service delivery coverage indicators shown in the policy matrix for the Child Survival Program. Because the determinants for some coverage indicators are not exclusively within DOH's control, the indicators are presented in declining order of proximate DOH influence.

B. DOH IMPLEMENTATION

AID disbursements under the Child Survival Program are linked to GOP performance. However, it may be helpful to illustrate the process the DOH intends to follow in order to achieve the intended policy changes and increases in child survival-related service delivery levels.

The Child Survival Program will encourage DOH's expansion of existing child survival-related health services through the adoption of such policy changes as decentralized planning and budgeting, integration of services, and the intentional geographic and epidemiologic targeting of populations with the highest risks of infant, child and maternal morbidity and mortality.

Primary DOH services will be directly provided to clients by midwives in Barangay Health Stations and by the staff of Rural Health Units. Planning, financing and logistical support for field implementation will continue to come from Provincial Health Offices, with planning, supervision and some training support from the Regional Health Offices. Provincial DOH planning will also incorporate mobilization of the private sector and local government resources for child survival-related objectives. DOH central office services (MCH, family planning and nutrition) will continue to formulate technical standards for the various child survival-related services and provide training support and technical oversight over field personnel.

The MCH, Family Planning and Nutrition Services, under the direction of the Assistant Secretary for Public Health Services, will be responsible for the preparation and implementation of an annual central office plan for meeting child survival objectives. The plan is expected to consist primarily of activities supporting field operations in MCH, nutrition and family planning. The provincial health offices will be responsible for the

formulation and implementation of provincial plans, with technical assistance for planning made readily available through Regional Offices when required.

The prioritization of provinces and cities for expanded services and the selection of priority services will be accomplished prior to the release of the first program tranche. Underserved provinces and those with the highest rates of infant, child and maternal morbidity and mortality will be given top consideration. The targeting of services to priority provinces will be phased, starting with the highest-priority provinces in 1990, gradually expanding coverage until all provinces are included in the program of decentralized, targeted service delivery.

DOH will begin a series of consultative workshops during the last quarter of 1989 to orient all regions to the policy changes and planning guidelines for expansion of child survival services that will be implemented by DOH. The workshops will also serve as fora for refining the mechanism, criteria and process for the integration of child survival-related services and the decentralization of planning and budgeting.

Planning guidelines will be developed by the central DOH staff. These guidelines will include provisions for provincial-level, epidemiology-based plans, with budget amendments based on the plans' requirements. The plans will be reviewed by regional committees, which will focus on the plans' operational and technical feasibility and their consonance with regional plans. A central DOH committee will review and approve plans endorsed to it by the regional committees.

The central office of the DOH, primarily the office of the Assistant Secretary charged with coordination of child survival activities, will be responsible for overall day-to-day implementation. A monitoring and implementation unit within the DOH responsible for the IBRD project will serve as technical staff under the Assistant Secretary. The DOH Undersecretary and Chief of Staff will be the senior GOP counterpart responsible for this program.

The principal functions of this national-level coordination will be to: (a) monitor the preparation and execution of central, regional and provincial child survival plans to ensure that planning and implementation are accomplished in a timely manner; (b) assist in translating central, regional and provincial child survival proposals into work and financial plans, submit them to the Department of Budget and Management, and see to the timely issuance of funding warrants; and (c) direct supervision of implementation to ensure performance is achieved on schedule.

C. TECHNICAL ASSISTANCE PLAN

In addition to the $45 million authorized for performance-based disbursements to the GOP, about $4.25 million of program funds will be set aside for AID-direct provision of technical assistance in four areas: improvement of the health information system; epidemiology-based planning; social marketing/IE&C; and health care financing.

The technical assistance package, to be competitively procured, is designed to enhance the performance of the DOH in areas of mutual interest; utilize Filipino experts to the extent possible; assist in monitoring and

preparation for annual reviews; and strengthen DOH linkages with Filipino national and provincial technical assistance resource groups.

The TA package will include four long-term resident advisers and forty person months of short-term technical assistance in health care financing; statistical monitoring of performance, including HIS implementation; epidemiology-based planning; and social marketing, including IE&C. The TA package will also include local administrative support staff; funds for subcontracting of necessary operations and survey research related to functional areas of responsibility; and IQC-like subcontractual arrangements with local research and TA organizations so that local expertise can be quickly and easily tapped as needed.

The technical assistance package will be financed by USAID under an AID-direct contract with a U.S. or Philippine organization. The decision to contract for all TA with one entity was made after comparison of several alternative approaches, including the development of individual personal services or institutional contracts, use of Participating Agency Service Agreements or Technical Advisors in Child Survival from universities or the U.S. Public Health Service, or a combination of these approaches. However, use of one competitively-selected "umbrella" contractor will ensure that maximum coordination among TA advisers takes place. In addition, use of one contractor to manage several advisers will shift a large portion of the contract support and administration responsibility from USAID to the private sector.

Although USAID expects to provide the TA under an AID-direct contract, the DOH will be fully involved in the development of scopes of work and will collaborate with USAID in evaluating the TA proposals received. In the Request for Proposals, USAID will include as evaluation criteria the proponent's demonstrated knowledge of and access to local individuals and institutions that have capability in the required areas of expertise and the proponents' capability to enter into IQC-like contractual arrangements with local TA and research organizations.

Brief descriptions of the services to be provided by the four long-term advisers follow:

1. **Health Information System.** A revised integrated Health Information System (HIS) is to be installed by the Department of Health (DOH) by the end of 1989. Installation of the HIS and training of staff are scheduled for the first quarter of 1990. Assuring that the revised HIS can provide timely and useful program planning, coverage and monitoring data is essential for the development of the DOH's long-term planning capacity. Provision for a long-term adviser in this area will ensure that the HIS is fully developed and sustainable by enhancing DOH capabilities to manage the system and to utilize HIS data for targeting of services.

Specific TA activities will include the development of an HIS monitoring and evaluation system. One of the more urgent needs is for the development of a system for monitoring the nationwide implementation of the revised HIS, particularly in the early stages of implementation where there are likely to be many problems and questions. On a long-term basis, a system for the routine monitoring of HIS operations and evaluation of the quality of

the data will be required. In addition to systems design, this will require that central office and field staff have sufficient understanding of the HIS system to perform monitoring, evaluation and routine operational management functions.

The HIS adviser will also assist with the development of a central office computer capability for processing HIS data. At the present time, the DOH central office relies on "hard copies" of HIS output reports from the PHO level. The adviser will assist with the development of a timely and non-disruptive system for periodically modifying the HIS in response to the implementation of new nationwide health programs and/or changes in existing programs. In addition, as the HIS is based upon supervision/program management concepts that at present are not widely practiced in the DOH, training in the intended uses of the HIS data will be needed. The HIS adviser will also work to develop the DOH central staff capability to plan, manage and evaluate systems of data collection that are complementary to the HIS, e.g., population based surveys, coverage surveys, the National Health Survey and special studies.

2. **Epidemiology-based planning**. Improved targeting is necessary to reduce the variance in child survival rates among and within provinces and regions. Continued progress in targeting will require improved, epidemiology-based provincial health planning. The current constraint to improved targeting centers on the need to improve the epidemiologic soundness of plans to deliver child survival-related services to high risk groups. With basic health information generated by the new HIS as a tool, an epidemiology-based planning process can proceed.

The regional and provincial health offices, in particular, require assistance to implement needs-based planning. The new IBRD Philippine Health Development Project will address many training needs and will provide contractual provincial based planners. While the IBRD project recognizes the need for targeting of services, it is not the principal focus of the project-funded planning TA, and long-term advisers in planning are not contemplated.

The planning adviser under the Child Survival Project will have two principal functions: to assist the DOH in the development of its epidemiology-based planning capability, especially at the regional and provincial levels, and to assist with the implementation of decentralization-related policy changes. The assistance with development of planning skills will focus on improving both functional and geographic targeting, program planning and budgeting at the provincial level, and providing guidance to DOH on the allocation of resources by area and function in order to address equity and efficiency concerns. The adviser will also monitor the integration of child survival program planning at the national level.

3. **Social Marketing/IE&C**. Experience has demonstrated that social marketing can be useful to preventive health and child spacing programs in many ways, but can especially increase public awareness of the value of health practices and can lead to an increased demand for services or interventions that enable the consumer to practice positive health behaviors. One example is the role of social marketing in generating a demand for immunization services at health centers. Promotion of immunization for an illness like

measles, which mothers believe leads to fatal complications like pneumonia, can be used as a "hook" to generate demand for complete immunization.

The primary objective of IE&C TA will be to assist the DOH to address the demand constraint to greater utilization and access to health and child spacing services. The adviser will help sustain these communications approaches by providing inputs to the IE&C planning process.

The IE&C advisory services will build upon the two and a half years of TA provided through a PHCF Project buy-in to the AID/W Health Communications Project (HealthCom). Most of that effort to date has been limited to market research and pilot testing of EPI and ORT campaigns in limited geographical areas, with only minimal institutionalization within DOH. Continuation of the HealthCom-assisted institutional development of PIHES is expected, with capacity building for effective collaboration with private sector market research and advertising agencies (social marketing) a primary ingredient of this approach. Development of a national IE&C plan, which is also an objective of the IBRD project, will be a shared responsibility of the IE&C adviser.

4. Health Care Financing. TA in the area of health care financing will primarily address the financial sustainability of child survival-related services. The adviser's tasks will include exploring ways to generate resources for child survival services, such as expanding the role of the private sector (both NGOs and commercial firms); cost recovery schemes; and the realization of cost efficiencies, especially in public-financed curative services. The role of the health care financing adviser is not only to address technical issues regarding the financing of health care, but to systematically and creatively work with the DOH on the broader health policy issues related to financial sustainability and efficiency, in the delivery of expanded preventive services as well as in the larger health sector. In this context, the adviser will assist with the development of the Medicare system and will provide advisory services in areas including the development of franchising schemes, National Health Insurance, and other health care financing areas addressed in the section on the Policy Agenda.

D. IMPLEMENTATION SCHEDULE

	Implementation Action	Actor(s)	Date
FY 89	Program Agreement signed	USAID, NEDA	Sep. 1989
FY 90	PIL No. 1 issued	USAID	Oct. 1989
	Priority provinces selected	DOH	Oct. 1989
	PIO/T for Program TA signed	USAID, DOH	Oct. 1989
	RFP for long-term advisers issued	USAID	Oct. 1989
	Evaluate proposals for L/T advisers	USAID, DOH	Dec. 1990
	Contract for L/T advisers signed	USAID, Contractor	Jan. 1990
	First tranche deposited with Treasury	USAID	Jan. 1990
	L/T advisers arrive in country	USAID, Contractor	Apr. 1990
	Grant Agreement Amendment for incremental funding	USAID, NEDA, DOH	Jul. 1990
FY 91	Review of 1990 accomplishments	Ind. Contractor, USAID, DOH	Nov. 1990
	Agreement on 1991 performance targets	USAID, DOH	Nov. 1990
	Second tranche deposited with Treasury	USAID	Jan. 1991
	Grant Agreement Amendment for incremental funding	USAID, NEDA, DOH	Jul. 1991
FY 92	Mid-program evaluation/review of 1991 accomplishments	Ind. Contractor, USAID, DOH	Nov. 1991
	Agreement on 1992 performance targets	USAID, DOH	Nov. 1991
	Submission of revised policy matrix to AID/W	USAID	Dec. 1991
	Third tranche deposited with Treasury	USAID	Jan. 1992
	Grant Agreement Amendment for incremental funding	USAID, NEDA, DOH	Jul. 1992
FY 93	Review of 1992 accomplishments	Ind. Contractor, USAID, DOH	Nov. 1992
	Agreement on 1993 performance targets	USAID, DOH	Nov. 1992
	Fourth tranche deposited with Treasury	USAID	Jan. 1993
FY 94	Final Program Evaluation	USAID, DOH, Ind. Contractor	Jan. 1994

VI. MONITORING, EVALUATION AND AUDIT

A. MONITORING

Within USAID, program implementation will be the responsibility of OPHN. In consultation with other USAID offices, OPHN will provide routine monitoring of program implementation including adherence to the implementation schedule; management and monitoring of technical assistance, progress reviews, midterm and final evaluations; and monitoring the performance of DOH in the intervals between annual progress reviews.

USAID's routine monitoring of DOH performance will be done in close collaboration with the technical assistance advisers and will focus on assessing the adequacy of the program design; resolving unanticipated implementation problems; maximizing the impact of the TA inputs; formulating the scopes of work for the annual progress reviews, midterm and final evaluations; and preparing the draft policy implementation matrix for implementation the following year.

B. ANNUAL PROGRESS REVIEWS

Of the $50 million in program assistance funds, $600,000 will be set aside for AID-direct contracting of services for annual progress reviews, and for the midterm and final evaluations.

In August 1990, USAID will prepare a scope of work and PIO/T for the procurement of services necessary for conducting the November 1990 progress review. The progress review will assess the performance of the GOP against the agreed policy objectives and performance benchmarks for that year. USAID will determine whether to disburse the second tranche of program funds based on the results of this review. At the same time, USAID and DOH will agree on the policy objectives and performance benchmarks to be achieved during the second year of the program, as well as establish interim service delivery targets for the priority provinces.

The second and third annual progress reviews, to be held in November 1991 and 1992, respectively, will follow the same format: examination of DOH progress in meeting the agreed objectives and benchmarks, including the annual service delivery targets set the previous November. USAID will again determine whether to disburse the next tranche based on the results of the review.

C. MIDTERM AND FINAL EVALUATIONS

The team that conducts the second annual review in November 1991 will concurrently perform the program's midterm evaluation. The evaluation will be both process- and impact-oriented, focusing on the extent to which the DOH has accomplished: (a) the policy objectives agreed to at the time of the Grant Agreement and those established annually by DOH; (b) the annual service delivery coverage indicators established by the priority provinces; and (c) movement toward the national end-of-program service delivery coverage indicators. The evaluation will also review the process of program implementation (annual reviews and establishment of performance benchmarks; tranche disbursements; implementation of TA activities; etc.) and will include

recommendations for any needed revisions to the implementation design for the second half of the program. DOH will participate in the development of the scope of work for the midterm evaluation, as well as in the evaluation itself.

Based on the results of the evaluation, USAID and DOH will amend the program's policy matrix and implementation arrangements, as needed. The revised policy matrix will be sent to AID/W for review and concurrence prior to formal agreement to the third year's policy agenda and disbursement of the third program tranche.

The end-of-program impact evaluation, scheduled for January - March 1994, will determine whether the program achieved its end-of-program service delivery and policy reform targets. In addition, the evaluation will review the overall child survival strategy and program mode of assistance. The DOH will participate in the development of the scope of work for the final evaluation, and is expected to actively contribute to the actual evaluation. The primary users of the information collected under the program will be USAID/Philippines; the Department of Health; NEDA; and other USAID country missions that are considering the development of similar programs.

Following are the priority questions to be addressed by the program evaluation at the goal, purpose and output levels. (The program's goal, purpose and outputs are summarized in Annex C, Logical Framework.)

-- To what extent have the program activities helped USAID and the GOP to contribute to a reduction in the variance in infant and child mortality and morbidity rates among and within regions and provinces, and to lower the corresponding national rates?

-- Is the program contributing to an increase in the availability, utilization and sustainability of child survival-related services, including child spacing? Has the program contributed to an increase in these services to underserved and high-risk groups?

-- What specific outputs has the program produced? Have the specified policy changes been accomplished?

The key methods used to answer the management questions outlined above will include a review of program documentation; key informant interviews of the users of the information; interviews of program implementors; and routine monitoring documentation.

The annual progress reviews, midterm and final evaluations will be completed by contractors independent of the TA contractor. USAID plans to contract with a qualified 8(a) or Gray Amendment firm for the annual progress reviews, midterm and final evaluations.

D. AUDIT SERVICES

Primary responsibility for audits of AID programs lies with the Regional Inspector General for Audit (RIG/A); however, non-federal auditors may be contracted by RIG/A for the purpose. Of the the total grant funds, $150,000 has been allotted for non-federal audit services to be rendered by U.S. and/or local auditing firms. It is anticipated that the audit will cover the financial and compliance aspects of the program.

VII. SUMMARIES OF PROGRAM ANALYSES

A. FINANCIAL ANALYSIS

1. Need for and Impact of USAID Assistance

The need for additional assistance is clearly demonstrated in the DOH's budget for its child survival-related programs over the next five years (Annex G, Table 1). The budget shows total requirements of P5.655 billion, equivalent to $269.3 million at an exchange rate of P21 to $1. Of this amount, only 75 percent, approximately $202 million, is certain to be funded. At the time of PAAD preparation, DOH expected the following: GOP -- 32.1 percent; United Nations Fund for Population Activities, Rotary and other private sector sources -- 21.2 percent; USAID (present and proposed project activities) -- 16.4 percent; IBRD (through the Philippine Health Development Project) -- 3.1 percent; CIDA -- 0.9 percent; and WHO -- 0.04 percent. (See Annex G, Table 2.)

Funding sources for the remaining 25 percent or $67.3 million of the total budget have not been identified. The proposed $45 million in performance-based disbursements to the GOP could potentially free up GOP funds to cover about 67 percent of the unsourced budget requirements, thereby alleviating the GOP's funding problems, which limit its ability to provide much needed health services to the people.

Current donor assistance, including AID's PHCF Project, is concentrated in selected national programs such as EPI and CDD, which makes it difficult to either address integrated health programming or target areas of greatest need to maximize benefits to the mother and child target group. Program assistance will address this need by providing performance-based disbursements to the GOP that can be programmed to meet specific health needs, particularly at the provincial level.

2. Sustainability

The anticipated growth in the overall economy and the increasing share of the national budget going to the health sector are positive indications that the GOP may be able to sustain program activities after the end of the program. However, these positive developments are not adequate assurance that the GOP will indeed be able to continue program activities. The GOP must undertake further cost reduction strategies to be able to finance the program's recurrent costs. One way this can be done is to reallocate the health budget so that preventive services receive a larger budget portion than hospital-based (curative) services. The GOP should also encourage the private sector to increase its involvement in the provision of health care services to ease the government's burden.

B. ECONOMIC ANALYSIS

Although a conventional economic cost-benefit analysis is difficult to undertake in terms of quantifying the program's costs and benefits, the program's potential benefits appear large enough to outweigh the program's costs.

Benefits of the program include: (1) overall improvement in health status; (2) reduction in health status variances among regions and provinces; (3) expansion in child survival-related health service coverage; (4) increased future earnings and higher productivity of children saved; (5) reduction in costs of treating illnesses which are avoided or made less severe, e.g., savings in public health expenditures due to reduced incidence of communicable and preventable illnesses; (6) enhanced overall efficiency and effectiveness of tne DOH's child survival-related services through decentralized planning, integration of existing health programs, and concentration of child survival-related services to underserved and high-risk geographical areas of the country; and (7) expansion of private sector participation in the provision of health services.

The client-targeting strategy that the assistance program will adopt will ensure that resources will go to population groups most in need of care. The benefits arising from the equity dimension of such a strategy are immeasurable. The public health nature of the assistance indicates a focus on the health status of high-risk groups that could, in turn, help drastically reduce the probability of epidemics, a drain on the inadequate health budget and a cause for substantial economic losses.

Coupled with the strengthening of the HIS, decentralization of health management and planning can be an effective means of overcoming inefficiency, wastage and cost escalation due to the inability of central planners to assess the real needs of local populations. Greater involvement of district and provincial health officers in targeting clients, budgeting and planning is expected to result in better identification of needs and better utilization of scarce financial resources.

Integration of services is based on the principles of economies of scale and economies of scope. Integration efforts will provide greater coordination of donor-funded activities, thus preventing duplication and easier program management. Integration of activities such as IE&C, training and logistics will redound to a more cost-effective program.

A positive outlook exists for a three-fold increase in the health sector budget allocation in the short term. In the long run, reductions in the financial requirements of child survival services may be realized as a result of better health status, reduction in population growth, institutional deficiencies gained and technological developments.

Better health reduces the frequency of illness and the probability of complications among those who do get sick, and these translate directly into cost reduction. Large scale preventive health measures also reduce the probability of epidemics, control of which is very costly. Also, USAID assistance encourages the DOH to consider: (1) adopting alternative health care financing schemes; (2) expanding the present coverage of the Medicare system; (3) imposing user fees; (4) reviewing the hospital subsidy program; (5) contracting out some government health services; (6) undertaking networking arrangements with the private sector; (7) exploring private sector alternatives for the delivery of services currently provided by the government; (8) increasing the involvement of NGOs in health development; and (9) possibly privatizing specialized quaternary hospitals, which are a big drain on DOH's resources. The impact of these efforts on financial

sustainability is not likely to be felt in the near future but is more likely to be realized in the longer term.

The following analysis demonstrates that the program assistance is likely to achieve sufficient benefits to cover the costs. Given the economic cost of the program of $45 million, the social discount rate in the Philippines is used to determine the required economic impact to justify the investment in the program assistance. In order to do this, the following simplifying assumptions are used: (1) program funds are disbursed immediately upon signing of the grant agreement; (2) economic returns over a twenty-year period will flow evenly beginning in the first year for each dollar invested; (3) no new returns are attributed to the program after its completion; and (4) an exchange rate of P21.00:$1.00 prevails.

Using the NEDA estimated social rate of discount of 15 percent (capital recovery factor for years one to twenty = 0.159761), the program assistance must achieve an annual economic benefit of P151.0 million annually to cover the total cost of the assistance. The likelihood of achieving the required level of annual benefits may be demonstrated by comparing its magnitude to the health care expenditures of Filipino families per year.

Results of the 1988 Family Income and Expenditures Survey (FIES) show that a Filipino family typically spends 1.7 percent of its total expenditures on medical care. Given average family expenditures of P32,214 per year, a typical family spent an average of P548 in health care in 1988. With total number of families of 10.7 million, total family expenditures in health care reached P5.8 billion in 1988. This P5.8 billion represents health care expenditures of all members of the family (an average of 6 members). Assuming that a typical family has two members 0-6 years of age and assuming that family members spend an equal amount on health care, total health expenditure of children is about P1.8 billion a year, an amount that can be drastically reduced (and therefore saved) given a comprehensive child survival program. The minimum required benefits of P151.0 million annually require only an 8.4 percent reduction in the current level of spending on children's health per year.

The above analysis assumes uniform income elasticity of health services across households. In the Philippines, this may not be the case considering the high income disparities among households, i.e., lower income households have smaller budget allocation for health care while higher income households have bigger budget allocations for the same expenditure item. In order to address this issue, family expenditures on children's health by income class were used instead of the overall family expenditures on health. In the absence of the income decile data for 1988 (still being processed), results of the 1985 FIES were used.

The 1985 FIES shows that the lowest income class spent 1.2 percent of family expenditures on medical care, while the highest income class spent 2.5 percent. Using the varied proportions of family expenditures on medical care for each income decile, it is estimated that total medical care spent on children for the year of all income classes reached P1.86 billion. This shows that the minimum required benefits of P151.0 million annually require only an 8.1 percent reduction in the current level of family spending on children's health per year. This indicates a great likelihood that the required minimum benefits will be achieved.

In terms of cost-effectiveness, worldwide experience has shown that the activities to be undertaken in the program as a whole are cost-effective since (1) they have a definite bias toward preventive rather than curative care (e.g., immunization versus treatment); (2) they emphasize early detection and monitoring (e.g., use of growth charts and home-based mothers' records); and (3) they make use of low-cost proven technologies (e.g., midwife or home-based treatments of respiratory infections and oral rehydration therapy).

C. SOCIAL SOUNDNESS ANALYSIS

The purpose of the Child Survival Program is to increase the availability, utilization and sustainability of child survival-related services, in order to contribute to the goal of reducing infant and child mortality and morbidity rates. The program emphasizes the targeting of underserved and high-risk groups, so that the program goal will be achieved chiefly through the reduction in the variance in the infant and child mortality and morbidity rates among and within provinces and regions. The high mortality rate in the under-five population has been identified as a significant development problem because of its negative impact on the overall socioeconomic well-being of the country.

The DOH child survival-related services are all embodied in its integrated MCH program, which the USAID program will strengthen. The direct beneficiaries of the program are the estimated nine million Filipino children below the age of five and the 13.5 million married women of reproductive age, particularly the two million who are expected to become pregnant each year. The benefits that will accrue to child beneficiaries are in the form of goods and services that will promote health and prevent premature mortality, such as immunizations, oral rehydration salts for diarrhea, drugs to control pneumonia, etc. Women beneficiaries can expect the following benefits: regular pre- and postnatal care, maternity services, tetanus toxoid administration, and a broad range of contraceptive supplies and services.

The cultural acceptability of the MCH program interventions is not considered an issue, as the interventions have been widely promoted by the DOH over the past several years, and the services have been well patronized by the population. Although family planning services are not supported by the Roman Catholic Church, the major religious institution in the Philippines, family planning is politically and culturally acceptable, evidenced by the GOP Medium Term Philippine Development Plan, the May 1987 population policy, its prominence in the August 1989 State of the Nation address, and confirmed by the National Demographic Surveys of 1988, 1983 and 1973; the 1978 Philippines Fertility Study; and the Contraceptive Prevalence Survey of 1986.

The Child Survival Program is designed to ensure that benefits reach the intended primary beneficiaries. These assurances are provided by such program features as deliberate targeting of underserved and high-risk areas; decentralization of program planning and budgeting; and direct releases of funds to provinces. The DOH is also seriously addressing the issue of sustaining the levels and intensity of the expanded child survival services beyond the period of USAID support. Section III.B. of the PAAD outlines the various efforts that are being considered to ensure sustainability, from both inside and outside the program.

Contributing to the lowering of infant and young child mortality and morbidity rates will be the major achievement resulting from the Child Survival Program, although changes in these rates can not be accurately measured within the life of the program. Lowering of these rates is expected to produce in turn a significant economic impact, to be brought about by reduced treatment costs for illnesses avoided and future earnings of children saved. The policy changes that will be implemented during the course of the program will significantly improve the DOH system of planning and delivery of services. The linkages between increased child survival rates and reduced population growth rates make the economic impact of the program very significant, because population growth rates have a strong correlation to the country's real economic gains.

The goal, purpose and general design of the Child Survival Program reveal features that point to its social soundness. It responds to a real social and developmental need and its design has taken into account the lessons and experiences that the DOH has accumulated in the delivery of child survival-related services. During the planning of this program a thorough analysis was made of the various constraints that prevent the DOH from maximizing its capacity to delivery MCH services, and the program's implementation strategy is intended to address precisely these constraints and ensure long-term sustainability. On these bases, the Child Survival Program, as designed, is determined to be socially sound.

D. INSTITUTIONAL ANALYSIS

1. Current Capabilities for Health Planning

Planning in the DOH has essentially been top-down in the sense that general guidelines and targets have been set at the national level. The tendency to mechanically adopt national program targets and priorities has often reduced subnational health planning to a routine exercise in computing numeric coverage targets. Needs assessment has often been limited to computing the numbers of eligible people for specific services.

While there are existing mechanisms for intersectoral health planning at the provincial and regional levels, these are generally weak and inoperative. In most cases, operational health plans for each province are prepared by the program coordinator of the Integrated Provincial Health Office (IPHO).

Technical and managerial skills at the provincial and city levels need development. Capabilities for epidemiology-based planning are especially weak, particularly the provinces and cities with the greatest needs. This poses a targeting problem, as there is need to be both efficient and equitable in the allocation of program resources. On the plus side, DOH field officers do recognize the need for focused planning and service delivery, and have expressed willingness to learn how this can best be done at their level.

2. Plans for Strengthening Subnational Health Planning

The recently approved Philippine Health Development Project financed by the IBRD provides for the improvement of health planning and management capabilities at the regional and provincial levels. All provinces are expected to prepare five-year health development plans by 1990. The planning

exercise is expected to have intersectoral participation. A special training cum practicum exercise will be set in motion to technically prepare the IPHOs for their substantive role in the formulation of provincial health plans and preparation of corresponding budget proposals. Under PHDP, a Committee for Community Health Policy will be established to define strategies for reaching tne most deprived and underserved communities in the country, and to establish partnership arrangements with NGOs and local government units.

A National Task Force on Comprehensive Maternal and Child Health has been organized under the Office of the Undersecretary for Public Health Services, which will contribute to integrated delivery of MCH services as well as planning at all levels through the issuance of a field operations manual.

At the subnational level, administrative reforms accelerated since 1986 have set the stage for effective decentralization of planning and financial management of health services in 1990 and beyond. There is also a higher level of commitment and support for child survival services among provincial and city health officers and staff. What is usually lacking is systematized, decentralized planning to achieve the most results.

3. Suggested Criteria for Targeting Services

The uneven spread of problems and opportunities for child survival makes it necessary to focus attention on priority programs and geographic areas. Among the proposed criteria for prioritizing functional programs and geographic areas are: (a) focus on priority child problems that have not been adequately addressed by existing programs such as ARI; (b) expand support for the most cost-effective programs; (c) focus on provinces and cities with many underserved areas/groups; and (d) classify cities and provinces according to needs and capabilities, with corresponding planning or management models for each type.

4. Program Implementation Actions

In order to achieve more precise, accurate targeting of program and geographic areas, immediate attention will be given to the revalidation of the data base for identifying priority areas. Key indicators to be used will include health status and degree of geographic accessibility. Second, geographic areas in need of additional midwife services should be identified, as they are the front line staff required to achieve the desired levels of service coverage. Finally, strengthening of regional and provincial health planning capabilities is another priority implementation action. Technical assistance will be required to undertake the above tasks, including the training of provincial health planners on the processes and methods of epidemiology-based health planning, targeting and health information system management.

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VII. CONDITIONS PRECEDENT AND COVENANTS

A. CONDITIONS PRECEDENT TO DISBURSEMENT

1. Initial Disbursement:

a. A written opinion of counsel acceptable to AID that the Grant Agreement has been duly authorized and/or ratified by, and executed on behalf of the GOP, and that it constitutes a valid and legally binding obligation of the GOP in accordance with all of its terms.

b. A written statement setting forth the names and titles of persons holding or acting in the Office of the GOP and of any additional representatives, and representing that the named person or persons have the authority to act as the representative or representatives of the GOP, together with a specimen signature of each such person certified as to its authenticity.

c. Agreement in writing to PIO/Ts for technical assistance as described in the Program Description (Annex 1 to the Grant Agreement).

2. Initial Performance-Based Disbursement:

a. Written, agreed-upon policy objectives and performance benchmarks for the first year of the program.

b. A list of the priority provinces and cities for expanded coverage of child survival services.

c. An implementation plan specifying: (1) the responsibilities and interrelationships of the entities involved in the receipt and disbursement of U.S. dollar funds; (2) a schedule of payments, identifying payees, amounts and due dates of the loans, proposed to be made by the GOP using U.S. dollars provided in the tranche releases and any interest earned thereon; and (3) the type of documentation to be obtained and maintained by or on behalf of the GOP evidencing the use of U.S. dollars disbursed from funds provided through the Program.

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

e. Evidence that conditions precedent in Section VII.A.1. above have been met.

3. Each Subsequent Performance-Based Disbursement:

a. Written evidence of performance in meeting the performance benchmarks for the prior year as agreed upon with AID.

b. A written agreement on the policy objectives and performance benchmarks for the ensuing year.

c. An implementation plan as specified under Section VII.A.2(c) above.

d. A statement as specified under Section VII.A.2(d) above.

e. Written evidence that the payments specified pursuant to paragraph (c) above in connection with any prior disbursement of U.S. dollars have been made in accordance with Section 5.2 of the Grant Agreement ("Disbursements from U.S. Dollar Account").

B. SPECIAL COVENANTS

1. U.S. Dollar Account

U.S. dollars being held in the account identified by the GOP shall not be commingled with funds from any other source, provided however that the account shall include interest, if any, earned on funds held in the account. The GOP shall promptly furnish to AID in form and substance satisfactory to AID: (a) documentation evidencing deposits into the account and (b) periodic statements of balances held in the account, including interest, if any, earned on funds held therein.

2. Disbursements from U.S. Dollar Account

U.S. dollars held in the account referred to above shall be disbursed by the Central Bank of the Philippines in accordance with the implementation plan submitted in satisfaction of the implementation plan specified in Sections VII.2(c) and VII.3(c) to pay debt service obligations of the GOP (other than obligations incurred for public corporations) and of the Central Bank of the Philippines to the International Monetary Fund, the IBRD, the International Development Association, or the Asian Development Bank, in accordance with the schedules of payments provided pursuant to Section 3.3 of the Grant Agreement (terminal date for submission for requests for disbursement). Funds held in the account shall be used solely for the foregoing purpose, or for such other purposes as AID and the GOP may mutually agree upon, until all funds held in said account from time to time have been disbursed for such purpose.

3. Review of Policy Reforms, Objectives and Benchmarks

The GOP agrees to conduct annual reviews in cooperation with AID and the monitoring contractor of progress being made toward policy reforms to be implemented by the GOP, as set forth in the Program Description (Annex 1 to the Grant Agreement), along with the actions undertaken in support of the policy objectives and benchmarks agreed upon the previous year, and to agree with AID on the policy objectives and performance benchmarks for the ensuing year.

4. Program Evaluation

AID and the GOP agree to conduct a midterm and final evaluation as part of the program. Except as AID and the GOP otherwise agree in writing, the evaluations will include the elements of the evaluation component as set forth in the Program Description (Annex 1 to the Grant Agreement).

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ANNEX A

GOP LETTER OF REQUEST

ANNEX A

REPUBLIC OF THE PHILIPPINES
NATIONAL ECONOMIC AND DEVELOPMENT AUTHORITY
NEDA sa Pasig, Amber Avenue Pasig, Metro Manila

Cable Address: NEDAPHIL
P.O. Box 419, Greenhills
Tels. 673-50-31 to 50

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USAID/C&R

Mr. Malcolm Butler
Mission Director
U.S. Agency for International
Development
Ramon Magsaysay Center Bldg.
Roxas Blvd., Manila

Dear Director Butler:

We would like to request for USAID grant assistance in the amount of $50 million for the proposed Child Survival Program. To be implemented by the Department of Health, the said program aims to help achieve child survival objectives in the Medium Term Development Plan by increasing the availability and utilization of child survival-related services, including child spacing, to underserved and high-risk groups. The program assistance will be utilized over a period of four (4) years with the first annual tranche expected to be obtained in early FY 1990.

It is also envisioned that a significant portion of the program assistance will be used as parallel financing for key components of the Philippine Health Development Project loan recently negotiated with the World Bank which are consistent with the said program's objectives.

Attached is a copy of the Department of Health's request for the said program assistance.

We shall highly appreciate USAID's favorable consideration of this request.

With best regards.

Very truly yours,

FLORIAN A. ALBURO
Acting Director-General

cc: Secretary Alfredo R.A. Bengzon, DOH
Undersecretary Mario M. Taguiwalo, DOH

ANNEX B

PAIP APPROVAL CABLE

ACTION: AID-6 INFO: AMB DCM AA ECON/10 SF

VZCZCML0542 02-AUG-89 TOR: 16:28
PP RUEHML CN: 14321
DE RUEHC #5039/01 2141625 CHRG: AID
ZNR UUUUU ZZH DIST: AID
P 021620Z AUG 89 ADD: SF
FM SECSTATE WASHDC
TO AMEMBASSY MANILA PRIORITY 7224
BT
UNCLAS SECTION 01 OF 03 STATE 245039

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: CHILD SURVIVAL PROGRAM (492-0406) - APPROVAL OF PAIP

1. SUMMARY. AA/ANE APPROVES THE PROGRAM ASSISTANCE INITIAL PROPOSAL (PAIP) FOR THE CHILD SURVIVAL PROGRAM AND REDELEGATES AUTHORITY TO APPROVE THE PROGRAM ASSISTANCE APPROVAL DOCUMENT (PAAD) TO THE MISSION DIRECTOR. HOWEVER, WE ASK THE MISSION TO REVIEW SOME POSSIBLE ADDITIONAL ASPECTS OF THE POLICY AGENDA AND PROVIDE CRITERIA AGAINST WHICH PROGRESS WILL BE MEASURED AND AGAINST WHICH DISBURSEMENTS WILL BE MADE FOR AID/W REVIEW. THE PAAD SHOULD ALSO COVER THE OTHER ISSUES AND CONCERNS COVERED IN THIS CABLE. END SUMMARY.

2. THE POLICY AGENDA. THE PROJECT COMMITTEE REVIEWED THE PAIP JUNE 21. OUR PRINCIPAL CONCERN WAS THAT THE CRITERIA AGAINST WHICH PROGRESS TOWARD THE POLICY AGENDA WOULD BE MEASURED LACKED SPECIFICITY. WE DID NOTE THAT THIS PROGRAM HAD BEEN BROUGHT FORWARD FROM A FY 1990 TO A FY 1989 START AND THAT THIS HAS REQUIRED PAIP SUBMISSION BEFORE MANY ASPECTS OF THE POLICY AGENDA AND MEASUREMENT CRITERIA COULD BE WORKED OUT. WE FOUND THE AREAS FOR REFORM INDICATED IN THE PAIP TO BE A GOOD BASIS FOR THE POLICY AGENDA, BUT THE SUBSTANCE OF WHAT IS TO BE IMPROVED AND PERFORMANCE INDICATORS TO MEASURE PROGRESS NEED ELABORATION.

RATHER THAN ASKING TO SEE THE PAAD BEFORE APPROVAL, WE ASK THAT YOU SEND US THE FINAL POLICY AGENDA AND PERFORMANCE INDICATORS FOR A QUICK TURN-AROUND REVIEW BY AID/W WHEN THEY ARE MORE DEFINED AND THERE HAVE BEEN PRELIMINARY DISCUSSIONS WITH GOP, BUT BEFORE FINAL PAAD AUTHORIZATION AND INCLUSION IN THE PROGRAM AGREEMENT. THIS PROCESS HAS WORKED WELL WITH OTHER MISSIONS' SECTOR PROGRAMS WHEN THERE HAS NOT BEEN ENOUGH TIME TO WORK OUT DETAILS AT THE PAIP STAGE.

3. PROGRESS REVIEW. IN KEEPING WITH BUREAU PRACTICE WITH POLICY-RELATED ASSISTANCE, WE ASK THAT YOU ESTABLISH AN AGREED UPON POINT ABOUT 18-24 MONTHS INTO

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THE PROGRAM TO REVIEW PROGRESS WITH THE DEPARTMENT OF HEALTH, ASSURE THE CONTINUED APPROPRIATENESS OF THE BENCHMARKS BASED ON THE EPIDEMIOLOGICAL-BASED PLANNING BUILT INTO THE PROGRAM, AND MAKE ANY NECESSARY ADJUSTMENTS TO THE POLICY AGENDA AND BENCHMARKS. A REPORT OF PROGRESS AND ANY CHANGES IN AGENDA AND BENCHMARKS SHOULD BE SUBMITTED FOR AID/W CONCURRENCE BEFORE THIRD YEAR FUNDING IS APPROVED.

4. DESIGN OF MEASUREMENT CRITERIA FOR THE POLICY AGENDA.

THE TECHNICAL CONTENT OF THE AGENDA COULD BE ORGANIZED AROUND A CORE AGENDA FOLLOWED BY A MENU OF OTHER ITEMS THAT SUPPORT AND EXPAND ON CORE CONCERNS WITH INDICATORS BY WHICH PROGRESS CAN BE VERIFIED. THE CRITERIA FOR MEASUREMENT OF PROGRESS TOWARDS POLICY REFORMS SET BY THE USAID AND GOP FOR THE FOUR YEAR PROGRAM MUST BE EASILY MEASURED BY STANDARDS OR TESTS THAT BOTH A.I.D AND GOP WOULD SEE THE SAME WAY.

EARLY DISBURSEMENT CONDITIONS PRECEDENT MAY BE BASED ON PLANS FOR POLICY REFORMS SUCH AS: PLANS IN PLACE, LEGISLATION PROPOSED/APPROVED, INCREASED BUDGET FOR UNDERSERVED PROVINCES AND INCREASED COVERAGE WITH PARTICULAR SERVICES (MCH, BIRTH SPACING, ORS, ETC.). LATER INDICATORS (THIRD OR FOURTH YEARS), MIGHT BE PROCESS INDICATORS OF SERVICE DELIVERY AS WELL AS ADMINISTRATIVE REFORMS SUCH AS THE PERCENT OF IMMUNIZED TARGET POPULATION, PERCENT OF CHILDREN/INFANTS WITH DIARRHEA TREATED WITH ORT, CONTRACEPTIVE PREVALENCE,

IMPROVEMENT IN NUTRITIONAL STATUS OF TARGETTED AGE GROUPS, CHANGES IN WEANING PRACTICES, ETC.

JHU TIER 3 IMPACT EVALUATION WORK MAY PROVIDE SOME MORE SOPHISTICATED INDICATORS. BUT WITH FOCUS ON A NUMBER OF UNDERSERVED AREAS, WE ASSUME THAT MOST INDICATORS WILL COME FROM CURRENT ROUTINE REPORTING SYSTEMS. IF MISSION FEELS IT IS NECESSARY, QUICK SURVEYS COULD BE DEVELOPED TO PROVIDE BASELINE AND PROGRESS DATA.

REGARDING DECENTRALIZATION, CRITERIA MIGHT INCLUDE ACTUAL BUDGET AUTHORITY TRANSFERRED TO REGIONS OR DISTRICTS, PLANNING AUTHORITY DELEGATED TO LOWER LEVELS, APPROVAL FOR RETENTION OF FEES COLLECTED AT LOCAL LEVEL.

SUSTAINABILITY CRITERIA COULD COVER ITEMS SUCH AS: RESOURCE GENERATION INCLUDING FEES, INSURANCE SCHEMES, COST RECOVERY, OR COMMUNITY FINANCING EFFORTS; EFFORTS AT COST CONTAINMENT INCLUDING CONTINUATION OF THE PRELIMINARY WORK WITH THE MEDICARE SYSTEM, ENCOURAGING THE PRIVATE SECTOR DELIVERY OF APPROPRIATE SERVICES, BT

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EFFORTS TO REDEFINE THE ROLE OF THE PUBLIC SECTOR FROM A MAJOR PROVIDER OF SERVICES TO A MORE REGULATORY AND QUALITY ASSURANCE ROLE WITH PRIMARY SERVICE DELIVERY ROLE FOR PREVENTIVE ACTIVITIES.

5. CONTENT OF POLICY AGENDA.

THE POLICY AGENDA IN THE PAIP APPEARS TO BE ON TARGET, BUT WE REQUEST THE MISSION TO CONSIDER INCLUSION FOR THE FOLLOWING AREAS WITHIN THE POLICY FRAMEWORK OF THE PAAD.

A. NUTRITION. LEVELS OF CHILD MALNUTRITION ARE UNUSUALLY HIGH IN THE PHILIPPINES, PARTICULARLY GIVEN INCOME AND EDUCATION LEVELS. ACCORDING TO THE MISSION'S CHILD SURVIVAL STRATEGY DOCUMENT, MODERATE AND SEVERE MALNUTRITION HAS ACTUALLY INCREASED AMONG PRE-SCHOOLERS IN THE LAST DECADE. GIVEN THE STRONG LINK BETWEEN NUTRITIONAL STATUS AND HEALTH, IT IS IMPORTANT TO STRENGTHEN THE INFORMATION BASE AND ANALYTICAL FRAMEWORK FOR UNDERSTANDING THE CAUSES OF MALNUTRITION SO THAT THE DOH CAN ADDRESS THOSE WHICH DO LIE WITHIN THE SCOPE OF ITS PROGRAMS.

B. COMMUNICATIONS. IE AND C PLAN, INCLUDING USE OF PRIVATE SECTOR ADVERTISING AGENCIES, FOR MAJOR FOCUSSED HEALTH EDUCATION EFFORT SHOULD BE INCORPORATED INTO THE FINAL DESIGN.

6. THE PAAD SHOULD ALSO ADDRESS THE FOLLOWING ADDITIONAL CONCERNS WHICH WERE DISCUSSED BY THE PRC.

A. POPULATION FUNDS. THE PROJECT COMMITTEE UNDERSTANDS THAT THE PAAD WILL INCLUDE SIX MILLION IN POPULATION FUNDS ~~FOR FY 89~~. THE PAAD SHOULD MAKE CLEAR THAT SUPPORT IS INTENDED FOR CLEARLY IDENTIFIABLE POPULATION/FAMILY PLANNING SERVICE ACTIVITIES OVER THE FOUR-YEAR PROGRAM. THE MISSION AND THE GOP SHOULD NOTE THAT THE POPULATION/FP ASPECTS OF THE PROGRAM ARE BEING FORWARD FUNDED IN THE FIRST YEAR AND REFLECT THIS IN FUTURE BUDGET SUBMISSIONS.

B. ADDITIONALITY. THE PRESENT GUIDANCE ON USES OF LOCAL CURRENCY SUPPORT FOR HOST GOVERNMENT ACTIVITIES STRESSES THAT OUR OBJECTIVE SHOULD BE THAT AN APPROPRIATE LEVEL OF RESOURCES ARE DEVOTED BY THE HOST GOVERNMENT BUDGET TO THE ACTIVITIES WE SUPPORT, NOT NECESSARILY THAT THIS IS ADDITIONAL TO PREVIOUS RESOURCE LEVELS. IT IS MORE IMPORTANT TO SHOW THAT OUR ASSISTANCE MAKES A DIFFERENCE. THE DIFFERENCE CAN BE QUANTITATIVE, QUALITATIVE OR IN THE POLICY AREA. THE PAAD CAN DRAW ON ANY OF THESE APPROACHES.

C. PRIVATE SECTOR. THE PROJECT COMMITTEE UNDERSTANDS THAT THERE ARE PLANS FOR A NEW PROJECT TO DEAL WITH HEALTH CARE FINANCING NEXT YEAR. HOWEVER, THE PAAD SHOULD ENCOURAGE USE OF PRIVATE MECHANISMS WHERE POSSIBLE; FOR EXAMPLE, ENCOURAGEMENT OF OF PRIVATE PROVISION OF MORE PREVENTIVE SERVICES.

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CARE SHOULD BE TAKEN THAT WE DO NOT GIVE THE GOVERNMENT SYSTEM AN INCENTIVE TO TAKE OVER PRIVATE SERVICES. FOR EXAMPLE, INDICATORS SET FOR INCREASED CONTRACEPTIVE PREVALENCE AND IMMUNIZATION COVERAGE SHOULD INCLUDE SERVICES BY PRIVATE PROVIDERS AS WELL AS THE GOVERNMENT SYSTEM SO THERE IS NO INCENTIVE FOR THE GOVERNMENT PROVIDERS TO TAKE OVER SERVICES NOW PROVIDED PRIVATELY.

D. SUSTAINABILITY. PRC WAS CONCERNED THAT THE PAIP MAY HAVE UNDERSTATED SUSTAINABILITY PROBLEM. WE SEE LINKAGES OF THE POLICY AGENDA TO THE ABILITY OF THE TOTAL HEALTH SECTOR TO SUSTAIN COSTS OF ACTIVITIES WE SUPPORT UNDER THIS PROGRAM. MISSION AND GOP SHOULD PREPARE A CREDIBLE RECURRENT COST PLAN WHICH IDEALLY WOULD INVOLVE A DECLINING A.I.D. SHARE OF BUDGET OVER THE LIFE OF THE PROGRAM.

E. TECHNICAL ASSISTANCE. THE PRC RECOMMENDED THAT THE MISSION CONSIDER AN INCREASED PACKAGE OF TECHNICAL ASSISTANCE FUNDED UNDER THE PROGRAM TO MEET POSSIBLE MISSION MANAGEMENT CONSTRAINTS THAT COULD CROWD OUT OTHER POTENTIAL SECTOR INITIATIVES. THIS INCREASED ASSISTANCE WOULD BE ESPECIALLY IMPORTANT TO TRACK BUDGET AND PERFORMANCE INDICATORS.

F. OTHER CONCERNS.

THE PRC URGES THE MISSION TO CONSIDER SETTING ASIDE A PORTION OF THE TECHNICAL ASSISTANCE PACKAGE FOR A GRAY AMENDMENT FIRM.

WE NOTE THAT THE PAIP OMITS THE STANDARD 25 PERCENT COUNTERPART CONTRIBUTION. WE ASSUME IT WILL BE INCLUDED AS PART OF THE FINAL PAAD.

WE NOTE THAT NEW DATA FROM POP REFERENCE BUREAU INDICATES IMR IN THE PHILIPPINES IS CURRENTLY 48 PER

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1,000 WHICH IS AT ODDS WITH THE 54 PER 1,000 FIGURE USED IN THE PAIP.

7. FYI: URGE MISSION TO SUBMIT CN FOR SUBJECT PROJECT ASAP. END FYI. BAKER
BT
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ACTION: AID-6 INFO: AMB DCM AA ECON/10

VZCZCMLO109 30-AUG-89 TOR: 18:45
OO RUEHML CN: 24608
DE RUEHC #8745/01 2421842 CHRG: AID
ZNR UUUUU ZZH DIST: AID
O 301837Z AUG 89 ADD:
FM SECSTATE WASHDC
TO AMEMBASSY MANILA IMMEDIATE 8595
BT
UNCLAS SECTION 01 OF 02 STATE 278745

RECEIVED AUG 31 10 47 AM '89 USAID/CBR

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: CHILD SURVIVAL (492-0406) POLICY AGENDA

1. SUMMARY: PRC MET AUGUST 25 TO REVIEW SUBJECT POLICY MATRIX TRANSMITTED VIA FAX AUGUST 21. DON PRESSLEY PARTICIPATED IN THE REVIEW AND WAS VERY HELPFUL. WE COMPLIMENT MISSION ON QUALITY OF YOUR SUBMISSION. YOU ARE AUTHORIZED TO PROCEED WITH AUTHORIZATION/OBLIGATION SUBJECT TO GUIDANCE PROVIDED BELOW. END SUMMARY.

2. TARGETTING OF CHILD SURVIVAL: BUREAU IS CONCERNED ABOUT THE NEED FOR GREATER SPECIFICITY REGARDING STRATEGY I, ITEM A AND THE PRIORITIZATION OF BUDGETARY ALLOCATIONS TO HIGH RISK PROVINCES. WE BELIEVE THE MISSION NEEDS TO COME TO AN AGREEMENT WITH THE GOP BEFORE RELEASE OF THE INITIAL TRANCHE REGARDING BUDGETARY PRIORITIES IN HEALTH (CHILD SURVIVAL) AND HOW THE REQUIRED CHANGES IN BUDGETARY ALLOCATIONS AND/OR IMPROVED EFFICIENCY FROM YEAR TO YEAR WILL BE MEASURED AGAINST AGREED UPON, OBJECTIVE CRITERIA.

FOR EXAMPLE, WHAT IS THE MINIMUM LEVEL OF BUDGETARY INCREASE THAT WILL SATISFY MISSION REQUIREMENTS FOR RELEASE OF SUBSEQUENT TRANCHES? THIS NEEDS TO BE AGREED UPON AND SET TO AVOID CONFUSION IN SUBSEQUENT EVALUATIONS/REVIEWS. AS NOW WRITTEN, BENCHMARK COULD BE SATISFIED BY SMALL INCREASE -- SURELY NOT YOUR INTENT. ALTERNATIVELY, IF THE INTENTION IS TO ENSURE THAT THE PRIORITY PROVINCES GET WHAT THEY REQUEST FOR THEIR PLANS, THEN THAT SHOULD BE SPECIFIED MORE CLEARLY. THIS CONCERN ALSO APPLIES TO STRATEGY II, ITEM A, REGARDING INCREASED ALLOCATIONS FOR PREVENTIVE SERVICES.

3. DELIVERY OF SERVICES (STRATEGY I, ITEM B): WE URGE THE MISSION TO ADD THE FOLLOWING TWO ITEMS UNDER END-OF-PROGRAM SERVICE DELIVERY COVERAGE INDICATORS:

--PERCENT OF DOH-FUNDED OUTREACH WORKERS TRAINED TO DELIVER A COMPREHENSIVE RANGE OF FAMILY PLANNING SERVICES INCREASES FROM (SOME PERCENT) IN 1989 TO (SOME PERCENT) EOP. (MISSION AND GOP TO AGREE UPON AND SET PERCENT FIGURES)

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——PERCENT OF DOH HEALTH DELIVERY CENTERS DELIVERING A BROAD RANGE OF FAMILY PLANNING SERVICES INCREASES FROM (SOME PERCENT) IN 1989 TO (SOME PERCENT) AT EOP. (MISSION AND GOP TO AGREE UPON AND SET PERCENT FIGURES.)

WE BELIEVE THESE ADDITIONS ARE IMPORTANT, ESPECIALLY IN VIEW OF LARGE LEVEL OF POPULATION FUNDING IN THE PROGRAM. THESE ADDITIONS SHOULD HELP TO FACILITATE DISCUSSIONS WITH THE GOP ABOUT THE IMPORTANCE OF FAMILY PLANNING IN THE OVERALL CHILD SURVIVAL PROGRAM.

4. THE ANNUAL EVALUATION COMPONENT OF THE PROJECT IS A CRITICAL ELEMENT FOR MEASURING AND HELPING TO ENSURE THE SUCCESS OF THIS PROGRAM. THE FIRST EVALUATION WILL SET THE TONE FOR DISCUSSIONS WITH GOP REGARDING THE ACHIEVEMENT OF THE INDIVIDUAL OBJECTIVES AS WELL AS THE OVERALL SUCCESS OF THE PROGRAM AND THIS MODE OF FINANCING. WE GIVE HIGH PRIORITY TO THIS EVALUATION COMPONENT. ANE/TR WILL BE PLEASED TO COLLABORATE WITH THE MISSION ON THE DESIGN OF THE SCOPE OF WORK FOR THE FIRST EVALUATION AND STANDS READY TO HELP IN RECRUITING TEAM MEMBERS.

5. SUSTAINABILITY: WE BELIEVE THE MISSION IS PROCEEDING PROPERLY IN ITS APPROACH TO DEVELOPING SUSTAINABLE CHILD SURVIVAL-RELATED SERVICES FROM THE FINANCIAL AND INSTITUTIONAL POINT OF VIEW. HOWEVER, THE HIGH LEVEL OF AID AND OTHER DONOR FINANCIAL SUPPORT FOR THE HEALTH SECTOR IS A LONG TERM SUSTAINABILITY CONCERN.

WE BELIEVE YOUR STRATEGY II IS LAYING THE GROUNDWORK FOR ENSURING MOVEMENT TOWARD SUSTAINABILITY THAT WILL BE ADDRESSED MORE DIRECTLY WITH YOUR UPCOMING NATIONAL HEALTH INSURANCE DEVELOPMENT (NHID) PROJECT WHICH WILL ADDRESS LONG TERM RATIONALIZATION OF HEALTH SECTOR COST BURDENS. IN STRATEGY II, PART C. ON PAGE 4 OR IN THE PAAD, THE MISSION MAY WANT TO SPECIFY IN GREATER DETAIL THE RELATIONSHIP BETWEEN THE CHILD SURVIVAL PROGRAM AND THE UPCOMING NHID PROJECT.

USAID IS UNDERTAKING WITH THE GOP AN OVERALL, COMPREHENSIVE APPROACH TO SERVICE DELIVERY IN THE HEALTH SECTOR. IN THE CHILD SURVIVAL PROGRAM, IT IS ADDRESSING THE NEEDS OF THE POOR AND NON-WAGE-BASED POPULATION, AND IN THE NHID PROJECT IT IS RESTRUCTURING SERVICE DELIVERY TO THE ENTIRE WAGE-BASED POPULATION, INCLUDING GOVERNMENT WORKERS. THIS COMBINED AND COORDINATED EFFORT WILL PROVIDE POLICYMAKERS IN THE DOH WITH THE DATA BASE ON SERVICE UTILIZATION AND COSTS FOR THE DEVELOPMENT OF BT

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OPTIONS ON NATIONAL HEALTH INSURANCE WITHIN THE NEXT TEN YEARS, COVERING ALL MEDICARE I AND MEDICARE II BENEFICIARIES. THIS COMBINED APPROACH IS ESSENTIAL TO THE LONG-TERM SUSTAINABILITY OF THE RECURRENT COSTS OF THE TOTAL HEALTH SYSTEM.

SUSTAINABILITY, THEN, IS NOT SOLELY A QUESTION OF THE FINANCING FOR HEALTH SERVICES WITHIN CHILD SURVIVAL, BUT MORE IMPORTANTLY, AN ISSUE OF PROVIDING EQUITY THROUGH CROSS SUBSIDIZATION FROM THE WAGE-BASED POPULATION TO THE POOR ONCE INSTITUTIONAL INFRASTRUCTURE IS ESTABLISHED IN THE MOST DIFFICULT GEOGRAPHIC AREAS FOR SERVICE DELIVERY. FINANCIAL SUSTAINABILITY IN TERMS OF COST RECOVERY OR GOVERNMENT/DONOR FINANCING FOR SERVICES TO THE POOR IS NOT AS CRITICAL IMMEDIATELY AS INSTITUTIONAL SUSTAINABILITY FOR THIS POPULATION GROUP -- THE TARGETS OF THE CHILD SURVIVAL PROGRAM. MUCH OF THE POLICY AGENDA IN THIS PROGRAM IS TO SET IN PLACE THIS KIND OF SUSTAINABILITY.

6. AT THIS POINT, WE ENCOURAGE YOU TO CONTINUE YOUR EFFORTS AT INCREASING PRIVATE HEALTH CARE PROVISION, INCREASING EFFICIENCY IN THE PROVISION OF SUCH SERVICES THROUGH THE PUBLIC SECTOR, BUILDING THE INSTITUTIONAL BASE FOR CHILD SURVIVAL, AND SECURING ADEQUATE LEVELS OF GOVERNMENT FINANCING FOR PREVENTIVE (PRIMARILY CHILD SURVIVAL) SERVICES ESPECIALLY IN AREAS MOST POORLY SERVICED. WE WILL FOLLOW YOUR PROGRESS IN THESE AREAS WITH GREAT INTEREST. EAGLEBURGER
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#8745

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ANNEX C

LOGICAL FRAMEWORK

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PROGRAM DESIGN SUMMARY
LOGICAL FRAMEWORK

Program Title & Number: CHILD SURVIVAL (492-0406)

Life of Program
From FY 89 to FY 94
Total U. S. Funding 150,000,000
Date Prepared: 8/31/89

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1) To contribute to a reduction in the variance in infant and child mortality and morbidity rates among and within provinces and regions, while simultaneously lowering the corresponding national rates.	**Measures of Goal Achievement: (A-2)** --Lower national infant and child morbidity and mortality rates. --Reduced variance in child morbidity and mortality rates among and within provinces and regions.	**(A-3)** GOP health statistics.	**Assumptions for achieving goal targets: (A-4)** -- Policy changes and expanded service delivery will lead to lower infant/child morbidity and mortality rates. -- GOP will continue to provide resources at least equal to its FY 1990 level. -- GOP will continue efforts after USAID program has ended. -- Other socioeconomic factors that affect child survival rates, such as educational levels, will continue to have a favorable effect.
Program Purpose: (B-1) To increase the availability, utilization, and sustainability of child survival-related services, including child spacing, particularly to underserved and high-risk groups.	**Conditions that will indicate purpose has been achieved: End-of-Program Status. (B-2)** Increased delivery and utilization of child survival-related services; implementation of health policies affecting child survival-related activities.	**(B-3)** -- Midterm and final evaluations. -- DOH records and reports. -- Consultants' periodic reports. -- Special population-based surveys. -- Intermittent field monitoring.	**Assumptions for achieving purpose: (B-4)** -- Identified constraints are the significant barriers to progress. -- GOP will agree to and implement needed policy changes. -- DOH service delivery system has the capacity to absorb additional resources.
Program Outputs: (C-1) 1. Implementation of policy changes to foster efficient delivery, increased availability and utilization of child-survival related services, particularly to underserved areas and high-risk groups. 2. Implementation of policy changes to ensure sustained commitment to, demand for and financing of child survival services through public and private sectors. 3. Expansion of child survival-related services at the provincial level.	**Magnitude of outputs: (C-2)** 1. Performance indicators as shown in the Policy Implementation Matrix, including priority-ranked list of provinces and cities; prioritized budgets/fund releases; provincial health plans; HIS operational in all provinces. 2. Performance indicators as shown in the Policy Implementation Matrix, including appropriate DOH budget levels; national IE&C plan; comprehensive NCF strategy; work plan for increased private sector role. 3. End-of-program service delivery coverage indicators as shown in the Policy Implementation Matrix, including immunization rates; prenatal visits; training in ARI management; contraceptive prevalence rate.	**(C-3)** -- DOH reports. -- USAID documentation of meetings, etc. -- Independent contractor for monitoring.	**Assumptions for achieving outputs: (C-4)** -- IBRD program in place and addressing uneven DOH institutional capacity. -- DOH agreeable to policy changes. -- Present DOH initiatives (HIS) in place. -- IE&C campaigns generate additional demand for services.
Program Inputs: (D-1) AID INPUTS 1. Policy dialogue in areas of efficient delivery, increased availability/utilization, sustainability of child survival-related services. 2. Technical assistance 3. Monitoring, evaluation and audit AID TOTAL GOP INPUTS Estimated LOP expenditures for child survival-related services.	**Implementation Target (Type and Quantity) (D-2)** AID GRANT ($000) $45,000 4,250 750 $50,000 $72,000	**(D-3)** -- GOP reports of fund utilization. -- Reports of IA contractor.	**Assumptions for providing inputs: (D-4)** -- Availability of DA funding over life of program.

ANNEX C

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ANNEX D

STATUTORY CHECKLIST

3(A)2 - NONPROJECT ASSISTANCE CHECKLIST

The criteria listed in Part A are applicable generally to FAA funds, and should be used irrespective of the program's funding source. In Part B a distinction is made between the criteria applicable to Economic Support Fund assistance and the criteria applicable to Development Assistance. Selection of the criteria will depend on the funding source for the program.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED?	Yes. Country Checklist is included as Annex D to the Project Paper for the PVO Co-Financing III Project (492-0419), which was authorized on February 17, 1989.
A. GENERAL CRITERIA FOR NONPROJECT ASSISTANCE	
1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.	A Congressional Notification was submitted to the Congress on August 4, 1989; the waitin period expired without Congressional objection on August 19, 1989.
2. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	No further legislative action is required.
3. FAA Sec. 209. Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.	(a) No. The program, which will provide grant funds to the GOP in exchange for policy changes including increased service delivery, is bilateral in nature. The IBRD also provide significant assistance to the GOP health sector; the two development activities will be implemented with close coordination. (b) N/A.

4. FAA Sec. 601(a). Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.	(a) No. (b) Yes. The consideration of private initiatives and competition in the health sector comprises a significant portio of the program's policy agenda (c) N/A. (d) N/A. (e) Yes, to the extent that commerce and industry are utilized to provide goods and services to the health sector. (f) N/A.
5. FAA Sec. 601(b). Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	The program calls for approximately $4.25 million in U.S. technical assistance services.
6. FAA Secs. 612(b), 636(h); FY 1989 Appropriations Act Secs. 507, 509. Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.	To the extent practicable, U.S owned local currency will be utilized in lieu of dollars for meeting local costs for the expatriate advisory services.
7. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No.
8. FAA Sec. 601(e). Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes.
9. FAA Sec. 121(d). If assistance is being furnished under the Sahel Development Program, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of A.I.D. funds?	N/A.
10. FY 1989 Appropriations Act. Will assistance be designed so that the percentage of women participants will be demonstrably increased?	Yes. The recipients of the increased child survival-relate services will be mothers and their children. In addition, it is anticipated that the GOP will need to hire additional midwives to meet the increased service delivery targets.

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B. FUNDING CRITERIA FOR NONPROJECT ASSISTANCE

1. Nonproject Criteria for Economic Support Fund N/A.

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

b. FAA Sec. 531(e). Will assistance under this chapter be used for military or paramilitary activities?

c. FAA Sec. 531(d). Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

e. FY 1989 Appropriations Act. If assistance is in the form of a cash transfer: (a) are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? (b) will all local currences that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account to be used in accordance with FAA Section 609 (which requires such local currencies to be made available to the U.S. governnent as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA

would themselves be available)? (c) Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

2. Nonproject Criteria for Development Assistance

a. FAA Secs. 102(a), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

(a) The program will increase service delivery to geographically underserved areas, primarily rural, and to high-risk population groups, primarily the poor. The program's policy agenda includes the development of health care financing alternatives such as expansion of private insurance and Medicare coverage and the development of health maintenance organizations. In addition, the program will encourage the involvement of the private sector in the provision of basic health care goods and services. All these activities will promote the participation of and benefits to the poor.
(b) N/A.
(c) The program's health care financing and private sector foci will assist the country to become more self-reliant in the provision of health care services.
(d) Improvement of women's health and reproductive health status will have a positive impact on the role of women in the national economy as more women are able to participate productively in the work force
(e) N/A.

b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Is assistance being made available (include only applicable paragraph which corresponds to source of funds used; if more than one fund source is used for assistance, include relevant paragraph for each fund source):

(1) [103] for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with efforts carried out under Sec. 104 to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution. N/A.

(2) [104] for population planning under Sec. 104(b) or health under Sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outrearch.	Both health and population funds are being used to provid an integrated package of preventive, early intervention and child spacing services to mothers and young children in high-risk groups and in geographically underserved areas.
(3) [105] for education, public administration, or human resources development; if so, (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.	N/A.
(4) [106] for energy, private voluntary organizations, and selected development problems; if so, extent activity is:	N/A.
(i)(a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and (b) facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;	

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

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster and programs of disaster preparedness;

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

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

(5) [120-21] for the Sahelian region; if so, (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom)? N/A.

c. FY 1989 Appropriations Act. Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U. S. Government?	N/A.
d. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A.
e. FAA Sec. 281(b). Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	The provision of basic health services is a priority of the GOP, and is responsive to the needs of the Filipino people. Under the program, the Department of Health is responsible for designing and implementing the increased service delivery levels, in order to meet the program targets.
f. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	

ANNEX E

INITIAL ENVIRONMENTAL EXAMINATION

ANNEX E

INITIAL ENVIRONMENTAL EXAMINATION

A. COUNTRY: Philippines

B. ACTIVITY: Child Survival Program (492-0406)

C. TOTAL A.I.D. FUNDING: $50 MILLION

D. LIFE OF PROGRAM: FY 1989 - FY 1994

E. STATEMENT PREPARED BY:
Patricia L. Jordan
Office of Development Resources
USAID/Philippines

F. ENVIRONMENTAL ACTION RECOMMENDED: Categorical Exclusion under A.I.D. Regulation 16, Section 216.2(c)(2)(viii)

G. ENVIRONMENTAL OFFICER CLEARANCE:
Kevin Rushing
Office of Rural and Agricultural Development
USAID/Philippines

H. USAID/PHILIPPINES ACTING DIRECTOR'S DECISION:
APPROVED: [signature]
DISAPPROVED:
DATE: 6 June 1989

I. ANE ENVIRONMENTAL OFFICER'S DECISION:
APPROVED: [signature]
DISAPPROVED:
DATE: 6-16-89

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EXAMINATION OF THE NATURE, SCOPE AND MAGNITUDE OF THE ENVIRONMENTAL IMPACT

A. DESCRIPTION OF THE PROGRAM:

The proposed program will provide approximately $44 million in program sector assistance to the Philippine Department of Health (DOH) to support the expansion of their child survival activities and related services. Additional funding of approximately $6 million will be provided for technical assistance, monitoring, evaluation and audit services, to be contracted by USAID.

The $44 million in program sector assistance will be additional to DOH's regular budget for child survival-related activities, and will be attributed to disbursements against specific budget line items related to these activities. A.I.D. will not be involved in determining how the program sector assistance funds are spent, and will not have knowledge or control of specific expenditures within those budget categories. The proposed technical assistance will be in the areas of epidemiological-based planning; development and operation of the nationwide health information system; social marketing/information, education and communication services; and health care financing consultant services.

B. RECOMMENDED ENVIRONMENTAL ACTION:

Considering the program approach, a categorical exclusion from A.I.D.'s Initial Environmental Examination, Environmental Assessment and Environmental Impact Summary requirements is proposed. This proposal is in accordance with A.I.D. Regulation 16, Section 216.2(c)(2)(viii), which provides for such an exclusion for "programs involving nutrition, health care or population and family planning services, except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.)." The proposed program will not include activities of this nature.

ANNEX F

GRAY AMENDMENT CERTIFICATION

ANNEX F. **CERTIFICATION PURSUANT TO THE UTILIZATION OF GRAY AMENDMENT ORGANIZATIONS**

I, MALCOLM BUTLER, Director of the Agency for International Development in the Philippines, having taken into account the potential involvement of small and/or economically and socially disadvantaged enterprises, do hereby certify that in my judgment the technical assistance required under this program can best be procured through open competition. However, all other factors being equal, preference will be given to firms that submit joint proposals with Gray Amendment-satisfying firms. Furthermore, for the scheduled progress reviews and external evaluations, joint efforts involving both local expertise and Gray Amendment-satisfying organizations are anticipated. My judgment is based on the recommendations of the Program and Mission Review Committees.

Malcolm Butler

MALCOLM BUTLER
Director, USAID/Philippines

SEP 27 1989

DATE

ANNEX G

FINANCIAL ANALYSIS

ANNEX G: FINANCIAL ANALYSIS

A. DOH COMPREHENSIVE MCH/FP PROGRAM

The indicative MCH/FP budget for 1990-94 by major budget items and program components is shown in Table 1. The indicative budget includes (1) those items and activities to be financed by the Philippine government; (2) those activities currently financed by donors and lending agencies and those activities they have already committed to undertake; and (3) those activities for which the funding sources have not been identified.

Assuming all activities are financed over the five-year period, the MCH/FP program is likely to cost Pesos 5.65 billion equivalent to US$ 269.3 million, assuming an exchange rate of Pesos 21 per US$ 1. On an annual basis, the indicative budget increases from a level of Pesos 1.03 billion in 1990 to Pesos 1.2 billion in 1994, or an average annual level of Pesos 1.13 billion (US$ 53.9 million).

B. NEED FOR AND IMPACT OF USAID PROGRAM ASSISTANCE

The need for USAID program assistance is indicated in Table 2, which shows the expected source of funding of the indicative MCH/FP budget. Of the total five-year budget, almost one-third (32.1%) will be funded by the Philippine government. The rest will be provided by UNICEF (1.2%); the Philippine Health Development Project (PHDP III) financed primarily by the IBRD (3.1%); CIDA (0.9%); WHO (0.04%); and UNFPA, the Rotary and other private sector sources (21.2%). USAID's existing commitments under the Primary Health Care Financing Project are expected to account for 16.4% of the MCH/FP budget.

The funding sources of a substantial amount required for programmed MCH/FP activities, however, have not been identified. These activities total Pesos 1.4 billion (US$ 67.5 million) over the five-year period, or an average annual level of Pesos 283.6 million (US$ 13.5 million). Of the total unsourced budget amount, 15.8% represents the personnel cost of recruiting 2,000 additional midwives. A substantial portion (42.9%), however, will be needed for the construction and equipping of additional barangay health stations.

Current donor assistance is concentrated in specific activities. CIDA and Rotary are involved in the provision of vaccine and supplies for the EPI component. The PHDP Project of the IBRD supports the ARI and nutrition components. UNICEF provides assistance for nutrition, prenatal, natal and under-six care. Current USAID assistance is concentrated on EPI, CDD and family planning. UNFPA and the Netherlands Government have commitments to the family planning program. The component that appears to require the most substantial financial support is prenatal and natal care, specifically in the detection of high-risk pregnancies and deliveries as well as complications.

The proposed program assistance of US $45 million is expected to be disbursed in annual tranches over a period of four years. The program assistance to the GOP could potentially free up GOP funds to cover about 67 percent of the unsourced budget requirements, thereby alleviating the GOP's funding problems, which limit its ability to provide much needed health services.

C. FINANCING OF SERVICES

A recent IBRD report notes that serious problems have been identified regarding the quality of services in public health facilities, arising from inadequate funding, inadequate financial management and planning capabilities, and from weak supervision and monitoring. Government health expenditures account for only a relatively small proportion (26% in 1985) of total spending compared to private health expenditures (74%). As a result of the economic crisis in the mid-80s, total and per capita health care expenditures declined from 1981 to 1985. As to distribution, the government spends most of its resources in curative care and, since 1982, the proportion spent for preventive care has declined. Between 1981 and 1985, curative services took up 57.4% of all government health funds, preventive care used up 33.3%, and the rest were utilized for training and administrative services.

Since the Aquino administration took over, drastic reforms have been undertaken to correct the anomalies in the structure of government health care financing. An increased share of the government budget is being devoted to health. Since 1988, budget increases have been allocated, with 65% of the increment going to public health and 35% to hospitals. At the hospital level, allocation is being done on the basis of occupancy rate. These resource allocation strategies are in response to the need to shift resources to the poor.

D. SUSTAINABILITY ANALYSIS

1. Recurrent Costs. The recurrent costs of the comprehensive MCH/FP budget include personnel, materials and supplies, IE&C, management support and training (although much of training is really an investment). Recurrent costs of the MCH component are anticipated to rise from Pesos 496.1 million in 1990 to Pesos 518.5 million in 1994. No similar figures are available for the FP component.

There are no available national budget projections that will permit closer analysis of the problem of funding recurrent costs. The overall economy is anticipated to grow at a faster rate (4 to 6% per year), which will provide the basis for larger tax collections. The share of the national budget going to the health sector is also likely to increase. The Medium Term Plan projects a three-fold increase in health budget allocations. These positive developments alone, however, do not ensure that the activities to be financed by the A.I.D. program assistance will be sustained after the program ceases.

To be sure, in the long run, reductions in the financial requirements of the MCH/FP program may be realized as a result of better health status, reduction in population growth, institutional efficiencies gained, and technological developments. Better health reduces the frequency of morbidity and the probability of complications among those who will get sick; these translate directly into cost reductions. Large-scale preventive health measures also reduce the probability of epidemics, control of which is very costly.

The targeted decline in the birth rate from 31.3 per 1,000 population in 1987 to 28.6 in 1992 and even lower rates for succeeding years reduces the growth of the client population and hence, costs. The target, however, hinges critically on the seriousness of government efforts to implement a population

control program. After years of skirting the issue, the Aquino administration is beginning to place a priority on the family planning program, as evidenced by the President's State of the Nation address in July. Action, however, is still required to translate such broad statements into reality.

Cost-reduction strategies in the delivery of health services are also being undertaken by the DOH. These are discussed in greater detail below. One of the strategies is the introduction of a much better health information system, with USAID support, which is expected to diminish the clerical workload of health field workers, thus increasing their efficiency in delivering care.

Technological developments are also expected to make the provision of preventive health care less expensive. While curative technologies in advanced countries have been cost-increasing (due largely to premiums placed on high-quality care), preventive care technologies adopted in less developed countries have the virtue of being low-technology but low-cost, e.g., simple rehydration salts for the treatment of diarrhea; home-based treatment of respiratory infections; powerful antibiotics for the treatment of a range of diseases. The thrust towards using indigenous materials is also expected to bring costs down.

Lastly, the present strategy of undertaking a comprehensive immunization program has profound cost-reduction implications. Immunization programs have been seen to reduce the disease burden not only of the immunizable disease but related diseases as well.

2. Cost-Reducing Strategies for Health Services Delivery. Through the years, the provision of health care in the Philippines has evolved such that it has given emphasis to curative rather than preventive care; management and planning is overcentralized; and the existing management structure is unable to respond adequately and promptly to the requirements of the public health system. These problems have exacted their toll either by limiting the resources made available to preventive care, by unduly increasing costs of providing preventive services, or by making preventive services unavailable in areas where they are most needed.

DOH invests over 55% of its resources in hospital operations, which in turn serve less than 10% of the population. Moreover, hospitals cost 20 times more per beneficiary than ambulatory and public health care. It is obvious that the present mix of service delivery is cost-ineffective and inequitable. A reallocation of 10-20% of hospital funds to ambulatory care can substantially increase the financial resources in public health and expand the number of beneficiaries served (Intercare: 1987). Current DOH efforts are in this direction and must be supported. However, there is still a strong penchant for the construction of hospitals for political purposes. Such a practice must be curbed.

Overcentralization of management and planning can also be a cause of inefficiency, wastage and therefore cost escalation, due to the inability of central planners to assess the real needs of local populations. The greater involvement of district and provincial health officers in targeting clients, budgeting, and planning is expected to result in better identification of needs and better utilization of scarce resources. The IBRD's PHDP III project includes a component on Strengthening Regional and Provincial Health Planning Capability. The proposed A.I.D. assistance therefore can support such an initiative.

The DOH's management information system is antiquated, hampers resource allocation decisions, and distracts field workers' time. The lack of an efficient communication system causes delays. Long, tedious and repetitive reports take up too much of field workers' time, making them unable to serve a greater number of clients. A new Health Information System (HIS) is currently being developed with support from A.I.D. and WHO. The new HIS is expected to simplify the current DOH reporting system and free up a substantial portion of field workers' time. In tandem with the HIS, the IBRD's PHDP III project also provides support for the development of a computerized management information system (MIS), a critical element in resource allocation.

3. Strategies to be Considered in the Financing of Health Services. Sustainability of the proposed Child Survival Program ultimately hinges on the ability of the Philippine government to finance the program's recurrent costs. The bias toward hospital-based care results in limited budgetary resources for child survival and other preventive health care programs. Budgetary resources allocated to hospitals account for 50 - 60% of the health budget. To ensure sustainability, the health budget must be drastically reallocated away from hospital-based health expenditures. Current DOH thinking is in this direction; the Department envisions that 65% of the budget will be allocated for public health and 35% for hospitals.

Given limited budgetary resources, however, sustainability can be addressed adequately only if the total resources available in the country are taken into account. Experience in the Philippines as well as in other countries shows that there are mechanisms and institutions that can be tapped to provide financial resources for health care, including the introduction of user fees; expansion of Medicare and insurance coverage; encouragement of company-provided health care services; enhancement of the development of health maintenance organizations (HMO); and strengthening of private sector initiatives.

Health care services provided by the government are heavily subsidized. De Ferranti (1983) estimated that in 1981, revenues from user charges as a percentage of recurrent expenditures on government health services was only 7% in the Philippines, compared to 28% in Colombia and 16% in Indonesia. The high subsidy rate engenders overutilization of publicly provided health services, especially curative care, which, in turn, forces the DOH to allocate significant proportions of scarce resources for hospitals. As a result, only a limited amount is left for public health services.

Preventive health services are universally accepted as a merit good with considerable externalities. Hence, it is unwise to extract resources from it. At the same time, there is clearly a need to generate additional revenues for public health so that programs can be expanded. A cross-subsidy mechanism between preventive care and curative care can be worked out that brings about the desired results. Demand elasticity studies worldwide have shown that while user fees would be socially disadvantageous for primary health services (especially for children), it is helpful for hospital care (Shepard and Benjamin: 1987). As a way of mobilizing funds, therefore, hospital user fees can be imposed, and such fees used to finance public health activities. Imposing user fees on public hospital services has the added virtue of preventing overutilization of facilities.

About 20% of the government's health care spending is for its Medicare program. Current Medicare membership includes government employees (members

of the Government Service Insurance System) and employees of private sector firms (members of the Social Security System). These currently number under 10 million, or roughly 54% of the working population. Employees contribute 2.5% of their salaries and employers contribute 2.5% of their payroll costs. At present, Medicare benefits cover only hospitalization; this constraint must be addressed before Medicare can be tapped as a source of funds for public health. Medicare also has to increase its support value of only about 33% in 1987 (down from 80% in 1972) as a result of which the insured employee still faces substantial financial risk. An increase in the current 2.5% contribution rate to 8-10% will increase the rate of cost recovery and provide additional resources to public hospitals admitting Medicare patients. Proposals to expand Medicare coverage to self-employed persons must also be given serious consideration to expand the Medicare fund.

Philippine law requires that companies provide for the health care needs of their employees. Although the government does not have the resources to enforce this particular piece of legislation, the large corporations do provide varying levels of health care. Through an agreement between company management, labor representatives, and the Department of Labor and Employment, a number of companies have established family planning clinics. These corporate programs can potentially generate substantial resources for maternal and child health and must be encouraged.

Health care insurance is often sold as an add-on to life insurance. In general, because of low incomes, health insurance coverage has not been very extensive. However, in the past few years a considerable number of health maintenance organizations (HMOs) have evolved in Metro Manila area. At present, there are 19 HMOs, with roughly 400,000 members (Alfiler: 1989), representing less than 1% of the total population. The HMO business, however, appears to be thriving and industry leaders expect to cover a potential market of 5.4 million persons (10% of the population) in the next few years. HMOs finance the costs of both preventive and curative care. Their importance lies in the fact that they cater to higher-income households, thus freeing considerable government resources for the needs of the lower stratum of society.

While most HMOs in existence today have corporate structures and profit orientations, experiments with cooperative or community-based HMOs are currently underway, some of them funded under A.I.D.'s Primary Health Care Project. These models have strong appeal because by spreading risk and pooling resources, they can potentially provide the financial requirements of the health needs of poor rural households. However, these models have tremendous informational and operational requirements (e.g., screening members, collections). For these reasons, there are suggestions to use already existing institutions like rural electric cooperatives and agricultural credit cooperatives.

The Philippines has a long history of utilizing private sector initiatives in the provision of public health care in various forms, and these need to be expanded. Civic clubs have been involved in the provision of puericulture centers, equipment or supplies but these are sporadic. Rotary International is currently providing vaccine requirements for polio. An increasing number of nongovernmental organizations (NGOs) extend health services to the poor. Medical missions of religious congregations also provide services in remote areas usually occupied by tribal minorities. Such activities must be expanded.

Table 1
INDICATIVE MCH AND FP BUDGET BY MAJOR BUDGET ITEMS
AND PROGRAM COMPONENTS: 1990-94
(In 000 Pesos)

Cost Item	1990	1991	1992	1993	1994	Total Pesos	Total Dollars (000)
CONSTRUCTION OF NEW BHS	121.550	121.550	121.550	121.550	121.550	607,750	22.940
PERSONNEL COST							
Incumbent Midwives	207,517	207,517	207,517	207,517	207,517	1,037,585	49,409
Additional Midwives	44.801	44,801	44.801	44.801	44.801	224.005	0
Subtotal	252.318	252.318	252,318	252.318	252,318	1.261.590	60.076
MATERNAL & CHILD HEALTH (MCH)							
Equipment							
Prenatal and Natal Care	55.653	57.460	2.685	2.685	2.685	151.168	7.198
EPI	13.864	19,901	14,955	14.894	0	63.614	3.029
ARI	21	146	205	190	186	748	36
Subtotal	99.538	77.507	17,845	17,769	2.871	215.530	10.263
Materials and Supplies							
Prenatal and Natal Care	51,455	49.803	49,954	50,056	50.112	251,380	11.970
Under 6 Care	5.621	5.367	5.506	5.643	5.774	28.911	1.234
EPI	29.848	30.165	30.591	30,701	30,804	151,909	7.234
CDD	16,950	17,406	17.876	18.359	18,858	89,449	4.259
ARI	3.146	4,212	5,401	6,433	4,465	23.707	1,129
Nutrition	20.808	24.150	26,867	31.597	30,532	133.954	6.379
Dental Care	9,739	10.226	10,737	11,274	11,838	53,814	2.563
Subtotal	140,567	145,381	150,734	158,063	156.383	751.128	35,768
I.E.C.							
Prenatal and Natal Cost	17.353	23,103	25,003	35,073	40,943	144,475	6,880
EPI	9,229	6.328	6,506	6,526	5,296	33,885	1,614
CDD	1,180	1,334	929	856	893	5,192	247
ARI	4,710	4,960	600	600	123	10,993	523
Nutrition	8,777	9,718	10,338	11,295	12,347	52,475	2,499
Dental Care	776	499	525	554	585	2,939	140
Subtotal	42,025	45.942	44.901	54.904	60,187	249.959	11,903
Training							
Prenatal and Natal Care	25.840	26.101	6.050	10,990	12,276	51,247	3.869
EPI	3,231	3,299	1,025	842	0	8,397	400
CDD	2.229	2.401	2,178	2,244	2.311	11.363	541
ARI	2,210	14.849	14.071	14.871	14.871	60.872	2.899
Nutrition	6.228	2.155	2.182	2.057	2,018	14,643	697
Dental Care	300	300	300	300	300	1,500	71
Subtotal	40,038	49.108	25.806	31.294	31,776	178.022	8.477
Management Support Cost	21,105	26.601	25.894	18,951	17.885	110.436	5.259
MCH Total	343,273	344.539	267,180	280,981	269,102	1.505,075	71.670
FAMILY PLANNING	313,111	427,750	472,301	505,705	561,234	2.280.101	108,576
GRAND TOTAL	1,030,252	1,146,157	1,110,349	1,160,554	1,294,204	5,654,516	269,263

NOTE: SFP program refers to 1989-93.
Exchange rate is assumed at ₱21 to $1.00.

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Table 2
INDICATIVE MCH AND FP BUDGET, BY EXPECTED SOURCE OF FUNDING: 1990-94
(In 000 Pesos)

Cost Item	Total	GOP	USAID*	WHICH	HS-PEMP**	CIDA	WHO	Others***	Uncertain Source Pesos	US$ (000)
CONSTRUCTION OF NEW RHUs	607,750	0	0	0	0	0	0	0	607,750	28,940
PERSONNEL COST										
Existing Midwives	1,037,585	1,037,585	0	0	0	0	0	0	0	0
Additional Midwives	224,005	0	0	0	0	0	0	0	224,005	10,667
Total Personnel Cost	1,261,590	1,037,585	0	0	0	0	0	0	224,005	10,667
MATERNAL & CHILD HEALTH (MCH)										
Equipment										
Prenatal and Natal Care	151,168	5,044	0	590	0	0	0	0	145,534	6,930
EPI	63,614	931	22,785	38,898	0	0	0	0	0	0
ARI	748	0	0	0	748	0	0	0	0	0
Subtotal	215,530	5,975	22,785	39,488	748	0	0	0	145,534	6,930
Materials and Supplies										
Prenatal and Natal Care	251,380	207,527	0	2,920	0	0	0	0	40,933	1,949
Under 6 Care	46,915	1,773	0	5,000	286	0	0	0	39,856	1,898
EPI	151,989	46,385	0	391	0	51,774	0	32,210	21,189	1,008
CDD	89,449	44,852	0	0	0	0	0	44,597	0	0
ARI	22,707	0	0	0	22,707	0	0	0	0	0
Nutrition	130,954	94,532	0	3,035	34,284	0	0	0	2,123	101
Dental Care	53,814	51,744	0	0	0	0	0	0	2,070	99
Subtotal	751,128	446,793	0	11,346	58,257	51,774	0	76,807	106,151	5,055
I.E.C.										
Prenatal and Natal Care	144,475	0	0	2,910	78,700	0	0	0	63,865	3,041
EPI	33,885	0	33,885	0	0	0	0	0	0	0
CDD	5,192	1,438	2,939	594	0	0	0	0	221	11
ARI	10,993	0	0	0	910	0	440	0	9,643	459
Nutrition	52,475	49,814	0	0	0	0	0	0	2,661	127
Dental Care	2,938	1,500	0	0	0	0	0	0	1,439	69
Subtotal	249,958	52,752	36,824	4,504	77,610	0	440	0	77,829	3,706
Training Cost										
Prenatal and Natal Care	81,247	0	1,280	2,280	2,358	0	0	0	75,379	3,589
EPI	8,397	0	6,276	880	0	0	0	0	1,241	59
CDD	12,383	0	9,828	482	0	0	0	0	1,273	61
ARI	85,572	435	0	0	35,586	0	822	0	31,224	1,487
Nutrition	14,643	1,805	0	0	0	0	0	0	12,838	611
Dental Care	1,500	0	0	0	0	0	0	0	1,500	71
Subtotal	202,722	2,040	17,184	3,622	40,974	0	822	0	113,851	5,419
Management Support Cost	130,436	22,888	3,181	6,342	220	0	2,442	0	85,357	4,065
MCH Total	1,585,875	521,621	80,814	65,302	177,821	51,774	2,504	76,607	529,532	25,160
FAMILY PLANNING****	2,268,101	254,175	845,382	0	0	0	0	1,122,313	57,831	2,744
GRAND TOTAL	5,854,516	1,812,221	926,196	65,302	177,821	51,774	2,504	1,199,120	1,417,914	67,528

Notes:
* Refers to current USAID assistance.
** Refers to the World Bank's Philippine Health Development Project.
*** Refers to assistance provided by Rotary in immunization as well as other private sector efforts. In family planning, this refers to the assistance provided by UNFPA, the Government of Netherlands, and other private sector efforts.
**** FP Program refers to 1989-93.
Exchange rate is assumed at P21 to $1.00.

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ANNEX H

ECONOMIC ANALYSIS

ANNEX H: ECONOMIC ANALYSIS

A. ECONOMIC RATIONALE

Child survival is a critical element in the overall Philippine health delivery system since maternal, infant and child deaths and illnesses still claim a significant proportion of total deaths and illnesses in the country.

Existing socio-economic conditions do not ensure survival for many Filipino children (0-6 years old) who comprise 20 percent of the total Philippine population. Deaths under five years of age accounted for over 30 percent of all reported deaths in 1985, with infant mortality claiming one-fifth of total deaths. Acute respiratory infections (ARI) and diarrhea continue to be the major causes of deaths among infants and preschoolers. Malnutrition remains a serious problem; about 18 percent of Filipino children are underweight. Vitamin A deficiency afflicts about 3.1 percent of children 1-6 years of age while anemia prevalence is 70 percent among infants and 40 percent among 1-6 year olds.

Every year, an estimated 2 million married women of reproductive age become pregnant. For every 10,000 reported births, nine mothers die of pregnancy-related causes, representing 1,800 deaths a year. Maternal deaths are mainly due to hemorrhage and complications. Of the deaths due to hemorrhage, about half are related to post-partum conditions such as uterine atony, uterine rupture and retained placenta. These conditions are often associated with multiparity, thus highlighting the relevance of child spacing as a standard device toward better maternal health.

Direct interventions are a practical means of reducing the rate of infant and child morbidity and mortality in less developed countries. Since economic development, a major requirement for the ultimate achievement of fully satisfactory nutritional and health status of citizens, is a slow process, there exists growing evidence that the use of direct health and environmental interventions can help bring about substantial improvement in health status, especially among infants and young children.

Features of any direct intervention related to child survival services should include all social and economic determinants of child morbidity that should necessarily operate through a common set of biological mechanisms, or proximate determinants, to exert an impact on mortality. These proximate determinants include: (1) maternal factors such as age, parity and birth interval; (2) nutrient deficiency; (3) personal illness control involving preventive measures and medical interventions; (4) environmental contaminations via air, water, soil, food, etc.; and (5) accidental or intentional injury.

USAID's Child Survival Program covers the first three factors: (1) maternal care and child spacing; (2) maternal and child nutrition; and (3) measures to prevent illness or to contain it at an early stage.

Worldwide experience has shown that the activities to be undertaken in the DOH comprehensive maternal and child health program as a whole are cost-effective since (1) they have a definite bias towards preventive rather than curative care (e.g., immunization versus treatment); (2) they emphasize early detection and monitoring (e.g., use of growth charts and home-based

mothers' records); and (3) they make use of low-cost proven technologies (e.g., home-based treatments of respiratory infections and oral rehydration therapy). Assessment of the cost effectiveness of individual activities, however, must be made a part of the regular program planning process.

B. FRAMEWORK FOR THE ECONOMIC ANALYSIS OF HEALTH PROJECTS AND PROGRAMS

Resources invested in the improvement of health status and conditions are considered as investment in human capital. Investment in health care is, like investment in physical capital, a process that yields benefits over time in the future and which may also produce costs in the future. Health improvement results in both quantity and quality effects on labor supply. An improvement in health status may result in an increase in the number of productive labor units available in the economy at any point in time. For instance, improved health conditions of children can bring about longer lifespan, hence more productive labor supply in the economy. The increase in productive labor units over time can be estimated and multiplied by their marginal product to provide an estimate of the incremental output attributable to any given health improvement. While the human capital approach has been used extensively, it also poses serious conceptual difficulties, especially when used to quantify the benefits from child survival assistance programs. The approach values health only to the extent that it is an investment good that increases aggregate output while assigning no value to health as a consumption good.

C. ANALYSIS OF MINIMUM REQUIRED BENEFITS

The following analysis demonstrates that the program assistance is likely to achieve sufficient benefits to cover the costs. Given the economic cost of the program of $45 million, the social discount rate in the Philippines is used to determine the required economic impact to justify the investment in the program assistance. In order to do this, the following simplifying assumptions are used: (1) program funds are disbursed immediately upon signing of the grant agreement; (2) economic returns over a twenty-year period will flow evenly beginning in the first year for each dollar invested; (3) no new returns are attributed to the program after its completion; and (4) the exchange rate of P21.00:$1.00 prevails.

Using the NEDA estimated social discount rate of 15 percent (capital recovery factor for years one to twenty = 0.159761), the program assistance must achieve an annual economic benefit of P151.0 million annually to cover the total cost of the assistance. The likelihood of achieving the required level of annual benefits may be demonstrated by comparing its magnitude to the health care expenditures of Filipino families per year.

Results of the 1988 Family Income and Expenditures Survey show that a Filipino family typically spends 1.7 percent of its total expenditures on medical care. Given average family expenditures of P32,214 per year, a typical family spent an average of P548 in health care in 1988. With the total number of families at 10.7 million, total family expenditures in health care reached P5.8 billion in 1988. This P5.8 billion represents health care expenditures of all members of the family (an average of six members). Assuming that a typical family has two members 0-6 years of age, and assuming that family members spend an equal amount on health care, total health expenditure of children is about P1.8 billion a year, an amount that can be drastically reduced (and therefore saved) given a comprehensive child survival program. Clearly, the minimum required benefits of P151.0 million annually

require only an 8.4 percent reduction in the current level of spending on children's health per year.

The above analysis assumes uniform income elasticity of health services across households. In the Philippines, this may not be the case, considering the high income disparities among households, i.e., lower income households have smaller budget allocations for health care, while higher income households have larger budget allocations for the same expenditure item. In order to address this issue, family expenditures on children's health by income class was used instead of the overall family expenditures on health. In the absence of the income decile data for 1988 (it is still being processed), results of the 1985 Family Income and Expenditures Survey (FIES) were used. The 1985 FIES shows that the lowest income class spent 1.2 percent of family expenditures on medical care while the highest income class spent 2.5 percent. Using the varied proportions of family expenditures on medical care for each income decile, it is estimated that total medical care spent on children for the year of all income classes reached P1.86 billion. This shows that the minimum required benefits of P151.0 million annually requires only a 8.1 percent reduction in the current level of family spending on children's health per year. This indicates that it is likely that the required minimum benefits would be achieved.

In terms of cost-effectiveness, worldwide experience has shown that the activities to be undertaken in the program as a whole are cost-effective since (1) they have a definite bias toward preventive rather than curative care (e.g., immunization versus treatment); (2) they emphasize early detection and monitoring (e.g., use of growth charts and home-based mothers' records); and (3) they make use of low-cost proven technologies (e.g., home-based treatments of respiratory infections and oral rehydration therapy).

D. PROGRAM IMPACT

The focus of the proposed A.I.D. program is to encourage the GOP to fill in serious gaps in staffing, supplies, and other inputs required in the delivery of child survival services. A direct impact of the assistance, therefore, is the expected expansion in service coverage, the overall improvement in health status, and reduction in health status variances among regions and provinces.

Of more lasting impact, however, are proposed reforms that will ensure wiser use of resources. The client-targeting strategy that will occur as a result of the program will ensure that resources will go to population groups most in need of care. The equity dimension of such a strategy is incalculable. The public health nature of the assistance also means that focused attention on the health status of high-risk groups would drastically reduce the probability of epidemics which, aside from being a drain on the already-inadequate health budget, cause substantial economic losses.

Decentralization and integration have a direct bearing on resource allocation. Centralized planning and budgeting often result in the provision of inputs and services not required by field units (resulting in wastage), or the nonprovision of inputs and services required by field units (resulting in unmet demand). Provincial planning and budgeting activities undertaken as a result of the proposed A.I.D. program are expected to provide a more accurate assessment of local needs and requirements, thus reducing if not eliminating resource misuse.

Integration of services is anchored on the principles of economies of scale and economies of scope. The previous vertical strategy of service delivery engendered duplication of manpower and capital inputs as well as of supplies. The integration efforts supported by the proposed A.I.D. program will provide greater coordination of donor-funded activities, thus preventing duplication and providing easier program management. Integration of activities such as IEC, training and logistics will redound to a more cost-effective program.

E. RESOURCE ALLOCATION CONSIDERATIONS

Although the technical feasibility of child survival technologies has been amply demonstrated, resource constraints restrict the adoption or expansion of these technologies. In most instances, resource constraints are in terms of funds, but the actual binding constraints may take many forms. In the Philippines, these involve chiefly the shortage of skilled personnel, specifically midwives; deficits in administrative and managerial capacity; and weak logistical support (DOH: 1989). Administrative and logistical strengthening are addressed in the IBRD's PHDP III project and will be supported by activities to be undertaken under the proposed A.I.D. program.

The issues of how to allocate resources among the various child survival interventions and among the different regions and provinces remains unresolved. In countries with good health data, the evaluation of alternative interventions is carried out through the application of a nonlinear optimization model that, given the epidemiological characteristics of the population, the availability of resources, and the effectiveness of health interventions, chooses the set of intervention activity levels lying within the resource constraints to maximize the probability of child survival (Barnum, Barlow, Fajardo and Pradilla: 1980). Salient features of such a model include the use of interactive simultaneous equations to model the causes of death in a setting of multiple diseases, the clear distinction between preventive activities affecting morbidity and curative activities affecting case fatality rates, and the separation of the early childhood period into age subgroups with distinct morbidity characteristics. The optimization model distinguishes between program use (demand) and program availability (supply), and operates in such a manner as to set intervention levels that tend to equilibrate use and availability.

Owing to the inadequacy of data to compute such model, an alternative adopted in this proposed assistance is to institutionalize certain program assistance features that ensure rational allocation of resources, such as epidemiologically-based planning, targeting based on need (high-risk areas) and opportunity (efficient administrative setup), and a decentralized planning process.

Linked to these processes is a regular policy dialogue, which is the venue for the discussion of several resource allocation issues that are broader in scope than the detailed examination of the cost-effectiveness of individual health measures. Among the resource allocation issues that the policy dialogue must be able to thresh out are: (1) choice of classes of interventions -- health promotion versus actual provision of services; access versus usage; (2) choice of program organization -- integrated versus vertical service provision; further decentralization versus program control and direction; and (3) choice of target population subgroups -- urban versus rural; specific age groups to be targeted.

ANNEX I

SOCIAL SOUNDNESS ANALYSIS

ANNEX I. SOCIAL SOUNDNESS ANALYSIS

A. INTRODUCTION

The high rate of infant and young child mortality and morbidity in the Philippines has been identified as a significant development problem because of its negative impact on the overall socioeconomic well-being of the country. In addition to being emotionally draining, frequent child illnesses and deaths further drain the already meager resources of families.

The official infant mortality rate for 1988 is 54 per thousand live births. Although it is low compared to developing country standards, it is one of the highest among ASEAN countries. This figure is a national aggregate and does not reflect the substantial mortality differences that exist among and within regions and provinces, where rates can go above 100, such as those found in underdeveloped areas of Regions V, IX or XII. (Sulu and Tawi-Tawi, for example, register levels of 133 per thousand.)

The mortality rate among the under five population in 1985 was estimated by UNICEF to be 78 per thousand live births (around 16 if the denominator used was the under five population), placing the Philippines in the midrange between the lowest rate of 8 (Sweden) and the highest of 329 (Afghanistan). This rate could be an underestimate. A joint DOH, USAID, UNICEF and WHO survey in 1985 placed the national rate at 26 per thousand under five population, with a range of 18 to 43.

Reducing infant and young child morbidity and mortality, or improving the chance of survival among the under-five population, is the central thrust of the USAID Child Survival Program. Demographic data suggest that Filipino children who survive to the age of five enjoy approximately the same longevity as those in the developed nations in the West.

The purpose of the program is to increase the availability and utilization of child survival-related services, including child spacing, particularly to underserved segments of the population and areas with the highest risk of infant and young child morbidity and mortality.

The Philippine Department of Health does not actually have a "child survival program" per se. The phrase "child survival-related services" as used in this paper refers to a set of basic services that are being provided by the DOH to promote the health of mothers and children, otherwise known as the integrated Maternal and Child Health (MCH) Program. The integrated MCH program includes the following services and sub-programs: Expanded Program for Immunization (EPI), Control of Diarrheal Diseases (CDD), Control of Acute Respiratory Infections (ARI), Nutrition, Maternal Care, Promotion of Breastfeeding, Family Planning, Under Six Clinic, Dental Health and Control of Major Diseases Affecting Mothers and Children.

MCH is the flagship program of the DOH, and attracts the largest number of consumers of non-hospital health services. It has been an integral component of the DOH program of basic services since the establishment of Rural Health Units in the country in 1954, and has grown in breadth and complexity as more efficacious interventions to deal with maternal and child mortality and morbidity have been added to the program. Because of the broad variety and

technical intricacies of the services delivered under the program, technical oversight at the central level is being performed by three offices, namely the Maternal and Child Health, Family Planning and Nutrition Services, all of which are directly under the office of the Undersecretary of Public Health Services. However, these services are delivered in an integrated fashion at the District Health Office, Rural Health Unit and Barangay Health Station levels.

This report will examine the social soundness of the integrated MCH program, including an estimate of the project beneficiaries, the social and cultural acceptability of the interventions and the spread effects that are likely to occur.

B. PROGRAM BENEFICIARIES

The direct beneficiaries of the program are the estimated nine million Filipino children below the age of five, and the 13.5 million married women of reproductive age, particularly the two million who are expected to get pregnant each year. Two-thirds of these direct beneficiaries reside in the rural areas. The benefits that will accrue to children beneficiaries are in the form of goods and services that will promote health and prevent illness and premature mortality. They include complete immunization services to protect infants from such vaccine-preventable diseases as tuberculosis, diphtheria, whooping cough, tetanus, poliomyelitis and measles; services and oral rehydration salts to prevent dehydration during acute diarrhea episodes; services and drugs to control pneumonia; and nutrition services including promotion of breastfeeding, growth monitoring, malnutrition surveillance and the administration of food supplements and micronutrients to the undernourished. Other services that will be provided to promote the health of children are morbidity and well-baby clinics for the diagnosis and treatment of illnesses and the periodic assessment of growth and development of children.

The provision of services for the promotion of maternal health, i.e., the health of the mother during pregnancy, is important not only because a pregnant woman is subjected to an enormous amount of stress, but also due to the fact that the condition of the mother during the course of pregnancy and during the perinatal period is a major determinant of the survival potential of newborns. Child spacing is considered an important program component because data from all over the world consistently point to child spacing as the single intervention with the greatest impact on child survival.

Benefits that mothers and women of child bearing age can expect from the program are: regular prenatal and post-natal care; delivery services either at a health facility or at home; tetanus toxoid administration; and a broad range of contraceptive services and supplies. These women will also benefit from the health education and social marketing activities that will be undertaken by the program to disseminate information and develop skills for the promotion of maternal and child health.

The program's deliberate approach of targeting underserved areas and the employment of epidemiological-based planning will ensure that program benefits will reach problem populations and geographic areas that have not been adequately covered by the DOH delivery system as well as areas where child morbidity and mortality are highest. A major intent of the program is to minimize child mortality differentials among and within regions and provinces.

Indirectly, the households to which the nine million children under age five belong will benefit. Family medical expenses are expected to decrease as a result of the program's efforts to prevent major childhood diseases, and parents will be spared the emotional trauma over the loss of a child. In addition, with fewer children becoming ill, household members will be freed from attending to the sick and can devote more time to productive activities. Finally, the Philippine economy itself will stand to benefit from the program. The expected reduction in morbidity will lessen required investments in expensive curative care facilities and services. The program will help ensure the health of the country's children and improve their chances of maturing into adulthood to be able to contribute their share to nation building.

C. SOCIOCULTURAL COMPATIBILITY

The cultural acceptability of the MCH program interventions is not considered a major issue, since they have been promoted by the DOH for many years and have gained wide acceptance among the population. Immunization, for example, is now becoming increasingly popular. It is estimated that 70% of infants are now fully immunized with the six antigens being offered in the program. The use of oral rehydration therapy (ORT) for diarrhea management is still low* because of the mistaken notion among many mothers that the immediate objective of diarrhea management is to stop the purging. This misconception has been abetted by physicians of the old school who have not kept abreast of more recent research findings on the pathophysiology of diarrhea. ORT use is high among mothers who are aware that it is the dehydration and not the diarrhea itself that is life-threatening. The program will seek to correct this misconception through aggressive person-to-person and mass communications campaigns.

A multi-media public promotions campaign is currently being pilot-tested in Regions VI, VII and X under the ORT component of USAID's Primary Health Care Financing Project. Results of the pilot testing will form the basis for the planning and implementation of a nationwide social marketing effort. Training of physicians and nurses in the government and private sectors on the use of this safe, inexpensive and effective mode of treating acute diarrheas has been initiated, and this program will broaden the coverage of the training. It is expected that the effects of the mass media campaign and the more active involvement of the medical profession in promoting ORT, in conjunction with making oral rehydration salts more readily available, will dramatically increase ORT use.

A nationwide study conducted in July 1987 by the Philippine Information Agency on public awareness and perception of government programs revealed that family planning was ranked by the respondents as the most helpful government program. More specifically, the Filipino's attitude toward and acceptance of family planning can be gauged from the various national studies that have been conducted: the National Demographic Surveys of 1968, 1973 and 1983; the Republic of the Philippines Fertility Survey of 1978; and the Contraceptive Prevalence Survey of 1986. These surveys have revealed that:

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*Surveys done in 1988 in Regions VI, VII and X found the effective ORS use rate among mothers to be less than 10%.

-- Two-thirds of married Filipino women approve of modern family planning methods.

-- More than one-half of women with three living children do not want to have any more children; and

-- Religion is not a significant variable for Catholics in terms of family planning attitude and practice; for Catholic women 25 to 34 years old, the ideal family size is four children; in contrast, Muslim women want five to seven children.

The other interventions in the integrated MCH program such as growth monitoring, promotion of breastfeeding, control of acute respiratory infections and prenatal, natal and postnatal services are compatible with existing health-related practices and beliefs. Maternity services, for example, are so consistent with the local culture that they have become the most popular among the services offered by DOH. In fact, traditional birth attendants have been successfully trained by the DOH to deliver this form of maternal health care.

D. SPREAD EFFECTS

The Child Survival Program is designed to encourage the full range of maternal and child health services to reach the intended primary beneficiaries. Policy reforms such as decentralization of planning and budgeting and direct funds releases to provinces will encourage the field units to respond promptly to service delivery requirements. The program's approach of targeting underserved areas and the use of location-specific epidemiologic data for program planning will ensure that isolated areas will benefit from the program and that services will be available where they are actually needed. The program also provides technical assistance services that will promote the availability of MCH services through various social marketing channels in order to stimulate their demand and utilization.

Special concern is being given to the issue of DOH maintenance of the level of intensity and magnitude of the expanded child survival services after the completion of the AID program. Sustaining the program will require an annual increase of five percent to the DOH budget. Given the priority that the national government is according the DOH and the pattern of budgetary increases that DOH has been receiving since 1986, the annual five percent increase that is needed to sustain the program is not an unreasonable goal. Other measures that will be undertaken to ease the financial burden on DOH and ensure sustainability include the aggressive promotion of family planning in order to lessen the requirement for MCH services, and efforts to internalize the demand for MCH services so that utilization rates will be high and servicing of demand can be moved transitionally from the public to the private sector.

E. POTENTIAL IMPACT

The expected direct impact of the USAID Child Survival Program is the lowering of infant and young child morbidity and mortality, which in turn is expected to produce a significant economic impact. Potential improvements to the economy will be brought about by reduced treatment costs for illnesses avoided and future earnings of children saved. As children enjoy more

illness-free days, proper growth and development is assured, school performance will improve, and these will lead to higher productivity in later years.

Increased child survival rates have been linked to lower fertility rates and reduced population growth rates. These linkages make the economic impact of the program even more significant because rapid population growth has been largely responsible for the erosion of the country's real economic gains.

The program is also expected to impact positively on the DOH program management system. Policy changes that will be implemented under the program are expected to improve the overall effectiveness and efficiency in the planning and delivery of child survival-related services. Duplication and overlapping of services will be reduced through better integration of health programs. The goal of reducing inter- and intraregional differences in infant and child morbidity and mortality rates will enable the DOH to give priority to high-risk and underserved areas, thereby also addressing the important issue of equity.

Promotion of political stability is another impact that can be expected from the program. The intensified implementation of a decentralized and visible program whose impact of saving children's lives is easily appreciable will enable even the remotest barangays to feel the positive presence of government. This can broaden grassroots support for the participatory processes of the Aquino administration.

F. SOCIAL SOUNDNESS STATEMENT

The goal, purpose and general design of the Child Survival Program reveal features that point to its social soundness. It responds to a real social and developmental need, and its design had been guided by the experience that the DOH has accumulated in the delivery of MCH services. During the planning of this program an incisive analysis was made of the major constraints that prevent the DOH from maximizing its capacity to deliver MCH services, and the program's implementation strategy is intended to address these constraints and enhance long term sustainability. On the basis of the above, we conclude that the program, as designed, is socially sound.

ANNEX J

INSTITUTIONAL ANALYSIS

ANNEX J: INSTITUTIONAL ANALYSIS

A. BACKGROUND

The DOH is making a firm commitment to child survival and has moved toward decentralized planning, budgeting and program management in order to make child survival services more responsive to local needs. A policy to expand coverage of existing child survival services among the underserved and the population at greatest risk is currently being formulated. Focused targeting is encouraged in order to deliver essential maternal and child health services to those in greatest need. By focusing on health problems that affect large numbers and targeting services in underserved communities where high risk children and mothers are concentrated, the DOH expects to achieve both equity and efficiency in resource utilization.

As a way of encouraging the DOH efforts at expanding health service coverage and reducing child mortality, the U.S. Agency for International Development is developing program assistance for child survival services. In return for specified policy changes and the expanded delivery of services, USAID will disburse tranches of program assistance funds to the GOP.

This paper analyzes the technical and administrative capacities of the Department of Health (DOH) to plan, monitor, and supervise the implementation of expanded levels of child survival services at the sub-national level. Current practices in planning, monitoring and supervising Maternal and Child Health and other public health programs were investigated and assessed. Planned improvements in relevant aspects of program management were also considered and analyzed for their prospective impact on managerial capabilities, both at central and sub-national levels.

The analysis took into account the need to establish a rational basis for programming and allocating additional resources for DOH child survival activities in order to achieve meaningful reductions in child morbidity and mortality. Variations in local situations were considered, and the need for flexibility in planning and resource programming at the subnational level was recognized. It also recognized the need for clear guidelines and directions to ensure that local activities in support of child survival are nationally coherent and cost-effective.

The manner and processes by which DOH central policies are translated into programs and services at the operating level was investigated. Specific attention was focused on planning, monitoring, and supervising child survival services at the provincial and city levels. Key personnel and staff at regional, provincial and city health office levels were interviewed to gain insights on the processes and criteria adopted in program planning, resource allocation and performance evaluation. Local health plans, budgets and accomplishment reports were reviewed along with available guidelines on target setting, costing, and monitoring. Impressions and conclusions were discussed with key DOH officials at the central level and additional insights were gained on the extent and degree of commonality of experiences observed in the provinces and cities visited and the other health offices throughout the country. Key implementation action programs needed to strengthen current capabilities for planning, monitoring and supervising child survival services

at sub-national levels were also discussed with central office program managers.

B. OBJECTIVES

The primary purpose of the assessment is to determine the administrative preparedness of the DOH to implement and manage expanded levels of child survival-related services. The assessment also sought to examine the ways of strengthening or developing the capacity of DOH for decentralized and epidemiologically-based planing for child survival; to outline the technical and administrative issues that need to be addressed preparatory to USAID program assistance for child survival; and to recommend policy and program implementation actions, including technical assistance requirements of the DOH to facilitate the effective, efficient and equitable use of resources for child survival.

C. CURRENT CAPABILITIES FOR HEALTH PLANNING

Two kinds of health plans are prepared at both national and subnational levels. The five-year directional plans generally define the broad policies and strategies to be adopted under each major vertical program and set medium-term targets, both in terms of service coverage and achievement of desired levels of improvement in health status. The annual operational plans, on the other hand, define the service targets per year and the estimated costs of maintenance and operating expenses needed to achieve these targets.

The operational plans serve as the basis for the preparation of annual operating budgets. A zero-based budget is supposed to have been adopted. However, since annual budgets are often pegged at "X" per cent increase over the previous year's allocation or expenditure, it has been standard practice to adopt an incremental budget plan wherein previous year's allocations are simply increased to match the budget ceilings for the year.

Planning is essentially top-down in the sense that general guidelines and targets are set at the national level. Each major vertical program has adopted a standard formula for estimating needs and costs based on national averages. Eligible population and service targets for each major program are defined nationally, although regional and provincial offices may deviate from these targets. The tendency to mechanically adopt national program targets and priorities has often reduced subnational health planning to a routine exercise in computing numeric coverage targets and corresponding service delivery costs without much qualitative analysis of local situations and needs.

While there are existing mechanisms for intersectoral health planning at the provincial and regional levels, these are generally weak and inoperative. The Provincial Development Councils are often inactive and the Regional Development Councils are often occupied with numerous policy formulation and budget review functions. Hence, in most cases, operational health plans for the province are prepared by the respective program coordinators of the Integrated Provincial Health Offices (IPHOs). Operational plans are prepared for each program and consolidated, usually by the Chief of Technical Services, to become the operational provincial health plan for the year. The individual program plans may be discussed internally by the various program coordinators and the budget officer for purposes of budget adjustments, but seldom would

they be subjected to intersectoral review or discussion except during budget hearings at the RDCs.

In provinces where integrated area development (IAD) project assistance is available, intersectoral planning committees have been set up. The DOH field office may be involved in these committees and may participate in intersectoral planning exercises to determine what projects or activities could be supported by IAD funds. In these committees, health priorities and activities may be discussed, but it is doubtful whether they influence the targets and priorities set by the respective IPHOs for the use of DOH funds. At best, they can only influence the use of IAD funds for health.

As can be gleaned from the above, the existing structures and mechanisms favor resource-based and program-based health planning. Needs assessment is often limited to computing the number of eligible persons for specific services. The qualitative dimension of needs is seldom taken into account. This bias extends to the program implementation levels. Performance is geared toward achieving the numeric targets rather than toward achieving results in terms of morbidity or mortality reductions. Little thought is given to the idea of focusing services on individuals and families at highest risk because the current monitoring and performance appraisal systems do not give incentives to qualitative targeting. The budget system supports this same bias by adopting average costs, which make it more convenient for workers to focus services on the most accessible rather than the most needy. Since needy groups are often hard to reach and costly to serve, they are usually left out of the delivery of services.

Technical and managerial skills at the provincial and city levels are often limited. Capabilities for epidemiologically-based planning are often nonexistent or weak. Also, quite often, the provinces with the greatest needs are the ones with the weakest institutional capabilities for planning and program management. Cities are particularly weak in both program coverage and managerial capacities. This poses a targeting problem as there is need to be both efficient and equitable in the allocation of resources. The neediest provinces/cities clearly need to have more resources to enable them to expand service coverage and contribute to the achievement of national child survival goals. However, if the institutional leadership and management capacities in these provinces/cities are weak, they may not be able to maximally use these resources to achieve both coverage and mortality reduction targets.

On the plus side, DOH field officers do recognize the need for focused planning and service delivery, and have expressed willingness to learn how this can best be done at their levels. They are also generally aware of which population groups and households are most needy and deserving of attention. However, they do need clear policy guidelines and directions in order to focus their efforts toward achieving impact rather than simply attaining quantitative service targets.

D. PLANS FOR STRENGTHENING SUBNATIONAL HEALTH PLANNING

The recently approved Philippine Health Development Project (PHDP) has made provisions for the improvement of health planning and management capabilities at the regional and provincial levels. It has also set the stage for the full operationalization of the risk approach to service delivery and management. At the same time, it has addressed the issue of equity in service

delivery by calling attention to the needs of the most deprived and underserved segments of the population and encouraging partnership arrangements with NGOs and other local government units in addressing the health problems of underserved communities.

All provinces are expected to prepare five-year health development plans by 1990. The planning exercise is expected to have intersectoral participation, but will be coordinated by the IPHOs. A special training-cum-practicum exercise will be implemented to technically prepare the IPHOs for their substantive role in the formulation of provincial health plans and preparation of corresponding budget proposals. A block grant funding mechanism will be put in place to support budget proposals prepared by IPHOs, subject to regional or national appraisal. Block grant allocation by province will be made centrally based on perceived needs. The respective IPHOs will then prepare their detailed work and financial plans to expand coverage of child survival services and avail of the block grant funds.

The provincial health planning exercises are expected to take place in 1990. Preparatory work and capacity development activities for priority provinces will be initiated in the final quarter of 1989. Operational plans will be updated annually. Program reviews will also be conducted annually to assess the performance of the province in meeting planned targets. Both physical and financial performance will be assessed based on pre-identified indicators. Capacity-building for planning and program management will be a continuing activity in all provinces, with priority provinces receiving more focused attention. The annual program reviews will also be the basis for fine-tuning the training design for staff development at the national and sub-national levels.

Also to be set up in 1990 under PHDP is the Committee for Community Health Policy, which will define the approaches and strategies for reaching the most deprived and underserved communities in the country. The Committee will establish partnership arrangements with NGOs and local government units and will establish a community health development fund that can be channeled to NGO and LGU partners for purposes of improving community health conditions in identified priority communities with special health problems. It is expected that in these special communities, the services needed to improve health conditions will include community organization and health management, and that NGOs and LGUs will provide and/or manage the non-health technical inputs.

With regard to the child survival services of the DOH, a national mechanism for integration of maternal and child health related programs of the DOH has been set up. A National Task Force on Comprehensive Maternal and Child Health has been organized under the Office of the Undersecretary for Public Health Services. The Task Force is adopting the risk-management approach to service delivery and management and has begun the task of prioritizing provinces and cities according to specified risk factors. Classification of provinces and communities by health risk is on-going.

At the subnational level, the series of administrative reforms instituted as early as 1985 and accelerated since 1986 has resulted in developments that favor the decentralization of planning and financial management of health services. The integration of planning and budgeting was initiated in 1985 when the technical program coordinators and budget officers sat down for the

first time to jointly prepare their program plans and budgets. The adoption of the universal child immunization policy in 1986 also paved the way for more intensive planning and monitoring of services at the local level, and is a positive demonstration of what can be achieved locally with a coherent national policy and supportive national leadership.

There has also been a review and strengthening of the health information system to make it more supportive of planning and management concerns at the local and national levels. A nationwide effort is on-going for the modernization of the DOH communication and information system, starting with the acquisition of computer and radio facilities for all provincial, city and regional health offices throughout the country. Plans are also under way for the improvement of the logistics and financial management systems within the DOH in order to make them more responsive to the resource needs of programs. Admittedly, much still needs to be done to strengthen the infrastructure and mechanisms for rational program planning and management at subnational level, but the stage has been set for decentralization, and the national leadership is committed to pursuing the institutional reforms initiated in 1986.

E. INSTITUTIONAL NEEDS AND CAPACITIES

The current DOH leadership has injected a sense of purpose and urgency to the planning and management of health services throughout the country. Administrative reforms have been instituted and there are concrete plans to further strengthen the administrative support systems of the DOH, particularly in such aspects as training, public health education, information and communication systems, logistics, financial management and, more recently, decentralized health planning and budgeting at the provincial levels.

Planning and managerial skills at the provincial and city levels need to be upgraded. The current practice of operational planning is inadequate since it focuses only on computing numeric targets and costs based on national standards that may not be relevant to the needs and situations in the provinces. There is no systematic procurement plan to translate targets into monthly or quarterly supply requirements. Procurement is still largely governed by separate rather than integrated requisition vouchers from various program coordinators. Analytic skills need to be upgraded, and intersectoral participation in target setting and prioritization need to be institutionalized in order to make provincial health plans truly responsive to local needs. Mechanisms and structures for intersectoral planning need to be strengthened and activated. Provincial health planners need to be trained on the mechanics of and rationale for epidemiological-based health planning. Attitudes need to be changed and managerial capacities for risk-based health management need to be internalized among key local health implementors and supervisors.

Variances in local health situations, particularly with respect to child survival, are often a function of health leadership as well as the socio-economic and political environment. The levels of skills differ among provinces and cities. While there is close correlation between health status and managerial skills in the local health office, various combinations exist between institutional capacities and local health conditions. It may be useful to develop various models of health planning and capacity-building schemes for specific types of provinces. National performance standards may be set, but the specific subnational approaches to attain specified health goals could be tailored to local needs and capacities.

There is a relatively high level of commitment and support for child survival among provincial and city health officers and staff. What is usually lacking is the ability to think creatively about how programs and services can be delivered to achieve the most results. A combination of skills training and conscientization may be needed to stimulate creativity in health planning and management at the local levels.

Management and supervision systems, both at provincial and district levels, need to be strengthened and improved. The value of risk-targeting and monitoring must be made an integral part of the performance appraisal system. A reward and recognition system for qualitative targeting and service delivery needs to be set up and institutionalized.

Regarding program performance and emphasis, it has been noted that the government priority placed on immunization, breastfeeding, growth monitoring and diarrheal disease control has contributed to morbidity and mortality reduction among infants and children. However, success in these programs has not been evenly spread across geographic areas and population groups. Variances in mortality and morbidity indicators remain high and there are still communities and households with poor access to essential child survival services.

Program coverage has been particularly low in cities and urban poor areas. The basic infrastructure and management systems for public health services in cities have lagged behind those of rural areas. Urban poor sectors who have limited access to the private health facilities that abound in cities have been particularly deprived.

It should be noted that city health offices have been traditionally managed and financed by their respective city governments. The move to nationalize city health offices has only recently been implemented. Past programs to upgrade capabilities for planning and management have been focused on rural health facilities rather than city health offices. As a result, city health offices have lagged behind their rural counterparts in terms of training and support facilities for public health services. City health offices were also generally not covered by the restructured health care delivery system initiated in 1975. Thus, many cities have not fielded midwives to barangay health stations to deliver a broad range of primary health services. Also, because city populations are large and concentrated, city health offices often have very high worker to population ratios, making it difficult for the health system to adequately respond to the needs of its catchment population. Cities are therefore a primary target for the strengthening of child survival services.

While the basic MCH programs of immunization, oral rehydration, breastfeeding and growth monitoring have achieved modest success in terms of service coverage, the same cannot be said for acute respiratory infections (ARIs), which are still a very significant cause of child morbidity and mortality. Current and past program efforts to control ARIs have been inadequate. A primary health care approach to ARI management is being pilot-tested in Bohol Province and shows promise as an effective means of expanding coverage of ARI services and reducing ARI-related mortality risks. There are expected management complications in administering a nationwide ARI program, but the magnitude and severity of ARIs in contributing to childhood mortality demands a dramatic increase in ARI operations in order to make a substantial impact on infant and child mortality. With these prevailing

conditions, the DOH may have to face squarely the expected administrative problems of widescale ARI operations, and make the effort to expand ARI program coverage to all provinces.

F. SUGGESTED CRITERIA FOR TARGETING PROGRAM ASSISTANCE

The uneven spread of problems and opportunities for child survival makes it necessary to focus attention on priority programs and geographic areas. Program assistance must be targeted to achieve the most dramatic results within a reasonable time frame. For this reason, some criteria must be adopted in targeting assistance for child survival services. Both program and geographic targeting are essential in assuring that the program responds to the most urgent needs. The first suggested criterion for prioritizing program assistance is to focus on priority child problems that have not been adequately addressed by existing programs, in particular ARI management and basic health service coverage in cities and urban poor areas.

Mention was made earlier of the variances in program coverage across provinces and households. One key factor contributing to effective program coverage is the quality and commitment of the health worker and program manager. Another key factor is the geographic access of health facilities to targeted population. As stated earlier, resource requirements for service delivery has often been standardized based on average conditions. Hard-to-reach areas generally require higher costs to deliver the same level of coverage. Provinces with many hard-to-reach areas therefore tend to be deficient in resource support and therefore unable to achieve the same level of coverage as areas with relatively good access to services. A second criterion therefore for prioritizing program assistance is to support current cost-effective programs that suffer from inadequate inputs or resource support to expand coverage. In particular, program assistance could be used to improve access to services by fielding of additional health workers, provision of infrastructure and operating support for transport of personnel and supplies, or stimulation of consumer demand for preventive services such as immunization, growth monitoring and oral rehydration, among others.

Corollary to the above, a third suggested criterion for prioritizing program assistance is to focus first on provinces and cities with many underserved areas/groups. The focus on provinces with many underserved communities or groups is suggested for purposes of equity and impact. Since these provinces and communities are likely the largest contributors to infant and child mortality, their expanded coverage could have a positive impact on the overall infant and child mortality picture. Recognizing the key role of program managers in effecting desired results in program coverage and mortality or morbidity reductions, managerial and technical capacities must be strengthened in those priority provinces.

Recognizing the variations among provinces and cities, it is further suggested that a classification of cities and provinces by typology according to needs and capabilities be made, and corresponding planning or management models for each type be developed and tested accordingly. Possible types include: a) high level of need with low levels of IPHO capability; b) high level of need with average or high levels of IPHO capability; and c) high level of need with available support from NGOs and LGUs to supplement IPHO management capability. Planning/management models could include: a) intersectoral planning/management coupled with skills development and

attitudinal change; b) internal IPHO planning/management coupled with skills upgrading; and c) intersectoral planning and partnership arrangements, with LGUs and NGOs actively involved in program implementation and community organization.

G. SUGGESTED IMPLEMENTATION ACTIONS

The priority concern of the program is the strengthening of subnational health infrastructure for child survival services and the expansion of service coverage to levels required to effect sustained reductions in child morbidity/mortality. A key factor in the success of the program is the correct choice of geographic areas and program activities to be supported. Program activities with high impact on morbidity and mortality reductions must be supported. Communities and households that account for the largest number and proportion of morbidity and mortality cases should be targeted for priority coverage. Appropriate choices in program and geographic coverage are a function of rational and focused planning, which hinges on accurate, valid information and data.

Equity and efficiency considerations dictate that program support be focused in areas of greatest need. These are areas that contribute substantially to the levels of child morbidity and mortality and where existing health coverage is relatively low. In order to achieve a more precise and accurate targeting of program and geographic areas to be given priority in program support, it is recommended that immediate attention be given to the revalidation of the data base for identifying priority provinces and areas.

Key indicators to be used should include health status indicators as well as program coverage indicators. Relevant health indicators could include rates for: infant mortality, child mortality, maternal mortality, malnutrition prevalence, specific disease morbidity and mortality, and crude birth and death rates. Program coverage indicators could include: contraceptive prevalence rates, percentages of medically attended births and deaths, percentage of households with safe water supply, midwife to population ratios, per capita health budget allocations, percentage of fully immunized eligible children, and ORT coverage or proportion of eligible children enrolled in under-6 clinics. In addition, indicators of program efficiency and effectiveness may have to be developed and validated. Among the possible indicators are: expansion of effective coverage of essential services, reductions in morbidity or mortality, cost-effectiveness of program interventions, etc.

A second major implementation action program that needs to be immediately undertaken is the review and rezoning of midwife catchment areas, taking into account access factors and other anticipated difficulties in service delivery. A classification of catchment area based on terrain, ease of travel, population size and the like, needs to be undertaken. The classification suggested by the Cebu IPHO could be used as starting point for discussion and policy decision making. Difficult areas should be identified and appropriate provisions made to facilitate delivery of services to targeted clients. Special provisions could include: the provision of transport facilities or transport allowances, the adoption of lower midwife to population ratios to reflect the difficulty of extending services to clients, the provision of hardship subsidies or allowances to compensate for extra

efforts exerted to deliver services (such as walking long distances), and the provision of support for non-health inputs such as community organization, livelihood services and the like as may be required to facilitate effective use of health services.

With the rezoning of midwife catchment areas, the need for additional midwives is anticipated, particularly in traditionally underserved rural areas and cities. Geographic areas where new midwives need to be recruited and deployed should be identified. An estimated 2,000 new midwives will be required to achieve the desired levels of coverage of services. It is essential that the qualification standards, recruitment and screening procedures and pre-service training designs related to the new midwives be developed and adopted at the soonest possible time, possibly within the last quarter of 1989.

The strengthening of regional and provincial health planning capabilities is another priority implementation action that needs immediate attention. For this purpose, it is essential that a set of interrelated preparatory tasks be undertaken. This includes: a) the conduct of program preparation workshops for child survival, involving key central and regional health officials for purposes of defining key policies, approaches and measures to be adopted prior to program implementation; b) the refinement of the risk approach to provincial health planning and management, including the methodological processes and practical application in target setting and service management, etc.; c) the development of appropriate training designs for provincial health planners to impart skills, develop positive work attitudes, and provide practical experiences in actual provincial planning and resource allocation; d) setting up the plan and budget appraisal system for locally developed plans and budgets; and e) setting up the mechanisms for block grant releases to provinces with approved work and financial plans, including a system for performance auditing and evaluation. Technical assistance may be required to undertake the above tasks, including the training of provincial health planners on the processes and methods of epidemiological-based health planning.

H. SUGGESTED PHASING OF PROGRAM ASSISTANCE

Most program activities in the first year will probably be devoted to setting up the systems and infrastructure for decentralized health planning and budgeting for child survival. These include: a) the classification of provinces and municipalities according to risk and access factors; b) the rezoning of midwife catchment areas based on a classification system that takes into account both risk and access factors; c) the development and pilot-testing of various health planning and budgeting models based on provincial classifications; d) the conduct of consultative workshops to prepare regional and central program managers for their supportive role in program implementation and to discuss policy and operations issues that need to be addressed; e) the training of provincial health planners and the conduct of phased provincial health planning exercises in the first priority provinces and cities; and f) the recruitment and training of new midwives and other health personnel needed to improve the effectiveness and outreach of child survival services.

I. IDENTIFICATION OF PRIORITY PROVINCES AND CITIES

As a basic program strategy, priority attention should be given to areas that are at highest risk with respect to child morbidity and mortality. Child risk is a function of environmental, socio-economic and behavioral factors. A suggested means of determining risk by province involves the use of health indicators, service access and coverage indicators, and health risk indicators related to the major causes of death among children. Both physical and financial access indicators such as road networks, agricultural productivity scales, poverty incidence, etc., could also be added as criteria for classification of provinces.

Provinces and cities that consistently rank low in many of these indicators should be targeted for immediate technical and financial support to enable them to catch up to their more advanced neighbors. Pockets of poverty or risk in the targeted provinces as well as the rest of the provinces should likewise be targeted for focused services. The ultimate targets of services are the high risk households within the targeted provinces. Provinces classified as high risk are expected to have the largest concentration of high risk households.

The Community Health Service (CHS) of the DOH previously ranked priority provinces and cities based on several health status and coverage indicators. The assessment for the PAAD has ranked the provinces and cities based on the following criteria:

1. Priority child problems that have not been adequately addressed by existing programs, in particular ARI management and basic health service coverage in cities and urban poor areas.

2. Support of current cost-effective programs that suffer from inadequate inputs or resource support to expand coverage.

3. Provinces and cities with many underserved areas.

4. Classification by typology, according to need and capabilities.

The table on the following page compares these two rankings. It is expected that the DOH will utilize these two assessments to establish the priority list for child survival interventions, to be finalized prior to initial funds disbursement.

LIST OF PRIORITY PROVINCES AND CITIES

A. Provinces

DOH/CHS	THIS ASSESSMENT
1. Masbate	1. Surigao del Sur
2. Northern Samar	2. Catanduanes
3. Surigao del Sur	3. Northern Samar
4. Quezon	4. Batanes
4. Camarines Norte	5. Albay
4. Camarines Sur	5. Sorsogon
4. Biliran	6. Antique
5. Aurora	7. Camarines Norte
6. Antique	8. Aurora
7. Surigao del Norte	8. Quirino
8. Eastern Samar	9. Agusan del Sur
8. Romblon	9. Sulu
9. Sorsogon	9. Capiz
10. Quirino	10. Mindoro Occ.
10. Zambales	10. Mindoro Or.
11. Mindoro Occ.	10. Camarines Sur
11. Negros Occ.	10. Western Samar
12. Agusan del Norte	10. Camiguin
12. Abra	11. Abra
12. Nueva Ecija	12. Marinduque
12. Aklan	12. Quezon
12. Capiz	12. Bukidnon
13. Leyte	
13. Sulu	
13. Camiguin	
13. Mindoro Or.	

B. Cities

1. Legaspi City	1. Cotabato City
2. Naga City	2. Gingoog City
3. Bago City	3. Canlaon City
3. Cadiz City	4. Ozamis City
3. Canlaon City	5. Dagupan City
4. Lapu-Lapu City	6. Calbayog City
4. Toledo City	6. Pagadian City
4. Roxas City	7. Lapu-Lapu City
5. Cebu City	7. Tacloban City
5. Bais City	8. Dumaguete City
5. Bacolod City	9. Lucena City
	9. Butuan City
	10. Trece Martires
	11. Roxas City
	11. Dipolog City
	11. Iligan City

HEALTH STATUS INDICATORS BY PROVINCE/CITY

	% 2&3 Degree 1988 (a)	Est. CBR 1988 (a)	IMR 1986 (b)	IMR 1988 (a)	TMR 1987 (c)	Total FR 1984 (d)	MMR 1986 (b)	MMR 1988 (a)
PHILIPPINES		23.8	35.0	30.4	7.0	4.5	1.10	0.79
NCR		26.9	33.4	33.9	11.0	2.9	0.50	0.47
1st District		19.4		42.2				0.70
Manila		25.4	27.7	32.0	12.4		0.30	0.36
2nd District		28.5	40.4	57.0	11.0		1.00	1.20
Quezon City		34.7	40.3	29.1	11.3		0.50	0.34
3rd District		24.1	42.0	16.5	11.9		0.70	0.15
Caloocan City		32.1	34.9	30.6	12.4		0.40	0.21
4th District Mun.		21.7	29.1	38.2	91.3		0.60	0.59
Pasay City		23.4	36.4	31.0	8.2		0.40	0.24
Region 1		24.4	37.7	24.5	7.2	4.6	0.90	0.58
Abra	33.5	23.2	48.9	37.9	5.9	4.9	3.20	1.38
Benguet		24.2	18.5	18.7	5.5	4.5	0.70	0.54
Ilocos Norte	19.5	27.6	37.6	34.5	4.0	4.4	0.50	0.62
Ilocos Sur	18.6	20.6	34.9	28.7	5.5	4.8	1.60	0.56
La Union	19.9	24.8	39.0	34.0	6.7	4.8	0.60	0.44
Mt. Province	17.5	21.9	18.6	27.2	5.7	5.0	2.30	2.40
Pangasinan	23.9	24.2	41.3	36.0	7.9	4.6	0.70	0.60
Baguio City		37.1	17.9	12.5	3.0		0.30	0.36
Dagupan City		37.1	57.1	38.9	25.9		2.20	1.19
Laoag City		16.2	25.3	18.6	10.9		0.50	0.00

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HEALTH STATUS INDICATORS BY PROVINCE/CITY

	% 2&3 Degree 1988 (a)	Est. CBR 1988 (a)	IMR 1986 (b)	IMR 1988 (a)	TMR 1987 (c)	Total FR 1984 (d)	MMR 1986 (b)	MMR 1988 (a)
San Carlos City		23.8	49.4	29.7	8.9		1.10	0.36
Region 2		23.4	43.6	30.6	7.1	5.0	1.20	0.68
Batanes		25.4	55.7	39.2	1.2	5.2	2.80	0.00
Cagayan		24.7	59.5	34.7	9.9	5.1	1.40	0.96
Ifugao	26.7	20.9	20.7	25.9	5.3	4.8	1.10	1.46
Isabela	18.5	24.2	37.7	31.3	6.7	5.0	1.00	0.43
Kalinga-Apayao	27.2	17.0	27.3	26.6	2.7	4.8	0.80	0.77
Nueva Vizcaya	19.8	22.3	34.4	18.4	4.5	4.8	1.20	0.44
Quirino		25.6	41.9	31.2	9.1	5.2	1.40	0.71
Region 3		24.3	29.6	27.2	5.8	4.1	0.70	0.58
Bataan	20.0	19.0	32.7	24.3	7.2	4.1	0.80	0.49
Bulacan		25.1	32.8	24.7	7.4	4.0	0.90	0.67
Nueva Ecija	26.0	25.4	36.2	25.2	3.6	4.4	0.60	0.84
Pampanga	18.6	23.6	19.0	20.2	3.5	4.1	0.60	0.32
Tarlac	22.7	23.1	29.0	37.1	6.6	4.2	0.40	0.32
Zambales	21.7	27.4	29.2	41.7	5.1	3.8	1.40	0.80
Angeles City			26.9		7.6		0.50	
Cabanatuan City			25.9		9.3		0.70	
Olongapo City			42.4		6.8		0.80	
Palayan City			17.9		4.3			
San Jose City			37.0		13.9		0.90	

HEALTH STATUS INDICATORS BY PROVINCE/CITY

	% 2&3 Degree 1988 (a)	Est. CBR 1988 (a)	IMR 1986 (b)	IMR 1988 (a)	TMR 1987 (c)	Total FR 1984 (d)	MMR 1986 (b)	MMR 1988 (a)
Region 4		24.0	37.3	35.5	8.5	4.5	1.10	0.70
Aurora	22.1	25.2	54.5	41.4	14.8	4.5	3.60	
Batangas		21.7	28.7	35.3	4.8	4.4	0.40	0.25
Cavite	17.3	18.9	37.0	29.6	6.2	4.3	0.50	0.58
Laguna	21.2	23.7	32.8	26.9	7.3	4.3	0.80	0.19
Marinduque	21.6	23.8	42.0	38.8	9.8	4.5	0.70	1.26
Mindoro Occ.	30.3	23.6	31.4	29.0	5.9	5.3	2.80	1.07
Mindoro Or.	23.0	23.0	45.3	48.0	9.4	5.2	1.80	1.39
Palawan	23.5	17.9	20.6	26.2	4.8	4.7	1.30	2.37
Quezon	24.2	27.9	49.2	43.2	13.1	4.9	1.30	0.98
Rizal	21.7	23.7	33.1	30.8	9.0	3.6	1.40	0.40
Romblon	26.2	28.0	42.1	41.3	13.2	4.3	1.10	0.49
Batangas City		26.6	31.7	43.8	3.8		0.60	0.44
Cavite City		25.3	40.5	49.2	6.5		0.70	0.77
Lipa City		33.8	34.4	33.4	6.6		1.10	0.61
Lucena City		29.2	43.5	39.9	18.1		1.60	1.25
Puerto Princesa		27.8	24.3	23.6	7.7		0.70	
San Pablo City		34.3	33.5	29.6	11.1		0.60	0.73
Tagaytay City		19.9	40.3	29.6	2.8			
Trece Martires		36.9	66.0	29.0	46.4		1.60	
Region 5		30.2	41.4	27.0	11.5	5.9	1.90	1.32

HEALTH STATUS INDICATORS BY PROVINCE/CITY

	% 2&3 Degree 1988 (a)	Est. CBR 1988 (a)	IMR 1986 (b)	IMR 1988 (a)	TMR 1987 (c)	Total FR 1984 (d)	MMR 1986 (b)	MMR 1988 (a)
Albay	24.7	28.4	32.3	28.1	11.4	5.1	1.60	1.08
Camarines Norte	25.9	36.8	61.0	39.4	19.9	5.8	1.50	0.76
Camarines Sur	36.6	32.2	41.8	23.4	11.6	5.0	1.80	1.09
Catanduanes	30.4	32.3	51.5	32.8	13.4	5.1	3.50	0.49
Masbate	19.6	25.8	50.3	30.9	5.8	5.6	3.40	1.90
Sorsogon	26.0	28.9	51.2	29.9	12.4	5.3	2.60	0.80
Iriga City			36.6		10.8		0.80	
Legaspi City			30.5		12.4		1.40	
Naga City			15.8		12.3		0.50	
Region 6		18.5	43.5	34.2	5.2	4.7	1.10	0.88
Aklan	27.7	16.0	42.2	30.0	4.3	5.3	1.00	0.16
Antique	27.1	19.1	59.1	42.2	9.4	5.1	1.30	0.88
Capiz	28.7	18.7	54.9	37.7	6.0	5.2	1.70	0.98
Guimaras		16.4		26.0				0.00
Iloilo	28.0	21.6	41.2	29.6	4.5	4.6	1.20	0.73
Negros Occ.	25.1	16.8	38.4	36.7	3.9	4.6	0.90	1.14
Bacolod City			49.6		5.8		1.80	
Bago City			63.3		4.0			
Cadiz City			22.4		2.2			
Iloilo City			39.1		7.1		0.60	
La Carlota City			30.1		4.0		1.50	

HEALTH STATUS INDICATORS BY PROVINCE/CITY

	% 2&3 Degree 1988 (a)	Est. CBR 1988 (a)	IMR 1986 (b)	IMR 1988 (a)	TMR 1987 (c)	Total FR 1984 (d)	MMR 1986 (b)	MMR 1988 (a)
Roxas City			46.5		13.3		1.50	
San Carlos City			51.6		8.0		2.50	
Silay City			32.4		5.0		1.10	
Region 7		24.9	35.2	32.0	6.1	4.5	1.10	0.83
Bohol		27.2	41.6	30.0	5.4	4.8	1.30	0.92
Cebu		26.7	40.0	32.6	6.0	4.3	0.90	0.51
Negros Or.	21.3	16.5	24.3	21.6	3.3	4.6	0.90	2.14
Siquijor		22.6	33.9	23.8	3.2	4.4	1.00	0.56
Bais City		29.8	12.8	23.4	2.5		2.20	0.58
Canlaon City		27.5	99.6	99.1	24.4		2.30	5.83
Cebu City		26.8	27.9	37.3	8.4		1.00	0.58
Danao City		33.7	33.6	27.4	10.8		1.40	0.00
Dumaguete City		25.6	41.9	8.3	10.8		2.00	0.00
Lapu-Lapu City		25.4	42.5	76.7	10.6		0.80	0.35
Mandawe City		18.5	39.1	40.5	5.5		1.20	1.05
Tagbilaran City		22.7	21.5	31.3	4.6		1.30	0.00
Toledo City		36.4	25.2	19.0	9.2		1.20	0.26
Region 8		19.9	41.1	32.6	7.8	6.2	2.30	1.13
Leyte del Norte	23.8	22.0	44.2	31.9	8.9		2.40	0.68
Leyte del Sur	21.1	19.0	36.2	21.8	4.1		1.10	0.00
Eastern Samar	27.5	16.1	24.6	28.3	3.2	5.7	2.80	1.46

HEALTH STATUS INDICATORS BY PROVINCE/CITY

	% 2&3 Degree 1988 (a)	Est. CBR 1988 (a)	IMR 1986 (b)	IMR 1988 (a)	TMR 1987 (c)	Total FR 1984 (d)	MMR 1986 (b)	MMR 1988 (a)
Northern Samar	27.9	14.9	59.5	49.5	10.8	6.2	4.30	2.61
Western Samar	38.7	19.7	28.6	29.3	4.4	6.7	2.00	1.93
Calbayog City		14.0	43.5	44.7	8.8		3.10	3.83
Ormoc City		25.8	23.5	8.6	5.8		0.50	0.32
Tacloban City		31.6	51.0	51.1	17.3		1.70	0.53
Biliran sub-prov.		21.4		37.2				1.40
Region 9		20.0	32.4	26.7	4.0	4.7	1.30	1.44
Basilan		9.6	37.3	16.8	1.4	4.9		0.84
Sulu	21.8	7.9	72.9	50.1	4.7	4.6	1.70	3.56
Tawi-Tawi	18.1	12.4	8.7	36.2	0.04	4.5		0.34
Zamboanga del Norte		23.6	27.5	15.7	3.9	4.8	1.80	0.99
Zamboanga del Sur	22.6	21.9	21.6	22.3	3.4	4.6	1.30	2.17
Dapitan City		21.1	30.5	33.4	5.8			0.72
Dipolog City		33.3	43.7	30.9	9.3		1.70	0.00
Pagadian City		32.9	65.7	35.9	8.5		1.50	0.60
Zamboanga City		28.0	43.4	35.1	6.4		1.30	1.09
Region 10		27.5	33.2	26.0	4.9	4.9	1.20	0.87
Agusan del Norte		29.2	36.6	28.5	6.5	4.8	0.50	0.71
Agusan del Sur	17.2	32.8	20.9	19.7	3.5	5.2	1.00	1.62
Bukidnon	24.0	29.8	18.7	13.6	3.0	5.3	0.90	0.85
Camiguin	20.4	31.4	46.9	21.9	3.6	5.0	1.70	

HEALTH STATUS INDICATORS BY PROVINCE/CITY

	% 2&3 Degree 1988 (a)	Est. CBR 1988 (a)	IMR 1986 (b)	IMR 1988 (a)	TMR 1987 (c)	Total FR 1984 (d)	MMR 1986 (b)	MMR 1988 (a)
Misamis Occ	16.5	20.1	30.1	32.0	4.2	5.2	0.50	0.19
Misamis Or		20.1	41.9	32.5	4.6	4.4	2.50	0.54
Surigao del Norte	24.3	17.4	42.1	32.5	4.7	5.1	1.60	0.96
Butuan City		33.5	48.8	38.6	7.7		1.70	1.12
Cagayan de Oro		35.5	41.9	27.9	5.2		0.80	0.79
Bingoog City		25.2	51.6	56.8	11.6		1.30	0.83
Oroquita City		23.3	34.8	34.3	4.3		1.40	
Ozamis City		39.3	52.3	35.2	7.3		0.70	0.82
Surigao City		32.2	30.9	21.7	9.3		2.70	0.32
Tangub City		26.2	50.6	31.2	6.7		1.90	2.53
Region 11		21.5	23.0	23.4	5.0	5.3	0.90	0.88
South Cotabato	17.4	7.7	17.8	24.8	4.5	5.2	0.70	0.67
Davao del Norte		21.4	19.8	14.0	5.2	5.5	0.80	0.38
Davao Or		15.1	20.1	28.8	5.1	5.3	1.70	1.43
Davao del Sur		16.1	18.4	25.1	3.2	5.0	0.80	1.18
Surigao del Sur	25.8	22.7	53.0	42.4	7.2	5.6	1.80	1.41
Davao City		29.4	18.8	17.1	4.2		0.70	1.03
Gen Santos City		32.5	31.4	31.7	9.2		0.40	0.32
Region 12		20.0	25.3	23.3	3.0	4.8	0.80	1.12
North Cotabato	18.5	22.4	14.5	11.3	2.7	5.2	0.80	0.88
Lanao del Norte	22.3	25.8	16.7	23.7	3.6	4.3	0.20	0.66

HEALTH STATUS INDICATORS BY PROVINCE/CITY

	% 2&3 Degree 1988 (a)	Est. CBR 1988 (a)	IMR 1986 (b)	IMR 1988 (a)	TMR 1987 (c)	Total FR 1984 (d)	MMR 1986 (b)	MMR 1988 (a)
Lanao del Sur	24.7	16.4	7.2	24.1	0.1	5.0	1.00	2.36
Maguindanao	21.0	9.9	11.0	27.6	0.2	4.5		2.60
Sultan Kudarat	20.0	20.1	12.9	8.6	2.6	5.0	0.70	0.88
Cotabato City		20.2	115.7	119.8	16.6		2.10	2.98
Iligan City		37.8	43.1	32.5	10.2		0.40	
Marawi City		10.2	72.8	33.5	5.8		7.10	

Sources of Data:

(a) 1988 Regional Annual Reports, DOH

(b) 1986 Philippine Health Statistics

(c) Public Health Services, DOH

(d) 1988 Philippine Data Sheet, DRDF & PCF

PROGRAM COVERAGE INDICATORS BY PROVINCE/CITY

	% OPT Coverage 1988 (a)	% Fully Immunized 1988 (a)	% Births Attended 1986 (b)	% Births Attended 1988 (a)	% Deaths Attended 1986 (b)	% w/ Safe H2O 1987 (c)	% w/ Safe H2O 1988 (a)	MW:Pop 1988 (a)	PER CAPITA (Budget) F H S 1988 (P) (a)	H S 1988 (P) (a)	C D 1988 (P) (a)	Total 1988 (P) (a)
PHILIPPINES	62.0	70.98	54.4	62.74	36.4		41.6	1:5,561	7.82	22.07	6.89	36.78
NCR	50.1	62.90	90.8	81.40	58.0		11.8	1:13,336	22.38	4.62	1.13	28.13
1st District	45.0	46.90		77.40			29.7	1:10,903	19.12	1.97	2.25	23.34
Manila	36.2	74.20	99.0	87.80	61.8			1:14,921	39.24			39.24
2nd District	78.3	51.30	89.9	86.60	64.3		9.9	1:19,700	11.91	7.74	4.69	24.34
Quezon City	55.6	65.50	86.8	84.10	61.0		3.6	1:8,311	21.41	16.67	0.54	38.62
3rd District	26.9	57.70	82.3	73.60	43.0		4.1	1:15,412	18.42		0.08	18.50
Caloocan City	78.3	72.80	78.6	67.80	48.7		6.5	1:5,993	14.90			14.90
4th District Mun.	23.7	48.50	84.5	75.30	52.0		28.4	1:13,716	12.44	1.82	2.22	16.48
Pasay City	95.6	84.00	86.4	81.30	49.0		4.3	1:9,403	16.62			16.62
Region 1	72.7	74.20	60.9	75.63	33.0		63.0	1:3,765	6.14	15.89	5.70	27.73
Abra	65.0	61.16	40.3	64.19	23.4		56.3	1:2,230	7.47	24.15	11.18	42.80
Benguet	76.4	70.65	55.7	81.10	44.2		2.5	1:2,758	5.64	20.01	6.74	32.39
Ilocos Norte	79.9	78.01	77.5	86.99	39.0	84.0	81.8	1:2,967	6.47	16.62	8.94	32.03
Ilocos Sur	74.4	72.60	56.3	84.60	24.8	75.0	21.2	1:3,554	6.36	17.58	10.35	34.29
La Union	80.9	75.69	67.8	67.63	33.3	70.0	76.0	1:4,498	6.06	11.68	7.02	24.76
Mt. Province	77.4	78.72	44.9	61.14	25.8		33.1	1:1,680	8.66	70.56	26.34	105.56
Pangasinan	68.9	71.91	53.6	73.85	28.7		84.9	1:3,675	5.85	15.54	2.44	23.83
Baguio City	85.4	96.18	91.5	92.18	64.0				5.65			5.65
Dagupan City	55.7	74.53	80.6	60.12	51.0		19.0		5.85			5.85

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PROGRAM COVERAGE INDICATORS BY PROVINCE/CITY

	% DPT Coverage 1988 (a)	% Fully Immunized 1988 (a)	% Births Attended 1986 (b)	% Births Attended 1988 (a)	% Deaths Attended 1986 (b)	% w/ Safe H2O 1987 (c)	% w/ Safe H2O 1988 (a)	MW:Pop 1988 (a)	PER CAPITA (Budget) F H S 1988 (P) (a)	H S 1988 (P) (a)	C D 1988 (P) (a)	Total 1988 (P) (a)
Laoag City	61.1	74.34	68.2	86.16	52.0		78.7		6.48			6.48
San Carlos City	63.2	80.66	51.1	72.47	21.4		75.6		5.86			5.86
Region 2	75.0	77.00	38.9	65.94	29.8		7.1	1:4,110	6.74	31.78	7.40	45.92
Batanes	100.0	148.00	94.4	96.02	52.3	2.4	10.3	1:14,036	26.22	243.09	0.05	269.36
Cagayan	71.5	79.00	34.3	63.77	26.3	78.0	7.1	1:5,201	7.06	45.98	10.67	63.71
Ifugao	81.7	86.00	39.4	79.50	23.0		8.1	1:2,984	6.40	46.80	25.46	78.66
Isabela	76.0	74.00	41.2	64.69	34.8		4.3	1:4,529	6.38	10.35	3.44	20.17
Kalinga-Apayao	57.0	70.00	42.3	83.00	24.0		18.8	1:2,647	6.86	44.20	4.49	55.55
Nueva Vizcaya	93.0	79.00	45.9	71.56	25.0		6.6	1:3,582	6.50	33.01	8.44	47.95
Quirino	77.0	80.00	20.6	35.67	43.0		10.0	1:3,294	6.11	54.05	2.75	62.91
Region 3	67.8	73.00	72.6	75.44	39.3			1:5,771	4.88	32.01	4.81	41.70
Bataan	63.6	81.00	83.0	91.52	45.0		48.1	1:4,207	7.68	81.39	6.77	95.84
Bulacan	62.3	84.00	78.4	83.54	47.2		37.9	1:6,035	4.27	33.93	4.39	42.59
Nueva Ecija	60.3	70.00	60.7	71.90	34.9		76.0	1:6,058	5.12	21.84	4.01	30.97
Pampanga	80.9	84.00	78.8	76.25	35.1		56.9	1:5,897	3.88	23.47	5.38	32.73
Tarlac	75.4	64.00	62.6	59.99	24.2		62.2	1:5,475	5.52	32.43	3.87	41.82
Zambales	60.8	60.00	57.6	72.57	54.3		81.4	1:6,350	5.39	34.52	6.08	45.99
Angeles City		67.14	75.8		37.6							
Cabanatuan City		77.70	84.2		44.8							
Olongapo City		44.29	84.5		51.8							

PROGRAM COVERAGE INDICATORS BY PROVINCE/CITY

	% OPT Coverage 1988 (a)	% Fully Immunized 1988 (a)	% Births Attended 1986 (b)	% Births Attended 1988 (a)	% Deaths Attended 1986 (b)	% w/ Safe H2O 1987 (c)	% w/ Safe H2O 1988 (a)	MW:Pop 1988 (a)	PER CAPITA (Budget) FHS 1988 (P) (a)	HS 1988 (P) (a)	CO 1988 (P) (a)	Total 1988 (P) (a)
Palayan City			37.3		17.6							
San Jose City		76.97	59.9		28.1							
Region 4	68.0		47.5	57.00	39.4		55.5	1:7.063			7.29	47.41
Aurora	76.0	76.00	14.1	46.50	18.1	44.0	33.5	1:3,302			41.37	103.25
Batangas	90.0	84.74	54.8	78.00	33.2	60.0	49.8	1:6,903			4.10	36.64
Cavite	82.4	64.52	63.2	64.00	39.3		42.1	1:7,476			4.13	51.80
Laguna	64.0	73.74	62.2	57.00	43.1		70.9	1:7,231			6.69	45.56
Marinduque	69.1	55.15	22.9	43.00	26.7		68.5	1:50,754			15.69	81.97
Mindoro Occ.	63.8	61.35	25.6	31.00	41.7		82.0	1:4,931			16.85	81.84
Mindoro Or.	75.0	75.13	12.9	40.00	36.9		81.0	1:6,439			13.04	48.32
Palawan	46.0	67.07	23.9	37.00	29.4		93.8	1:4,551			14.99	71.17
Quezon	76.0	43.00	29.7	51.00	32.7		22.5	1:6,633			7.77	49.68
Rizal	62.5	52.25	74.6	73.10	56.4		22.5	1:7,907			4.13	43.42
Romblon	78.6	54.52	30.8	55.00	47.6		202.4	1:3,349			14.03	114.74
Batangas City	49.0	77.31	71.3	61.70	43.4							
Cavite City	87.0	39.92	89.2	88.20	69.9							
Lipa City	64.0	61.33	41.4	42.00	33.3							
Lucena City	41.0	39.88	67.0	59.00	44.1							
Puerto Princesa	75.0	72.78	33.2	24.00	47.8							
San Pablo City	40.0	57.97	66.8	63.00	44.2							

PROGRAM COVERAGE INDICATORS BY PROVINCE/CITY

	% OPT Coverage 1988 (a)	% Fully Immunized 1988 (a)	% Births Attended 1986 (b)	% Births Attended 1988 (a)	% Deaths Attended 1986 (b)	% w/ Safe H2O 1987 (c)	% w/ Safe H2O 1988 (a)	MW:Pop 1988 (a)	PER CAPITA (Budget) FHS 1988 (P) (a)	HS 1988 (P) (a)	CO 1988 (P) (a)	Total 1988 (P) (a)
Tagaytay City	68.0	76.58	40.5	61.00	14.7							
Trece Martires	93.0	69.22	91.6	60.40	86.0							
Region 5	73.8	80.96	31.4	45.46	23.7		62.7	1:5,688	8.84	18.98	5.56	33.38
Albay	86.8	82.90	26.1	31.46	16.8	48.0	52.9	1:6,992	8.37	12.34	6.93	27.64
Camarines Norte	76.7	76.76	39.6	59.68	24.0		73.0	1:4,997	15.68	13.48	7.89	37.05
Camarines Sur	64.8	90.34	23.4	48.16	16.0	70.0	77.9	1:5,362	6.90	26.94	1.09	34.93
Catanduanes	68.9	82.76	37.5	49.35	32.3	26.0	30.8	1:4,166	10.36	53.44	22.25	86.05
Masbate	75.2	74.49	27.7	59.29	32.6	47.0	70.4	1:5,646	8.66	10.80	5.56	25.02
Sorsogon	70.1	75.72	26.9	33.71	26.6	26.0	36.4	1:6,023	9.28	13.42	6.20	28.90
Iriga City	73.8	59.39	37.4		30.1							
Legaspi City	92.9	72.44	60.5		42.7							
Naga City	57.8	72.18	66.4		44.6							
Region 6	56.2	73.72	41.9	56.67	36.0		48.7	1:5,022	6.24	26.71	6.13	39.08
Aklan	60.2	70.52	37.5	45.30	25.6	61.0	35.7	1:3,425	6.51	49.36	6.20	62.07
Antique	59.5	67.09	32.8	57.29	34.8	73.0	51.9	1:3,640	6.41	49.80	19.23	75.44
Capiz	57.7	64.06	22.7	59.15	14.7	42.0	30.3	1:4,614	7.04	38.01	7.03	52.08
Guimaras	69.8	69.98		45.35			31.6	1:4,236	9.23	33.26	7.26	49.75
Iloilo	50.6	74.71	36.5	54.47	40.8	79.0	61.6	1:4,799	6.58	28.87	7.08	42.53
Negros Occ.	58.0	77.41	33.8	60.06	22.6	66.0	47.1	1:6,351	5.60	14.24	2.88	22.72
Bacolod City		73.75	82.5		58.5							

PROGRAM COVERAGE INDICATORS BY PROVINCE/CITY

	% OPT Coverage 1988 (a)	% Fully Immunized 1988 (a)	% Births Attended 1986 (b)	% Births Attended 1988 (a)	% Deaths Attended 1986 (b)	% w/ Safe H2O 1987 (c)	% w/ Safe H2O 1988 (a)	MW:Pop 1988 (a)	PER CAPITA (Budget) FHS 1988 (P) (a)	HS 1988 (P) (a)	CO 1988 (P) (a)	Total 1988 (P) (a)
Bago City		89.34	48.0		30.7							
Cadiz City		71.74	44.8		17.2							
Iloilo City	45.4	58.29	73.9		54.9							
La Carlota City		80.62	60.1		38.4							
Roxas City		74.85	47.9		49.3							
San Carlos City		72.44	29.5		34.9							
Silay City		62.33	71.0		42.7							
Region 7	49.5	69.34	54.5	66.87	25.7		32.1	1:4,786			2.64	37.96
Bohol	71.1	76.86	52.9	14.69	15.4	36.0	35.3	1:3,044			3.67	46.32
Cebu	56.2	87.35	44.3	25.49	15.1	58.0	22.0	1:3,594			3.90	49.23
Negros Or.	41.7	63.24	34.5	7.38	24.0	42.0	46.2	1:3,798			3.74	60.00
Siquijor	58.6	58.95	91.3	1.52	14.9	58.0	34.5	1:2,153				129.55
Bais City	24.5	41.28	26.3	0.45	37.7							
Canlaon City	122.4	26.31	10.9	0.15	7.0							
Cebu City	12.1	50.95	80.5	10.80	49.6							
Danao City	32.5	62.70	44.2	1.16	6.8							
Dumaguete City	34.9	39.81	84.9	0.36	75.3							
Lapu-Lapu City	58.2	46.40	31.9	1.69	4.0							
Mandawe City	61.3	42.63	68.1	1.47	15.8							
Tagbilaran City	70.1	71.72	99.3	0.55	65.9							

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PROGRAM COVERAGE INDICATORS BY PROVINCE/CITY

	% OPT Coverage 1988 (a)	% Fully Immunized 1988 (a)	% Births Attended 1986 (b)	% Births Attended 1988 (a)	% Deaths Attended 1986 (b)	% w/ Safe H2O 1987 (c)	% w/ Safe H2O 1988 (a)	MW:Pop 1988 (a)	PER CAPITA (Budget) FHS 1988 (P) (a)	HS 1988 (P) (a)	CO 1988 (P) (a)	Total 1988 (P) (a)
Toledo City	18.6	46.27	48.7	1.16	14.2							
Region 8	54.0	75.10	39.5	54.29	24.3		47.2	1:4,394	6.11	14.04	14.10	34.25
Leyte del Norte	61.2	81.70	29.2	48.90	20.7		40.3	1:4,412	6.38	18.60	9.97	34.95
Leyte del Sur	77.2	63.80	50.3	62.00	18.9		30.9	1:3,670	5.06	19.23	13.62	37.91
Eastern Samar	47.3	66.60	45.1	65.30	36.4		71.9	1:3,268	8.33	21.02	20.22	49.57
Northern Samar	43.8	79.40	28.8	43.70	23.0		82.7	1:4,829	7.21	18.90	31.50	57.61
Western Samar	44.3	74.30	51.0	67.20	25.2		47.3	1:3,390	10.09	1.59	17.07	28.75
Calbayog City	23.9	37.90	37.1	46.20	23.7		24.0					
Ormoc City	56.1	82.90	37.7	29.40	37.6		40.6					
Tacloban City	25.0	81.70	90.6	85.40	38.0		11.9	1:29,617				
Biliran sub-prov.	57.0	85.50		33.90			11.3	1:3,115				
Region 9	57.1	61.00	47.0	64.20	39.9			1:5,084	11.37	14.77	10.19	36.33
Basilan	67.0	55.00	39.3	41.24	40.0			1:4,576	7.15	5.79		12.94
Sulu	14.9	30.00	62.1	58.17	75.8			1:7,153	11.39	13.21		24.60
Tawi-Tawi	52.8	35.00	77.1	62.83	23.2			1:4,162	10.14	8.04		18.18
Zamboanga del Norte	85.0	67.00	36.7	60.15	24.5			1:4,011	15.27	18.04		33.81
Zamboanga del Sur	56.9	78.00	31.7	60.65	32.0	53.0		1:3,787	18.37	10.03		28.40
Dapitan City	48.0	57.00	58.6	59.76	87.9							
Dipolog City	52.0	75.00	74.9	66.72	37.7							
Pagadian City	69.0	76.00	78.6	79.62	47.1							

PROGRAM COVERAGE INDICATORS BY PROVINCE/CITY

	% OPT Coverage 1988 (a)	% Fully Immunized 1988 (a)	% Births Attended 1986 (b)	% Births Attended 1988 (a)	% Deaths Attended 1986 (b)	% w/ Safe H2O 1987 (c)	% w/ Safe H2O 1988 (a)	MW:Pop 1988 (a)	PER CAPITA (Budget) FHS 1988 (P) (a)	HS 1988 (P) (a)	CO 1988 (P) (a)	Total 1988 (P) (a)
Zamboanga City	73.0	59.00	73.0	77.08	43.5			1:32,568				
Region 10	69.7	76.84	37.6	46.50	27.3		32.2	1:4,541	9.86	8.05	3.44	21.35
Agusan del Norte	72.5	80.34	35.3	46.92	33.5		66.7	1:3,704	27.92	17.42	3.87	49.21
Agusan del Sur	103.4	94.09	30.2	38.06	35.6		30.7	1:5,387	13.33	12.36	9.94	35.63
Bukidnon	59.4	85.71	32.6	39.86	36.1		24.4	1:3,934	7.81	5.33	4.65	17.79
Camiguin	94.8	62.52	52.8		20.4		8.7	1:4,162	8.47	40.14	5.31	53.92
Misamis Occ	86.6	75.77	42.3		15.4		40.1	1:2,774	17.20	15.76	2.17	35.13
Misamis Or		83.82	39.8		11.1		34.9	1:3,500	15.36	4.50	3.88	23.74
Surigao del Norte	82.3	80.13	25.6		13.3		44.3	1:4,211	11.87	17.59	3.25	32.71
Butuan City		54.21	38.0		32.8		41.6	1:16,390				
Cagayan de Oro		48.51	51.7		32.8		7.4	1:13,308				
Singcog City		55.00	35.9		25.8		22.9	1:10,633				
Oroquita City		68.82	58.3		52.9		34.8	1:4,695				
Ozamis City		77.44	41.8		24.9		51.4	1:8,422				
Surigao City		70.24	41.8		43.1		12.8	1:6,007				
Tangub City		78.61	45.8		21.1		47.3	1:3,014				
Region 11		67.68	34.8		34.6		72.3	1:6,289	7.30	27.42	9.77	44.49
South Cotabato	56.9	68.68	35.8		36.7		89.8	1:4,931	8.58	39.74	14.22	62.54
Davao del Norte		76.24	28.3		29.7		84.5	1:5,380	5.83	20.32	6.25	32.40
Davao Or		75.57	25.3		22.4		92.6	1:4,040	9.86	39.65	10.45	59.96

PROGRAM COVERAGE INDICATORS BY PROVINCE/CITY

	% OPT Coverage 1988 (a)	% Fully Immunized 1988 (a)	% Births Attended 1986 (b)	% Births Attended 1988 (a)	% Deaths Attended 1986 (b)	% w/ Safe H2O 1987 (c)	% w/ Safe H2O 1988 (a)	MW:Pop 1988 (a)	PER CAPITA (Budget) F H S 1988 (P) (a)	H S 1988 (P) (a)	C D 1988 (P) (a)	Total 1988 (P) (a)
Davao del Sur		60.90	24.6		25.0		89.0	1:4,536	15.00	37.52	11.73	64.25
Surigao del Sur	42.8	76.70	32.3		27.3		68.9	1:4,774	10.65	53.77	26.40	90.82
Davao City		55.61	53.6		51.0		75.0					
Gen Santos City		57.92	36.9		36.6		22.8					
Region 12		61.68	46.8		45.2		30.0	1:4,413	5.80	34.35	12.49	52.64
North Cotabato	47.0	77.26	27.0	32.27	39.0		27.0	1:4,655	6.26	18.60	16.75	41.61
Lanao del Norte	54.2	71.05	64.7	120.82	30.0		54.0	1:4,904	9.02	78.53	21.63	109.18
Lanao del Sur	23.4	48.62	56.0	76.67	26.5			1:4,400	6.62	38.34	12.33	57.29
Maguindanao	45.9	54.78	44.9	62.21	53.0		44.0	1:3,899	5.82	21.91	10.77	38.50
Sultan Kudarat	70.3	70.05	39.9	47.96	36.9		46.6	1:3,524	6.78	27.83	11.10	45.71
Cotabato City	22.4	44.20	73.6	70.13	87.4		1.8	1:19,952				
Iligan City	74.8	46.62	68.1	59.62	35.3							
Marawi City	8.0	49.08	81.7	81.82	84.7		48.9					

Sources of Data:

(a) 1988 Regional Annual Reports, DOH

(b) 1986 Philippine Health Statistics

(c) Public Health Services, DOH

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Morbidity & Mortality Rates of Six ARI Related Diseases, All Ages
By Province/City, 1986

	Bronchitis		Pneumonia		Influenza		Measles		Pertusis		Diptheria	
	Mrbidity Rate	Mrtality Rate	Mrbidity Rate	Mrtality Rate	Mrbidity Rate	Mrtality Rate	Mrbidity Rate	Mrtality Rate	Mrbidity Rate	Mrtality Rate	Mrbidity Rate	Mrtality Rate
PHILIPPINES	11,076.4	3.5	339.6	90.4	710.1	2.2	106.0	11.2	28.8	0.1	2.9	0.5
NCR	548.2	1.2	248.2	95.6	140.6	0.5	92.1	10.4	7.7	0.0	5.1	0.6
1st District												
Manila	306.8	0.7	411.8	99.0	92.1	0.2	142.7	7.5	15.3		14.3	1.5
2nd District	173.0	0.9	163.0	89.4	73.0	0.6	54.9	10.6	5.5		1.7	0.7
Quezon City	573.0	0.9	253.7	126.8	140.8	0.1	95.4	11.3	7.2	0.1	4.6	0.3
3rd District	424.7	1.6	180.9	84.9	96.9	0.4	64.6	18.1	8.5		0.9	0.1
Caloocan City	840.9	2.1	279.2	100.2	138.0	1.6	52.9	7.2				
4th District Mun.	471.4	1.9	99.4	65.2	168.3	0.7	73.6	9.6	5.5		0.5	0.1
Pasay City	12,812.7	0.6	292.3	101.0	576.6	0.6	114.9	15.3	7.9		5.0	0.3
Region I												
Abra	13,434.8	1.7	406.8	112.1	17,866.3	3.9	288.0	6.7	199.2		0.5	0.5
Benguet	11,216.5	0.4	367.8	52.0	821.8	1.8	220.8	4.0	1.1			
Ilocos Norte	11,160.4	1.1	177.8	87.4	853.5	3.9	56.1	4.7	1.9		1.1	0.3
Ilocos Sur	534.9	3.4	146.6	107.6	574.1	3.0	71.3	3.4	5.6		0.6	0.2
La Union	984.8	4.0	945.4	116.3	345.9	4.2	168.2	5.2	27.5		0.8	0.4
Mt. Province	12,175.4		303.1	48.9	11,415.3	1.7	171.2	1.7	4.4			

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Morbidity & Mortality Rates of Six ARI Related Diseases, All Ages
By Province/City, 1986

	Bronchitis		Pneumonia		Influenza		Measles		Pertusis		Diptheria	
	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate
Pangasinan	176.20	3.70	492.40	322.70	35.20	4.60	24.10	17.60			8.30	6.50
Baguio City	2108.30		185.70	68.60	884.00	9.40	192.40	5.40	16.10		13.40	4.00
Dagupan City	2010.60	34.70	345.50	154.00	901.10	38.30	120.20	32.10			0.90	
Region 2												
Batanes	5298.80	7.10	486.80	155.20	3349.30		70.60				7.10	
Cagayan	992.40	12.30	404.80	125.60	873.60	2.80	74.10	7.70	13.30	0.10	1.50	0.70
Ifugao	683.70		378.90	42.60	424.70		185.80	12.10	1.60			
Isabela	1341.30	10.00	221.60	93.30	1777.80	0.80	51.70	1.60	5.20	0.10	0.70	0.30
Kalinga-Apayao	1041.00	2.30	183.40	27.70	632.10	0.50	170.50	13.40	3.20	0.90	2.80	0.50
Nueva Vizcaya	4133.20	1.00	742.50	76.20	2198.30	0.30	100.60	8.00	22.30		1.40	0.30
Quirino	3239.30	8.70	480.10	59.60	1758.70		252.10	10.60	15.40		25.00	
Region 3												
Bataan	708.90	2.80	195.00	66.50	109.40	0.50	51.00	3.30	4.00	0.20	0.20	0.20
Bulacan	1215.00	0.90	307.90	76.20	672.60	1.00	129.10	8.70	5.20	0.10	0.30	0.10
Nueva Ecija	494.40	0.90	179.70	68.40	461.80	0.90	41.50	4.00	5.40			
Pampanga	810.10	1.60	210.90	36.60	1471.60	0.09	57.40	8.10	24.00		0.70	0.30
Tarlac	468.30	1.40	174.90	86.70	379.10	1.00	115.70	7.50	25.40		1.00	0.30

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Morbidity & Mortality Rates of Six ARI Related Diseases, All Ages
By Province/City, 1986

	Bronchitis		Pneumonia		Influenza		Measles		Pertusis		Diptheria	
	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate
Region 4												
Aurora	973.9	9.3	248.9	96.9	11,642.3	11.6	143.4	10.1	31.0			
Batangas	531.9	2.8	180.6	63.1	424.2	1.3	47.4	2.7	16.3		0.5	
Cavite	400.6	1.7	105.0	83.9	302.2	1.2	53.0	7.6	2.5	0.1	4.0	0.1
Laguna	483.2	2.5	191.4	105.1	342.1	0.5	37.4	8.5	0.5		0.7	0.2
Marinduque	208.3	7.7	229.3	90.1	135.6	4.6	105.4	20.0	4.6		8.7	1.5
Mindoro Occ.	11,560.3	5.0	229.0	62.5	684.9	2.7	222.5	43.4	16.0		9.5	
Mindoro Or.	474.7	10.9	230.4	87.4	767.9	0.9	126.9	11.6	6.2	0.2	31.4	0.9
Palawan	732.7	0.5	199.1	19.7	11,686.5	0.3	126.5	1.6	5.0			
Quezon	387.8	7.8	139.5	122.9	283.7	2.6	26.2	14.2	3.3		0.8	0.5
Rizal	378.9	1.9	276.5	95.7	341.0	0.9	38.7	8.5	5.3			
Romblon	697.5	5.6	163.3	62.5	944.8	2.3	201.1	11.7	11.7		1.9	1.4
Batangas City	168.0	1.2	90.6	68.9	546.3	3.6	48.3	3.0			2.4	1.2
Cavite City	11,891.4		314.4	60.2	153.6	1.0	117.2	15.6	1.0			
Lipa City	264.3	1.4	135.8	70.4	148.0	0.7	34.5	7.2				
Lucena City	539.3	4.6	218.5	110.0	153.1	2.3	114.6	23.8	2.3		9.2	4.6
Puerto Princesa	488.9	4.0	181.5	49.0	11,037.4		29.1	11.9	5.3			
San Pablo City	145.4	6.1	125.8	73.7	113.0		21.0	16.9	2.0			
Tagaytay City	119.1		69.5	39.7	84.4		49.6	5.0				

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Morbidity & Mortality Rates of Six ARI Related Diseases, All Ages
By Province/City, 1986

	Bronchitis		Pneumonia		Influenza		Measles		Pertusis		Diptheria	
	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate
Catanduanes	944.9	12.3	486.8	134.7	11,852.8	8.7	84.8	31.9	3.6		39.1	
Masbate	11,082.3	3.2	255.9	59.5	11,487.4	0.5	72.4	6.8	33.4		0.9	0.1
Sorsogon	12,050.4	5.0	263.4	112.9	797.4	3.1	119.5	6.1	8.0		1.4	0.5
Iriga City	398.1	9.8	104.1	59.1	711.7	23.9	33.8	5.6				
Legaspi City	186.1	7.8	154.0	124.3	46.9	4.7	57.6	28.9	0.8		7.8	2.3
Naga City	185.1	2.0	531.0	121.0	669.3		276.7	10.2			16.3	7.1
Region 6												
Aklan	12,180.1	6.5	193.4	84.3	200.0	2.7	137.7	4.6	42.0		3.2	0.8
Antique	11,797.8	2.8	150.3	162.7	11,652.5	6.5	92.9	15.1	71.0		3.0	1.3
Capiz	881.1	1.9	243.2	123.1	11,004.3	4.4	99.9	15.5	12.6		0.6	0.4
Iloilo	799.9	6.2	209.3	98.8	474.6	1.9	33.2	2.9	6.0	0.1	2.9	0.5
Negros Occ.	629.1	5.3	87.1	57.5	595.5	9.1	37.3	8.1	16.2	0.1	1.1	0.5
Bacolod City	450.5	0.3	163.6	91.6	244.6	6.0	68.3	20.3	7.3		6.7	2.3
Bago City	34.8	0.8	255.8	109.6	179.3	1.7	25.5	2.5				
Cadiz City	53.9		41.5	28.4	47.3	3.6	25.5	10.9				
Iloilo City	926.9	0.4	455.6	151.4	615.8	5.5	95.5	15.1	30.9		1.1	0.7

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Morbidity & Mortality Rates of Six ARI Related Diseases, All Ages
By Province/City, 1986

	Bronchitis		Pneumonia		Influenza		Measles		Pertusis		Diptheria	
	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate
Cebu	730.4	4.7	200.6	120.1	208.0	1.0	51.1	8.3	17.9		0.7	0.1
Negros Or.	607.1	3.0	122.8	76.0	369.8	0.4	43.1	3.4	6.1		0.4	0.1
Siquijor	776.6	2.6	368.2	133.5	256.7		58.3	2.6	2.6			
Bais City	515.5		77.6	53.6	101.6		24.0		3.7			
Canlaon City	396.4	87.0	322.3	148.2	464.1	70.9	135.3	16.1	3.2			
Cebu City	586.9	0.3	306.0	121.1	349.0	0.7	68.3	22.5	0.7		2.7	0.7
Danao City	70.2		307.4	162.3	235.6		7.8	1.6				
Dumaguete City	500.0	2.7	254.1	182.4	163.5	1.4	114.9	36.5	9.5		13.5	5.4
Lapu-Lapu City	11,546.5		561.2	97.7	514.9	39.4	490.1	13.7	114.8			
Mandawe City	322.1	0.7	178.2	65.4	90.4	0.7	59.4	39.6	2.6			
Tagbilaran City	604.3		329.6	90.9	272.6	2.1	63.4	21.1				
Toledo City	56.7		210.8	127.2	232.2	0.9	42.7	14.9				
Region 8												
Leyte del Norte	11,062.8	0.9	428.9	148.7	490.9	4.6	127.6	13.6	25.5	0.1	0.1	0.1
Leyte del Sur	12,173.2	2.3	546.3	78.0	607.3	7.9	66.9	14.3	16.3			
Eastern Samar	11,882.1	0.8	268.6	63.2	923.7	2,2	151.0	10.1	185.2		2.7	0.3
Northern Samar	11,593.2	4.5	271.6	114.4	316.1	2.3	327.2	13.6	228.5		1.1	0.4
Western Samar	11,274.2	3.4	373.8	48.2	11,047.7	2.2	323.2	6.4	69.0		0.2	0.2
Calbayog City	310.5	26.4	313.7	34.0	184.6	3.4	142.1	23.0	100.4			
Ormoc City	822.0		268.3	91.1	228.1		87.0	45.9	4.9		5.7	0.8

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Morbidity & Mortality Rates of Six ARI Related Diseases, All Ages
By Province/City, 1986

	Bronchitis		Pneumonia		Influenza		Measles		Pertusis		Diptheria	
	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate
Dapitan City	406.8	1.6	206.6	60.2	823.3	1.6	232.7		6.5			
Dipolog City	11,672.5	1.4	4466.6	138.8	11,750.8	1.4	236.4	4.1			22.0	4.1
Pagadian City	14,678.7		11,086.6	87.3	12,023.8		313.5	78.9	12.6	2.1	18.9	3.2
Zamboanga City	64.6	3.8	206.8	91.0	119.3		41.4	18.2	0.8		1.8	0.2
Region 10												
Agusan del Norte	11,955.2	2.2	920.4	83.5	11,762.2		74.2	24.3	11.9			
Agusan del Sur	11,830.1	8.4	581.4	63.5	745.2		260.7	23.4	53.8			
Bukidnon	11,180.8	2.1	633.8	69.3	11,888.0	0.3	112.0	15.3	18.9	0.1	0.4	0.4
Camiguin	11,700.8	1.6	216.7	143.4	12,536.5		73.3	30.9			8.1	1.6
Misamis Occ	14,928.7	2.0	692.4	97.5	11,073.9	3.9	44.2	4.7	5.9		0.8	
Misamis Or	11,114.4	1.1	306.0	120.6	603.3	0.7	73.9	30.9	31.1	0.2	2.3	0.2
Surigao del Norte	11,679.8	3.3	182.4	68.0	480.3	3.0	90.2	7.4	20.7		10.9	
Butuan City	870.0	1.5	464.5	163.9	401.0	0.5	99.4	23.6	9.3		23.6	1.0
Cagayan de Oro	248.8	0.3	798.9	147.5	721.4		273.0	40.4	5.6		7.6	0.3
Gingoog City	12,275.9	20.2	646.1	145.8	919.7	4.3	283.1	28.7	469.4			

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Morbidity & Mortality Rates of Six ARI Related Diseases, All Ages
By Province/City, 1986

	Bronchitis		Pneumonia		Influenza		Measles		Pertusis		Diptheria	
	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate	Morbidity Rate	Mortality Rate
Davao Or	12,835.3	1.8	11,270.2	40.4	12,173.0	2.3	167.5	5.5	23.2		2.0	0.8
Davao del Sur	14,926.9		11,697.2	84.8	11,691.8		239.2	7.4	81.9		3.2	0.3
Surigao del Sur	14,181.7	2.2	811.0	96.9	11,833.9	2.5	245.9	33.8	67.8	0.7	1.1	0.2
Davao City	300.0	0.9	279.2	59.1	140.4		100.3	27.9	14.6		2.2	0.9
Gen Santos City	11,193.8	1.0	467.7	92.4	661.5	1.0	224.6	73.6	21.9		6.0	1.0
Region 12												
North Cotabato	11,068.8	0.9	438.5	30.5	747.8	0.1	117.8	3.1	77.4		1.2	0.4
Lanao del Norte	15,353.1	10.0	11,278.5	42.9	12,791.3		248.5	4.2	296.4		3.1	0.8
Lanao del Sur	11,566.1		416.8	1.0	646.9		269.7	0.5	105.1			
Maguindanao	11,091.1		458.6	3.1	653.5		214.8	0.8	59.1		15.2	
Sultan Kudarat	11,321.0	0.5	11,324.7	25.0	12,145.7		67.8	3.0	39.8			
Cotabato City	556.1	3.1	743.9	152.0	11,259.7	1.0	268.4	11.2	53.1		16.3	2.0
Iligan City	11,418.4	2.1	588.9	141.2	806.9		257.7	19.9	14.0		7.0	1.6
Marawi City	337.6		405.1	62.5	492.9		101.3	11.8	216.1		11.8	1.7

Source: 1986 Philippine Health Statistics

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ANNEX K

USAID/PHILIPPINES CHILD SURVIVAL STRATEGY

ANNEX K

USAID/MANILA

CHILD SURVIVAL STRATEGY FOR THE PHILIPPINES

JANUARY, 1989

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LIST OF ACRONYMS

ADAB	Australian International Development Assistance Bureau
A.I.D.	The Agency for International Development
ARI	Acute Respiratory Infections
BHS	Barangay Health Station
BHW	Barangay Health Worker
CARE	Cooperative for American Relief Everywhere
CDC	Centers for Disease Control
CDD	Control of Diarrheal Disease
CDSS	Country Development Strategy Statement
CIDA	Canadian International Development Agency
CRS	Catholic Relief Services
CSS	Child Survival Strategy
DBM	Department of Budget and Management
DOH	Department of Health
EPI	Expanded Program of Immunizations
FETP	Field Epidemiology Training Program
GOP	Government of the Philippines
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
MCH	Maternal and Child Health
NGO	Non-Governmental Organization
OPT	Operation Timbang
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy

PACD	Project Assistance Completion Date
PASA	Participating Agency Service Agreement
PHCF	Primary Health Care Financing
PRICOR	Primary Health Care Operations Research
PVO	Private Voluntary Organization
RHU	Rural Health Unit
TA	Technical Assistance
USAID	Country Mission of the United States Agency for International Development
UNICEF	United Nations International Children's Fund
WHO	World Health Organization

INTRODUCTION

This paper presents the Child Survival Strategy (CSS) of USAID/Manila for the period 1990 through 1994. The Philippines is not identified by the Agency for International Development (A.I.D.) as a "child survival emphasis country" and, as such, is not required to develop a CSS. However, USAID/Manila has supported several child survival interventions under the Primary Health Care Financing (PHCF) Project and plans to develop a child survival project starting in FY 1990. The CSS presented here draws upon lessons learned under the PHCF project and will be used as a background context against which to design the new project.

Among the lessons learned, the most troublesome have been the slow and cumbersome nature of disbursement and the difficulty of identifying impacts that could be attributed to child survival activities. The CSS takes these lessons into account and lays the groundwork for the inclusion of high impact, quick disbursement activities in the new project design.

Consistent with guidance from AID/W, (STATE 18702) the CSS includes the following:

- Background on the Philippines
- Discussion of child survival problems
- Health priorities of the Government of the Philippines (GOP)
- Health system resources
- Current USAID support for child survival
- Other donor support for child survival
- Overview of the strategy
- Cross-cutting themes of the strategy
- Relationship to the Country Development Strategy Statement (CDSS)
- USAID staffing

I. BACKGROUND ON THE PHILIPPINES

The Republic of the Philippines consists of some 7,100 islands with a land area of about 300,000 square kilometers. The 1988 population of 58.3 million is expected to increase by 1.4 million to 59.7 million in 1989. In 1985 the population density was 182 persons per square kilometer. In 1980 approximately 62 percent of the population was rural. There is, however, a rising level of urbanization. The annual rate of population growth is around 2.4 percent, the highest among major Southeast Asian countries. The Philippines ranks among lower middle income countries and, in 1986, had a GNP per capita income of $560. Realistic projections of population and economic growth suggest that the 1983 GNP per capita of $820 will probably not be regained until about the year 2000. Life expectancy in the Philippines was 63.1 years in 1985, which marks an increase of five years in life expectancy from 1980. In 1985, the crude birth rate was 32.2 and the crude death rate 7.9. In 1980 adult literacy was 85.4 percent of the population 15-64 years old. Rural females had a literacy rate of 76.1 while their urban counterparts had a rate of 92.3 percent. There is little difference between male and female literacy rates.

II. CHILD SURVIVAL PROBLEMS

More than half (52.8 percent) of Filipinos are under 20 years old. Of these, 20 percent (11.6 million) are less than seven years old. Although the infant mortality rate (IMR) is considerably lower than that found in many developing countries, at 54 it is still high and accounted for 22 percent of all deaths in 1980. In some areas of the Philippines, the IMR rate is double the national average. The 1980 Philippine Census statistics reported an IMR of 112 and 118 for Central and Western Mindanao, respectively.

Communicable diseases account for approximately 43 percent of infant deaths, with Acute Respiratory Infections (ARI) being the number one cause of infant mortality. Forty-one percent of infant deaths occur during the first month of life, a significant proportion of these being attributable to neo-natal tetanus (2.3 per 1000 live births).

Leading Causes of Infant Deaths, Philippines, 1980-1984
(per 1,000 live births)

Causes	1980	1981	1982	1984	1984
Pneumonia	11.4	10.5	10.2	10.2	11.5
Respiratory Conditions of Fetus and Newborn	5.5	5.3	6.1	7.8	13.5
Diarrhea	4.0	4.7	3.4	4.0	8.7
Avitaminoses and other Nutritional Deficiencies	2.1	4.7	1.3	1.7	2.4
Birth Injury and Difficult Labor	1.5	1.5	1.1	1.1	-
Measles	1.0	1.3	1.2	1.5	1.0
Acute Bronchitis and Bronchitis	1.0	1.0	0.8	0.7	3.9
Tetanus	-	-	-	-	2.3
Septicemia	-	0.5	0.5	0.6	0.9

With an expected mortality among 0-5 age group of 78 per 1000 births, child mortality remains high in the Philippines. The major causes of death in 1-4 year olds are ARI and diarrhea. In 1983, pneumonia was responsible for 40 percent of all deaths among children in this age group. Diarrhea was the cause of 11.8 percent of deaths among children 1-4. Among children suffering from third-degree malnutrition, diarrheal attacks resulted in death in 56 percent of all reported cases. Undernutrition continues to be a significant factor in child mortality in the Philippines. Moderate and severe malnutrition increased among pre-schoolers from 17.2 percent in 1982 to 21.6 percent in 1985, declining slightly to 19.0 percent in 1987.

The health of each Filipino child is largely influenced by the health and child rearing practices of the mother. Thus, the mother becomes a critical element in child survival. Several maternal factors are associated with high levels of infant and child mortality, including continued high parity, decline in the duration of breast feeding, improper weaning practices and poor maternal nutrition.

The Philippine total fertility rate has dropped from 5.9 (1968-1972) to 4.65 (1982-1986), but it remains high and a threat to child survival. The total contraceptive prevalence rate was 43.9 percent in 1986; a prevalence rate of 19.4 percent represents reversible clinical methods and sterilization.

There is little national data about the incidence of low birth weight of infants. One study cites a figure of 18 percent.

A major determinant of nutritional status of infants is breastfeeding. Survey data reveal that the initiation of breastfeeding has declined from 87 percent in 1978 to 83 percent in 1983. Further, the mean duration of breastfeeding has declined from 12.1 months in 1982 to 9.6 months in 1987.

Maternal mortality has dropped from 1.14/1000 live births in 1979 to 0.9/1000 in 1984. About one half (46 percent) of the maternal deaths were due to hemorrhage before, during or after delivery; 70 percent of these deaths occurred after delivery. It is well established that the risk of post delivery hemorrhage increases with increasing number of pregnancies. In 1985, only 18.5 percent of pregnant women were immunized with tetanus toxoid. The 1982 National Nutrition Survey reported that one out of every three pregnant women in the country was deficient in iron.

III. HEALTH PRIORITIES OF THE GOVERNMENT OF THE PHILIPPINES

Prior to the 1986 revolution, the priorities of what was then the Ministry of Health were not focused on the health problems of women and children. The health problems of these groups are largely preventable and controllable through early detection of the problem, immunization, promotion of proper hygiene through education and simple curative measures. However, in the past, the bulk of government expenditures were devoted to expensive urban-based curative care in hospitals.

The current Government has recognized the dichotomy between the profile of mortality and morbidity and the Government's response. The Medium Term Philippines Development Plan, 1987-1992, laid out strategies that focus on improvements in the provision and accessibility of basic health, nutrition and child spacing services focusing on the poor, underserved and high risk groups. The new policies emphasize more vigorous implementation of preventive and promotive health, nutrition and family planning services. Additionally, the new policies and strategies call for greater integration of programs within the Department of Health (DOH); better integration of efforts among other sectoral agencies involved in the delivery of health related services; closer collaboration with the private sector; and increased attention to the role communications can play in educating the public to the responsibility it bears for the health of the nation's children.

The GOP has already begun to increase budgetary allocations to the DOH. The DOH budget has steadily increased since 1975.

Budget of the Department of Health

	1975	1980	1985	1988
- Billions of Pesos	0.72	1.36	3.41	4.99
- Percent of National Budget	3.40	3.50	5.10	5.70

In 1985, the DOH used only 14 percent of its budget for preventive care. Currently, approximately 25 percent of the DOH budget is used for preventive care, 67 percent for curative care, and the balance for training and administrative services.

Since the 1986 Revolution, the DOH has had strong political and competent managerial leadership, committed to revitalizing the DOH through strengthening and integrating key interventions in the Maternal and Child Health (MCH) programs, including Control of Diarrheal Diseases (CDD), immunization, nutrition, treatment of respiratory infections, maternal care and child spacing.

The immunization component of the DOH program seeks to increase the percentage of vaccinations in the under one year old age group from 25 percent in 1985 to 90 percent in 1990. To accomplish this, the DOH has embarked on an ambitious program which includes the training and retraining of personnel, vaccine distribution via a cold chain, communication and education of mothers, and improved monitoring and evaluation. The nutrition element of the DOH program combines the promotion of breastfeeding and appropriate weaning practices with the provision of micro-nutrients to mothers and children. Nutrition education and the promotion of growth monitoring are also important components of the DOH program. These activities are aimed at improving the four major nutritional problems in the Philippines: Protein energy malnutrition and deficiencies in Vitamin A, iron and iodine. In the past, the Nutrition Service of the DOH has focused on the provision of micro-nutrients, food supplementation and nutrition education to attack these problems. Operation Timbang (OPT), the yearly weighing of pre-school children by midwives, has been the major source of nutritional status information for the DOH. But inadequate coverage of the pre-school population (less than 50 percent coverage) has made it difficult for the Nutrition Service to adequately use this methodology for planning or for identifying children at risk.

Diarrheal disease remains one of the major public health problems in the Philippines. Among children under five, it is the second leading cause of mortality and morbidity, with an official mortality rate of 2.1 per thousand and a morbidity rate of 19 per thousand. The CDD program of the DOH includes production of ORESOL, an Oral Rehydration Solution (ORS), which is distributed through the DOH delivery system; in-service training of DOH personnel to

familiarize them with and promote the use of Oral Rehydration Therapy (ORT); development of Information, Education and Communication (IEC) materials on ORT; and improved disease reporting in order to gain more accurate information on the actual incidence of diarrhea mortality and morbidity. To strengthen the CDD program, the DOH is collaborating with the Philippines Pediatric Society in order to encourage pediatricians to recommend use of ORT as the preferred treatment of diarrhea.

ARIs, chiefly pneumonia, are the number one killer of infants and children in the Philippines. There is currently no national program to reduce infant and child mortality from ARI, but an ARI plan has been drafted. A pilot project in Bohol Province has demonstrated that Filipino midwives and mothers can be taught to detect moderate to severe ARI cases and that midwives can responsibly treat ARI with oral antibiotics and instruct mothers in proper home management of respiratory illnesses.

The maternal health care program of the DOH is designed to provide ante-natal, postnatal and safe birth delivery to the women of the Philippines. Further, in 1987, the DOH began to promote the concept of the health benefits of child spacing alongside the provision of maternal care services through the DOH delivery system. Although the DOH recognizes that the present system is inadequate to meet the needs of Filipino women, it is a major provider of clinic-based health and family planning services.

IV. HEALTH SYSTEM RESOURCES*

Health care services are provided through public and private hospitals, Rural Health Units (RHUs), Barangay Health Stations (BHSs), private physicians, various non-governmental organizations (NGOs) and traditional health practitioners.

In 1986, there were 1,949 hospitals, 1,363 private and 586 public. Of the total, 956 were primary care hospitals, 703 were secondary care hospitals, and 290 were tertiary care hospitals and medical centers. Private hospitals accounted for 83 percent of primary care hospitals, 57 percent of secondary care hospitals, and 59 percent of tertiary care hospitals.

Primary care hospitals are relatively small hospitals with limited diagnostic and treatment capabilities in general medicine, simple surgical procedures, obstetrics and pediatrics. Their large numbers indicate the inadequacy of preventive and promotive health care services being delivered in the rural areas through the RHUs and BHSs.

The hospital bed ratio was one bed per 600 population for the entire country; however, these beds were unevenly distributed across the country. In 1985, there were about 90,000 hospital beds, about half of which were accounted for by private hospitals. They were highly concentrated in the National Capital Region, where the hospital bed ratio was 1:200. In the rest of the regions the hospital bed ratio ranged from 1:600 to 1:1,000.

* Information in this section is derived from The Poverty Challenge in the Philippines: What is to be Done?, The World Bank, March 1988.

There is still significant differential physical access to public health facilities. Public health services for the rural population are provided mainly through the RHUs and BHSs. In 1985, there were 1,991 RHUs, each serving close to 30,000 population on the average. Each RHU is headed by a municipal health officer who is a physician, and is staffed by a public health nurse, sometimes a public health dentist, a sanitary inspector and four or five public health midwives. There were 7,991 BHSs, each serving close to 7,000 population on the average. A BHS is staffed by a trained midwife and serves as the base for a team of volunteer Barangay Health Workers (BHWs) at a rate of 1/20-30 households. Both RHUs and BHSs are relatively more evenly distributed across the country than hospital beds as far as ratios to population are concerned. However, such relatively even ratios to population tend to hide the fact that some BHSs and RHUs are more accessible to the population residing close to major transportation networks and closer to towns, while a large part of the population still resides in remote rural areas quite far from these health facilities.

Aggregate ratios of government health workers to population reveal that the least number of workers are nutritionists, with a ratio of 1:86,000 population in 1985, followed by dentists with a ratio of 1:48,000 population, and sanitary inspectors, with a ratio of 1:28,000 population. Physicians, nurses and midwives have ratios of about one per 6,000 population.

When both private and government health workers are combined, one finds substantial differences in the regional distribution of health manpower. Although public health personnel are relatively evenly distributed across the regions, the population residing close to public health facilities have better physical access to these personnel than the population residing in more remote areas. Particularly evident is the primacy of the National Capital Region for both private and public personnel although the ratio of midwives to population is lower.

The formal public and private health care delivery system is supplemented by various NGOs which provide mainly maternal and child health, family planning and nutrition services. Although they attempt to focus on the depressed areas in the country, their size of operations is relatively small. Because their coverage is small, and because a large proportion of the rural population does not have easy access to modern public health services from the RHUs and BHSs, a large majority of the rural population continues to rely upon the services of traditional health practitioners.

V. CURRENT USAID SUPPORT FOR CHILD SURVIVAL PROGRAMS

A. Primary Health Care Financing Project

The proposed FY 1990 Child Survival Project is the logical continuation of the child survival efforts initiated under the PHCF Project. Along with ORT, field epidemiology training and a focus on immunization and social marketing, these activities were part of a rolling design effort which had altered the focus of PHCF from an emphasis on financing schemes, studies and primary care services to an emphasis on child survival activities.

In 1985, USAID added a $4 million grant component by amending the existing PHCF Project to support the DOH CDD program. The purpose of this activity is to assist the DOH expand its effort to reduce mortality from diarrheal disease through increased utilization of ORT. To achieve this purpose, three main activities are being undertaken:

1) Training of medical professionals and para-professionals within the DOH services delivery network;

2) Development of IEC materials for the public and health communities, using all channels of communication, including TV and radio;

3) Strengthening of institutional capacity of the DOH to manage, coordinate and monitor the national CDD program.

In 1988, long and short-term Technical Assistance (TA) is being provided to the DOH through a buy-in to PRITECH. This component, provides a Resident Operations Advisor to work with the CDD program management team of the DOH. Short-term TA to assist the DOH in the following areas is also being provided:

- Improving current ORS distribution channels and coverage.

- Strengthening training and private sector promotion.

- Promoting preventive interventions.

- Conducting evaluations and operations research.

- Improving the information services of the DOH.

To enhance the DOH's capability to plan a communications strategy and implement social marketing activities in support of the CDD program, USAID initiated a buy-in to the HEALTHCOM project in 1987. This buy-in provides approximately $900,000 to support a Resident Advisor for two years and the local private sector sub-contracting of IEC promotion via mass media. The HEALTHCOM will assist the DOH in planning, testing and partially implementing EPI and ORT campaigns and with the development of a research methodology to evaluate the impact of the communications programs on levels of awareness and changes in health behaviors with respect to the child survival program.

A further buy-in, this one to the REACH project in 1988, enabled USAID to support a Resident Advisor to the national immunization program. The Resident Advisor provides the DOH's Expanded Program of Immunization (EPI) Unit with program management assistance, develops IEC materials and provides training and disease surveillance. The Resident Advisor arrived in country early in 1988 and will provide assistance to the program through the PACD. The Advisor also serves as a liaison between USAID and the DOH for implementation and use of USAID-funded activities and commodities related to immunization.

There is a shortage of professional epidemiologists in the DOH. In 1986, epidemiological services were practically nonexistent. Yet, the successful implementation of child survival activities will be determined, to a great extent, on the DOH's capability to understand the epidemiology of diseases affecting children. Based on the preceptorship type training program of the Epidemic Intelligence Service of the U.S. Centers for Disease Control (CDC), the $2.2 million Field Epidemiology Training Program (FETP) Component of the PHCF project provides support through a Participating Agency Service Agreement (PASA) with CDC. This support includes the provision of a long-term Resident Advisor from CDC, national staff, laboratory support and in-country training. This two-year training program is designed to develop a cadre of trained field epidemiologists (30 over the five-year period) who can gather and analyze Philippine epidemiologic information in order to support the design and evaluation of an effective public health program. Currently six trainees are in their second year of training and seven trainees are enrolled in the first year program.

Under the PCHF project USAID also supports a number of activities in the area of research, monitoring and evaluation for child survival. Through a grant to the World Health Organization (WHO) and a PASA with the Bureau of the Census, support is being provided to the DOH to review and suggest modifications to the Department's health information system. Reducing the reporting requirements, streamlining the process and training personnel are priorities for this activity. Finally, through co-sponsorship of a Tier III study in collaboration with Johns Hopkins and San Carlos University in Cebu, USAID is assisting in furthering the state-of-the-art of impact evaluation of child survival interventions, not only in the Philippines but globally.

The current PHCF project is thus addressing several important aspects of the CSS. This project, with its current PACD, is due to expire before the new child survival project is fully in place. It will be important, therefore, to extend the PHCF project for a period sufficient to ensure an orderly transition between projects. This is especially critical because several specific aspects of the PHCF project, such as Resident Advisors, can be expected to also be included under the new project.

B. Title II Food Assistance

A major nutrition intervention in support of the Mission's child survival activities is Title II Food Assistance. The 1988 value of the food commodities is $10.3 million. Food is distributed through two U.S. voluntary agencies, namely Cooperative for American Relief Everywhere (CARE) and Catholic Relief Services (CRS). CARE collaborates with the Department of Education, Culture and Sports and the DOH to reach 1.8 million primary and pre-school children while CRS works through the Department of Social Welfare and Development and with the Social Action Centers of the Catholic Church to reach 920,000 pre-school children. Other nutrition interventions include an $800,000 grant to Helen Keller International to support the Philippine Food and Nutrition Institute; and to assist the DOH to conduct baseline surveys, train staff, assess the magnitude of Vitamin A deficiency and plan for a national program.

C. Child Spacing and Population

Since 1967 USAID has provided approximately $80 million in bilateral and central population assistance to the Philippines. The Population Planning III Project (1981-1988) has provided about $39 million in bilateral funds to support family planning service delivery, training, IEC, demographic measurement and private sector activities. About $6 million has been provided through centrally-funded contractors and grantees to support small research, training and IEC activities. USAID will continue to support child spacing and population activities through a new Population Sector Support Project which is scheduled to be authorized in FY 89.

VI. OTHER DONOR SUPPORT FOR CHILD SURVIVAL

There are several other bilateral, multilateral and private donors cooperating to provide assistance to the DOH's child survival programs. They are the Canadian International Development Agency (CIDA), Australian International Development Assistance Bureau (ADAB), Japan, United Nations International Children's Fund (UNICEF), WHO and Rotary International.

CIDA

CIDA began its support to the Philippine health sector in 1987. This five-year package of assistance provides Canadian $5 million for the purchase of the total DPT and measles vaccine requirements of the DOH and the provision of a Resident Advisor in the cold chain. In September 1988, CIDA gave an additional Canadian $5 million to UNICEF's Area Based Child Survival and Development Program. (A description of this program is presented below.) CIDA is anticipating a request from the GOP to provide vaccines for the period 1991-1995, which it will likely support.

ADAB

Since 1983 ADAB has provided assistance to the DOH to implement an ARI pilot project in Bohol Province. This grant of about Australian $2.10 million has provided technical assistance, training, education materials and operations research. Much of the technical assistance and operations research has been conducted by the Research Institute for Tropical Medicine. This project has demonstrated over the last five years that midwives can successfully identify ARI and treat the infections with antibiotics, as well as teach mothers how to identify ARI and properly manage their child's illness. The pilot activity will end in 1991. A wealth of information has been generated concerning the treatment of ARI in the Philippines over the last nine years. ADAB is willing to consider future support in ARI control programs provided the DOH builds upon the experience gained and lessons learned in the Bohol pilot areas. ADAB has also provided Australian $4.5 million through UNICEF for the purchase of syringes and needles.

UNICEF

The 1988-1992 plan of operations for Strengthening Health Services for Child Survival and Maternal Care is a $5.83 million program with three main components: EPI, care of the mother and the under-six child, and CDD through promotion of breastfeeding.

In 1987, the DOH adopted the Under Six Clinic as the integrating mechanism for the delivery of MCH care at all levels. The UNICEF program is designed to support and expand this initiative with the goal of decreasing maternal and child mortality through full immunization coverage and improvement of the quality of services to women and children. UNICEF and CIDA are assisting the DOH in the implementation of the Area Based Child Survival and Development Program. The project works directly with seven provincial governments and, through these local governments, with the NGO community. At the provincial level, the project collaborates with local government agencies to provide child survival services, equipment and training aimed at improving health and nutritional status of women and children. The total cost of this five-year DOH program (1988/89 to 1992/93) is $20.06 million, of which UNICEF will provide $3.41 million and CIDA about $5 million.

WHO

WHO provides technical assistance and funds to support mid-level training and workshops in support of child survival activities. In 1989, the regional CDD advisor will become the national CDD/ARI advisor to assist the DOH in launching a national ARI program. WHO has also provided technical assistance to the curricula of the medical and nursing schools to include state-of -the-art information in CDD and EPI. WHO is particularly interested in assisting the DOH to examine ways in which individual child survival activities can complement each other and in the structuring of programs to maximize the benefits of the individual interventions.

Rotary International

Since 1980, Rotary International has provided virtually all of the DOH's requirement for polio vaccine. Rotary has informally committed to continue to provide all of the vaccine through 1990, after which it will phase out its contribution at the rate of 20 percent each year.

Japan

In 1988, the Philippine government submitted a grant request to Japan in support of upgrading the Alabang Vaccination Laboratory to enable the Philippines to become self-sufficient in the manufacture and provision of DPT vaccines. The request includes support for complete renovation of the Alabang facility including new equipment and technical assistance. A Japanese team will conduct a needs assessment in late 1988-early 1989.

The World Bank

The Philippine government and the World Bank are discussing a $100 million health sector project for 1990. Three major components are planned:

1) Programs to support DOH impact programs, i.e. MCH/FP, CDD, EPI, malaria, schistosomiasis and TB;

2) Programs to improve the institutional capability of the DOH to deliver services;

3) Support to community-based programs through NGOs.

In addition to a $40M IBRD loan, the project will seek grant fund buy-ins from other donors totalling another $38M with $20-25M GOP counterpart.

VII. OVERVIEW OF THE USAID/MANILA CHILD SURVIVAL STRATEGY

The 1990-1994 Child Survival Strategy of USAID/Manila for the Philippines is based upon the health status and programmatic background described above. It also reflects the strategic and tactical guidance prepared by A.I.D.

The central thrust of USAID's approach to child survival is to support those interventions that are known to have the greatest impact on mortality. These interventions are ORT, EPI, treatment of ARI, child spacing and possibly nutrition (especially breastfeeding). USAID will work with public and private sector groups to assist them to plan, implement and institutionalize these interventions.* It is especially important to continue to encourage the DOH to remain firm about its emphasis on promotive and preventive public health measures targeted to mothers and children. USAID plans, therefore, to continue many aspects of the support and technical assistance being provided to DOH, but relying less on centrally-funded projects and more on a bilaterally funded package of TA.

There is concern, however, about the absorptive capacity of the DOH. This concern, coupled with USAID's commitment to encourage the private sector, leads USAID to include a private sector component in the child survival strategy. This component includes support for Private Voluntary Organizations (PVOs) as well as for private, for-profit health resources.

USAID/Manila shares the concerns of A.I.D. regarding the sustainability issues inherent in an expanded child survival program. There is no question that the greater emphasis the DOH now places on preventive and promotive programs will require greater resources. However, we concur with the 1988

*As noted earlier, child spacing is not included here because USAID support for family planning will be provided under the new population project.

World Bank Report, that it is too soon to estimate the amount of additional resources that will be required to finance preventive, promotive and simple curative services. It is not yet clear how the pattern of demand for these services will evolve as a result of the new planned activities. This demand will require increases in certain cadres of trained personnel, drug supply and facilities. As the DOH gains more experience in implementing child survival activities, operations research will be required to enable the DOH to obtain realistic cost estimates. It is at this point that USAID should assist the DOH to address sustainability.

VIII. CROSS-CUTTING THEMES OF THE STRATEGY

Overall, USAID will support the momentum of the DOH and the private sector to expand the coverage of child survival interventions in the Philippines. These interventions are the prevention and treatment of ARI and diarrheal diseases, immunization against childhood communicable diseases and tetanus, and interventions that improve the nutritional status of women and children. The program of support will provide financial, technical and commodity assistance to child survival activities (ORT, EPI, ARI and nutrition) that reflect the six cross-cutting themes listed below:

1. Increased access to services through decentralization.

2. Enhancement of integrated services.

3. Communication strategies that help families to meet child survival needs.

4. Training to improve management and technical expertise.

5. Mobilization of the private sector.

6. Selected, highly-targeted research studies.

A. Increased Access to Services Through Decentralization

The health status of children varies widely among different parts of the Philippines, and child survival services are unevenly distributed. The DOH suggests that as much as 30 percent of the population live in underserved areas.

The GOP has initiated some overall pilot decentralization activities, with an emphasis on four provinces. The DOH has also established a policy whereby funds in some categories can flow directly to the district level, giving District Health Officers some budgetary discretion. As discussed above, some donors have concentrated their efforts in particular areas. This has added to the unevenness of resource distribution in the health sector.

"The Poverty Challenge in the Philippines: What is to be Done?" World Bank

Given the spotty nature of service delivery and external assistance, there would be some advantages for USAID to select certain underserved areas as the target of its support. In the past, due in large part to the policy that all USAID funds be channelled through the Department of Budget and Management (DBM), this option has been difficult to implement. Based on current World Bank and DOH negotiation with DBM this situation is expected to change, permitting CS project design efforts to examine USAID's alternatives with regard to directly funding the activities of DOH at sub-national levels.

B. Enhancement of Integrated Services

DOH policy calls for the provision of child survival services at Under Six Clinics to be held at the Rural Health Unit and the Barangay Health Station. It is at these clinics that the DOH programs (ORT, EPI, ARI, promotion of breastfeeding and child spacing) come together in an integrated fashion. USAID support for ORT and EPI has contributed to the development of the Under Six Clinic concept. This support will continue under the new project. Further, as the DOH adopts plans to integrate the treatment of ARI, the project design effort will examine ways in which USAID might be supportive of such integration. As the number one cause of death among small children, the inclusion of ARI treatment is a priority.

Midwives are the mainstay of the child survival effort, assisted by BHWs and supervised by public health nurses. In actuality, midwives often find themselves without assistance or supervision. While supportive of the ideas behind this policy, USAID is concerned that the care provided by midwives is of widely differing quality. There are not enough public health nurses to provide the needed supervision. Even where there are nurses, they usually lack the transportation needed to conduct supervisory visits. A recent DOH personnel decision will create a new category of supervising midwife. USAID sees this as a positive move to both provide the necessary oversight and create a career path for midwives. Training of midwives in supervisory skills and their support through the provision of equipment and transportation is a priority. USAID is willing to assist this effort as well as a major expansion of the number of midwives in the DOH network.

Midwives will require reliable and steady access to supplies of drugs, educational materials and refresher training in order to carry out their added responsibilities. To guarantee this access, DOH must establish and maintain a system which delivers drug supplies and educational materials on time and in the amounts required. USAID will help the DOH locate the problems in the logistics system and will assist the DOH in addressing these problems as is appropriate. Midwives also need to be able to move around their catchment area, especially if they are to take on responsibility for active case finding and targeting within the community. USAID has provided a number of small motorcycles for midwife transportation and is prepared to do much more in this priority area.

C. Communication Strategies that Help Families to Meet Child Survival Needs

Studies show that the majority of mothers do not know that severe cases of ARI and diarrheal disease are life threatening. This suggests that child mortality is as much the result of ignorance as of disease.

The DOH recognizes the importance of IEC and has recently established a new division to serve the department's needs in this area. While it has begun to show considerable promise, especially in social marketing through the media, this division remains small, understaffed and underequipped. USAID will continue to assist the DOH to enhance its social marketing capability through the support of a Resident Advisor, equipment and training, and the production and dissemination of messages with child survival themes.

While very supportive of DOH's initiatives in this area, USAID considers it essential that the department define its responsibilities in IEC in the broadest sense. While social marketing through the mass media is an important component of IEC, there is also a need for materials for use of face-to-face communicators as health workers discuss ORT, immunization, breastfeeding and other aspects of child survival with families. Health workers at all levels need audio-visual aids to help them to explain, reinforce and personalize the messages transmitted through the mass media. This is all the more important when a number of different groups (DOH, PVOs and private practitioners) are working within the same community. If materials with consistent messages are not available, there is considerable risk that mistakes will be made and credibility lost. USAID will assist the DOH to help families in this way.

Given the emphasis being placed on IEC by the DOH, and given the central role that IEC could play in increasing child survival, a comprehensive IEC plan should be developed. Such a plan would identify a long-term social marketing program for child survival, determine the range of audio-visual materials that would be needed to support the marketing effort and recommend resource requirements. USAID is willing to support the development of such a plan, in close collaboration with the DOH, as part of the project design process. The new project will include assistance in implementing aspects of such a plan.

D. Training to Improve Management and Extend Technical Expertise

The DOH recognizes the importance of training and has initiated a variety of training activities. More is needed, however, in order to meet the anticipated demands. USAID will continue to assist the DOH with training support.

In the area of management, there is some concern that there are insufficient numbers of competent managers. Management skills are needed to support the increasing emphasis on child survival at the regional, provincial and district levels. DOH officials at these levels are being given increasing responsibility for supervision, budgetary planning and disbursement and other aspects of program management. Training in management functions would be useful to them.

A training program designed to address these needs could also serve as a resource to officials at the central DOH in Manila. Senior officials at headquarters are under a great deal of pressure and do not always have staff upon whom they can rely. A management training program would prove useful in developing skills among mid-level officials so that they may take on increasing responsibility.

Communication management training would also be of value to DOH. Social marketing requires careful management of a complex process involving sophisticated contractors, and the DOH needs a cadre of communications managers who can take on this function. At present there are not enough people with these skills to manage the expanding IEC agenda. The preceptor-based training program for epidemiology would be a useful model for this new program.

Less formal training strategies are also needed to complement child survival program implementation. Trainers at the provincial level must be trained to fulfill their responsibilities to midwives and nurses at the periphery. This is especially important as new child survival interventions are introduced, such as treatment of ARI and tetanus toxoid immunization concurrent with childhood immunization. USAID is willing to assist the DOH with the extension of technical expertise through training of trainers and the support of local training. A further aspect of training that is of interest to USAID is follow-up and regular reinforcement of concepts, facts and messages that have been included in child survival training. This can be done through a mixture of continuing education approaches and newsletters or bulletins. The routine meetings that take place at the district, provincial and regional levels provide good opportunities for using techniques such as video tapes for in-service training. USAID would be willing to make equipment available for this purpose.

E. Mobilization of the Private Sector

The DOH cannot meet all Philippine child survival needs alone, nor should it. There is a thriving private sector in health that must be mobilized to share the burden. The private sector includes traditional practitioners, self-employed doctors, nurses and midwives, for-profit hospitals and other facilities, professional associations and PVOs. It is estimated that two-thirds of health expenditures are in the private sector and that well over half of the Filipino people choose to go first to a private sector resource.

The DOH has already taken some creative and innovative steps to incorporate the private sector into the child survival movement. For example, the Philippine Pediatric Society is deeply involved in appropriate treatment of diarrhea, and discussions are underway with the Hospital Association to

integrate private hospitals into EPI and, maybe, child spacing. Activities of this kind are valuable first steps towards a more integrated approach. USAID stands ready to support further collaboration through grant support to private groups through the DOH.

There is a tradition of PVOs in the Philippines and some 22,000 organizations exist. Many of these PVOs have objectives in health and/or child survival and are in a position to serve people who do not have access to DOH services. A USAID priority is to encourage and support those PVOs that a) meet child survival needs, b) complement the service provided by the DOH, c) are willing to cooperate with other providers and d) meet standards of medical quality and fiscal responsibility.

There are a number of alternate approaches that could be used to channel USAID child survival support to PVO efforts. One would be to expand the assistance given in collaboration with PL 480 food. A second avenue would be to add funds to the PVO Co-Financing Project. Another way of reaching PVOs would be through UNICEF. UNICEF currently collaborates with the DOH in seven provinces to assist local government offices and local PVOs to work together to address community needs. A fourth alternative would be through local planning grants made by DOH to local PVOs, a model being supported under the planned World Bank Project. Finally, it may be possible for USAID to identify an indigenous PVO to serve as an umbrella group through which PVO child survival efforts could be coordinated and supported. The design team for the new targeted project will analyze these approaches and determine to what extent each could be used as a way of enhancing USAID's child survival assistance effort.

It is crucial to the success of child survival interventions in the Philippines that there be consistency among providers. Therefore, PVOs and commercial private sector organizations must be encouraged to cooperate closely with the DOH at every level. Such cooperation should include shared plans and joint planning wherever appropriate, participation together in training sessions, and the use of identical or complementary health education materials. Private sector and DOH providers should see themselves as mutually supportive of the same goals, not as competitors. USAID support of for-profit and not-for-profit organizations to undertake child survival activities will reflect this need for consistency.

F. Selected, Highly Targeted Research Studies

USAID does not usually support much in the way of health research. Presently PRICOR has an AID/Washington-funded, operations research project underway to identify some of the operational constraints in EPI, CDD and growth monitoring. However, in the Philippines, there are several areas in which targeted research is needed in order to develop sound policy. A research agenda and criteria for USAID support will be developed as a collaborative effort of the DOH and USAID building upon our current support to Health Information System development and the National Health Survey.

Perhaps even more important than the sponsorship of research activities is the compilation and dissemination of research findings. The large quantity and

high quality of researchers in the Philippines means that a considerable amount of research relevant to child survival has already been undertaken. Findings of this body of relevant research need to be assessed and integrated into ongoing activities.

IX. RELATIONSHIP TO THE CDSS

USAID's CSS is designed to complement the current CDSS and the Interim Strategic Concept Paper (September 1988). The overall objective of both documents is to raise the living standards of the country's rural population by harnessing the resources in both the public and private sector to increase coverage and effectiveness of child survival interventions, including child spacing and promotion of breastfeeding activities. Although the primary focus of the CSS is rural, the strategy recognizes the desirability of reaching poor urban area women and children with an intervention package of child survival activities.

The CSS complements the policy agenda of USAID, which includes broadening of consciousness among government officials about the implications of rapid population growth on the development objectives of the Philippines. The strategy further complements USAID's private sector emphasis by building upon the recent efforts of the DOH to collaborate more fully with both the private commercial sector and the PVO community. The CSS also seeks to find creative ways to implement child survival activities by assisting the DOH in decentralizing responsibility and authority for program initiatives. These cross-cutting themes are part of the overall USAID strategy to improve the access of the poor to a selected package of maternal and child care services, targeted towards reducing mortality from diarrhea, respiratory and vaccine-preventable diseases and improving the delivery of child spacing services.

X. USAID STAFFING REQUIREMENTS

The strategy presented here will become the basis of USAID's 1990-1994 Child Survival Project. USAID has one full-time U.S. direct-hire Health Officer and two Filipino professionals who will be responsible for the management of this new project. In addition to the health staff, USAID also has a direct-hire Population Officer and three Filipino professionals who provide assistance to the management staff on population activities. Additional technical expertise and management support of their efforts is provided by the direct-hire Office Chief.

In order to facilitate the integration and implementation of USAID support to the DOH's child survival efforts, USAID will continue to support the use of Resident Advisors for specific components of the program, i.e. CDD, EPI and IEC, however, we expect to rely more on a TA package under one bilaterally funded umbrella, than the current fragmented TA under multiple central buy-ins and inter-governmental agreements. The concept of a Project Management Staff located in the DOH to facilitate the administrative aspects necessary for project implementation has worked well for both the DOH and the Mission. This mechanism is expected to continue under the new project. USAID will also continue to call upon the services of Filipino professionals for selected project activities.