

**MIDTERM ASSESSMENT OF
INTERMEDIATE RESULT 1 OF
STRATEGIC OBJECTIVE 3
"INCREASED PUBLIC SECTOR PROVISION
OF FAMILY PLANNING AND MATERNAL
AND CHILD HEALTH SERVICES"**

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LIST OF ABBREVIATIONS

| | |
|----------|--|
| ARI | Acute respiratory infections |
| ASAP | Araw ng Sangkap Pinoy |
| AVSC | Access to voluntary and safe contraception |
| BCG | Bacillus Calmette-Guérin |
| BHS | Barangay health station |
| BHW | Barangay health worker |
| BOT | Build-operate-transfer |
| CA | Cooperating Agency |
| CARI | Control of acute respiratory infection |
| CBD | Community-based distribution (of contraceptives) |
| CDD | Control of diarrheal diseases |
| CDLMIS | Contraception Distribution Logistics and Management Information System |
| CEDPA | Centre for Development and Population Activities |
| CHCA | Comprehensive Health Care Agreement |
| CHO | City health officer |
| CPR | Contraceptive prevalence rate |
| CSM | Contraceptive social marketing |
| CYP | Couple years of protection |
| DBM | Department of Budget and Management |
| DHS | Demographic and health survey |
| DILG | Department of the Interior and Local Government |
| DMPA | Depo-medroxy progesterone acetate, an injectable contraceptive |
| DOF | Department of Finance |
| DOH | Department of Health |
| DPT3 | Diphtheria pertussis tetanus, third dosage |
| EPI | Expanded Program of Immunization |
| FHSIS | Field Health Services Information System |
| FIC | Fully immunized child |
| FP | Family planning |
| FPLM | Family Planning Logistics Management (JSI) |
| FP/MCH/N | Family Planning/Maternal & Child Health/Nutrition |
| FPMD | Family Planning Management Development (MSH) |
| FPS | Family Planning Service (DOH) |
| GOP | Government of the Philippines |
| GSO | General Services Officer |
| GTZ | Association for Technical Cooperation (Germany) |
| HDF | Health Development Fund |
| HDP | Health Development Program |
| HES | Human and Ecological Security |
| ICHSP | Integrated Community Health Services Project |

| | |
|---------|---|
| IEC | Information, education and communication |
| IFP/MHP | Integrated Family Planning, Maternal Health Program |
| IMR | Infant mortality rate |
| IR | Intermediate result |
| IRA | Internal Revenue Allotment |
| IUD | Intrauterine device |
| JHU | Johns Hopkins University |
| JPIL | Joint Project Implementation Letter |
| JSI | John Snow International |
| LCE | Local chief executive |
| LGAMS | Local Government Assistance and Monitoring Service |
| LGU | Local government unit |
| LPP | Local Government Unit Performance Program (Component of IFPMHP) |
| MCH | Maternal and child health |
| MCHS | Maternal and Child Health Service (DOH) |
| MGP | Matching Grant Program |
| MHC | Main Health Center |
| MICS | Multi-Indicator Cluster Survey |
| MMCPR | Modern method contraceptive prevalence rate |
| MMCYP | Modern method couple years of protection |
| MMR | Maternal mortality rate |
| MOA | Memorandum of Agreement |
| MSH | Management Sciences for Health |
| NCA | Notice of cash allocation |
| NCR | National Capital Region |
| NGO | Nongovernmental organization |
| NS | Nutrition Service (DOH) |
| NTAT | National Technical Assistance Team |
| OPHS | Office for Public Health Services (DOH) |
| OPV3 | Oral polio vaccine, third dosage |
| OSC | Office of Special Concerns (DOH) |
| PBAC | Pre-qualification Bids and Awards Committee |
| PCS | Population Communication Services |
| PGR | Population growth rate |
| PHN | Office of Population, Health and Nutrition (USAID) |
| PHO | Provincial Health Officer |
| PIHES | Public Information and Health Education Service (DOH) |
| PIL | Project Implementation Letter |
| PMO | Project Management Office |
| PMT | Project Management Team |
| PMTAT | Project Management Technical Assistance Team |
| POPCOM | Population Commission |
| POPTECH | Population Technical Assistance Project |

| | |
|-------|---|
| PPDO | Provincial Planning and Development Officer |
| PPO | Provincial Population Officer |
| RESU | Regional Epidemiological Surveillance Unit |
| RFA | Rapid Field Appraisal |
| RHU | Rural health unit |
| RMT | Regional Management Team |
| RTAT | Regional Technical Assistance Team |
| SO | Strategic Objective |
| SOW | Statement/Scope of work |
| SpO | Special Objective (USAID) |
| TA | Technical assistance |
| TB | Tuberculosis |
| TEV | Travel expense voucher |
| TFR | Total fertility rate |
| TT | Tetanus toxoid |
| TT2+ | Second and succeeding tetanus toxoid immunization |
| TTV | Tetanus toxoid vaccine |
| UNFPA | United Nations Fund for Population Activities |
| USAID | United States Agency for International Development |
| VAC | Vitamin A capsule |
| VS | Voluntary sterilization, voluntary surgical contraception |
| WHO | World Health Organization |
| WHSM | Women's Health and Safe Motherhood Project |

EXECUTIVE SUMMARY

Introduction

This is a midterm assessment of Intermediate Result 1 of Strategic Objective 3, including the Local Government Unit Performance Program (LPP),¹ which is one of three components of the Integrated Family Planning and Maternal Health Project (IFPMHP). The program helps local government units (LGUs) define their individual needs in family planning, child survival, and nutrition. The LPP provides funding and technical assistance to meet these needs while building the LGUs' management capability to plan, implement, and assess their programs. The Department of Health (DOH), through its Office for Special Concerns (OSC), manages the program with assistance from the U.S. Agency for International Development (USAID). Technical assistance is provided to LGUs by teams from DOH central and regional offices and from several USAID contractors.

LPP started with 20 large LGUs in 1994 and expects to have 75 active LGUs when it ends in 2000. Financially, the program assists LGUs by augmenting existing funds budgeted for ongoing family planning/maternal and child health/nutrition (FP/MCH/N) programs. Before funds are given as grants for the subsequent year, each LGU needs to reach annual performance objectives, or "benchmarks," that show progress in such areas as capacity development and expanded services. LGUs must achieve their benchmarks each year in order to continue receiving assistance from the LPP.

USAID/Philippines asked POPTECH to assemble a four-person team to assess the achievements to date of LPP, its design, its management structure and processes, and the role played by the institutional contractor (Management Sciences for Health—MSH) and USAID itself. The Team spent four weeks in the Philippines reviewing documents, interviewing DOH and USAID officials, and visiting 15 LGUs, DOH regional offices, and rural health units (RHUs) around the country.

LPP Achievements

The LPP has been successful in many ways. That success is most clear at the service delivery and capacity development levels. Many examples of expansion of services and improvement of quality result from LPP inputs at these levels. Trends in higher level indicators, such as the contraceptive prevalence rate (CPR), fully immunized children (FIC), and tetanus toxoid (TT) immunization, for example, are moving in the right direction. Over time the program should make a significant

¹Also known as IR 1 of *SO 3*, Intermediate Result No. 1, increased public sector provision of FP/MCH services, *Strategic Objective No. 3*, Reduced population growth rate and improved maternal and child health. LPP is the primary vehicle to achieve IR 1.

contribution to improved health and reduced fertility. LPP is likely to have more impact as the participating LGUs gather experience and learn to take on more and more responsibility for their own health and family planning activities.

LPP Design

Overall, the LPP seems to be well designed. It has many strengths, but it also has some weaknesses. The objectives are appropriate, timely, and acceptable to LGUs and the DOH, although there is some concern about the almost exclusive emphasis on national rather than local priorities. The LGU selection criteria (population size and commitment/capability) are reasonable and acceptable. The involvement of the local chief executives (LCEs) is an important element, but more involvement is needed during implementation to ensure that the program runs smoothly. The comprehensive plan and the planning process are very helpful to LGUs and DOH managers alike, but they have been too detailed and time-consuming. The new two-year plan is a welcome change. The concept of budget augmentation not budget substitution is appropriate, understood and acceptable, although it may need to be relaxed temporarily to permit funds to be used for travel during the current fiscal crisis. The technical assistance element has been appropriate and clearly needed, although it has been too reliant on USAID contractors. The DOH needs to take on primary responsibility for this function. LGU capacity development has been important and appreciated. It contributes to sustainability as well.

The major weaknesses are in benchmarking, performance measurement, and sustainability. The benchmark concept is useful, is appropriate, and has been an important management tool. But the selection of the particular benchmarks has been uneven, and the targets have been too easy for some and too difficult for others. It is likely that many LGUs will not be able to meet the FIC and TT2+ (2nd and succeeding tetanus toxoid immunization) targets for 1998 and 1999. If more than 10 of the 85 LGUs miss any of the benchmarks in 1998, the DOH will not meet its benchmark either. This would effectively shut down the LPP.² The performance-based disbursement system is innovative and effective. It is an excellent element that everyone seems to appreciate. However, this system does not measure current performance and there seems to be no economic incentive to meet the benchmarks specified in the 2000 plan. There are also problems with the timing of the cluster surveys (which produce performance data for three key benchmarks), with definitions of FIC, TT2+, and Vitamin A capsules (VACs), and with decision rules for determining whether an LGU passes or fails. Sustainability is one of the weakest design elements. No policies, plans, or mechanisms have yet been set for sustaining LPP or the LGU capability and service gains that have been made through LPP.

Fortunately, all of these weaknesses can be remedied.

² In addition, the DOH would not receive its annual tranche if any of the National Services benchmarks (IR 2) were not met. This would also shut down LPP.

LPP Management

LPP has relied on centralized management in the first years of project implementation. There has been a shift in the past year to greater reliance on regional technical assistance teams (RTATs) to take the lead in managing the increasing numbers of enrolled LGUs. The DOH manages the project through a number of structures that range in function from policy setting to provision of technical assistance both to DOH regional offices and to LGUs. There has been some dependence on project structures rather than on DOH units to manage the project. Participants in LPP have appreciated the plan development and review process despite its time-consuming, voluminous, and repetitive elements. Implementation constraints are mostly due to factors such as procurement delays, problems with travel expenses both at provincial and municipal levels, and central procurement and delivery systems. The Team noted some innovations, including the addition of provincial LPP management teams, the replication of LPP at the municipal level, and an increasing use of service statistics to improve accessibility. The project has attained a maturity that would allow for certain revisions in management and structure. These revisions will build on previous successes, such as the increased local capacity to plan for and to manage FP/MCH/N programs, the capacity of regions to provide technical assistance, and the ability of existing central office structures and processes like comprehensive health care agreements (CHCA), Health Development Fund (HDF), and Health Development Program (HDP) to help manage local government and regional affairs.

LPP Revisions

As LGUs and the DOH have gained experience in implementing LPP, both problems and opportunities have become evident. Decentralization of roles should be expanded. Many LGUs now have the experience and the capacity to manage LPP activities with less central direction. They can also participate in managing LPP nationwide. Delegation to the regions has proved successful and should continue, with RTATs providing an increasing portion of LPP technical assistance (TA) and the regional management teams (RMTs) assuming decision-making roles. LGUs should be encouraged to replicate LPP structures and procedures in their interactions with municipalities. As LPP gains maturity, the role of the DOH as funder of LPP should increase while the role of USAID as the principal donor decreases. Given the key function of LCEs in determining the support for program activities, the LPP should expand activities that ensure LCE support. Benchmark selection processes should include LGU negotiation of benchmarks. Performance measures should more specifically match the performance time period and the definition of the indicator being measured. The annual planning process should be altered so that following years require only updates and action plans. The institutional contractor should divest itself of managerial roles and should focus instead on strengthening TA capacity at the national and regional levels. LGUs that have demonstrated success at building capacity in support of FP/MCH/N services should shift from the more directive approaches of LPP to a new Matching Grant Program (MGP) that encourages more LGU participation in the selection of benchmarks and targets.

Future Directions

As LPP is an excellent program for building local capacity in management and FP/MCH/N services. But it has weaknesses and limitations. It is highly centralized, not truly based on current performance, and not sustainable in its present form. What is needed is a follow-on grant program that builds on LPP strengths while overcoming its limitations. The Team is proposing such a program, which it calls a Matching Grant Program. Successful LPP grantees would transition into the MGP where they would receive true performance grants to (1) strengthen management capacity at the municipal and city levels, (2) expand FP/MCH/N services, and (3) improve FP/MCH/N quality. They would receive individual grants from the DOH to achieve coverage benchmarks that they negotiate individually with the DOH. The grants would include a guaranteed minimum that could be paid as an advance plus additional incentive payments for exceeding their benchmarks. How the LGUs achieve their benchmarks would be up to them. They would prepare a multiyear plan that describes their approach, but once approved by DOH, the implementation would be their responsibility. This scheme could be pilot tested as early as 1999 with funds from the “windfall” expected this year. LPP would continue to enable all of the remaining LGUs that are interested to develop their management and service capacity. After two years in LPP these LGUs should be ready to graduate to the MGP themselves. The Team believes that the MGP is feasible. It would follow the same funding mechanism as LPP and would easily fit into the USAID Strategic Objective (SO) framework.

LIST OF RECOMMENDATIONS

Chapter 2

1. LPP seems to be the right program in the right place at the right time. It appears to be having the desired effects on health and family planning services and coverage. However, it may need more time to mature before significant quantitative achievements become obvious. Our recommendation is that support for LPP should continue.

Chapter 3

2. The LPP objectives should be “repackaged” to place more emphasis on responding to local needs and priorities.
3. Mechanisms need to be developed to increase the involvement of LCEs in the program’s implementation to ensure that it runs more smoothly.
4. The benchmarks need to be revised to (1) phase out those that are no longer required once an LGU has developed the appropriate capability (including annual plans, a contraceptive distribution logistics management information system [CDLMIS], staff training, information/education/communication [IEC] plans, establishment of voluntary sterilization [VS] services, and distribution of adequate stock of condoms and pills); (2) delete those benchmarks that individual LGUs had already achieved and sustained prior to enrollment (e.g., Vitamin A); and (3) set realistic targets for those benchmarks that are population coverage measures (e.g., FIC, TT2+ and VAC).
5. The performance-based disbursement system should be redesigned to link funding to performance, but there may not be enough time left in the LPP to do that. If there is a follow-on project, that linkage should be taken into consideration in the design.
6. The performance measures need to be standardized and revised to be consistent with the LGU plans. That is, the measures should cover the same time period as the plan whose performance is being measured. The measures and the program should define the target groups the same way. Confidence intervals should be taken into consideration when making decisions about LGU performance.
7. Decisions need to be made by LPP management with respect to what, if anything, should be sustained, both at the LPP/DOH and LGU levels. Specific plans then need to be prepared outlining sustainability objectives, mechanisms, and schedules.

Chapter 4

8. The DOH should activate the IFPMHP steering committee and should include USAID and LGU representatives.
9. Given the experience with LPP to date, the DOH should consider whether LPP could be better managed through units responsible for decentralization mechanisms and for regional affairs.
10. LPP managers should expand efforts to promote further decentralization. This decentralization should include a shift of authority both to the regions, and within the LGUs, increasing the responsibility of the municipalities. It should also include more regional and provincial attention to performance on the part of municipalities.
11. The institutional contractor should work together with the RTATs to provide technical assistance to LPP in local procurement. Such TA could be based on previous experience gained by HFDP.
12. The Secretary of Health should actively and personally champion LPP to LCEs.
13. The LPP planning process should be simplified and phased into multiyear plans that can be updated annually. These action plans should focus more specifically on achieving benchmarks. The plans should be expanded to include other health services, including those that are local priorities.
14. The IFPMHP steering committee should monitor those factors that are outside of LPP control but essential to LPP performance (e.g., travel expenses [TEVs], provision of contraceptives and vaccines) and should negotiate solutions if such factors begin to constrain LPP operations.
15. Cluster surveys serve central more than LGU monitoring requirements. LGUs rely more on service statistics for planning and monitoring. The expense of collecting service statistics should be attributed to central project management costs.
16. The DOH should set up a performance-based grants system for LGUs as a follow-on mechanism. System management should be placed in the appropriate DOH unit merging local government assistance.
17. The DOH should create a line item for a grant-based system or increase current items that are in place.

18. Responsibility for technical assistance is shifting from the institutional contractors to the DOH (central and regional). This trend should be encouraged and continued.

Chapter 5

19. Both the LGUs and the regions should play an expanded role in LPP. Decision making should be increasingly delegated to RMTs. RTATs should become the primary source of technical assistance. Municipalities should be encouraged to replicate LPP structures in their municipalities. Citizen participation in local health boards should be encouraged to produce a more vibrant constituency for FP/MCH/N services.
20. As LPP gains maturity, the role of USAID as the primary donor should decrease and DOH funding of LPP should increase.
21. The institutional contractor should work with the DOH to develop new approaches to ensure continuous support from LCEs.
22. The benchmark targets should be negotiated by the RTATs directly with each LGU and incorporated in their annual plans.
23. The LPP annual planning process should be simplified. Initial year detailed plans should be followed by brief annual updates and action plans.
24. The institutional contractor should divest itself of all LPP managerial roles and should increase its focus on strengthening the TA capacity of national technical assistance teams (NTATs) and RTATs.
25. LGUs that demonstrate success at building capacity within LPP should be graduated from LPP into a new program that provides them greater freedom in designing and meeting their own FP/MCH/N targets.
26. USAID and the DOH, with assistance from the Local Government Assistance and Monitoring Service (LGAMS) and the institutional contractor, should use the exchange rate “windfall” funds to begin pilot testing the new MGP.

CHAPTER 1. INTRODUCTION

1.1 USAID's Strategic Objective for Population and Health in the Philippines

The goal of USAID/Philippines is to support the effort of the Government of the Philippines (GOP) to achieve the status of a newly industrialized democratic country by the year 2000. Toward this end, USAID/Philippines is supporting two Special Objectives (SpOs) and six major Strategic Objectives (SOs), one of the largest of which is *SO 3: Reduced population growth rate and improved maternal and child health*.

SO 3 has three sub-objectives, called "Intermediate Results," or IRs, designed to (1) increase public sector provision of FP/MCH/N services; (2) strengthen national systems (such as contraceptive distribution, training, and research); and (3) increase private sector provision of contraceptives and services. See Appendix D for a summary of SO 3 components and indicators.

Currently, the public sector provides contraceptives to over 70 percent of users of a modern contraceptive method and will remain the backbone of the national family planning (FP) and maternal and child health (MCH) program for the near future. The public sector component of SO 3 will support the increase of family planning and MCH services in public sector facilities, most of which are operated by the local government units (LGUs—provinces, cities, and municipalities).

1.2 The Department of Health's Devolution of FP/MCH/N Services

In the past, the DOH employed all government health workers and managed a nationwide network of hospitals and health centers around the country. In 1991 the government decentralized many central government functions, including health. The Local Government Code of 1991 (RA 7160) shifted the responsibility for planning, managing, and evaluating health services from the central to the local level. LGUs now provide most health services. Provinces provide services directly through provincial and district hospitals. Municipalities are responsible for rural health units (RHUs) and barangay health stations (BHS). Cities provide services through hospitals and health centers in their jurisdictions.

The devolution of health services created a host of problems that neither the DOH nor the LGUs were prepared to resolve. Among these problems were the transferring of central health staff to the LGUs; the local procurement and distribution of drugs, equipment, and supplies; the recording and reporting of health information; and the monitoring of services. With experience and assistance, many LGUs not only are overcoming such problems but also are developing innovative programs that respond better to locally identified needs.

1.3 The Local Government Unit Performance Program (LPP)

The Local Government Unit Performance Program (LPP) was designed to help empower LGUs to meet and resolve local health problems, needs and demands. The program provides a mechanism for helping LGUs define their individual needs in family planning, child survival, and nutrition. The LPP provides funding and technical assistance to meet these needs while building the LGU's management capability to plan, implement, and assess their programs. The DOH, through its Office for Special Concerns (OSC), manages the program with assistance from USAID. Technical assistance is provided to LGUs by teams from DOH central and regional offices and from several USAID contractors.

The program started with 20 large LGUs in 1994 and expects to have at least 75 active LGUs when the project concludes at the end of 2000. Financially, the program assists LGUs by augmenting existing funds budgeted for ongoing FP/MCH/N programs. Before the DOH provides an LPP grant to an LGU, the LGU must have met its annual performance objectives, or "benchmarks," that show progress in such areas as capacity development and expanded services. LGUs must achieve their benchmarks each year in order to continue receiving assistance from the LPP.

1.4 Scope of Work of the Assessment

This assessment had the following purposes:

1. To assess the LPP design and implementation processes. How appropriate is LPP as an approach for achieving the goals and objectives of the Integrated Family Planning/Maternal and Child Health Program (IFP/MCHP)? Is the design appropriate? Will the targets for the indicators be achieved? If not, how can the design be improved?
2. To assess the responsiveness and effectiveness of the LPP management structure and its administrative and operational processes. How is the DOH (central and regional offices) managing the implementation of LPP, and how effective is this management process? How is USAID managing the process? How are the LGUs managing and implementing LPP? How is the technical assistance contractor set up for this purpose? How are these management processes influencing program implementation and accomplishments?
3. To make recommendations regarding revisions or modifications that the program implementers (DOH, LGUs, TA contractors, and consultants) can make so that the program objectives can be achieved.
4. To determine if the LPP approach should be continued in the next strategic planning period. If not, what modifications or improvements are necessary?

See Appendix A for a complete version of the scope of work (SOW).

1.5 Methodology

A four-member team was assembled by POPTECH to carry out the assessment. The members were as follows:

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Cliff Olson, M.A., Health Service (MCH/Nutrition) Analyst
Juan Perez III, M.D., M.P.H., Health Management Specialist
Agnes Villarruz, R.N., M.N., Health Management Specialist

The Team spent four weeks on the assessment, including almost two weeks in the field visiting 15 LGUs from the first three batches enrolled. The fourth batch was not included because it was in its start-up year and had not yet received a grant or implemented any LPP activities. The fifth and last batch under LPP will be enrolled in 1998. A complete list of all LGUs enrolled by batch, including identification of those visited by the Team, is in Appendix E.

Interviews were conducted with local executives (governors and mayors), regional DOH staff, LGU recipients (provincial, municipal and city), and service providers who received assistance from the LPP (rural health units and barangay health stations). In addition to reviewing documents and data files in Manila, the team also interviewed central DOH staff members who were involved in the project, USAID staff and contractors, and others who were familiar with LPP. A complete list of contacts is included in Appendix C, and a list of documents reviewed is in Appendix B.

Oral briefings on the Team's findings and recommendations were presented to DOH and USAID staff February 5, and a draft report was delivered to USAID the next day. Reactions and feedback from DOH, USAID and other readers were incorporated into the final report, which was submitted to POPTECH in late February.

CHAPTER 2. PROGRAM ACHIEVEMENTS

The LGU Performance Program has been successful in many ways. That success is most clear at the service delivery and capacity development levels. Many examples of expansion of services and improvement of quality result from LPP inputs at these levels. Trends in higher level indicators (e.g., CPR, FIC, TT) are moving in the right direction, and over time the program should make a significant contribution to improved health and reduced fertility. LPP is likely to have more impact as the participating LGUs gather experience and learn to take on more and more responsibility for their own health and family planning activities.

Table 1

Summary of LPP Achievements

| Achievements | Summary Assessment |
|------------------------------------|--|
| 1. Population Growth and MCH Goals | Trends positive. Should see improvements in all SO 3 indicators; may not meet some goals (PGR, TFR, IMR, MMCPR). |
| 2. Intermediate Results 1 | VAC and No. Active LGUs achievable, others doubtful (FIC, TT, CYP, HES). |
| 3. LPP (DOH) Benchmarks | DOH should reach all benchmarks, except FIC, TT2+ and VAC if enough LGUs do not meet their benchmarks. |
| 4. LGU Benchmarks | New LGUs should not have any problems. Many continuing LGUs will not meet FIC, TT2+ targets. |
| 5. Other Achievements | Significant improvements at LGU level in planning, provider capability, service expansion, quality, sustainability. RTATs gaining TA capability. |
| 6. Constraints | Politics, religion, LGU bureaucracy, DOH "re-nationalization," economic crisis. |

2.1 Population Growth and Maternal and Child Health Goals

Table 2 shows the available data on population and health indicators. Shaded cells indicate goals that the Team believes may be difficult to achieve. Accurate figures will not be available on population growth changes until the 2000 census is completed. Data for all of the other indicators will be collected in the 1998 DHS. Cluster and rider surveys are also planned for 1998, 1999, and 2000.

In general, the trends are in the right direction for population growth, modern method contraceptive prevalence rate (MMCPR), the infant mortality rate (IMR), and high-risk births. The overall increase in the CPR in 1995 was due to increased use of traditional methods following

the Pope's visit to the Philippines. The declines since then mask the general upward trend, which is apparent in the increase in the use of modern methods.

Improvements are expected in all of these indicators over the next two years, but it is uncertain that all of the goals will be met, in particular the population growth rate (PGR), the total fertility rate (TFR), the modern method contraceptive prevalence rate (MMCPR), and the infant mortality rate (IMR). These goals may be too high to reach in the time remaining. However, the LPP LGUs, which make up a large proportion of the total population, had an average CPR of 55.8 percent according to the 1997 cluster survey. If contraceptive use continues to increase in these LGUs, the national figures could rise enough to reach the 2000 goal of 50.5 CPR.

Table 2

Population and Health Indicators (Strategic Objective Level)

| Year | PGR (1) | TFR (2) | CPR (2,4) | MMCPR (2,4) | IMR (2,3) | MMR (2) | High-Risk Births (2,4) |
|-------------|--------------------|--------------------|----------------------|------------------------|----------------------|--------------------|-----------------------------------|
| 1990 | 2.35 | | | | 56.7* | 209* | |
| 1991 | | 4.1* | | | 55.1 | | |
| 1992 | | | | | 53.6 | | |
| 1993 | | | 40.0 | 25.2 | 52.0 33.6 (2) | | 62.4 |
| 1994 | | | | | 50.5 | | |
| 1995 | 2.32 | | 50.7 | 25.7 | 48.9 | | 60.5 |
| 1996 | | | 48.1 | 30.2 | | | 59.2 |
| 1997 | | | 47.0 | 30.9 | | | 56.2 |
| 1998 | | | | | | | |
| 1999 | | | | | | | |
| Goal 2000 | 1.93 | 3.1 | 50.5 | 35.7 | 41.2 | 190 | 56.0 |

Sources:

1. Census on Population and Housing (1990), Intercensal Survey (1995).
2. National Demographic and Health Survey (1993 DHS). MMR is the maternal mortality ratio
3. Infant Mortality Task Force.
4. National Statistics Office, MCH Rider to Labor Force Annual Survey.

* The 1993 TFR covered a three-year period centered on 1991; the IMR and MMR covered a five-year period centered on 1990.

2.2 Intermediate Results

The Intermediate Results for IR 1 (Public Sector Services) are shown in Table 3. Shaded cells labeled “Goal” indicate targets that the Team believes will be difficult to meet. All but three of these goals (VAC, No. LGUs enrolled, and No. Active LGUs) may not be achieved by the target dates.

These figures are national. Those drawn from surveys are more reliable and include both public and private contributions. Those drawn from DOH service statistics are often inflated and reflect public sector accomplishments. Public-private breakdowns can be computed for LPP provinces from the multi-indicator cluster surveys (MICS). Those data are available only for 1997, however.

The DOH service statistic data for FIC and VAC are high, and there is every expectation that the goals for 2000 will be met. Both FIC and VAC have targets of 90 percent coverage, which is well above the WHO target of 80 percent. Thus, even if achievement is in the high 80s, “universal coverage” will be ensured if these statistics are correct. Unfortunately, the survey data for FIC (1993 and 1997) show much lower coverage, with no improvement over the past five years. The FIC figures from the 1997 LPP cluster surveys show a higher coverage average for the LGUs (78.2 percent). That is encouraging. These figures are for children of 12–23 months, however.

It is less likely that the tetanus target (TT2+) will be met. Coverage actually declined from its high in 1994 because of statements by the Philippine Catholic clergy that the inoculations caused abortions. The DOH has increased its IEC efforts to counter this fear and has had gradual success. However, TT2+ rates are still well below the target of 80 percent coverage by 2000, depending on the statistic used. The Bureau of the Census computed three different rates from the 1997 rider survey: a rate of 36.1 percent for surviving children under age 3 whose mother received two or more TTVs during her last pregnancy; a rate of 51.2 percent for children under age 3 protected from neonatal tetanus; and a rate of 67.4 percent for mothers (of children under age 3) received two or more TTVs without regard to the timing of vaccination.

Table 3

Intermediate Result 1 Indicators

| Year | FIC (1) | TT+ (2) | VAC (3) | MMCYP (Million) (4) | LGU Enrolled (5) | LGU Active (5) | HES 25% (5) |
|-----------|------------|------------|------------|---------------------------|------------------------|----------------------|-------------------|
| 1990 | | | | | | | |
| 1991 | | | | | | | |
| 1992 | | | | | | | |
| 1993 | 90.0/61.9 | 70.0/42.2 | 90.0 | | | | |
| 1994 | 88.4 | 69.3 | 93.0 | 1.67 | 20 | 20 | |
| 1995 | 86.4 | 57.6 | 88.0 | 1.61 | 30 | 28 | |
| 1996 | 90.6 | 47.0 | 88.0 | 1.55 | 55 | 46 | |
| 1997 | 58.2 | 36.1/67.4 | 78.0 | | 80 | 66 | |
| 1998 | | | | | 100 | 75 | |
| 1999 | | | | | Goal 1998 | 75 | |
| Goal 2000 | 90.0 | 80.0 | 90.0 | 2.56 | | Goal 1999 | 75 (25%) |

Sources:

1. DOH service statistics (0–11 mo.) and 1993 NDS (12–23 mo. = 61.9%), and 1997 MCH rider survey (12–23 mo. = 58.2%).
2. 1993 NDS (under 5; 42.2); 1993–1996 DOH service statistics (70.0, 69.3, 57.6, 47.0); and 1997 rider surveys (under 3) two estimates (36.1% and 67.4%)
3. Post National Micronutrient Day Survey
4. DOH FPS, CLDMIS, AVSC VS reports
5. IFPMCH MIS (to be achieved by 1998)

Modern method couple years of protection (MMCYP) have been declining, which may seem surprising since modern method use has increased. MMCYP data are collected to monitor public sector output. The CPR figures include both public and private users. Intrauterine devices (IUDs) and VSs are heavily weighted in the CYP calculations. If they start declining then total CYPs will probably decline. That change seems to be what is happening. Both IUD distribution and VS performance have declined significantly in recent years, while pill and injectable use have increased. That shift may explain why MMCPR is increasing while public sector MMCYP is decreasing. Other possible explanations are (1) women are switching from public to private providers, and (2) a reduced contraceptive pipeline has been achieved by improvements in the reliability of the distribution system.

The CPR is included in the MICS, as are three other coverage indicators (FIC, TT2+, and VAC), all of which are benchmarks. As an unexpected result, the CPR has been unconsciously linked to the benchmarks by LGU staff, who are as conscious and proud of their CPR achievements as they are of the other three benchmarks. The CPR is not an official benchmark because it is too controversial, but it appears to have achieved that same informal status and as such is motivating LGU staff to work harder to increase CPR. The 1997 cluster survey showed the average CPR at 55–56 percent, a full 7–8 points above the national average in 1997.

The original enrollment target was 100 LGUs by 1998. An agreement was reached between the DOH and USAID that the target enrollment of 100 LGUs will be adjusted accordingly based on the efficiency of reaching the 75 LGUs end goal. Accordingly, this year’s plan calls for 19 new LGUs to be enrolled, which is a safe margin to ensure that at least 75 LGUs meet their benchmarks within the life of the program.

The human and ecological security (HES) contribution³ was originally planned as an indicator of sustainability of FP/MCH/Pop/Nutrition programs at the LGU level. The number of LGUs allocating a certain percentage of their HES funds for these programs was expected to increase beginning in 1997, with 41 LGUs reaching a 10 percent allocation. This increase would culminate in 2000 with 75 LGUs reaching a 25 percent allocation. The DOH asked to defer this plan until it completed an assessment of the appropriateness of the HES measure as a sustainability indicator. Preliminary results of the study indicate that HES is probably not an appropriate measure, in part because the government’s list of suggested uses of HES funds did not give high priority to FP/MCH/N.

Although no aggregate data are currently available on HES contributions, the Team collected sufficient information during its field visits to conclude that many LPP LGUs have already secured commitment of HES funds for FP/MCH/N services. However, it is not likely that all will be able to secure such funds, especially those LGUs in poorer areas. Only a few are likely to meet the 25 percent target, from what we were able to observe. A much more concerted effort will be needed this year to reach that target. Given that it is an election year and that opponents of the program could be elected in some LGUs, the prospects are not encouraging.

³Each year LGUs receive an Internal Revenue Allotment (IRA). Twenty percent of the IRA is a development fund. This money can be used for any development project the LGU decides to implement. It is not supposed to be used for recurring costs. A June 17, 1995, government memorandum from the Department of Interior and Local Government (DILG) stated that 20 percent of the development fund should be used for HES, “Human Ecological Security.” The LPP objective is to tap some of these funds to provide continued support to population, health, and related activities. The LPP indicator is for all 75 “active” LGUs to receive 25 percent of HES by 2000.

2.3 LPP (DOH) Benchmarks

In addition to the overall indicators, the DOH has a number of benchmarks to achieve each year. In 1995 and 1996, the benchmarks were few in number and were relatively easy to achieve.

| | | |
|-------|------------------|--|
| 1994: | OSC Benchmark #1 | Issues a description of the LPP, including program planning and performance standards |
| 1995: | OSC Benchmark #1 | Selects first group of 20 LGUs to participate |
| | OSC Benchmark #2 | Contacts LGUs, explains program, encourages participation through technical assistance |
| | OSC Benchmark #3 | LGUs develop integrated plans |
| | OSC Benchmark #4 | LGUs obtain endorsements for their plans from the LCE |
| 1996: | LPP Benchmark #1 | ≥41 LGUs meet their benchmarks for 1996 |
| | LPP Benchmark #2 | DOH-OPHS (Office for Public Health Services) reviews the current LGU benchmarks and develops LGU and LPP benchmarks for 1997 based on revised IFPMHP indicators. |

The benchmark achievements for 1997 are shown in Table 4. Most of these are accumulations of LGU benchmarks. That is, each LPP LGU has its own benchmarks and the DOH benchmarks are based on the number of LGUs who achieve each of their benchmarks. For example, each LGU must develop a comprehensive plan in order to receive a grant. The DOH target is to have at least 60 of the 67 LGUs develop a comprehensive plan in 1997. For 1998 and 1999, the target is 75. The DOH must reach the target for each of its benchmarks each year to receive the overall grant from USAID.

Table 4**DOH/LPP Level 1997 Benchmark Achievement**

| Benchmark | 1997 |
|---|-------------|
| 1. Comprehensive plan developed (60) | 66/67 |
| 2. Administrative order issued (new LGUs) | 21/21 |
| 3. CDLMIS (60) | 67/67 |
| 4. Trained staff (41) | 45/46 |
| 5. IEC plan implemented (41) | 45/46 |
| 6. VS services available (41) | 45/46 |
| 7. Cluster survey conducted (41) | 45/46 |
| 8. VAC coverage (90%) | 46/46 |
| 9. No. LPP LGUs fully meeting benchmarks | 66/67 |

Source: 1997 IFPMHP Performance Review, December 9, 1997, Hyatt Regency Hotel, Manila.

As the table shows, the DOH did not have any problem meeting all of its benchmarks last year. In 1997 all of the benchmarks were achieved, and 66 of the 67 LGUs enrolled achieved all of their individual benchmarks. Many of the DOH benchmarks include subcategories. The cluster survey benchmark, for example, requires that the survey produce data on four indicators: CPR, FIC, TT2+, and VAC. If one of the surveys does not include one of these indicators, the LGU would be dropped from the program. If more than five LGUs do not include that indicator in their surveys, the DOH would not qualify for its grant. A list of all of the DOH benchmarks for 1997 is included in Appendix F together with a table summarizing achievements for 1997 (Appendix G).

The DOH benchmarks for 1998–2000 were set in January 1998. They are described in Appendix F and summarized in Table 5.

The Team believes that the DOH should have no problem achieving most of these targets, with the possible exception of TT2+ and FIC. The DOH could fail to receive this year's annual tranche if more than 10 LGUs fail to meet any of their annual benchmarks. The 45 continuing LGUs that have TT2+ and FIC benchmarks might find the targets difficult to achieve based on reasons discussed in the next section.

Table 5**DOH/LPP Level 1998–2000 Benchmark Targets**

| Benchmark | 1998 | 1999 | 2000 |
|---|-------------|-------------|-------------|
| 1. No. LGUs that develop comprehensive plans | 19 (new) | 56 | 75 |
| 2. Administrative order issued (new LGUs) | 19 | NA | NA |
| 3.1 No. LGUs with CDLMIS (new =19) or adequate | 79 | 75 | 75 |
| 3.2. No. LGUs with % trained staff and equipment as | 60 | 75 | 75 |
| 4. No. LGUs implementing IEC plans | 60 | 75 | 75 |
| 5. No. LGUs providing VS services | 60 | 75 | 75 |
| 6. No. LGUs meeting FIC targets set by DOH | 41 | 60 | 75 |
| 7. No. LGUs that meet TT2+ targets set by DOH | 41 | 60 | 75 |
| 8. No. LGU meeting 90% VAC targets | 60 | 75 | 75 |
| 9. No. LPP LGUs fully meeting benchmarks | 75 | 75 | 75 |

Source: Joint Program Implementation Letter (JPIL) No. 17, dated January 20, 1998. Shaded cells indicate benchmarks that the Team believes may be difficult to achieve.

2.4 LGU Benchmarks

Benchmarks at the LGU level are summarized in Appendix H. In the first year, the new LGUs have to meet only three benchmarks: (1) develop a comprehensive plan, (2) set up an operating CDLMIS, and (3) issue an official order from the LCE defining the roles and functions of the health and population offices.

Through 1997 the benchmarks for continuing LGUs also concentrated on capacity development (preparing a comprehensive plan; setting up a contraceptive distribution system, a management information system, a procurement system, and a VS service; training providers in basic FP/MCH/N service delivery; and conducting a cluster survey). The only coverage benchmark was for Vitamin A, and this goal was easy to meet because most LGUs were already at or around 90 percent VAC coverage before they enrolled in LPP.

For 1998–2000 two more coverage benchmarks were added for continuing LGUs: FIC and TT2+. As noted above (Table 3), VAC and FIC coverage (as measured by service statistics) are

already high, so achievement should be relatively easy for most LGUs. But there are exceptions. Expanded Program on Immunization (EPI) coverage targets for some of the LGUs visited by the team may be difficult to reach. TT2+ is low nationwide, and many LGUs may have trouble meeting their targets for this benchmark.

The Team computed the 1998 and 1999 targets for these benchmarks for each of the 15 LPP LGUs it visited. The baseline (taken from the 1997 cluster survey) and the targets for FIC, TT2+, and VAC are shown in Table 6 for a sample of seven of those LGUs. (The baseline and target data for all of the LGUs visited by the Team can be found in Appendix I). Those LGUs that may have difficulty meeting their targets are shaded.

Table 6

LGU-Level Benchmarks for Coverage of FIC, TT2+, and VAC

| LGU Name/Code | Pangasinan Prov. | Davao City | Cotabato Prov. | Albay Prov. | Cavite Prov. | Malabon Munic. | La Union Prov. |
|---------------|------------------|------------|----------------|-------------|--------------|----------------|----------------|
| Year started | 1994 | 1994 | 1995 | 1995 | 1996 | 1996 | 1996 |
| 1997 Baseline | | | | | | | |
| 6. FIC | 67.1 | 93.6 | 80.0 | 80.4 | 78.7 | 89.0 | 62.1 |
| 7. TT2+ | 56.0 | 66.6 | 82.0 | 69.1 | 61.9 | 56.7 | 73.0 |
| 8. VAC | 95.0 | 97.0 | 93.0 | 91.2 | 94.1 | 97.0 | 93.6 |
| 1998 Target | | | | | | | |
| 6. FIC | ≥82.1 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥77.1 |
| 7. TT2+ | ≥71.0 | ≥76.6 | ≥80.0 | ≥79.1 | ≥71.9 | ≥71.7 | ≥80.0 |
| 8. VAC | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 |
| 1999 Target | | | | | | | |
| 6. FIC | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 |
| 7. TT2+ | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 |
| 8. VAC | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 |

Note: This table assumes that the 1998–1999 benchmarks will be revised to set targets at a maximum of 90% for FIC and 80% for TT2+.

Cavite, for example, will have to raise TT2+ coverage by 10 percentage points in 1998 and another 8 points in 1999 to reach the national goal of 80 percent coverage. The Team believes that any increase over five percentage points in a year will be difficult to achieve, especially given the short period of time (3–6 months) that is effectively available to achieve these increases.

Because of the “all or nothing” achievement requirement, an LGU that misses even one of these targets by one percentage point would be dropped from the program and would not receive its grant for that year. These and other issues involving the benchmarks and the performance data used to assess achievement are discussed in more detail in Chapter 3.

2.5 Other Achievements

There have been a number of achievements that are difficult to quantify, but are important just the same. Many of these were stated explicitly or implicitly as LPP objectives. Among the most important achievements are (1) development of LGU management capability, (2) strengthening of DOH technical assistance capability, (3) strengthening of provider capability, (4) expansion of FP/MCH/N services, (5) improvement of service quality, and (6) enhancement of the sustainability of LPP.

There have been gains in all of these areas, although the gains vary by element and by LGU. Many of the reasons for these variations will be discussed in Chapters 3 and 4. At this point we merely wish to describe the achievements that have been identified.

2.5.1 Development of LGU Management Capability

Almost everyone agrees that LPP has been directly responsible for strengthening LGU planning and monitoring capability. The comprehensive FP/MCH/N plans improve with experience, and many of the “first batch” of LGUs are now capable of developing their plans without assistance. Some LGUs have even shown staff members at lower administrative levels (municipal and barangay) how to plan and monitor their own activities. In many cases, this training has had the effect of empowering LGU staff, boosting morale, and encouraging local staff members to take on more responsibilities.

2.5.2 Strengthening of DOH Technical Assistance Capability

LPP has been responsible for developing technical assistance capability at the regional level, although this development has been uneven. Some regions have been more open to accepting this new responsibility than others have been. Those regions that have increased technical assistance capability are making a significant contribution to LGU planning, implementation, and monitoring.

2.5.3 Strengthening of Provider Capability

Another important achievement has been the strengthening of the capability of local health staff to provide additional and better services. Basic and specialized training programs have been appreciated by most providers who have been chosen to participate in such training. The training has also been a big morale booster and has had a significant impact on job satisfaction.

2.5.4 Expansion of FP/MCH Services

Perhaps the most obvious expansion has been of voluntary sterilization (VS) services, which is the direct result of LPP support for the training of VS teams, the provision of VS equipment, and the refurbishing of VS facilities (operating rooms, in particular).

Expansion of DMPA (injectable contraceptives), IUD, CARI (control of acute respiratory infection), micronutrient, and other LPP-supported services has also occurred in many LGU health centers. Staff members were quick to identify LPP as directly responsible for such expansion. Many also attributed the expansion to increases in new family planning acceptors, to increased treatment and referral of acute respiratory infection (ARI) cases, and to things similar to LPP. Some were convinced that these additional services have had a direct impact on the reduction of infant mortality (because of quick treatment of respiratory and diarrheal diseases) and maternal mortality (because of reduced complications of pregnancy and childbirth).

2.5.5 Improvement of Service Quality

Health staff members also see improvements in the quality of care, largely as a result of the provision of training, equipment, and supplies that enable doctors, nurses, midwives, and counselors to provide better services to their clients. IEC has led to better-informed clients who have a greater understanding and appreciation of FP/MCH and nutrition services.

2.5.6 Enhancement of the Sustainability of LPP

Many of the LGUs visited by the Team had already taken steps to “institutionalize” aspects of LPP that they would like to continue after this particular program comes to a close in 2000. This effort includes finding ways to maintain and enhance the technical capability of service staff, continuing to provide contraceptive supplies to health centers in a timely manner, and identifying such alternative funding sources as counterpart funds and HES.

2.5.7 Other Benefits of LPP

- LPP reduces the management burden on DOH central and regional offices, as well as on USAID. Because this is a performance-based program, audits will focus only on outputs—whether the benchmarks were actually achieved—not on inputs, such as local costs for training and equipment.
- LPP is starting to be replicated in other provinces and emulated by other services.

- LPP is supporting the democracy agenda by assisting LGUs to become more involved in policy and program decisions at the local level.
- LPP has re-established the link in vertical programs between central and local units that was lost in the early days of devolution.

2.6 Constraints on Achievement

Achievement has been somewhat constrained by external factors beyond the control of LPP and the organizations that implement it. Most of these factors are well known in the Philippines and will only be listed here.

- **The Political Environment and Upcoming Elections:** This may be the most topical issue. Campaigning has already begun, and most staff members are acutely aware that their programs and jobs could be in jeopardy if the “wrong” mayor, governor, or president is elected. There is ample precedent for post-election staff changes, budget realignments, and shifts in priorities. The possibility of such changes is a serious constraint and a potential threat, not only to LPP, but to the IFPMHP as well.
- **Religious Opposition:** The Catholic Church remains a formidable opponent of all “artificial” means of contraception. Religion and politics are so entwined that this gives added concern that the upcoming election could usher in another anti-family planning era.
- **LGU Bureaucracies:** Red tape is found at the local level as well. This bureaucracy has been a serious constraint on release of LPP funds, purchasing, and reimbursement. Delays of one to two months in signing memoranda of agreement (MOAs) and in procurement are common, and delays of up to six months have been experienced.
- **DOH Re-nationalization:** Some former DOH central staff members who have been “devolved” to the provinces and municipalities long to be “re-nationalized.” This feeling is particularly so among provincial hospital staff, but it is also true among public health doctors, nurses, and others who are now assigned to provincial and municipal health offices. There have been a number of bills introduced in Congress to re-nationalize health services, and the pressure to do so will probably continue through the election. This pressure is a significant distraction and impediment to the institutionalization of health services at the local level.
- **Limited Financial Resources and the Currency Crisis:** Money for travel, medicines, supplies, and other resources is limited, and that affects the ability of

the most enterprising LGUs to carry out their LPP activities effectively. The currency crisis in Asia has also affected the Philippines. Costs of imported and local goods are increasing. Government strategies to contain costs include a recent directive from the president to cut spending this year by 25 percent across the board. A short-term advantage to LPP could be a windfall in pesos when the USAID tranche for 1997 is converted from dollars to pesos at what is expected to be a significantly higher rate (40–43 pesos/\$US) than in 1996.

2.7 Conclusions

LPP achievements in capacity building, service expansion, and quality of care have already been noticed. Improvements in coverage and utilization of health and family planning are expected to rise, although perhaps not as much as planned. Over time, those effects should increase and should lead to improved health and reduced fertility in the long run.

2.8 Recommendations

1. LPP seems to be the right program in the right place at the right time. It appears to be having the desired effects on health and family planning services and coverage. However, it may need more time to mature before significant quantitative achievements become obvious. Our recommendation is that this LPP should continue to be supported.

CHAPTER 3. LPP DESIGN VALIDITY

The purpose of this chapter is to assess the “design elements” of LPP. How appropriate and effective are the overall design and each of the key elements (such as the objectives, the LPP selection criteria for LGUs, the involvement of the LCEs, the comprehensive planning, and so forth)? Three of these elements have been singled out for more in-depth review because of their importance: benchmarks, performance-based disbursement, and sustainability. The focus in this chapter is on the elements themselves. The implementation of LPP, the management structure, and the tools and processes used to bring it to life are examined in Chapter 4.

3.1 LPP Design Elements

There is no formal listing of LPP’s design elements. Table 7 lists those that were identified by the Team for purposes of this assessment.

Table 7

Summary Assessment of LPP Design Elements

| Design Elements | Summary Assessment |
|--|---|
| 1. Objectives | Generally appropriate, timely, and acceptable to LGUs and DOH. Some concern about central vs. local priorities. |
| 2. LGU selection criteria | Appropriate given the objectives, reasonable, and acceptable. |
| 3. Local Chief Executive involvement | Key factor in success of LPP. Not enough after MOA. |
| 4. Comprehensive plan | Very helpful, appreciated, primary management tool, but too detailed and time-consuming. |
| 5. Budget augmentation, not substitution | Appropriate, understood and acceptable. |
| 6. Technical assistance (USAID and DOH) | Very appropriate, clearly needed, but too reliant on USAID contractors; need to shift to DOH. |
| 7. LGU capacity development | Very helpful and important for sustainability. |
| 8. Benchmarking | Concept very useful, definitely appropriate, but there are significant design flaws. |
| 9. Performance-based grants | Innovative and effective system, but not really performance-based. Measurement problematic. |
| 10. Sustainability | Weak link, but some LGUs well on their way. |

3.1.1 Objectives

The LPP has two interrelated objectives:

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

Both of these objectives seem reasonable and appropriate, given the government's devolution strategy. The first is well understood by the participating LGUs. The focus on "targeted integrated family planning/maternal and child health services" is understood and accepted as well. This point is important to note because, at the same time, there is some criticism of this limitation in focus. Some LGUs would prefer a broader program that would allow them, as the brochure says, to "meet and resolve local health problems, needs and demands," and to "clearly define their individual goals...."⁴ For some LGUs, particularly those that have been in the program for three to four years, the program seems too restrictive and too centralized. At the extreme are those LGUs that see the LPP as a device for getting them to implement national family planning, EPI, and micronutrient programs at the local level. But most, including the critical LGUs themselves, welcome the program and believe it is helpful to them.

One insightful LPP coordinator suggested that the answer might simply be a matter of "packaging." If the program were packaged as assistance to LGUs to help them identify their local health needs and priorities, whatever they are, the LGUs would be satisfied. The following is how the coordinator would phrase it:

LPP is not a program *per se*, but assistance for establishing the elements that the province has adopted for its own program. The national government is willing to assist some of those. We are building our own program and LPP is helping us with some of the elements that are also national priorities.

LPP could limit its financial and technical assistance to strengthening the FP/MCH/N services, and that change would be acceptable. The LGUs would accept that they would have to tap other sources for support for tuberculosis (TB), leprosy, water and sanitation, and so forth. The planning and monitoring techniques they learn through LPP could easily be applied to these other services, but LPP funding for them would not be expected.

The second objective, to strengthen DOH technical assistance and monitoring capability, seems to

⁴"The LGU Performance Program, An Introduction." DOH, OSC brochure, with support from USAID under contract to MSH. Undated.

be getting a mixed reception at the DOH. The Team did not find a great deal of interest in LPP at the central level. One service component made it clear that it sees LPP as detracting its staff from its real work. There is no “home” for LPP at the central level, as far as we could tell. The Project Management Office (PMO) is a temporary unit funded to serve all of IFPMHP, not just LPP.

In the regions, acceptance of LPP also seems mixed. Some regional offices complain about the extra burden and that they just “do what they are told by Manila.” Others enthusiastically embrace LPP and have taken initiatives to expand the LPP planning and monitoring procedures to the municipal and barangay levels. Those that embrace LPP state that it has enabled the regions to re-establish a direct link with the LGUs that had been lost in the early stages of devolution. This link has enhanced and improved working relationships between the regions and LGUs.

3.1.2 LGU Selection Criteria

Until 1997 there were only two criteria—“large population size” and “high commitment/capacity”—that an LGU needed to satisfy to implement population, family planning, and child survival programs. Both criteria seem reasonable and highly appropriate. By selecting LGUs with large populations, the program not only has a chance to expand coverage significantly, but also has to work with cities and provinces that have enough human and other resources to implement the program. Commitment and capacity are also important criteria, as experience has shown. Three of the four LGUs that dropped out of the program did so because of a lack of commitment—to family planning, in particular. In 1997 a third criterion, regional representation, was added. This change, too, seems both appropriate and important.

3.1.3 Local Chief Executive (LCE) Involvement

This may be one of the most critical design elements. Practically all of the interviews conducted and assessments read by the Team identified the LCE as the key to success. Support from the governor, mayor, or administrative officer was repeatedly mentioned as essential not just to getting started, but also to implementing a project. In fact, the lack of involvement of LCEs after the project began was seen as a gap that needs to be filled. Most LPP coordinators have quarterly meetings with their LCE, but that is not always enough to ensure that the project proceeds smoothly. Two of the provincial LGUs that we visited had set up LPP management teams that included a representative of the LCE and such key LGU staff as the finance officer and general supplies officer. These teams met monthly and as needed to anticipate and resolve problems that could affect LPP. Both provinces said that this mechanism was very useful.

3.1.4 Comprehensive Plan

The development of an integrated and comprehensive plan is one of the most appropriate and useful elements of the LPP design. The situation analysis that precedes the development of the first plan has been invaluable to many LPP coordinators and component managers. Many have commented that this analysis lets them determine exactly where gaps exist in supplies, equipment, training, and other resources. The plan enables them to make requests for additional resources that are specific and justifiable.

The biggest criticism of the plan, however, is that it is overly detailed, labor intensive, time consuming, and repetitive. The two-year plan that was introduced in 1997 was very welcome. A five-year plan that is updated annually probably would have been a less complex, but equally useful, approach. Apparently, this approach was the original intent, but for some reason an annual planning scheme was adopted instead.

3.1.5 Budget Augmentation, Not Substitution

This element is especially important to USAID and the central DOH, which normally try to avoid supporting recurring costs. As far as the Team can tell, the LGUs and the DOH understand and accept this position, and the funds they receive are being used to augment local budgets. However, as the government of the Philippines attempts to control costs by cutting travel and procurement expenditures, it will become increasingly difficult for some LGUs to provide sufficient counterpart funds to implement LPP effectively. For example, travel budgets have been reduced to three days per person per month in several provinces. This money is not enough to carry out the various planning, training, monitoring, contraceptive delivery, and other tasks required by LPP. Fortunately, LPP funds can be used to augment TEV ceilings, as long as they follow the LGU standards for travel.

3.1.6 Technical Assistance (USAID and DOH)

Technical assistance comes from two main sources: USAID contractors (MSH, AVSC, Johns Hopkins University/Population Communication Services [JHU/PCS], etc.); and the DOH (PMO, the national technical assistance team [NTAT], RTAT, etc.). The assistance is definitely needed and has been valuable. One of the national service benchmarks (IR 2) for 1996 was to develop and implement a DOH strategy for providing TA to LGUs. That strategy is being implemented. TA has been shifting from the USAID contractors to DOH central, then to DOH regional, and now, in some areas, to the LGUs themselves. This is a positive development that should lead to institutionalization and enhance prospects for sustainability.

3.1.7 LGU Capacity Development

Development of LGU capacity to plan and implement an integrated FP/MCH/N program is the primary objective of LPP, so this element is obviously essential. The assessment question is directed at the type of capacity selected by LPP to be developed. Are these the most needed and important? The answer depends on one's point of view. From the point of view of the central DOH and USAID, these are essential to the implementation of the IFPMHP. To a number of the LGUs they are (1) largely family planning and (2) largely national. One LPP coordinator told the Team about a meeting with the provincial *sanggunian* (council) where she was asked if LPP was a provincial health program. As she listed and described each component, a council member said, "That sounds like a national program of DOH."

- CDLMIS
- Procurement tracking system
- FP/MCH/N data system
- IEC plan
- FP/RH basic training
- VS services development
- Cluster survey

There is no doubt that the capacity development is welcome and is paying off. Nevertheless, there is a sentiment among some local people that these "capabilities" are being imposed on the LGUs by the central government in order to institutionalize its priorities, rather than to help the LGU fulfill its own priorities. This sentiment is not universal, and it is not a major problem, at least, yet. But it could become one if it is not dealt with. As noted previously, this sentiment may be an issue that can be addressed by "repackaging" the product.

3.1.8 LPP Benchmarks

The purpose of the benchmarks is clear and is accepted by both the LGUs and the DOH as well. The benchmarks are also extremely effective motivators. Almost all of the regional, central DOH, and LGU staff members whom we interviewed stated that the benchmarks guide behavior, that staff members work very hard to achieve their benchmarks, and that they are pleased when they achieve their targets. This well-known and documented phenomenon in the administrative literature is borne out by experience with health and family planning programs. People work to meet performance objectives when rewards are based on those objectives. If the objective is stated as CYPs, managers and staff will produce CYPs. If it is new acceptors, new acceptors will be recruited.

Selection

Thus, it is important to select benchmarks that direct behavior toward the program's fundamental goals, that challenge staff, and that can be achieved. The benchmarks selected for LPP meet those criteria to a degree. The initial benchmarks emphasized capacity development: comprehensive plans, CDLMIS, systems for delivery of adequate supplies of contraceptives, basic training in FP/RH services, development and implementation of IEC plans, establishment of VS services, data collection and reporting systems, and cluster surveys. These benchmarks seem completely appropriate in the early stages, especially for those LGUs with little experience in the planning and delivery of family planning services.

However, it does not seem necessary to maintain these activities as benchmarks for more than one year, unless an LGU needs more time to develop and install a system, to train staff, or to set up a VS service. In that case, a two- or three-year period may be needed. If so, interim targets should be set for each year. Development of a comprehensive plan has remained a benchmark every year, even though a number of the older LPP grantees are now preparing their own plans and require no further technical assistance. The Team believes that many of these capacity benchmarks should be phased out as soon as possible. If necessary, they can be recast as "conditions of the grant" to ensure that they continue to be produced. This approach will leave room for higher order benchmarks that measure such health outcomes as prevalence and coverage.

Vitamin A

One benchmark that has been included for all continuing LGUs since the beginning is 90 percent coverage of Vitamin A capsule supplementation (as measured by service statistics on the percentage of children who are 12–59 months and who received Vitamin A twice each year). This coverage is free for most LGUs, since coverage had exceeded 90 percent before they were enrolled in LPP. Several LGUs told us that they had maintained over 90 percent coverage for three to four years before enrolling in LPP. All of the 15 LGUs visited by the Team exceeded 90 percent in 1997. Half exceeded 95 percent. The MICS found only 4 of the 46 continuing LGUs had less than 90 percent coverage.

For most LGUs, there is no challenge in this benchmark and, therefore, no reason to include it. An argument has been made that the purpose of this benchmark is to encourage the LGUs to maintain that high level of coverage. Obviously, for many LGUs, this was not a problem before LPP, so there is no reason to expect it to become a problem after enrollment. In fact, a counter argument can be made that providing outside support for an intervention that is already sustained could unwittingly weaken its sustainability. If a donor is willing to support Vitamin A, why should the government do it?

Another argument in favor of retaining the benchmark is that the results of the latest post-ASAP (Araw ng Sangkap Pinoy) coverage survey⁵ show a significant drop in VAC supplementation coverage, from 88 percent in 1979 to 78 percent in 1996. That drop would indicate that greater effort is needed to raise VAC coverage; the VAC benchmark would stimulate that effort.

The problem with this argument is that the ASAP survey indicator produces a population-based national estimate, while the benchmark is based on service statistics where the denominators are determined by formulas. The definition is also slightly different (children who are 12–59 months and who received one VAC each year). The MICS, which is a provincial level cluster survey, could be used instead of service statistics, but the MICS is based on the percentage of children who ever received Vitamin A. Obviously, the amount of effort required to achieve 90 percent coverage for all children under five on a given day is going to be much greater than that required to provide those same children one VAC in their lifetime. Thus this indicator can be expected to be higher than the post-ASAP survey. If the DOH and USAID believe that the cluster surveys should be used, then the samples and indicator for MICS and the post-ASAP surveys should be the same. If service statistics continue to be used to assess LGU performance, the LGUs can be expected to meet the current VAC benchmark as easily in the future as they have in the past.

The Team also believes that DOH's National Micronutrient Day program is evidence of its commitment to maintaining Vitamin A coverage at a national average of 90 percent. Although the program was scheduled to end in 1998, the DOH report cited above recommends that ASAP continue to be conducted annually. That recommendation is added reason not to include a benchmark that is going to be met without LPP in any case. The DOH and USAID may want to examine this issue further before taking a decision, but the Team believes that this benchmark, as currently measured, serves no useful LPP purpose and should be deleted.

FIC and TT2+

There was a significant change in 1998 when these two immunization benchmarks were added. These are coverage benchmarks that will not be as easy to achieve as the “capacity” and Vitamin A benchmarks. This difficulty is because the LGU staff will have less control over the results and because the targets are very ambitious. In general, the lower the baseline coverage, the greater the required increase. A 15 percentage point increase is required if FIC coverage is below 80 percent and a 10 percent increase if it is between 80 and 89 percent. If the baseline is 90 percent or more, no further increase is needed.

⁵Report released by DOH January 20, 1998.

| FIC: Baseline | 1998 Target |
|---------------|---------------|
| ≤79% | ≥15% increase |
| 80–89% | ≥10% increase |
| ≥90% | Maintain |

| TT2+ Baseline | 1998 Target |
|---------------|---------------|
| ≤59% | ≥15% increase |
| 60–79% | ≥10% increase |
| ≥80 % | Maintain |

Obviously, there is an attempt here to be fair and to place the burden on those LGUs that have lower coverage by setting higher targets for them than for those that have already achieved higher coverage. The latter will still have to maintain that coverage, which requires effort as well, of course. This approach sounds reasonable, but, unfortunately, there are a number of problems with setting targets this way.

1. An inherent assumption in these targets is that unmet need is easier to fill where coverage is lower. Although this assumption may be true in some areas and at the start of a campaign, it is not necessarily true in all areas or after a campaign has been going on for several years. In a country where national campaigns have mobilized almost all mothers to get their children immunized, it is reasonable to assume that low coverage areas have more difficulty reaching the national target than high coverage areas. It is unrealistic to expect a low coverage area to match the target set for a high coverage area, much less surpass it.
2. The time available to achieve these targets is extremely limited. The benchmarks and targets for 1998 were set in late 1997 (somewhere around October). The tranche for meeting the 1997 benchmark targets will not be released before March 1998. Given delays in processing, many LGUs will not receive their funds until May or June. That delay gives them six months at best to reach their targets for 1998. Since the documentation and reports to the DOH and USAID have to be submitted around October, the LGUs actually will have only three to four months to meet their targets. For those who have to raise their coverage rates 15 percentage points, this is, as one provincial EPI manager said, “an impossible dream.” La Union, for example, which has a low baseline of 62.1, has to jump 30 percentage points to 92.1 by 1999.
3. There is an anomaly in the formulas that we are sure was unintended. LGUs on the borderline between low and medium may have to achieve higher coverage than those in the high coverage category do. For example, an LGU whose current FIC coverage is 90 percent just has to maintain 90 percent. An LGU at 79 percent has to achieve 94 percent in one year. An LGU that is only one point lower at 89 percent has to have a 10 percentage point increase, according to the current formula. That difference would require the LGU to achieve 99 percent coverage in 1998. Once it has reached 90 percent or more, the formula also requires it to “maintain” that level. The LGU would have to maintain 99 percent.

4. LGUs that miss one of these targets by one percentage point will be dropped from the program. If the LGU in question only reaches 98 percent in 1998, it will be dropped. If Pangasinan increases TT2+ coverage by 14 percent instead of the targeted 15 percent, it would be dropped.

When the Team presented these findings in its debriefings to both the DOH and USAID, it was made clear to the Team that these consequences were not intentional and that action would be taken immediately to modify these oversights. We also learned that exceptions have been made for LGUs that have had difficulties meeting one or more benchmark because of reasons beyond their control. We learned after we had completed our assignment that the project management office (PMO) had revised the targets in the MOAs that were sent out to the LGUs. Apparently, they have rectified the “anomaly” mentioned above and have set maximum targets for TT2+ at 80 percent, and for FIC at 90 percent. The formulas that accompanied the MOAs, however, have not been changed. The “maximum” target of 80 percent TT and 90 percent FIC applies only to those who have already met that target. No grace periods or exceptions are mentioned in the MOA or instructions.

It will be especially important to formalize these and other needed changes quickly and to convey them to the LGUs. When we raised this issue with the LGUs we visited, and when we asked LGU staff members if they had brought this up with the DOH, they said, “We have no voice,” and “They told us they will think about it and decide, but that was last October.” No one wants the LGUs to think that they have been assigned impossible targets. But several LGUs told us during the field visits that they “had no hope” of meeting their targets for 1998. Some seemed ready to give up. It would be very unfortunate if the benchmark process turns out to discourage, rather than encourage, staff to try to improve FP/MCH/N services.

It is also important to emphasize that if more than 10 of the total number of both the newly selected and continuing LGUs fail to meet any of their annual benchmarks, which include FIC and TT2+ for 45 of the 66 continuing LGUs, the DOH will not reach its targets and the entire LPP grant could be lost. Everyone would lose in that case, including those LGUs that were able to meet their benchmark targets. Clearly, no one wants that to happen.

It is hoped that there is enough time left to revise the targets. We were told that a meeting on benchmarks had been scheduled for February 16 and that other actions had been planned to address this problem. We hope that these observations will be of help in the deliberation.

3.1.9 Performance-Based Disbursement

This element is considered one of the most attractive features of the design by all concerned. The DOH likes it because it eliminates detailed budgets and the PILs (project implementation letters) that authorize funding. USAID likes it because the audits will focus on results rather than inputs. The LGUs like it because it provides flexible funding that they can use to procure equipment,

training, supplies, and other important inputs that they cannot usually afford. The Team was intrigued by the concept because of its potential for use in other countries.

The Nature of the System

In most foreign assistance programs, the grantee presents a detailed plan and budget to a donor and receives funding to procure various commodities and to carry out various activities. In a performance-based system, the emphasis is on results rather than on how the work is done, on outputs rather than on inputs and activities. Achievement of the results is measured by benchmarks, which are supposed to be clear, objective performance standards. In LPP, the DOH agrees to achieve certain results (e.g., 45 LGUs will provide VS services, 19 new participants will prepare comprehensive FP/MCH/N plans, and so forth). USAID agrees to provide a certain amount of grant funds if the DOH produces the agreed-upon results⁶. The same relationship exists between the DOH and the LGUs. Those LGUs that achieve the agreed-upon results (such as setting up VS services and preparing a comprehensive plan) receive a grant from the DOH.

This innovative system appears to be working very well in LPP. In addition to being much easier to implement and manage than the traditional project, it has stimulated LGU and DOH staff to focus on achieving targets, rather than on spending budgets. The DOH and the LGUs realize that they will not receive next year's grant if they do not achieve this year's benchmarks, and that realization clearly motivates them to perform well.

Another important characteristic of the system is that it is neither punitive nor competitive. USAID wants the DOH to succeed, and it provides technical assistance to make sure that happens. The DOH (and USAID) wants the LGUs to succeed, and it also provides TA whenever needed to help any LGU that has a problem. The LGUs are not competing with one another for the same pie. Each LGU has a predetermined grant that it will receive if it achieves its benchmarks.

From a truly performance-based perspective, however, this linkage between performance and payment is not ideal. To get LPP started, USAID had to provide DOH with "start-up money," because the DOH does not have any discretionary "extra-budgetary" funds that it could use to fund the LGUs. This approach has put the system out of synch in that the LGUs (and the DOH) are not compensated for current performance. For example, in their start-up year, LGUs are enrolled and given a grant after they have established a CDLMIS, developed a plan, and had that plan endorsed by the LCE. This first grant is not really designed to compensate the LGUs for the work involved in completing these benchmarks—it is far out of proportion to the work

⁶In LPP, USAID does not actually provide anything directly to the DOH. Instead, USAID pays an agreed-upon amount of \$US to the Government of the Philippines to pay some of its foreign debt. In return, the GOP then provides the equivalent amount of pesos to the DOH. See Chapter 4 (4.2.7 Disbursement) for a description of this innovative process.

entailed⁷—but to help implement the plan they developed for the following year by augmenting their available funds. It is, in effect, an advance to help them carry out the work described and budgeted in the approved plan. In the second year, the LGU carries out the plan and also develops a second plan for activities to be conducted the following year. If the LGU meets the targets set in its first-year plan, it receives a second advance to carry out the third-year activities. This process continues year after year.

From the DOH and LGU perspective, the award of each grant is dependent on the LGU achieving “performance benchmarks.” The fact that the sequence is not ideal (payment after performance), does not seem to matter very much to the DOH, the LGUs, or USAID. The system still works.

The Team identified two other characteristics that are worth mentioning:

- The dollar funds provided are not linked directly to the cost of achieving current benchmarks, which one could argue is inconsistent with the concept of "performance based disbursement." However, because it is a foreign assisted grant, different rules apply and that linkage is not required.
- The peso budgets for each LGU are set beforehand by the DOH and communicated to the LGUs before they complete their plans for the following year. Thus, the LGUs are told what they will get for the following year and budget accordingly. One could say that this system is counter to the concept of performance budgeting that would allow the LGUs to negotiate the results they will achieve in return for a set tranche of funds. However, the grants do not pay the full cost of performance. They are designed to augment LGU budgets and to leverage those funds to achieve desired results.

There is one other programmatic implication that the Team believes could become a problem.

- During the last year of the program (2000), the LGUs will have a plan to implement and benchmarks to meet. They will have funds to carry out the activities that they included in their plan for 2000, as well, because the money they will receive for meeting their 1999 benchmarks will be paid to them in 2000. However, since there will be no grant for meeting the 2000 benchmarks, there is no economic incentive for them to carry the plan out. It will not matter if an LGU meets that year’s benchmarks or not, because there will not be any grants at the end of the year. In addition, there would be no incentive to develop a plan for 2001. This problem could be avoided by designing an appropriate follow-on to provide the LGUs with an economic incentive to meet their 2000 benchmarks and to help in the implementation of their plan for 2001.

⁷Pangasinan, for example, received P5.9 million for the first year.

Grant Formulas

Most of the LGUs we visited did not understand how their grants were set and why. It is clear to the Team that the process is not based on need, much less performance. The amount of money available for LPP grants is set each year by the DOH and is based on funds budgeted for LPP by USAID, plus any unused funds from previous years. This year the high exchange rate is expected to produce a windfall of additional money.

Individual grants are set according to a formula that gives equal weight to three factors: (1) population size, (2) per capita income, and (3) year enrolled. The amount each LGU receives is also dependent on the number of LGUs that qualify (which increases each year). In addition, the amount given to an LGU is designed to decline each year. Albay, for example, received P3.1 million in 1995, P2.4 million in 1996, and P2.1 million in 1997. Although this mechanism is supposed to be designed to encourage sustainability, there is no phase-out policy. The program will simply stop providing grants after 2000. It appears to the Team that this procedure needs to be revised to conform more to the concept and philosophy of performance-based disbursement.

Consequences of Nonperformance

Both the LGUs and the DOH appear to understand clearly and to accept the consequences of not meeting one or more benchmark targets. The consequence is that they will not receive their grant tranche for the following year.

As implied previously, there is little margin of error for LGUs. All of the LGU and DOH staff members we interviewed agreed that this is the case. If an LGU misses just one target by as little as a fraction of a percentage point, that LGU will not receive the next grant. The DOH has more leeway. For example, the target for the number of LGUs meeting their annual benchmarks has been set at 75% of enrollment following the original plan of enrolling 100. In 1997, this meant that 60 of the potential 80 LGUs enrolled and participating in the program had to achieve their targets for the DOH to get its grant. If one LGU misses one of these benchmark targets, it is out of the program, but the DOH is not. The unused grant for that LGU would be carried over to the next year.

This approach has been described as an “all or nothing” rule. Although there have been exceptions, they were for unusual circumstances. There are no formal policies governing exceptions and, as far as we can tell, no one expects flexibility. The Team believes that neither the DOH nor the LGUs fully understand the implications because they have met their benchmark targets relatively easily every year so far. As Table 4 showed (Chapter 2), 66 of the 67 LGUs enrolled in LPP met all of their benchmarks in 1997. But as Tables 5 and 6 showed, that record is not likely to continue through 1998 and 1999.

Measuring Performance

Measuring performance may soon become the most contentious element of the system if left as it is. That is because the performance measures for three coverage benchmarks will be generated from cluster surveys and there is concern that these surveys will not accurately measure true performance.

The first MICS (multi-indicator cluster survey) was conducted in 1997 to serve as the baseline for four coverage indicators (CPR, FIC, TT2+, and VAC). A separate cluster survey was conducted in each of the 46 continuing LGUs. The results were provided to each LGU in individual reports and summarized for inclusion in the 1997 IFPMHP performance review.

At first glance, these data are impressive. The overall averages for the 45 LGUs that completed their surveys are shown below. Some revisions were made, but the averages seem to be about the same. The methodology is also impressive. It is straight out of the World Health Organization (WHO) cluster survey literature and was standardized for all 45 surveys. So we could reduce sampling error, the standard number of clusters (30) was doubled (62); and the standard number of respondents per cluster (7) was also doubled (15). Thus, the results shown in Table 8 have a confidence interval of +/- 5 percentage points, instead of the standard +/- 10 points.

Table 8

1997 Cluster Survey Results (unweighted)

| | CPR | FIC | TT2+ | VAC |
|---------|------|------|------|------|
| Average | 55.0 | 78.3 | 73.4 | 94.6 |
| Revised | 55.8 | 78.2 | NA | NA |

These figures are unweighted for population size, so they may not reflect accurately the aggregate coverage of the 66 LGUs enrolled in LPP. Even so, they indicate that the CPR for the LGUs is well above the national average of 47.0 percent in 1997 and that the VAC is above the 88.0 percent recorded for 1996. FIC and TT2+ also look good, although the national targets are 90 and 80 percent respectively.

The problem is that some individual LGU figures are much lower than expected by the health staff, especially for FIC and TT2+. Their service statistics showed much higher results in some cases. LGU staff members are worried that the next cluster survey may also show low results that will not be accurate and that the LGU could lose its grant as a result.

When we took a closer look at the surveys, we identified a number of issues that we believe need to be dealt with as soon as possible. These are summarized below:

- Timing:** The next survey will be conducted before many LGUs implement their 1998 plans. The next survey is scheduled for May or June, but the LGUs are unlikely to receive their funds much before then. Thus, they will have little or no time to do anything to increase performance. In addition, the surveys will measure performance for only about half of the year. Ideally, the surveys should be conducted in January, after the fiscal year ends. However, this schedule would further delay getting the results in time to be useful for the following year. Performance will also be affected by the national campaigns. EPI is usually carried out in April and May, and the National Micronutrient Day campaign is in October.
- Measurement:** FIC, VAC, and TT2+ do not measure current performance. The sample is drawn from women who have a child who is 12–59 months of age. Thus, these measures are of “under fives.” So while the LGU is concentrating on immunizing children under one year of age, the survey is selecting children between one and five years old. Increases in coverage will show up in the survey only if there is a large increase in immunizations of children under the age of one. But the survey does not include children under the age of one year old. That means that no matter how hard the LGU staff members work to improve performance, the survey will not reflect this effort. See Appendix J for a more detailed discussion of this problem and possible solutions.

Even if the survey were revised to include children under age one, or those aged 9–12 months (to make sure they were fully immunized), it would be impossible to immunize enough children in 1998 to raise the overall coverage figures of under fives by 10 percentage points.

Table 9 illustrates this point. The survey would include about 186 respondents under age one, but it would need to identify 242 who had been fully immunized in order to conclude that the 90 percent target had been met. Since there are only 186 in the sample, the maximum coverage that could be reached would be 84 percent (if all 186 children under age one in the sample were fully immunized). See Appendix K for a more detailed explanation of this issue

Table 9

Cluster Survey Respondents Needed to Reflect Target Coverage

| Scenario No. 1 | | | Current Coverage | Target Coverage | Maximum Coverage |
|----------------|----------|----------|------------------|-----------------|------------------|
| A | B | C | D | E | F |
| Age (mo.) | Sample N | Sample % | 80% | 90% | 84% |
| 0-11 | 186 | 20 | 148.8 | 241.8 | 186.0 |
| 12-23 | 186 | 20 | 148.8 | 148.8 | 148.8 |
| 24-35 | 186 | 20 | 148.8 | 148.8 | 148.8 |
| 36-47 | 186 | 20 | 148.8 | 148.8 | 148.8 |
| 48-59 | 186 | 20 | 148.8 | 148.8 | 148.8 |
| Total | 930 | 100 | 744.0 | 837.0 | 781.2 |
| Check | 930 | | 744.0 | 837.0 | 781.2 |

Note: Shaded numbers are those mentioned in the text.

It would be more accurate to revise the cluster survey to draw the sample of children from only the under-one cohort (0–11 mo.). However, this revision would require more effort because there are very few children in this age group who are fully immunized—they won’t be fully immunized until they are at least nine months old. In addition, the results would not be comparable with the baseline survey, the DHS, or the MCH rider survey. Another alternative would be to change the benchmark targets instead of the surveys. Instead of a 10 percent increase, a more realistic figure for under-age-five immunizations might be two percentage points, (which equals a 10 percentage point increase among children under age one). However, the most realistic option might be to base the performance assessment on service statistics (see Appendix J), if the system can accurately identify women and children in need of contraception, tetanus toxoid, child immunizations, and Vitamin A.

- **Definitions:** The definitions of the variables are different for the cluster survey, the SO 3 indicators, and the DOH program targets. The most important programmatic implication is that the survey may not measure the same thing as the DOH performance (see Appendix J).

Table 10

Definitions of Target Groups for VAC, FIC, and TT2+

| Variable | DOH Target | MICS Definition | SO 3 Definition* |
|-----------------|--------------------------|---|---|
| VAC: | Children < 5 years | Percentage of children 12–59 months who received Vitamin A at least once in their lifetime. | Percentage of children between 12 and 59 months receiving Vitamin A capsule during the National Micronutrient Day. |
| FIC: | Children < 1 year | Children 12–59 months who were fully immunized (BCG, OPV3, DPT3, and measles) before their first birthday. | Proportion of living children between the ages of 12 and 23 months who have been vaccinated before their first birthday—three times in the cases of polio and DPT, and once for both measles and BCG. |
| TT2+: | Currently pregnant women | Children 12–59 months whose mother was given two or more doses of TTV during and prior to pregnancy with reference child. | Percentage of pregnant women and mothers of children under 5 who have received two doses of tetanus toxoid. |

Note: OPV3 = Oral Polio Vaccine (third dose); DPT3 = Diphtheria, Pertussis, and Tetanus (third dose), and TTV = tetanus toxoid vaccination.

* The SO 3 definitions will be revised to conform to DOH service statistics data, per USAID e-mail of March 5, 1998.

- **Confidence Intervals:** (+/- 5%) are not reported or explained. The confidence intervals should be computed for each of the four variables for each survey because they are likely to vary. Some may be +/- 3%, others +/- 6%. Very few LGUs understood that the figures from the survey are estimates, and that if their TT2+ result was 75.4, the true result was probably somewhere between 70.4 and 80.4. This range is not taken into account in assessing performance. One LPP coordinator thought that this margin of error is greater than that of the service statistics.
- **Public Sector Coverage:** The LPP component deals with the public sector only. The cluster survey covers the entire population, which also includes those served by the private and nongovernment organization (NGO) sectors. Ideally, the survey would segment the population and draw the LPP sample only from those who are the responsibility of the public sector. But this division is difficult to do. In addition, LPP may want to leave the survey as it is in order to encourage the public

sector to work with the private and NGO sectors so that the overall LGU target can be met.

Several provincial EPI component managers stated that they are having trouble finding enough pregnant women to inoculate with TT. As one joked, “Perhaps the family planning program has been too successful.” The Team has not been able to find an explanation for this phenomenon, but it seems that the managers believe that pregnant women who are already fully protected are not receiving TT during pregnancy and, therefore, are not being counted as immunized in the cluster survey. This results, they say, in lower coverage figures in the surveys than is the true case. Both the MSH advisors and the USAID staff members thought that these women were being counted as fully immunized. We checked the cluster survey questionnaire and found that it counted fully immunized women as protected.

A number of LGUs complained that the surveys are inflexible and that, even though they pay for the surveys, they are not allowed to add questions of local interest. This complaint reinforces the perception that this is a program being forced on them to meet central needs, not to meet their own needs.

Finally, we heard that there is a plan is to stratify the next cluster survey to compare rural and urban populations or socioeconomic classes on these variables. Unfortunately, this type of cluster sample cannot be stratified. It produces a single value for the target population. To “stratify” one would have to conduct a separate ample, one rural cluster sample and another urban cluster sample, each of 62 clusters each.⁸

3.1.10 Sustainability

Sustainability is one of the weakest elements of the design. No specific mechanisms have been identified for sustaining LPP as an intervention or for sustaining the capabilities, services, and improvements produced by LPP. In fact, there is no clear sustainability objective at this time and no indicator for the LPP component (there is for the national systems component, however). There is a general understanding (or hope) that the DOH and LGUs would take over LPP, or parts of it, when USAID funding comes to a close in 2000. But there has not been a clear agreement on who should sustain what.

The LPP component manager told the Team that no decision has been taken yet as to whether or not to continue LPP after USAID funding ends. That may be just as well, since LPP is neither sustainable nor replicable as it is now constituted. The key financial arrangement (USAID payments in \$US to reduce Philippine foreign debt in return for the equivalent amount of pesos to be used for LPP) cannot be replicated by the DOH or LGUs. LPP should probably be thought of

⁸See Jack Reynolds, *Assessing Community Health Needs and Coverage, Primary Health Care Management Advancement Programme*. Aga Khan Foundation, Washington, DC, 1993, pp. 38–39.

as a transition mechanism that would be replaced by a different DOH performance-based mechanism (such as a matching grant or other incentive grant scheme). This consideration is discussed further in Chapter 5.

More important than the sustainability of LPP is the sustainability of the expanded and improved FP/MCH/N services LPP has helped to develop. A number of sustainability mechanisms have been identified by the LGUs as they have attempted to leverage the support they are now receiving from LPP to raise local funds so that they can continue providing services that were developed or enhanced through LPP. Chief among these are the HES, line items for FP/MCH/N in local budgets, and increased counterpart contributions from the IRA and other sources. The HES earmark for FP/MCH/N is an indicator for DOH but not a benchmark for the LGUs. It was tentatively listed as an LGU benchmark for 1998–1999 but then deleted. The explanation given to the Team was that some LGUs were unable to tap into the HES, and it would be self-defeating to establish a benchmark that the DOH knew beforehand some LGUs could not meet. Thus, the HES indicator will be deleted. Nevertheless, the Team believes that HES may be an appropriate benchmark for LGUs that have been able to tap into it. It might help the local LGUs that cannot now tap into HES to do so if the LCEs realize that this is a benchmark and that continued funding depends on it. This issue could also be solved if DOH were to begin negotiating individual benchmarks for each LGU. Those that could secure HES funds could include that as their sustainability benchmark. Those that could not would have to identify another source of funding (which could be counterpart, line item or other sources).

The LGUs, and perhaps the DOH as well, are supportive of a “matching grant” mechanism administered by the DOH. They are also used to providing counterpart funds for donor-funded programs. The RFAs (Rapid Field Appraisals) of the GOLD project have identified a number of revenue-enhancing mechanisms that LGUs are developing, including BOT (build-operate-transfer) arrangements, property tax collection, and user’s fees. At least some of these funds have been invested in health services.

Some cost containment options have been identified, but apparently few have been tried to date. Some LPP activities (training, surveys) are seen as unnecessarily expensive, and sustaining them may be difficult. Scaled down training courses, for example, might be more attractive.

3.2 Conclusions

Overall, the LPP seems to be well designed. It has many strengths, but it also has some weaknesses. The objectives are appropriate, timely, and acceptable to LGUs and to the DOH, although there is some concern about the almost exclusive emphasis on national rather than local priorities. The LGU selection criteria (population size, commitment/capability and regional representation) are reasonable and acceptable. The involvement of the LCE is an important element, but more involvement is needed during implementation to ensure that the program runs smoothly. The comprehensive plan and the planning process are very helpful to LGUs and DOH

managers alike, but they have been too detailed and time-consuming. The new two-year plan is a welcome change. The concept of budget augmentation, not budget substitution, is appropriate, understood, and acceptable. The technical assistance element has been appropriate and clearly needed, although it has been too reliant on USAID contractors. The DOH has begun to take on primary responsibility for this function. LGU capacity development has been important and appreciated. It contributes to sustainability as well.

The major weaknesses are in benchmarking, performance measurement and sustainability. The benchmark concept is very useful, is definitely appropriate, and has been an important management tool. But the selection of the particular benchmarks has been uneven, and the targets have been too easy for some and too difficult for others. It is likely that many LGUs will not be able to meet the FIC and TT2+ targets for 1998 and 1999. If more than 10 of the 85 LGUs miss any of their annual benchmarks, which for some LGUs include the FIC and TT targets, the DOH will not meet its benchmark. This would effectively shut down LPP. The performance-based disbursement system is innovative and effective. It is an excellent element that everyone seems to like. But it has some limitations. It does not measure current performance, and no grant will be provided as an incentive to carry out the final year's plan. There are also problems with the timing of the cluster surveys (which produce performance data for three key benchmarks), definitions of FIC, TT2+, and VAC, and with decision rules for determining whether an LGU passes or fails. Sustainability is one of the weakest design elements. No policies, plans, or mechanisms have yet been set for sustaining LPP or the LGU capability and service gains that have been achieved.⁹ Fortunately, all of these weaknesses can be remedied.

3.3 Recommendations

2. The LPP objectives should be “repackaged” to place more emphasis on responding to local needs and priorities.
3. Mechanisms need to be developed to increase the involvement of LCEs in the program's implementation to ensure that it runs more smoothly.
4. The benchmarks need to be revised to (1) phase out those that are no longer required once an LGU has developed the appropriate capacity (e.g., annual plans, CDLMIS, staff training, IEC plans, establishment of VS services, and distribution of adequate stock of condoms and pills); (2) delete those that were already achieved and sustained by individual LGUs prior to enrollment (e.g., Vitamin A); and (3) set realistic targets for those that are population coverage measures (e.g., FIC, TT2+, and VAC).

⁹The DOH commented on the draft of this report that strategies have been identified at the national level and will be presented to the regions during an upcoming RTAT orientation.

5. The performance-based disbursement system should be redesigned to link funding to performance, but there may not be enough time left in the LPP to do that. If there is a follow-on project, that plan should be taken into consideration in the design.
6. The performance measures need to be standardized and revised to be consistent with the LGU plans. That is, the measures should cover the same time period as the plan whose performance is being measured. The measures and the program should define the target groups the same way. Confidence intervals should be taken into consideration when making decisions about LGU performance.
7. Decisions need to be made by LPP management with respect to what, if anything, should be sustained, both at the LPP/DOH and the LGU levels. Specific plans then need to be prepared outlining sustainability objectives, mechanisms and schedules.

CHAPTER 4. MANAGEMENT STRUCTURES AND IMPLEMENTATION PROCESSES

4.1 Key Players, Processes, and Management Tools

4.1.1 Key Players

The IFPMHP organogram on the following page illustrates the relationship between key players in the management of IFPMHP. The Secretary of Health serves as **Project Director**, the Assistant Secretary as **Project Manager**. The head of the Family Planning Service serves as the **Assistant Project Manager**. IFPMHP is managed within the DOH Office of Special Concerns, headed by the **Assistant Secretary**. This office includes all of the technical offices (e.g., Maternal and Child Health Service [MCHS], Nutrition Service [NS], and Family Planning Service [FPS]) that support IFPMHP implementation. Three component managers, one for each of the IFPMHP components, are assigned from within the FPS. The NTAT brings the LPP component manager together with representatives of the other technical offices. this NTAT process has been organized into geographical clusters to facilitate greater consistency in monitoring.

The Project Management Office, also at the central level, facilitates technical and monitoring interactions between the **RTATs** at the regional level and the NTAT. The PMO typifies the way the DOH has traditionally managed donor assistance. Individual PMOs are funded by donor projects and help manage the additional burden the DOH accrues from each of these projects. The life of the PMO is likely to be limited by the IFPMHP project life. The PMO serves as secretariat for the National Advisory Committee, which includes the service directors (e.g., MCH, FPS, NS), the Project Management Technical Assistance Team (PMTAT), LGAMS, and PIHES (Public Information and Health Education Service). USAID-funded cooperating agencies (CAs) are invited to sit with the National Advisory Committee on an ad hoc basis, as requested. These CAs include AVSC (VS), John Snow International (CDLMIS), Johns Hopkins/PCS (IEC), and Helen Keller (micronutrients). CAs play a more consistent role within the **expanded LPP committee**, which also includes service directors and the PMTAT. This group, together with working groups for each of the technical areas, backstops each of the LPP technical areas.

Policy management, conversely, is less clearly assigned. Typically, the DOH establishes steering committees for each donor-funded project. The **IFPMHP steering committee** is unusual in that the donor is not included. The steering committee has never met. Policy issues appear to be resolved in ad hoc meetings between the DOH and USAID, and the institutional contractor facilitates resolution of some policy issues in separate discussions with USAID and the DOH. RTATs, in the course of assuming increasing responsibilities, have expanded their membership during the past year. Information officers have been added to the original membership, which includes technical officers from the regional DOH offices and representatives from regional POPCOM offices, as well as LGAMS and RESUs (Regional Epidemiological Surveillance Units).

The USAID management team for Intermediate Results package no. 1 includes broad membership from within the mission and the DOH. Much of the ongoing decision making at USAID for IR 1 has been devolved to the core team leader who is supported by a designated “coach.”

Figure 1, Organizational Structure for IFPMHP Management, available in hard copy

LGU management of LPP activities includes the Provincial Health Office (PHO) or City Health Office (CHO) and the population officers. The LPP coordinator, who is designated by the LCE, performs a lead role. In many LGUs, this person comes from the PHO or CHO. In others, the LPP coordinator is a population officer. In still others, the LPP coordinator is the Provincial Planning and Development Officer (PPDO). An LPP team at the LGU level supports the LPP coordinator. Site visits by the evaluation team suggest that these teams are indeed actively involved in managing LPP at technical levels.

4.1.2 The Processes and Supporting Management Tools

The **LPP Annual Cycle of Activities chart** illustrates key LPP activities (Figure 2). In many cases, roles are shifting as responsibilities are transferred from the institutional contractor to the DOH and from central to regional levels. Much of this transfer is facilitated by extensive process documentation developed during the initial years of LPP. These management tools are listed by activity in Appendix L, **LPP Management Processes, Actors, and Tools**.

4.2 Implementation Issues

4.2.1 Selection of LGUs

LGUs are selected by the DOH–OSC with technical assistance from the PMTAT and PMO. The original 20 LGUs were selected early in 1994 and during their first year received an average of four technical assistance visits in addition to participating in national level orientation workshops. Until 1997 LGUs were selected for participation in LPP on the basis of two criteria: (1) population size and (2) commitment to and capability in family planning. Regional representation was added in 1997. The last batch of 19 LGUs was just selected and will begin their orientation shortly.

The program relies on interviews with LCEs to assess commitment; however, in many instances these interviews become the only significant contact with the LCE for the project, and they happen during the orientation. In 1997, the National Capital Region (NCR) was given the opportunity to select specific LGUs. It is the only 1 of the 16 regions that has been involved in LGU selection.

While the process and the LGUs selected appear appropriate, an unanswered question is this: What happens to the remaining LGUs? Unless there is a follow-on project, they will not be able to take advantage of the LPP experience. No other LGUs will be selected in 1999 or 2000. If there is a follow-on, it may be best to delegate the selection to the regions, since the pace of the program is increasingly dependent on regional support. Selection at the regional level can be delegated to the RMT, with technical support from the RTAT. The RTAT would be able to

expand the validation process beyond a one-time check and provide a more detailed analysis of the political will of the LGU to implement the program prior to selection.

Constant political changes in provincial/city leadership may also mean that the regions will need to repeat the process of orientation whenever these changes transpire (elections, replacement of LCE).

Figure 2, Annual Cycle of Activities, LGU Performance Program (LPP), available in hard copy

4.2.2 Orientation of LCEs and LGUs

The PMTAT and PMO support the NTAT in the orientation of LCEs and LGUs with RTATs slowly being included in the process. The one-day orientation includes the PHO staff, the General Services Office (GSO), the provincial accountant, the budget officer, the PPDO, and the provincial population officer (PPO). The orientation covers roles and responsibilities, grounds for suspension, funds management, and monitoring and reporting. A program presentation providing a regional overview is provided specifically for the LCE.

Increasing RTAT involvement in the orientation is a positive move that began in 1997. The regional health director's personal relationship can quickly bring about LGU commitment to LPP. However, when the orientation is used as the sole venue to establish LCE commitment, it may become the only significant involvement of the LCE in the program.

If we are to avoid superficiality in the process, it may be useful to use actual LGU data in the orientation (rather than regional aggregates). The orientation could also be turned into a two-stage process in which the LCE is revisited after the LGU's technical people have studied the program and given a recommendation.

4.2.3 Benchmark Selection

OSC, PMT, and NTAT work together closely to develop and approve benchmarks based on the performance of continuing LGUs. MSH, the cooperating agencies (CAs), and the PMO play technical advisory roles in the process. USAID is consulted through the technical working groups that support NTAT and during meetings with DOH for this purpose. Initially, LGUs were consulted on the benchmarks.

LGUs appreciated their involvement in the review of benchmarks from 1994 through 1996. Consultation with most technical units ensured that early LGU benchmarks properly built up capacities for sustainability of the benchmarks.

The latest benchmarks, however, are perceived to be nationally determined. Most LGUs visited by the team professed a strong desire to be part of any review and approval process of benchmarks because they would have to consider local administrative processes and priorities. The DOH position was that there was no need to involve the LGUs after 1996 because the benchmarks did not change, only the targets to be achieved.

The benchmark selection could involve a more clearly defined discussion between the DOH, USAID, and LGUs. Clearly, it would be a cumbersome process if all LGUs were consulted individually on benchmarks, but a system of representation could be set up. Given the importance of the task, benchmark selection should occur in a transparent manner and at a high enough policy level, such as the program steering committee.

4.2.4 Plan Development and Review

The provincial LPP coordinator leads the process, eventually involving all key players in LPP. Regions, through their RTAT, now provide much of the technical assistance for the LGUs, with significant backup support from the PMO, MSH, and NTAT. Final approval of the plan comes from PMT/NTAT, supported by advice from participating CAs.

Planning workshops are usually conducted in the second quarter of the year, and technical assistance on plan development is provided during the third quarter. LGUs submit their plans at the end of September. Final approval usually is conveyed at the end of January, concluding a nearly year-long process.

One regional LPP coordinator saw the value of carefully identifying and documenting programmatic needs (e.g., training and equipment) and activities intended to meet those needs. The coordinator thought this approach worthwhile, as LPP is a program where funds are indeed available to implement the plans. This year's plan is for a two-year period, eliminating the need for full plan development in 1998.

The planning process, however, was described as a "meticulous" one. One typical plan and attachments came to 128 pages and reportedly required 75 person days to complete. The review guide for this plan took up an additional 32 pages and probably required considerable staff time. Because it is in plan development where the DOH and the program combine supervision, technical assistance, and even control, one can understand why three calendar quarters are required for plan approval.

The most extensive activity is the plan review process which, because of time constraints, often appears to serve as a surrogate for more frequent implementation monitoring. Local review of plans is followed by submission to Manila where the PMO, PMTAT, and NTAT offer further comments.

Review of an increasing number of plans continues to lay a heavy burden on the time of technical staff from the central office to the regions, with some NTAT people reportedly spending 50 percent of their time reviewing the plans. At the regional level, LPP competes with the regular staff work of FP, MCH, and nutrition coordinators, including plan review and development for their own programs.

Now that many LGUs have written these plans for a number of consecutive years, it should be possible to simplify the process through multi-year planning. Greater efficiency may be possible by using the LPP process as a template for many of the program plans being developed for local use at the regional and provincial levels. As LGUs and regions become more expert at the planning process, less TA will be required—particularly from Manila—and increased LCE and *Sanggunian* involvement could serve to institutionalize the process.

4.2.5 Implementation and Monitoring

Implementation and monitoring of the approved LPP plan is primarily the task of the regional and provincial LPP coordinators. Assistance is generally available from the RTAT members or the LPP program managers at the LGU level. Support from the national level (NTAT, PMO, and MSH) is available if required, but is less pervasive. Monitoring forms and guidelines have been developed by the PMTAT to support monitoring of LPP performance at various levels. These forms track training, procurement, and expenditures.

FP/MCH/N programs are implemented at field level in the rural health units (RHUs), BHSs, and main health centers (MHCs) of the municipalities and cities of the LPP province or city. The PHO field and technical services staff, which usually makes up the LPP management team at the province, provides supervision and technical support for preventive health programs at municipal and city levels.

It is clear that LPP has significantly revived the field and technical services units in many of the provinces, primarily because the program gave them the tools and resources to function as coordinators of province-wide public health programs.

Up to 1997, many of the benchmarks for LPP have been provincial in nature and have not required the support of health workers below the provincial level, except for in the submission of reports and in the receipt of commodities and new equipment. Thus, implementation and the monitoring of that implementation have been relatively easy to accomplish.

However, starting in 1998, the performance of municipalities and cities in achieving benchmarks for FIC, VAC, and TT2+ in accordance with LPP-prescribed percentages will be the most contentious goals to achieve. Given the experience in the past, with some resistance from municipalities that perceived their accomplishments were being used to embellish the performance of higher authorities (an example is NID 1995, when there were delays and even nonsubmission of reports), orientations on LPP may be necessary at the sub-provincial level.

As benchmarks change, implementation and monitoring need to conform to the levels of LGU actually performing the benchmarks required by LPP. Involvement of subprovincial level LGUs, not only in implementation and monitoring but also in planning, may be necessary as LPP evolves. As LGUs become more competent and work cooperatively with other LGUs, it may be necessary to move them out of LPP and into other mechanisms.

4.2.6 Assessment and Cluster Surveys

Assessment is an activity led by NTAT/PMO and RTAT using forms developed by PMTAT. One new tool used to provide baseline data for future use in assessments is the cluster survey. This tool was developed by PMTAT for the provincial LPP coordinators to implement in 1997 with

the support of a number of accredited research institutions. At the provincial level, the conduct of the cluster surveys required the support of administrative, budget, and Pre-qualification Bids and Awards Committee (PBAC) to select the survey institution.

Up to the present, assessments have been relatively uncomplicated. The introduction of the cluster surveys, however, has been met with skepticism by those who would give greater weight to their own service statistics or by those who doubted the capability of some research institutions to conduct the surveys.

The cluster surveys tend to be viewed as national monitoring activities by the LGUs because they have their service statistics to guide their actions. Therefore, it could be argued that program funds from the PMO budget could be used as part of the start-up activities for LGUs, to establish baselines. Cluster surveys could then be applied as the program sees the need, but not necessarily on a year-to-year basis.

4.2.7 Disbursement

LGUs submit annual certification of their compliance with benchmarks. After verification, these certifications are aggregated into a single bound presentation. The DOH presents this certification of benchmark compliance to USAID during a formal session in December of each year (one of two formal meetings between the DOH and USAID every year). USAID Manila notifies Washington of DOH compliance. Washington then releases an appropriate tranche of US\$ in New York for use by GOP to pay foreign debts. The Department of Finance (DOF) then tells the Department of Budget and Management (DBM) to release the equivalent peso amount to DOH in the form of an NCA (notice of cash allocation), that parcels out the amounts needed by the central office and the LGU grants.

Information from evaluation site visits indicates that last year these funds arrived at trust accounts established by each LGU in March or May. Actual release of funds from this source still needs action by the LCE and by a local procurement system that is often cited as too centralized and overburdened at the LCE level (the LCEs must sign all vouchers, and there can be only one Bids and Awards Committee for public bidding). Late releases also mean that, assuming an annual planning cycle with an October deadline, LGUs were in possession of funds for as little as four months before they commenced preparation for the next plan.

Working committees of the DOH and other government agencies concerned (DOF, DBM) should be tasked with developing a policy to reduce the time that the LGU has to wait for funds release. The policy could be reviewed by the steering committee when appropriate. Action also needs to be taken at the local level to speed up submission of signed MOAs so that DOH central can release LGU grants.

4.3 Constraints

The Team noted a number of management issues that either constrain or threaten to constrain the implementation of LPP. These include (1) local procurement, (2) payment of travel expense vouchers (TEVs), and (3) central procurement and distribution. Although these are not component activities of LPP, any malfunction in these areas will limit the results produced by LPP grants.

4.3.1 Procurement

Once funds become available at the local level, the provincial LPP coordinator and a management team lead the process of procurement based on plans prepared the previous year. Local procurement processes themselves are supervised by the GSO and supported by a variety of local administrative staffs (budget, accounting, and LCE). LPP documentation includes a procurement-tracking sheet that lists the number of working days required for procurement undertaken with LPP funds. Procurements that required public bidding—typically in excess of P50,000—often required 45 to 90 working days, the equivalent of two to four calendar months.

At two or three LGUs visited, the inclusion of provincial-level offices in formal LPP management teams was found beneficial in terms of cutting down the time required in the procurement process.

Nevertheless, problems with procurement may have been the management problem most consistently mentioned to the evaluation team during the field visits. Delays in procurement result in significant amounts of unspent LPP funds at the end of the year. For some LGUs, 20 percent of their 1997 annual grant remained unspent in January 1998 because of procurement difficulties. Procurement delays also delayed supplies, equipment, and training, thereby diminishing the likelihood that health indicators would be affected during the same year that the grant arrived.

Procurement constraints are a local, specific problem that could be resolved finally by actions from the DBM or the auditors (COA), or even by revising the local code to make the rules adapt to the pressures on the local system caused by devolution. In the meantime, innovations or improvements within current systems could be made (such as those developed in the Health Finance Development Project) and provided by the Project Management Technical Assistance Team (PMTAT) when necessary.

4.3.2 Travel Expense Vouchers (TEVs)

LGU monitoring of service delivery in municipalities and distributing contraceptives to those municipalities require the payment of travel allowances. LGUs are allowed to include these amounts in their LPP annual budgets. In an effort to wean LPP from paying recurrent operational costs, the LGUs are encouraged to tap other found sources to augment their existing TEV ceilings.

Many LGUs report being subjected to a 10 percent austerity cut in their 1998 non-LPP LGU budgets and note that TEVs are among the line items most at risk during budget cutting. The successful interaction between the LGUs (which receive LPP grants) and the municipalities (which provide MCH/FP services) is essential to the overall success of LPP. The TEV funds, although small in magnitude, are essential to maintaining this relationship. This issue needs continuous monitoring during 1998 to ensure that this constraint does not negatively affect LPP operations.

4.3.3 Central Procurement and Distribution

Although support to central procurement is neither part of LPP nor of IR 1, reliable distribution of contraceptives, vaccines, and vitamin A to LGUs is essential to the success of LPP. This support has not recently been the case for contraceptives. Some LGUs report having not received their fourth quarter shipment of contraceptives and attribute this delay to the failure of the DOH to pay the freight forwarder. With only a single month's buffer at the LGU level, the system cannot afford to miss a quarterly shipment.¹⁰ Domestic production of bacillus Calmette-Guérin (BCG) has reportedly been stopped while new production facilities are constructed. International procurement has been in place during this transition period. The DOH also procures 50 percent of the syringe supply used by the public sector. Vitamin A supply also is erratic and is tied to ASAP campaigns. Many LGUs buy their own Vitamin A. Central procurement is another technical area that, although not within LPP, could prevent LGUs from achieving targets and benchmarks owing to problems not of their own making.

4.4 Innovations

4.4.1 Provincial LPP Management Teams

The team found that Pangasinan and North Cotabato had developed an interdepartmental team structure to manage the LPP. These teams included representatives from GSO, accounting, and

¹⁰After reviewing the draft of this report, DOH commented that their guidelines call for a six-month buffer at the provincial and RHU levels, and a one-month buffer at the BHS level. The benchmark, however, calls for only a one-month buffer at 80 percent of all LGU contraceptive delivery points.

budgeting. Although the LPP orientation materials recommend the inclusion of these officers on the LPP teams, in the LGUs visited this inclusion was rarely the case. The inclusion of these offices in the two LGUs mentioned facilitated LPP procurement and general management. Representatives from GSO, accounting, and budgeting presumably had a greater appreciation of the need for LPP procurements and would facilitate the processing of LPP requests.

4.4.2 Replicating LPP Devolution to the Municipalities

One measure of the regard that LGUs have for LPP is their attempt to replicate the LPP processes in their relationship with municipalities. This replication is not required by LPP; but it occurs in some areas, nevertheless. One province, Capiz, has organized LPP teams and LPP coordinators in each of its 16 municipalities. LPP coordinators from the municipalities meet quarterly. Another province, Misamis Oriental, is testing methodologies that shift resources more directly to municipalities. For example, it is proposing to pay the TEVs of midwives from provincial budgets. Other LGUs have implemented variations on LPP relationships with their municipalities.

4.4.3 Use of Household Registers

Team members were impressed by the effective use of household registers at the local level to identify underserved populations. The master listing of married couples of reproductive age, for example, facilitated identification of couples in need of contraceptive counseling. At the very local levels, household registers often appeared to provide more reliable denominators than did the population forecasts provided by the National Statistics Office. Whereas LPP grants were invested in the training of service delivery staff and the purchase of equipment, it was often the ability of the barangay health worker (BHW) to identify unserved clients that was instrumental in increasing the number of customers for LPP services. These efforts to improve service statistics through master listing can increase confidence in the system.

4.5 Conclusions

4.5.1 Evolving Roles

Relationships between key players within LPP are not static. Roles required to initiate LPP are shifting gradually to roles more appropriate for institutionalization. At LPP commencement in 1994, 20 LGUs received considerable technical attention, primarily from the institutional contractor. The intensity of this technical assistance facilitated the origin and documentation of LPP systems.

At least three things led to changes in roles: (1) replicable systems were developed early, (2) the number of LGUs expanded beyond the capacity of the institutional contractor to directly provide

technical assistance, and (3) all parties recognized the importance of institutionalizing LPP within the DOH well before its project completion date. As a result, technical assistance roles have incrementally shifted from the institutional contractor to the PMO, the NTAT, and the RTATs. Continuation of the PMO, however, is linked to the life of IFPMHP. Without LPP, the PMO will cease to exist. The RTATs, however, are independent of IFPMHP funding. RTATs have been targeted during 1997 for increased responsibilities in orienting and monitoring LGUs. Their role should continue to expand in these areas, preferably at an accelerated pace.

4.5.2 IFPMHP Steering Committee

The Team noted many examples of the PMTAT, members of the NTAT, and representatives of the CAs coming together in technical level working groups to monitor and adjust LPP procedures. The evaluation team also noted the absence of any designated committee in which both USAID and the DOH sit to monitor and assess higher level LPP program issues. The IFPMHP steering committee has never met, and USAID is not represented on it in any case. There is a National Advisory Committee, but USAID is not a member of that either. In the absence of such a functioning steering committee, the DOH and USAID meet on an ad hoc basis to discuss mutual concerns, and the institutional contractor acts as a go-between on some issues. Many issues seem to be decided on this ad hoc basis rather than from any formal policy dialogue. The normal practice within the DOH is to establish a steering committee to manage policy for each donor-funded project. LPP needs access to a committee that brings the donor and the DOH together to review policy issues. Given the maturity of LPP and the devolution intentions, LGUs should be well represented in this steering committee.

4.5.3 LGU Ownership

The intention underlying LPP design emphasizes the devolution of decision making, but the field visits yielded only examples of LGU compliance with centrally determined benchmarks. We found little evidence of LGU-designed activities. This lack may have been appropriate for an early phase of LPP focused on maintaining services threatened by decentralization, but this earlier challenge has been overcome. The new challenge is to encourage LGU ownership of LPP and, through LPP, a long-lasting commitment to the provision of quality MCH/FP services at the local level. For this challenge to occur before the LPP ends, LGUs should become more involved in LPP decision making. LGUs could be better represented on the IFPMHP steering committee, for example. The LGUs could participate in the selection of standardized performance benchmarks directed toward achieving SO 3 and IR 1 objectives. LPP teams could assume increased technical assistance roles through cross-visit exchanges and case study presentations at LPP consultative workshops organized by LGUs and supported by the institutional contractor.

4.5.4 Counterpart Funding and Sustainability

The 20 percent of 20 percent of the HES fund for LPP support that is listed as an IR 1 indicator is too difficult to monitor. Discussions with LGUs during site visits suggest that they were well aware of the need to demonstrate counterpart commitment. A number of LGUs mentioned that they were accustomed to creating line items that were funded as counterpart commitments to donor-funded projects. The creation of an LPP line item may be construed as contrary to institutionalization priorities. The interim plan is to ask LGUs to submit plans in 1998 for sustainability measures that will be implemented in 1999.

4.5.5 Role of the Institutional Contractor

The institutional contractor has provided much of the early technical assistance which moved LPP from concept to near nationwide implementation in a few short years. This success occurred in the midst of challenges that included devolution, a recent shift of responsibilities from the Population Commission (POPCOM) to the DOH, and a prior history of neglect of family planning services. The institutional contractor had the advantage of association with the prior Family Planning Management Development (FPMD) project. The contractor had also been able to attract staff with considerable relevant field experience. These advantages helped to ensure competent support to the early LPP LGUs. The current challenge, though, requires the institutional contractor to divest itself of project maintenance functions and to focus exclusively on the transformation of LPP into a more truly DOH program. Considerable progress has been achieved during 1997 as regions assumed a significantly increased role in support of LGUs. Nevertheless, the sheer mass of maintenance functions is likely to distract the institutional contractor from its role to help strengthen the TA and monitoring capability of the DOH at the central and regional levels. The Team believes that the contractor understands the importance of a role shift and encourages USAID and the DOH to continue to support the gradual divestiture of LPP management and maintenance roles.

4.5.6 USAID Management of IR 1

USAID management of IR 1 is built upon re-engineering principles of **enhanced participation** and **managing for results**. Reporting by LGUs on the accomplishment of benchmarks to the DOH, and the annual reporting by DOH to USAID on benchmark compliance could be seen as an extension of the results-based reporting that the mission uses in reporting to USAID Washington. The early inclusion of the results-based format into the monitoring of IR 1 may reflect USAID/Manila's early experience with re-engineering. USAID/Manila is 1 of the 10 missions selected by the agency in 1994 to test re-engineering.

Enhanced participation is another key element of re-engineering reflected in USAID's management of IR 1, which is particularly true at the technical level. CAs meet with Office of

Population, Health and Nutrition (PHN) staff monthly to review technical outputs. The same CA participants, plus the USAID IR 1 team leader, sit on the LPP component working groups at the DOH. Semi-annual meetings between USAID and the DOH review benchmark progress. During the second of these meetings, at the end of the year, the DOH presents certification of its compliance with benchmark requirements. A midyear meeting reviews progress toward achieving benchmarks and suggests any interventions that may be required to ensure success before the end of the year. A current shortcoming is the absence of a forum at which design level discussions might occur between USAID and the DOH. Such a forum, for example, would be used to examine larger themes arising from technical level meetings.

4.5.7 DOH Management of Program Sustainability

Four years of LPP implementation have produced a crop of LGUs that has demonstrated a capacity to plan for and manage FP/MCH/N programs. As LPP funds for early batches of LGUs dwindle, there may be less incentive for them to maintain high standards. At this point, DOH might consider setting up a true performance-based grants system for LGUs that “graduate” from LPP. USAID and the DOH should consider setting up such a grant fund from the peso dividend that will be generated from the current peso/dollar exchange rate.

4.5.8 Decentralization of LPP Management

Management of the program up to this time remains highly centralized. Such a system may have been beneficial in the early development years of the program, but with increasing LGU numbers and complexity, management needs to turn to more appropriate units within DOH to manage LGU relations at central and regional levels. Management should design a simplified structure reflecting actual working relations. This structure might develop along the lines of current projects like the Women’s Health and Safe Motherhood Project (WHSM) and the Integrated Community Health Services Project (ICHSP). Both of these projects are focused on institution strengthening and technology transfer. Both have identified other units in the DOH that would benefit from the projects and brought them together under technical coordination committees where they meet with components that are run by their institutional counterparts. ICHSP, for example, is technically based in LGAMS, but it has broadened its base to include other services, even the regional offices. This expansion has the effect of broadening and decentralizing technical work. Administration (including procurement and logistics) is left to the PMO and the implementing LGUs.

4.5.9 Planning and Management at the LGU Level

The DOH uses the plan development process to provide technical input, to provide supervision, and even to exert some control on local processes. In some areas this control may not be enough

because of the inertia of local administrative processes that are not used to large transactions (a consequence of devolution). Devolved health personnel actually doubled in size, and the number of facilities under LGU control increased significantly. In other areas, the problem may be the LCE's lack of political will to prioritize work like LPP. This problem may require attention from the Secretary of Health.

4.6 Recommendations

8. The DOH should activate the IFPMHP steering committee and include USAID and LGU representatives.
9. Given the experience with LPP to date, the DOH should consider whether LPP could be better managed through units responsible for decentralization mechanisms and regional affairs.
10. LPP managers should expand efforts to promote further decentralization. This expansion should include a shift of authority both to the regions and within the LGUs, increasing the responsibility of the municipalities. It should also include more regional and provincial attention to performance on the part of municipalities.
11. The institutional contractor should work together with the RTATs to provide technical assistance to LPP in local procurement. Such TA might be based on previous experience gained by HFDP.
12. The secretary of health should actively and personally champion LPP to LCEs.
13. The LPP planning process should be simplified and phased into multiyear plans that can be updated annually. These action plans should focus more specifically on achieving benchmarks. The plans should be expanded to include other health services, including those that are local priorities.
14. The IFPMHP steering committee should monitor those factors outside of LPP control but essential to LPP performance (e.g., TEVs, provision of contraceptives and vaccines) and negotiate solutions to these problems if they begin to constrain LPP operations.
15. Cluster surveys serve central more than LGU monitoring requirements. LGUs rely more on service statistics for planning and monitoring. Therefore, this expense should be attributed to central project management costs.
16. DOH should set up a performance-based grants system for LGUs as a follow-on mechanism. System management should be placed in the appropriate DOH unit merging local government assistance.

17. The DOH should create a line item for a grant-based system or increase current items that are in place.
18. Responsibility for technical assistance is shifting from the institutional contractors to the DOH (central and regional). This trend should be encouraged and continued.

CHAPTER 5. FUTURE NEEDS AND DIRECTIONS

This chapter summarizes revisions that the Team believes should be made in the current LPP. It also describes a follow-on matching grant program that the team believes would be an appropriate complement to the LPP.

5.1 LPP Revisions

LPP should be repackaged to make it more appropriate and responsive to current needs and priorities. Many LPP LGUs now have multiple years of experience with LPP and have the management capacity to implement LPP activities on their own. Many have sufficient experience to join in the management of LPP at the national level. Revisions in design, structure, and processes should enhance capabilities for local management, and expand and improve FP/MCH/N services. The DOH should continue to define national policy and standards. LGU participation should include selection of LPP benchmarks. Stakeholders (including the local chief executive, local administrative and health personnel, and local health boards) must be involved in redesigning the LPP package.

Table 11

Summary of Proposed Revisions

| Program Areas | Proposed Revisions |
|---|---|
| 1. Decentralization | LGUs and regions should expand roles. More RMT decision making. LGUs replicate LPP within LGU. |
| 2. Central Leadership/Ownership | Increase DOH role in policy, service standards, coordination, monitoring. |
| 3. LCE Involvement | Increase involvement of LCE in program design and implementation. |
| 4. Plan Simplification | Simplify planning process while increasing breadth of use. |
| 5. Technical Assistance | Divest institutional contractor of management responsibilities, focus on building TA/monitoring capacity, preparing for future. |
| 6. Sustainability of LPP at the LGU Level | Support LGU development of sustainability objectives, mechanisms, and transition plans. Determine what should be sustained, both at LGUs and at LPP/DOH. |
| 7. Benchmarking | Benchmark revisions: (1) phase out items already uniformly achieved; (2) set more realistic population coverage measures (FIC, TT2+, VAC); and (3) involve LGUs in developing new BM. |
| 8. Performance Assessment | Revise to cover same time period as LGU plan; standardize definitions of indicators. |
| 9. Phase-out/Weaning of LGU | Develop transition strategy to graduate LGUs out of LPP to a more challenging matching grant program. |

5.1.1 Decentralization and LPP

At the beginning of LPP, soon after decentralization of health services, there was some doubt about the commitment of LGUs to providing the package of services currently included in LPP. LPP grants were intended to serve as an incentive, encouraging LGUs to adapt best practices in the distribution of commodities, the training of staff, the equipping of service delivery sites, the provision of voluntary sterilization services, and the use of IEC. With very few exceptions, LGUs have welcomed LPP as a vehicle for achieving competency in these technical areas. In the process, these LGUs have achieved a significant management capacity.

Similarly, in the course of implementing LPP, the DOH has begun, particularly in 1997, to rely on regional offices, RTATs, to provide technical assistance to LPP LGUs. This delegation to the regions has been successful.

Both the LGUs and the regions should play an expanded role in LPP. Decision making should be delegated increasingly to RMTs. RTATs should become the primary source of technical assistance. Municipalities should be encouraged to replicate LPP structures in their relations with municipalities. Citizen participation in local health boards should be encouraged to produce a more vibrant constituency for FP/MCH/N services.

Technical assistance from the DOH via the RTATs should include a priority on developing the capabilities of LGUs in resource generation and mobilization, procurement tracking, mechanisms for sustainable program implementation, introduction of financing schemes, and community-based approaches for broader citizen participation.

LPP may need to involve the League of Leagues as an enabler of their LGUs. The various leagues may provide the best venue for sharing experiences and best practices, policy support, leveraging resources, and inter-LGU cooperation for improved service delivery.

5.1.2 Central Leadership/Ownership

LPP is an example of a national government agency learning to implement national policy and national targets in a decentralized system. While service delivery structures have been devolved, the ownership of LPP health programs, such as the Family Planning (FP) program and EPI, is perceived by the LGUs as largely national. The responsibility for policy development, minimum standards of service, and performance and coordination at all levels should remain with the DOH. In a decentralized set-up, the problem facing the DOH is how to ensure that national health policies and LGUs will implement programs uniformly. With LPP, equitable distribution or access to FP/MCH/N services should be ensured, as well as quality of care standards.

Through LPP, USAID provides the vehicle that assists the DOH in soliciting LGU collaboration in achieving national policies and targets. As LPP gains maturity, the role of USAID as the primary donor should decrease, and DOH ownership and funding of LPP should increase.

5.1.3 Involvement of Local Chief Executive

During field visit discussions that ranged from such topics as procurement to relations between the LGU and municipalities, informants repeatedly referred to the importance of support from the chief executive, the city mayor, or the provincial governor. These LCEs are required to sign the MOAs and are often required to approve procurements; but there is little activity in LPP that ensures the continuing support of LCEs for FP/MCH/N services. This shortcoming is particularly relevant as the Government of the Philippines faces upcoming elections. A number of new LCEs will be elected. The institutional contractor should work with the DOH to develop new approaches to ensure continuous support from LCEs.

5.1.4 Plan Simplification

LGU LPP teams appreciated the LPP planning process. They believed the annual assessment of training and equipment needs, the IEC planning, and other elements of the LPP plan were all useful, particularly given that their plans were likely to be funded by LPP. Nevertheless, the planning process need not be as cumbersome as it is. A detailed, multiyear plan should be developed and updated each year to reflect changes and to provide an up-to-date budget.

5.1.5 Technical Assistance

As discussed earlier in this document, donor-funded, resident technical assistance has been key to ensuring the early success of LPP. The quantity of TA required initially was probably beyond the capacity of the DOH at the time. The conversion of this TA into documented, replicable procedures also required one-time, donor-funded technical assistance. The current challenge, though, is for the institutional contractor to divest itself of any and all LPP managerial roles. Efforts on the part of the institutional contractor should be focused instead on strengthening the TA capability of the NTAT (and perhaps the RTATs) and preparing for future LPP developments and follow-on. Regular TA roles should be assumed by the PMO, the NTAT, RTATs, and the LGUs themselves.

5.1.6 Sustainability of LPP at the LGU Level

LPP funds typically are used for one-time expenditures (e.g., training, equipment), rather than for recurrent costs. These expenditures are investments in improved and expanded services rather than long-term financial commitments. Earlier USAID experience with the Child Survival Project suggests that LGUs will continue to bear the recurrent costs after the project completion date. Efforts to require a commitment of 20 percent of the HES seem to be inappropriate and unmanageable. Current efforts should be designed to help the LGUs identify alternative sources of support that can be raised locally and that will contribute to the sustainability of the structures, systems, and services they have developed with LPP support.

5.1.7 Benchmarking

All of the organizations involved in benchmarking need to understand the benchmarking or performance assessment process and its implications. Action should be taken immediately to revise the FIC and TT2+ benchmarks and targets for 1998–1999, in particular. A working group that includes representatives of the LGUs should be formed as soon as possible to develop a more rational and relevant set of benchmarks and targets. Individual LGUs should be involved in negotiating their own benchmarks with the DOH.

Some benchmarks need to be phased out once the LGU has developed the desired capability. Annual plans, staff training, IEC plans, and the establishment of VS services are all examples of benchmarks that need not be repeated each year. Once an LGU has clearly met these requirements, these benchmarks should be dropped and replaced by new, more challenging benchmarks. The VAC benchmark should be deleted. This deletion has been achieved and sustained by almost all LGUs, even prior to LPP enrollment. VAC is no longer a cutting-edge challenge at the national level.

5.1.8 Performance Assessment

Performance measures need to be more specific to the appropriate time period and to the appropriate definition of the indicator. The measures, unlike those used in the annual cluster surveys, must cover the same period as the LPP plan for which performance is being measured. The measures and the program should define the target groups the same way. Confidence intervals should be taken into consideration when making decisions about LGU performance. LGUs must be actively involved in the analysis of results and learn how to draw conclusions from the data.

5.1.9 Phase-out/Weaning of LGUs

LPP benchmarks are intended to ensure that participating LGUs have essential capacities for the provision of quality FP/MCH/N services. LPP provides for services such as the training of staff, the procurement of required equipment, the distribution of commodities, the conduct of IEC campaigns and MICS, and the provision of voluntary surgical sterilization. Plans are developed to implement these services. Funds are provided. Success is monitored. Many LGUs have been in this mode for a number of years now. Their staff is trained. The equipment has been procured. Their IEC campaigns are up and running. These LGUs—those that joined LPP early—are ready for new challenges. They should be graduated from the more directive processes of LPP, and initiated into a new status that recognizes their demonstrated ability to manage their own services.

5.2 Future Directions

5.2.1 LPP—A Good Start

The LPP is clearly an effective vehicle for developing LGU management and service delivery capability. As this report has shown, such essential management elements as planning, monitoring, logistics, and information systems have been put in place through LPP. The program has also helped local providers develop the capacity to provide essential family planning, child survival, and nutrition services through training, provision of needed equipment and essential supplies.

However, the program also has its weaknesses and limitations. As noted previously, it is highly centralized, not truly based on current performance; it is not sustainable in its present form. While the Team believes that the revisions described above are needed and will help improve LPP, it is also clear that—because LPP is primarily a short-term, capacity-development initiative—it is not the most appropriate vehicle for achieving significant impact on such health and family planning objectives as immunization coverage and contraceptive prevalence. What the Team believes is needed is a follow-on initiative that puts greater emphasis on impact—building on the strengths of LPP, while overcoming its limitations.

Future Directions

LPP Effective in Developing LGU Capacity

- Helps develop LGU capacity in management and FP/MCH/N services
- LPP has limitations: highly centralized, not truly performance based, not sustainable
- Needs a follow-on grant program that builds on LPP strengths, but overcomes its limitations

A Follow-on Matching Grant Program Needed to Affect Outcomes

- Successful LPP grantees transition to MGP
- More local control, truly performance based, matching grant required
- Uses windfall from 1997–1999 LPP to pilot test with first batch of LPP graduates
- Continues LPP for remaining LGUs, limit to two years, transition to MGP

New Project Objectives

- SO to reduce the population growth rate and to improve maternal and child health
- IR to improve LGU management, expand FP/MCH/N services, and improve quality of care
- Benchmarks to give emphasis on coverage and prevalence
- Performance disbursement to guarantee minimum performance with incentives for performance that exceeds the minimum

5.2.2 A Follow-on Matching Grants Program

A number of the original LPP grantees are now ready to move on. They have the basic capacity to plan and to manage their own programs. As LPP winds down, they will be looking for ways to sustain the achievements they have gained. They are also ready to take on new challenges that will enable them to use the skills they have developed. There is an opportunity, therefore, to capitalize on this situation by providing these LGUs with a new incentive aimed at increasing health and population outcomes. For lack of a better name, we are calling this new initiative the Matching Grants Program (MGP).

Those LPP LGUs that are ready to “graduate” from LPP would be eligible to apply for the new program. This program would allow more local control, would be truly performance based, and would require the applicants to have all of the systems and service capacity developed through LPP in place. Thus, the new program would also serve as an incentive to all LPP grantees to graduate.

At the same time, LPP would continue as the entry-level performance program for those LGUs that have not yet been enrolled. For a period of time, both programs would be operational, with new LGUs being enrolled in LPP as older grantees transition over to the new MGP (see Figure 3). Adjustments undertaken by LPP should be directed at developing a consistent LPP process that develops LGU capacities in FP/MCH/N programs in particular and public health programs in general. This system should include the development of criteria for an LGU to graduate from the LPP into the MGP. An inducement for LGUs to move from one system to the next would be the possibility of grants that are significantly larger than current LPP grants. Enrollment of non-LPP LGUs should be given priority by LPP. If enrollment of all LGUs is not completed by 1999, the DOH should consider adopting this as a regular offering from 2000 onward.

Figure 3, LPP/Matching Grant Transition, available in hard copy

5.2.3 Structuring MGP

The MGP could be structured in a variety of ways. The Team suggests that it be “packaged” as a “partnership” between LGUs and the DOH. MGP grantees would have to meet certain minimum requirements to qualify (ability to prepare their own plans, monitor their own activities, etc.). They would be eligible to apply for DOH funds to do one or more of the following: (1) strengthen management capacity at the municipal and city levels, (2) expand FP/MCH/N services, and (3) improve the quality of FP/MCH/N services.

The grantee would have the latitude to determine what it wanted to do and how, as long as the general objectives fell within the parameters set by the DOH. No DOH monitoring or technical assistance would be provided, unless specifically requested by the LGU. Thus, the management burden on DOH central and regional offices would be minimal. In effect, the LGUs would be responsible for achieving agreed-upon coverage targets, but how they did it would be up to them and not the responsibility of the DOH.

Coverage benchmarks would be negotiated with each applicant. These could include, for example, FIC, TT, CARI, iron sulfate, or even contraceptive prevalence if that is acceptable locally. The annual targets would also be negotiated and performance incentives built in. The grantee would be guaranteed a fixed amount of money for a set number of years. The performance incentives would provide additional funds for exceeding targets. These incentives could be set in various ways, such as achieving a target ahead of schedule, exceeding the target, or exceeding quality standards. The incentives could be set on a fixed schedule, such as P100,000 for exceeding the target by 5 percent, P250,000 for exceeding the target by 10 percent. They could also be set on a sliding scale, such as payment of an additional 1 percent of the grant for every 1 percent of achievement over the base target. Penalties could be included for underperformance, such as a 1 percent deduction if deficient by more than 5 percent. However, we believe that penalties could be counterproductive and we would not recommend including them.

Payment of the grant could be made all at once or in quarters, with the performance incentives paid separately. The guaranteed portion of the grant could be paid annually in advance to enable the LGU to fund its planned activities. The matching portion of the grant could come from local resources, “counterpart” funds, HES, or even “in-kind” contributions for those LGUs that are less well off.

Performance would need to be measured and verified independently, which could be done in several ways. For example, the cluster survey data could be used as a baseline for the LGUs. The survey could include indicators for other health activities that are important to the LGU but that the DOH would not necessarily fund. Service statistics could be used to measure performance on an annual basis with a follow-up cluster survey conducted at the end of the grant period (perhaps three to five years) to verify changes. DOH regional offices could check annual performance data to make sure they are accurate.

Three stakeholders should jointly manage the MGP: DOH, LGUs, and donors (USAID). If the IFPMHP steering committee is revived, it would be appropriate for that group (expanded to include representatives of the LGUs) to discuss this proposal. If the committee agrees to the concept, a pilot test could be set up in 1999. There are a number of LPP LGUs from the first and second batches that would be ready to enroll in such a program. The pilot could be funded with the windfall that is expected this year and that might also be generated next year. Once the kinks in the MGP are worked out, it could be launched nationwide.

5.2.4 Funding the MGP

The proposed program would fit nicely into USAID's Strategic Objective framework and would not be significantly different from the LPP in terms of the funding mechanism.

The relevant Strategic Objective could be to reduce the population growth rate and improve maternal and child health. The Intermediate Results for the program could be (1) to strengthen LGU management at the municipal and city levels, (2) to expand family planning and MCH services, and (3) to improve the quality of FP/MCH/N services. Benchmarks at the DOH level could be aggregates of the individual grantee benchmarks, as many are now. For example, at least 35 MGP LGUs will achieve the FIC targets negotiated with the DOH. Financing could follow the same system as established under LPP. USAID would negotiate a budget with DOH for the amount of funds to be provided each year to reduce national debt. That money would be released as soon as the annual benchmark report was submitted and approved by USAID. The dollar amount would be used to determine the equivalent peso amount that would be generated to finance the MGP.

It is also important to know that the DOH is already managing grant funds for LGUs and already has line items for these grants that can be increased annually. Just as important, LGUs have shown a willingness to commit counterpart funds for LPP as well as for Comprehensive Health Care Agreement and other foreign-funded projects. Sources for larger grants could be set up in a joint DOH-USAID health development fund that could combine uncommitted LPP money and current DOH grants for LGUs. The DOH could also request an increase in the current line item to top up such a fund incrementally, beginning with the 1999 budget.

5.3 Recommendations

19. Both the LGUs and the regions should play an expanded role in LPP. Decision making should be increasingly delegated to RMTs. RTATs should become the primary source of technical assistance. Municipalities should be encouraged to replicate LPP structures in their municipalities. Citizen participation in local health boards should be encouraged to produce a more vibrant constituency for FP/MCH/N services.

20. As LPP gains maturity, the role of USAID as the primary donor should decrease, and DOH funding and ownership of LPP should increase.
21. The institutional contractor should work with the DOH to develop new approaches to ensure continuous support from LCEs.
22. The benchmark targets should be negotiated by the RTAT directly with each LGU and incorporated in their annual plans.
23. The LPP annual planning process should be simplified. The initial year's detailed plans should be followed by brief annual updates and action plans.
24. The institutional contractor should divest itself of all LPP managerial roles and increase its focus on providing TA to NTATs and RTATs.
25. LGUs which demonstrated success at capacity-building within LPP should be graduated from LPP into a new program that provides them greater freedom in designing and meeting their own FP/MCH/N targets.
26. USAID and the DOH, with assistance from LGAMS and the institutional contractor, should use the exchange rate windfall funds to begin pilot testing a new Matching Grant Program.

APPENDICES

APPENDIX A

Scope of Work

Mid-term Assessment – Intermediate Result No. 1, Strategic Objective No. 3, USAIDPhilippines

I. INTRODUCTION

The goal of USAID/Philippines is to support the effort of the Government of the Philippines (GOP) to achieve the status of a newly industrialized democratic country by the year 2000. Towards this end, USAID/Philippines is supporting six major Strategic Objectives (SO) and two Special Objectives (SpO), as follows:

- SO 1 : Broad-based Economic Growth in Mindanao
- SO 2 : Improved National Systems in Trade and Investment
- SO 3 : Reduced Fertility and Improved Maternal & Child Health
- SO 4 : Enhanced Management of Renewable Natural Resources
- SO 5 : Reduced Emission of Greenhouse Gasses
- SO 6 : Broadened Participation in the Formulation and Implementation of Public Policies in Selected Areas
- SpO : Rapid Increase in HIV/AIDS Prevented
- SpO : Assistance to Amerasians in the Philippines

USAID/Philippines is also on the leading edge of USAID's worldwide reengineering effort, having served as a successful experimental laboratory for the new results-oriented program approach and management. The Mission has shifted from a project orientation and has developed a country strategy based on SOs with clearly defined Intermediate Results, benchmarks and indicators that lead to the achievement of the overall Mission Goal to enable Philippines to achieve the status of a newly industrialized democratic country by the year 2000.

II. ASSESSMENT BACKGROUND

This assessment will focus on SO 3, and in particular, its Intermediate Result No. 1, Increased Public Health Sector Provision of Family Planning/Maternal Child Health (FP/MCH) Services. The goal of SO 3 is Reduced Fertility Rate and Improved Maternal and Child Health. To attain this goal, the following ambitious but attainable indicators have been established jointly by USAID\Philippines and GOP Department of Health (DOH), to be achieved by the year 2000:

1. Total Fertility Rate will drop from 4.1 in 1991 to 3.1.
2. Infant Mortality Rate will fall from 57 in 1990 to 49.
3. Maternal Mortality Ratio will fall from 209 in 1990 to 190.
4. Contraceptive Prevalence Rate for all methods will increase from 40.0 percent in 1993 to 50.5 percent.
5. Contraceptive Prevalence Rate for modern methods will increase from 25.2 percent in 1993 to 35.7 percent; and

6. Percent of births in high risk groups will fall from 62.4 percent to 56 percent.

Three Intermediate Results (IR) have been designed and developed jointly by USAID and DOH to achieve these SO results by February 28, 2000. They are:

- IR No.1: Increased public sector provision of family planning/maternal child health services;
- IR No.2: National systems strengthened to promote and support the family planning/MCH program; and
- IR No.3: Increased private sector provision of family planning/MCH services.

The primary USAID-funded program for the attainment of these SO/IR objectives and results is a \$153 million (\$65 million bilateral, \$62 million Global Bureau, and \$26 million GOP contribution), six-year, Integrated Family Planning Maternal Health Program (IFPMHP), which was initiated in 1994 prior to USAID's reengineering effort and the design and development of the SO and its IRs. However, a new Results Framework, as mandated by USAID/W reengineering guidelines, was prepared in 1996, which superseded the IFPMHP Program Assistance and Approval Document (PAAD) and which sets forth how SO 3 will contribute to sustainable development in the Philippines, how each of the IRs will contribute to achievement of the SO results, and how the IRs themselves will be achieved. It also presents the measures and targets that will be used at the SO-level, IR-level, and activity-level to manage the program in such a way as to maximize the chances of success and to determine whether the expected results have been achieved. A one-page spreadsheet summarizing the detailed Results Framework is attached to this Scope as an Annex.

The performance-based approach, developed jointly by USAID and DOH, under SO 3 is based on the successful experience with a similar performance-based approach under the previous USAID-funded program in the Philippines, the Child Survival Program. Under the SO 3 performance-based approach, DOH, Commission on Population (POPCOM), National Statistical Office (NSO) and the collaborating agencies must achieve certain benchmarks for IRs 1 and 2 (the public sector components of the program) each year in order for the GOP to receive an annual tranche of funds from USAID. This tranche is then available for grants to Local Government Units (LGUs) that have achieved the benchmarks and for DOH activities in family planning and MCH. Over the life of the program, \$29.2 million are budgeted for tranche disbursements. Tranche funds are not conditional on achievement of benchmarks under IR 3, the private sector component of the program.

A mid-term review of SO3 and its IRs is being undertaken by USAID to determine if the SO is on target with regard to its stated goals for the year 2000 and to determine if any mid-course corrections or changes in program strategies or implementation approaches are warranted. This review is also intended to provide insights into future needs and potentially strategies, including if any of the present strategies are worthy of emulation or should be changed or dropped.

Because of the magnitude and complexity of the SO3 and the IRs, three separate assessments are

planned, one for each IR. This scope of work relates to the assessment of IR 1 (Increased Public Sector Provision of Family Planning/MCH Services), the first to be undertaken. Other assessments will follow.

III. PURPOSE OF ASSESSMENT (IR No. 1)

Currently, the public sector provides contraceptives to over 70 percent of users of a modern contraceptive method and will remain the backbone of the national family planning and MCH program for the near future. IR No. 1 will support the attainment of SO 3 objectives by increasing the provision of family planning and MCH services in public sector facilities, most of which are operated by the LGUs, to achieve the following performance indicators by the year 2000:

- The number of CYPs provided will increase from 1.67 million in 1994 to 2.6 million;
- The percent of children fully immunized will remain at least 90 percent;
- The percent of pregnant women immunized against tetanus will have increased from 42.2 percent in 1993 to 80.0 percent in 2000; and
- The proportion of children receiving Vitamin A capsule supplements will remain at least 90 percent.

In addition, in order to enhance the sustainability of LGUs' population/family planning/child survival activities, they will be required to allocate increasing proportions of their Internal Revenue Allotments from the central government for programs in these areas.

A performance-based grant program to the LGUs, known as the LGU Performance Program (more popularly known as LPP) has been established as the primary vehicle to achieve the IR 1 indicators and objectives. Under LPP, LGUs (provinces and cities) that achieve certain benchmarks receive a grant to expand and improve their family planning/child survival programs. LGUs are brought into LPP in batches, usually consisting of 20 LGUs per year, starting with the most populous and those with the strongest political commitment to family planning/population and child survival activities. The first 20 entered the program in 1994. To date 67 LGUs have been enrolled and when the LPP ends in 1999, at least 75 LGUs are expected to be implementing integrated family planning/maternal health/child survival programs.

IR 1 supports the GOP's devolution efforts under the Local Government Code of 1991 which, among other things, transferred the responsibility for the delivery of health care services to the LGUs. IR 1 also supports the policy and institutional reform process necessary to establish a new, post-devolution relationship between the DOH and LGUs in support of population, family planning, MCH, and nutrition services. [The changes in the role and functions of DOH as envisaged under Local Government Code are being supported through IR 2, National Systems Strengthened to Promote and Support Family Planning and MCH Programs.]

Activities supported under IR 1 are managed by a Project Management Unit (PMU), established within the Department of Health, under the direction of an Assistant Secretary, who serves as the

IFPMHP Program Manager. The LGUs are responsible for preparing and implementing annual plans which are reviewed and approved by DOH. Technical assistance to the PMU and participating LGUs is provided by Management Sciences for Health (MSH), institutional contractor, which is fielding a Project Management Technical Assistance Team (PMTAT), consisting of a Chief of Party, a Finance and Operations Officer, a National Systems Development Advisor/Coordinator, a Training Advisor, a MIS Advisor, an Urban Advisor, a Program Sustainability Advisor, an LGU Systems Development Advisor, an LPP Coordinator, and four Regional Program Coordinators, and supported by local and U.S. short-term consultants and staff from MSH/Boston. Technical assistance to the LGUs is provided through National and Regional Technical Assistance Teams (NTAT and RTAT), established jointly by the PMU and MSH/PMTAT.

In addition, the Association for Voluntary Surgical Contraception (AVSC) is supporting the establishment of quality voluntary sterilization services in all the LGUs, while Johns Hopkins University/Population Communication Services (JHU/PCS) is supporting LGU-based information, education, and communication programs in all the participating LGUs through their respective Cooperative Agreements with USAID/W. With technical assistance from John Snow Inc. (JSI), a Contraceptive Distribution and Logistics Management Information System (CDLMIS) has been established within the DOH and it is fully operational.

Specifically, this assessment of IR 1 has the following purposes:

- A. To assess the intermediate result (IR) 1 or LGU Performance Program (LPP) design and implementation process. How appropriate is IR 1/LPP as an approach for achieving the goal and objectives of SO 3/IFPMHP, including an assessment of the appropriateness of IR 1/LPP benchmarks, both for the DOH and the LGUs. Is the IR 1/LPP design appropriate? Will the IR 1 indicators be accomplished? If not, how can the design be further improved?
- B. To assess the responsiveness and effectiveness of its management structure and its administrative and operational processes. How is the DOH (central and regional offices) managing the implementation of IR 1/LPP and how effective is this process? How is USAID managing the process from its end? How are the LGUs managing and implementing LPP? How is the Technical Assistance Team/Institutional Contractor set up for this purpose? How are these management processes influencing program implementation and accomplishments?
- C. To make recommendations regarding revisions or modifications on how the program implementors (DOH, LGUs, TA contractors and consultants) can best meet program objectives for the remainder of the Program.
- D. To determine if the IR1/LPP approach is appropriate for continuation in the next strategic planning period. If not, what modifications/improvements are necessary.

IV. SCOPE OF THE EVALUATION

The midterm evaluation will cover the period starting from project initiation (1994) until the time of the evaluation. It will cover the performance of all actors in the program, particularly those involved in IR 1, and include all elements of the program, namely: technical assistance, DOH/PMU, NTAT/RTATs, MSH/PMTAT, AVSC, JHU/PCS, USAID and LGUs.

V. KEY EVALUATION ISSUES/OBJECTIVES

Assessment of IR 1 Validity

A. To assess the objectives, strategies and associated performance benchmarks of IR 1, specifically the LGU Performance Program (LPP) from the point of view of how well the DOH and the LGUs have implemented reforms to improve and expand service delivery. Are these the critical ones to achieving the overall goals of SO 3? To recommend any changes that ought to be made in the agreed upon USAID/DOH strategy regarding the achievement of SO 3 over the remaining years of IFPMHP.

B. To review the LPP performance benchmarks in order to determine whether they are, in fact, the most appropriate benchmarks for the achievement of IR 1 relative to SO 3? Do these benchmarks reflect significant progress toward the objective of improving and expanding service delivery and the overall goal of reducing fertility and improving maternal and child health? If considered necessary, to recommend a possible restructuring of the benchmarks.

C. To determine the extent to which the performance benchmarks have helped the DOH as a "management tool" as well as the extent to which the benchmarks have been effective in meeting IR 1 and SO 3 objectives. Has LPP contributed to strengthening the institutional capacity of the DOH to fulfill its role under a devolved set up, e.g., provision of technical, financial and resource assistance to the LGUs in sustaining the delivery of FP/MCH/Pop/Nutrition services?

D. To assess the process of performance benchmarks (using performance based disbursement as a funding assistance mode) to determine how well it has worked so far and how it can be improved for the second half of IFPMHP. What evidence is there that the LPP has actually added to or expedited reforms or measures by the DOH and the LGUs to expand the delivery and improve the quality of health services by the LGUs in the devolved setting beyond what probably would have been carried out irrespective of LPP? How has the LPP helped or hindered the "health devolution transition" process?

E. To date, what impact on financing, access to and delivery of FP/MCH/Pop/Nutrition services has LPP made or is likely to make over the LOP?

F. To review the extent to which LPP has affected efforts to reduce infant and maternal mortality, increase FP coverage and demand for FP services in the Philippines. To suggest ways in which LPP might achieve greater impact in the remaining years of IFPMHP.

G. What is the likelihood of achieving the IR 1 objectives as measured by the indicators by 2000? Are those targets realistic given the availability and state of baseline data? Are the currently participating LGUs meeting their annual targets? What specific steps might be taken for LPP to increase its likelihood of achieving IR 1 targets?

H. Assuming diminished USAID financial and human resources in the next planning period, assess if the present approach is worthy of emulation. How can the effectiveness and efficiency of this approach be further improved?

Assessment of Management Structure and Processes

A. To assess the overall implementing structure and implementing process, i.e., the Program Management Office (PMO), Program management Team (PMT), National Advisory Committee (NAC), the different Technical Assistance Teams (PMTAT, NTAT, RTAT). Is this structure appropriate? How effectively has the process been managed by the DOH (including the PMO and the Office of Special Concerns and the Services involved in LPP)?

B. To assess the administrative structure established by the technical assistance team/institutional contractor to manage or carry out contract objectives. Is it adequate and responsive? How can management be improved at the technical assistance team/institutional contractor level? How effectively has the technical assistance team/institutional contractor functioned and how can its performance/effectiveness be improved?

C. To assess the reengineered USAID set up (SO team, et al) to manage IFPMHP. How effectively has USAID managed the process from its side and what lessons might be learned?

D. To assess the interaction of all the players involved. Has the interaction of DOH PMO/PMT/NTAT/RTAT), PMTAT/IC, and USAID been effective in achieving goals and objectives and how can this interaction be improved?

VI. THE EVALUATION TEAM

The midterm evaluation will require the services of a 4-member team consisting of one Health Service (FP/Pop) Analyst, (expat, for 40 working days) who will serve as team leader and responsible for the overall evaluation and reporting requirements. He/she must have broad experience in the evaluation of health service as well as health policy activities particularly in the areas of family planning and population. Knowledge of FP/Pop issues in developing countries is required.

Other team members include:

- one Health Service Analyst (expat for 30 working days) who will be responsible for reviewing issues and concerns relative to MCH/Nutrition services. Knowledge

of MCH/Nutrition issues in developing countries is required.

- one Health Management Specialist (Filipino for 29 working days) who will look at issues affecting DOH-LGU relationships within the context of the Local Government Code. Knowledge of and experience in planning and information systems regarding public health activities, particularly FP/Pop/MCH/Nutrition, under a devolved set up is required.
- one Health Management Specialist (Filipino, for 30 working days) who will look at issues affecting LGU-LGU and LGU-community relationships under a devolved set up. Knowledge of and experience in community health service delivery (particularly FP/Pop/MCH/Nutrition activities) at the local level is required.

The evaluation is expected to entail not more than 40 working days to be completed in four calendar months, with not less than 30 days spent in-country. This includes briefings and debriefings that the Team will provide for USAID and DOH. The Team Leader will be allowed to spend 2 working days in the U.S. to contact U.S. based program participants (e.g. MSH-Boston) and to finalize the report. Data collection and report writing up to the final draft (including consultations for report revision) should be completed in-country.

VII. DATA SOURCES AND REPORT FORMAT

The evaluation will rely principally on secondary data sources and IR 1's and IFPMHP's monitoring data, as well as various program documents, interviews with key officials and staff knowledgeable about the program and field site visits. USAID and DOH, with the evaluators, will select a representative set of LPP LGUs (provinces and cities) for site visits to assess the importance of policy, organizational and budgetary changes supported by LPP and IFPMHP.

The final report will be prepared by the Team Leader in the U.S. after receipt of USAID and DOH comments.

The evaluation report with tables and annexes should not exceed 50 pages. The report format will be as follows:

1. Executive Summary (to follow Project Evaluation Summary [PES] format) stating findings, conclusions and recommendations, not exceeding 3 pages;
2. Table of Contents;
3. Body of the Report which includes brief program description, the environment in which the project operated, a statement of the methodology used, major findings, conclusions and recommendations; and
4. Annexes, to include the evaluation scope of work, list of persons consulted, background supplemental materials useful for a fuller understanding of the report, an annotated bibliography of significant documents used or consulted, and a list of acronyms.

APPENDIX B

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APPENDIX C

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APPENDIX D

INDICATORS

Pop Growth Rate 2.35 (1990) to 1.93 (2000)
 Total Fertility Rate 4.1 (1991) to 3.1 (2000)
 Infant Mortality Rate 57 (1990) to 49 (2000)
 Maternal Mortality Ratio 209 (1990) to 190 (2000)

STRATEGIC OBJECTIVE #3**Reduced Population Growth Rate and Improved Maternal and Child Health**INDICATORS (Cont.)

Contraceptive Prevalence Rate (all methods) 40.0% (1993) to 50.5% (2000)
 Contraceptive Prevalence Rate (modern methods) 25.2% (1993) to 35.7% (2000)
 Percent of births in high risk groups 62.4% (1993) to 56% (2000)

Intermediate Result 1

Increased public sector provision of FP/MCH services

INDICATORS

Percent of Children Fully Immunized 90% (1993) to 90% (2000)
 Percent of Women Immunized Against Tetanus 70.0% (1993) to 80% (2000)
 Percent of children receiving vitamin A capsule supplement 90% (1993) to 90% (1998)
 Modern method couple years of protection (CYP) from a public sector source 1.67 million (1994) to 2.55 million (2000)
 Aggregate no. of LGUs ever enrolled in LPP 20 (1994) to 100 (1998)
 Aggregate no. of LGUs that have achieved the LPP annual benchmarks 20 (1994) to 75 (1999)
 FP/MCH sustainability enhanced by the aggregate no. of LPP LGUs that are expending IRA funds in accordance with Presidential Memorandum dated June 17, 1995 for Human Ecological Security with an increasing amount of these funds expended for FP/MCH/POP/nutrition 41 LGUs/10% (1997) to 75 LGUs/25% (2000)

Activities

- 1 LGU integrated teams develop annual plans and budgets for FP/MCH/Population activities
Benchmark Not less than 75 LGUs have developed comprehensive annual plans and budgets for FP/MCH/POP programs by December 1999
- 2 LGUs expand FP/MCH services delivery
Benchmarks 1) All LPP LGUs will provide all reversible program methods at appropriate service facilities 41 (1997) to 75 (2000) 2) No. of LPP LGUs meeting the annual FIC targets set by DOH 41 (1997) to 75 (2000) 3) No. of LPP LGUs meeting the TT targets set by DOH 41 (1997) to 75 (2000) 4) No. of LPP LGUs meeting DOH annual VAC supplementation targets 60 (1997) to 75 (1998) 5) No. of LGUs where voluntary sterilization services are available 53 (1997) to 75 (2000) 6) No. of LPP LGUs that have implemented the DOH approved IEC annual plan 41 (1997) to 75 (2000)
- 3 LGUs improve the quality of FP services
Benchmark Percent of LPP LGU public sector service sites that have personnel trained in basic FP/Compre FP or integrated FPRH 60% (1997) to 80% (2000)

Intermediate Result 2

National systems strengthened to promote and support the FP/MCH program

INDICATORS

PFPP sustainability enhanced by DOH assuming full operational responsibility for the following support functions: contraceptive distribution and logistics mgmt. FP/IEC training research and evaluation service delivery technical support and program monitoring 10% (1996) to 100% (1999)
 PFPP sustainability enhanced by increased allocation of budget for Family Planning Service by at least 50% per year P25.1M (1996) to P127.1M (2000)
 DOH release of annual LPP grants for LGU programs by June of the following year 0 (1994) to 75 (2000)
 Updated National PFPP strategy reviewed and jointly approved by DOH and POPCOM Board by November 1996
 Quality of FPRH services improved through establishment of competency based training system in LGUs participating in LPP 0 LGUs (1993) to 75 LGUs (1999)

Activities

- 1 Nationwide contraceptive distribution system strengthened
Benchmarks 1) DOH assumes full responsibility for FP contraceptive logistics management for the PFPP by the end of 1998 2) 80% of FP clinics (delivery sites) maintain at least a one month supply of oral contraceptives and condoms by the second quarter of 1999
- 2 FP/IEC program strengthened in DOH
Benchmarks 1) Revised communications strategy focusing on LGUs produced and approved by June 1996 2) National communications programs executed on a yearly basis
- 3 National FP training program strengthened
Benchmarks 1) By Sept 1996 DOH will have developed and approved a training strategy for 1996-1999 2) By June 1997 DOH will have initiated implementation of revised Basic FPRH curriculum using a competency based teaching approach 3) By Dec 1997 enriched integ FP/reproductive health curriculum for midwifery developed and implemented in 90% of midwifery schools 4) By Dec 1997 enriched integrated FP/reproductive health curriculum for nursing developed and implemented in 90% of nursing schools
- 4 Research and technical support programs strengthened at the national level
Benchmarks 1) National FP/MCH guidelines and service standards/protocols reviewed updated and disseminated by Dec 1996 2) 30 LPP/LGUs have developed capacity to manage and utilize OR studies on service delivery issues by Dec 1999 3) 6 OR studies on cross cutting issues conducted and their results disseminated by December 1999 4) DOH will develop a system by April 1996 and implement the system by June 1996 for FP/MCH assistance to LGUs
- 5 National program monitoring system strengthened
Benchmarks 1) Yearly population based FP survey conducted by NSO 2) Yearly National FP/MCH Status Report produced by DOH/OPHS 3) A national management information system to monitor FP/MCH performance in place by 1998
- 6 PFPP advocacy program strengthened at POPCOM
Benchmarks 1) National pop and devt advocacy plan (1996-2000) developed and implemented including advocacy for PFPP among professional assns 2) 1995 and 1998 post election surveys conducted to measure commitment to PFPP at the LGU level 3) No of professional assns supporting FP increased from 1 (1993) to 7 (1999)

Intermediate Result 3

Increased private sector provision of contraceptives and FP/MCH services

INDICATORS

Percent of family planning services provided by the private sector 27% (1993) to 34% (2000)

Activities

- 1 Contraceptive social marketing (CSM) program expanded
Benchmarks 1) CSM implemented in 33 urban areas by December 1999 2) Annual CYPs provided by current CSM project expanded from 28,837 in 1993 to at least 212,306 in Oct 1998
- 2 The provision of FP services in private/NGO hospitals and clinics expanded
Benchmarks 1) 135 industry based clinics have Responsible Parenthood MCH programs by December 1999 2) Between January 1997 and December 1999 USAID assisted NGO affiliated services (PCPD JSI CARE) will provide at least 601,171 CYPs (cumulative) including CYPs for completed referrals
- 3 The role of the private sector on the PFPP enhanced
Benchmarks 1) Situational analysis on the involvement of the private commercial sector in FP services developed by June 1996 2) Studies conducted on factors that affect private sector participation including market segmentation legal and regulatory issues and the feasibility of re-targeting public sector facilities on low income and underserved areas 3) At least 2 policy reforms identified in the studies are adopted by December 1998

DATA BASELINES

- * Demographic Health Surveys 5 yrs
- * Safe Motherhood Surveys 5 yrs
- * Annual Population Surveys 1 yr
- * Population Census 10 yrs
- * Intercensal Surveys 5 yrs

APPENDIX E

LGUs Enrolled in LPP

| Region | 1994 LGUs (1st Batch) | 1995 LGUs (2nd Batch) | 1996 LGUs (3rd Batch) | 1997 LGUs (4th Batch) | 1998 LGUs (5th Batch) | Total |
|--------|---|------------------------------------|--|---|--------------------------------------|---------|
| CAR | Baguio City | Benguet | | Mt Province | Ifugao | 4 |
| I | Pangasinan | | Ilocos Union Ilocos Sur | | | 3 |
| II | Isabela | Cagayan | | Nueva Viscaya | | 3 |
| III | Bulacan, Pampanga | Nueva Ecija* Tarlac | Bataan | Zambales | Angeles City Olongapo City | 8 |
| IV | Batangas* Laguna* | | Cavite Palawan | Quezon Rizal Or Mindoro Occ Mindoro | Romblon Lucena City Marinduque | 11 |
| NCR | | | Quezon City Pasay City Muntinlupa Marikina Pasig | Manila Mandaluyong Valenzuela | Las Piñas Parañaque Caloocan | 11 |
| V | Camarines Sur* | Albay | Masbate | Sorsogon Camarines Norte | Catanduanes | 6 |
| VI | Iloilo Province Negros Occidental Iloilo City Bacolod City | | Capiz | Antique Aklan | Guimaras | 8 |
| VII | Cebu City Cebu Province | | Negros Oriental Bohol | | | 4 |
| VIII | Leyte | | | North Samar Western Samar Eastern Samar | | 4 |
| IX | Zamboanga City Zamboanga Sur | | | Zamboanga Norte | Basilan | 4 |
| X | | Bukidnon Cagayan de Oro City | Mis Occidental Mis Oriental | | Camiguin | 5 |
| XI | Davao City Davao Norte South Cotabato | Davao Del Sur | Davao Oriental | | Gen Santos City Sarangani | 7 |
| XII | | North Cotabato | | Sultan Kudarat Lanao Norte | Iligan City | 4 |
| XIII | | | Sungao Norte Sungao Sur | Agusan Sur | Agusan Norte Butuan City | 5 |
| ARMM | | Maguindanao | | | Tawi-tawi | 2 |
| Total | 20 | 10 | 19 | 21 | 19 | 89-4=85 |
| Visits | 7 | 2 | 6 | | | |

Note * indicates 4 dropped LGUs, shaded text indicates LGUs visited by team

APPENDIX F

DOH/LPP Benchmarks

LGUs' Performance (1997)

- 1 Plan No less than 60 LGUs have developed their comprehensive annual plans for FP/MCH/Population Programs for 1998
 - Accomplishment Report (January-September 1997)
 - 1998-1999 LPP Comprehensive Plan Developed
 - Plan Endorsed by LCE
- 2 Admin Order Newly selected LPP LGUs should have an Administrative Order or any similar official document signed and issued by LGU Chief Executive specifying the roles and responsibilities of the LGU's Health and Population Offices/Staff in the management and implementation of the Population, Family Planning and Child Survival Programs
- 3 CDLMIS No less than 60 LPP LGUs
 - Newly selected LGUs have an operational Contraceptive Distribution and Management Information System (CDLMIS)
 - Continuing LGUs have at least 80 percent of contraceptive delivery points with at least one month supply of oral contraceptives and condoms at the time of supplies delivery
- 4 Training At least 41 LGUs will have ___ percent of their health facilities with personnel trained on Basic FP, FP/RH or equivalent and equipped appropriately (Batch 1 = 80%, Batch 2 = 70%, Batch 3 = 60%)
- 5 IEC Plan At least 41 LGUs have implemented the 1997 IEC plan approved by DOH-OSC
- 6 VS VS services are available in not less than 41 LPP LGUs
 - No hospitals with trained team
 - No hospitals with refurbished OR
 - No hospitals with adequate drugs/medications
 - No hospitals providing VS services
 - OR
 - No hospitals providing VS services
 - Referral system established
 - No hospitals that have submitted report (required for all)
- 7 Survey A 1997 Integrated FP/MCH cluster survey has been conducted in at least 41 LPP LGUs Results required
 - CPR
 - FIC
 - TT2
 - VAC
- 8 VAC At least 41 LPP LGUs will have at least 90% coverage for Vitamin A capsule supplementation

Source LGU Performance Program Component Benchmarks DOH Office of the Secretary December 3 1997

LGUs' Performance (1998-2000)

- 1 Plan** Same as 1997 except for number of LGUs
- 1998 No less than 19 new LGUs develop plan for 1999-2000
 - 1999 No less than 56 LGUs develop plan for 2000
 - 2000 No less than 75 LGUs reprogram 2000 plans
- 2 Admin Order** Same as 1997 for "all newly selected LPP LGUs," which is 19 Not applicable for 1999 and 2000
- 3 1 CDLMIS** Same as 1997
- 1998 Newly selected LGUs (19) have an operational CDLMIS NA in 1999 and 2000
 - Continuing LGUs have at least ___ of contraceptive delivery points with at least one month supply of oral contraceptives and condoms at the time of supplies delivery
 - 1998 ≥60 LGUs, 1st and 2nd batches ≥90%, 3rd and 4th batches ≥80%
 - 1999 ≥75 LGUs, 1st, 2nd and 3rd batches ≥90%, 4th and 5th batches ≥80% (add IUDs and DMPA)
 - 2000 ≥75 LGUs, 1st, 2nd, 3rd and 4th batches ≥90%, 5th batch ≥80% (add IUDs and DMPA)
- 3 2 Training** Same as 1997
- 1998 ≥60 LGUs 1st and 2nd batches ≥80%, 3rd and 4th batches ≥70%
- 1999 ≥75 LGUs 1st - 2nd batches ≥90%, 3rd - 4th batches ≥80% ≥5th ≥70%
- 2000 ≥75 LGUs 1st, 2nd, 3rd and 4th batches ≥90%, 5th batch ≥80%
- 4 IEC Plan** Same as 1997
- 1998 ≥60 LGUs implement 1998 IEC plan
- 1999 ≥75 LGUs implement 1999 IEC plan
- 2000 ≥75 LGUs implement 2000 IEC plan
- 5 VS** Same VS services are available in not less than ___ LPP LGUs
- 1998 60 LGUs, 1999 75 LGUs, 2000 75 LGUs
- 6 FIC** 1998 New LGU conduct MICS
- 1998-2000 (All) Continuing LGUs meet FIC coverage Targets
- ≥15% increase if coverage ≤79%
 - ≥10% increase if coverage 80-89%
 - maintain same level if coverage ≥90%
- 7 TT2+** 1998 New LGU conduct MICS
- 1998-2000 (All) Continuing LGUs meet FIC coverage Targets
- ≥15% increase if coverage ≤59%
 - ≥10% increase if coverage 60-69%
 - maintain same level if coverage ≥80%
- 8 VAC** At least ___ LPP LGUs will have at least 90% coverage for Vitamin A capsule supplementation 1998 60 LGUs 1999 75 LGUs 2000 75 LGUs

Source USAID Joint Project Implementation Letter No 17 dated Jan 20 1998

APPENDIX G

DOH/LPP-Level 1997 Benchmark Achievement

| | 1997* |
|---|-------|
| 1 Comprehensive Plan Developed (≥ 60) | 66/67 |
| • Accomplishment Report | 45/46 |
| • 1998-1999 Comprehensive Plan | 66/67 |
| • Plan Endorsed | 66/67 |
| 2 Administrative Order Issued (New LGUs) | 21/21 |
| 3 CDLMIS (≥ 60) | 67/67 |
| • New LGU operational system | 21/21 |
| • Continuing 80% CDPs have 1 month stock | 46/46 |
| 4 Trained staff (≥ 41) | 45/46 |
| • First batch 80% | 17/17 |
| • Second batch 70% | 9/10 |
| • Third batch 60% | 19/19 |
| 5 IEC Plan implemented (≥ 41) | 45/46 |
| 6 VS services available (≥ 41) | 45/46 |
| 7 Cluster Survey conducted (≥ 41) | 45/46 |
| • CPR | 45/46 |
| • FIC | 45/46 |
| • TT2 | 45/46 |
| • VAC | 45/46 |
| 8 VAC coverage (≥ 90%) | 46/46 |
| No LPP LGUs fully meeting benchmarks | 66/67 |
| • First batch | 17/17 |
| • Second batch | 9/10 |
| • Third batch | 18/18 |
| • New | 21/21 |

*Source 1997 IFPMHP Performance Review, December 9, 1997, Hyatt Regency Hotel, Manila

APPENDIX H

LGU Benchmarks

A Startup LGU (1994-1998)

- | | |
|---------------|---|
| 1 Plan | A Comprehensive Plan on Population, Family Planning and Selected Child Survival Programs (EPI, CDD, CARI, Micronutrient Supplementation) approved by DOH-OSC |
| 2 CDLMIS | Contraceptive Distribution and Management Information System is operational |
| 3 Admin Order | Issuance of an Administrative Order by the LGU Chief Executive specifying the roles and responsibilities of the LGU's Health and Population Offices/Staff in the management and implementation of the Population, Family Planning and Child Survival Programs |

B Continuing LGUs (1995)

- | | |
|-----------------|---|
| 1 Plan | Same (1996 Plan) |
| 2 Condoms/Pills | At least 80 percent of LGU contraceptive delivery points will have at least one month supply of Lo Gentrol and condoms at the time of supplies delivery |
| 3 MIS | A system for data collection and reporting for FP, EPI, CDD, CARI and Micronutrients is in place and functioning |
| 4 Procurement | An LGU procurement system that tracks and records the progress of LPP-funded procurement requests is in place and functioning |
| 5 Training | At least 75 percent of the health and population trainees for LPP-funded training have been trained by the LGU |

C Continuing LGUs (1996)

- | | |
|-----------------|---|
| 1 Plan | Same (1997 Plan) |
| 2 Condoms/Pills | Same |
| 3 MIS | Same |
| 4 Procurement | Same |
| 5 Training | By September 15, 1996 a) at least 50% of the facilities with untrained staff on specified courses on FP and CSP as of January 1, 1996 should have trained staff, b) at least 50% of untrained Population Officers on specified courses as of January 1, 1996 have been trained and c) status of training related to Natural Family Planning has been reported |

D Continuing LGUs (1997)

- | | |
|-----------------|---|
| 1 Plan | Same (1998-1999 Plan) |
| 2 Condoms/Pills | Same (except oral contraceptives in place of Lo Gentrol) |
| 3 Training | At least ___ percent of all health facilities in the LGU have personnel trained on Basic FP FP/RH or equivalent and equipped appropriately (Batch 1 = 80% Batch 2 = 70%, Batch 3 = 60%) |
| 4 IEC Plan | The LGU has implemented the 1997 IEC plan approved by DOH |

- 5 VS VS services are available in the LGU
- 6 Survey The 1997 Integrated FP/MCH cluster survey conducted in the LGU
- 7 VAC The LGU has at least 90% coverage of Vitamin A capsule supplementation

E Continuing LGUs (1998)

- 1 Plan Same (1999-2000 Plan)
- 2 Condoms/Pills At least ___% of all contraceptive delivery points have at least one month stock of oral contraceptives, condoms, IUDs and DMPA at the time of supplies delivery (Batch #1 ≥ 90%, #2 ≥ 90%, #3 ≥ 80%, #4 ≥ 80%)
- 3 Training At least ___ percent of all health facilities in the LGU have personnel trained on Basic FP, FP/RH or equivalent and equipped appropriately (Batch #1 ≥ 80%, #2 ≥ 80%, #3 ≥ 70%, #4 ≥ 70%)
- 4 IEC Plan Same (1998 Plan)
- 5 VS Same
- 6 FIC* The LGU has met the annual fully-immunized child (FIC) targets (10% increase if coverage 80-89%, 15% if ≤ 79%, maintain if ≥ 90%)
- 7 TT* The LGU has met the annual TT+ targets (increase ≥ 10% if already 60-79%, increase ≥ 15% if ≤ 59%, maintain if ≥ 80%)
- 8 VAC* The LGU has at least 90% coverage of Vitamin A capsule supplementation

* Current coverage level based on 1997 Multi-indicator Cluster Survey, not service statistics

F Continuing LGUs (1999)

- 1 Plan Same (2000 Plan)
- 2 Condoms/Pills At least ___% of all contraceptive delivery points have at least one month stock of oral contraceptives, condoms, IUDs and DMPA at the time of supplies delivery (Batch #1 ≥ 90%, #2 ≥ 90%, #3 ≥ 90%, #4 ≥ 80%, #5 = 80%)
- 3 Training At least ___ percent of all health facilities in the LGU have personnel trained on Basic FP, FP/RH or equivalent and equipped appropriately (Batch #1 ≥ 90%, #2 ≥ 90%, #3 ≥ 80% #4 ≥ 80% #5 ≥ 70%)
- 4 IEC Plan Same (1999 Plan)
- 5 VS Same
- 6 FIC* The LGU has met the annual fully-immunized child (FIC) targets (10% increase if coverage 80-89%, 15% if ≤ 79% maintain if ≥ 90%)
- 7 TT* The LGU has met the annual TT+ targets (increase ≥ 10% if already 60-79%, increase ≥ 15% if ≤ 59%, maintain if ≥ 80%)
- 8 VAC* The LGU has at least 90% coverage of Vitamin A capsule supplementation

* Current coverage level based on 1997 Multi-indicator Cluster Survey not service statistics

APPENDIX I

LGU-Level Benchmarks 1997 Baseline and Targets for 1998-1999

LGUs Visited by the Team Shaded cells indicate targets that the team believes may be difficult to reach

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
|--------------|-------------|------------|-------------|-------------|-----------|-----------|-----------|------------|------------|-----------|-----------|-----------|------------|-----------|------------|
| LGU Name | PangasinanP | Davao City | Iloilo Prov | Iloilo City | Cebu Prov | Cebu City | CotabatoP | Albay Prov | Leyte Prov | Cavite Pr | Malabon C | LaUnion P | Capiz Prov | Misa OrPr | Pasig City |
| Year started | 1994 | 1994 | 1994 | 1994 | 1994 | 1994 | 1995 | 1995 | 1995 | 1996 | 1996 | 1996 | 1996 | 1996 | 1996 |

1997 Baseline

| | | | | | | | | | | | | | | | | |
|-----------------|------|------|------|-------|------|-------|------|------|------|------|------|------|------|------|------|---|
| 1 Plan | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 2 Condnms/Pills | 89.9 | 91.7 | 81.7 | 100.0 | 96.6 | 100.0 | 87.5 | 93.0 | 84.5 | 83.8 | 100 | 80.7 | 88.9 | 93.3 | 88.6 | |
| 3 Training | 85.1 | 88.1 | 85.7 | 90.2 | 94.6 | 95.9 | 72.3 | 71.2 | 86.4 | 78.1 | 83.3 | 61.4 | 60.2 | 59.8 | 60.5 | |
| 4 IEC Plan | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 5 VS | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 6 FIC | 67.1 | 93.6 | 88.1 | 85.0 | 77.7 | 81.0 | 80.0 | 80.4 | 80.5 | 78.7 | 89.0 | 62.1 | 81.1 | 82.9 | 77.4 | |
| 7 TT2+ | 56.0 | 66.6 | 84.0 | 85.2 | 84.4 | 82.5 | 82.0 | 69.1 | 48.7 | 61.9 | 56.7 | 73.0 | 82.7 | 87.0 | 57.0 | |
| 8 VAC | 95.0 | 97.0 | 97.8 | 96.7 | 94.2 | 99.0 | 93.0 | 91.2 | 94.5 | 94.1 | 97.0 | 93.6 | 97.5 | 96.4 | 96.7 | |

1998 Target

| | | | | | | | | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1 Plan | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 2 Condnms/Pills | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 80 | 80 | 80 | 90 | 90 | 90 | 90 |
| 3 Training | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 70 | 70 | 70 | 80 | 80 | 80 | 80 |
| 4 IEC Plan | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 5 VS | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 6 FIC | ≥82.1 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥77.1 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 |
| 7 TT2+ | ≥71.0 | ≥76.6 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥79.1 | ≥63.7 | ≥71.9 | ≥71.7 | ≥80.0 | ≥80.0 | ≥65.4 | ≥72.0 | ≥90.0 |
| 8 VAC | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 |

1999 Target

| | | | | | | | | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1 Plan | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 2 Condnms/Pills | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 |
| 3 Training | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 80 | 80 | 80 | 90 | 90 | 90 | 90 |
| 4 IEC Plan | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 5 VS | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| 6 FIC* | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 | ≥90.0 |
| 7 TT2+ | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥73.7 | ≥80.0 | ≥80.0 | ≥80.0 | ≥80.0 | ≥75.4 | ≥80.0 | ≥80.0 |
| 8 VAC | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 | ≥90 |

Note: This table assumes that the 1998-1999 benchmarks will be revised to a set targets at a maximum of 90% for FIC and 80% for TT2+

APPENDIX J

Suggestions for LPP Benchmarking and Performance Measurement

Benchmarks

A “bench mark” (two words in the dictionary) is defined as “a standard or reference by which others can be measured or judged” Bench marks are usually quantified (inches, liters, pounds, etc) and may have a tolerance level (13 cm +/- 0001 mm) In USAID’s usage benchmarks (one word) are often qualitative (implement a plan, set up a CDLMIS) and define minimum levels of achievement (at least 1.5 million CYPs, FIC of 90 percent)

The quantitative benchmarks set for LPP fall into three categories

- 1 Those that set a standard level of achievement for all LGUs (e.g., at least 90% coverage of VAC)
- 2 Those that set a range by LGU batch (e.g., at least ___% of health facilities have trained personnel Batch 1 = 80%, Batch 2 = 80%, Batch 3 = 70%, etc)
- 3 Those that set a range by current level of coverage (e.g., at least ___ increase in FIC coverage 15% if coverage is \leq 79%, 10% if coverage is 80-89%, maintain if coverage is \geq 90%)

The first and second type of benchmark would be fine as long as every LGU has a realistic chance of reaching the level specified But this is not always the case LGUs with high levels of trained staff might not have a problem reaching 80%, but those with low levels might Vitamin A was thought to be above 90% everywhere But the MICS shows that four LGUs are below 90% (77.1, 87.9, 88.8 and 89.2) Four others are less than three points above 90% (91.2, 91.7, 92.1, 92.7) They could easily miss the cutoff point

The third type of benchmark is defined in ranges that result in such inconsistencies as were described in Chapter 3 For example, an LGU at 79% has to reach 94%, while one at 80% only has to reach 90% An LGU at 89% would have to reach 99%, which is a practical impossibility We are assuming that this was unintentional and that this type of benchmark will be revised to set a maximum numerical target of 80 percent for TT2+ and 90 percent for FIC The word “maintain” should be deleted or qualified, since it means that an LGU that reached 95% has to “maintain” 95% The following is an example of how this type of target could be reworded

The LGU should have at least ___%*** FIC coverage

- ***
- a) For those LGUs with \geq 90% coverage, maintain at least 90%
 - b) For those LGUs with 80-89% coverage, achieve at least 90%
 - c) For those LGUs with less than 80% coverage, a 15 percentage point increase or 90%, whichever is less

However, the Team does not believe that it would be better to negotiate benchmarks individually with each LGU. This would allow the DOH and LGU to come to a mutual agreement that would give all LGUs a reasonable chance of meeting their benchmarks. It would also help remove one of the “top-down” irritants that some of the LGUs have complained about.

Setting individual benchmarks need not require extra effort. It can be done in conjunction with the development and approval of the annual plans and included in the MOA amendments (as they are now). The LGUs wouldn't have any problems with their qualitative benchmarks. They have always been able to meet those. Since many of the LGUs have high performance figures on their quantitative benchmarks, they would not be worried about achieving high targets. The benchmarks that would be most subject to negotiation would be the three coverage benchmarks (TT2+, FIC and VAC) that have low baselines.

This would also be a good time to introduce a true performance range, which could be financed from the “windfall” expected this year. Instead of a single figure, the benchmarks could cover a range, with varying levels of awards for each level of achievement. For example, Cavite's baseline for FIC is 78.7%. The LPP could set a range of targets: 75% minimum to stay in the program, 79% to receive an additional P100,000, 84% to receive an additional P 250,000. A variation would be to provide a specified amount, say P50,000, for every point above 75%. Although we do not advocate penalties, they could be imposed for underachievement, if need be. That is, instead of being dropped from the program the LGU could be “fined” P100,000 for missing a target. This could be deducted from the next base grant. This type of arrangement, combined with intensive technical assistance to those LGUs in serious trouble of not meeting a benchmark, should ensure that all LGUs that are motivated to succeed will be able to meet all of their benchmarks.

Performance Measures and the Cluster Surveys

The performance measures for the three coverage benchmarks need to be consistently defined and standardized. The most serious problems are that the target groups are not the same across data sources and that the surveys do not measure current year performance. The following are the various definitions used for VAC, TT and FIC.

Vitamin A The MICS sample for Vitamin A is “children under five who received Vitamin A at least once in their lifetime.” This indicator will yield the greatest achievement figure. The FETP cluster surveys, which are used by USAID to assess national coverage (for the SO3) is defined as “the percent of children between 12-59 months receiving Vitamin A capsules during the National Micronutrient Day (ASAP).” The DOH provides Vitamin A to all children under five, largely, but not exclusively, on that same day. Thus, to raise performance, health center staff can add in those children under five (0-59 months) who are given VAC on other days throughout the year.

Tetanus Toxoid The MICS sample is of “children 12-59 months whose mother was given two or more doses of TTV during and prior to pregnancy with the reference child.” The NDS definition (which was used by USAID for the national baseline of 1993) is “percent of live births in the past five years in which two or more doses were received during the corresponding pregnancy.” The MCH Rider Survey (used by USAID to assess national performance) is “the

percent of surviving children under age 3 whose mother received two or more TTV during the corresponding pregnancy” A second definition used to get a “more accurate” measure for estimating protection of the children under age 3 rather than the mother is “1) at least two doses of TTV during pregnancy with the reference child, OR 2) one dose during pregnancy plus at least two doses prior to pregnancy, OR 3) at least three doses prior to pregnancy The DOH service statistics system uses “percent of pregnant women who have received two or more doses of TTV without regard for timing”

FIC The target group in the MICS is children 12-59 months who were vaccinated before their first birthday This is a measure of the immunization status of the cohort of children under five The Rider Surveys and the NDS respondents are 12-23 months This is a measure of the status of one-year old children The DOH service statistics report on children under one year of age

Measuring performance FIC as an example It would probably be better for the MICS to redefine its FIC sample to conform to the Rider and NDS samples That is, children 12-23 months This would ensure that the surveys are comparable

However, this does not solve the problem of being out of synch with the LGU’s immunization program The surveys measure the performance in the previous year, not the current year If the program year is January to December 1998 and the MICS is conducted in January 1999 the youngest respondent will be 12 and the oldest 23 months old That is, they would all have been born between January and December 1997 Thus, there is nothing the LGU can do in 1998 to improve 1998 performance The surveys will always measure the previous year’s performance In this case, 1997 This “lag” characteristic is not a significant problem in most DHS-type surveys because it is not linked to performance It is a serious problem for LPP because the whole idea is to link program effort with achievement -

There is nothing that can be done to modify the sampling design to make it measure current year performance because very few children born in 1998 would be fully immunized in 1998 Thus, if surveys are going to be used to measure performance, then everyone must accept that the performance that is being measured is for the previous year and not the current year That is, it will not be possible to measure current performance via surveys

The only feasible way to make sure that the performance data coincide with the program year is to use DOH service statistics The Team realizes that service statistics have significant limitations and that this may seem to be a step backwards But there may be no realistic alternative Some improvements have been made recently in the FHSIS, which begins with target client lists for all of the LPP client groups (pregnant women, newborns, FP users) Improvements in this area could provide the denominators needed to set program and benchmark targets The national/regional authorities would have to set up a validation system to ensure that local targets are as close to their actual target populations as possible This could be done through spot checks or rapid sampling of client lists It would still be useful to conduct occasional cluster surveys to validate these data and to assess the impact of LPP efforts on coverage

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There are several advantages to basing performance on this type of data. The most important is the linkage. LGU staff would have the opportunity to affect the performance data. They could increase efforts to find and fully immunize as many children as possible and be certain that this effort would be reflected in the year's performance data. They would have more control over their performance, since they would know exactly where to go and what to do to increase performance. Program staff would be able to carry out program activities over the entire year, while the cluster surveys have to be conducted at mid-year in order to have the results available in October. Finally, the LGUs would not have to use their limited LPP funds on the surveys (which will total P15-19 million by 1999).

APPENDIX K

Coverage Worksheet

Cluster Survey Respondent Requirements to Meet Coverage Targets

| Scenario No 1 | | | Current Coverage | Target Coverage | Maximum Coverage |
|---------------|----------|----------|------------------|-----------------|------------------|
| B | C | D | E | F | G |
| Age (mo) | Sample N | Sample % | 80% | 90% | 85% |
| 12-23 | 232 5 | 25% | 186 | 279 | 232 5 |
| 24-35 | 232 5 | 25% | 186 | 186 | 186 |
| 36-47 | 232 5 | 25% | 186 | 186 | 186 |
| 48-59 | 232 5 | 25% | 186 | 186 | 186 |
| Total | 930 | 100% | 744 | 837 | 790 5 |
| Check | 930 | | 744 | 837 | 790 5 |

Note Only shaded cells can be changed All others are protected

This table shows the distribution of respondents in a cluster survey designed to measure FIC coverage. This survey is designed to gather data from children aged 12-59 months. This type of survey would also apply to TT2+ and perhaps VAC. Fifteen respondents are interviewed in 62 "clusters," for a total sample size of 930. Women with children between 12-59 months are asked, for example, if their youngest child was fully immunized before its first birthday. The coverage estimate is calculated by dividing the number who answer "yes" by the total number of respondents (930 less any disqualified). To achieve 80 percent coverage 744 "yes" responses would be needed. For 90 percent coverage it would be 837, and so forth.

The only way that a program can increase coverage is by increasing the proportion of children immunized before their first birthday. When a cluster sample is drawn, those children are not included. That means that the program cannot do anything in the current year to affect the survey's estimate of coverage. It can only influence the estimate that will be made in the following year. At that time the 0-11 children that it immunizes will be 12-23 months old and will be included in the sample. However, even then the program's influence on survey results will be small because 75% of the sample will be older than 23 months.

This spreadsheet can be used to determine the number of "yes" responses required from children 12-23 months to achieve any given target in a typical 12-59 sample. Set the current coverage percentage in column E (cell E4) and the target percentage in Column F (cell F4). Press F9 to calculate the number of "yes" respondents needed to reach the target (cell F5). In the example shown, the number required (279) is greater than the number of respondents available (233). The maximum coverage attainable with 237 positive responses is shown in Column G (cell G4), which in this example is 85 percent.

The example assumes an equal distribution of respondents for each year. It is more likely that because of attrition there will be more respondents in the most recent years. You can change the percentage figures in Column D as you wish to test other distributions. Just make sure that the total (Cell D9) adds to 100%. You can also change the sample size by changing the total in cell C9 (which is now set at 930).

APPENDIX L

LPP Management Processes, Actors and Tools

| Processes | Actors | Tools |
|---|---|--|
| Selection of LGUs | Project Director (SEC Reodica)/Coordinator (ASEC Infanteado) USAID PMT NTAT MSH/PMO | Memorandum of Agreement for the LGU Performance Program (LPP) Administrative Order (Benchmark #3) LPP MOA and Implementing Guidelines (Session #1, Orientation Workshop on the LPP Implementing Guidelines) |
| Orientation of LCEs and LGUs Benchmark Selection | NTAT, RTAT, MSH/PMO PMT/NTAT MSH/PMO USAID | Guidelines for Orienting LGU for Implementation |
| Plan Development | PMT/NTAT MSH/PMO RMT/RTAT Prov'l LPP Coordinator LCE occasionally Prov'l Case Managers Prov'l LPP Management Teams | General Guide in Accomplishing LGU Performance Program (LPP) Forms Situation Analysis (SA) Guide and LPP Forms Attachment D Summary of Documentation Requirements from LGUs per Performance Benchmarks Memorandum of Agreement for the LGU Performance Program (LPP) Plan Review Guide (LPP) |

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|-------------------------------|---|--|
| Implementation and Monitoring | <p>NTAT/RTAT PMO/MSH <u>Regional LPP Coordinator/Point person (monitoring)</u> Reg'l/Prov'l FP/MCH Program Managers Reg'l/Prov'l Population Officers <u>Rural Health Units/BHS (implementation)</u> occasionally LGU Administrative staff and others(budget, accounting, general services, office of the governor, <i>Sanggumani</i>,) DOH Representatives LGAMS Coordinator RESU LCE</p> | <p>LPP Monitoring Guidelines (Session #2, Orientation Workshop on the LPP Implementing Guidelines) <i>Start-up LPP Monitoring Form for the LGUs</i> <i>National LPP Monitoring Form for the Region (attachment F)</i> <i>LPP Monitoring Guidelines - Regional Level (Session #3, Orientation Workshop on the LPP Implementing Guidelines)</i> <i>LGU Tracking Form (attachment C-1)</i> <i>Quarterly Status Report on the LGU Performance Benchmarks (Attachment E1)</i> <i>Revised CDLMIS Field Monitoring Checklist (for monitoring RHUs MHC, Hospitals, NGOs, and GO FP Facilities)</i> <i>Accomplishment Report on FHSIS Submission or Similar Report by Quarter (LPP form 3 1)</i> <i>Procurement Accomplishment Report (LPP Form 4)</i> <i>LGU Operation Plan for 1997 (Plan Worksheet #2)</i> <i>Budget Details for LPP Funded Activities (Worksheet #4)</i> <i>LPP Budget Summary and LGU Budget (Worksheet #5)</i> <i>LGU Population and Health Budget (Worksheet #6)</i></p> |
| Assessment | <p>PMT NTAT/RTAT MSH/PMO USAID LCE</p> | <p><i>Detailed Assessment of LGU Performance</i> <i>Annual Performance Program Accomplishment Report</i> <i>Fund Utilization Report (Attachment B 3)</i></p> |
| Disbursement | <p>LCE <u>Provincial LPP Coordinator</u> <i>Sanggumani</i> LGU Budget/Accounting staff</p> | <p><i>Memorandum of Agreement signed by LGU/DOH</i> <i>Certification of Availability of Funds</i></p> |
| Procurement | <p>Provincial LPP Coordinator FP/MCH/Population managers LGU PBAC <u>LGU Budget, Accounting, General Services, Office of the Governor</u></p> | <p><i>Purchase Request</i> <i>Bidding forms</i> <i>Notice of Award</i> <i>Purchase Order</i> <i>Acceptance</i> <i>Vouchers for Payment</i> <i>Memorandum Receipt</i></p> |
| Reporting and Documentation | <p>PMT NTAT/RTAT USAID MSH/PMO LPP Coordinator FP/MCH/Population technical staff</p> | <p><i>Certification of Benchmark Accomplishment</i> <i>Annual DOH-USAID Benchmark Review Documents</i></p> |

| | | |
|-----------------|---|---|
| Cluster Surveys | MSH/PMO RTAT <u>Provincial LPP Coordinator</u> LGU Budget, Accounting, General Services, Office of the Governor LGU PBAC Survey Institution | <i>Cluster Survey Guidelines</i> <i>Bidding Documents</i> <i>Proposals</i> <i>Notice of Award/Contract Award</i> <i>Preliminary Report</i> <i>Final Report</i> |
|-----------------|---|---|

* Leader underlined