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**THE CHILD SURVIVAL PROGRAM**

**MID-TERM EVALUATION**

**NOVEMBER, 1991**

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## EXECUTIVE SUMMARY

The Child Survival Program (CSP) is a sector assistance program supporting policy and institutional reforms to expand and strengthen child survival-related health services. CSP began in late 1989 and is scheduled for completion in March, 1994. The purpose of this mid-term evaluation is to suggest how CSP can work toward sustaining improvements in child survival-related services.

The evaluation is exceedingly positive about the accomplishments of the DOH in implementing policy and institutional reforms. These actions have the potential for significantly improving service delivery, particularly in underserved areas. The pace at which the reforms have proceeded is impressive and reflects the DOH's very strong ownership of the program. Collaboration between the DOH and USAID is equally impressive. However, the reforms enacted to date and their effects on management and service delivery systems are far from being fully institutionalized as standard operating procedures, particularly at the provincial level. What has been accomplished thus far could be quickly lost if support for this long-term process is prematurely terminated. Therefore, the major recommendation of the evaluation is to amend the current program, extend the completion date by two years and increase funding by at least \$25 million for additional performance disbursements and continued technical assistance.

The focus on priority provinces was a useful starting point for implementing reforms and providing assistance to the most underserved provinces first. However, continued emphasis on priority provinces is neither operationally nor politically viable for the DOH over the longer term. The priority province concept should be allowed to "die a natural death" as all provinces are included in the planning, budgeting and management systems being implemented under the CSP policy matrix. All other elements of the CSP goal, purpose and strategy remain valid and useful.

The benchmarks that lead to the accomplishment of policy and institutional reform objectives have been reasonable and intelligent steps in support of this process. No additional benchmarks are recommended for the current program, but new benchmarks will be necessary if the program is amended. The only problematic area has been the health care financing and private sector involvement benchmarks. Initial estimates of what could be accomplished in these areas by 1991 were overly optimistic. CSP managers rightly modified these benchmarks, and USAID senior management is encouraged to view CSP's policy matrix more flexibly.

Overall, DOH and USAID program management has been very sound, particularly in their collaboration on program management and in developing a thorough program performance monitoring system. However, the DOH and USAID need to determine whether the current level of effort directed to benchmark documentation is warranted.

One of the most important effects of CSP over the past two years has been DOH's use of the program to implement numerous management improvements in support of child survival objectives. The team found ample evidence that field offices have taken the area-based planning process very seriously. Training funded through CSP has been instrumental. These plans have helped to target child survival services on areas most in need. The quality of the plans of seventy-five provinces needed to revise their 1991 plans because they initially failed to meet quality standards. A Core Group has been organized and trained to assist provincial offices with program planning.

Field personnel report that the planning improvements have been useful but initially very time consuming. The plans produce more meaningful strategies and budget estimates. However, budget allocations are not adequate to support planned levels of activity, there is no consistent linkage between planned achievements and actual results and service delivery targets are largely determined by central program offices. Changes in planning guidelines have produced confusion; a sense of ownership of the planning process is still uneven among DOH/Manila and provincial staff; and use of the plans as operational guides is still inadequate.

The evaluation recommends: a) strengthening the Core Group function, b) continuing the use of augmentation budgets to improve planning quality, c) increasing the responsibility of central program offices for planning quality, d) developing provincial plans under different budget level assumptions.

Provincial health officers are better able to relate annual plans to resource allocations than in the past, but they see this connection largely based on CSP augmentation budgets as opposed to total resource allocations. Planning and budgeting has also not been linked to actual service delivery performance or strategic improvements. However, CSP demonstrates that benchmarks and their linkage to budget allocations can be an effective management tool for the DOH. Work on financial modeling has also heightened staff awareness about program cost requirements for annual planning. The evaluation recommends that the DOH/Manila should: a) provide each province a complete accounting of resources for child survival, b)

explore how a benchmark approach could guide the future relationship between the central and provincial health offices and c) encourage wider use of financial models for annual provincial planning.

Monitoring and supervision are becoming increasingly important in the emerging DOH management system. CSP has contributed to improvements in these functions, but further upgrading is necessary, especially in light of the Local Government Code. FHSIS needs to give greater support in its management information role to monitoring and supervision requirements.

CSP support for service integration has encouraged considerably greater collaboration among DOH offices, especially in the area-based planning exercise. However, field training continues to be program-specific, as are service delivery targets. At this point, integration of services involves changes in perceptions and attitudes of health workers to a much greater extent than organizational changes. Recognition and rewards need to be directed to efforts that integrate service delivery. CSP-supported activities, such as the Integrated IEC kit for midwives, should be given higher priority for completion.

The evaluation team found that modest improvements in child survival-related services resulting from CSP support were occurring. These improvements have principally involved quantitative increases in numbers of clients and area of coverage. The team found no clear evidence of systematic qualitative improvements in services which will be necessary to achieve a sustainable improvement in services. Moreover, progress to date could be quickly reversed if support for CSP is prematurely terminated.

CSP needs to initiate or accelerate several actions to improve child survival-related services. These include:

- a) Issue a compendium of CSP guidelines which includes drug protocols, program memoranda, administrative orders, procedures for area-based planning, standards for child survival-related services, and monitoring and supervision materials.
- b) Orient future training programs to emphasize the integration of child survival services and systems.
- c) Develop a logical sequence to the provision of skills training.

- d) Keep track of the training that individuals have received and identify minimum skills training for categories of health workers.
- e) Work toward developing a logical, well-organized series of training materials and curricula.
- f) Include the PHDP midwives in 1992 budget allocations for training.
- g) Distribute the IEC Midwife Kit as quickly as possible. Obtain additional technical assistance if necessary.
- h) Issue an official DOH recognition of the important role played by BHWS.
- i) Explore the possibilities for expanding the training of hilots so that they can provide services in addition to safe motherhood.
- j) Develop guidelines which provincial health offices can adapt to local circumstances on involving NGOs in the child survival program.

Nine service delivery indicators were established as measures of program success. The evaluation team believes these targets can be reached; however, the more important issue is whether the indicators are: a) epidemiologically valid; b) managerially useful at the level of delivery; c) reflective of the quality of services delivered; d) promotive of integration; e) accurate surrogates for positive impact on health; and f) faithful to the capacity of the DOH system at all levels to support them. Most of the present indicators fail in one or more of these attributes.

The weaknesses in the indicators are detailed in the report and recommendations for making these measures more useful for management purposes, as well as epidemiologically valid, are provided. The evaluation recommends that the DOH and USAID, assisted by the technical assistance team, continue its work in reviewing the current indicators, the way they are computed, and the associated data collection procedures. Changes in baseline measures and the targets for the indicators as previously identified by the DOH, are warranted for several of the indicators. In the future, greater attention needs to be directed toward using measures of quality improvement in services to judge program performance and progress toward sustainability.

Generalizable recommendations from the review of the service indicators are: a) targets should be designed to support service integration; b) targets for the local service delivery point should gradually shift to indicators of quality; c) numeric targets established at the local level should as far as possible reflect the catchment area population and baseline rates; d) national outcome figures and trends should be determined by statistically valid sample surveys and by monitoring at sentinel sites instead of by national service delivery monitoring systems such as FHSIS; e) each target must be examined for epidemiologic validity, and be as closely related to health impact as possible; f) targets must above all reflect the resources of the system - if an activity cannot be done, or is not meaningful without key supplies, then the process target of supply comes before any others; and g) before adding a new target or activity, one must need to know the health workers' capacity to take on more work.

Two principal recommendations are made concerning the nutrition program. The first is to train barangay health workers and midwives to measure mid-upper arm circumference. The second is to use low-dosage vitamin A, administered by the barangay health worker on some regular weekly or bi-weekly rotation. Operations research needs to field test both of these recommendations before they are adopted system-wide.

FHSIS is an improvement over previous program-specific monitoring and reporting systems. However, FHSIS is more complicated than necessary as a management information system for DOH/Manila, for provincial health offices and for midwives. FHSIS only generates reliable information for two of the nine CSP service delivery indicators. Additional work is needed to simplify the system for management purposes and to use statistically valid survey methods for service delivery and other key measures of health status. One specific recommendation to simplify FHSIS is to design two basic client lists: one for women (with columns for family planning, prenatal care and postpartum care) and one for children (with columns for EPI, diarrhea/pneumonia, nutrition). The columns should list only the absolute minimum of information needed to identify the person and essential services. A separate monthly tickler file is easily made to remind the midwives and nurses about revisits. These forms are for daily use.

Program managers and research staff from the DOH (e.g., FETP, Research Institute for Tropical Medicine, Nutrition Center of the Philippines, PIHES) should meet at regular intervals, with the technical assistance team as secretariat. The purpose of this ad

hoc body is to come up with interesting and researchable (or pilotable) ideas to improve services in maternal and child health.

Changes in function and assignments of the technical assistance team (TAT) are recommended. CSP's health care financing and private sector involvement benchmarks have been largely achieved. With the new Health Care Financing Project coming on stream, further support in these areas should be moved from CSP to the new project, including public sector health care financing. The TAT needs to provide assistance that: a) focuses on strengthening area-based planning at the local level, using the Core Group as a field-oriented consultancy service, and b) assists DOH/Manila and the provincial health offices adapt CSP to the changes the Local Government Code will produce. The current advisor for planning should be re-assigned to work on improving service delivery at the client level through the Public Health Office. The objective here is to increase technical assistance to programs in an effort to produce tangible CSP successes - a sustainability strategy. Additional short-term assistance could be used to work on simplification of the FHSIS as described above and to expedite dissemination of IEC materials to the field.

The evaluation sees in CSP the potential for achieving significant development results in improving the development results in improving the health conditions of lower income women and children. However, this will require continuing CSP beyond 1993 to institutionalize recent accomplishments and focus on improving the quality of health services.

## **ACKNOWLEDGEMENTS**

The evaluation team greatly appreciates the generous assistance Department of Health staff provided in conducting this evaluation. The Child Survival Technical Assistance Team was also very helpful and we benefitted substantially from their candor and assistance. Dr. Rosendo Capul of USAID/Philippines has been instrumental in assuring that the evaluation would provide an objective assessment as well as suggestions for sustaining program accomplishments.

**1. INTRODUCTION: THE MIDTERM EVALUATION OF THE CHILD SURVIVAL PROGRAM (CSP) - PURPOSE, METHODOLOGY AND MAJOR RECOMMENDATION**

The Child Survival Program (CSP) is a sector assistance program which supports policy and institutional reforms to expand and strengthen child survival-related health services. The program contributes to the reduction of child mortality and morbidity by increasing the availability, utilization and sustainability of child survival-related health services. CSP provides \$45 million in performance disbursement payments and \$4.25 million for technical assistance to the Department of Health (DOH) to support the implementation of reforms and improvement of child survival-related services. Annual funding disbursements are linked to the DOH's achievement of critical benchmarks (i.e., completed actions) in implementing policy and institutional reforms. CSP was authorized in 1989 and is scheduled for completion in March, 1994. Four annual performance disbursements are planned over the course of the program. As of October, 1991, when this evaluation was conducted, two disbursements had been released. The third disbursement is expected to be made shortly, pending the outcome of the 1991 annual program performance review.

This midterm evaluation reviews the implementation progress of CSP. The purpose of the evaluation is to review program progress and identify how the improvements in child survival services CSP supports can be sustained. In general, program sustainability will require continued funding for expanded and improved health services, commitment on the part of DOH staff to the child survival strategy and institutionalization of operational and management improvements at both central and provincial levels. The evaluation focuses on the following topics:

- a) the continuing validity of the overall strategy guiding the CSP;
- b) the achievement of the performance disbursement benchmarks, their significance with respect to the program's goals and purposes and the need for modifying the strategy and benchmarks;
- c) the management of the program by the DOH and A.I.D. and, in particular, the DOH's use of the program to implement internal management improvements;
- d) the effects of reforms at the provincial and district levels and on service delivery at the health worker - client level;

- e) the likely epidemiological impact of the program, how that impact could be increased and the basis for assessing impact on the health status on women and children under five; and
- f) the management of the program by DOH and USAID, the effectiveness of the technical assistance team (TAT) and modifications to the assistance being provided.

The evaluation team assembled to address these issues consisted of the following individuals:

- a) Ms. Carmencita Abella, institutional specialist and president of the Development Academy of the Philippines with substantial experience with the institutional development of the Department of Health, as well as with other government organizations in the Philippines.
- b) Dr. Jaime Z. Galvez Tan, M.D., health service delivery specialist and program analyst for UNICEF, a public health physician with extensive field experience in managing health service delivery in rural communities in the Philippines.
- c) Dr. Norbert Hirschhorn, M.D., child survival specialist with John Snow, Incorporated, a public health physician and researcher with extensive international experience in developing national health delivery systems.
- d) Mr. Chris Hermann, program analyst (and team leader) in the Asia Bureau, AID/Washington, who has worked on the planning, implementation and evaluation of numerous policy-based, sector assistance programs worldwide.

The evaluation is based principally on the following sources of information: a) numerous interviews with DOH staff directly involved with the Department's Child Survival program; b) review of program documentation; c) CSP funded studies and reports; and d) field visits to six CSP priority provinces and interviews with various DOH staff, Provincial Health Officers, nurses and physicians assigned to rural health units and midwives providing services to rural communities. A special study was conducted by Kabalikat ng Pamilyang Pilipino Foundation to collect preparatory information identified in the evaluation scope of work. The Kabalikat report was based on numerous interviews with DOH staff in Manila and field visits for additional interviews in ten CSP priority and three nonpriority provinces. The Kabalikat team used two general questionnaires to guide their interviews in Manila and in the selected provinces so the information obtained would be

generally comparable. The Kabalikat report provided the evaluation team with very useful information, giving it a "jump start" on the assignment and helping to guide the team's work. The findings of the Kabalikat report were largely verified by the evaluation team's work and have been used to expand the data base upon which this evaluation is based.

As the following sections of the report will show, the evaluation of CSP is exceedingly positive about what CSP has accomplished to date. The expeditious implementation of CSP and its potential for producing a substantial development impact makes it one of the most effective sector assistance programs USAID/Manila, and probably A.I.D. overall, has funded in recent years. Most impressive is the DOH's use of CSP as its own internal management tool for introducing numerous institutional changes throughout the health system. The ownership of CSP by the DOH is a genuinely refreshing contrast to so many donor funded projects and programs around the world. Much of what has been accomplished thus far is only at a preliminary stage of being fully internalized at the DOH's various administrative and operational levels. The entire structure of health service delivery will also undergo major changes beginning in 1992 with the implementation of the Local Government Code which will decentralize many important functions currently funded and supervised by DOH/Manila.

What is vital at this point in the program is to continue to support the process CSP has helped to initiate as planned and to extend that support beyond the current completion date of early 1994. Therefore, the major recommendation of the evaluation is to amend the current program agreement, extending the completion date to early 1996 and adding at least \$25 million for performance disbursements and continued technical assistance.

## **2. PROGRAM OBJECTIVES, STRUCTURE AND MANAGEMENT**

### **2.1 Background to CSP: Sectoral Problem and Program Development**

A number of factors led to the design of the Child Survival Program in 1989. These included:

- a) persistent inadequacies in the health service delivery system;
- b) on-going efforts to re-orient the health system from primarily curative to more preventive services;
- c) new concern beginning in 1987 about unacceptable health conditions for major segments of the population (especially the rural poor); and
- d) the DOH's own plan for organizational change and the development of new strategies and program management systems to deal with these problems.

In large part, CSP capitalized on the opportunity created by new, dynamic leadership in the DOH. They envisioned child survival as a framework for carrying out organizational and program improvements and for integrating and improving health services focused on the client's needs. (This process is described in Section 3 - CSP's Effects in Internal Management Changes).

CSP was designed to assist the DOH to deal with fundamental weaknesses in health service delivery. Substantially greater emphasis needed to be given to preventive health services which could have a significant effect on the health of rural and poor people. Many of the health problems of the rural poor are easily preventable and controllable at relatively low cost per beneficiary, through immunization, proper hygiene, early detection and simple cures. However, physical access to public health facilities and personnel vary widely, particularly between urban areas and rural, remote communities.

Infant deaths comprised approximately fifteen percent of all reported deaths. Infants and children under five accounted for the large majority of morbidity cases, particularly pneumonia, bronchitis, diarrhea and measles. Infant and child mortality and morbidity is strongly and directly correlated with poverty and inversely correlated with mother's education. Infant mortality is also higher when the mother has three or more children, indicating that family planning could contribute to gains in child survival. Major causes of these conditions include poor environmental

sanitation, crowding due to inadequate housing, poor child care from low education of mother and child caretakers - all characteristic of low income households.

The DOH's strategy to address these problems focuses public health care programs on mother and child survival. The most efficient use of the public health budget is to target services on the underserved areas of the country. As noted above, relatively inexpensive preventive health interventions could make substantial improvements in these areas, as well as reduce regional disparities in health status throughout the country. Greater awareness and knowledge about preventive health care, leading to increased demand and utilization of health services, were also needed. This required more effective public education about the benefits of preventive health care through social marketing and other communication channels.

Local health problems must serve as the basis for targeting the services needed by the community. This requires decentralization of planning, budgeting and program implementation responsibilities to the provincial level. Child survival-related programs also need to be viewed and managed as an integrated package that meets the health needs of the client to maximize their effectiveness.

The goal of the CSP, therefore, is to contribute to a reduction in the variances in infant and child mortality and morbidity rates among and within provinces and regions while simultaneously lowering the corresponding national rate. The purpose of CSP is to increase the availability, utilization and sustainability of child-survival services, including child spacing, particularly to underserved and high risk groups. CSP pursues two main strategies to accomplish the program's purpose; these are:

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

Four main areas of policy and institutional reform carry out the first strategy. These are: a) targeting of child survival services; b) increasing the delivery of these services; c) decentralization of planning and service delivery; and d) integration of services.

The second strategy includes: a) government commitment to the child survival program; b) increasing demand for preventive health services; c) financial sustainability; and d) increased private sector involvement. A policy agenda specifying the actions to be taken to implement reforms in these areas is found in the CSP policy matrix (see Annex 2).

CSP's sector assistance mechanism operates as follows. The CSP policy matrix contains sets of actions which the DOH and USAID have previously agreed would be undertaken. Annual benchmarks serve as targets for implementing these actions. Some of the benchmarks are one-time events (e.g., the completion of a plan on cost containment). Other benchmarks are multi-year (e.g., the expansion of area-based planning from twenty-seven priority provinces to all provinces over a three year period). When the DOH and USAID agree that the benchmarks for that year have been fully met (or agree that there are legitimate reasons why a particular benchmark was only partially met, or that the benchmark needs revision), USAID disburses CSP funding for that year to the GOP (actually to dollar denominated accounts per instructions from the Department of Finance). The dollar disbursement is used for purposes agreed to by USAID and the GOP, primarily for foreign debt repayment.

USAID requires no local currency generation commensurate with the dollar disbursements. However, the GOP's Department of Budget and Management (DBM) has itself elected to do so. The DOH receives a local currency (peso) equivalent of CSP disbursements which the DOH has used as an augmentation budget to its regular budget. Approximately twenty percent of these funds are used for DOH/Manila's centrally managed activities (e.g., preparation of training programs for provincial health staff). Fifty percent is provided to provincial health offices to augment their regular budgets in support of their annual service delivery plans and operations. The remaining thirty percent has been used by the DOH as a discretionary account for a variety of activities and needs that are not easily funded through the normal budget or by donors (e.g., small improvements to rural health units, horses for transportation to remote communities). To date, this mechanism has worked smoothly with the local currency funds being used in accordance with GOP procurement and audit regulations.

## 2.2 CSP's Goal, Purpose and Strategies

### Findings

As of October, 1991, CSP has been underway for roughly two years. Available data indicate that most of the basic problems which characterized the health sector when CSP was designed remain largely unchanged. One exception is in preventive health services. Section Four - Child Survival-Related Health Services - argues that recent training, improved planning and targeting of services and initial steps toward improvement of service delivery are helping to give greater emphasis to preventive health care.

What has also changed is that the GOP's overall budget continues to decline. Consequently, its ability to fund expanded child survival-related health services has degenerated over the past two years with no foreseeable reversal in this trend for the next several years. This gives even greater importance to maximizing the effectiveness of those expenditures as envisioned through the child survival program and to continuing CSP's funding as planned.

One element of CSP's goal, purpose and service delivery strategy that appears to have run its course is giving priority to underserved regions and provinces in the implementation of the program. DOH officials report that developing a list of CSP priority provinces which were first to receive training in area-based planning and an augmentation budget to carry out the plan was a useful starting point for implementing CSP. Data provided by the Project Coordinating Unit verifies that the priority provinces indeed were first to receive augmentation budgets, staff training and additional midwives assigned to underserved areas.

However, the priority province concept has diminishing utility for the DOH due to both operational and political realities. It is, after all, the Department of Health for the entire country, not just twenty-seven underserved provinces. Preferential treatment of a subset of provinces is possible only over the short-term for the DOH. However, if the area- and program-based planning system works as planned, underserved areas should still receive special attention, though they will not be labelled "priority" provinces.

CSP's Program Assistance Approval Document (PAAD) appears ambiguous about the targeting of program activities on priority provinces. Regarding the priority CSP provinces, it states:

"Underserved provinces and those with the highest rates of infant, child and maternal morbidity and mortality will be given top consideration. The targeting of services to priority provinces will be phased, starting with the highest priority provinces in 1990, gradually expanding coverage until all provinces are included in the program of decentralized, targeted service delivery." (CSP PAAD, pg. 37)

One reading implies that the operational and program improvements supported by CSP will begin in the most underserved of the priority provinces, and then be expanded until all priority provinces are included. Another equally valid reading is that CSP will begin with the initial priority provinces and then expand to all provinces for nationwide coverage of improved child survival services. It is the latter approach which has actually been followed in program implementation. Moreover, the benchmarks for implementing improved planning, decentralization of child survival-related service delivery, training and budgeting begin with the priority provinces and then expand to fifty percent of all provinces and then one hundred percent of provinces.

The results of a recently completed survey funded by CSP to measure its service delivery targets raise additional doubts about the priority versus nonpriority province distinction. The survey data indicate that the differences between priority and nonpriority provinces are not as great as previously believed, and some measures show no statistically significant difference at all.

### Conclusions

The overall goal and purpose of CSP continue to be valid - the health status of the rural and urban poor remains unacceptably low and institutionalization of improved public health services is only at a rudimentary stage. The need for external funding for restructuring and expansion of public health services focused on child survival is very real, particularly in light of declining GOP budgets. Ever greater budgets for public health services will not solve national health problems. However, the GOP's worsening financial situation makes expenditures on child survival-related services, which produce the greatest improvement in health status per unit of expenditure, even more important.

The distinction between priority and nonpriority provinces was initially useful. It gave a headstart to provinces that needed assistance the most. Focusing initially on priority provinces enabled the DOH to introduce new planning and budgeting systems,

The distinction between priority and nonpriority provinces was initially useful. It gave a headstart to provinces that needed assistance the most. Focusing initially on priority provinces enabled the DOH to introduce new planning and budgeting systems, and provide the training associated with them, and then expand these systems to the rest of the country. However, continuing this distinction through the remainder of CSP would be counter-productive to the DOH's mandate to support national health programs. Furthermore, the priority/nonpriority distinction has little operational reality for the DOH nor is it a politically viable strategy over the longer term.

On the other hand, the idea of targeting on underserved areas is probably useful as a basis for testing new program approaches and services. Though distinctions among provinces as priority/nonpriority may have only limited utility for CSP at this point, identifying underserved areas within provinces will continue to be central to area-based planning and the targeting of child survival-related services.

### Recommendations

The only modification to the goal, purpose and service delivery strategy needed is to let the distinction between priority and nonpriority provinces in the implementation of CSP "die a natural death" as the existing benchmarks are met. CSP should be viewed as national in scope. Selected priority provinces should be used to test new program approaches and services.

## **2.3 Policy Benchmarks and Service Delivery Indicators**

### Findings

The initial CSP policy matrix (see Annex 2) contained thirty-four benchmarks, several of which contained multiple year targets (e.g., the expansion of the planning, budgeting, decentralization and training activities from the initial priority provinces to nationwide inclusion). The 1990 program review revised eight of the benchmarks, and in so doing, added five more benchmarks. Nine service delivery indicators to be measured annually using varying sources of data were also included in the matrix. Annual targets were to be established for 1991 and 1992 so that the final 1993 targets would be achieved.

The PAAD proposed a formula for shifting the basis of program performance reviews from exclusively the policy benchmarks (in 1990), to a mix of policy benchmarks and service delivery indicators (in 1991 and 1992), and then exclusively to the service delivery indicators (in 1993). Between 1990 and 1993, relative "weights" assigned to policy benchmarks in guiding performance assessments decreased annually (100%, 75%, 40% and zero); whereas the relative importance of service delivery indicators increased (zero, 25%, 60% and 100%). The PAAD did not state precisely how program reviewers were to establish these relative weights in their decision making. Furthermore, basing the final 1993 review on service delivery indicators would be a rather sterile exercise given that the last CSP disbursement is based on the 1992 review.

Complicating this mysterious weighting process further is the fact that the DOH replaced its previous Health Information System with the Field Health Services Information System (a single, integrated reporting system). Section 5 of the evaluation - Indicators and Technologies - discusses weaknesses in most of the original service indicators and recommends the need for further review of these indicators. More recent epidemiological data also question the accuracy of the baseline used in the PAAD for the nine service delivery indicators.

The evaluation scope of work asks whether the benchmarks in the policy matrix are most appropriate for achieving CSP's policy objectives. It is the team's opinion that for the most part, the current set of benchmarks are reasonable, appropriate steps toward the policy and institutional reforms supported by CSP. We do note that the benchmarks concentrate on quantitative improvements in service delivery with very little attention to qualitative improvements. Emphasizing quantitative improvements was appropriate for this first phase of CSP (viewing the DOH's child survival initiative as a ten-year process). However, qualitative improvements will be fundamental to sustaining effective child survival-related services.

In the short to medium term, the contribution of the policy benchmarks to achieving the CSP purpose and goal varies. Based on the information available to the evaluation team, the benchmarks associated with improved planning, budgeting, decentralization and integration have had the most immediate effect on DOH operations and service delivery. In some cases, their importance goes far beyond from what is apparent in the statement of the benchmark.

A good example is the benchmark for area-based planning which targets child survival-related services on the most underserved communities. Often the development and submission of plans as a benchmark in policy-based programs is a sterile exercise because the plans have no real operational validity to those who prepare them. The benchmark is mechanically met, plans are submitted but they then just collect dust. The planning improvements in CSP are in stark contrast to this, in large part because augmentation budget allocations are linked to the provincial plans.

At the provincial level, the plans are also beginning to influence operational decisions. Field interviews revealed that some Provincial Health Offices (e.g., Capiz) are using the data needed for the annual planning process to identify those health units whose performance is weakest. Supervision and assistance are then concentrated on these units to improve their performance. Such broader implications of the planning benchmark are not readily apparent from its brief statement in the policy matrix.

The benchmark for increased delivery of child survival services which specifies achievement of nine service delivery targets by 1993 is causing the most consternation - and confusion - within the DOH. These targets were based on available data in 1989 and assumed that consistent, reliable measurement of these indicators would be possible on an annual basis. That assumption is simply unfounded. As noted above, the DOH's information system has been organized into a more efficient integrated system. As discussed in more detail in Section 5, the indicators suffer from apparent weaknesses as valid epidemiological measures or as useful management information. Recent data also raise serious questions about the baseline and targets for a number of these indicators. As discussed above, annual progress toward those targets was supposed to have been factored into annual program assessments.

The 1993 time frame for full achievement of the targets also has little utility for performance disbursement. The last disbursement of CSP will be made in 1992. Achievement of the targets in 1993, therefore, will be a moot point. Perhaps most worrisome for DOH staff is that they are confronted with trying to achieve targets which they, and the evaluation team, recognize as needing revision.

The benchmarks on DOH commitment and internalization of demand are also important, especially those concerning the Information, Education and Communication (IE&C) function and promoting preventive health behaviors (though smoking cessation connection to CSP seems rather tenuous).

The longer-term significance of other benchmarks, particularly those associated with health care finance and private sector involvement, with respect to child survival objectives remains to be seen. The evaluation team could not determine what immediate effect meeting these benchmarks was having on improving child survival-related services and the health status of the underserved. A number of these benchmarks generate new information through special studies or produce plans for new initiatives (e.g., cost containment schemes). Perhaps their greater importance will emerge over the coming years.

Inclusion of the health care finance and private sector involvement benchmarks was reported by DOH and USAID staff as useful, if not immediately relevant, to child survival objectives. The work carried out for these benchmarks gave needed attention to health care finance and private sector issues. Prior to CSP, there was little, if any, genuine concern about health care financing issues. This has changed in the past year or so. DOH program managers are showing greater interest in the costing implications of their programs and the longer term resource requirements for continued support for the child survival framework. This work also contributed to the development of the Health Care Financing Project which will begin in 1992.

### Conclusions

The policy matrix as amended after the 1990 program review is sufficient for CSP given its present funding level and completion date. After the November 1991 program review, most of the policy benchmarks will have been completed in any case. Additional benchmarks focusing on qualitative improvements in service delivery would be needed only if the program is amended to increase performance-based funding and extend the completion date, as recommended by this evaluation. (Section Seven provides a brief description of the recommended amendment.)

The weighting system that somehow would combine policy benchmarks and service delivery indicators for annual program assessments was an impractical idea. The assumption that the previous Health Information System would provide timely, reliable data for the service delivery indicators was unfounded. Moreover, Section 5 - Indicators and Technologies - will show that the majority of the original service delivery indicators need re-formulation to make them valid, reliable measures. In the future, program designers should avoid such clever but sterile formulas for decision making. What is needed are better program monitoring systems which provide

managers with concise, accurate and timely information on implementation progress and the conditions affecting the policy reform process.

With the successful conclusion of the 1991 program review, the health finance and private sector benchmarks will have been largely met (only one private sector benchmark - a risk-sharing program with HMOs - remains for 1992 and work on that topic is nearing completion). This will phase out what has been the only troublesome portion of the CSP policy agenda (troublesome in the sense that it required considerable mid-course corrections). Work on health finance will be continued through a separate project, making further involvement in this area through CSP redundant. In short, the program will be in a position to declare success and move on to other activities that also contribute to improving and institutionalizing the DOH's child survival program.

The inclusion of the health service delivery indicators and targets in the policy matrix was, in retrospect, probably not a wise design decision in planning this program. They have no real implementation utility for the program in respect to performance disbursement. However, they are important measures of progress toward the development purposes of CSP and should remain a focus for CSP, though they should have been monitored separately from the policy benchmark agenda.

### Recommendations

- a) No additional benchmarks should be included in the present CSP policy matrix.
- b) If CSP is amended as recommended by this evaluation, new benchmarks for additional performance disbursements will be necessary. These should focus on improvements in the quality of child survival-related services.
- c) The notion of a weighting system combining policy benchmarks with service delivery indicators as described in the PAAD is unworkable and should be ignored.
- d) The health finance and private sector portions of the policy matrix will soon be completed and taken up by the Health Care Finance Project. Remaining resources, i.e., technical assistance, should be re-directed to other areas that will help institutionalize CSP progress at the provincial level (see recommendations in Section Six - Technical Assistance).

- e) The service delivery indicators and achievement of targets should continue to be a program focus. The DOH and USAID, assisted by the Technical Assistance Team, need to continue their work in reviewing and revising as necessary the service delivery targets based on more recent and reliable data (also recommended in Section 5 - Indicators and Technology).

## **2.4 Program Monitoring and Progress Reviews**

### Findings

Achievement of the CSP benchmarks is central to program management by both the DOH and USAID because that is what triggers the disbursement of funding. However, CSP has had much broader implications beyond simply moving money from USAID to the GOP. The DOH has made highly effective use of CSP's benchmark system to introduce various organizational, operational and management changes (see Section 3 - Effects on Internal Management). Equally important, CSP has been used by the DOH as an overall framework for directing and managing assistance from other donor organizations. In other words, CSP helps coordinate World Bank and UNICEF programs which also support child survival-related services with USAID funding. Hence, donor coordination occurs to a large degree because of the DOH's use of the CSP approach to manage donor assistance.

USAID staff report that the structure of the program enables them to work as colleagues with their DOH counterparts on technical and management problems. The benchmarks have also been a focal point for what can only be described as a remarkable degree of professional collaboration and cooperation between the DOH and USAID on program management. This is in stark contrast to the all too often adversarial relationship which unfortunately occurs between donors and client organizations.

The Project Coordinating Unit (PCU) under the Office of the Chief of Staff has responsibility for monitoring CSP implementation. The PCU, assisted by the technical assistance team, tracks the implementation of actions needed to reach the annual benchmarks and produces the necessary documentation on progress toward the benchmarks for the various CSP review meetings.

USAID and the DOH have established an effective system of monthly and quarterly meetings to review progress to date and identify actions that are needed to reach annual benchmarks (see Annex 3 for a summary description). A major annual program review is conducted in the Fall to assess the adequacy of implementation actions with respect to meeting the annual benchmarks. Thus far, there has been one annual review which was very thorough and meticulous in its appraisal of whether eighteen benchmarks had been fully met for 1990. A similar process is currently under way for the 1991 program review. (See Annex 4 for the documentation submitted by the DOH for the 1991 review.)

No mechanism was included in the original design for modification of the benchmarks, though program planners recognized that certain benchmarks would need to be more fully articulated as the program proceeded. The lack of such a mechanism complicated the 1990 program review which identified eight benchmarks for 1991 which needed revision.

USAID senior management apparently viewed the CSP policy agenda as somewhat comparable to a legal contract. They may have been concerned that revision of the benchmarks represented a lack of commitment by the DOH particularly to privatization and an expanded role for the private sector in health service delivery. Only after several senior level meetings between USAID and the DOH was it agreed that the revisions were fully justified.

The benchmarks in need of revision were overly optimistic about the pace at which certain actions could be accomplished. For example, a benchmark on privatization of four specialty hospitals was included in the original CSP policy agenda because they were on the list of GOP assets to be privatized in the next year or two. In reality, privatization of the hospitals was far from "a done deal". These hospitals are viewed by the GOP as equivalent to the U.S. National Institutes of Health with important public functions, such as research, training and services to the poor, which are not readily amendable to "for-profit" solutions. Various legal, financial and social policy factors were simply unrecognized at the time of developing the original CSP policy matrix. As a consequence of the strict interpretation of the benchmarks taken by USAID senior management in 1990, even greater time and effort is now being invested in the documentation of progress and achievement of the 1991 benchmarks than in 1990.

## Conclusions

The DOH and USAID program managers have established a very sound, intelligent management system for monitoring program implementation on the basis of the policy matrix and its benchmarks. The original matrix was "a best guess" made by the CSP designers in 1989 and the need for subsequent modifications over time was expected. In retrospect, USAID's senior management took what appears to be an overly rigid approach to the policy matrix. It is certainly important to assure that standards for performance are maintained and commitments are kept. Nonetheless, an even more intense effort is being made to document compliance with the 1991 benchmarks which consumes time that could be spent on more substantive, technical work, as opposed to programmatic administrative matters.

It is certainly important to take the benchmarks seriously, but they should be viewed as projections or targets as opposed to fixed levels of achievement. In the case of CSP and the DOH's clear ownership of program objectives, if progress falls short of the benchmark, it is equally likely that the benchmark itself is an important part of the problem.

## Recommendations

DOH and USAID program managers have established a very sound benchmark monitoring system for assessing annual performance and no changes are needed. The documentation process for the annual reviews has reached a maximum level of intensity and after the upcoming 1991 review, the DOH and USAID should assess whether this level of effort is really necessary.

### **3. CSP'S EFFECTS ON INTERNAL MANAGEMENT CHANGES**

The CSP evaluation examined the scope and depth of the internal management changes in the DOH which have a direct impact on the delivery of child survival services, as well as on sustaining the gains from the CSP. These changes are cited in the benchmarks of the CSP policy matrix. The internal management changes cover: provincial health planning systems, improved resource allocation (particularly for CS-related activities), the field supervision system, the field training system, and the Central Office-field relations.

#### **3.1 Provincial Health Planning**

##### Findings

There is ample evidence, from both the documents reviewed and the results of individual and group interviews in the field, that DOH field offices have taken the Area/Program-Based Planning (APBP) exercises of the past two years quite seriously. Several rounds of training on the planning methodology, supplemented by the provision of detailed guidelines through an APBP Manual and direct technical assistance from the DOH Internal Planning Service (IPS) staff, have been cited as the main factors contributing to the perceptible improvements in the plans submitted by the different provinces.

The evaluation team found that a concerted effort was being made at the provincial level down to the barangay/midwife level to produce a plan: a) based on analysis of actual field data; b) reflective of specific strategies to meet service delivery targets; and c) focused on identified priority client groups and programs.

An Evaluation Checklist was developed by IPS to assess the quality of Provincial Health Plans; this checklist was used to determine whether a submitted Plan is of "acceptable quality", i.e., it satisfies the criteria of the various programs as well as those of the APBP approach. Only provinces with plans of acceptable quality become eligible for the Child Survival augmentation budget for the year. Of the seventy-five provincial submissions, only thirteen provinces had to revise their 1991 plans.

A Core Group of planners has been organized to provide training and assistance to the PHOs, while at the same time performing monitoring and evaluation functions on behalf of the IPS and the different programs under the Office of Public Health Service.

Field personnel have expressed that their participation in the data analysis and target-setting under the APBP approach has been both instructive and empowering. They have also indicated greater confidence and pride in their Provincial Health Plans. However, the tediousness of the planning process has taken valuable time away from equally important tasks, such as client servicing (some RHUs had to close up early just so the staff could attend to the needed data-gathering) and field supervision (time and money sometimes ran out for program coordinators to undertake this critical task). This jeopardized achievement of service delivery targets.

Implementing units (PHOs and RHUs) bewailed the fact that despite the thoroughness of their plans and the accompanying budget requests, they still received the same level of budgetary support as in the previous year. The efficacy of the APBP is invariably put in question, and those interviewed are concerned that unless there is some improvement in the levels of financial support, the current enthusiasm and thoroughness in the planning effort cannot be sustained.

Two other points relevant to field support for provincial plans pertain to implementation issues. The first concerns the absence of effective rewards and sanctions for performance against plans. Field personnel do not see any significant institutional response to their attainment of set targets, or conversely, any significant setback when they are unable to deliver on their plans. The second is the degree of real negotiation on targets. Lower levels (PHOs downward) continue to feel strong pressure to accommodate to the targets suggested by higher levels in the organization, and feel unable to manage this pressure effectively.

### Conclusions

The current state of the decentralized health planning system introduced under the CSP can be summarized as follows:

- a) The field units now want to have real and reliable plans that will guide their operations. The APBP approach, though tedious, has yielded, from their point of view, more meaningful plans, strategies, and budget estimates. The provision of augmentation budgets gives the system credibility, as this budget is tied up with both the content and quality of their plans. However, regular budgetary allotments have not occurred despite the substantial improvement in planning. This is beginning to raise questions about the long-term usefulness of the planning effort.
- b) The evolving nature of the planning system is appreciated; however, stabilizing the planning guidelines is needed to reduce confusion and wasted effort, especially at the lowest field levels. The negotiation of targets also needs to be improved to ensure real commitment on the part of the field implementors to attaining these targets.
- c) Because of the way the APBP system has evolved, and the existing DOH organizational culture, the sense of ownership of the system among DOH Central Office staff is uneven. While the IPS has played a major role in advancing the planning methodology, the technical review inputs from all the public health programs are very critical. Some of the difficulties in mobilizing the Core Group suggest that certain programs need to be helped to take greater ownership for the outputs of the APBP system.
- d) After two planning cycles using the APBP approach, the field units report greater confidence in their capacities for targeted planning. However, actual use of the Plan to manage their operations is still inadequate, especially in respect to adjusting their strategies during the year to respond to changing conditions or invalid assumptions. Assistance needs to shift to analyzing implementation shortfalls, so that plans can be modified and resources reallocated.

## Recommendations

- a) Continue the use of the Core Group to provide planning and implementation assistance. Initial efforts to bring together the planning and program perspectives at the service of the provinces has shown encouraging results. These efforts need to be made more systematic and reliable by making the Core Group membership better selected and more stable. Availability of a competent Core Group as an advisory pool to both the field units and the central program units is the key to sustaining the APBP system in the provinces. Additional training, and perhaps partial secondment to the CSP, should be considered.
- b) Continue the use of augmentation budgets, and maximize their value for improving the quality of provincial plans and/or the quality of plan implementation. Variances in amounts, as well as in the timing of release, of such augmentation budgets can provide powerful incentives/rewards to the different PHOs if they know that these are related to planning quality.
- c) Increase efforts to have Central Programs assume responsibility for the quality of provincial planning outputs. Strengthen Program commitment to the Core Group by assigning appropriate staff and providing the needed time for Core Group tasks. The Core Group should report regularly to the OPHS Management Committee and to the DOH Executive Committee.
- d) Enhance the present budgeting component of the APBP to include strategizing under different budget assumptions, i.e., how would implementation strategies be different under conditions of budget restraint (same level as previous year) or conditions of minimal budget increase (e.g., five percent increase), or conditions of budgetary cuts (less than the previous year). Aside from challenging the creativity and resourcefulness of the PHOs, this would also keep their expectations (and plans) more realistic.

## 3.2 Resource Management

### Findings

Field data indicate that PHOs are now able to make clearer connections between their service delivery targets and their resource plan (budget). Given the flexibility they are allowed in the use of augmentation budgets, PHOs are learning to develop their own mechanisms for allocating these additional resources among their priority activities.

There have been multiple funding sources supporting child survival activities; however, the field tends to identify CSP support only with the augmentation budgets they receive. Additional investments in training, personnel, logistics, etc. which contribute to achieving service delivery targets are non-CSP funded and are insufficiently recognized as supporting their CSP targets.

Benchmark attainment is successfully driving access to resources at different levels. For provinces, the submission of acceptable plans is related to receiving augmentation budgets. For programs, technical activities supportive of end-of-program service delivery targets are able to get the needed funding. Conversely, the application of CSP funds to low-budget but important DOH programs (e.g. blindness prevention) is building a broader base of support for CS concerns in the Department.

A financial model for projecting cost requirements of selected child survival programs has been developed as part of the work on the benchmark related to sustained financing of child survival services. Results of initial testing of this model have sparked a strong interest among program managers to learn how to use such a model for improved program planning and development.

While the CSP has provided a clearer connection between plans and resources at the level of developing provincial plans, this planning-budgeting linkage is still weak. Higher service delivery targets or improvements in program strategies are not matched by corresponding increases in budget. Such discrepancies tend to reduce the confidence of field implementors in their ability to attain the targets, as well as in the new planning system itself.

## Conclusions

- a) Considerable progress has been made in increasing field-level appreciation of child survival-focused health planning and its resource management implications. The use of budgetary augmentation has provided PHOs an excellent opportunity to develop their own resource management skills and to improve the decision-making processes about resource allocation for child survival-related services. However, PHOs have responded to this opportunity in various ways. Some are able to take decisive action on the use of the additional funds, while others appear to be stymied about how much freedom they really have and are still concerned about clearer expenditure guidelines from central offices. Others simply lack a sense of how to optimize the use of the augmentation budget.
- b) There is a need to improve the province's appreciation of child survival targets as being linked to different categories of funding. In this regard, it is important to communicate to them the total child survival financial support picture for their province, i.e., the full extent of manpower, logistics, training, finances, etc. allocations they are/have been provided to support their provincial targets. This would principally require consolidating all pertinent information by province, communicating this information clearly to the PHO, and then holding the province accountable for how they manage these various resources to accomplish their stated plans.
- c) The CSP experience clearly indicates that benchmarks can be effectively used as a management tool. Given clear and agreed-upon objectives tied to resource allocations, the organization can mobilize to undertake important changes. Without losing effective management control, the financial center (DOH/Manila) is able to empower the beneficiary organization (provincial health office) to pursue its objectives more effectively. This financing approach has worked quite well between DOH and USAID, and likewise between the DOH Central Office and its provincial offices. This suggests that it might be a model for future relationships between the DOH and the provinces under a fully decentralized health system. In light of the expected implementation of the new Local Government Code and the attendant anxieties of all DOH field staff, the CSP benchmark model takes on even more relevance.

- d) The development and testing of a financial model for determining program cost requirements has made a significant contribution to creating a health financing consciousness among public health programs. The broad interest that the model has generated indicates the potential for strengthening resource management capabilities in both central and field units of DOH. The model's usefulness should, therefore, be fully exploited.

### Recommendations

- a) Provide each province, to the extent possible, the complete Child Survival Resource Support Profile. Such a profile would reflect all types of support, their value in pesos, and the source(s). If possible, develop a way of evaluating provincial performance not only against service delivery targets per se, but also in terms of target accomplishment vis-a-vis resource outlays. This would provide a different kind of "quality" norm for the provinces in terms of their decentralized operations.
- b) Consider how a "benchmark approach" might be used for managing the relationship of DOH with the various provinces in the context of the new Local Government Code. The scheme could be piloted with some high-performing provinces in 1992.
- c) Encourage all public health programs to use the financial model for projecting long-term cost requirements, in order to:
  - a) improve their program development efforts,
  - b) assist provinces in determining/reviewing their provincial plans, and
  - c) establish a more defensible basis for negotiating the Department's future budgetary requirements.

### **3.3 Monitoring and Supervision**

#### Findings

One of the most frequently cited management changes which field personnel attribute to the CSP is the improvement in their monitoring and supervision of programs and personnel. The Field Health Services Information System (FHSIS) data, particularly at

the provincial level, has helped pinpoint low-performing units. The APBP process of determining priority underserved areas has also led to more targeted monitoring and assistance (both who and what) by the PHO coordinators and DHO/RHU staff.

Due to technical and hardware problems in the FHSIS, most DHOs and RHUs have not yet been able to use the output tables to support their supervision and monitoring tasks. There is increasing pressure on the FHSIS to respond to this field management concern. The requirements of the provincial planning process on the time and effort of technical staff at the field levels have distracted them from their monitoring and supervision tasks. They believe that this neglect has contributed, to a significant degree, to non-attainment of their program targets.

The lack of technical staff to undertake supervision and monitoring for each program area has led to some fortuitous changes in many PHOs: an integrated approach is encouraged by the fact that program coordinators now have to add the monitoring of related health services to their own program concerns.

### Conclusions

- a) As provincial plans improve in scope and quality, it will become increasingly important to focus on implementation issues and plan adjustments. In this regard, the extent and quality of field supervision and monitoring will need to be further upgraded. It is widely acknowledged that sustained supervision and monitoring makes a big difference in improving service delivery. Adequate funding and time are absolutely necessary for effective supervision and monitoring at the provincial and lower field levels.
- b) The APBP approach has emphasized data-based problem analysis and client targeting as the foundation for provincial plans. The FHSIS will need to be made more responsive to the data requirements of the provinces, districts and RHUs so that performance toward targets can be better tracked, and subsequently, targets themselves can be better validated/refined.

## Recommendations

- a) Invest in upgrading the capacities of field personnel in monitoring and supervision, especially in view of the anticipated changes resulting from the implementation of the new Local Government Code. Under a decentralized system, regional and provincial program supervisors will need to learn process-oriented supervision skills. As the FHSIS is made more responsive to the management requirements of field units, both technical and line supervisors will also have to strengthen their data analysis and interpretation skills to optimize the value of the management information which will be available to them.
- b) Place priority on developing FHSIS' management information function by addressing the monitoring and supervision needs of the different field levels.

### **3.4 Service Integration**

#### Findings

The policy objective of service integration has involved greater collaboration between DOH technical and management units together with those of child survival-related program staff in working on CSP benchmark outputs. This has included: a) the APBP exercise, with its focus on targeting provincial plans on child survival-related services (OPHS and IPS); b) the operationalization of the IEC Plan around the objective of ensuring sustained demand for child survival-related services (OPHS and PIHES); and c) the health care financing studies (OPHS and Finance Service).

The Integrated MCH Operations Guide has been completed and disseminated through orientation workshops. A Department Order detailing the changes in job descriptions of frontline health workers (MHO, PHN, RHM) due to integration of child survival services has also been prepared.

There are two areas where service integration objectives are not yet being addressed. One is in field training: training programs continue to be program-focused, and field workers are not given enough help to develop an integrated view of the various training inputs coming from different units in the DOH. The second area concerns service delivery targets, which remain program-based.

While it is acknowledged that all of them support child survival concerns, the fact that field units pursue specific program performance targets tends to reinforce a program focus.

### Conclusions

- a) Management changes are needed to address service integration through facilitative processes. DOH organization and structure is not at issue here. The change being sought largely involves the health workers' perception of the strategy for promoting child survival -- the integration of services for mothers and children. That change is being facilitated by processes which bring disparate but related efforts together: area-based and program-based planning; health service delivery and health education; and financial planning and management with program planning and management. These processes have helped to minimize the perception of service integration as a radical re-organization. Other integration-promoting processes need to be encouraged at other administrative levels in the DOH.
- b) Service integration is helped by clear organizational statements. The Integrated MCH Operations Guide provides a good start in this direction, as does the Department Order on the revisions in roles and functions of frontline health workers. To help move people from prescriptions to the new behaviors, however, will need other interventions. Aside from the evident need for capacity-building efforts in this area, better monitoring of how field staff are adopting an integrated service approach in their work is needed.

### Recommendations

- a) Continue integration-promoting efforts that have already been started; provide institutional recognition and rewards for the efforts that are producing the desired results. Consider how parallel efforts can be undertaken among the regional, provincial and district staff.
- b) Accelerate or "fast-track" the CSP activities that will directly support the development of an "integrated service" mindset among frontline health workers. Particular mention must be made of the integrated IEC kit for the midwives -- this has been long awaited by the field, and will have tremendous impact on their client servicing.

- c) Accelerate or "fast-track" current development of an integrated supervisory checklist to improve monitoring of how well health workers are integrating services in their work.

#### 4. CHILD SURVIVAL-RELATED HEALTH SERVICES

The evaluation team visited provincial hospitals and rural health units during its field work. The purpose of these visits was to obtain information on general conditions of health services central to the Child Survival Program and factors affecting the delivery of those services. The following summarizes the findings of interviews with provincial health staff.

##### Findings

##### Quality of Services

Provincial health staff consistently reported that the delivery of child survival-related health services has improved measurably over the past two years. Midwives stated that they now have a better understanding of the services they are to provide and have acquired improved skills as a result of recent training. Nurses and midwives reported that mothers in their catchment areas are more knowledgeable about proper child care practices. A good indicator of this is that they see fewer cases where children have become seriously ill because they were not brought for treatment earlier. They also reported a decline in severely malnourished children and in immunizable diseases. The training provided to midwives and other health workers appears to be having additional beneficial effects in improving their relationships with the communities they serve as they have become more competent health care providers. In short, there is evidence that progress is being made in improving the quality as well as the quantity of child survival-related health services in these provinces.

##### Training

All DOH midwives interviewed reported that they had received training on area-based planning and the use of the FHSIS. The exception were midwives hired through funding by the Philippines Health Development Project (PHDP - World Bank funded). Training on the delivery of specific program services varied; this included training for EPI, CDD, ARI, FP, IFC, VAD/IDA/IDD, and HBMR. The

PHDP midwives had generally not received training for these program services. However, it is PHDP midwives who are assigned to the most remote, underserved communities. HIS reports it is budgeting for such training for FHSIS next year.

### Supplies

In most of the rural health units visited, supplies of syringes and especially needles were inadequate. The lack of needles lasted from weeks to one to two months at a time. Rural health unit staff stated that they had sterilizers which they used to sterilize syringes, even disposables. However, they had to purchase needles themselves or, more often, instruct mothers to buy needles prior to their next immunization day in the community or visit to the health unit. Needles cost approximately P1.25 to P1.50. Staff also frequently reported that they often did not have iron tablets and deworming medicines for months at a time.

We typically found that the health units had adequate supplies of family planning supplies - pills, condoms and IUDs. Supplies of Vitamin A, HBMR and FHSIS forms also were reported as adequate. However, we found at least one health unit in Capiz which lacked polio, measles and BCG vaccines. This unit had not had these vaccines since July, 1991. They also reported inadequate supplies of Oresol and growth charts. In effect, most of the basic supplies needed for the child survival program were not available in this health unit.

Most of the health units visited had weighing scales for children. In barangay health stations, we were informed that bathroom scales were often used for weighing pregnant women. In one unit, the midwives noted that they had to use their own personal funds to purchase a bathroom scale which they were currently using. Many of the midwives also noted a critical shortage of simple calculators which they needed for their work and requested that these be provided by the DOH.

### Drug Protocols

We found a critical shortage of protocols for administering medicines by the midwives. Only one health center was able to produce its copy of the Vitamin A protocol. It was clear that in other units, these and other protocols were not commonly used - when asked to produce them, staff began digging through various files. There were no written guidelines readily available for the use of iron and deworming medicines and the practices the midwives reported they followed to administer these medicines varied

substantially. However, they did report that they have notes from training courses on how to use co-trimoxazole and other ARI drugs.

The lack of protocols observed by the evaluation team is apparently occurring despite the concerted efforts of DOH program managers, such as those of the Nutrition Service, to disseminate guidelines for vitamin A. In other words, the problem does not appear to be a result of inattention to the need for guidelines; suggesting the cause(s) lay elsewhere.

#### IEC Materials

The types of IEC materials available in the health units varied widely. Staff commonly reported that they had not received new posters, handouts, flipcharts or other educational materials this year. Some appeared to have received a number of posters and other materials in the past, while others had very few. There did not appear to be a common set of IEC materials made available uniformly to health units. How the materials were displayed and cared for also differed appreciably. In some, posters were poorly located, torn or in ratty condition. In others, the materials were prominently placed and clearly well treated (e.g., they had been taped or repaired if damaged).

The IEC materials were a good indicator of the management of the health unit itself. For example, in Bago City, Negros Occidental and Panay, Capiz, the IEC materials that they had were poorly displayed in what were poorly maintained facilities. In contrast, at the health centers in San Fernando, Pampanga; Talisay and Valladolid, Negros Occidental and Pontevedra, Capiz, posters and other IEC materials were neatly displayed, consistent with the overall good management and maintenance of the facility.

#### FHSIS

All interviewees reported that the FHSIS was difficult to do when first introduced. The majority of midwives, however, stated that they have become more familiar with the requirements of the system. Several reported that they have found some of the data for FHSIS to be very useful to them in identifying mothers and children who need follow-up services. Whatever else the FHSIS has affected, recordkeeping has clearly become more systematic. Midwives reported that they transcribe their records on to the FHSIS forms in the afternoons after patient hours.

Though they have become more familiar with the system, midwives also noted persistent problems in monitoring and reporting. Some reported that even though FHSIS was to be the single reporting system used, regional program managers continue to demand that they collect and report additional data to them. The midwives see this as an unwarranted additional burden placed on them and inconsistent with the purpose of FHSIS.

There also appears to be continuing confusion over the correct use and reporting of data in FHSIS. In Pampanga, for example, different supervisors apparently have interpreted FHSIS instructions quite differently. The midwives cited the example of prenatal care reporting, where one supervisor said to record the trimester of the client whereas another said to record the number of visits. However, HIS reports that they have issued an addendum to the FHSIS guidelines to correct these problems and further emphasize correct data entry through monitoring and training.

Computers in the provincial health offices were usually operational, though it was reported in Capiz and Negros Occidental that a "virus" had recently been detected and major damage had been done to data sets stored on the hard disk in removing the virus. We also heard reports in several provinces visited of computer breakdowns which prevent timely data entry.

### Supervision

Supervision from DOH/Manila was reported to be sparse and very infrequent. Capiz staff could not remember when central staff (DOH and/or the CSP technical advisors) had last visited them. Negros Occidental staff reported they were visited once in 1990 and again in 1991. The evaluation team did meet an IPS team which was monitoring the implementation of the provincial plan in Mindoro Occidental (more an audit of whether the PHO was abiding by the provincial plan - no doubt a thankless task, but one which is important and should be continued). We also found that an IPS team had recently been in Capiz according to the log book at a district hospital.

At the provincial level, staff reported that they periodically made unannounced supervisory visits to rural health units. A doctor makes the visit to those units where a resident physician is assigned - important for the supervisory visit to have credibility. Attempts at developing an integrated supervisory checklist were reported, but program-specific lists are still used. None of the PHOs had a "model" checklist at this time, though the CSP technical assistance team is currently working on one.

## Community Participation

Midwives reported that they have, on average, roughly ten volunteer barangay health workers actively assisting in community education and mobilization. Other forms of community participation include mothers' classes and assistance by barangay captains or council members in organizing the community to participate in immunization and other health campaigns.

Training of hilots (traditional birth attendants) is currently under way in the provinces visited. The PHO in Negros Occidental saw hilots as playing a vital role in improving the work of midwives. He reported that a recent study of the time allocation of midwives found that attending normal deliveries consumed a significant portion of the midwives' time. Combined with training sessions and regular meetings, some midwives were actually available for as few as ten days a month in their health stations. Training of hilots, therefore, was seen as an important way to free midwives from activities that the hilots could handle.

We found no evidence of barangay participation in decision-making regarding health problems, service delivery or setting of priorities for programs in their communities.

## Priority versus Nonpriority Provinces

The priority province emphasis of CSP was evident in that the staff in priority provinces had received training in various elements of the child survival initiative. In Nueva Vizcaya, a nonpriority province, the concept of area/program-based planning has not reached the midwife level, unlike priority provinces. Priority provinces also appeared to have somewhat better supplies, medicines and equipment than some of the nonpriority provinces. This might enable the priority provinces to expand or upgrade child survival services somewhat more rapidly than nonpriority provinces, but we have no hard data to confirm this nor that the quality of services is improving faster in priority provinces.

No major differences were found in the use of FHSIS. Nueva Vizcaya had also received an augmentation budget to support their priority programs and extend services to remote, underserved barangays.

## Conclusions

The preceding findings suggest that there are indications that some improvement in child survival-related services is occurring. Expanded immunization coverage and education of mothers about proper child care appear to be where improvements are most readily apparent to midwives. Training is resulting in upgrading the skills of midwives which should lead to further improvements in the near term. However, what improvements can be determined at this point is very tentative and could be quickly reversed if the concerted effort to focus services on child survival is abandoned. The improvements we think are occurring have more to do with quantitative measures - numbers of clients served and areas reached. Major qualitative improvements in services are not readily apparent at this time. Continued support - financial as well as strengthening of service delivery systems - over a longer period of time is needed to solidify these initial steps toward improved service delivery.

The staff of health units could benefit substantially from simply codifying and pulling together in one manual the systems and procedures they are to follow regarding the child survival program. The DOH has started preparing materials of this sort but the process needs to be accelerated.

Training on specific programs has been very useful, but it does not support integrated service delivery. Program-by-program training fragments people's perceptions about these services when, in fact, training should be stressing the obvious interrelationships among various child survival-related programs. There is real need to immediately train the newly hired PHDP midwives.

These are the very people who are assigned to the most underserved communities where supervision and monitoring is most difficult and who would benefit most from child survival training.

The lack or inadequacy of IEC materials is a serious impediment to more effective implementation of the child survival program. We know that work on new materials that stress the integration of services is underway. Over the past year, the DOH has been working on and testing an "integrated IEC kit" for midwives. This kit will provide materials to aid midwives in their face-to-face interactions with mothers. This kit could well be the major tool

of midwives for health care promotion and preventive medicine equivalent in the same manner that the stethoscope and sphygmomanometer have symbolized diagnostic and curative care. Work on this kit needs to be accelerated to put it into the hands of the midwives.

Community participation needs to receive greater attention in the child survival program. The barangay health workers (BHW) have been serving their communities effectively. In a very real sense, they work at the frontlines in expanding health care services. They need recognition and encouragement by the DOH. Similarly, hilots could be used to provide a broader range of services if given the necessary skills and knowledge of child survival promotion. They are also community opinion leaders and could play an important role in encouraging necessary attitudinal and behavioral changes.

CSP sustainability could be advanced if communities have greater responsibility for the care of their children. This requires a certain amount of coordination and leadership which NGOs have traditionally provided in rural communities. Strengthening the relationship between the DOH and NGOs serving rural communities, perhaps involving collaboration in program implementation, could contribute to improved service delivery in the most underserved communities.

### Recommendations

- a) Develop and issue CSP Guidelines which include drug protocols for the essential CSP medicines, program memoranda, administrative orders, procedures for area-based planning, standards for child survival-related services, monitoring and supervision materials and other program related directions.
- b) Orient future training programs to emphasize the integration of child survival services and systems, such as integration of planning targets, supervision, logistics and monitoring.
- c) Develop a logical sequence to the provision of skills training.
- d) Keep track of the training that individuals have received and identify what the minimum skills training should be for each category of health worker in the system.

- e) Work toward developing a logical, well-organized series of training materials and curricula.
- f) Include the PHDP midwives in the 1992 program training budget.
- g) Bring to completion the current testing of the IEC Midwife Kit and disseminate this tool as quickly as possible. Fine tuning and other refinements can be made later. Include a small, pocket size reference book for use by midwives who have to travel to very remote barangays and cannot carry the IEC Kit with them. Obtain additional technical assistance to accelerate the process.
- h) Issue awards or other announcements showing official DOH recognition of the important role played by BHWs.
- i) Explore the possibilities for expanding the training of hilots so that they can provide child survival-related services in addition to safe motherhood.
- j) Develop guidelines which provincial health offices can adapt to local circumstances on involving NGOs in the child survival program.

## 5. CHILD SURVIVAL PROGRAM SERVICE DELIVERY TARGETS AND TECHNOLOGIES

In the CSP Policy Matrix detailing the reforms "to increase the availability, utilization and sustainability of child survival-related services", Strategy I includes targeting of Child Survival services, increased delivery of Child Survival services, decentralization of health planning, and integration of Child Survival services (respectively itemized as A, B, C, D). This section of the report deals with item B, service delivery indicators, in detail; and touches upon technological issues related to item D, integration, with respect to the National Nutrition Plan and the FHSIS.

The major purpose of this section is to stimulate thought about how the service delivery indicators can be made more meaningful, useful measures for program management. We recognize that several of these indicators are promoted by other international agencies, and for that reason, the DOH might not want to make changes to the current indicators. We also recognize the inherent tension between selecting indicators and setting standards and procedures for their computation that are sufficient for management purposes versus meeting statistical standards for epidemiological validity. The review of CSP's current indicators and the discussion of their apparent weaknesses focus solely on their use in the Child Survival Program. This discussion of the indicators is not a commentary on the specific programs with which they are associated.

The following review does not consider the strategic use of the indicators for general management purposes. For example, regardless of the technical shortcomings in the indicators, if they enable the programs to lay claim to and obtain additional resources, then they have been effective for management purposes. Similarly, even if the indicators are not highly accurate but only show broad trends or general directions, then this too may be sufficient for management purposes.

The recommendations made should be viewed as suggesting various issues which need to be considered by the DOH and USAID in their own review of the indicators. Given the limited amount of time available for this review, the evaluation team is not able to determine the extent to which some of the following recommendations are already being considered by the DOH or how acceptable these recommendations are to the specific programs involved. In short, this section attempts to facilitate the process of refining the service delivery indicators as opposed to offering definitive directions as to how this should be done. The following analysis

was based on one of several drafts of the nine service delivery indicators provided to the evaluation team. We understand that this draft was not the final draft.

## 5.1 National End-of-Program Service Delivery Coverage Indicators (EOPSDCI)

### Findings

There are nine service delivery indicators whose achievement is scheduled for December 1993. The question is not whether the CSP can achieve these targets; the evaluation team believes it can. The important question in relation to CSP is whether the targets are: a) epidemiologically valid; b) managerially useful at the level of delivery; c) reflective of the quality of services delivered; d) promotive of integration; e) accurate surrogates for positive impact on health; and f) faithful to the capacity of the DOH system at all levels to support them?

Most of the indicators fail in one or several of these attributes. A detailed review of each EOPSDCI follows.

- a) "Percent of all children under age one who are fully immunized increases from 70% (1988) to 90%."

This indicator is the international standard. Its chief advantage over coverage compilations by individual antigens is in the emphasis it gives to complete immunization, on time, especially with the last and most important antigen, measles. In the Philippine experience, routine data and coverage surveys give comparable results, which speaks well to the accurate recording and faithful implementation of EPI by health workers. As hepatitis B antigen is added to EPI (and others to come), the definition of a fully immunized child will change; it will be important for health worker morale not to "move the goal posts," as if prior achievements were no longer valid. Some other indicator will be needed that still recognizes the population level of coverage.

- b) "Percent of pregnant women with tetanus toxoid immunization increases from 37% (1988) to 80%."

The indicator is measured internationally by the number of second doses of tetanus toxoid (TT2) given each year divided by the population times the crude birth rate (essentially the number of pregnancies). This computation is troublesome in

two respects. It does not recognize that TT2 protection lasts up to three years, and so underestimates the actual protection from neonatal tetanus that exists. Because of this cumulative effect, the incidence of neonatal tetanus falls much faster than the ostensible annual "coverage" rate would suggest. The second problem is that health workers routinely translate the indicator as meaning that two doses must be given in each pregnancy, with the result that some women get many more doses than needed, and it becomes harder to reach the final target. The lifetime protection of five doses can be achieved within three pregnancies (or two, if DPT3 had been given in the woman's own infancy).

The proposed program initiative to eliminate neonatal tetanus has several important strategies: provide all women with a lifetime vaccination card; continue to stress tetanus toxoid protection during prenatal visits; vaccinate nonpregnant women bringing children to EPI sessions; provide toxoid to sub-populations of women such as school girls, mothers of children with tetanus seen in hospital, during polio sweeps. These will make any attempt to measure national coverage by the indicator listed above meaningless.

We recommend that several indicators be used to measure protection. First, the lifetime card should be made available to all women of child-bearing age; this is the tool necessary for any sample survey of protection. Second, the individual sub-populations can form the denominators for the successive doses of TT given each group; the targets set should be commensurate with resources put in, and should be measured nationally.

Third, the midwives working in barangays should be monitoring their own achievements within the client list for prenatal care. With each pregnancy counted once in the denominator, the numerator is the number of women whose newborns will be protected by valid TT dosage, known as TT2+. (A valid dosage is one that would still protect the coming child; a woman with TT3 given six years ago would not be protected as TT3 protects for five years, until she gets TT4; a woman with TT4 completed 8 years before would be validly protected as TT4 gives protection for 10 years.) The midwife will need to follow protocol about which mother needs which dose in the series of

five. The target ratios can be both the TT2+ coverage in the women the midwife actually sees (a measure of missed opportunities), and the TT2+ coverage in the number of pregnancies expected in the catchment area. TT vaccine should be available everyday, not just on EPI days; this is feasible as the vaccine is stable for several weeks at usual tropical temperatures. Permission from EPI staff may be needed for this change in procedure.

Finally, as proposed in the tetanus elimination plan, each case of neonatal tetanus discovered, whether in-hospital or heard about in the barangay, needs thorough investigation, a mini-campaign of TT vaccination in the area, training or retraining of the birth attendant.

- c) "Percent of all births attended by trained personnel, including trained traditional health personnel, increases from 62% (1988) to 80%."

While achievable, the indicator presumes that the training has sufficiently changed birthing practices of the traditional birth attendant. Many birth attendants, or so we were told, have not been supplied with the necessary kit for clean delivery and cord cutting. This indicator should be supplemented with a supervisory indicator, applied locally, that at least examines the birth attendant's knowledge and preparedness.

- d) "Percent of all pregnant women served by DOH with at least three prenatal visits increases from 40% (1989) to 80%."

One could ask if the indicator means, "of all pregnant women," or, "of all pregnant women served by DOH..." Since the actual proportion of pregnancies proceeding without knowledge of the DOH is not known with any accuracy, it seems more fair to target what DOH personnel can control. Since at least one visit may be important (to identify major problems right away, to give at least the first dose of TT, to identify the probable birth attendant), a sub-indicator could deal with number of women registered for at least the first visit out of the expected catchment area pregnancy rate.

More important, however, than number of visits is what happens during the visits. If midwives have insufficient supplies of iron tablets, insufficient needles and syringes for TT, no scale, no blood pressure meter and no dipsticks to examine urine protein, then just the number of visits is not sufficient to improve maternal and fetal outcomes. Some supervisory indicators, to be used locally, may be developed to check for such supplies and how they are used.

- e) "Percent of all DOH outreach workers trained to deliver a wide range of family planning services increases from 24% to 75%."

The 24% baseline was set at the outset of CSP; we understand that the baseline should have been 60%; this reveals the necessity to get accurate baseline data, far better done by sample surveys than by routine service statistics, before setting targets. The quality of the training can be assessed at the same time during supervision; the health workers should be able to answer basic questions, like what happens if a woman misses one oral contraceptive pill, or misses two days in a row.

The Family Planning Service is working on the quality of services issue. It conducted a baseline assessment of clinic capabilities to deliver family planning services in 1990. This included measuring the quality of services and training on a pilot basis in Regions 3, 7, 10 and 11. Pending the results of this assessment, FPS plans to expand the assessment of quality of services nationwide. The recently revised family planning curriculum includes post-training evaluation six months after completing the course. Family planning clinical standards were also revised to provide guidelines that would improve the quality of family planning services, monitoring and supervision.

- f) "Percent of DOH health centers delivering a broad range of family planning services increases from 82% (1989) to 97%."

We understand that a fresher survey (1990 FPS/UPPI) shows baseline levels at 1.9% at barangay health stations, 0.5% at rural health units, 0% at district hospitals. The marked difference may be due to the way data were gathered: what was thought to exist from routine reporting versus an on-the-spot sample survey. In any case, a considerable reduction in target is warranted, based on the logistical realities, not on some idealized state. Based on recent clinic assessment data, the Family Planning Service reported it is considering

differentiating among barangay health units, rural health units and district hospitals and setting targets appropriate for each. They also plan to increase the percentage of health workers trained to deliver a wide range of family planning services from 59.5% (1990) to 75% (1993).

- g) "Percent of all midwives and District Hospital doctors and nurses with DOH training in new ARI case management and provided with adequate ARI drugs/supplies increases from 0% (1989 excluding Bohol Province demonstration program) to 40% (midwives) and 70% (doctors and nurses) respectively."

The key phrase here is, "provided with adequate ARI drugs/supplies ..." Because the training is profitless unless a timer is available to all trainees (to take back to their worksites), and sufficient co-trimoxazole for at least one month, the indicator should be split in two, with training only after supplies are secured.

- h) "Use of public-and private-supplied ORT in all diarrhea cases in children aged 0-5 (sic) increases from 22% (1989) to 60%."

The indicator is difficult to achieve and only by some tortured definitions of ORT (Oresol plus any of several other defined home fluids). One difficulty is in the way the indicator is measured: for any bout of diarrhea in the past 24 hours, in children under 5 (aged 0-4). Diarrhea within 24 hours of questioning is necessarily selected for mild cases (because mild cases are so much more common), and children between 36-59 months generally have much milder illness. The ORT use rate will be low. The longer the recall period, the more a mother remembers more serious illness in which ORT, especially Oresol, was used purposefully. The ORT use rate will be higher.

Overall ORT use rate does not reveal how ORS is used in the most serious cases, the ones who will die without it; these are in the minority, perhaps as much as 0.1-0.5% of all episodes. If, however, it is important to the CDD program to measure use rate (as a rough correlate of overall acceptance of the technique by health workers and families alike), we propose a simple study be done first, during the diarrhea season: ask mothers with children under 2 or 3 if there is diarrhea within the past 24 hours and/or within the past two weeks and/or within the past month; whether the mother considered the bout mild or serious; what fluids were given; if breastfeeding or usual diet continued; and had she "ever

used" Oresol. The profile of use rates will suggest which is the most useful one to follow the trend of (our preference is for "ever use" and use in last two weeks in the diarrhea season).

More important than ORT use rate are measures of impact. Data should already be available:

- In hospitals with good ORS units and records going back at least a few years, measure the admission rates and proportion of children with severe, and with moderate dehydration.
- From the health information systems, or civil registers, measure the proportion of annual infant and age 1-4 deaths contributed by the months of May to August (or June to September); if there is no seasonality to deaths, any four month period should contribute 33%; if diarrhea is highly seasonal, the peak four months may contribute as much as half the annual total. As rehydration is more widely used, that proportion should come down towards 33%.

We believe such studies will show an impact on severity and mortality, with most of the credit going to the CDD program.

Indicators of quality of care for use at the district, provincial and barangay levels can include the proportion of cases in hospitals given only ORS (it should approach 85-90%), and not given antibiotics (required in only about 10% of episodes); the rate of ORS prescription for cases seen by midwives (a function of packet availability); the correct mixing of ORS by mothers in small samples during supervisory visits to barangays (should exceed 80 -90%).

The excellent IEC campaign about to be launched nationally will increase everyone's awareness of ORS/ORT. Since only a minority of cases of diarrhea are seen by DOH staff, ORS must also be made available through the private sector if use rates are to climb quickly. Perhaps the name "Oresol" (christened such by Jack Sumpaico, retired head of the Bureau of Research and Laboratories) should be made the generic name.

- i) "Total public-and private-supplied contraceptive prevalence rate for all married women ages 15-44 increases from 47% (1988) to 55.4%."

The CPR is a robust measure of family planning practice. The DOH is focusing on the effective program methods only (pills, condoms, IUDs, VSC, and well-taught NFP). This indicator will best be measured by survey. The targets for each province's DOH services should accurately reflect the local real figures of population and proportion of total family planning services provided by the DOH.

A cluster survey to determine the CPR for a sample of priority provinces is underway and will assess the accuracy of provincial data. FPS reports that they are considering revising the targets to 22% (1988) to 35% (1993).

### Recommendations

The principal and generalized recommendations from this review of EOPSDCI are as follows:

- a) Targets should be designed to support integration. Currently, the intense focus on a target for each program cannot but help convey the message that the program is the important event, instead of the mother or child with multiple needs.
- b) Targets for the local service delivery point should gradually shift to indicators of quality. This recommendation reflects the maturity and achievements of the Child Survival Program and the primary care system built by the DOH. The numeric targets for quality can be easily determined by local supervisors who know what can be expected given the local resources, and how to stretch their staff's capacity.
- c) Numeric targets established at the local level should as far as possible reflect the catchment area population and baseline rates.
- d) National outcome figures and trends must be determined by statistically valid sample surveys, and by monitoring at sentinel sites.
- e) Each target must be examined for epidemiologic validity, and be as closely related to health impact as possible. Some targets may need validation through pilot study.
- f) Targets must above all reflect the resources of the system; if an activity cannot be done, or is not meaningful without key supplies, then the process target of supply comes before

any others. Before adding a new target or activity, one must need to know the health workers' capacity to take on more work.

- g) Refinement of the EOPSDCI should be viewed as a periodic process where indicators are modified, added or deleted as program management information needs change over time. There is no single, definitive formulation of indicators; however, indicators should reflect the short-to-medium term management information requirements of the programs. The data required for the indicators must be within the capacities of the programs and DOH to collect it. The analysis of the indicators should highlight trends in accomplishments.

Given the weaknesses noted about the current indicators, the evaluation recommends that the DOH and USAID, assisted by the Technical Assistance Team, continue its work in reviewing the current set of the CSP service delivery indicators and consider how these indicators can be refined over the next six to twelve months. The suggestions made above concerning each indicator should be used as a starting point for this review process.

## 5.2 The DOH Comprehensive Nutrition Plan

### Findings

Nutrition as such has not been included as a service delivery indicator (although success in immunization and rehydration will have positive impacts on children's nutrition); instead, a detailed nutrition plan has been accepted by the DOH and meets one of the CSP benchmarks.

The plan is excellently written, scientifically-based; it proposes to make nutrition a community affair, not simply a medical intervention. Diagnosis will be principally through the national weighing program, Operation Timbang. Interventions planned are IEC and nutrition advocacy, food and micronutrient supplementation, food fortification and disaster response. A detailed training plan in the form of a pyramid begins with national level trainers who

teach regional and provincial officials the training technology; the latter train district physicians, public health nurses and municipal nutritionist dieticians; these pass on the training to barangay midwives, who in turn teach barangay health workers. Essential to all interventions is the complete supply of weighing scales and supplements.

### Conclusions

One wonders how much extra load this plan will impose on the province staff and rural midwives, along with new reporting requirements; and how much competition for already rationed resources will the plan create. One could also ask if the praiseworthy philosophy of community responsibility is congruent with interventions and training so highly dependent on the center, whose major weakness is in supplying materials and equipment.

### Recommendations

Two simpler approaches may make the effort more modest, but more fitting for the barangay level. The first is to train barangay health workers and midwives to measure mid-upper arm circumference. The second is to use low-dosage vitamin A, administered by the barangay health worker on some regular weekly or bi-weekly rotation. These ideas were discussed with Dr. Florentino Solon, Executive Director of the Nutrition Center of the Philippines. He says that he has been trying to promote the very same proposals. He suggests that NCP do operational research on these two ideas. We support this recommendation.

## **5.3 Field Health Services Information System (FHSIS)**

### Findings

The FHSIS is an ambitious attempt to secure a standardized data set on all health programs with forms that also act as worksheets, especially at the BHS and RHU level. The emphasis is on the maternal and child programs supported by CSP. Monthly tally sheets are completed for 14 activities: prenatal care, postpartum care, family planning, CDD, EPI, under-fives (at risk) clinic, nutrition, TB, schistosomiasis/malaria, leprosy, general medical services (a log of all encounters), vital events register, and logistics; notifiable diseases are to be filed weekly. The tally sheets are

compiled at the provincial level, computerized, and output tables give the summaries quarterly. 11,000 BHSs would submit monthly forms for about 11 programs, 12 times a year month, or 1,452,000 forms nationally, or an average of 19,360 per province. This seems excessive for the information obtained, which amounts essentially to a monthly census. The monthly supply form (logistics) is probably the one most accurately filled out, deserving of most attention.

The FHSIS has replaced the profusion of forms previously demanded by each program, and is thus a considerable improvement; however, the system was designed by asking the program staff what information they thought they needed, rather than what they actually use to make decisions, and the midwives had little input. Three of the five CDD indicators, for example, are not useful because they tally referral of serious diarrhea cases, an event fairly uncommon in a small catchment of 3000-5000 people (1-2 per month). A child with diarrhea may be entered in four different places: CDD, under-fives clinic (if it is a third bout), notifiable diseases, and general medical services.

HIS has taken pains to assure the quality of data entry through training guidelines and monitoring trips. The importance of accurate entry of data is emphasized to the midwives. However, statistical estimates of the error rate of data entry are unknown and may be problematic. Midwives tend to view even their target client list workbooks as something not to get smudged, so many enter data on loose bits of paper, transfer it later to the client list, then further transcribe tallies to the FHSIS, often just at the end of the month, not daily, as the form is seen as a reporting requirement, not a daily tool.

The FHSIS is useful to track indicators only in two of the nine service delivery areas, EPI and prenatal care. Much of the information gathered routinely is far better obtained by careful surveys: the dozen or so reasons why a woman dropped her method of family planning, for instance.

The FHSIS office and the technical assistance team are working carefully to condense the FHSIS. For example, they are reformatting the output tables and are examining ways to make the system more useful at the field level. In general, they plan to streamline and simplify recording and reporting.

## Conclusions

By its modular approach, the FHSIS tends to promote emphasis on individual programs, rather than individuals with multiple programmatic needs. Perhaps the experience nationally has been useful, but we would caution against wholesale change in a hurry as it will be demoralizing, and any new system or changes must be piloted first, in manual form.

## Recommendations

To further the concept of integration, two basic client lists should be designed: one for women (with columns for family planning, prenatal care and postpartum care), one for children (with columns for EPI, diarrhea/pneumonia, nutrition). The columns should list only the absolute minimum of information needed to identify the person (by household number) and essential services (in family planning, type of method; in EPI, the antigens). A separate monthly tickler file is easily made to remind the midwives and nurses about revisits. These forms are for daily use. Though the HIS rejected a comparable approach in developing the current FHSIS, they need to reconsider this in their efforts to simplify and streamline the system over the coming years.

Visits outside of the services represented on the client lists should be unrecorded, treated like the dispensary visits they are (scabies, uncomplicated respiratory illness, injuries, among others).

Summary statistics are particularly useful to supervisors on the spot. The client lists should be printed to take 10 or 20 clients to a page, with boxes beneath each column for page totals. If pages are numbered sequentially and the entire page filled in, a count of clients is immediately available for denominators. Column totals by page can then be added for the numerators.

### **5.4 Proposal for a Research/Information Group**

We propose that program managers and research staff from the DOH (FETP, Research Institute for Tropical Medicine, Nutrition Center of the Philippines, PIHES, among others) meet at regular intervals, with the technical assistance team as secretariat. The purpose of this ad hoc body is to identify interesting and researchable (or pilotable) ideas to improve services in maternal and child health.

A number of the ideas presented in this part of the evaluation have already been thought of by one or another of the DOH staff who might attend such a group; their ideas, however, tended to be considered somewhat in isolation, and without regular feedback from colleagues who might enjoy another perspective. The Internal Planning Service provided an excellent example of how an idea was turned to valuable data: they studied the time spent by midwives on different activities, and what variables in themselves and their environment correlated with quality of work. The Research and Information Group would play an important role in disseminating such studies widely. The Technical Assistance Team is providing some support along these lines and more is needed. The TAT should pull together recent research findings for dissemination to interested DOH staff. The TAT budget should also support analyses of existing data bases, such as the completed midwife study.

## 6. THE TECHNICAL ASSISTANCE TEAM

### Findings

CSP provides \$4.25 million for long- and short-term technical assistance to the DOH. Initially, the Technical Assistance Team (TAT) consisted of four long-term, resident advisors through a contract with Management Sciences for Health (MSH) in the areas of epidemiological-based health planning, health care financing, management information systems and social marketing/IEC. The TAT started work in August, 1990. A fifth resident advisor in the area of programs and evaluation (epidemiology), a technical manager and administrative support services from SGV (a local consulting firm) were added in January, 1991.

According to DOH officials, during the design of CSP, the composition of the technical assistance component was determined by the Department's technical weaknesses in implementing the CSP. The scopes of work of the five resident advisors focus largely (in some cases, exclusively) on technical responsibilities and functions. The TAT reports to the Undersecretary/Chief of Staff, whereas the bulk of responsibilities for implementing programs and making operational changes are located in other DOH technical offices.

Recent Quarterly Reports by the TAT and interviews with DOH officials verify that the TAT has provided useful assistance to the DOH in each of the technical areas where the advisors are working. Short-term assistance has also been used effectively, largely for studies and/or plans related to benchmarks and contracting for additional support services.

However, there has been considerable dissatisfaction in the past with the technical assistance function by all parties - the DOH, USAID and the TAT itself. Shortly after the start of the project, the TAT, USAID and DOH perceived a lack of administrative and managerial direction of the team. The DOH saw this as a lack of responsiveness to its needs and no coherence to the TAT as a team supporting and advancing the DOH's "vision" of child survival. USAID expected a self-directed team which would assist the DOH with its needs in implementing the CSP with minimum direction by USAID program managers, who found this lacking in the TAT. USAID also found the administrative systems and reporting by the TAT to be inadequate.

There was also a perceived lack of congruence between the perceptions of USAID and the DOH, on the one hand, and the TAT, on the other, over what should be priorities for the technical assistance. DOH and USAID wanted more attention to the benchmark process; the TAT was more interested in working on improving actual service delivery in the field. Complaints about the TAT as being "too critical and questioning" of decisions made long ago about CSP illustrate this perceived divergence.

Over several months in 1991, several attempts were made to address this situation through various retreats, team building exercises, numerous meetings and discussions. Communication improved (perhaps at increasing decibel levels) but, unfortunately, problems had to come to the boiling point before reaching resolution. To everyone's credit, especially USAID which worked to correct acknowledged deficiencies in the TAT (e.g., additional external assistance with administrative procedures, team management and reporting), the situation now appears to have been corrected. The TAT has a work plan which is acceptable and perceived as responsive to DOH needs, and working relationships seem to be on the upswing. Divergent views about CSP seem to be narrowing. The issue of focusing on benchmarks versus field services is quickly becoming a moot point as CSP meets the bulk of its annual policy benchmarks this year and attention shifts to the service delivery targets.

### Conclusions

The past problems with the TAT appear to be precisely that - in the past. The current workplan and improved communication with DOH offices suggest that the TAT has turned the corner in resolving past problems with the DOH and USAID. Considerable progress is being made in each of the areas where the TAT is working productively.

There is plenty of blame to go around for everyone's past disgruntlement, but that is pointless. What is apparent is that administrative and managerial skills should be included in the selection of a technical assistance team the size of TAT. USAID and the DOH selected five technical advisors and that is precisely what they got - skilled technicians not project managers.

(The remainder of this section draws on material presented in preceding portions of the report.)

One result of determining the composition of a long-term technical assistance team on the basis of institutional weaknesses in the client organization at the time of design is that the project/program becomes locked into those specific functions. In some cases, continued support over a period of years is necessary. In many instances, that assistance could be for a shorter period or divided into a series of recurrent consultancies over time to support an on-going activity. CSP chose a more structured approach, selecting resident advisors for the duration of the program. However, the following factors suggest that this needs to be re-considered at this time:

- a) the pace at which the program has proceeded is bringing a close to the benchmarks in the area of health care financing and private sector involvement, whereas other areas, e.g., institutionalization at the provincial level, require continued support;
- b) a separate project on health care financing has been developed by the DOH and USAID;
- c) major changes in DOH operations and functions resulting from the initiation of the Local Government Code in 1992;
- d) continued support for institutionalization of the area-based planning and integration of child survival-related services is needed at the provincial level;
- e) there is continuing dissatisfaction with FHSIS data collection requirements at the health worker/midwife level;
- f) CSP needs to make maximum use of the TAT's technical strengths in the remaining two years of the program; and
- g) the sustainability of the child survival program of the DOH would benefit substantially, offsetting anticipated changes in senior DOH leadership, from additional successes in improving specific program services (e.g., major improvements in CDD).

## Recommendations

- a) The health care financing function should be phased out from CSP over the next few months, bringing to an orderly conclusion work in this area.
- b) The new Health Care Financing Project should include technical assistance for further work on public sector health care financing issues, building on what CSP has produced.
- c) The current health planning advisor should be re-assigned to work on improving program operations and service delivery at the client level, where this individual's experience and professional strengths are greatest. The objective would be to work toward producing tangible CSP successes. This advisor and the current programs and evaluation advisor would work with the Office of Public Health, increasing the assistance provided to that office.

Given the widely recognized need for improving the logistics system, this advisor could devote at least part of his time to this problem.

- d) A new resident advisor with a public health and public administration background should be added who is responsible for strengthening the "Core Group" as a team of planning advisors to the provincial health offices (making it a service-oriented, consultancy service); and in assisting DOH/Manila and provincial health offices adjust their activities in response to the Local Government Code.
- e) Additional short-term assistance should be directed to reviewing the FHSIS to determine what is the minimum information needed by DOH/Manila for its new management responsibilities after 1992 and what information the provincial health offices and health workers/midwives actually need and can collect with reasonable accuracy. Use of sample surveys to collect basic service delivery data should be introduced as a regular DOH function in lieu of its current reliance on FHSIS for such data. A more effective logistics monitoring system should be developed. These actions would augment current TAT support for FHSIS and lead to a simplification of the system.

- f) The TAT should help to crystalize the "think tank" function through additional support for epidemiological and operations research, involving the Office of Public Health Services and FETP.
  
- g) Even greater priority should be given to the development and expeditious dissemination of the IEC Kit ("recipe box") for midwives, using additional short-term technical assistance if necessary (i.e., it should be distributed within a matter of months in its present form and refined later).

## **7. CSP AMENDMENT: GIVING MEANING TO THE CONCEPT OF PROGRAM SUSTAINABILITY**

The major recommendation of the evaluation is that CSP should be amended to extend the program for two additional years, add at least \$25 million for two additional performance disbursement tranches (in 1993 and 1994) and continue technical assistance.

The findings of the preceding sections show that the program is making significant progress in implementing important policy and institutional reforms that support child survival-related health services. There is clear evidence of new, more effective management systems being started in DOH/Manila and at the provincial level. It is equally clear that institutionalization of these systems is a long-term proposition and that CSP is only in the initial phase of this process.

Considerably more effort needs to be directed at the provincial level in targeting and integrating child survival related-services. At this point there is a wide range of understanding of the child survival approach by health workers, from vague familiarity to fairly thorough comprehension. Over the coming years, the child survival approach needs to be more fully internalized by health workers and supported by training, supervision, reliable logistics, better transportation and other systemic improvements. The re-orientation of health services from a curative to preventive focus is also just starting to make some headway, albeit limited. This too needs to be advanced much further over the next several years.

Equally important is adapting the child survival program to the changes in public administration which will result from the Local Government Code in 1992. Decentralization will affect a major portion of the DOH's budget allocation and responsibility for construction and other capital costs will shift to local government. There is considerable uncertainty how these and other changes will affect regional and provincial health services. Moreover, there is no assurance that the law will be implemented in the same way across different provinces. It is predictable that the next year or two will be a period of considerable change as new procedures are established. This will affect health service delivery, but precisely how is as yet unclear.

It is in this environment that CSP will be operating and continued support will be critical for the success of the program. DOH/Manila will also need assistance in re-directing its current operations to this new environment. At the very least, it will need to re-orient its own functions from one of development of

programs and direction to the provinces to one that stresses services and technical assistance to the field for meeting program standards for service quality.

The budget support that the DOH has derived from CSP has been instrumental in gaining attention for its child survival initiative. The augmentation budgets that provinces receive give a tangible reality to the improved planning process and the implementation of those plans. The augmentation budget will also continue to be critical in providing health workers with the skills they need for the child survival program. This support must be continued beyond 1993 for the changes currently being made to become more fully institutionalized and accepted as standard operating procedures.

Most importantly, CSP has the potential at this point to produce significant developmental impact on the health status of the most underserved portions of the society. It also constitutes a major step toward increasing the efficiency and effectiveness of public expenditures for health services, resulting in a more sustainable health delivery system. Should USAID not provide additional support for CSP, it will, in effect, be stepping away from an activity that has the potential to be a major success which will not be fully achieved by the time of the current completion date - early 1994.

The amendment to the program focuses on sustainability of CSP accomplishments beyond 1994. The following are recommended elements of the CSP amendment:

- a) Extend the PACD of CSP until March 1996. Add two more performance disbursements of \$12 million each for 1994 and 1995 and \$1 million for approximately eighteen months of additional technical assistance through the DOH but focused on delivery of services at the provincial level.
- b) Develop additional policy benchmarks for the performance disbursement mechanism in 1993 and 1994 which reflect improvements in the quality of services being delivered.
- c) Focus the technical assistance on activities to institutionalize child survival-related services at the provincial level.

- d) Move to a more flexible contracting mechanism which provides an "umbrella" under which a broad range of technical assistance can be procured as needed by the DOH and provincial offices. Minimize the use of long-term resident advisors; limit this to only those areas that cannot be adequately supported through recurrent consultancies of varying duration made over an extended period of time. It might be possible to have only one long-term advisor who serves as the manager/administrator of this "umbrella" contract, liaises with DOH and provincial level staff on technical assistance needs, drafts the scopes of work for this assistance, and supervises short-term advisors.

Child Survival Program  
Mid-Program Evaluation

SCOPE OF WORK

A. Project Background

The Philippine Child Survival Program (CSP), a 4 year (October 1989-September 1993) 50 million dollar grant from USAID to the Philippine government, will have reached its half-way point in October 1991. The primary goal of the CSP is "to contribute to a reduction in the variance in infant and child mortality and morbidity rates among and within provinces and regions while simultaneously lowering the corresponding national rate." The CSP's stated purpose is "to increase the availability, utilization, and sustainability of child survival-related services, including child spacing."

In order to achieve these goals and purposes, the Philippine CSP relies on two principal strategies:

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

A primary means by which the Department of Health (DOH) implements these strategies (as part of the CSP) is by enacting policy reforms. At the beginning of the Child Survival Program, the Philippine DOH and USAID jointly agreed upon a series of performance benchmarks which, if achieved, would indicate that the critical policy reforms and policy objectives had been carried out. These performance benchmarks, (except for nine service delivery benchmarks to be achieved by the end-of-project) are reviewed in November of each year and if all benchmarks for that year have been achieved, USAID provides its annual tranche to the Philippine government. This funding mechanism, known as performance-based disbursement, allows the DOH to manage the funds it received from USAID according to its own best judgement, as long as all performance benchmarks are achieved. To support the DOH in managing the CSP, a Program Coordination Unit (PCU) has been set up under the direction of the DOH's Office of the Chief of Staff. In addition, a Technical Assistance Team (TAT) of five long-term advisors supports the DOH and the CSP in the area of management information systems, health finance, social marketing, health planning, and evaluation. In order to focus program efforts on those geographical areas in greatest need of additional assistance, 27 (out of 75) provinces were selected as CSP "priority provinces".

**B. Purpose of Evaluation**

This midterm review/evaluation, which will be both process and impact-oriented, has the following major purposes:

1. To determine the extent to which the DOH has accomplished policy objectives agreed to at the time of the Grant Agreement (and subsequently amended), and to determine whether the chosen policy objectives/reforms are in fact, the most appropriate ones for achieving CSP goals.
2. To assess "movement" towards achieving the annual and end-of-program service delivery coverage indicators for priority provinces and for the Philippines as a whole.
3. To assess the process of program implementation and make recommendations regarding revisions of the implementation design affecting the final two years of the program.

The entire ESP will be reviewed; of particular importance will be those recommendations which can be implemented during the final two years of the program. The theme of the mid-term review takes the form of a question: -- "Is what we are doing leading us to where we want to go, with regard to meeting the child survival service delivery benchmarks?" There is a need to take stock regarding what has happened so far, so that the program can be appropriately guided to increase its chances of "getting there."

**C. Scope of the Review**

The CSP mid-term review will cover the entire period starting from the initiation of the CSP (October 1, 1989) until the time of the review. In terms of technical subject scope, it will include all elements and components of the program, including aspects related to the DOH, USAID, and the TAT.

**D. Key Evaluation Issues/Objectives**

The specific issues/objectives of the midterm review should include the following:

1. To assess the policy objectives (and associated performance benchmarks) of the CSP from the point of view of how well the DOH has implemented reforms to improve service delivery. Are these objectives the most critical ones to achieving overall goals of CSP? To recommend any changes that ought to be made in DOH/USAID strategy regarding achieving the policy objectives over the last two years of the program.
2. Where necessary, to suggest additional policy objectives/performance benchmarks that should be added (or existing ones modified or deleted) for the final two years of the CSP.

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3. To review the performance benchmarks in order to determine whether they are, in fact, the most appropriate benchmarks for achievement of the CSP policy objectives. Do these benchmarks accurately reflect significant progress toward the policy objectives and overall program goal of improving service delivery? If considered necessary, to recommend a possible restructuring of policy objectives and benchmarks.
4. To review the current validity of the original CSP assumptions, given the changes that have occurred in the DOH and Philippines environment (e.g., budget cuts, limitations regarding activities, etc.) since the CSP began, and in light of those changes make recommendations about steps to be taken to increase the likelihood of CSP sustainability.
5. 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 CSP policy objectives. Has CSP contributed to strengthening the institutional capacity of the DOH for policy analysis and implementation?
6. To suggest what new strategy, if any, the CSP could adopt regarding provincial targeting during the last two years of the program in order to narrow the gap between priority and non-priority provinces.
7. 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 during the second half of the CSP. What evidence is there that the CSP has actually added to or expedited policy reforms by DOH that improve service delivery and improved child survival beyond what probably would have been carried irrespective of the program? How has this funding mode helped or hindered the process of policy reform?
8. To assess the Child Survival Program implementation process:
  - a. How effectively has the process been managed by the DOH (including the Program Coordination Unit (PCU) and the Office of the Chief of Staff). How have the service delivery programs been affected by the CSP?
  - b. How effectively has the technical assistance team (TAT) functioned and how could its performance/effectiveness be improved?
  - c. How effectively has USAID managed the process from its side and what lessons might be learned for future programs of a similar nature?
  - d. Has the interaction of the above players (PCU, TAT, AID), together with DOH program managers, been effective in achieving program goals and how could this interaction be improved?

9. To review the extent to which the CSP has affected efforts to reduce infant, child, and maternal mortality in the Philippines and to suggest ways in which the CSP might achieve greater impact in the next two years.

What is the likelihood of achieving the 9 service delivery targets by 1993? Are those targets realistic given the available baseline data? Are the 27 priority provinces meeting their annual targets? What specific steps might be taken to increase the likelihood of achieving these targets?

#### E. Data Sources, Report Format and Scheduling

The evaluation will rely principally on secondary data sources and CSP's implementation monitoring data, as well as various project documents, interviews with key officials and staff knowledgeable about the program and field site visits. The team will select a representative set of priority and non-priority provinces and cities for site visits to assess the importance of policy, organizational and budgetary changes supported by CSP. Focus group interviews may be used to obtain information from the staff of provincial and city health centers about changes at the operational level affecting child survival related services.

The evaluation will address each of the preceding topics and questions stated in Section D. For each topic in turn, the evaluation report will present the major findings of the team, noting where information on the topic is adequate or lacking; the conclusions of team concerning what the finding mean or indicate about the topic being addressed; and recommendations for actions program managers should take based on the team's conclusions. In short, conclusions should be substantiated by the findings and professional judgement of the team, and recommendations should follow logically from the conclusions.

The evaluation will be conducted over a four week period. The first two days of the evaluation will be devoted to team planning, consisting largely of briefings from key program managers, the team developing a common understanding of tasks specified by the scope of work, what types of information will be needed and how this will be obtained and how it will organize to carry its work. Data collection and analysis will be carried out over the following three weeks with a report submitted for review by the beginning of the fourth week. The team will revise the report based on comments from reviewers by the end of the fourth. Any further revisions will be made by the team leader. The team is required to make all factual corrections identified by the reviewers. However, the team will use its own professional judgement concerning matters of interpretation and analysis of findings.

#### F. Team Composition

- Public health/child survival specialist
- Public health/service delivery specialist
- Institutional analyst
- Program Analyst/team leader

CHILD SURVIVAL PROGRAM  
POLICY IMPLEMENTATION MATRIX\*  
(Revised December 1990; Updated November, 1991)

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

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

<u>CATEGORIES OF POLICY REFORM</u>	<u>POLICY OBJECTIVES</u>	<u>PERFORMANCE BENCHMARKS</u>	<u>DUE DATE</u>	<u>REMARKS</u>
<u>STRATEGY 1: TO CREATE CONDITIONS THAT FOSTER THE EFFICIENT DELIVERY, INCREASED AVAILABILITY AND UTILIZATION OF CHILD SURVIVAL-RELATED SERVICES, PARTICULARLY TO UNDERSERVED AREAS AND HIGH-RISK GROUPS.</u>				
A. Targeting of Child Survival Services	Determination of priority underserved geographic areas.	1. Priority ranked list of provinces and cities, based on classification of provinces and cities using DOI-established high-risk and geographical access criteria.	Prior to release of first tranche.	1. Met 11/89
	Budget allocations linked to program and geographic targeting.	2. Increased budget appropriations given to priority high-risk and underserved provinces and cities.	Oct. 1990	2. Met 10/90
	Determination of functional (programmatic) priorities for additional services and programs.	3. DOI provincial plans address priority child survival-related programs, including family planning and nutrition a. Priority provinces b. 50 percent of total provinces c. 100 percent of provinces	Oct. 1990 Oct. 1991 Oct. 1992	3. a) Met 10/90 b) Met 10/91 c) Documentation: submission of provincial plans of acceptable quality from 100 percent of provinces that (a) address priority CS-related programs, (b) specify service priorities, service levels, commodities

\*The 1992 performance benchmarks will be reviewed after the issuance of the implementing guidelines of the Local Government Code.

B. Increased Delivery of Child Survival Services

Supply of services from DDI, NGOs and private commercial sector increases in accordance with prioritized provincial plans.

1. Annual service delivery performance targets for all\* provinces, based on national end-of-program indicators, set by DDI

2. Achievement of national end-of-program service delivery coverage indicators.

Prior to release of tranches 2, 3 and 4

Dec. 1993

required, annual performance targets and required resources including staff; & (c) include input from provincial representatives of other GOP agencies, e.g., POPCOM, INIC.

The same documentation will satisfy Benchmarks I-C.1 and I-D.11. A checklist will be developed jointly by DDI and USAID which will prescribe the attributes of a plan of acceptable quality.

c) Same as (b) above for all 75 provinces

1. The setting of the 1991 & 1992 provincial performance targets will be negotiated using a process that will ensure that each province will contribute its fair share towards achieving the 1993 national service performance targets.

2. Documentation required to be determined.

\*Original text: " for priority provinces"

2

a. Percent of all children under age one who are fully immunized increases from 70% (1988) to 90%.

b. Percent of pregnant women with tetanus toxoid immunization increases from 37% (1988) to 80%.

c. Percent of all births attended by trained personnel, including trained traditional health personnel, increases from 62% (1988) to 80%.

d. Percent of all pregnant women served by DOI with at least three prenatal visits increases from 40% (1989)<sup>1/</sup> to 80%.

e. Percent of DOI outreach workers trained to deliver a wide range of family planning services increases from 24% (1989) to 75%.

f. Percent of DOI health centers delivering a broad range of family planning services increases from 82% (1989) to 97%.

g. Percent of all midwives and District Hospital doctors and nurses with DOI training in

<sup>1/</sup>Baseline figure to be confirmed in early 1990 when HIS becomes operations nationwide.

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new ARI case management and provided with adequate ARI management drugs/supplies increases from 0% (1989) excluding Bohol Province demonstration program) to 40% (midwives) and 70% (doctors and nurses) respectively.

h. Use of public- and private-supplied ORT in all diarrhea cases in children aged 0-5 increases from 22% (1989) to 60%<sup>2/</sup>

i. Total public- and private-supplied contraceptive prevalence rate for all married women ages 15-44 increases from 47% (1988) to 55.4%<sup>3/</sup>

C. Decentralization

Decentralization of health planning to the regional and provincial levels.

- 1. Provincial health plans that specify service priorities, service levels, commodities required, annual performance targets and required resources, including staff.
  - a. Priority provinces
  - b. 50 percent of total provinces
  - c. 100 percent of provinces

- Oct. 1990
- Oct. 1991
- Oct. 1992

- 1. a. Met 10/90
- b. Met 10/91
- c. See I-A.3.c above

<sup>2/</sup>10/92 measured using special population-based surveys.

<sup>3/</sup>Total contraceptive prevalence includes program and non-program methods. (DOH HIS reports program method acceptance only.) Total CFR will be measured by 1988 National Demographic Survey, 1990 Contraceptive Prevalence Survey and 1993 National Demographic Survey.

2. Regional and provincial health managers trained in health planning

- a. Priority provinces Oct. 1991
- b. 50% of total provinces Oct. 1992
- c. 100% of provinces Oct. 1993

3. Provision of needed health planning technical and managerial personnel to priority provinces (e.g., through transfer of existing personnel, establishment of incentives for relocation of personnel, hiring of short-term contractors). Oct. 1991

2. a. Met 10/91

b. Documentation required:

Report on the number & type of regional & provincial health personnel trained. The provincial staff who will be trained are: Provincial Health Officer and Asst. Provincial Health Officer or Medical Specialist III. From the Regional Health Office, the following will be trained: Asst. Regional Director, Chiefs of Technical Services and Health Manpower Development Division, and Supervisory Planning Officer

c. Same as (b) for all 75 provinces.

3. Met 10/91.

Note: This benchmark has been revised by DOI and USAID as follows:

Organization and activation of a centrally-based core group of skilled DOI planners from relevant DOI units that will function as consultants/trainers to develop the health planning capabilities of provincial planners.

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1. Integration of Child Survival Services	Development of implementation arrangements for population activities outlined in the June 1989 "Integrated Population and Development Program Plan."	1. Completed implementation plan, which considers the administrative and financial feasibility of proposed actions, availability of human and financial resources, and commitment to proposed activities by all implementing agencies.	Oct. 1990	1. Met 10/90
	Development of a national strategy to address malnutrition problems.	2. Completion of a prioritized work plan for the provision of comprehensive nutrition services, including implementation actions needed, time frame for completion and responsible agencies, including responsible agency concurrence.	Oct. 1990	2. Met 10/90
		<u>Note:</u> The review of the 1990 performance benchmarks recommended the addition of the following to the 1991 benchmarks:		
		3. <u>Completed DOI Nutrition Program Plan</u>	Oct. 1991	3. Met 10/91
	Integrated delivery of child survival-related services at the provincial level.	4. Completion and distribution of an integrated MCH operations guide (including child spacing and nutrition activities.).	Oct. 1990	4. Modified. Completion of manual due December 31, 1990
		<u>Note:</u> This benchmark was modified by extending the due date of manual to December 31, 1990. In addition, the following is added to the 1991 benchmarks:		

10/90

	5. <u>Distribution of Integrated MCH Operations guide to all regions.</u>	Oct. 1991	5. Met 10/91
	6. Training of provincial health workers in the integrated service approach.		6. (a) Met 10/91 (including revised job descriptions of staff concerned that will reflect integration of services).
	a. Priority provinces	Oct. 1991	(b) Documentation required: Training syllabus and a report on the number & type of provincial health workers trained.
	b. 50 percent of total provinces	Oct. 1992	
	c. 100 percent of provinces	Oct. 1993	
Integrated health information reporting at the local and national levels.	7. New Field Health Information System (FHIS) operational in all provinces, including an approved management policy statement identifying central, regional and provincial level staff responsible for FHIS operations and monitoring.	Oct. 1990	7. Met 10/90
	8. Plan for the reorganization of the Health Intelligence Service approved, including the identification and training of staff to manage the Health Information System; strengthening of DOH central Health Intelligence Service staff (e.g., upgrade statistical, analytical skills); provide required staff at RHO and FHO levels for FHIS.	Oct. 1990	8. Met 10/90

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Coordination of child survival-related programs at the national level.

Full implementation of program-based budgeting system at provincial, regional and national levels.

Participation of other GOP agencies providing child survival related services in the development of integrated provincial health plans.

9. Designation of DOI Assistant Secretary or DOI official at comparable level for coordination of all GOP and foreign-assisted child survival-related activities.

10. Program plan-based budgeting system (PPBS) in place and fully operational, including trained DOI staff.

11. Integrated provincial health plans that include input from provincial representatives of other GOP agencies, e.g., POPCOM, National Nutrition Council.

- a. Priority provinces
- b. 100 percent of provinces\*

Oct. 1990

Oct. 1991

Oct. 1991  
Oct. 1992

9. Met 10/90

10. Met 10/91

11. (a) Met 10/31

(b) See I-A.3.c

\*Original text: "50% of provinces"

STRATEGY 11: TO ENSURE THE SUSTAINED COMMITMENT TO, DEMAND FOR AND FINANCING OF CHILD SURVIVAL SERVICES THROUGH BOTH THE PRIVATE AND PUBLIC SECTORS

Government Commitment	Demonstrated commitment to increase DOH technical capability in IIS, epidemiological-based planning, IE&C and health care financing.	1. DOH-signed PIO/T for AID-direct financing of technical services in IIS epid.-based planning, IE&C and IICF.	Prior to release of first tranche	1. Met 12/89
	Program budgetting of DOH demonstrates funding for child survival activities.	2. Activities planned by DOH to achieve performance targets are given priority in the DOH budget as evidenced by advices of allotment <sup>1/</sup> a. Priority provinces. b. 50 percent of total provinces c. 100 percent of provinces	Prior to release of:  a. 2nd tranche b. 3rd tranche c. 4th tranche	a. Met 10/90 b. Met 10/91  c. Certification from DOH Finance Office that 1992 field health services budget is adequate to fund Child survival-related services of DOH <sup>2/</sup>
	AID-funded Field Epidemiology training Program (FETP) institutionalized in DOH and used as a resource for targeted, epidemiological-based planning	3. DOH organizational structure formally revised to incorporate FETP as a division or service with permanent positions and budget established	Oct. 1992	3. Administrative Order creating the FETP Service or Division and prescribing its organizational structure & staffing complement <sup>3/</sup>
B. Internalizing the Demand for Preventive Health Services	Development and implementation of a plan to increase consumer demand for preventive health services.	1. IE&C plan for child survival is issued.	Oct. 1990	1. Met 10/90
		2. IE&C plan is operational	Oct. 1991	2. Met 10/91

<sup>1/</sup>Original text: "Activities planned by DOH to achieve performance targets are fully funded as evidenced by advices of allotment".  
<sup>2/</sup>Original text: "Advices of Allotment".  
<sup>3/</sup>Original text: "Documentation required to be determined".

	Development of a strategy for internalizing promotive/preventive health behaviors.	3. Adoption & execution of a strategy promoting smaller family size, complete immunizations, breastfeeding & early illness/disease intervention, etc. <sup>1/</sup>	Oct. 1992	3. A report that analyzes the degree to which the DON has met its target of promoting the internalization of promotive/preventive behaviors planned for in their family planning EPI, breastfeeding, CDD & ARI programs. <sup>2/</sup>
c. Financial Sustainability	Development of a plan for an enhanced Medicare system.	4. Completion of a concept paper for a bilateral National Health Insurance Development project.	Oct. 1990	4. Met 10/90
	Development of a health care financing strategy.	5. Completion of the research agenda and prioritized work plan for development of a comprehensive national HCF strategy. Strategy to include analysis to determine resources needed to sustain child survival-related services; resource generation, cost containment, private sector delivery of appropriate services, shifting role of GOP to regulatory/quality assurance.	Oct. 1991	5. Met 10/91
		Note: USAID & DON have agreed to re-state this benchmark as follows:		
		<u>Formulation &amp; application of methodology to determine total amount &amp; sources of health sector resources needed to support child survival services over the next ten years.</u>	Oct. 1991	

<sup>1/</sup>"delayed marriages" and "smoking cessation" deleted from original text.

<sup>2/</sup>"Original text "Documentation required to be determined."

Development of a cost containment strategy for DOH services.

6. Completed study identifying potential cost containment actions, including contracting for clinical/support services with private sector; procurement, distribution, storage of supplies; preventive maintenance; hospital shared services

Oct. 1991

6. Met 10/91

Note: USAID & DOH have agreed to re-state this benchmark as follows:

Development of a program of action for the implementation of identified cost-containment schemes in DOH facilities at the regional, provincial & district levels.

Development of an improved cost recovery scheme for DOH facilities and services.

7. Completed analysis of user fees for DOH hospitals clinics, pharmaceuticals with recommendations for strengthening user fee retention system.

Oct. 1991

7. Met 10/91

Note: DOH & USAID have agreed to re-state this benchmark as follows:

11

Completed analysis of (a) existing user-fee and cost sharing experiences in selected facilities and services; (b) potential of user fees to cover PNH recurrent costs; and (c) recommendations for strengthening user fee retention system.

In addition, the following has been included in the 1991 performance benchmarks:

8. Completed analysis of existing shares of local and national government in funding of health care services, specifically child-survival related activities.

Oct. 1991

8. Met 10/

D. Increased Private Sector Involvement

Development of plans for the privatization of the Philippine Heart Center, Philippine Children's Medical the National Kidney Institute and the Lung Center of the Philippines

1. Completion of the privatization plans for these four institutions and, in consultation with the Committee on Privatization, decisions made re: implementation of the plans.

Oct. 1990

Note: The review of 1990 performance revised this benchmark as follows: Oct. 1991

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Completed Studies on: (a) the policy, regulatory, and legislative framework for health services privatization and (b) the privatization of the four specialty hospitals.

1. Met 10/91

\*Clarification of documentation requirement

a) A study will be undertaken to examine the policy, regulatory, and legislative framework of the following privatization options: (a) complete divestiture; (b) privatization of management (management contracting); and (c) privatization of support services.

The report will (a) establish the rationale for health services privatization; (b) define the overall regulatory framework for privatization by reviewing GOP's overall privatization policy and implementing mechanisms; (c) identify political issues and considerations regarding the privatization of the four specialty hospitals; and (d) generate criteria for evaluating privatization options for the four specialty hospitals.

b) The privatization study will investigate the feasibility of the following options: (a) complete divestiture; (b) privatization of management (management contracting); and (c) privatization of support services.

The report will (a) assess the performance of the four specialty hospitals; (b) evaluate each of the privatization options, starting with complete divestiture, then management contracting, then privatization of support services; (c) recommend a privatization strategy based on the evaluation.

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Establishment of partnerships for the provision of basic health services.

2. Implementation of a grant partnership program, including management arrangements for provision of child survival related services in geographically inaccessible areas by provincial based NGOs.

Oct. 1990

2. Met 10/90

Expansion of private sector participation in health planning

3. Consumer and private sector health provider representation on Provincial Health Councils in priority provinces.

Oct. 1991

3. Met 10/91

Note: The review of 1990 performance revised this benchmark as follows:

Identification of appropriate mechanism/s for private sector participation in health planning and implementation in 8 provinces.

Oct. 1991

Development of a strategy for increased role of the private sector in the provision of health services.

4. Completion of a prioritized work plan for the increased role of the private sector, including strategy for the privatization of health facilities, the areas of direct service provision; local provision of equipment, medicine and supplies; contract services; policy incentives to make provision of health services more attractive to the private sector.

Oct. 1991

Note: For better clarity, DOH & USAID have agreed to restate this benchmark as follows:

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4. (a) Designation of organizational unit in DOI and articulation of its mandate to develop and implement opportunities for public-private sector collaboration.

4. (a) Met 10/91

(b) Development of an agenda for public-private sector collaboration in the provision or financing of health services, e.g. privatization of service delivery, service contracting, COP-HMO risk-sharing scheme.

(b) Met 10/91

Stimulation and facilitation of HMO development

5. Proposed regulations and quality control guidelines for HMO operations.

Oct. 1991

5. Met 10/91

6. Develop a government/private sector risk-sharing program for HMO development

Oct. 1992

6. A report on the status of PHCC-tie-up.\*

NOTE: In order to intensify efforts for increased private sector involvement, the following policy objective and two performance indicators have been incorporated into the CSP policy matrix:

Privatization of DOI services

7. Private sector entity contracted for field distribution of Hepatitis B vaccine.

Oct. 1991

7. Met 10/91

\*Original text: Documentation required to be determined."

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8. Amount in DOI/PIHES budget contracted to private sector increaseds from zero in 1990 to at least ¥50 million in 1991.	Oct. 1991	8. Met 10/91.
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Review Procedures for Evaluating GOP Progress  
Towards Meeting 1991 Performance Benchmarks  
Under the Child Survival Program

1. In December 1990, the Mission and DOH reached agreement on the 1991 set of Child Survival Program (CSP) Performance Benchmarks (PBs). The PBs were approved by the USAID Director and the Secretary of Health.
2. The Mission together with DOH will arrange quarterly workshops to review progress of DOH performance toward meeting benchmarks. The workshops are to be attended by the staffs of DOH (Undersecretary Mario Taguiwalo, Program Coordinating Unit, and Program Chiefs) and USAID (OPHN, DRM), and CSP Technical Assistance Team. The first such workshops was held on January 23, 1991. The objectives of that workshop were to:
  - o Clarify and specify each PB.
  - o Identify documentation and data required to prove achievement of each PB.
  - o Develop work plans and specify resource requirements for achieving each PB; identify individuals and offices within the DOH, USAID, and the Technical Assistance Team that will be responsible for meeting PBs.
  - o Establish PB Tracking Team consisting of members of the DOH Program Coordinating Unit (PCU) and the TAT.
3. Each month, the PB Tracking Team and USAID/OPHN will review and report on the progress in the implementation of the PB work plans.
4. The USAID Child Survival Program Team will meet at least quarterly (in conjunction with Quarterly Progress Status Report preparation, and as required) to:
  - o review process and progress of meeting PBs
  - o resolve process or progress issues
  - o report on progress or problems.
5. The Mission and DOH will continue to sponsor the second and third CSP-PB Quarterly Workshops. The objective of these sessions will be to assess progress, and discuss and resolve identified issues and constraints towards achieving PBs.
6. The objectives of the fourth quarter's meeting, which will include representation from NEDA, will be to:
  - o assess progress in achieving PBs
  - o review and prepare final documentation required as proof of achievement of PBs and preliminary preparations of following year's set of PBs
  - o prepare all required documentation for USAID Mission Review of PBs achievement.

7. OPHN will then convene a meeting of the Child Survival Program Team and submit relevant documentation (i.e., policy benchmarks and documents validating successful achievement of the PBs) to team members. The purpose of the meeting is to:
  - o determine achievement of PBs and outline the next set of benchmarks for FY 1992
  - o identify and act on any outstanding issues
  - o recommend drafting of Action Memo by DRM on release of funds and follow-up actions with the DOH.
8. The CS Program Team will then forward its recommendations to the Mission Review Committee (MRC), which will meet to determine whether the PBs have in fact been met. MRC members will signify concurrence that PBS have been satisfactorily met by clearing Action Memorandum (drafted by DRM) approving tranche release and FY 1992 PBs.
9. If required, OPHN will arrange a meeting between the Mission Director and the senior DOH officials to discuss any shortcomings.

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ACTION MEMORANDUM FOR THE DIRECTOR

THRU : Richard A. Johnson, Deputy Director 

FROM : Dr. Emmanuel Voulgaropoulos, OPHN   
Cameron L. Pippitt, ODRM

SUBJECT: CHILD SURVIVAL PROGRAM (CSP) 492-0406  
1991 Performance Benchmark Review

Requested Action:

Your approval is required to approve the provision of the 1991 tranche of \$13 million for the subject program.

Discussion:

The Department of Health (DOH) has submitted the documentation required under the CSP Grant Agreement to demonstrate compliance with the 1991 performance benchmarks by October 31, 1991. This documentation included evidence of completion of all 22 required benchmarks due in 1991. Guidelines for reviewing performance of sector assistance programs issued by DRM in February 1991 were followed in assessing DOH progress in meeting these benchmarks. In addition, the DOH and OPHN had agreed on a progress tracking process that involved monthly and quarterly meetings between USAID and the DOH to review progress. Following these procedures, the CSP Program Team met on November 5 to evaluate the adequacy of the documentation submitted. Issues raised and additional information requested by the Team was satisfied by the DOH during the formal USAID/DOH/NEDA review of the 1991 CSP performance benchmarks on November 6. USAID was represented at this meeting by Dr. Emmanuel Voulgaropoulos, Ms. Patricia Moser and Dr. Rosendo Capul of OPHN, and Mr. Cameron Pippitt of ODRM.

An additional requirement for this year's disbursement is USAID and DOH agreement on the 1992 performance benchmarks. The recently completed mid-term evaluation of the program concluded, among other things, that the policy implementation matrix' performance benchmarks are adequate measures of the policy objectives to be met, and that the CSP is well on its way to meeting the 1993 service delivery benchmarks. Consequently, the evaluation recommended that the policy matrix remain as it is, and that additional performance benchmarks are not necessary in order to meet program goals.

CSP Performance Review

The Mission review to evaluate the grantee's performance versus the 1991 CSP performance benchmarks was held on November 15. Following are the results of the CSP performance review:

1. Compliance with the 1991 CSP Benchmarks

Except for partial compliance with benchmark II.C.8, which is likely to be fully accomplished before the end of the CY 1991, the 1991 CSP performance benchmarks have been met;

2. Other CPs Satisfied

The Grantee has furnished documents, in form and substance satisfactory to USAID, as evidence of compliance with all other CPs to the release of the third tranche.

Attached are the Mission's review of each of the performance benchmarks attesting to the Mission's level of satisfaction with the submission and any action taken or required.

DOH-OPHN Agreement on the 1992 Benchmarks

Representatives of the DOH and OPHN met on November 8, 1991 to agree on the 1992 performance benchmarks. The process took into account the recommendations of the mid-term evaluation and the outcome of the 1991 performance review held on November 6. Since the evaluation did not recommend any modification of the matrix and since no major issues emerged during the performance review, there were no substantive changes made in the 1992 CSP benchmarks. Textual revisions were made for clarification and to specify the documentation required for compliance. The revised 1992 benchmarks are also attached.

The committee concurs with the action taken on the 1992 CSP performance benchmarks.

Conclusion

On the basis of the above, the Committee finds that, except for full completion of Benchmark II-C.8, all the requirements (Section 4.3(a) to (e) of the CSP Grant Agreement for the 3rd performance-based tranche as having been satisfied.

Recommendations:

It is recommended that:

1. You accept the above conclusion of the Mission Review Committee;
2. Since substantial progress has been made on Benchmark II-C.8, viz, the report on central and local government shares in financing the delivery of health services has been completed; the DOH has discussed the report with the President of the League of Provincial Governors; and the DOH has written USAID of its intent and immediate plans to widen the arena of discussion of the report, you accept Benchmark II-C.8 with the following modification:

A report on the discussions held by DOH with local government representatives responsible for policy formulation on the study on National and Local Government Shares in Health Care Financing, which outlines study implications and future policy action, to be submitted before December 31, 1991.

- 3. You approve the release of the 1991 CSP tranche of \$13 million subject to receipt and satisfactory Mission review of report identified in (2) above.

APPROVED : MB

DISAPPROVED : \_\_\_\_\_

DATE: DEC 5 1991

Attachment:  
 Mission Review Committee Memorandum  
 Updated CSP Policy Implementation Matrix

Clearance: Program Team:  
 DRM:CPippitt (draft)  
 OLA:GBanzon (draft)  
 OPHN:RCapul (draft)  
 OFM:SFrancisco (draft)  
 CSO:WReynolds (draft)  
 OPE: Trinidad (draft)

Mission Review Committee:  
 DRM:RMcLaughlin (draft)  
 OFM:DOstermeyer (draft)  
 OLA:LChiles (draft)  
 OPE:PRDeuster (draft)  
 OFFPVC:BGeorge (draft)  
 PESO:BCornelio (draft)

Drafted: *RC* OPHN:RCapul:fcs  
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Ms. Eireen Villa, Program Coordination Unit

Dr. Avenzado, Provincial Health Officer, Mindoro Occidental  
Dr. Ramos, Assistant Provincial Health Officer, Mindoro Occidental  
Dr. Milagros Balgos, Provincial Health Officer, Capiz  
Ms. Concepcion Rendon, Midwife Supervisor, Roxas City Capiz  
Dr. Gomez, Assistant Provincial Health Officer, Pampanga  
Dr. Blas Costelo, Assistant Provincial Health Officer, Agusan del Norte  
Dr. Rana, Nutrition Coordinator, Agusan Del Norte  
Ms. Tulang, Administrative Officer, Agusan del Norte  
Ms. Costelo, Family Planning Coordinator, Agusan del Norte  
Dr. Inocentes Dagohoy, Provincial Health Officer, Bukidnon  
Ms. Imelda Balcosa, Administrative Officer, Bukidnon  
Ms. Erlinda Tenorio, Supervising Rural Health Midwife, Bukidnon  
Ms. Violeta Almacen, Family Planning Coordinator, Bukidnon  
Ms. Nita Gacos, FHSIS Coordinator, Bukidnon  
Dr. Resurrecion Creer, Sumilao RHO, Bukidnon  
Ms. Melba Cabahug, Rural Health Nurse, Bukidnon  
Ms. Venus Cunada, Rural Health Midwifr, Bukidnon

Nurses and Midwives at:

San Fernando Rural Health Unit, Pampanga  
Talisay Rural Health Unit, Negros Occidental  
Bago City Health Unit, Negros Occidental  
Valladolid Health Unit, Negros Occidental  
Panay Rural Health Unit, Capiuz  
Pontevedra Rural Health Unit, Capiz

#### USAID

Dr. Emmanuel Voulgaropoulos  
Dr. Rosendio R. Capul  
Ms. Patricia Moser

#### CSP Technical Assistance Team

Dr. Steven Solter  
Dr. Benjamin Loewinsohn  
Mr. Manueal S. Sta. Maria  
Mr. Jose Raphael Hernandez  
Ms. Emelina S. Almario

#### References

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Vitamin A Nutrition Strategy, USAID, 1991 (draft).

Public Health Midwife Utilization Study, DOH/IPS, 1991.

Maternal and Child Health/ORT Use Rate Survey, DOH, 1991 (draft).

Summary of a Baseline Health Facility Survey, DOH, 1991.

National Plan of Action for elimination of Neonatal Tetanus from the Philippines, DOH, 1991 (draft).

Field Health Service Information System, Manula of Procedures, DOH

Cost Effectiveness Study for Diarrhoeal Disease Control Programme, WHO (Dr. Birger Carl Forsberg), 1990.

Department of Health Comprehensive Nutrition Program 1992-1996, Nutrition Service DOH, 1991.

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CSP/Technical Assistance Team Workplans, October 1991 to March 1992.

CSP/Technical Assistance Team, Quarterly Progress Reports for January-March, 1991 and April-June, 1991.

PIO/T and Contract Amendment with Management Systems for Health, 1990. USAID/Philippines.

Area and Program Based Health Plans for 1991 for Capiz and Mindoro Occidental.

Memorandum to the Files: MSH Child Survival Program Technical Assistance Team, September 12, 1991. Rosendo R. Capul, O/HPN, USAID/Philippines.