MEMORANDUM

November 30, 1987

TO: Distribution

FRCM: ANE/PD/EA: Carla Barbiero

SUBJECT: Philippines: Targetted Child Survival PID (492-0371) - Project Review Committee Meeting.

A Project Review Committee meeting to review the subject document will be held on Friday, December 4, 1987 at 3 P.M. in Room 3320A, New State.

Your participation is invited.

Attachment: PID

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Department of State

INCOMING TELEGRAM

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ACTION AID-00

ACTION OFFICE ANPD-05
INFO ANPD-03 ANTR-06 STHE-02 ES-01 RELD-01 ANEA-02

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TO SECSTATE WASHDC 2860

UNCLASS MANILA 38406
AIDAC

E.O. 12350: N/A
SUBJECT: PHILIPPINES' TARGETED CHILD SURVIVAL PROJECT
- (492-0371)

REF: MANILA 33864

1. THE PID FOR THE REDESIGN OF THE PRIMARY HEALTH CARE
FINANCING PROJECT INTO THE TARGETED CHILD SURVIVAL
PROJECT WAS SENT VIA WANG LINK TO ANE/PD NOVEMBER 20,
1987. AS STATED REFTEL, THE PID SEEKS TO CONSOLIDATE
THE MISSION'S ONGOING AND PROPOSED HEALTH ACTIVITIES
INTO ONE CHILD SURVIVAL PROJECT. PLEASE REFER TO REFTEL
FOR DETAILS OF REDESIGN STRATEGY AND RATIONALE. HARD
COPY OF PID, INCLUDING SIGNED FACESHEET, POUCHED TO

2. THE PID SEEKS TO INCREASE THE AUTHORIZED LEVEL OF
THE PROJECT BY DOL 7.5 MILLION, EXTEND THE PACD TO
JANUARY 1993, AND CHANGE THE NAME OF THE PROJECT FROM
PRIMARY HEALTH CARE FINANCING TO TARGETED CHILD SURVIVAL.

3. PROJECT CONCEPT HAS BEEN DISCUSSED WITH NEDA, AND
THEIR CONCERNS HAVE BEEN REFLECTED IN PID OR WILL BE
REFLECTED IN PP. NEDA HAD NO PROBLEMATIC ISSUES TO
RAISE WITH REGARD TO THE PROJECT.

4. MISSION REQUESTS AID/W EXPEDITIOUS REVIEW OF PID AND
APPROVAL FOR MISSION TO AUTHORIZE THE PROJECT IN THE
FIELD, INCLUDING REDELEGATION OF AUTHORITY TO EXTEND THE
PACD. WOULD VERY MUCH APPRECIATE RECEIPT OF PID CABLE
BEFORE END OF DECEMBER. PLATT
EXECUTIVE SUMMARY

1. Grantee: The Government of the Philippines (GOP)

2. Implementing Entity: The Department of Health (DOH)

3. Grant Amount: $25.0 Million Life of Project (LOP)

4. Project Purpose: The purpose of the project is to improve the services, to maximize child survival.

5. Project Amendment Summary: This amendment is to redesign the project formerly titled Primary Health Care Financing, change the title to Targeted Child Survival and extend the PACD to 1/31/93. Existing components of the project related to Child Survival will be retained or expanded. Those to be retained include the Barangay Health Worker Activity, Institutional Development, Botica sa Barangay, and the Field Epidemiology Training Program. Programs to be expanded include the Expanded Program on Immunization, the Control of Diarrheal Diseases/Oral Rehydration Therapy, and Communications and Social Marketing. In addition, an Acute Respiratory Infection activity will be added to the Project. Project support for financing schemes will continue at a reduced level, and will be reoriented to child survival activities.

6. AID Project Inputs The project authorization will be increased by $7.5 million, bringing the life-of-project total to $25.0 million, as follows:
<table>
<thead>
<tr>
<th>Description</th>
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<td>Child Survival Impact Programs</td>
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<td>Financing Schemes and Special Studies</td>
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<td>Emphasis areas</td>
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<td>Project Management</td>
<td>500</td>
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<td>Evaluation and Audit</td>
<td>300</td>
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<td>Inflation and Contingency</td>
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<td><strong>TOTAL</strong></td>
<td><strong>25,000</strong></td>
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</tbody>
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## ANNEX
Preliminary Logframe

## ACRONYMS

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infections</td>
</tr>
<tr>
<td>BHWS</td>
<td>Barangay Health Workers</td>
</tr>
<tr>
<td>CDD</td>
<td>Control of Diarrheal Diseases</td>
</tr>
<tr>
<td>CDSS</td>
<td>Country Development and Strategy Statement</td>
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<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<td>CS</td>
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<td>DOH</td>
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<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<td>FETP</td>
<td>Field Epidemiology Training Program</td>
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<td>HEALTHCOM</td>
<td>Communication for Child Survival Project (931-1018.1)</td>
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<td>IE&amp;C</td>
<td>Information, Education &amp; Communication</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>KAP</td>
<td>Knowledge, Attitude and Practices</td>
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<td>LBW</td>
<td>Low Birth Weight</td>
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<td>MCH</td>
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<td>Midwife</td>
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<td>National Rehydration Training Center</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>--------------</td>
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<td>ORT</td>
<td>Oral Rehydration Therapy</td>
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<td>United Nations International Children Emergency Fund</td>
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<td>UP</td>
<td>University of the Philippines</td>
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<td>USAID</td>
<td>U.S. Agency for International Development, Manila, Philippines</td>
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<tr>
<td>USC</td>
<td>Under Six Clinic</td>
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<td>USDH</td>
<td>United States Direct Hire</td>
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<td>WHO</td>
<td>World Health Organization</td>
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TARGETED CHILD SURVIVAL PROJECT (492-0371)

I. PROJECT DESCRIPTION

A. Background and Problem Statement

The background material and description of health sector problems in the original project paper (PP) and supplements remain valid. The service delivery gap described in the original PP continues to exist. Diarrheal disease still constitutes a serious developmental problem, as noted in the Oral Rehydration Therapy Supplement to the PP. The shortage of professional epidemiologists in government health services addressed by the project's Field Epidemiology Training Component is still a threat to the successful implementation of the country's health care policy. Finally, the need for streamlined implementation described in the June 1987 PP Supplement remains. To update these statements and more fully explore the causes of childhood morbidity and mortality, the following information is provided:

1. Although the Philippine Infant Mortality Rate (IMR) has continued to decline since the seventies and is considerably lower than that found in many developing countries, it is still unacceptably high at 54 per 1000 live births (DOH, 1986). Furthermore, regional mortality differences within the country remain substantial. The less developed regions (Regions V, IX and XII) have higher IMRs compared to the more economically developed portions of the country (NCR, Regions III and IV). Regions which have a considerable proportion of ethnic minority groups invariably have higher IMRs than areas inhabited by predominant social groups.

2. Communicable diseases remain an important cause of childhood morbidity and mortality and affect both rural and urban target groups. The leading causes of under-five mortality in the Philippines are pneumonia, diarrhea, bronchitis, and measles. Recent studies on acute respiratory infection (ARI) conducted in rural and urban areas showed that the mortality rate due to ARI is more than twice as much in urban slum communities than in rural areas.

3. Available nutrition data from the Philippine Department of Health (DOH) reveal that the proportion of newborn infants with low birth weight (LBW), i.e. less than 2500 gm, was 18.3% in 1977; 17.7% in 1982; and 15.5% in 1985. Area specific studies conducted by non-government institutions show that further decreases in the proportion of LBW is possible. In 1982, 17.2% of preschoolers were underweight, 20.6% were stunted and 9.5% were suffering from wasting. As a result of the economic downturn, however, the prevalence of underweight among preschoolers reached 22%, stunting rose to 24.8% while wasting
was recorded at 14.3% in 1985. Moreover, 1982 survey results indicate that there were more preschoolers suffering from wasting in all urban areas combined (11.2%) than in rural areas (8.9%). On the other hand, the rural areas showed a higher proportion of stunting (21.9%) than in urban areas (17.6%).

4. Review of Current GOP Activities - The maternal and child health program of the DOH, which consists of maternal care, child care, expanded program on immunization (EPI) and care of school children, and the control of diarrheal diseases program, is implemented at the field levels using a primary health care approach. The DOH Under Six Clinic (USC) program provides comprehensive promotive, preventive and curative care to the preschool child. Rooming-in, promotion of breastfeeding, supplementary feeding, growth monitoring and treatment of illness are done in USCs.

a. EPI is a priority thrust of the DOH, with the goal of immunization of every Filipino child against polio, measles, diphtheria, pertussis, tetanus and tuberculosis by 1990. Together with the WHO, USAID through the Primary Health Care Financing Project, and UNICEF, the DOH has stepped up efforts to reduce the morbidity and mortality rates of the six EPI diseases mentioned above by increasing the proportion of fully immunized children in their first year of life and by providing pregnant women with tetanus toxoid immunization to reduce the incidence of neonatal tetanus.

b. The DOH program of reducing diarrheal morbidity and mortality focuses on oral rehydration therapy (ORT), although morbidity reductions are also to be achieved through non-case management control strategies. USAID has provided assistance through the ORT component of the subject Project. A National Rehydration Training Center (NRTC) was established at the San Lazaro Hospital and clinical management courses held. Efforts are also being focussed on the private sector.

c. With the growing recognition of the impact of acute respiratory infections (ARI) on childhood mortality and morbidity, the DOH has started to plan for the phased implementation of a national ARI program based on the WHO model of early detection and management. Wider administration of Vitamin A, perhaps in conjunction with the EPI program may also play a role.

d. One of the major obstacles for the achievement of reasonable levels of childhood mortality and morbidity is the failure of intervention programs to be sufficiently targeted at the highest risk populations. Preventive, low cost technologies such as EPI and ORT should be focussed on population groups and geographic areas that are contributing the most to high mortality and morbidity rates. The development of comprehensive
epidemiologic services is critical to the successful policy of targeting health services. To support this effort, epidemiological data for health planning is being strengthened through the Field Epidemiology Training Program (FETP) component of the PHCF Project. The DOH has issued a Health Development Plan for unserved and underserved areas, identifying zones to be targeted.

B. Project Goal and Purpose

The project goal is to reduce infant and childhood mortality in the Philippines. The purpose is to improve the utilization of selected primary health care services, to maximize child survival. This purpose will be achieved by a strategy of supporting: (1) three key national DOH service delivery programs (CDD, ARI, EPI), (2) area based child survival plans (i.e., targeted at underserved high risk provinces, municipalities and urban poor); and (3) institutional support for these programs in the form of technical assistance, communications, training, and needed studies/research.

C. Expected Project Achievements/Outputs

The functionally selected and risk group targeted interventions supported in the project will result in: increased coverage of immunization for the six EPI diseases; increased use of ORT among children with diarrhea; improved diagnosis and treatment and reduced case fatality rate for ARI; and reduced morbidity through preventive and promotive actions in conjunction with the service delivery interventions. In addition, the project will provide critical policy, operational and financing studies and research schemes that will increasingly focus the DOH child survival impact programs on the most cost-effective, sustainable interventions.

This project amendment substantially reduces the amount of project support for financing schemes, changing its focus and that of the Special Studies activity to one directly related to child survival. Several other on-going components of the current PHCF project will continue as programmed, as they are clearly consistent with the child survival theme of this revised project. These include the BHW/MW activity, Institutional Development, Botica sa Barangay, and the FETP. At the same time, the emphasis of the project will shift to programs of child survival to be expanded such as EPI, CDD/ORT, and Communications and Social Marketing while ARI will be added as one of the mainstay interventions. These national emphasis programs will be complemented by comprehensive interventions in geographic areas of emphasis with high risk groups.
1. **Expanded Program on Immunization (EPI)**

In 1986, an accelerated EPI effort began with a national policy commitment to immunization expressed by Presidential Proclamation No. 6, and strong donor support including the reprogramming of substantial USAID funding in the PHCF project to address EPI program needs. While the groundwork for improved coverage through mass campaigns in the cities and an upgraded program in the countryside has been established, additional AID inputs are required to sustain these efforts over the next five years.

Current USAID support for EPI under the Primary Health Care Financing (PHCF) Project amounts to $1.65 million, for commodities, logistics and supervision support, training information, education and communication (IE&C), and evaluation. But these inputs last only through 1989 and require additional support to ensure a complete, sustainable EPI effort. For example, expansion of a functional national cold chain network is a top priority for EPI. An expanded effort in selected urban areas, where coverage is lowest, will require substantial inputs in support of an emerging urban EPI strategy. Greater attention to program management, reporting and monitoring will also be required, as EPI moves from an emphasis on increasing coverage to 90% by 1990, to guaranteeing long term program sustainability and effectiveness.

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

Current efforts to control diarrheal diseases are focussed on ORT, particularly on the training of medical practitioners and other health workers in the clinical management of diarrhea. While considerable success is being achieved in promoting ORT among the medical professionals, there is a need to enhance public promotion of ORT and private sector participation in ORT activities. In addition, the current CDD program needs to be strengthened to include technical assistance for management improvement, sustaining the correct use of ORT, promotion of breastfeeding, improving feeding practices during diarrheal episodes, and improving hygiene practices.

3. **Acute Respiratory Infections (ARI)**

Based on current ARI research in the Philippines and WHO worldwide studies, it is now possible to gradually phase in a number of program interventions on a national scale, to reduce the ARI/pneumonia contribution to child mortality through early recognition, appropriate treatment and referral of severe cases.

The ARI component of the project will contribute to achieving increased reductions in ARI mortality through several interventions, including: improved diagnosis and case management
of acute respiratory infections, particularly childhood pneumonia; training of nurses, midwives, and selected Barangay Health Workers (BHWS), to assess the severity of ARI infections; an IE&C campaign stressing the proper timing of bringing a sick child to a health facility, and teaching preventive measures; and improved understanding of the epidemiology and etiologies of ARI. Complementary to these interventions will be the accelerated immunization program, since deaths from vaccine preventable diseases, especially measles, constitute 20-50% of ARI mortality.

4. Social Marketing and Health Communication

The project will develop and implement a major mass media, social marketing campaign for child survival. It will seek to integrate and institutionalize the planning and execution of the child survival communication program initiated in Project Paper Supplement #3. This effort will include support for promotion of ARI, EPI and CDD.

5. Financing of Child Survival

Cost effectiveness of various child survival interventions, alone and in combination will be conducted; recurrent cost implications of these programs examined; and the financial sustainability of area based CS plans will be considered. Alternative sources of financing for these interventions will also be investigated.

6. Targeted Child Survival Areas

Although on a national scale the major causes of child mortality can be attributed to childhood pneumonias (ARI), diarrheal and immunopreventible diseases, the severity of their effects varies greatly by region and socio-economic group. It is thus important to target intensive child survival efforts in high risk areas and among high risk population groups, through more comprehensive CS plans that are specific to the health risks of given areas. For example, a comprehensive MCH approach including growth monitoring, birth spacing, breastfeeding promotion and Vitamin A supplementation, targeted at high risk of childbearing age and 2nd and 3rd degree malnourished children, supplementing CDD, EPI and ARI control, could be implemented on an area specific (i.e., province, slum area, municipality) basis.

The selection of the Emphasis Areas for concentration of CS inputs will be based on such criteria as high infant and child mortality; prevalence of malnutrition; current availability of health services, both public and private; water supply and sanitation situation; and willingness and ability to implement project-funded CS plans. The selection process will also take into account the current and proposed area-based programs of
other donors, such as UNICEF, WHO and the World Bank, avoiding duplication and overlap while maximizing complementarity.

Technical assistance and support arrangements will be set up under the project to assist designated Emphasis Areas. The total number and expanse of population/areas to be impacted will also be in part determined by funding levels available, and USAID and GOP implementation and monitoring capacity. It is expected that the project's focus will be more on demonstrating alternative organizational models and program mixes for improving child survival, rather than achieving broad coverage of the 30% of population (18 million) targeted by DOH as living in depressed underserved areas. The potential international and local PVO role in providing needed services and serving as a conduit for assistance will be explored during project development.

D. Project Inputs

The project will include extensive inputs of technical services, training, research, media costs, commodities and funding local support costs. Technical services will be provided through HEALTHCOM for DOH staff development, communication planning and program management, and design and implementation of media campaigns for EPI, ARI and CDD. Technical services in immunization, diarrheal disease control and communications and social marketing will be provided through buy-ins to the centrally funded REACH, HEALTHCOM and PRITECH projects, while additional technical services to be contracted locally will be provided for the development, implementation and monitoring of child survival plans in Emphasis Areas. Technical services will be provided through a PASA with CDC for training in field epidemiology. Additional TA may be requested from US Bureau of Census to strengthen the DOH's Health Information System (HIS). It is anticipated that a total of approximately 174 person-months of long term and 50 person-months of short term technical assistance will be provided under the project. Of these amounts, approximately 100-120 person months will be local technical assistance, although this is still a very preliminary estimate.

Effective service delivery depends in no small amount on a solid data base, operational, epidemiological, survey research, and routine service statistics. This input will serve to validate CDD, EPI and ARI as being highest priority interventions; to validate high risk Emphasis Areas; and for baseline data generation for monitoring and evaluating child survival program impact on mortality. In addition, this component should contribute to the improvement of the HIS.

Training inputs will include formulation of training curricula, production and distribution of training materials and training aids, development and conduct of courses and workshops in country and specialized participant training in US and third
countries. While each of the major impact programs as well as area CS Plans will entail some type of DOH staff, community or even private sector training as part of the service delivery element, the project will also provide support for training in child survival management and planning. Training will include short-term in-service courses for DOH and medium term (1-3 months) academic courses in Child Survival through the cooperation of the U.P. Institute of Public Health or other qualified sources.

Advertising costs, message development, promotional materials and media time and placement will be among the key information and communication inputs provided by the Project. Commodities will be a major input in support of the Child Survival program. Cold chain equipment, equipment for supporting training and lab research related to ARI, transport, especially motorcycles, weighing scales and health cards required for emphasis area high risk infant care and other supplies essential to the program will be provided. Local support costs will be required for all the program activities, but especially for implementation of child survival plans in emphasis areas.

E. Estimated Project Cost and Methods of Financing

The Child Survival related components of the current PHCF Project total approximately $13 million, most of which is for EPI, CDD and Communications for Child Survival. Currently, these inputs are scheduled to last through 1989. The amended project, which will extend the PACD to 1/31/93, will require additional financing for continuity and strengthening of these on-going programs, plus new financing for the national ARI program and emphasis area CS plans. The project authorization will be increased by $7.5 million for a life-of project total of $25.0 million. Existing obligations ($16,953,000) will cover project requirements until FY 89 or FY 90, at which time new funds will be incrementally added, subject to their availability. GOP inputs will total $15.0 million, as shown in the proposed budget on the following page:
### ESTIMATED CHILD SURVIVAL BUDGET ($000)

<table>
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<th></th>
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#### A. Child Survival Impact

**Programs:**

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#### B. Financing of CS

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#### F. Evaluation/Audit

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#### G. Inflation & Contingency

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**TOTAL**

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<td>17,500</td>
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In general, the method of financing for foreign exchange costs will be through either direct or bank letters of commitment issued to suppliers or direct payment under direct or host country contracts for technical services. Local costs will be financed principally by using the advance/liquidation scheme through the GOP system. USAID can pay directly to local suppliers, provided it is agreed to in writing by USAID.

#### F. Proposed Project Implementation Plan

The implementing agency for the project remains the DOH. Detailed implementation plans for on-going activities in EPI, Communications, CDD, FETP and other components have been developed by LOH and USAID covering the period 1988-89. A newly formed Project Management Staff office is also consolidating DOH management of all project activities under one manager and staff. The addition of ARI on a phased basis beginning in 1988 will be the only aspect of national programs requiring significant implementation planning during PP design and during 1988-89.
Implementation of child survival plans in Emphasis Areas, however, will be carried out through a new mechanism to more effectively and expeditiously direct resources to the local level. Several possible alternative organizational arrangements will be explored during PP development. One possible arrangement would be for regional or provincial health offices in the target areas to submit child survival action plans to a national foundation affiliated with the DOH. Other possibilities include joint programming with a new GOP effort to reach most depressed municipalities; working through a national PVO; a consortium of local PVOs with several entrees to local communities where DOH is weak; or contracting a private management firm(s) to implement this effort. The foundation, NGO, cooperating agency or other alternative would serve the following purposes: provide consultant technical assistance to local areas to develop, monitor, review and amend the child survival action plans; recommend plans for approval of DOH and USAID; manage funding for operating expenses, consulting expenses and sub-projects (approved action plans); maintain files and accounting records; and report regularly on project status.

G. Audit and Evaluation Plan

The evaluation plan for the Targeted Child Survival Project will include several evaluation activities undertaken jointly by AID, the DOH and the yet to be determined implementing organization for emphasis areas. Building upon the expected 1987 Tier III (Impact) CS Evaluation in Cebu, under Johns Hopkins auspices, the project will have baseline information on infant and child mortality, upon which to measure progress in emphasis areas at the conclusion of the project. The plan will also provide for periodic evaluations of the Tier I and Tier II type to measure inputs and effective use. This will depend on information routinely gathered in the Health Information System (HIS), as well as special purpose surveys and studies on selected questions such as ORS use, EPI coverage, and KAP surveys to measure impact of the communication program. A total of $250,000 is budgeted for establishing baseline information for impact evaluation and HIS improvement, with an expectation that additional central AID/W CS evaluation funds may also be made available. A total of $50,000 is budgeted for external auditing services.

II. FACTORS AFFECTING PROJECT SELECTION

A. Relationship to CDSS and GOP Development Plan

The ANE Bureau Background Paper on Poverty in Asia stresses that "Improvements in Human Capital may well be the most significant investment we can make in marginal areas," and states that child survival programs can provide quick payoffs in terms
of improvement. USAID's intermediate child survival objective as stated in the FY 88 Action Plan is to re-initiate declines in rates of infant and child mortality and malnutrition primarily by: improving expected value of interventions through better information and more focused programmatic and geographic targeting; improving the participation rates in preventive, promotive and early treatment programs. More specifically, our child survival assistance will support GOP efforts to lower: the infant mortality rate from 55.5 in 1986 to 47.8 in 1992; the child mortality rate from 4.9 in 1986 to 3.7 in 1992; the percentage of pre-school children with less than 75 percent of standard weight for age from 21.6 percent in 1986 to 14.4 percent in 1992.

The Mission had originally planned to develop an FY 87 Child Survival Project as described in the FY 88 CDSS Supplement. However, due to delays in DOH reorganization and the need to focus DOH attention on reprogramming the subject project, the introduction of a new project in child survival was delayed until FY 88. During recent months a PID for a new Child Survival Project was developed in close collaboration with DOH, WHO, and UNICEF. The scheduling of the new project remained uncertain, however, due to the limited amount of DA projected to be available and the considerable amount of existing pipeline in the subject project. Also considered was the fact that the subject project design had been rolling in the direction of child survival with the addition of the Oral Rehydration Therapy Supplement in 1985, Field Epidemiology Training Supplement in 1986 and the focus on immunization and social marketing in the 1987 revision. Based on a careful review of alternatives, the Mission has concluded that redesign of the subject project to consolidate all existing and proposed bilateral health activities into one child survival project is the best vehicle for achieving its child survival objectives.

The GOP Medium Term Development Plan, 1987-92, it states that "the government shall aim for a general increase in outreach and improvement in the service delivery of programs such as Primary Health Care and the Five Health Impact Programs." These impact programs include CDD, EPI and other MCH programs aimed at improving Child health. Since June, 1987, the Secretary of Health has added ARI as a national program priority. It is clear from this planning target; President Aquino's Proclamation in 1986 in support of Universal Immunization; and the large budget increases for DOH in 1987 (despite general GOP belt tightening), especially for public health prevention programs, that a health program for child survival as proposed by this PID is consistent and supportive of GOP health goals and objectives. As described earlier, the project will also respond to health development Emphasis Areas defined by the new Administration.
B. Social Considerations

The basic conclusions of the Social Soundness Analyses presented in the Project Paper and the PP supplements are still valid. The information presented in the original PP on the anticipated beneficiaries, social feasibility, spread effects and impact will be updated in the PP Amendment to reflect the redesign of the project. The project's anticipated and actual impact on women will also be examined.

C. Economic Considerations

Preliminary assessment of the project redesign using the required minimum benefits approach indicates its viability as a whole. Using the NEDA-estimated social discount rate of 15 percent, and assuming the funds are expended and the benefits start immediately in year one of the redesigned project, it must achieve an annual economic net return valued at $6.39 million at 1987 prices for 20 years. This means that the beneficiaries will have to gain economic benefits over any continuing operating costs equivalent to a value of at least $6.39 million or $134.19 million (based on the expected exchange rate of $1.00 = $1.00 in 1987) annually for twenty years as a result of the project. Given the current level of health care expenditures for the typical Filipino household ($598.25 annually), the required stream of economic benefits is achievable. If it is assumed that all 9.8 million households in the country will benefit from the project uniformly, then only 2.3 percent savings in the average annual health care expenses per household will be necessary to attain an acceptable economic rate of return for investment in the project. Alternatively, if it can be assumed that the project will result in an average 15 percent savings in the health care expenditures of beneficiaries then approximately 1.5 million households (or 15 percent of all households) will have to be reached by the project. If savings in time and earnings lost and in other illness and death related expenditures are also considered, the number of households needed to be reached and/or the amount of needed savings per household are substantially reduced.

In the course of PP preparation, two other issues will be looked into: cost effectiveness and sustainability. Analysis of cost effectiveness will involve the identification of alternative solutions to the problem of reducing infant mortality/morbidity, identifying and measuring costs and corresponding effectiveness of each alternative, and conducting sensitivity analysis of the different alternatives.

Long term viability of the project hinges on what strategies are employed to ensure sustainability, e.g., user charges, community participation, and DOH and local government budgets for recurrent costs. These issues will be studied in depth in the course of project design.
D. Relevant Experience with Similar Projects/Donor Coordination

Through the PHCF project USAID has abundant experience with Child Survival activities in EPI, ORT, health communications, field epidemiology training and other elements retained in this amendment. Child survival interventions are also an important element of the Mission's PL 480 Title II vulnerable group feeding programs. As for the Emphasis Areas approach, comprehensive Child Survival plans can be implemented drawing on the excellent experience with $1.5 million PVO Project CHILD in Davao area. It is a comprehensive, integrated approach using a private Foundation to guide, coordinate and fund health interventions in target high risk areas.

The only completely new program element is ARI. As noted earlier, a successful ARI program should build upon an effective EPI program and an effective delivery system such as being developed for CDD. There is ARI expertise in the Philippines through WHO and the DOH's Research Institute of Tropical Medicine. The World Health Organization has developed ARI case management modules which are being utilized on a small scale in an on-going Australia funded ARI Project in Bohol. The CS Project will finance research to further refine the ARI Program as it is phased in gradually.

The development of this project has been characterized by close, effective donor coordination. An ad hoc Child Survival Project Committee was formed by USAID to include DOH, UNICEF and WHO in conceptualizing and prioritizing CS activities described in this PID. For specific program elements, even closer working relationships have developed; i.e., with WHO on diarrheal disease control and EPI; UNICEF and CIDA for EPI; World Bank and Asian Development Bank on sector financing issues. These relationships, encouraged by the DOH, bode well for coordinated PP design and implementation in the future.

E. AID Support Requirements and Capability

The Chief of the Health and Nutrition Division within the Office of Population, Health and Nutrition (OPHN) will be responsible for the overall management and supervision of the project. Project management duties will be shared by the Physician Public Health Advisor (CDD, ARI and Emphasis Areas) and Program Specialist within the Health and Nutrition Division. It is not anticipated at this time that the administration of this revised project will require additional USDH or FSN staff.

F. Design Strategy

In the development of the PID, regular CS Planning Committee meetings have been held at the Department of Health, Chaired by
the Chief of MCH, with active participation of both the Undersecretary of Public Health and Chief of Staff. The design strategy outlined above revising this committee had the active participation of WHO and UNICEF, as well as several DOH program directors. During the PP design phase, this Committee, and small working groups attached to it, will be the major source of policy and technical direction for completing the full scale project design. Additional technical assistance required for the PP has been planned or is already underway. Through buy-ins to REACH and PRITECH we have already moved far along on identifying the EPI and CDD/ORT design details. During PP development, Mission staff will consider the potential impact of AID/W's intent to classify ORS as a pharmaceutical on the CDD component of the project. Because this would make it impossible to pursue the project's objective of promoting local ORS commercial production and distribution through procurement support, the design team will consider alternatives for meeting the project's commercialization objective. For ARI, we expect to rely heavily on the current Bohol Research project findings, extensive WHO expertise in country and DOH Tropical Research personnel. Regarding the economic and financial analysis aspects, the Mission has obtained the draft ANE Bureau Costing Guidance, and expects to adopt and test part or all of this guidance during the PP development.

During the design process, emphasis will be placed on improving project implementation and the rate of disbursements. There will be a consolidation and strengthening of project management, which will reduce fragmented progress and financial reporting. Second, the financial flows to the DOH and within the DOH will be revised in the new project to reduce delays in implementation. Third, major elements in the project that cannot expend the budget assigned to them are being reduced or phased out. Most notable is the reduction in the financing schemes budget. Finally, project components which have demonstrated an ability to disburse funds quickly and are of growing priority will be expanded. These include the components for IE&C and EPI, and the commodity budget in general.

The extent of original baseline work or data analysis required to complete PP analyses is minimal, given the number of existing and planned studies by USAID, UNICEF, World Bank and GOP.

G. Recommended IEE Threshold Determination

The provision of health services (immunization and control of diarrheal diseases and respiratory infections) and the training of health workers and mothers/households will not have a significant negative impact on the environment. Accordingly, a detailed environmental impact analysis is not needed.
H. **Gray Amendment Alert**

The Mission will give maximum practical consideration for contracting or subcontracting qualified Gray Amendment Firms where possible, especially for project evaluations. A sizeable amount of project technical assistance will come from buy-ins to the already awarded contracts under centrally funded health projects, which gave consideration to Gray Amendment concerns at an earlier stage. Qualified Gray Amendment contractors will be sought and identified through information readily available in the Mission and consultations with AID/W.

I. **AID Policy Issues**

The proposed project is clearly consistent with Agency Health Policy, as revised in December 1986. Child survival interventions, especially EPI and CDD, delivered through PHC mechanisms and targeted at high risk groups, are the core type of support indicated in the Policy statement. Much interest has been expressed by DOH in environmental sanitation and water supply improvement as essential to long term prevention efforts in CS. However, in order to be consistent with AID policy guidance as well as resource and implementation limitations, water supply and sanitation will not be supported under this project, except in terms of limited health education and public promotion related to the CDD program. The project may however, seek to coordinate targeted Emphasis Areas with those municipalities being selected for rural water systems under our new $20 million Rural Water and Sanitation Project (492-0401).
(Preliminary)

**A-1. Sector Goal**
Reduce infant and child mortality.

**A-2. Measure of Achievement**
- Lower infant mortality rate from 55 in 1986 to 47.8 in 1992
- Reduce child (0-5) mortality rate from 4.9 in 1986 to 3.7 in 1992.

**A-3. Means of Verification**
- Tier III evaluation in Cebu
- National health survey & Demographic survey data

**A-4. Assumptions**
1. DOH and GOP policy support for Child - Survival continues at required levels.
2. Peace and order situation allows for intensive health interventions, especially in emphasis areas.
3. Utilization by target population of PHC/Child Survival services offered such as ORT, EPI, and ARI.

**ANNEX A LOG FRAME **

**B-1. Project Purpose**
Improve utilization of selected primary health care services, to maximize child (0-5 yrs.) survival.

**B-2. End of Project Status**
- Immunization coverage increased to 90% by 1992
- ORT use increased to 70% by 1992 from average of 2.8 episodes/child/year to 2.0
- Diarrhea morbidity decreased
- Reduce number and % proportion of deaths from childhood pneumonias diarrheal and immunopreventible diseases

**B-3. Verification**
- Project records
- Evaluation of EPI, CDD and ARI
- Operational research
- Monitoring visits to emphasis areas by TA team

**B-4. Assumptions**
- DOH policies and priorities supportive of EPI, CDD and ARI do not change significantly
- Peace and order situation in Emphasis Areas permits implementation of the project
- People will adopt effective child survival preventive and curative practices if they are promoted, if trained staff is in place and resources available
- That inputs and TA can be delivered as planned in an acceptable form and in the high impact areas.
### Project Outputs

1. DOH personnel, community leaders and NGO staff trained in CS technology
2. Operational survey and behavioral research studies
3. Cold chain system operational nationwide
4. National communication plan implemented for ARI, CDD and EPI
5. Child Survival Plans operational in emphasis areas
6. DOH central, regional and provincial offices strengthened for C.S. program management
7. Comprehensive health information system developed and improved
8. Trained cadre of field epidemiologists
9. CDD program of preventive & ORS therapy functioning nationwide.
10. ARI case management referral system in place.

### Magnitude

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<td>New HIS system in place</td>
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<td>18 trained</td>
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<td>System functioning in half the Region of the country.</td>
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Project Inputs

1. Child Survival
2. Financing Schemes and special studies
3. Emphasis areas
4. Project Management
5. Evaluation and audit
6. Inflation and Contingency

Implementation Target

AID Inputs

Technical Assistance
a. 174 pm of long term
b. 50 pm of short term

Workshops

10 per year

Training

a. 684 pm of long term
b. 4760 pm of short term
c. 20 pm of observation tours

IE & C

a. Media time
b. Promotion materials

Commodity Procurement

a. Cold chain equipment
b. Vehicles and pump boats
c. Manuals and teaching aids, etc.
d. ORS
e. Lab and medical equipment
f. Computers and office equipment
g. TB drugs
h. B&W kits