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CLAPP & MAYNE INC.

Chemonics International, Inc.

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FINAL ASSESSMENT REPORT:

USAID/PHILIPPINES SUPPORT TO LOCAL GOVERNMENTS FOR FAMILY PLANNING AND HEALTH

PREPARED BY:

DESIGN TEAM FOR STRENGTHENING FAMILY PLANNING AND HEALTH SERVICES THROUGH LOCAL GOVERNMENTS

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CHEMONICS INTERNATIONAL

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Glossary of Abbreviations and Acronyms

BHW	Barangay Health Worker
BLHD	Bureau of Local Health Development
CA	Cooperating Agency
CBMIS	Community Based Monitoring Information System
CHD	Center for Health Development
CHO	City Health Office/Officer
DMPA	Depo-Medroxy Progesterone Acetate
DOH	Department of Health
DOTS	Directly Observed Treatment Short Course
CPR	Contraceptive Prevalence Rate
EPI	Expanded Program of Immunization
FHSIS	Field Health Service Information System
FIC	Fully Immunized Child
FP	Family Planning
FPOP	Family Planning Organization of Philippines
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IEC	Information, Education, Communication
IRA	Internal Revenue Allotment
IUCD	Intrauterine Contraceptive Devise
KII	Key Informant Interview
LCE	Local Chief Executive
LGU	Local Government Unit
LPP	Local Government Unit Performance Program
MCH	Maternal Child Health
MGP	Matching Grant Program
MHO	Municipal Health Officer
MOA	Memorandum of Agreement
MOOE	Maintenance and Other Operating Expenditures
MSH	Management Sciences for Health
NGO	Non-Government Organization
OIDCI	Orient Integrated Development Company Inc.
PMTAT	Project Management Technical Assistance Team
PMU	Project Management Unit
PopCom	Population Commission
RFA	Rapid Field Assessment
RHU	Rural Health Unit
RTAT	Regional Technical Assistance Team
SGD	Structured Group Discussion
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFR	Total Fertility Rate
TT2	Tetanus Toxoid #2
USAID	United States Agency for International Development
USEC	Undersecretary
VSC	Voluntary Surgical Contraception

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Executive Summary

This study used a rapid field appraisal methodology conducted in 24 LGUs – 19 LGUs participating in MGP and five non-participating LGUs – from the island areas of Luzon, Visayas, and Mindanao. Three approaches were used: (1) key informant interviews with 387 respondents representing local government officials, LGU health service providers, family planning clients, non-users of contraceptives, and representatives from the private for profit sector, the private not for profit sector, local influential and religious leaders, and regional Centers for Health Development; (2) structured group discussions with respondents from each of the 24 LGUs; and (3) a desk review of background documents.

Since 1999, MGP has provided grants to 183 cities and municipalities from a line item in the DOH budget for "assistance to LGUs." This line item has declined from P90 million in 2000 to P78 million in 2002. The DOH grant is accompanied by a 25% counterpart match from the LGUs. In 2001, DOH grants to cities and municipalities ranged from P25,000 to P500,000 per LGU. The median grant size is P250,000 in that year. The ratio of the MGP grant to health MOOE varies from 2.4% to 74.0% but on average is equal to 7.8%. Given the unit cost of family planning and MCH services exclusive of commodities, the average MGP grant is estimated to be sufficient to serve 20%-30% of households in a medium-sized LGU.

The assessment identified strengths in the MGP program design and implementation strategies that have contributed toward improved family planning delivery at the LGU level. In LGUs where MGP was implemented, family planning and family health were viewed as priority programs in the LGUs, and most have designated staff responsible exclusively for family planning. Innovative strategies were used to improve availability and expand access to family planning. The CBMIS is a valuable tool in the identification and referral of clients in need of family planning, immunization and Vitamin A supplementation. LGUs enrolled in the program were successful at achieving Sentrong Sigla status and enrolling in the PhilHealth Indigents Program. Technical assistance capacity has been established in regional CHDs, and the continuing budget appropriation for "assistance to LGUs" in the DOH budget represents an additional dedicated source of funding for family planning in LGUs, both of which contribute to the program's sustainability.

The assessment also identified weaknesses in program design that detracted from MGP's potential impact. The size of the grant was too small to attain impact. There was some evidence that the grant displaced funds that would otherwise have been allocated to health services. The grant is provided as project support with complex fund disbursement/replenishment procedures that impede utilization. It is not linked to performance, and lacks a satisfactory methodology to accurately monitor progress and performance. Deficiencies in IEC, interpersonal counseling, and local advocacy were consistently identified as

impediments to better family planning services and quality of care. Opportunities for linkages with partners in the private sector were not optimized. It can be concluded that MGP has had an impact in those barangay where the CBMIS is being implemented. Since the CBMIS is being implemented in less than 30-40% of barangay due to limitation of funds, the aggregate impact of the MGP in the 183 LGUs covered is negligible.

Important lessons learned emerged from the assessment. MGP was most successful where commitment to family planning was highest and where the LCEs understood the link between population growth and economic development. To achieve demonstrable improvements in family planning and health at the LGU level, more resources are needed, both from the LGU and from "other sources." Unless structured properly, the MGP grants can displace other LGU funds that otherwise would have been allocated to health. Integrating family planning services with other MCH care under the rubric of family health has enabled the LGU health system to address missed opportunities, and will be more politically acceptable to them.

There is a dearth of IEC and advocacy at the local level, and one-to-one counseling is currently not happening. Barangay Health Workers (BHW) play a critical role in the program, as long as they are deployed in BHW-to-household ratios that do not exceed 1:50. The introduction of the CBMIS contributes significantly to program success; however, it has not been demonstrated whether it can be used effectively on a wider scale. Linkages with the private sector are weak and seldom used by LGUs to segment their clients. The family planning program is totally female oriented. More males need to be actively engaged as positive role models and advocates for family planning, and demand needs to be created for contraception among men.

In three years, MGP has been able to reach only 183 LGUs, with just 30% of barangay covered in these. Given that there are nearly 1,600 LGUs in the Philippines and the MGP is active in 183, perhaps the most important lesson learned after three years of implementing MGP is that there is no way that MGP, as currently constituted, can achieve national impact on contraceptive prevalence.

Data from this assessment unearthed programmatic issues that will effect future program directions. LGUs zealously guard the autonomy granted them under the Local Government Code. They are likely to vigorously resist prescriptive programs imposed from above. In this climate, program support with performance benchmarks will be more acceptable. The program should emphasize family planning as a component of improving family health. A new program of assistance should build upon the strengths of MGP. Principal among these is the CBMIS, which has stimulated LGUs to think creatively about ways to meet unmet need using innovative approaches. Sentrong Sigla could be continued with modifications to make it more outcome oriented. Resources from

future, expanded if feasible, and transformed into more flexible disbursement arrangements that do not displace LGU resources. Collaboration with NGOs, commercial providers, other USAID projects, and other government agencies can be enhanced. In LGUs where HIV/AIDS programs are being implemented, family planning and TB control can be integrated at marginal cost.

The essential role played by the mayors was one of the most important program issues to emerge from this assessment. Mayors are critical to the support that family planning activities receive at the LGU level. If a mayor comes to understand that the family planning activities are a political plus and the program's success will make the mayor look good to his/her constituents and enhance the chances of reelection, then the family planning program at the LGU will move forward quickly.

INTRODUCTION

The Strategic Objective for USAID's Population and Health Program in the Philippines is: "Desired family size and improved family health sustainably achieved." Four Intermediate Results Packages have been designed in order to achieve the strategic objective:

- Local Government Unit (LGU) provision and management of FP/MCH/TB/HIV/AIDS services strengthened.
- Provision of quality services by private and commercial providers expanded
- Greater social acceptance of family planning achieved
- Policy environment and financing for provision of services improved

With a view toward developing a program design that will support the first Intermediate Results Package for the period 2002 to 2006, USAID/Philippines commissioned a team to (1) conduct an assessment utilizing rapid field appraisal approaches of the current LGU project; and, (2) prepare a design document for new support to LGUs for the provision of family planning services.

An external assessment team from Chemonics International and Clapp and Mayne was convened in Manila on March 7, 2002 to conduct this assignment. The members of the assessment team are:

Thomas D'Agnes	: Team Leader
Alma Porciuncula	: Field Project Manager and Deputy Team Leader
Gary Leinen	: Family Planning Specialist
Marilou Costello	: Evaluation Specialist
Rosario Gregorio-Manasan	: Local Government Administration Specialist
Rogelio Ilagan	: Local Government Health Specialist
Marilyn Gorra	: Health Program Specialist
Carlos Tan	: Health Economist
Gabriel Lopez	: Civil Society Specialist

The Rapid Field Assessment (RFA) methodology used three approaches:

1. Key Informant Interviews (KIIs) from 24 LGUs distributed over three island groupings were conducted with local government officials, LGU health service providers, family planning clients, non-users of contraceptives, and representatives from the private for profit sector, the private not for profit sector, local influential and religious leaders.

2. Structured Group Discussions with selected interviewees from each of the 24 LGUs.

3. Desk Review of documents that provided background on the population and health sector in the Philippines in general, and USAID assistance to LGUs in particular.

Orient Integrated Development Company, Inc. (OIDCI) conducted the key informant interviews and structured group discussions in the 24 selected LGUs.

This report is presented in two sections:

1. The first section focuses on the assessment of USAID's assistance to LGUs, with principal emphasis on the Matching Grant Program.

2. The second section presents a series of activities and key areas that need to be addressed to guide developing a new program of assistance to LGUs.

I. ASSESSMENT OF USAID PHILIPPINES ASSISTANCE TO LGUs THROUGH THE MATCHING GRANT PROGRAM (MGP)

1. BACKGROUND AND DESCRIPTION OF MGP

In order to address the needs of the devolved Philippine Health Care System, the Local Government Unit Performance Program (LPP) was launched in 1994. It was designed to improve the health of mothers and children through increased utilization of family planning (FP), maternal and child health (MCH) and nutrition services. The mid-term assessment of the LPP project conducted in 1998 posed several recommendations to enhance its impact and improve program performance. In response to these recommendations, the LPP was modified by adding two components: the Top Performers Program, and the Matching Grants Program (MGP). Base grants for 85 provinces and cities that had already started were continued. LGUs that exceeded the minimum coverage standards on outcome measures were given additional funding under the Top Performance Program. The third component, the MGP, was introduced to respond to the limitations of the base grant approach by focusing assistance directly for municipalities and requiring a counterpart funding from the participating LGUs.

The MGP was launched in February 1999 by the Department of Health with funding support provided by USAID and technical assistance from Management Sciences for Health (MSH).

A Project Management Technical Assistance Team (PMTAT) from MSH was assembled in Manila to support implementation of MGP. Regional technical assistance teams (RTAT) were created in the CHDs in each region to train LGUs in family planning and reproductive health using competency based training

strategies; to make performance based grants; and to provide the following technical assistance package to the LGUs:

- CBMIS (Community-Based Management Information System)
- Health Facility Assessment leading to Sentrong Sigla Certification
- Family Planning training packages
- Disease Surveillance (optional module in 5 LGUs only)

Grants are made to the LGUs by the CHDs in each of the regions with funds from a line item in the DOH budget that is earmarked specifically for assistance to LGUs. The LGU makes a matching contribution of 25% of the DOH grant. To date 183 cities and municipalities have been enrolled in MGP.

1.1 *SIZE OF GRANT*

In 2001, DOH grants to cities and municipalities under the MGP vary from P25, 000 to P500,000 per LGU. The median grant size is P250, 000 in that year. Given the unit cost of family planning and MCH services exclusive of commodities, the average MGP grant is estimated to be sufficient to serve 20%-30% of households in a medium-sized LGU.

The size of the grant is limited by the total amount of funding that is made available for "assistance to LGUs" in the DOH budget, the target number of LGUs and the prescribed cost sharing formula with LGUs. The allocation for the MGP in the DOH budget declined from P90 million in 2000 to P78 million in 2002. A comparison of the MGP grant with LGU spending on maintenance and other operating items in the health sector highlights the "smallness" of the MGP grant (Table 5)[1]. The ratio of the MGP grant to health MOOE varies from 2.4% to 74.0% but on average is equal to 7.8%.

MGP appears to have limited success in leveraging LGU spending on health. For instance, only 11 out of the 20 LGU included in the RFA posted increases in their real per capita health spending in 1999. Thus, the MGP appears to have displaced funds that would have been allocated to the health sector (Table 6).

Most LGUs contribute 25% of the total grant. Data from MSH indicates that over a quarter of LGUs put up more than 25% of the DOH grant (Table 6). For instance, Malaybalay registered the highest counterpart, contributing three times the grant amount. Key informants report that LGUs actually put more funds in the MGP than was required in the grant agreement. On the other hand, a small number of the LGUs had counterparts that are lower than 25% of the grant amount. This suggests that the grant design should also take into account the ability of poorer LGUs to provide counterpart funding support.

[1] Data for MGP grant refer to 2001 while those for LGU expenditure refer to 2000.

Table 4. MGP Grant and LGU Health Expenditures in Selected Sites, 2000

	LOCATION	MGP Grant	Total Health Expenditures				Ratio of MGP Grant to Health MOOE (%)
			PS	MOOE	CO	Total	
GOOD		3,700,000.00	111,661,410.67	43,191,647.63	6,647,666.68	161,620,847.18	8.6
LUZON	Ilagan City, Isabela		10,029,317.69	3,023,254.52	213,088.50	13,265,660.71	0.0
	Daraga, Albay	300,000	7,833,689.47	2,819,619.40	-	10,453,308.87	10.6
	Naga City, Camarines Sur	300,000	18,177,244.94	7,248,123.61	7,558.50	25,432,927.05	4.1
VISAYAS	Bayawan, Negros Oriental	1,500,000	7,480,591.94	2,027,116.89	1,006,609.59	10,514,318.42	74.0
	Bago City, Negros Occidental	300,000	33,316,274.63	8,026,422.36	1,064,677.14	42,407,374.02	3.7
	Ormoc City, Leyte	400,000	12,442,576.50	9,984,971.50	2,373,542.77	24,801,092.77	4.0
MINDANAO	Bislig City, Surigao del Sur	400,000	8,308,897.46	1,744,549.35	-	10,053,446.81	22.9
	Kidapawan City, North Cotabato	250,000	5,870,094.23	809,177.00	825,550.00	7,504,821.23	30.9
	Tagum City, Davao del Norte	250,000	8,422,722.11	7,508,313.01	1,156,862.18	17,087,897.30	3.3
POOR		2,900,000.00	100,428,061.82	47,408,851.32	4,878,046.21	152,714,749.35	7.1
LUZON	Dasmerinas, Cavite	500,000	5,629,223.45	9,078,271.89	325,050.00	15,032,545.14	5.5
	Conception, Tarlac	500,000	4,995,178.86	3,296,041.65	-	8,291,220.51	15.2
	Malasequi, Pangasinan	500,000	3,914,420.38	1,543,358.67	-	5,457,779.05	32.4
	Legaspi City	400,000	14,613,690.93	3,627,736.55	-	18,241,427.48	11.0
VISAYAS	Silay City, Negros Occidental	300,000	9,208,013.06	12,459,362.59	-	21,667,375.67	2.4
	Talisay City, Cebu	150,000	10,824,045.40	5,635,339.72	4,142,826.21	20,602,213.33	2.7
	Tacloban City, Leyte	N/A	11,742,136.20	3,303,266.21	167,618.00	15,213,020.41	-
	Calbayog City, Western Samar	N/A	21,603,740.85	2,017,531.50	-	23,621,272.35	-
MINDANAO	Magsaysay, Davao del Sur	250,000	2,524,922.96	1,198,109.08	-	3,723,032.04	20.9
	Pagadian City, Zamboanga del Sur	300,000	12,991,971.29	4,267,371.50	172,550.00	17,431,892.79	7.0
	Compostela, Compostela Valley	N/A	2,380,708.42	982,262.16	70,000.00	3,432,970.58	-
MGP		6,600,000.00	212,109,462.49	90,600,198.95	11,526,934.89	314,236,596.53	7.3
NON-MGP			61,808,763.03	15,922,611.73	1,609,270.92	79,340,639.68	
LUZON	Calabanga, Camarines Sur		4,490,309.14	1,290,000.00	-	5,780,309.14	
	Marikina, Metro Manila		28,707,247.00	9,104,271.73	1,609,270.92	39,420,789.65	
VISAYAS	Mandaue City, Cebu		8,982,808.83	3,590,871.19	-	12,573,680.02	
MINDANAO	Butuan City, Agusan del Norte		19,828,398.06	1,937,368.81	-	21,765,766.87	

Table 5. Per Capita Health Expenditures of Selected MGP and Non-MGP LGUs, 1998-2000

LOCATION		Per Capita Health Expenditures				in 1998 prices Per Capita Health Expenditures				in 1998 prices Per Capita Health Expenditures			
		PS 1998	MOOE 1998	CO 1998	Total 1998	PS 1999	MOOE 1999	CO 1999	Total 1999	PS 2000	MOOE 2000	CO 2000	Total 2000
GOOD		87.44	26.86	0.77	115.06	92.07	40.40	5.68	138.16	85.33	33.00	5.08	123.41
LUZON	Ilagan City, Isabela	71.70	9.15	-	80.85	63.11	20.76	-	83.87	72.40	21.82	1.54	95.76
	Daraga, Albay	69.29	21.31	1.37	91.97	63.25	22.61	0.45	86.31	65.49	24.19	-	89.69
	Naga City, Camarines Sur	117.42	44.29	-	161.70	106.32	41.91	0.67	148.90	114.39	45.61	0.05	160.05
VISAYAS	Bayawan, Negros Oriental	67.86	14.75	0.20	82.81	116.98	25.00	8.84	150.82	63.92	17.32	8.60	89.85
	Bago City, Negros Occidental	206.30	48.32	1.83	256.45	201.19	43.21	0.51	244.91	203.97	49.14	6.52	259.63
	Ormoc City, Leyte	74.84	60.17	2.94	137.94	68.09	54.23	27.02	149.34	69.97	56.15	13.35	139.46
MINDANAO	Bislig City, Surigao del Sur	75.50	14.78	-	90.28	71.23	16.81	-	88.04	74.00	15.54	-	89.54
	Kidapawan City, North Cotabato	45.85	2.12	-	47.97	72.11	13.96	0.84	86.91	50.19	6.92	7.06	64.17
	Tagum City, Davao del Norte	41.29	9.36	-	50.65	57.83	84.97	6.57	149.37	40.81	36.20	5.58	82.38
POOR		12.78	2.94	0.39	16.11	86.24	22.29	1.28	89.81	56.96	26.89	2.77	86.62
LUZON	Dasmarinas, Cavite	1.00	0.28	0.00	1.28	23.89	4.91	-0.41	29.20	12.73	20.53	0.74	34.00
	Conception, Tarlac	36.44	12.53	-	48.97	34.93	15.11	0.07	50.10	37.55	24.78	-	62.33
	Malasaqui, Pangasinan	35.72	14.07	-	49.80	31.44	6.47	0.25	38.17	29.96	11.81	-	41.77
	Legaspi City	83.55	19.77	-	103.32	87.83	28.12	-	115.95	80.66	20.02	-	100.68
VISAYAS	Silay City, Negros Occidental	119.04	26.62	20.06	165.73	67.87	85.15	-	153.01	74.70	101.07	-	175.77
	Talisay City, Cebu	65.07	12.18	0.74	77.99	72.68	33.77	18.84	125.29	118.33	61.61	45.29	225.23
	Tacloban City, Leyte	121.75	35.18	3.52	160.43	109.51	28.36	-	137.87	57.04	16.05	0.81	73.90
	Calbayog City, Western Samar	141.57	8.48	0.50	150.55	129.49	8.96	1.32	139.77	127.07	11.87	-	138.94
MINDANAO	Magsaysay, Davao del Sur	51.70	15.39	-	67.10	50.30	24.59	0.22	75.11	50.82	24.11	-	74.93
	Pagadian City, Zamboanga del Sur	102.53	26.04	0.92	129.48	99.78	31.68	0.27	131.73	78.92	25.92	1.05	105.90
	Compostela, Compostela Valley	35.76	15.19	1.06	52.01	34.91	15.09	-	49.99	33.44	13.80	0.98	48.22
MGP		21.56	5.76	0.44	27.76	77.52	30.19	3.20	110.91	69.06	29.49	3.76	102.29
NON-MGP		88.46	21.28	29.68	139.42	81.02	27.59	16.97	124.59	64.27	13.98	1.41	69.66
LUZON	Calabanga, Camarines Sur	80.26	9.38	-	89.65	73.62	10.27	-	83.89	57.67	16.57	-	74.24
	Marikina, Metro Manila	67.80	5.56	0.96	74.33	63.72	20.66	1.47	85.85	63.82	20.18	3.57	87.37
VISAYAS	Mandaue City, Cebu	41.14	57.70	0.10	98.94	35.15	57.35	0.09	92.59	29.77	11.90	-	41.68
MINDANAO	Butuan City, Agusan del Norte	162.93	14.51	105.31	282.76	151.06	14.19	56.03	221.28	63.70	6.29	-	69.98

Table 6. MGP Grant and LGU Counterpart: 2001

Region	Province	LGU	MGP Grant	LGU Counterpart	LGU Counterpart-MGP Grant Ratio (%)
1	Ilocos Norte	Laoag City	500,000	244,000	48.8
	Pangasinan	Asingan	100,000	150,000	150.0
		Bayambang	500,000	125,000	25.0
		Malasiqui	500,000	125,000	25.0
2	Isabela	Cauayan	500,000	125,000	25.0
		Isabela	500,000	150,000	30.0
3	Bulacan	San Miguel	500,000	125,000	25.0
	Zambales	Iba	500,000	125,000	25.0
	Tarlac	Concepcion	500,000	284,396	56.9
	Pampanga	Lubao	500,000	125,000	25.0
4	Rizal	Taytay	500,000	325,000	65.0
	Laguna	San Pablo	500,000	125,000	25.0
	Palawan	Puerto Princesa	500,000	125,000	25.0
	Cavite	Dasmariñas	500,000	135,000	27.0
5	Camarines Sur	Naga	300,000	350,000	116.7
	Albay	Daraga	300,000	75,000	25.0
		Tabaco	300,000	75,000	25.0
		Legaspi	400,000	100,000	25.0
6	Negros Occidental	Bago City	300,000	175,000	58.3
		Kabankalan	300,000	75,000	25.0
		Silay	300,000	300,000	100.0
7	Negros Oriental	Bayawan District	1,500,000	980,000	65.3
	Cebu	Bogo	300,000	75,000	25.0
		Talisay	150,000	37,500	25.0
		Lapu-lapu	500,000	125,000	25.0
8	Leyte	Ormoc City	400,000	100,000	25.0
	South Leyte	San Ricardo	500,000	100,000	20.0
		Padre Burgos	500,000	125,000	25.0
		Tacloban City			
	Western Samar	Calbayog City			
9	Zamboanga del Norte	Dipolog City	300,000	65,000	21.7
	Zamboanga del Sur	Pagadian City	300,000	62,500	20.8
10	Bukidnon	Malaybalay	500,000	1,500,000	300.0
	Misamis Occidental	Ozamis City	500,000	125,000	25.0
11	Davao del Norte	Tagum	250,000	62,500	25.0
		B.E. Dujali	125,000	31,250	25.0
12	North Cotabato	Kidapawan	250,000	62,500	25.0
	Sultan Kudarat	Esperanza	250,000	125,000	50.0
		Isulan	250,000	62,500	25.0
	Lanao del Norte	Magsaysay	250,000	62,500	25.0
NCR		Taguig	500,000	125,000	25.0
		Pateros	500,000	125,000	25.0
		Navotas	500,000	125,000	25.0
CARAGA	Surigao del Sur	Bislig	400,000	100,000	25.0

1.2 COVERAGE

The number of barangay covered by MGP is tied to the size of the DOH grant to the LGUs. The coverage target is the 30-40% of the barangay in each municipality that are considered either low performers, inaccessible, poor, or in greatest need. The number of households (and ultimately barangay) that can be covered in each municipality is determined by taking the amount of the DOH grant and dividing by P70, the estimated average cost of providing family planning, immunization, and Vitamin A for one family for one year. Based on this figure, the LGU decides the number of barangay that can be covered and which barangay to cover; and implements the CBMIS in these barangay. .

In most instances the DOH grant combined with the LGU counterpart is not sufficient to reach the target of 30-40% of barangay. Consequently, MGP is only being implemented in a small percentage of barangay in each LGU. The coverage data for those barangay, however, is quite good. FIC coverage ranges from 80-95%. TT2+ for pregnant women is above 70%. Vitamin A coverage is above 85%. CPR for modern contraceptive methods is above 40%[2].

2. METHODOLOGY FOR RAPID FIELD APPRAISAL (RFA)

The RFA methodology produces qualitative data that is tabulated to determine trends and commonly held beliefs. Extensive efforts were made to quantify KII responses. Each of the 24 structured group discussions was summarized to highlight consensus by the participants.

Specific Methodologies for the Rapid Field Appraisal

The methodology used for the diagnostic component of this assignment consisted of interviews with key informants, structured group discussions, and a desk review of relevant project documents. OIDCI was contracted to undertake fieldwork, and with the assistance of the Design Team developed the study protocols, pre-tested questionnaires, facilitated the group discussions and conducted the key informant interviews. Management Sciences for Health staff assisted in choosing the 24 LGUs. Briefing materials were provided to the RFA Survey Team to ensure uniform interpretation of the questions and data requirements.

Training of interviewers and facilitators was conducted in Manila for the Luzon island group, Davao for Mindanao and Cebu for Visayas. A member of the Design Team participated with each island group training and interviews. An

[2] These data are taken from reports of coverage as of 11/30/01. The data are incomplete for several reasons. Data are not available for all municipalities, and the number of barangay or households from which the data are derived is not available. It would be useful if methods were developed to make estimates of aggregate coverage rates for all barangay that are covered by the MGP program.

RFA Coordinator from OIDCI was responsible for the overall implementation of the survey.

Sample Size

The sample size covered by the RFA included 24 LGUs categorized as good performers, low performers[3] and non-participating LGU. The designation as a "low performer" was a subjective determination by the MSH technical assistance team.

Table 1. Geographic Distribution of the Sample LGUs

LOCATION	GOOD	LOW	NON-MGP
LUZON	Ilagan City, Isabela Daraga, Albay Naga City, Camarines Sur	Dasmarinas, Cavite Concepcion, Tarlac Malasiqui, Pangasinan Legazpi City	Calabanga, Camarines Sur Marikina, Metro Manila
Sub-total	3	4	2
VISAYAS	Bayawan, Negros Oriental Bago City, Negros Occidental Ormoc City, Leyte	Silay City, Negros Occidental Talisay City, Cebu Tacloban City, Leyte Calbayog City, Western Samar	Mandaue City, Cebu
Sub-total	3	4	1
MINDANAO	Bislig City, Surigao del Sur Kidapawan City, North Cotabato Tagum City, Davao del Norte	Pagadian City, Zamboanga del Sur Compostela, Comval	Magsaysay, Davao del Sur Butuan City, Agusan del Norte
Sub-total	3	2	2
TOTAL	9	10	5

2.1 Review of Relevant Documents

A list of documents was provided by USAID to the design team. In addition, other project documents relevant to the Philippine population program and the MGP were added to the list. The review of these documents helped to identify key issues related to the MGP and these were used as inputs in the development of the study protocols. A list of these materials is provided in Attachment 1.

[3] Subjective criteria, based on their level of commitment and performance in the four program areas, was used by MSH to classify LGUs as "low performers." There is no empirical basis for this designation.

2.2 Structured Group Discussion (SGD)

Structured Group Discussions (SGDs) were conducted in the 20 LGUs where the MGP was implemented. This data collection method is very similar to a focus group discussion in which the collective responses from a pre-selected group are obtained and consensus is used as an indicator of central tendency and dissension is an indicator of variability. In the structured group discussions the participants are not necessarily homogeneous but are selected on the basis of being stakeholders in the MGP and the delivery of family planning services or as clients. The typical composition of SGD per LGU would include the following participants:

- MHO/CHO Coordinator
- Family Planning Coordinator
- Local Population Officer
- Municipal/City Planning and Development Coordinator
- Midwives from the Rural Health Units and Barangay Health Stations
- NGO representative in the area
- Barangay Health Workers

The OIDCI facilitator led the SGD while a second staff member documented the proceedings using uniform formats/templates for uniformity of information. Generally, there were no observers during the SGD except in cases where some members of the Design Team participated as observers. The SGD was done on-site and held at the facility of the municipal or city health office and lasted two hours on the average. A facilitator and one research associate handled the discussions.

The total number of participants for the SGDs was 347: Luzon (100), Visayas (158) and Mindanao (88). Guide questions used for the SGDs are found in Attachment 2.

2.3 Key Informant Interview

The key informant approach uses interviews with key informants to obtain their views on MGP implementation. This approach is most effectively used to describe trends and make assessments of the MGP, taking into consideration different perspectives represented by the different respondents.

There were seven types of respondents covered by the KII: (1) representatives from the Regional Office of the Department of Health (now called Community Health Department or CHD); (2) LGU executives (municipal/barangay); (3) MGP implementers; (4) Non-MGP implementers; (5) Private Sector (for profit and not for profit) representatives; (6) Family Planning Clients; (7) and Non-users. Questionnaires were tailored for each respondent category.

A total of 387 key informants were interviewed as shown in Table 2.

Table 2. Profile of KII Respondents

Respondent	Luzon Number Reporting	Visayas Number Reporting	Mindanao Number Reporting	Total Number Reporting
CHD Director/LPP	5	3	2	10
Municipal/City Health Officer	10	9	7	26
Public Health Nurse	11	11	8	30
Rural Health Midwife	11	9	8	28
Mayor/City Admin	5	5	6	16
V. Mayor/SB Health	5	8	7	20
City Planning	7	6	6	19
Population Staff	13	6	6	25
BHW	16	16	14	46
Barangay Captain	8	10	7	25
Private Sector	8	8	8	24
User/Non user	40	40	35	115
Others	3			3
TOTAL	**142**	**131**	**114**	**387**

3. LIMITATIONS OF THE RFA

The RFA was conducted under acute time constraints. Because the study period coincided with the Holy Week holidays from March 28-31, the entire study – preparing and field testing questionnaires, training and standardizing interviewers, and collecting data – had to be completed in two weeks. Initial compilation of the results and interpretations were performed in the three days before Easter weekend. Given these considerations, the design team had to modify the group discussions, by adopting flexible criteria for inclusion of participants in the discussion groups, thus making the groupings less homogeneous. The facilitator made sure, however, that activities were guided carefully in order to obtain maximum participation from all members during the group discussions.

It must be pointed out that selection of participants in the study was not meant to constitute a representative sample of the population. The major purpose of the qualitative approach in this assessment is to be able to accurately gauge the general perceptions and opinions, and identify major trends and issues related to the MGP implementation.

Analysis and Interpretation of the Results

Data analysis consisted of a thorough review of the responses gathered from the KII and the SGDs, collated/tabulated by the staff of OIDCI. From the tabulations

the Design Team identified major themes and common perceptions. A process of data triangulation followed in order to validate findings derived from the different approaches.

4. FINDINGS

The findings which are summarized here have been synthesized from detailed data that has been compiled and tabulated from the key informant interviews and structured group discussions.

4.1 KEY SUCCESSES - STRENGTHS

The assessment identified strengths in the MGP program design and implementation strategies that have contributed toward improved family planning delivery at the LGU level. The successful elements of the MGP are summarized below:

- Family planning and family health were viewed as priority programs in the LGUs because of the visibility bestowed by MGP and the program's accompanying grant resources. In non-MGP areas, family planning and child health were never mentioned as priority programs.

- In over 80% of the LGUs a point person for family planning activities has been appointed to oversee the implementation of MGP activities.

- In all 20 LGUs with the MGP there was clear evidence that the public health nurse and other staff at the RHU had drawn up innovative strategies to expand the delivery of family planning. We found many examples where family planning services were integrated into a variety of maternal and child health services and included in community events. We discovered cases where BHWs were now re-supplying low dose pills to clients and barangay midwives had been trained and equipped to insert IUCDs.

- The CBMIS is a valuable tool in the identification and referral of clients in need of family planning, immunization and vitamin A supplementation. Several LGUs instituted the CBMIS in all their barangay on their own initiative. This was accomplished with very little cost and utilized the trained BHW from the small number of barangay selected under the MGP for installing the CBMIS.

- In barangay where the CBMIS was implemented, the BHW's role was enhanced, their performance improved, and RHU staff categorized these BHWs as "feeling empowered" as a result of the CBMIS.

- Most LGUs undertook special initiatives, such as organizing dedicated surgical sessions and transportation to the nearest hospital for women requesting tubal ligation, in order to make voluntary surgical contraception available for their clients.

- The MGP greatly facilitated the LGUs identifying and enrolling indigent persons in PhilHealth. At present, 55% of LGUs participating in MGP have enrolled in PhilHealth. In addition the MGP targeted LGU health resources towards the poorest barangay with the greatest need for services.

- MGP has established strong linkages with regional CHDs. Regional Technical Assistance Teams (RTAT) have been established in 16 regions that can provide technical assistance and training required under MGP to the LGUs. Sufficient technical capacity has been developed in 10 of 16 regions to provide requisite technical assistance to LGUs independent of MSH.

- A DOH budget line item for "assistance to LGUs" was created within the regional CHD budgets, from which grants are provided to LGUs for family planning and family health. This line item is a continuing appropriation that will continue beyond MGP. These funds constitute an additional dedicated source of funding for family planning and family health services in LGUs. This budget line item is a conduit for continued central funding to LGUs for family planning that can be maintained and possibly increased in the future.

- LGUs have been successful in improving quality of care by attaining the Sentrong Sigla status. Sixty percent of LGUs participating in MGP have attained Sentrong Sigla status, which in some cases was accompanied by a P 1 million award.

4.2 WEAKNESSES

Conversely, the assessment identified weaknesses in program design that detracted from MGP's potential impact. These are summarized below:

- The grant is provided as project support to LGUs from the regional CHDs. A project plan must be developed, an MOA must be signed, and then funds are advanced, liquidated, and replenished. This process was administratively cumbersome when done on the scale of 183 LGUs. As a result, fund utilization was slow, rates of expenditure were low, and the CHDs were left with year-end "savings" that could be reprogrammed for purposes not necessarily dedicated to family planning. LGUs identified the complex fund disbursement/replenishment procedure as an obstacle to the effective implementation of the programs.

- The size of the grant provided by the regional CHDs was too small to attain impact. For average sized LGUs the grant only represented about 8% of the annual MOOE for health.

- MGP only reached 20-30% of the Barangay in an LGU because of fund limitations. The size of total grant funds available for MGP decreased in real and nominal terms from 2001 to 2002 as MGP expanded to larger numbers of LGUs, further limiting potential impact.

- It was not possible to ascertain definitively whether the grant to LGUs resulted in a net increase in LGU expenditures on health. In fact, there was some evidence that the grant displaced funds that would otherwise have been allocated to health services.

- MGP was not well marketed and communicated to the LGUs. Communication was primarily linear through health channels, from the CHDs to the MHO/CHOs. Many LCEs were not aware that MGP was being implemented in their LGUs. It is only one of many programs vying for their attention and because of its size, was usually referred directly to the MHO/CHOs for action. This was a missed opportunity to gain political and programmatic support for family planning from the LCEs.

- MGP sets annual service targets but there is no linkage between performance and the grant. Funds may be allocated in subsequent years regardless of whether performance benchmarks were satisfactorily met.

- There is no satisfactory methodology in place that can track performance of the annual service targets on a regular basis. Without such a tool, it is not possible to monitor progress toward achievement of targets.

- All LGUs in MGP areas cited deficiencies with IEC, interpersonal counseling, and local advocacy as impediments to better family planning services and quality of care. These were not adequately addressed in the MGP design. Because it was dealing almost exclusively with the city/municipal health office of the participating LGU, MGP was not able to harness the resources and capability that are available in the population offices that are present in city governments. Given the structure and organization prevalent in most LGUs, the local health office is tasked with the delivery of family planning services while the local population office is tasked with IEC and advocacy.

- Opportunities for linkages with potential partners were not optimized. PopCom has an administrative infrastructure in the regions that could have been utilized to strengthen the RTATs. Local NGOs and private sector providers expressed willingness to assist LGUs with training and

service delivery for market segments that can afford to pay, but their assistance was not maximized by the LGUs.

- National level coordination and oversight from central DOH was minimal. Although this was partially compensated by MGP's excellent relationship with regional CHDs, the absence of strong institutional linkages in central DOH left MGP without a DOH structural or functional agency that can provide policy guidance, programmatic coherence; and serve as an advocate and champion for MGP within the central DOH.

- It can be concluded that MGP has had an impact in those barangay where the CBMIS is being implemented. Since the CBMIS is being implemented in less than 30-40% of barangay due to limitation of funds, the aggregate impact of the MGP in the 183 LGUs covered is negligible.

4.3 QUANTITATIVE AND QUALITATIVE ACCOMPLISHMENTS

In addition to the strengths and successful elements of MGP that have been cited previously, there are other qualitative and quantitative achievements that deserve to be mentioned:

- The basic training package for family planning was improved and simplified by the development of competency based training modules. Training in IUCD insertion is a case in point. Previously, providers had to perform 15 IUCD insertions in order to be certified. Under MGP, competency became the basis for certification, not number of procedures.

- CBMIS has been implemented in all MGP areas. It filled local needs for data to be used for LGU health planning. Although it only covered a small proportion of barangay in LGUs, the universal acceptance and acknowledgement by LGUs of its utility for identifying needs, targeting clients, rationalizing the work of service providers is impressive.

- MGP has surpassed its 2002 targets for enrolling LGUs, Sentrong Sigla certification, and enrollment in PhilHealth. As of January 2002, 183 LGUs had been enrolled (target=100), 110 LGUs had at least one facility that had achieved Sentrong Sigla status (target=80), and 102 LGUs enrolled in the Indigents program of PhilHealth (target=80).

- As of January 2002, 66 of the 183 LGUs enrolled in MGP had achieved the 2002 performance targets for FIC, TT2+, and vitamin A supplementation.

- MGP used operations research to guide its implementation and allowed the project to change pace and fine tune approaches at midstream. Several interesting pilot projects were conducted to test strategies for service delivery and local advocacy. Two examples are provided below:

  a. On a pilot basis, MGP demonstrated that supplying clinics with IUCD kits and training IUCD providers resulted in significant increases in IUCD acceptance. Where this strategy was piloted, the number of IUCD acceptors doubled in 12 months.

  b. In collaboration with PopCom, MGP formed Policy Champion Teams in municipality/city clusters in each of the four regions of Mindanao to advocate for the adoption of OR tested interventions such as CBMIS and service integration to enhance the information system and service provision. Both interventions were immediately adopted and funded by the local government. PopCom regional directors, who are locally influential, played critical roles as policy champions.

- Subsequent to MGP's embracing Sentrong Sigla as an essential component of its program of support, quality of care is now recognized as an important area for improving service delivery.

- The MGP provided a balanced mix of technical assistance, service expansion, the advantages of service integration, support for quality improvement, and provision of problem solving tools (CBMIS).

- Best Practices in service delivery and other aspects of the program were documented and shared with other LGUs

4.4 PROGRAMMATIC ISSUES

The assessment identified programmatic issues that will affect subsequent project design. The most critical issues are presented below:

- How do you target resources for greatest impact? MGP targeted LGUs based upon the CPR in the regions. It planned to expand in the 5 regions with the lowest CPR first. When asked the same question, respondents in the RFA and the regional consultative workshops felt that the best ways to target resources for greater impact were:
  a. Based upon current performance levels
  b. LGUs with highest population densities
  c. LGUs with the requisite commitment and resources
  d. Target LGUs in rural areas only
  e. LGUs with the highest unmet need.

- How do you reach large numbers of LGUs? MGP used RTATs in regional CHDs as conduits to work directly with LGUs. As the number of LGUs enrolled in the program expands, this channel may be too limited to reach large numbers of LGUs. For their part, LGUs expressed reluctance towards working with any administrative level other than the central level because they feel that they add unnecessary bureaucratic inertia without making any positive contribution.

- Should assistance to LGUs use a project or program mode of assistance? LPP used program assistance. MGP used project assistance. In the case of MGP, project assistance was cumbersome and led to delays in fund disbursement and low expenditure rates.

- Lack of resources was the most common reason given by LGUs for poor performance of the family planning program. This finding is substantiated by data indicating that, especially in the case of lower class municipalities, the IRA is not sufficient to cover the cost of devolved services. What is the most efficient strategy for LGUs to obtain sustained increases in financial resources for family planning?

- LGUs were quite receptive to the idea of charging fees for services in their health facilities. Is this a program option worth further exploration?

- The assessment encountered a variety of inhibitory policies regarding contraceptive service delivery being practiced in LGUs. Some examples: minimum age and parity requirements for bilateral tubal ligation, new acceptors of low dose oral pills must return to the clinic monthly for resupply to monitor side effects, some LGUs do not allow community based distribution of contraceptives through BHWs, young unmarried women are not given contraceptives unless referred through STI clinics. How can standardized policies be disseminated to LGUs to eliminate inhibitory policies?

- How can IEC and counseling be improved at the local level to counteract the "fear of side effects" that discourages new users or causes discontinuation?

- How can local advocacy with LCEs and political leaders be strengthened to obtain greater political and programmatic commitment for family planning at the LGU level?

- CBMIS was very successful when introduced on a limited basis. How can it be sustained if implemented on a wider scale?

- CBMIS has demonstrated utility and effectiveness as a tool to identify needs and target services. Can it be adapted to monitor program performance without reducing its utility?

- In MGP sustainability was addressed by establishing a DOH line item for "assistance to LGUs" and developing technical capacity in RTATs. If the program is expanded, will other measure be necessary to guarantee sustainability?

- At this time, Sentrong Sigla certification is based on input and process improvements. It does not include outcome indicators. By including only input and process measures, Sentrong Sigla channels resources toward capital expenditures for facilities and equipment, especially when accompanied by a P1,000,000 prize. How can outcome measures be incorporated into the Sentrong Sigla certification to assess real quality of care improvements?

- A common complaint from LGUs is that demand for voluntary surgical contraception exceeds supply. How can supply be increased, and/or referral systems improved to link existing supply with demand?

- Can better linkages be created with NGOs and private providers to segment the market so that persons who can afford to pay can be referred to private providers? This would reduce pressure on the LGUs and allow LGU health services to provide free care to persons who are unable to otherwise pay.

- Can service delivery projects implemented by USAID cooperating agencies, in this case Engender Health, Well-Family Midwife Clinics, and FriendlyCare be synchronized with the LGU family planning and health program to take advantage of synergies and maximize service availability at the LGU level?

4.5 LESSONS LEARNED

The following lessons learned were culled from the RFA data, and refer to both the assessment of MGP and the delivery of family planning and health services in LGUs:

- Service providers at the barangay level (rural health midwives, barangay health workers) play a critical role in the advocacy and delivery of FP and other health services. BHWs are key to the successful identification of clients with unmet need for services through the installation of the CBMIS and it's updating. They are also the most effective advocates for family

planning through counseling and one-on-one consultation. BHWs can also improve access to health services (especially if they are allowed to resupply contraceptives) precisely because they are closest to the client.

The deployment of an adequate number of knowledgeable health workers at the barangay level is imperative. The suggested BHW-to-household ratio is between 1:25 and 1:50. More important, there is need for more investments in competency-based training as well as incentives for BHWs. There should also be mechanisms to empower the BHWs in order to maximize their performance. The CBMIS is one such tool.

- The introduction of the CBMIS contributes significantly to program success. The CBMIS is a simple tool that is attractive to program managers and much preferred over the DOH's FHSIS. Several of the LGUs visited had installed the CBMIS into every barangay. The CBMIS is consistently referred to as a most useful tool to identify unmet need for family planning services.

- The MGP operated in a very small geographic area and could not create national impact. Given that there are nearly 1,600 LGUs in the Philippines and the MGP is active in 183, there is no way that MGP, as currently constituted, can achieve national impact on contraceptive prevalence.

- To achieve demonstrable improvements in family planning and health at the LGU level, more resources are needed, both from the LGU and from "other sources." Resource limitations are the first and most common reason cited as impeding access to services and service expansion.

- MGP was most successful where commitment to family planning was highest and where the LCEs understood the link between population growth and economic development. Developing this understanding should precede any new program assistance. Fostering political commitment to family planning needs to be an ongoing activity in order to maximize the program's impact.

- Counseling on a one-to-one approach is currently not happening and is a critical element for any successful family planning program. Without good quality counseling, the high rate of contraceptive discontinuation and fear of side effects will remain as large barriers to the success of the family planning program.

- The integration of family planning services with other MCH care has enabled the LGU health system to address missed opportunities. With the information provided through the CBMIS and the service delivery strategies developed at the RHUs there has been much more integration

of family planning into other health services, particularly those that involve outreach activities at the barangay health station level.

- Poor access to trained service providers of voluntary surgical contraception (VSC) constrains LGU delivery of said services. The new program will have to address this limitation by ensuring that appropriate staff at the provincial and district hospitals are trained and by strengthening collaboration and coordination between LGUs and NGOs (e.g., Engender Health, Friendly Care, FPOP) in the area of family planning services.

- There is a lack of IEC and advocacy for family planning. IEC materials were generally not available and need to be provided in the vernacular for indigenous peoples and the Muslim community. Many RHU staff expressed frustration that they have nothing to send home with clients, and they have no instructional materials or training in natural family planning. As a result they focus all their attention on three main contraceptives - the pill, DMPA, and s.

- Advocacy for family planning is spotty at best, focused at the national level, and has yet to create a positive image of a well planned family. Beginning at the LCE level and down through the health services there is no visible advocacy for family planning, very little understanding among some mayors as to why family planning is an important development issue and no sense that a planned family is a happy, better off family.

- More males need to be actively engaged as positive role models and advocates for family planning. Currently the clinical services are entirely female focused. There is a real need to create male-friendly environments for discussing family planning and seeking out male role models from the community, and creating demand for contraception among men.

- Linkages with the private sector are weak and seldom used by LGUs to segment their clients. This includes services being provided under other USAID health and family planning cooperating agencies. It appeared to the team that the LGU public sector health services operated as if they were the only service providers for family planning. There is a real need to get the LGUs and private sector, both NGO and private-for-profit, to link up and create a complementary service.

- MGP counterpart funds can displace other health funds that otherwise would have been allocated to health. It appears that MGP has had only limited success in leveraging increased LGU spending on health. Steps need to be taken to review the current MOAs that are signed by the LGUs to minimize designating existing health funds as counterpart. LGUs need

assistance to think creatively as to which local revenues can be tapped to constitute the LGU counterpart.

II. FUTURE PROGRAM DIRECTIONS

Based upon findings from the RFA, the three regional workshops, consultations with the Department of Health, USAID, Local Government officials, and other stakeholders at the national and local level, a series of options and issues considered intrinsic to the design of the program for Strengthening Family Planning and Health Services through Local Governments have been developed.

LGU Autonomy

LGUs are zealous about not diminishing the autonomy they have been granted under the Local Government Code. Many LGU officials complain about how nationally determined programs have been forced on them from above. At the same time, the central government and donors focus on national objectives. LGU concerns and central government concerns are not necessarily in conflict. Nonetheless, it is imperative that a win-win partnership be forged between them. In this regard, the new program should give LGUs flexibility in deciding on the strategies and activities they adopt as they implement their programs even as clear and measurable indicators of program success are negotiated with them. Given the mounting pressure from LCEs for true autonomy in program planning and implementation, it is imperative that the program of assistance should focus on results or performance rather than on line-item project activities.

Program assistance could be negotiated directly with LGUs, subject to clear agreements on performance benchmarks and a time frame for their achievements. The monitoring and supervision systems could also be agreed upon with LGUs, but to be credible, must be managed by an external organization, which could either be an NGO, the provincial or regional offices, or a TA team as the case may be.

Role of Provincial Governments

Provincial governments clearly have a role to play in the new program. Currently, they are one of the major providers of VSS. They are also a resource for the provision of training and technical assistance to cities and municipalities. They are a key player in the development of the Local Health Systems (or district health systems) which calls for the sharing of resources and complementation of services among different LGUs in order to put in place a functioning and integrated referral system. On the other hand, the experience with other programs (e.g., LPP and other programs in non-health sectors) suggests that central governments grants for cities and municipalities should not be coursed through provincial governments.

Coverage

For the new program to have nationwide coverage and national impact, it will have to work with a markedly larger number of LGUs than the MGP. Necessarily, this implies that the LGUs that will be targeted by the new program will not only be less homogenous in terms of overall level of economic development and health status than those included in the MGP, they will also come equipped with wide ranging technical capabilities as well as diverse amount of fiscal resources at their disposal. Program design should take this diversity into consideration. .

The program should build on the apparent success of the CBMIS in simulating local people to think more operationally in terms of identifying and responding to unmet needs. Everyone who has used the system seems to agree that the CBMIS is a potent tool for identifying what services are needed by whom, and how they can be effectively and efficiently delivered. LCEs need to be equally convinced that CBMIS is a useful tool as a database for local decision-making and program planning.

Services

The program should emphasize family planning as a component of improving overall family health. Family health should include a "basic package" of family planning, childhood immunization (EPI), antenatal care, post-partum care, and Vitamin A for children less than 6 years of age. EPI, pre/post-natal care, TT2+, and Vitamin A are mature national programs with high coverage being implemented in all LGUs. Including family planning in these programs makes public health sense without being excessively burdensome from a programmatic perspective.

An expanded service package could be designed to include the basic package plus TB DOTS and HIV/AIDS interventions. The "basic package" could be implemented in all LGUs receiving assistance from the program; the expanded package would be implemented in specific LGUs considered to have the greatest need for TB control or are classified as HIV/AIDS "hot spots."

Integration

By emphasizing family health, the program could benefit from synergies between family planning and other health services. By including other health services, the program could take advantage of missed opportunities for providing family planning services. Post-partum care is an opportunity to provide use effective family planning methods. When children are brought for immunization, it is an opportunity to review family planning status. LGUs overwhelmingly prefer providing family planning as part of an integrated package of family health services. If packaged in this way, the program will also receive strong support from LGUs.

Collaboration

PopCom needs to be involved in coordinating advocacy for family planning. Its network of regional and provincial officers could be mobilized as program advocates, trainers, and even as a research arm for evaluation. PopCom could also make a positive contribution if included in the RTATs.

The DOH/CHDs could also be given a role as provider of technical assistance, particularly in training, development of service protocols and standards, grant manager or coordinator, program monitor or health/FP advocate.

Indicators

Since the new program should be national in scope with national impact, end of project achievement targets should be consistent with national program targets for family planning and MCH established by the DOH; and should include indicators used by USAID to measure progress toward achieving its strategic objective. The following table contains a notional list of targets for end of project achievement, indicators that can be used to measure them, and DOH targets for 2004 where these have been specified.

Indicator	1998	2004	2006
TFR	3.7	2.7	2.2
CPR	46.5	58.5	61.0
CPR Modern Methods	28.2	40.5	45.0
Unmet need for family planning	19.8	10.0	8.0
Discontinuation Rate	41.1	32.0	28.0

TFR and CPR register small changes annually; hence their measurement on a five-year basis is sufficient to gauge impact. The National Demographic and Health Survey will be conducted in 2003 and 2008. For the purposes of this program, these are not particularly timely. To measure national level impact, it will be preferable to add these indicators to a rider on the Labor Force Survey that is done on an annual basis.

HIV/AIDS Integration with Family Health

HIV/AIDS prevention has always been a stand-alone program. Risk factors for HIV transmission are highest in isolated "hot spots," justifying the stand alone, targeted geographic approach. However, HIV/AIDS interventions are delivered at the LGU level, geographic coverage must be expanded, and HIV/AIDS prevention could be amenable to approaches being incorporated into the new program design. At the LGU level, HIV/AIDS prevention and control is considered a reproductive health service. There is overwhelming support, both from LCEs and LGU health officials, for integrating HIV/AIDS into a family health program. Programmatically, there are cogent reasons for integration, not only for

the economies of scale, but also for the synergies that can be maximized. While data from the RFA indicates that LGUs have been singularly delinquent in utilizing NGOs for outreach, the HIV/AIDS project has successfully used NGOs to counsel high risk groups like sex workers, injecting drug users, and men who have sex with men, that are difficult to reach. These networks can be used to complement and enhance the family planning and family health program at marginal cost.

Similar programmatic reasons argue for integrating TB control with HIV/AIDS and family health. Equally forceful public health reasons argue for integrating TB with HIV/AIDS. TB is a nationwide public health problem. In areas of high HIV prevalence, it will be especially virulent. If local government and NGO resources have been mobilized for family planning, family health, and HIV/AIDS prevention and control, TB prevention and control can be integrated at marginal cost. Request the AESP project of PATH to add family planning and other appropriate MCH services.

DOH Grants and LGU Cost Sharing

If grants will be provided to LGUs through the new program, design should allow LGUs flexibility in deciding the size of the grant they want to access, i.e. the program should be demand driven. Also, there might be a need to have the LGU cost share (in percentage terms) follow a sliding scale and so as to ensure that poorer LGUs are not excluded from the program.

There is a line item in the DOH budget for "assistance to LGUs," that has been utilized for the DOH support to LGUs. These funds should be maintained with annual real increases for continued grants from DOH to LGUs. This should be a condition of the assistance. The DOH grant can be "matched" by the LGUs with MOO&E funds dedicated to the family health program at a level that is sustainable by the LGU. In this way, the size of the "match" is demand driven based on resources available to the LGU.

If a performance based disbursement is used, what indicators should be used to set performance targets so that they measure current performance as opposed to past performance? The performance indicators should be sensitive enough to measure progress on an annual or biennial basis. At a minimum, the following indicators are recommended:

- CPR for Modern Methods
- CPR for use effective methods
- Unmet need
- FIC coverage
- GOP (central/local) funds allocated to family health.

Sentrong Sigla

Support for Sentrong Sigla should be continued with some modifications. Sentrong Sigla currently measures inputs and process to quality of care:

facilities, equipment, personnel, and systems. It does not measure outcomes. It should be revised to incorporate outcome measurements into the certification process. The P1,000,000 prize for Sentrong Sigla certifications should be rescinded as it creates distortions in resource allocations that favor inputs over outcome measures of quality of care.

Beyond STI and HIV/AIDS surveillance, disease surveillance systems are not perceived as a priority by the LGUs. Since they are neither perceived or recognized needs at the LGU level, further investment in expanded disease surveillance would have only marginal benefits at this time, except in larger LGUs where an expanded package is appropriate.

Technical Assistance

The need for technical assistance will continue in the new program, but the scope may change. In a new design, the TA should be able to set reasonable performance benchmarks for LGUs, monitor and certify achievement of benchmarks, disburse matching or performance grants to LGUs, and audit the validity and accuracy of CBMIS data. The technical assistance can be provided by local agencies with requisite capacity rather than contracting this service out to international contractors.

Coordination

Coordination between the MGP and other CA projects is perfunctory at present, and there is little synergy between these projects. Because of the intrinsic importance of LGUs in delivering FP and health services, it would seem natural that the LGU project should be the central coordinating mechanism for integrating inputs from other CA projects in order to maximize their impact at the service delivery level, in a hub and spoke arrangement. To the extent possible, inputs from the other CA project should be concentrated in sites where the LGU program is being implemented. Creation of a registry that identifies the qualified private practitioners and NGOs that can augment the LGU health services would assist the overall health program.

Central Level Support

There should be a structural or functional unit within the DOH organizational structure that is responsible for technical oversight of the LGU project. Such a unit would guarantee that the project adheres to DOH policy and priorities while simultaneously providing an advocate at the central level. Possibilities include BLHD, the Center for Family and Environmental Health, which has been designated as the lead agency in the DOH for family planning management, or the PMU under the USEC for External Affairs.

The data from this assessment clearly points to five essential components that should be included in all LGU assistance packages:

- Installing a CBMIS in at least 80% of the barangay in an LGU to identify needs and target services.

- Increasing the number of Barangay Health Workers to conduct the CBMIS and follow up with persons in need of services.
- Training BHWs to conduct the CBMIS, counsel women about family health program and the correct use of contraceptive methods, and refer in the case of side effects.
- Improving IEC and advocacy a the LGU level
- Assuring quality of care.

Politics

Mayors are key to the support that family planning activities receive at the LGU level. If a mayor comes to understand that the family planning activities are a political plus and the program's success will make the mayor look good to his/her constituents and enhance the chances of reelection, then the family planning program at the LGU will move forward quickly.

ATTACHMENT 1

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ATTACHMENT 2

GUIDE QUESTIONS

The FGD activity was divided into three sessions:

Session 1: Introduction FGD

The Facilitator put forth a series of progression questions that directed the thinking of the groups towards making a decision and elicited response through dialogue with the participants. The idea is to allow people to become conscious to how their thinking can become action and produce group reflections and decisions based on all the available information. The whole process took about 20 minutes.

The FGD Guide Questions are a as follows:

1. How long have you been involved in the family planning program? Oldest? Youngest?

2. Which aspect of the program have you been involved most? Who is the champion of family planning in your municipality?

3. How do you feel about the way the program is implemented in your municipality? Which aspect are you happiest? Which aspect are your most frustrated?

4. What do you feel about the devolution of the organizational structure in family planning service at the local level? Strongest links? Weakest links?

5. In your experience, what do you think are the strongest features of the FP Program? Weakest features? Which areas need to be strengthened? What works? What does not work?

6. If you were to redesign a program in family planning, what 2 areas would you first look into? Consider least?

The Facilitator closed and summarized the major points after the session.

Session 2: Current Reality Dialogue

Using the TOP technique, four questions were analyzed by the group. The group using metacards processed each question. Each individual would write his/her idea about the question and all ideas were displayed on the board. The facilitator

then asked the participants to group all similar ideas and label the clustered ideas. The labels served as the group's answer to the question.

The four questions were:

1. What do you see as the major trends in the delivery of family planning services in the LGU?

2. What are the major accomplishments in family planning service delivery over the last five years?

3. What are the hindering factors that affect family planning service delivery in the LGU?

4. What are the facilitating factors that contribute to effective family planning service delivery in the LGU?

This session was completed in one (1) hour.

Session 3: Key Action Areas Workshop

The group then held a mini-workshop to discuss among themselves the following:

- What activities or key areas need to be addressed immediately to enhance the delivery of family planning service in the LGU?

The group made a presentation at the end of the workshop. This lasted for about 40 minutes.