FINAL REPORT

Ex-Post Evaluation Study

of the

Family Planning/Maternal and Child Health (FP/MCH) Project Phase II

VOLUME I

MAIN REPORT

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shinfield consultancy
philippines inc.

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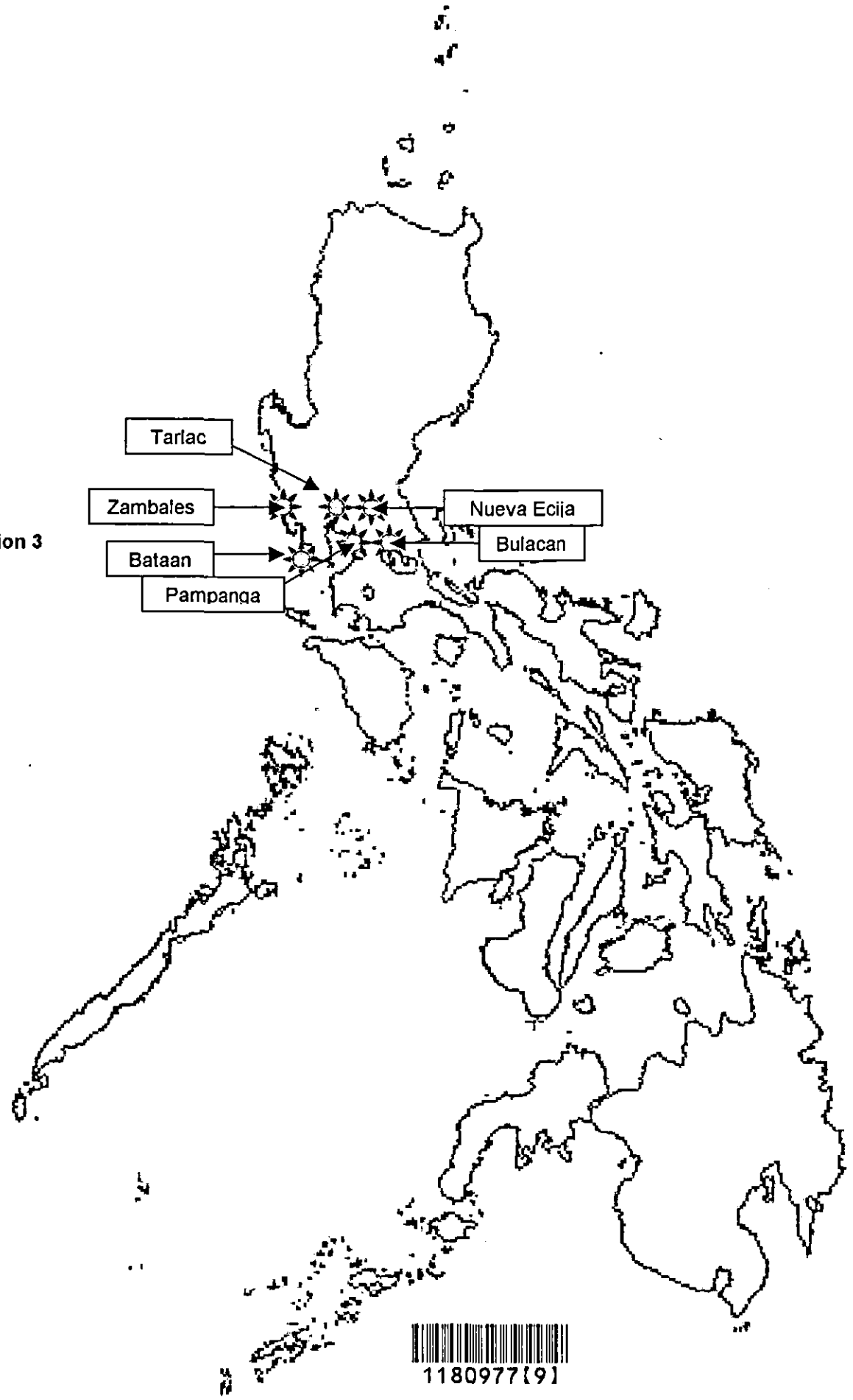

Survey Sites

ABBREVIATIONS AND ACRONYMS

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LGUs	Local Government Units
PHO	Provincial Health Office
RHUs	Rural Health Units
MHO	Municipal Health Office
UFC	Under Five Clinic Program
FP	Family Planning
MCH	Maternal and Child Health
MCHCs	Maternal and Child Health Centers
BHS	Barangay Health Station
BHWs	Barangay Health Workers
MDGs	Millennium development Goals
GOs	Government Organizations
PH	Provincial Hospital
TBAs	Traditional Birth Attendants
NGOs	Non Governmental Organizations
DOH	Department of Health
GOP	Government of the Philippines
GOJ	Government of Japan
ADB	Asian Development Bank
CPR	Contraceptive Prevalence Rate
HSRA	Health Sector Reform Agenda
IEC	Information Education Campaign
IMR	Infant Mortality Rate
CDR	Crude Death Rate
MMR	Maternal Mortality Rate
PTTC	Project Type Technical Cooperation
FGD	Focus Group Discussion
PDM	Project Design Matrix
TOR	Term of Reference
LCEs	Local Chief Executives
iMaCH	Integrated Maternal and Child Health

SUMMARY

SUMMARY

Evaluation conducted by: JICA Philippines Office

I. Outline of the Project		
Country Philippines		**Project title** Family Planning/ Maternal and Child Health Project (Phase II)
Issue/Sector Family Planning/Maternal and Child Health		**Cooperation scheme** Project- type technical cooperation
Division in charge		**Total Cost** _____ **yen**
Period of Cooperation	April 1997 to March 2002	**Partner Country's Implementing Organization:** Department of Health **Supporting Organization in Japan**
Related Cooperation	Family Planning/ Maternal and Child Health—Phase 1. Project for Upgrading of Facilities and Equipments in Selected Field Health Units in the Republic of the Philippines (Japan's Grant Aid)	

Background of the Project

The Department of Health (DOH) and the Japan International Cooperation Agency (JICA) jointly undertook the Family Planning/Maternal & Child Health (FP/MCH) Project 2. It was a Project-Type Technical Cooperation (PTTC) that was piloted in the Province of Tarlac. The positive results in the pilot- testing in Tarlac, motivated the GOJ and GOP to extend the project cooperation for another five years, from April 1997 to March 2002. The area of coverage of the second phase was expanded to include all provinces in Region III.

Project Overview

The FP/MCH Project Phase 2 was designed to achieve region-wide improvements in health status among all provinces in Region III (Central Luzon) through dissemination of the gains from the FP/MCH Project in Tarlac. The Project aimed to contribute to the overall goal of improving the health status in Region III through the DOH's Reproductive Health Strategy. To realize this goal, the Project conducted various training programs for health workers, upgraded the facilities and equipment of field health units, conducted health related partnership activities and developed and disseminated FP/MCH-related IEC materials.

Overall Goal

To improve health status through the Department of Health's Reproductive Health strategy in Region III.

Project Purpose

To achieve region-wide improvements in reproductive health status among all the provinces in Region III (Central Luzon) through dissemination of the gains from FP/MCH Project in Tarlac.

Outputs

1. Improved management & objective evaluation project.

2. Developed manpower resources thru formal/informal skills training, mutual exchange of information with other health workers & technical transfer by experts in relevant fields.

3. Improved capability of local government staff to manage health programs.

4. Improved health status of the community people in the project areas thru people's active participation in health activities

5. Smooth dissemination of IEC materials pilot-tested in the project area.

(The project goal, purpose and outputs were lifted from the Project Design Matrix of the Project)

Inputs

Japanese side	**Philippine Side**
Experts	
• Chief Advisor	counterpart personnel
• Coordinator	counterpart budget
• FP/MCH	office space and facilities
• Public Health	support & coordinating mechanism
• Statistics and Demography	
• Gender and Development	
• Other related fields	
Equipments	
• Medical equipments & supplies	
• IEC equipment for transportation and communication	
• Equipment for survey, monitoring and evaluation	
• Equipment for promotion of FP/MCH activities	
• Other equipment and materials mutually agreed upon as necessary	
Training in Japan	

II. Evaluator		
Evaluation Consultant	Prof. Wilfredo Carada Shinfield Consultancy Phils. Inc.	
Period of evaluation	October 21 to December 20, 2004	**Type of Evaluation** Ex-Post Evaluation

III. Results of Evaluation

Summary of Evaluation Result

Impact

The project generated a chain of impacts. It contributed to the *improvement of reproductive health status* that is manifested by increased live births, decreased in maternal and infant death. This improvement Is brought about by the *changes and improvement in reproductive health practices and services*- another impact created by the project, indicated by the increased in family planning acceptors or contraceptive prevalence rate (CPR), increase attendance in pre- and, post-natal checks-up, increased number of fully immunized children and infants, and increased number of infants that were exclusively breastfed up to fourth month, and increased number of deliveries done by professional medical staff.

The changes in practices mentioned above was a product of *improved health awareness of people and community involvement in health programs, improved quality of service provider/services and strengthening of the local referral system.* The facilities, equipments, information campaign and capacity building undertaken by the project facilitated all of them.

Project Sustainability

The effects of the project are sustained as institutional sustainability is being carried out by Department of Health (DOH) (regional and central) by providing inputs/drugs/medicines and by continuously extending technical and administrative assistance to LGUs. A mechanism to certify quality service delivery is also done by DOH. Production of information, education and communication (IEC) campaign materials and acquisition of new equipment are other measures DOH is doing to ensure project sustainability. Local government health offices are conducting trainings for volunteer health workers, organizing local health boards, hiring medical staff and distributing IEC materials. They are also implementing health programs. Sustainability was even more ensured in some areas where the health service providers enjoyed political, technical and financial support from LGU, DOH and other organizations.

Financial sustainability of basic services given the present demand is also ensured. However, increase in the number of clients and the need to replace facilities and equipment provided by the project will create a problem.

Technical sustainability is ensured by skills and knowledge transferred by the project. Knowledge and skills on under-five clinics, family planning, reproductive health, maternal and child health and effective IEC are being transferred through echo-seminars, regular meetings and demonstrations. New technologies are also introduced in training conducted by DOH or other agencies. Manuals, like the Midwives Manual on Maternal Care, are also published and distributed to promote technical sustainability.

Factors that have promoted project

There are several factors that have promoted the project. Project concept and components remain relevant. Family Planning/ Maternal and Child Health remained relevant to the recipient country and responsive to the needs of women and children. The restoration of the local health referral network and the improvement of the decentralized local government health remain a priority in the Philippine Health Sector Reform Agenda. The Philippines is committed to the realization of the Millennium Development Goals (MDGs), where the focal areas of the project are included: MDG#4 – Reduce Child Mortality and MDG#5 – improve maternal health (. In this regards DOH promotes FP/MCH program and supports LGUs in implementing it, thus ensuring impact and sustainability.

Another factor that promoted the project is institution of mechanisms that recognize and award good service delivery. The certification and award given by DOH to health facilities that provide quality services, maintain excellent facilities and equipment, through the Sentrong Sigla award and/or PhilHealth Accreditation scheme ensure maintenance of quality services and facilities, promoting project sustainability.

The political and financial support of the local government units is another critical factor. The advocacy of political leaders for better health for his/her constituencies raise awareness, improve health practices and increase patronage of health facilities. Financial support to ensure that basic equipment and supplies are available to provide basic health services is being provided by some local politicians. It is worthy to mention two FP/NCH champion lady mayors who even extended/constructed additional rooms (birthing rooms, laboratory room and storage room) to accommodate additional deliveries. This action inspired both health personnel; and clients- women and children.

The integrity in the performance of tasks, particularly in the case of Botika Binhi. Several Botika Binhi were not able to survive due to missing capital.

Another facilitating factor is the awareness and favorable attitude of mothers and husbands to look at health as wealth. Internalizing in their system the practice of regular consultation would create and sustain FP/MCH and its intended impact

The active involvement of the association/federation of BHWs in programming and implementing community-managed health activities is also a contributing factor. BHWs associations are also able to organize activities that will make full use of the facilities and equipment of the health centers. Finally, BHWs associations could be a source of community pressure that would ensure project sustainability.

Maintaining a network of organization or simply linkages between/among several organizations that jointly pool their resources together is also a contributing factor. The advocacy work of NGOs, the service delivery functions of LGUs, sharing of resources and competencies when integrated are helping facilities maximized their service delivery potentials.

Health workers and local chief executives, the direct beneficiaries of the project. The commitment of the health personnel to provide quality services and the commitment of the local chief executives to provide necessary support (technical, political, administrative and financial) are contributing factors.

Factors that have inhibited project

Several factors inhibited the impact and sustainability of the project. In some areas, there was a feeling of lack of support from local government units/low priority of health services in the local development agenda. Another is the lack of commitment of health organizations and workers to FP/MCH and poor maintenance and replacement of facilities and equipment.

Low awareness of claimholders regarding existing family planning and maternal and child health information and services is another factor. Some beneficiaries are not informed and/or not willing to avail of existing services. Reassignment or resignation of staff trained under the project to other job (without replacement by somebody who knows the project is another hindrance to the sustainability of the project.

Provision of similar program with a different strategy is another hindrance. Botika Binhi was not continued in some areas as Botika sa Barangay was introduced. While Botika Binhi is struggling to raise capital, Botika sa Barangay was a dole out. Beneficiaries shifted their interest/preference from a self-help approach to a dole out approach

Conclusions

The project was successful in generating impacts. Through its outputs, the project was able to increase health awareness of people and community involvement in health programs. Improved quality of service provider/services was also noted and local referral system was strengthened.

Consequently, changes and improvement in reproductive health practices and services were noted as increase in family planning acceptors or CPR, increase attendance in pre- and post-natal check-up, full immunization of infants and children, increase number of infants exclusively breastfed up to fourth month and more deliveries were handled by professional medical staff. Then improvement of reproductive health status is being generated manifested by increased live births; decreased maternal death and infant death. Eventually this will lead to the improvement in the overall health status.

The effects of the project are sustained as institutional and technical sustainability is assured but extra efforts need to be done to guarantee financial sustainability.

Recommendations

For the Government of the Philippines

Several recommendations were elicited during the conduct of the study most of which are addressed to DOH and LGU health office. Most recommendations are geared towards increasing project impact and sustainability. They are:

- A functional monitoring and evaluation (that is not purely a one-way reporting system) is also recommended to gauge progress and to provide updated and reliable information on project impacts.
- Continuous capacity building is recommended for health professionals and health volunteer workers. They felt the need to know the state of the art of FP/MCH in order to have confidence in the performance of their functions.

- Basic equipment (provided by the project) to handle cases/patients and facilities need to be maintained by LGUs. Together – training and facilities and equipment – ensures quality service delivery. As a midwife from Tarlac said, *" trainings plus new facilities and equipment give me self-confidence, especially in handling deliveries."*

- Aside from recommending budget allocation, increases from LGUs, fund/supply/material augmentation between national and local government is suggested. Such resource augmentation will help match the increasing number of clients/patients with budget scarcity. Along this line, pooling of resources (public, private and NGO partnership) in support of a common program should also be initiated by DOH-Regional office and LGUs.

- Innovative IEC need to be introduced to generate and sustain project impacts. IEC that move people, that market FP/MCH to political leaders are recommended. Strengthening of BHW associations and federations is also recommended. Aside from providing assistance in project implementation, they can advocate and exert community pressure to ensure that the project is sustained.

- DOH should recognize best practices in FP/MCH and continue to certify and reward good performance. Sentrong Sigla and PhilHealth accreditation motivates LGUs to maintain facilities, equipment and services on a given standard.

- The Philippines should also enact and implement an aggressive FP policy that will increase CPR and attain a population growth at a reasonable level. Without this policy, pushing FP is hard and reproductive health improvement becomes difficult.

- Project evaluation studies (ex-ante to ex-post evaluation) should be made an integral part of a recipient country commitment and such tasks should be done by the concerned department or ministry and/or by a national planning agency

<u>For JICA</u>

- In future project cycle management, the involvement of political leaders is suggested to JICA. As primarily responsible for delivering health services, political leaders should be in the driver's seat of this effort. Putting them on board from the planning stage is necessary.

- Aftercare support, five to seven years after program completion, small grants could be made available to replace vital equipment. Replacement of equipment (beyond the capacity of some LGUs) that will need a relatively small amount but generate more project impact is a reasonable investment

- Measures to enhance institutional, financial and technical sustainability should be integrated in the PCM as early as the design stage.

Lessons Learned

Several lessons are offered by the project. Some of them are already integrated in the discussion about recommendations. In addition, the following lessons are learned: Putting local political leaders in the forefront of health service delivery could ensure generation of project impact and sustainability. At the early stage of the PCM, put them on board, to increase their awareness and eventually to make them service delivery champions. Interventions that will address political leaders and impress upon them the role of political leaders in FP/MCH should be a component of a similar project. A project should balance the involvement of political leaders and technical staff to ensure sustainability.

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Another lesson is that an accreditation and reward system that recognizes quality performance should be installed parallel to projects like FP/MCH. An accreditation and certification mechanism working in the project areas at the moment is the Sentrong Sigla and the PhilHealth accreditation system. Quality of performance, facilities and services are regularly evaluated that facilitates sustainability beyond donor's life. Champion mayors and best practices can provide model for sustainability and impact generation. They offer also inspiration and road map for replication.

CHAPTER I

INTRODUCTION

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A. Background of the study

JICA has implemented and completed numerous projects in the Philippines, and those that have been completed are usually subjected to ex-post evaluation. For the Japanese Fiscal Year 2004, JICA decided to undertake an ex-post evaluation study for the FP/MCH project phase 2 which was implemented from April 1997 to March 2002. It was designed to promote a region-wide improvement in reproductive health status in all provinces in Region III (Central Luzon). The Project was implemented by the DOH, Region III.

The Project ended in March 2002 and its impact, sustainability and lessons learned need to be assessed. For this purpose, JICA commissioned Shinfield Consultancy Philippines Inc. to undertake the ex-post evaluation study. The study was conducted for two chronological months, October 21 to December 20, 2004. This study was completed despite the series of typhoons and floods delayed the retrieval of questionnaires, especially in Nueva Ecija, which was strongly affected by flooding.

B. Objectives of the study

This ex-post evaluation study seeks to assess the impact and sustainability of the project, two years after its completion. In addition, this is designed to:

1. Draw lessons and formulate recommendations for the improvement of planning and implementation of similar projects; and

2. Promote greater accountability and transparency by disseminating the evaluation results to the project stakeholders and the Japanese public.

C. Methodology

Various research methodologies such as Document Review, Key Informant Interviews, survey through the use of questionnaires, Focus Group Discussions (FGDs) and Material Inventory were used in the conduct of this ex-post evaluation study.

In Document Review, materials like reports were examined to get a deeper understanding of the project. As for the interviews, key informants were interviewed to determine project performance during and after JICA involvement.

In the survey, questionnaires were sent to all heads of Maternal and Child Health Centers (MCHCs), Rural Health Units and Barangay Health Stations (84 respondents) that were directly involved in the project to determine their opinions on the achievement of the overall goal and purpose, impact, sustainability, factors facilitating and hindering project impact and sustainability, lessons learned and recommendations regarding the project. Attachment A presents the responses generated from the questionnaire.

Six focus group discussions (FGDs) were also conducted to gather information, insights and remarks regarding project activities/components and effects that are sustained; impacts generated, lessons learned and recommendations for similar undertakings (Attachment B presents the result of the FGD).

Furthermore, material inventory was conducted to determine the utilization and working condition of facilities and equipment. The result of the material inventory is presented in Attachment C.

Visits and observations of facilities, equipment and service delivery were also done in 6 MCHCs, 8 RHUs and 12 BHSs. Lastly, Photo documentation was also undertaken to document the status of project facilities, equipment and their utilization.

D. Organization of the Report

The report is divided into five chapters. Chapter 1 contains the introduction, which provides the background and objectives of the study. Chapter 2 focuses on the project and presents the project structure, its logical framework and the stakeholders involved in the project.

Policies, programs and organizations involved in implementing health plans and programs are discussed in chapter 3. Project activities that are continuously being undertaken are presented along side with the problems of project continuity/ discontinuity.

The project impact and sustainability are assessed in Chapter 4. The achievement of the project goal and purpose is analyzed as well as the impacts and sustainability of project effects. Institutional, financial and technical sustainability are also discussed in this chapter. Finally the chapter presents factors facilitating and hindering project impact and sustainability.

Lastly, Chapter 5 deals with conclusions, recommendations and lessons learned from the project.

Separately submitted to JICA Philippine office as part of this Report are the: (a) photographs (in album); and (b) questionnaire survey results

CHAPTER II

PROJECT FRAMEWORK

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A. Outline of the project

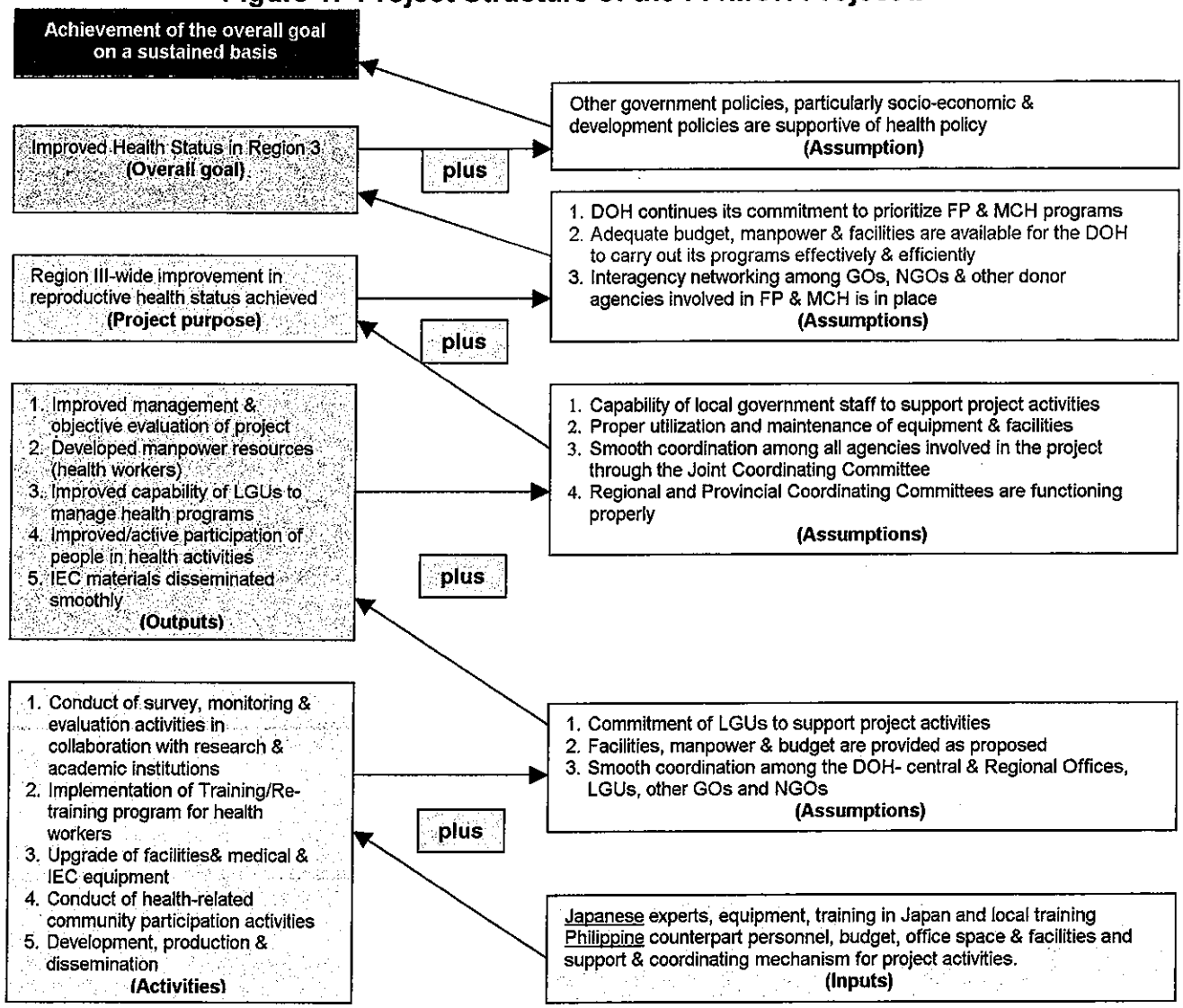
In 1995, the maternal and child health situation in Central Luzon (Region III) was reported by the National Demographic and Health Survey to be 40 infant deaths per 1,000 live births while maternal mortality rate was 171 per 100,000 live births. This was considered high against international standards and, given this situation; GOP requested the assistance of JICA. The positive achievements of the Project-Type Technical Cooperation (PTTC) on Family Planning/Maternal and Child Health (FP/MCH) Project in Tarlac was noted by the GOJ and GOP and, on this basis, agreed to extend the project cooperation (after it ended in March 1997) for another five years, from April 1997 to March 2002, this time covering Region III.

With the lessons learned from the Tarlac experience, FP/MCH II was designed to promote a region-wide improvement in reproductive health status in all provinces in Region III (Central Luzon). The Project sought to contribute to the overall goal of improving the health status through the DOH's Reproductive Health Strategy in Region III. To achieve the goal stated above, FP/MCH-II implemented various training programs for health workers, upgraded the facilities and equipment of field health units, conducted health related partnership activities and developed and disseminated FP/MCH-related IEC materials. The Project ended in March 2002.

The project structure of the Family Planning/ Maternal and Child Health Project is shown in Figure 1, below. The Project provided a set of inputs, consisting of Japanese experts, health facilities, medical and IEC equipment and supplies and training of health workers in Japan and locally. These inputs, together with several activities, (when implemented properly) would produce several outputs/results (identified in figure 1). These outputs would then contribute to the attainment of the project purpose (region-wide improvements in reproductive health status among all the provinces in Region III). Achievement of the project purpose would, in turn, help

achieve project goal (improved health status through the DOH's Reproductive Health Strategy in Region III).

Figure 1. Project Structure of the FP/MCH Project II



The project activities intended to produce the desired outputs/results are enumerated in the figure above. The assumptions for each level are also enumerated in the project structure shown above.

B. Logical framework

The logical framework of the project follows the project structure shown in figure 1 and is illustrated in the project design matrix (PDM), presented below, Table 1. It is the Project Design Matrix of the project and was used as guide in the process of evaluation.

Table 1. Project Design Matrix

Narrative Summary	Verifiable Indicators	Means of Verifiable Indicators	Important Assumptions
OVERALL GOAL To improve health status through the DOH's Reproductive Health in Region III	Indicators that goal has been achieved - Health indicators - Socio-economic indicators	Philippine Census: Demographic and Health Survey (DHS)	Other government policies, particularly socio-economic and development policies are supportive of health policy
PROJECT PURPOSE To achieve region-wide improvements in reproductive health status among all the provinces in Region III (Central Luzon) through dissemination of the gains from the FP/MCH Project in Tarlac	Indicators that project purpose has been achieved - Improvement of Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) in the project area; - Increase in Contraceptive Prevalence Rate (CPR) in the project area; - Increase in the % attendance for Prenatal and Post Natal Check-ups	Need Assessment Report/ Monitoring and Evaluation Reports/ Service Statistics	- DOH continues its commitment to prioritize FP and MCH programs - Adequate budget, manpower and facilities are available for the DOH to carry out its programs effectively and efficiently - Interagency networking among GOs, NGOs and other donor agencies involved in FP and MCH is in place
RESULTS/OUTPUTS 1. Improved management and objective evaluation of project		- Survey monitoring and evaluation report	- Capability of local government staff to support project activities - Proper utilization and maintenance of equipment and facilities - Smooth coordination among all agencies involved in the project through the joint Coordinating Committee - Regional and Provincial Coordinating Committees are functioning properly
2. Developed manpower resources through formal/ informal skills training, mutual exchange of information with other health workers and technical transfer by experts in relevant fields	- No of health workers sent for technical training - No. of local training course conducted	- Training documents - Training documents and attendance sheets	
3. Improved capability of local government staff to manage health programs	- List of medical and IEC equipment provided according to specifications	- Deed of donation - Equipment of Inventory	
4. Improved health status of community people in the project areas through people's active participation in health activities	- Increase in volume of clients who visit facility for primary health care - Community health welfare organization in place and functioning	- Clinics and BHS records - Documentation of activities	
5. Smooth dissemination of IEC materials pilot-tested in the project area.	- Quality and quantity of IEC materials and distributed	- Sample of IEC materials - No. of IEC materials disseminated	
ACTIVITIES 1. Conduct of survey, monitoring and evaluation activities in collaboration with research and academic institutions 2. Implementation of Training/ Re-training program for health workers (Midwives, Nurses, Health Officials) 3. Upgrade of facilities and medical and IEC equipment 4. Conduct of health-related community participation activities 5. Development, production and dissemination of IEC materials	**Japanese Side** - Experts Chief Advisor Coordinator FP/MCH Public Health Statistics and Demography Gender and Development Other related fields - Equipment Medical Equipment and supplies IEC equipment for transportation and communication Equipment for survey, monitoring and evaluation Equipment for promotion of FP/MCH activities Other equipment and materials mutually agreed upon as necessary - Training in Japan **Philippines Side** - Counterpart personnel - Counterpart budget - Office space and facilities - Support and coordinating mechanism for project activities		- Commitment of LGUs to support project activities - Facilities, manpower and budget are provided as proposed - Smooth coordination among the DOH – Central and Regional Offices, LGUs, other GOs and NGOs

The PDM is the basis for evaluating a project. It is relatively easy to evaluate a project if the indicators are specific. As constructed, the indicators of goal achievement (impact level) are broad. Indicators of improved health status like improved life expectancy should have been provided to measure goal achievement. It would be simpler (and more realistic for the project to achieve) if the project purpose is "improved reproductive health practices" where the indicators are increased CPR, increased pre- and post natal check ups, among others. Then *overall goals would be "improved reproductive health status" and the indicators are* decreased neonatal mortality rate, infant mortality rate and maternal mortality rate, among others. The development logic of the project then should be: the goods and services produced by the project (outputs) would change/improve reproductive practices/FP-MHC practices (outcome) that would lead to the improvement of reproductive status. The evaluator considers this logic more than looking into the success of the project in generating improved health status and socio-economic changes.

C. Stakeholders of the project

The stakeholders of the project are the DOH central and regional offices and the LGUs. The responsibilities of the DOH are the following (Primer on Devolution of Health Services):

- Formulation and development of national health policies
- Formulation and implementation of national health plans and programs
- *Formulation of guidelines, standards and manuals of operations for health* services and programs to ensure quality services at the local level
- Issuance of rules and regulations, licenses and accreditation pursuant to existing laws
- Promulgation of national health standards, goals, priorities and indicators
- Development of special health programs and projects
- Advocacy for legislation on health policies and programs

Local government units that include barangays, municipalities, cities and provinces are also stakeholders of the project. health and social welfare services, through the

maintenance of barangay health stations and daycare centers are responsibilities of barangays. The municipalities implement programs and projects on primary health care, maternal and childcare, and communicable and non-communicable disease control services; access to secondary and tertiary health services; and purchase of medicines, medical supplies and equipment needed to carry out the devolved health services.

The provinces are mandated to undertake primary, secondary and tertiary health services in provincial hospital, district hospitals/health offices and municipal hospitals. All health facilities and services provided by a municipality are to be provided by a component city and for a highly urbanized city, all health facilities and services provided by a municipality and a province. The project provided health facilities, equipments and capacity building activities to enable them to carry out their functions effectively and efficiently.

To help LGUs perform their new roles and responsibilities, DOH provides assistance that could be in the following forms:

- Monitor and evaluate local health programs, projects, facilities, services, and research studies
- Provide health information, statistics and other data to LGUs such as those pertaining to prevalent diseases and hospital operations that serve as annual indicators
- Install referral mechanisms and ensure that the public or medical beneficiaries have access, when necessary, to higher and more advanced health facilities under the control of DOH.

To further ensure effective implementation of the decentralized health services system, DOH makes available to LGUs the technical, administrative and logistical and financial support services. The technical support services include information-education-communication (IEC) development; health research and development; health intelligence; national and international training; planning assistance; and other technical consultancy services.

The administrative support services extended to LGUs covers program and project management; inter-agency coordination; networking; information and record management; and other administrative services. The logistics and financial support services available to LGUs include bulk procurement of drugs, medicines and medical equipment and supplies; grants-in-aid, block grants; resource mobilization, budget preparation assistance and other financial and resource management services.

Women and children are also stakeholders. They are the intended beneficiaries of the project. They expect to improve their health conditions the best and the cheapest way. Their interest is quality services.

The direct beneficiaries are health workers/staff. They expect to update their know-how and skills regularly. Their interest is to have complete facilities and equipment that would enable them to provide quality services. LGUs in general want to claim that they could offer better facilities and excellent services.

CHAPTER III

FINDINGS

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A. Policies and Programs

1. Policies

Philippine vision remains the promotion of better health for all. Various policies provide a legal framework for this. The 1987 Constitution of the Philippine provides the policy framework on health, Section 15, Article II provides that:

> *"The State shall protect and promote the right to health of the people and instill health consciousness among them."*

Furthermore, Section II, Article XIII says that:

> *"The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers."*

Improving access to health and nutritional services, especially for women, children and migrant or displaced persons and those living in remote and underserved areas continues to be a policy concern. It is committed to reduce hunger, under-five mortality, maternal mortality and increasing access to reproductive health services and combating HIV/AIDS, malaria and other diseases.

Family planning and maternal and child health is still and will continue to be a priority policy of the national government. Policies adopted to reduce child mortality included among others the following:

- Republic Act 7600 (Rooming-in and Breastfeeding Act of 1992)
- Executive Order 51 of 1986 (Milk Code)
- Republic Act 8976 (Philippine Food Fortification Act of 2000)
- Republic Act 9288 (Comprehensive Policy and a National System for Ensuring Newborn Screening of 2003)
- Republic Act 7160 (Local Government Code of 1991 that decentralized many central government functions, making the LGU the primary provider of basic health care services)

To promote reproductive health and family planning, the Philippine Population Management Program (PPMP), enjoined all stakeholders to: (1) assist couples in achieving their desired fertility goals and prepare individuals to become responsible parents with special focus to poor couples and adolescents with unmeet need for RH/FP information and services, (2) improve the RH of individuals and contribute to the reduction of maternal, infant and early child (under 5 years old) mortality; (3) reduce the incidence of teenage pregnancy, incidence of early marriage and other RH problems; and (4) contribute to policies that will assist government achieve a favorable balance between population distribution, economic activities and the environment.

A coherent strategic population policy that will aggressively promote the reduction of population growth does not exist due to the opposition of certain religious group that until now population growth rate remains to be as high as 2.3% annually. The Department of Health (DOH) through Administrative Orders (AO) issues most population policies. Several AOs have been issued as AO # 79 series of 2000 that promotes the Safe Motherhood Policy; AO #132 series of 2004, which creates the DOH Natural FP Program and its Program Management; AO #158 series of 2004 which provides guidelines on the Management of Donated Commodities under the Contraceptive Self-reliance (CSR) strategy; and AO #45-B series of 2000 or the Prevention and

Management of Abortion and its Complication (PMAC) Policy. The Department of Education, in performing its role as educators, has issued Memorandum Order (MO) # 132, series of 1999 which ensures the continues conduct of school teacher training on Population Education (POPED) and Adolescent Reproductive Health (ARH).

Family planning is implemented through the four pillars of the country's population and family planning policy which are responsible parenthood, respect for life (protection of the life of unborn), three-year birth spacing and informed choice of couples and individuals in family planning methods. However, these pillars are not enough to reduce population growth to the level adequate for its productive capacity to satisfy.

2. Programs

DOH and the LGUs in collaboration with other agencies implement several programs/projects to implement the policies and realize the priority concerns of the health sector. They include the following:

- The Expanded Program on Immunization (EPI) is a DOH program that has been institutionalized and adopted by all LGUs in the country. Its objective is to reduce infant mortality and morbidity by decreasing the prevalence of six (6) immunizable diseases (TB, dipteria, pertussis, tetanus, polio and measles).
- Mother and Baby Friendly Hospital Initiative (MBFHI) is another program to transform all hospital with maternity and newborn services into facilities that fully protect, promote and support breastfeeding and rooming practices.
- Breastfeeding program that encourages exclusive breastfeeding in the first four (4) to six (6) months after birth.
- Women's Health and Safe Motherhood Project which seeks to provide quality women's health and safe motherhood services in the total health services package delivered by LGUs.
- Responsible Parenthood Movement/Campaign which seeks to enable families to make informed choices on family planning

The DOH provides a menu of programs that LGUs can implement in their localities. LGUs can select programs to be given more emphasis than the others, depending on their needs/demands. Program areas that are the directly related to the projects are: (1) Expanded Program on Immunization (2) Under-Five Care Program, (3) Comprehensive Nutrition, (4) Family Planning, (5) Maternal and Child Health, (6) Dental Health Program and, (7) Environmental Sanitation

The thrusts of FP/MCH Project phase 2 are now components of the Women's Health and Safe Motherhood Project, Expanded Program on Immunization, Under Five Care Program, Maternal and Child Health, Responsible Parenthood Movement/ Campaign.

B. Implementing Institutions

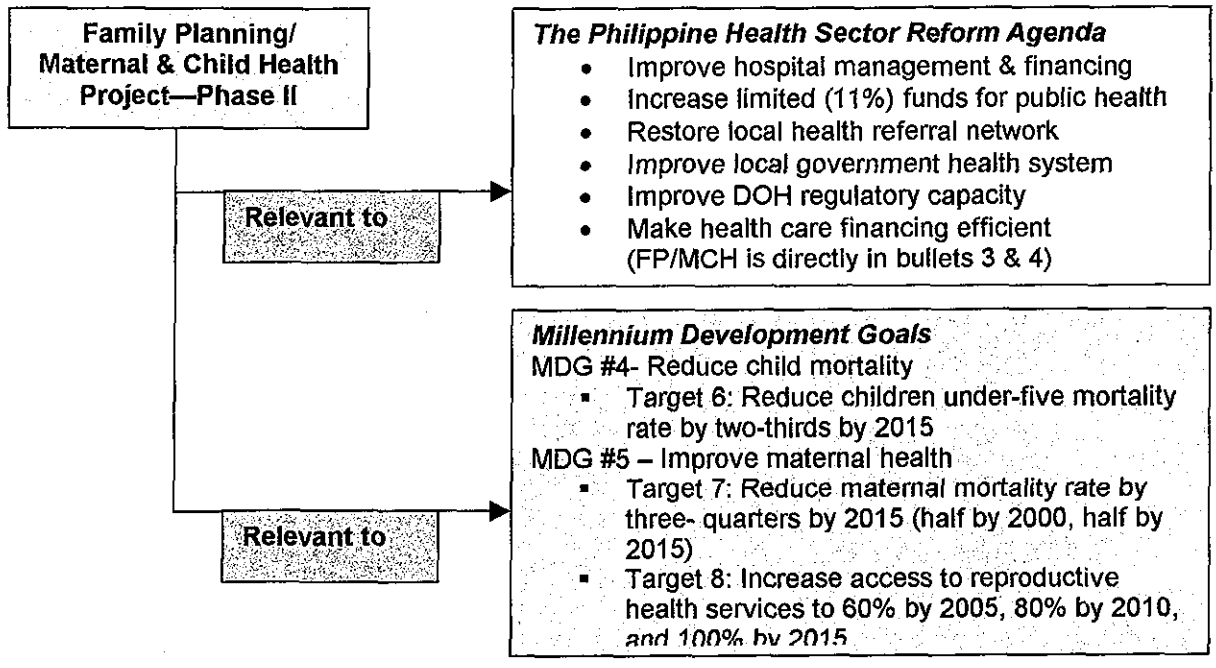
The organizational unit or the services, which the FP/MCH Project II worked with, remain in existence. The operation and maintenance of the Maternal and Child Health Center is a provincial concern while Rural Health Unit is under the jurisdiction of a municipal government. The operation and maintenance of a Barangay Health Station remains under the Municipal Health Office and operationally coordinated with the barangay administration.

C. Relevance of the Project

Two years after its completion FP/MCH remained relevant to the recipient country and responsive to the needs of women and children as evidenced by the following: one, the restoration of the local health referral network and the improvement of the decentralized local government health system remain high priority in the Philippine Health Sector Reform Agenda. Two, the Philippines is committed to the realization of the Millennium Development Goals (MDGs) and the Project is able to contribute to the attainment of MDG#4 – Reduce Child Mortality (Target 6: Reduce children under-five mortality rate by two-thirds by 2015) and MDG#5 – improve maternal health (Target 7· Reduce maternal mortality rate (MMR) by three-quarters by 2015.

The relevance of the Project is summarized in the illustration shown below.

Figure 2: Relevance of the Family Planning/Maternal and Child Health Project –Phase 2

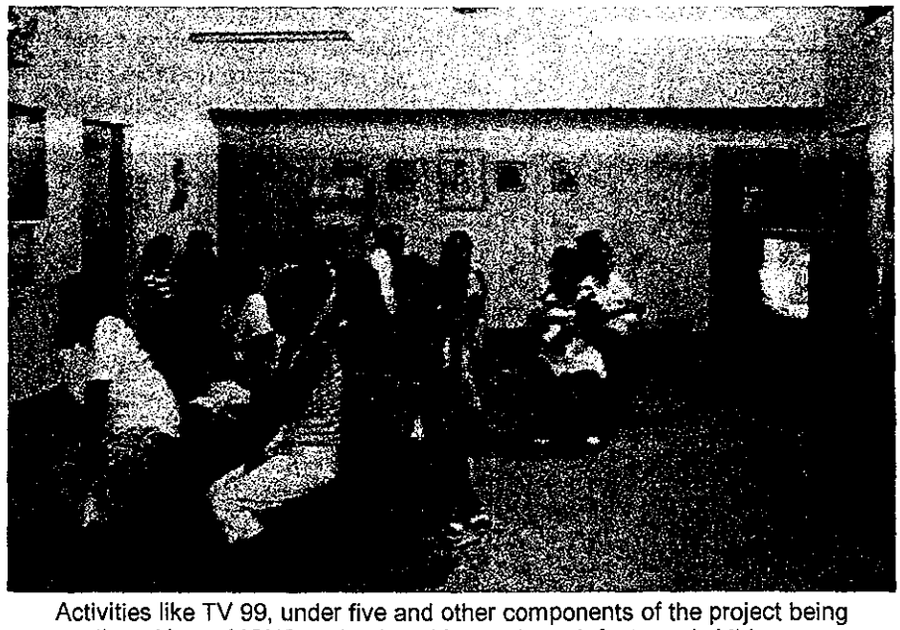


D. Continuity of FP/MCH Project Activities

Interviews with key informants, focus group discussions with health personnel and observations in the project areas revealed that various components of the FP/MCH Project II are being continued by the different Provincial Health Offices (PHOs), Rural Health Units (RHUs) and Barangay Health Stations (BHSs) even beyond project completion in 2002. The Under-Five Clinic Program is being continued in all levels (provincial, municipal and barangay) and will likely continue. The need for health services exclusively for under-five remains very high and has remained a regular national health program. Moreover, the reduction of children under-five mortality has become a millennium development goal that is being pursued both by international and national organization and, therefore, its continuity is assured.

Other sub-projects/activities remain part of a DOH program and continued to be implemented by the LGUs. The reproductive health training program has been integrated in the Women Health and Safe Motherhood Training Program and the Adolescent Reproductive Health Promotion Program. The Adolescent Video Series

remains to be an important tool in educating secondary and college students about adolescent reproductive health. Furthermore, the TV 99 Program is continuously being showed in most health facilities, while patients wait for their turn to be treated. It helps create awareness and understanding about different health concerns. This is a common scenario in most centers, as shown in the photo below.



Activities like TV 99, under five and other components of the project being continued in an MCHC and enjoyed by mothers, infants and children

Some sub-projects have been discontinued, examples of which are the 'tosang-making' (toilet bowl) project, male family planning motivation program and the Puppet show. In the case of tosang-making, the demand for toilet bowls has diminished and the preference is already on ready-made porcelain bowls. Male family planning advocates are difficult to recruit and so this activity was not continued. On the Puppet Show, the last time it was conducted was in 2002 and was halted because players and equipment are scattered around the region and organizing them for a show was difficult. But the utility of puppet show in creating awareness about health concerns remained to be recognized and given some determination, this activity could be done again.

There are a couple of Botika Binhi survivors as they were taken over by the Botika sa Barangay Project. Community capital build-up, which is needed to start a Botika Binhi, was relatively difficult to establish and so it was not replicated in the region. Moreover, people become more attracted and organized Botika sa Barangay, as it is

a dole-out project. The status or continuity of project activities is summarized below, on table 2.

Table 2. Continuity of Sub-project/activities of the FP/MCH Project 2

DOH-JICA FP/MCH sub-projects/ activities	Continuity of activities after the Project	Mechanism of continuity	Threats to continuity
A. Maternal & Child Health • Under-Five Clinic Program	continued at all levels (provincial, municipal & barangay) and will likely continue	DOH continues commitment to FP/MCH programs (i.e., expanded program on immunization, UFC, comprehensive nutrition, FP, MCH) and LGUs support to implement the program	Withdrawal of support from the Local Chief Executives (LCEs) and low capability of PHOs/MHOs to undertake social marketing of the service
• Integrated Maternal & Child (iMaCH)	The integrated manual was not completed and disseminated.	Most of the content of iMaCH is embodied in the "Midwives Manual on Maternal Care" published by the DOH	Reprinting of the manual is costly
B. Barangay Health Worker Empowerment (Capacity Building Program)	Occasionally undertaken	1. Initiative of the BHW association/group 2. Partnership between BHW - Midwives/nurses in BHS 3. Quarterly training for Traditional Birth Attendant (TBAs) in some LGUs	Capacity building are least priority when government implements austerity measures
C. Reproductive Health Initiative • Reproductive Health Training Supplementary Kit	Used occasionally, during the conduct of training on teenage fertility, RH, adolescent sexuality & fertility	1. Integrated in the women's health and safe motherhood training program 2. Part of the adolescent reproductive health training program	National & LGU programs are not synchronized
• Male Family Planning/ Reproductive Health Motivator Program	Not continued	Delegate this program to the Barangay	Difficulty in recruiting & sustaining interest of male motivators
• Adolescent Video Series	Occasionally undertaken after project completion	Initiatives of secondary schools and used in the adolescent reproductive health training program	Lack of awareness and commitment of secondary schools to adolescent RH
• Adolescent Reproductive Health Promotion Program	Occasionally undertaken after project completion	Initiatives of secondary schools and Population Commission Services	--ditto--
D. Community Empowerment • Tosang Making Project	Not continued	Delegate this project to the barangays	Preference of beneficiaries for ready- made porcelain toilet bowls and inclusion of construction materials (they can provide only labor)
• Botika Binhi Program	Sustained only in two or three barangays	(replaced by Botika sa Barangay)	1. community capital build-up is difficult 2. attraction of Botika sa Barangay (dole out) is high
• TV 99 Program	Not continued	Shown in MCHCs, RHUs and BHS and viewed by patients during consultation hours	Non-replacement of equipment
• Teatro 99 Program: Puppet Show	Not continued	(used 2002 during dengue festival)	Presence of trained players and paraphernalia
• NGO Collaboration & Support Program	Occasionally	Support from civic organizations or medical missions conducted by local officials	Differences in service delivery approaches; Poor networking of health workers
E. Medical Facilities and Equipment	Facilities & buildings are still in good working condition (except for broken door knobs and parts of some ceilings are slowly falling down) and are utilized for intended purpose	Certification and accreditation of facilities and services as Sentrong Sigla and by Phil. Health	Lack of funds for capital outlays and/or repair and replacement of equipment

Facilities and equipment donated by JICA enabled most of the project activities to be continued. Our material inventory revealed that most of the donated equipments

are in working condition (97.48%) and continued to be used (94.71%). The summary of the material inventory conducted by this study is presented in the tables 3 and 4 below.

Table 3. Frequency of use of donated equipment

Total No. of Particulars	2,814	100%
Used	2,665	94.71
Regularly used	1,912	67.95
Occasionally used	560	19.90
Rarely used	193	6.86
Never Used	120	4.26
No answer	29	1.03

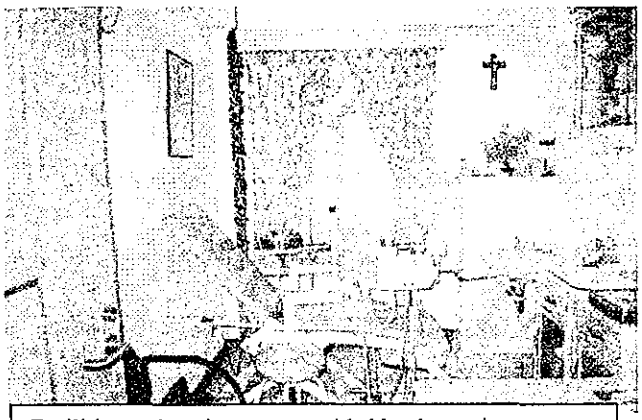
Source: Shinfield Material Inventory 2004

While most of the equipment is used (94.71%), some of them are regularly used (67.95%), occasionally used (19.90%) and rarely used (6.86%). Only 4.26% of the equipment has never been used. Most (97.48%) of the equipment are in working condition and only a few (1.78%) are not working. Some equipment (.14%) has been stolen. There are equipments in the inventory sheet where the respondents did not mark their frequency of used or their conditions. They are marked as no answer in both tables.

Table 4. Conditions of Equipment

Condition of Equipment	Frequency	%
	2,743	97.48
Not working	50	1.78
Stolen	4	.14
No answer	17	.60
Total	2,814	100

Source: Shinfield Material Inventory, 2004



Facilities and equipments provided by the project

E. Problems and Causes

There are problems that are felt and foreseen in the continuance of the activities of FP/MCH. First is the appeal of FP/MCH to LGU is not very high such that the budget allocation has not been raised and is just enough for routine and/or operation and maintenance functions. The funds allotted could not finance capital outlay and replacement of equipment provided by the project.

Another problem is the turnover of personnel. Since attraction to greener pastures is prevalent, the occurrence and constant threat of the exodus of trained personnel decreases the qualified manpower of the health facilities. In a province, the absence of a coordinator trained under the Project, practically left no one knowledgeable about the project.

CHAPTER IV

ANALYSIS OF THE IMPACT AND SUSTAINABILITY OF THE PROJECT

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A. Impact

1. Extent to which the Overall Goal is Achieved

The overall goal of the project is "to improve health status through the DOH's reproductive health in Region III."

The overall trend as reported by heads of MCHCs, RHUs and BHSs of key selected health indicators in Region III is improving, although not dramatic and linear (and sometimes sliding back.). As reported, crude death rate decreased from 4.12 per 1,000 population in 1998 to 2.47 in 2004. Infant mortality rate also decreased from 9.39 per 1,000 live births to 6.16 in 2004. Neonatal mortality rate per 1,000 live births also decreased. Table 5 below provides information about the health status in the region as reported by heads of MCHCs, RHUs and BHSs. The improvements mentioned could not be totally and directly attributed to the project, bur safely it could be said that FP/MCH Project II made and is making its contribution.

Table 5. Changes in selected health status, by province, Region III, 2004

Health Indicator	Bataan		Bulacan		Nueva Ecija		Pampanga		Tarlac		Zambales		Total	
	Mean	Number reporting	Mean	Number reporting	Mean	Number reporting	Mean	Number reporting	Mean	Number reporting	Mean	Number reporting	Mean	Number reporting
Crude Birth Rate (CBR) per 1000 population														
1998	24.78	1	28.10	1	17.47	1	24.10	2	18.42	2	21.94	7	**22.47**	**14**
1999	25.39	1	29.00	1	12.42	1	20.95	2	16.21	2	16.39	7	**20.06**	**14**
2000	22.37	1	29.00	1	17.00	1	22.59	2	15.45	2	21.44	7	**21.31**	**14**
2001	21.64	1	30.00	1	14.10	1	23.32	2	13.79	2	18.82	7	**20.28**	**14**
2002	22.26	1	31.20	1	19.49	1	23.74	2	13.68	2	17.42	7	**21.30**	**14**
2003	17.15	1	31.40	1	17.74	1	23.54	2	14.46	2	16.55	7	**20.14**	**14**
2004			29.00	1							27.23	1	**28.12**	**2**
Crude Death Rate (CDR) per 1000 population														
1998	3.52	1	4.32	4	4.09	1	3.68	2	4.06	2	5.03	7	**4.12**	**17**
1999	3.86	1	4.86	4	2.77	1	3.25	2	3.65	2	3.69	7	**3.68**	**17**
2000	2.99	1	5.95	4	3.47	1	3.76	2	4.65	2	5.00	7	**4.30**	**17**
2001	4.01	1	4.14	4	2.82	1	3.73	2	4.23	2	3.62	7	**3.76**	**17**
2002	3.56	1	4.85	4	4.26	1	3.35	2	4.81	2	4.56	7	**4.23**	**17**
2003	5.10	1	4.36	4	2.90	1	2.59	2	3.71	2	3.87	7	**3.75**	**17**
2004	2.62	1	2.70	2							2.23	1	**2.47**	**4**
Infant Mortality Rate (IMR) per 1000 livebirths (?)														
1998	7.11	1			7.25	1	4.69	2	14.22	3	23.04	7	**9.39**	**14**
1999	13.49	1			12.75	1	9.90	2	17.22	3	22.30	7	**12.61**	**14**
2000	13.03	1			3.49	1	5.78	2	8.91	3	9.10	7	**6.72**	**14**
2001	*16.85*	*1*			*5.60*	*1*	*6.48*	*2*	*13.61*	*3*	*5.76*	*7*	***8.05***	***14***
2002	19.53	1			7.30	1	3.67	2	11.18	3	9.81	7	**8.58**	**14**
2003	11.60	1			8.36	1	3.41	2	8.50	3	19.91	7	**8.63**	**14**
2004	12.31	1									0.00	1	**6.16**	**2**
Neonatal Mortality Rate (NMR) per 1000 livebirths														
1998									11.23	1	1.33	6	**6.28**	**7**
1999									1.83	1	2.30	6	**2.07**	**7**
2000									0.18	1	4.08	6	**2.13**	**7**
2001									4.86	1	1.36	6	**3.11**	**7**
2002									0.00	1	4.10	6	**2.05**	**7**
2003									0.00	1	3.42	6	**1.71**	**7**
2004														
Maternal Mortality Rate (MMR) per 1000 livebirths														
1998					0.18	1	1.92	2	0.00	2	0.01	7	**0.35**	**12**
1999					0.00	1	0.00	2	0.00	2	0.01	7	**0.00**	**12**
2000					0.13	1	0.00	2	0.00	2	0.00	7	**0.02**	**12**
2001					0.13	1	0.00	2	0.00	2	0.00	7	**0.02**	**12**
2002					0.00	1	0.00	2	0.00	2	0.71	7	**0.12**	**12**
2003					0.09	1	0.00	2	0.00	2	3.13	7	**0.54**	**12**
2004														

Note: Data for 2004 are until October 2004 only.
Source: Shinfield Field Survey 2004

The improvement in health status should contribute to the improvement in the socio-economic condition. With this postulate the FP/MHC project 2 has placed improvement in socio-economic status as an indicator to the improvement in health status. The respondents opined that there were improvement of utilities and communication facilities, improved farming and livestock activities, more non-agricultural economic opportunities and better access to health service (both public and private). Other respondents felt that there was no improvement except that more patients come to health center as, "the health center is now very conducive and accessible to the community" (RHU Bataan). Table 6 below presents the socio-economic improvements in the region, as noted by our respondents.

Table 6. Socio economic improvement in Region III

Improvement	Total	
	No. of times mentioned by respondents	Percent
Better provision of utilities and communication facilities	12	20.34
Better infrastructure (road improvement)	8	13.56
Better access to market	5	8.47
Improvement in farming and livestock activities	11	18.64
More non-agricultural economic opportunities	14	23.73
Better access to health service (public and private)	17	28.81
Improvement in knowledge, attitude and skills of health personnel	5	8.47
Increased awareness of people on health-related issues	9	15.25
Better attainment of ideal family size	4	6.78
Improvement of health condition of the people	6	10.17
Others	11	18.64
None	9	15.25
No response	8	13.56
Total	119	

Note: Total will not add to 100 due to multiple responses source: Shinfield Field Survey 2004 (Questionnaire)

The extent of achieving the overall goal of improving the health status was observed by respondents and by the participants to FGDs as partially achieved (meaning the change and improvement in health status has not been big but small changes leading towards a sustained improvement are seen). Other felt (10.17% of the respondents) that improving health status has been completely achieved.

Those who felt that the overall goal of the project has been achieved pointed out the following reasons: (1) presence of advance equipment and facilities; (2) improved health condition; (3) full implementation of FP/MCH program. The table below presents other indicators mentioned by the respondents to reason out that overall goal of the project has been completely achieved.

Table 7. Indicators showing the complete achievement of improving the health status in Region III

Improvement	Total	
	No. of times mentioned by respondents	Percent
Advanced equipment and facilities	7	31.8
Improvement in quality of service delivery	3	13.6
Increase health awareness among the constituents	4	18.2
Improved health conditions	4	18.2
Increased family planning acceptors	4	18.2
Full implementation of the FP/MCH Program	5	22.7
Well trained health personnel	1	4.5
Increasing number of clients	2	9.1
Health Indicators were satisfied	3	13.6
No response	1	4.5
Total	34	

Note: Total will not add to 100 due to multiple responses Source: Shinfield Field Survey (questionnaire)

Those who believed that the overall goal of the project was partially achieved (little changes were generated that will eventually led to the improvement of health status on a sustained basis) mentioned the following reasons (1) presently, the project has resulted in creating health awareness among constituents which should be translated into better health practices; (2) clients visiting health centers increased; (3) there is a little increase in current user and new family planning acceptors; (4) better health care facility exist; and (4) there was a decline in infant mortality rate and crude death rate. The project enhanced community participation and the value of networking and sustainability have been learned, (noted by a Rural Health Physician from Zambales). It was also mentioned that the project conducted a Malaria Festival and Dengue Festival (using puppet show) which became an eye opener to everyone that malaria is a deadly disease, but curable if early detected and properly treated, (a Rural Health Physician commented). Other reasons for saying that the overall goal of improving health status was partially achieved are presented in the table below.

Table 8. Indicators showing partial achievement in improving health status in Region III. 2004

Reasons for saying the objective was partially achieved	Total	
	No of times mentioned by respondents	Percent
Project objective too big to be immediately achieved	7	19.44
Increase in health awareness among the constituents	7	19.44
Increase in clients	12	33.33
Partial support of LGU	1	2.78
Regular reproductive health classes	4	11.11
Little increase in current user and new acceptor of family planning	8	22.22
Not all health personnel were trained	4	11.11
Improve health status (declining IMR/CDR)	10	27.78
Unsure of project sustainability	1	2.78
Better health care facility	8	22.22
Community participation	2	5.56
Health statistics/indicators	1	2.78
Others	2	5.56
Total	67	

Note: Total will not add to 100 due to multiple responses Source: Shinfield Field Survey 2004 (Questionnaire)

2. Extent of Contribution of the Project Purpose in Achieving the Overall Goal

Its project purpose is "to achieve region-wide improvements in reproductive health status among all the provinces in Region III (Central Luzon) through dissemination of the gains from the FP/MHC Project in Tarlac"

Two years after project completion, Region III is making headway in improving the reproductive health status and, consequently, health status, as evidenced by the following (summarized from the reports of DOH Region III -Attachment D)

- Family planning acceptors increased by 138,036: from 531,292 in 2002 to 670,228 in 2003;
- 85.03% of children (9-11 months) are fully immunized (with the Province of Bulacan as the highest at 96.76%)
- 77.33% of infants in 2003 were exclusively breastfed up to 4th month (Zambales and Nueva Ecija are the highest with more than 90%)
- Majority (97.23%) of deliveries was done by professional medical staff or trained hilot (trained birth attendants), deliveries by untrained hilots were 2.78%.
- Live birth was 21.67 per 1,000 population

- Maternal death was .30% per 1,000 population and infant deaths were 7.49 per 1,000 live births
- Infant mortality was reduced from an average of 1,092 cases from 1998 to 2002 to only 869 in 2003.

Reproductive health status is also improving. Contraceptive prevalence rate is increasing. Attendance in pre-post natal check up remains within a given ranged. The next table provided detail information of this situation.

Table 9. Improvements in reproductive health status by province, Region III, 2004

Health Indicator	Bataan		Bulacan		Nueva Ecija		Pampanga		Tarlac		Zambales		Total	
	Mean	Number reporting	Mean	Number reporting	Number	Percent	Mean	Number reporting	Mean	Number reporting	Mean	Number reporting	Mean	Number reporting
Infant Mortality Rate (IMR) per 1000 livebirths (?)														
1998	3.67	4	6.88	7	7.25	1	9.84	5	14.22	3	12.79	10	9.11	30
1999	5.49	4	8.87	7	10.25	1	15.24	5	17.22	3	8.08	10	10.86	30
2000	6.24	5	7.57	7	3.49	1	8.44	6	6.68	4	8.95	11	6.89	34
2001	6.76	5	9.99	8	5.60	1	7.19	7	8.01	5	5.53	11	7.18	37
2002	8.09	5	8.02	8	7.38	1	5.94	7	6.55	5	9.23	11	7.54	37
2003	5.23	6	7.84	8	8.36	1	4.26	7	5.10	5	8.32	11	6.52	38
2004	12.31	1	0.90	6			8.33	6	6.00	3	0.00	3	5.61	19
Maternal Mortality Rate (MMR) per 1000 livebirths (?)														
1998	0.04	5	0.00	7	0.18	1	0.40	5	6.67	3	0.75	10	1.34	31
1999	0.06	5	0.00	7			5.08	5	0.00	3	0.83	10	1.19	30
2000	0.33	6	0.00	7	0.13	1	2.13	6	0.30	4	0.90	10	0.63	34
2001	0.12	6	0.15	8	0.19	1	0.00	7	0.23	5	0.92	9	0.27	36
2002	0.13	6	0.00	8			1.80	7	0.00	5	1.44	10	0.84	36
2003	0.51	7	0.00	8	0.09	1	0.00	7	0.00	5	1.47	10	0.34	36
2004	0.00	2	0.00	6			0.00	4	0.00	3	0.78	4	0.16	19
Contraceptive Prevalence Rate (CPR) in %														
1998	71.42	2	48.98	3			13.13	2	26.21	2	49.29	6	41.81	15
1999	95.62	1	40.13	3			31.19	2	33.21	2	56.25	6	51.28	14
2000	85.70	3	45.89	3			27.03	3	38.23	3	56.83	7	50.74	19
2001	95.59	4	56.45	4			37.01	3	67.94	4	52.78	7	61.96	22
2002	95.59	4	63.31	4	59.50	1	30.52	3	69.14	4	60.72	7	63.13	23
2003	97.25	4	64.55	4			32.11	3	72.96	4	66.70	8	66.71	23
2004	97.82	2	56.79	4			29.29	3	53.50	2	44.56	3	56.39	14
%Attendance in Pre-natal Check-up														
1998	68.96	4	81.60	8			83.13	4	99.00	2	59.54	5	78.46	23
1999	71.71	7	70.84	8			84.38	4	88.80	3	52.72	5	73.69	27
2000	72.18	11	82.66	8	45.48	1	69.80	5	87.18	4	71.84	6	71.52	35
2001	69.64	11	84.31	9	25.49	1	72.38	5	91.98	5	65.12	7	68.16	38
2002	71.33	12	91.07	9	46.02	1	73.73	5	91.46	5	70.73	8	74.06	40
2003	73.81	12	93.18	9	56.87	1	74.53	6	89.28	5	69.11	9	76.13	42
2004	56.31	5	79.42	9			57.71	4	82.60	4	60.00	3	67.21	25
%Attendance in Post-natal Check-up														
1998	82.53	5	80.50	8			79.60	4	85.50	2	67.16	5	79.06	24
1999	83.94	7	78.61	8			91.13	4	75.33	3	58.58	5	77.52	27
2000	85.80	11	89.58	8	46.24	1	67.57	5	76.50	4	71.80	6	72.91	35
2001	78.94	12	98.12	9	27.67	1	67.81	5	80.60	5	58.52	7	68.61	39
2002	85.46	12	92.53	9	54.49	1	68.92	5	83.72	5	63.14	8	74.71	40
2003	82.67	12	96.77	9	64.57	1	72.09	6	77.88	4	56.96	9	75.16	41
2004	51.26	5	77.73	9			53.64	4	61.63	3	64.00	3	61.65	24

Note: Data for 2004 are until October 2004 only.
Source: Shinfield Field Survey 2004

3. Contribution of the Project to the Overall Goal

The project has contributed to the achievement of the overall goal. Majority (40.68%) of the respondents mentioned that the upgraded facility and equipment as one contributed to the goal achievement. Other contributions cited are trained health personnel (40.68%), service quality improvement (23.73%), social acceptability (18.64%) of its program and IEC (11.86%). The table below shows the contribution of the project to the achievement of the overall goals.

Table 10. Contribution of the project to the overall goal of improving the health status in Region III: 2004

Contribution of the Project	Total	
	No. of times mentioned by respondents	Percent
Upgraded facility and equipment	24	40.68
Training of health personnel	24	40.68
Information dissemination/advocacy	7	11.86
Improvement in the quality of service delivery	14	23.73
Pre-marriage counseling seminar	6	10.17
Increase health awareness among constituents	8	13.56
Improved health status of people	4	6.78
Under five monitoring	1	1.69
Program accepted by the community/collaboration	11	18.64
Provision of logistics (supplies/medicines)	2	3.39
Reduction in pregnancies	1	1.69
Health education classes for mothers/couples	15	25.42
Total	117	
Source: Shinfield Field Survey 2004	Multiple responses	

The contributions of the project were manifested or translated into increasing number of patients and area covered; improved knowledge, attitude and services of health personnel; improved quality of services and consequently better health status of constituents. The table below shows indicators/manifestations showing the contributions of the project to the overall goal of improving health status in the Region.

Table 11. Indicators/manifestations showing the contribution of the project to the overall goal of improving the health status in Region III

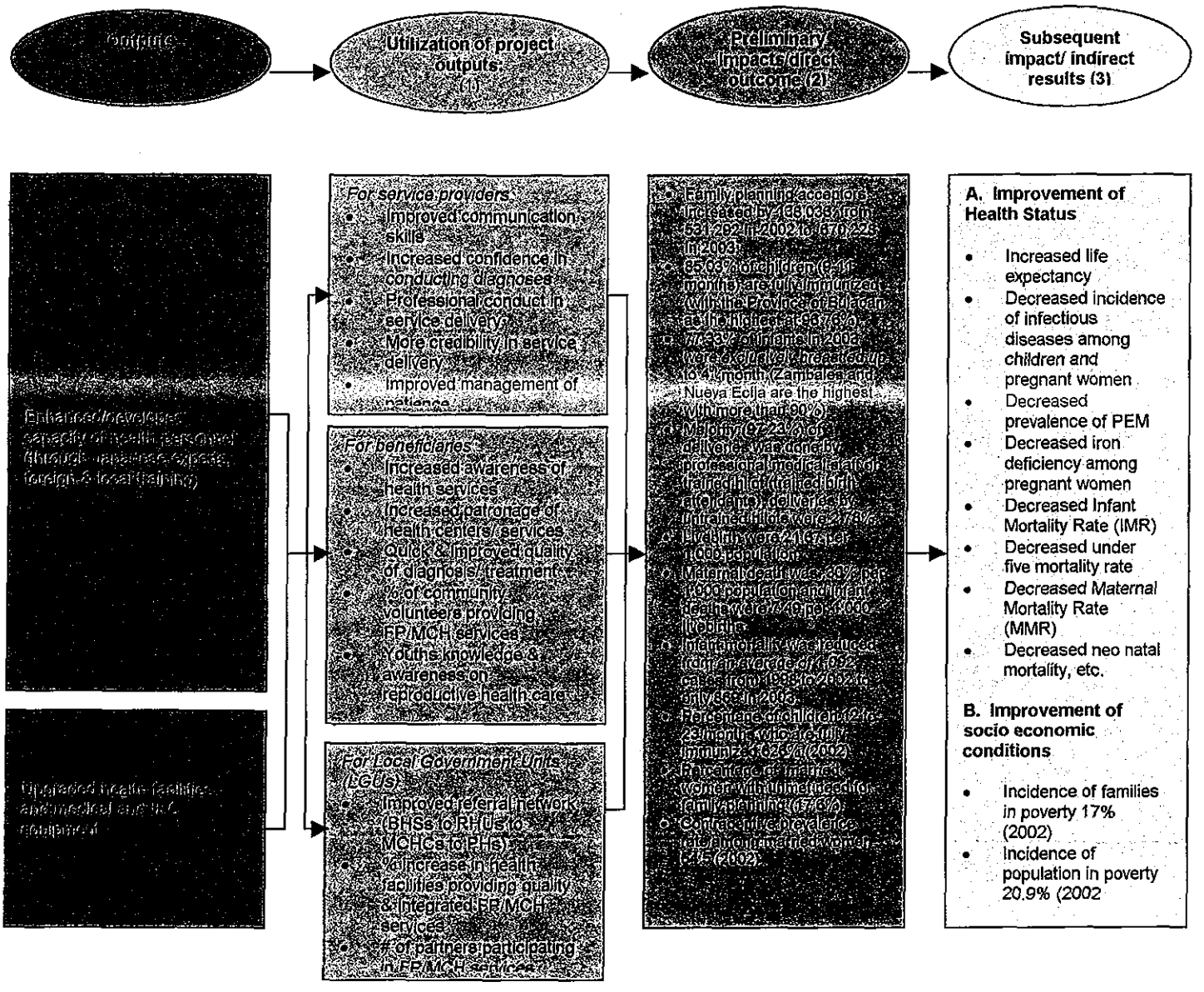
Indicators/manifestations of the contribution of the project	Total	
	No. of times mentioned by respondents	Percent
Increasing number of patients and area covered	23	38.98
Improved knowledge, attitude and service of health personnel	13	22.03
Information dissemination of learnings	7	11.86
Increased awareness on reproductive health	5	8.47
Improved quality of service	17	28.81
Better health condition of constituents	8	13.56
Program accepted by the community	3	5.08
Number of training conducted	3	5.08
Implement the program with the use of facilities	4	6.78
Others (under five monitoring)	6	10.17
No response	13	22.03
Total	102	
Source: Shinfield Field Survey 2004	Multiple responses	

4. Impact

A consolidation of the responses of respondents, consensus in the FGDs and observation and analysis of the local constituents reveal that FP/MHC project II is generating a chain of impact that started from the production of project outputs. The utilization of project outputs (capacitated health personnel and modernized health facilities and equipment) led to a change in behavior of service providers, beneficiaries and LGUs that are not creating preliminary impacts (like increased CPR, increased pre-natal check-ups, increased deliveries eventually led to the achievement of subsequent impacts (like increased life expectancy; decreased infant, neonatal and maternal mortality rate; reduced crude death rate, etc.)

The impact chain of FP/MCH project II is shown below. In the flow of impact chain shown below, the project has produced the following impacts which most likely will be continued in the future: (1) changes in behavior due to the utilization of project outputs and (2) preliminary impacts or outcome. Subsequent impacts (3), in terms of improvement of health status are forthcoming (but improvement in socio-economic conditions will depend on macro economic conditions and political stability which are beyond the control of the project).

Figure 3: Impact Chain of the FP/MCH Project II



5. Positive and Negative Impacts of the Project

The respondents identified several positive and negative impacts. A number of respondents mentioned the following positive impacts: (1) access to affordable and better quality health service; (2) presence of modern/complete facilities that resulted into organized, working environment; (3) awareness of the community; and (4) better trained health staff. A respondent emphasized that the establishment of a satellite health station in a resettlement area enabled them to conduct necessary laboratory procedures, thus, assuring the needed privacy of patients and improving patient diagnosis. Other positive impacts noted by the respondents are listed in the table below.

Table 12. Other positive impacts that can be attributed to the project in Region III

Positive Impact	Total	
	No. of times mentioned by respondents	Percent
Modern/complete facilities and organized working environment	14	23.73
Access to affordable and better quality health service	20	33.90
Trust of clients because of improved knowledge, attitude and skills of health personnel	5	8.47
Awareness of the community	13	22.03
Better trained staff	11	18.64
Improved health-seeking behavior of clients	2	3.39
Clients give donations	1	1.69
Support of LGU and NGOs	5	8.47
Improved health condition of the constituents	7	11.86
increase in FP users	2	3.39
Male involvement in family planning	1	1.69
Others	6	10.17
Total	87	147.46
Note: Total will not add to 100 due to multiple responses	source: Shinfield Field Survey 2004	

The respondents and FGD participants also noted negative impacts. They mentioned that facilities and services require funds for operation and maintenance. The scarce resources of LGUs make the cost of operation and maintenance a burden to them. Moreover, the facilities and equipment generated more demand for services – more clients are coming that consequently needed additional/adequate supply of medicine. The burdens to regularly/adequately provide medicine was also articulated as a negative impact. Another negative impact is that the project created a dependency among LGUs on outside fund.

Table 13. Other negative impacts that can be attributed to the project in Region III

Negative Impact	Total	
	No. of times mentioned by respondents	Percent
Insufficient fund to operate the program	5	26.32
Irregular supply of medicine	3	15.79
Create dependency among LGUs on outside funding	1	5.26
Irresponsible motherhood	3	15.79
Others	1	5.26
No response	6	31.58
Total	19	
Note: Total will not add to 100 due to multiple responses	***source: Shinfield Field Survey 2004***	

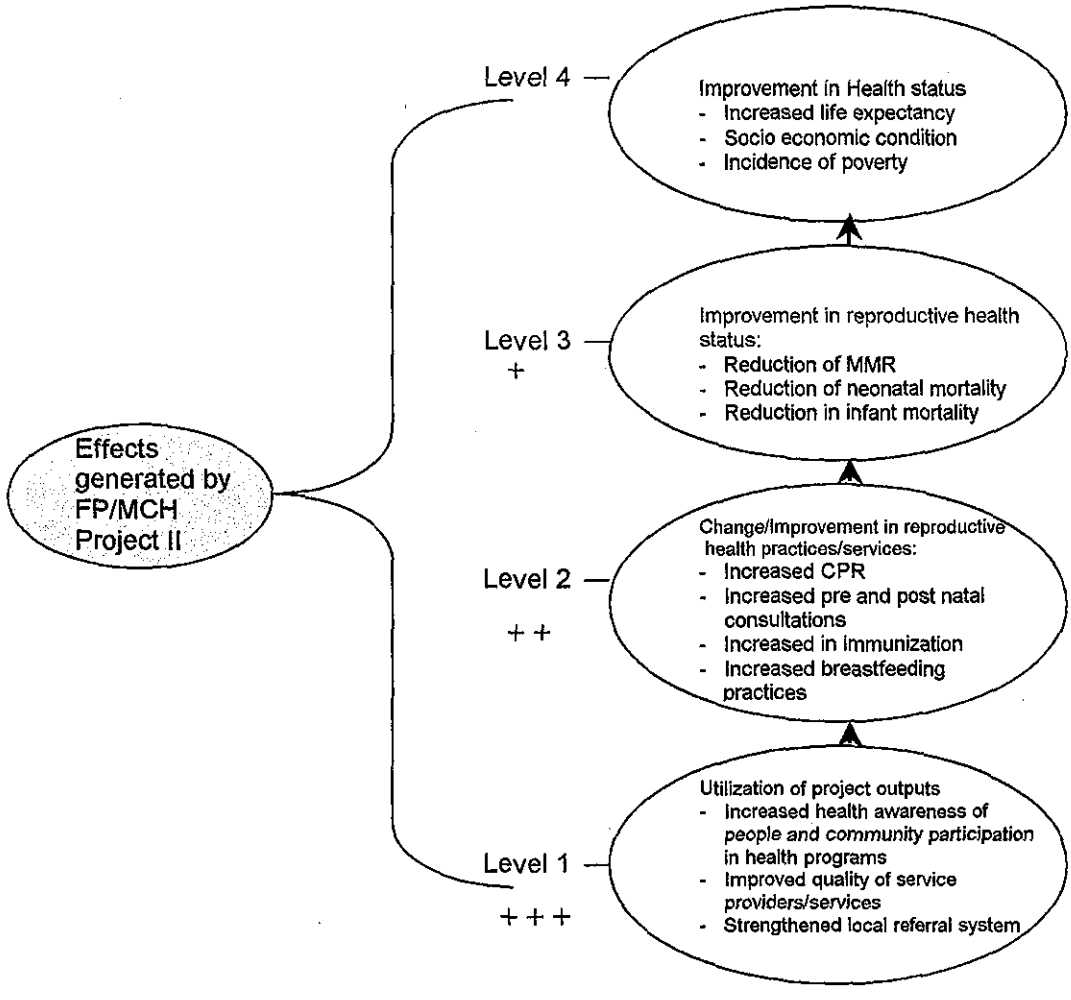
B. Sustainability

1. Sustainability of project effects

The effects of the project after its completion is sustained and it will likely be sustained in the future. The impacts/effects generated by the project are categorized in four levels: (1) utilization of project outputs, (2) improvement in reproductive health practices and services, (3) improvement in reproductive health status and (4) improvement in health status, as shown in figure 5, below. The degree of impact generated at the moment, in each level, is marked with a plus sign (the more + sign means more impact).

Two years after project completion, the effects generated by the project are highly visible in level 1 (utilization of project outputs) and 2 (change/improvement in reproductive health practices/services). It was also observed by the evaluator that effects for level 3 (improvement in reproductive health status) is slowly being generated and contribution to effects level 4 (improvement in health status) is expected/forthcoming.

Figure 4. Effects by level, generated by the Project
(Plus sign represents degree of impact achievement, which is relatively greater in level 1)



The effects of the project are sustained through continuous implementation of the project or its components. LGUs with guidance from the DOH, regional office, and NGOs continue to implement the Project. This observation is shared by most of the respondents who opined that the effects they are able to sustain are improved health status of constituents (50.85%), improved health awareness (22.03%), access to better quality health services (28.81%), and increase patronage or clients in health centers (25.42%). See table below for detailed information on how implementing agencies are able to sustain the outcomes/effects of the project.

Table 14. Ways that the implementing agency able to sustain the outcome/effect of the project in Region III.

Ways	Total	
	No. of times mentioned by respondents	Percent
Health awareness among the constituents	13	22.03
Improved health status of the constituents	30	50.85
Better knowledge, attitude and skills of health personnel	4	6.78
Better training	5	8.47
Upgraded facilities	7	11.86
Easy access to better quality health service	17	28.81
Maintenance of equipment and facility	1	1.69
Increase in the number of clients	15	25.42
Active community participation	1	1.69
Others	3	5.08
No response	6	10.17
Total	102	172.88

Note: Total will not add to 100 due to multiple responses Source: Shinfield Field Survey 2004

Strategies to sustain the outcome of the project vary. Some or 10.17% of the respondents answered that they just do the most that could be done from what they have while others (22.03% of the respondents) remarked that support from LGU/NGO is another strategy. Proper maintenance of equipment and continuous conduct of training are being undertaken to sustain project outcomes. Other mechanisms to sustain outcome are shown in the table below.

Table 15. How implementing agencies are able to sustain the outcome of the project in Region III.

How to sustain	Total	
	No. of times mentioned by respondents	Percent
Sustained despite limited funding support (do the best with scarce resources)	6	10.17
With support from LGU/NGO	13	22.03
Quality of service maintained	4	6.78
Conduct of monitoring and evaluation	5	8.47
Conduct of training	7	11.86
Health unit become self-reliant	1	1.69
Fully implemented the program	14	23.73
Sustained through better relationship among health personnel	3	5.08
Proper maintenance of equipment	6	10.17
Community empowerment	1	1.69
Continuous provision of supplies and equipment	2	3.39
Don't know	1	1.69
No response	12	20.34
Total	75	

Note: Total will not add to 100 due to multiple responses source: Shinfield Field Survey 2004

Volunteer health workers (officials of the federation of barangay health workers) discussing how to further sustain benefits derived from the projects

The desire to promote a continuing improvement in the provision of health services by the health providers is a major reason for the sustainability of project effects. Other factors contributing to the sustainability of the effects of the project are: (1) LGU support (in some areas); (2) monitoring and evaluation done by DOH Regional Office; (3) improved social interaction among health workers and users by using gender-sensitive approach in dealing with predominantly female participants (emphasized by a Rural Health Physician from Zambales); (4) the use of TV 99 video series in public areas and/or barangay health stations during immunization day; and (5) health education classes that promoted increased health awareness and community participation in health issues.

2. Institutional Sustainability

The Department of Health Central Office, Regional Office and the Provincial Health Office provide mechanism/strategies that will promote the sustainability of project effects. The strategies and structure of these institutions are capable of promoting the sustainability of project activities, effects and impacts. Moreover, support from other institutions including the necessary policy support is in place for the sustainability of the project. The table below summarized the measures taken by DOH and the Provinces to promote sustainability.

Table 16. Measures to promote sustainability by DOH and LGU

Measures to Promote Sustainability	DOH		PHO
	Central	Regional	
1. Provision of inputs/drugs/ medicines, etc.	✓	✓	✓
2. Continued technical support	✓	✓	
3. Sentrong Sigla Certification	✓	✓	
4. Monitoring and evaluation	✓	✓	
5. Establishment of Botica sa Barangay	✓	✓	✓
6. Production of IEC		✓	
7. Formulation of guidelines	✓		
8. Acquisition of new equipment		✓	✓
9. Coordination with local government chief executives		✓	
10. Provision of IEC materials			✓
11. Conduct of capacity building			✓
12. Conduct of regular meeting			✓
13. Organization of local health board			✓
14. Establishment of Sentrong Sigla			✓
15. Hiring of personnel			✓
16. Constant follow-up			✓

3. Financial Sustainability

Funds are not sufficient to carry out activities and buy necessary inputs to sustain the project effects, (especially in the future). The insufficiencies in funds are due to the following reasons: (1) LGU source of fund is limited and health concerns are not high in their priority, (2) number of patients is increasing (budget allocation remains the same), and (3) cost of health care services is increasing. There are exceptional cases when funds provided are sufficient and these are LGUs where health is classified as a priority program.

Although limited and not increasing, the revenue source is stable. Dependence on outside revenue is strong in funding vaccines. Funding source at the moment is good for routine functions but increasing cost of medical supplies, increasing number of patients, and replacement cost for facilities and inputs will require funding presently not available. More advocacies for funds and more resource generation activities are needed in the future.

4. Technical Sustainability

Technical sustainability is ensured by skills and knowledge transferred by the project. Knowledge and skills transferred pertains to: (1) under-five clinics, (2) family planning, (3) reproductive health, (4) maternal and child health, (5) establishment of botica in the barangay and (6) effective IEC. The table below shows the distribution of responses regarding skills and knowledge transferred by the project.

Table 17. Skills and knowledge transferred by the project in Region III

Item	Total	
	No. of times mentioned by respondents	Percent
None	3	5.08
Under 5 training	19	32.20
Family planning	15	25.42
Reproductive health	8	13.56
Maternal and child health	6	10.17
Establishment of Botika sa Barangay	4	6.78
Effective IEC	4	6.78
Counseling	2	3.39
Anti-tuberculosis program	1	1.69
Gender Sensitivity	2	3.39
DOT	2	3.39
Others	11	18.64
No response	14	24.73
Total	91	

Note: Total will not add to 100 due to multiple responses Source: Shinfield Field Survey 2004

Skills/knowledge gained is integrated within the institution through training of other health workers and beneficiaries and they are also utilized in managing health programs (like the national family planning program). Knowledge and skills gained are also used in the delivery of services and in the conduct of health education. Knowledge transferred is also utilized as foundation for further adaptation, for further studies and researches. New technologies are learned through training (although not sufficient). Then, they shared to other health personnel during meetings or through demonstration.

C. Factors Contributing and Hindering Project Impact and Sustainability.

The impact and sustainability of the project depends on several factors. Various factors were identified as contributing and inhibiting impact and sustainability.

1. Factors Contributing to project impact and sustainability

The relevance of the project to needs of the clients and to priorities of the recipient government is a facilitating factor. Due to the relevance and responsiveness of the FP/MCH, DOH continuously commits to support FP/MCH programs. LGUs ensure its implementation thus ensuring impact and sustainability.

Another factor facilitating impact and sustainability is the institution of mechanisms that will recognize and award good FP/MCH service delivery. The certification and award given by DOH to health facilities that provide quality services, maintain excellent facilities and equipment, through the Sentrong Sigla award and/or PhilHealth Accreditation scheme is also a ways that promotes project impact and sustainability. To be accredited, a certain level of standards of facility, equipment and service provision should be maintained. This scheme ensures maintenance of equipment plus the cash prize given is usually channel back for the improvement and maintenance of facilities.

The political and financial support of the local government units is another critical factor. The advocacy of political leaders for better health for his/her constituencies could raise awareness, improve health practices and increase patronage of health facilities. Financial support to ensure that basic equipments and supplies are available to provide basic health services needs to be done by local politicians. It is worthy to mention two FP/NCH champion lady mayors who even extended/constructed additional rooms (birthing rooms, laboratory room and storage room) to accommodate additional deliveries. This action inspired both health personnel and clients- women and children.

Respondents also mentioned the support provided by LGUs as another factor helping achieve project goal. According to them, LGUs provide funds for

logistics, payment of utilities and staff. They also maintain facilities and create an environment (peace and order) conducive to the delivery of health services. They also support health personnel attending capacity building programs. Other types of support are mentioned in the table below.

Table 18. Types of support extended by Local Government Units in achieving the overall goal of improving the health status in Region III

Type of Support	Total	
	No. of times mentioned by respondents	Percent
Funds for logistics (supplies, medicines), payment of utilities and staff	21	67.74
Allowing staff to attend training	3	9.68
Responsible for the maintenance of facility (peace and order)	5	16.13
Advocacy support	2	6.45
Continuous giving of quality service to the community	1	3.23
No response	3	9.68
Total	35	

Note: Total will not add to 100 due to multiple responses Source: Shinfield Field Survey 2004

The support of two champion lady mayors to FP/MCH is worth mentioning. Two mayors provided for the construction of additional rooms for birthing and laboratory to accommodate the increasing demand for these services brought about by the modernization of facilities.

The integrity in the performance of tasks is another factor promoting project impact and sustainability, A case given is the Botika Binhi. Several Botika Binhi were not able to survive due to unaccounted capital. Another facilitating factor is the awareness and favorable attitude of mothers and husbands to look at health as wealth. Internalizing in their system the practice of regular consultation would create and sustain FP/MCH and its intended impact.

The active involvement of the association/federation of BHWs in programming and implementing community-managed health activities is also a contributing factor. Barangay Health Workers are volunteer workers whose link to the community is close. They can make both parties aware and act. They could tell the receiving system/clients services available that are in the centers. On the other side, they could articulate to the service providers the needs and

sentiments of the clients. BHWs associations are also able to organize activities that will make full use of the facilities and equipment of the health centers. Finally, BHWs associations could be a source of community pressure that would demand sustained and quality FP/MCH services.

Maintaining a network of organization or simply linkages between/among several organizations that jointly pool their resources is also a contributing factor. The advocacy work of NGOs, the service delivery functions of LGUs, sharing of resources and competencies when integrated are helping facilities maximized their service delivery potentials. As a rural physical from Bulacan noted, "*quality health care which are acceptable, accessible, affordable and available to develop health people and community becomes a reality through good working relationship with other organizations.*" Another physician from Zambales said, *"in a resource-limited setting like in our situation, partnership with other sectors/community organization should be considered."*

The different types of support extended by non-government organizations in achieving the overall goal come in the forms of medical assistance, advocacy work and food supplementation are presented in the table below.

Table 19. Type of support extended by non-governmental organization in achieving the overall goal of improving the health status in Region III

Type of Support	Total	
	No. of times mentioned by respondents	Percent
Medical Assistance	16	59.26
Food supplementation	1	3.70
Advocacy work	7	25.93
Income generating projects	1	3.70
Others	3	11.11
No response	3	11.11
Total	31	114.81

Note: Total will not add to 100 due to multiple responses Source: Shinfield Field Survey 2004

Finally, facilitating factors are the health workers and local chief executives, the direct beneficiaries of the project. The commitment of the health personnel to provide quality services and the commitment of the local chief executives to provide necessary support (technical, political, administrative and financial) are contributing factors. As said by a rural health doctor from Pampanga, *"facilities*

have been improved but if supplies are not available and commitment of the health personnel are not sustained, the desired goals may not be achieved." Another health worker, a midwife from Bataan noted, *"if all midwives by chance were given this project plus the continuous provision of equipment and medicines, we will contribute to the attainment of DOH visions and missions."* A nurse from Bulacan emphasized this point, *"the Government of Japan and our government provided us with trainings on health, good facilities with equipment, it's up to us, health workers and local chief executives to use and maintain."*

Table 20. External factors that influenced the overall goal of improving the health status in Region III

External Factor	Total	
	No. of times mentioned by respondents	Percent
Support from non-government organizations	27	45.76
Presence of Volunteer Health Workers	8	13.56
Support from local government units	31	52.54
Support from DOH and other government units	3	5.08
Conducting of monitoring and evaluation	3	5.08
Politicking	2	3.39
Attitudes and beliefs of the people	1	1.69
Presence of religious organization	1	1.69
Construction of new health facility	2	3.39
Socio-economic conditions of constituents (better education and income)	5	8.47
Availability of IEC materials	3	5.08
Others	4	6.78
No response	11	18.64
Total	101	171.19

Note: Total will not add to 100 due to multiple responses source: Shinfield Field Survey 2004

2. Factors Hindering project impact and sustainability

Just as there are facilitating factors, there are also hindering factors. The following factors are hindering project impact and sustainability: lack of support from local government units/low priority of health services in the local development agenda; lack of commitment of health organizations and workers to FP/MCH and poor maintenance and replacement of facilities and equipment.

Low awareness of claimholders regarding existing family planning and maternal and child health information and services is another factor that hinders project impact and sustainability. Some beneficiaries are not informed and/or not willing

to avail of existing services. In so doing, reproductive health status and health status in general is not completely improved.

Reassignment or resignation of staff trained under the project to other job (without replacement by somebody who knows the project is a hindrance to the sustainability of the project. Personnel turnover is a reality as opportunities for health professional workers abound. If there is no transfer of knowledge, (from those who were trained by the project to those were not), then project impact and sustainability will not happen.

Provision of similar program with a different strategy is another hindrance. Botika Binhi was not continued in some areas as Botika sa Barangay was introduced. While Botika Binhi is struggling to raise capital, Botika sa Barangay was a dole out. Beneficiaries shifted their interest/preference from a self-help approach to a dole out approach. This shift hindered the sustainability of Botika Binhi, which has the potential to become a point for raising health awareness, case monitoring and follow-up and a social-cum-economic enterprise.

CHAPTER V

CONCLUSION RECOMMENDATIONS AND LESSONS LEARNED

CHAPTER V

CONCLUSION, RECOMMENDATIONS AND LESSONS LEARNED

This part of the report covers the conclusion and recommendations of the study and the lessons learned from the project.

A. Conclusion

The project was successful in generating impacts. Through its outputs, the project was able to increase health awareness of people and community involvement in health programs. Improved quality of service provider/services was also noted and local referral system was strengthened.

Consequently, changes and improvement in reproductive health practices and services were noted as increase in family planning acceptors or CPR, increase attendance in pre- and post-natal check-up, full immunization of infants and children, increase number of infants exclusively breastfed up to fourth month and more deliveries were handled by professional medical staff. Then improvement of reproductive health status is being generated manifested by increased live births; decreased maternal death and infant death. Eventually this will lead to the improvement in the overall health status.

The effects of the project are sustained as institutional and technical sustainability is assured but extra efforts need to be done to guarantee financial sustainability.

The effects of the project are sustained as institutional sustainability is being carried out by DOH (regional and central) by providing inputs/drugs/medicines and by continuously extending technical and administrative assistance. Sentrong Sigla, a certification of quality service delivery, is also done by DOH. Production of IEC materials and acquisition of new equipment are other measures DOH is doing to ensure project sustainability.

As part of its tasks, LGU health offices are conducting trainings for volunteer health workers, organizing local health boards, hiring medical staff and distributing IEC materials. They are also primarily tasked to implement health programs.

Financial sustainability of basic services given the present demand is also ensured. However, increase in the number of clients and the need to replace facilities and equipment provided by the project will pause a problem.

Technical sustainability is ensured by skills and knowledge transferred by the project. Knowledge and skills on under-five clinics, family planning, reproductive health, maternal and child health and effective IEC are being transferred through echo-seminars, regular meetings and demonstrations. New technologies are also introduced in training conducted by DOH or other agencies. Manuals, like the Midwives Manual on Maternal Care, are also published and distributed to promote technical sustainability.

B. Recommendations

For the Government of the Philippines

Several recommendations were elicited during the conduct of the study most of which are addressed to DOH and LGU health office. Most recommendations are geared towards increasing project impact and sustainability. They are:

- A functional monitoring and evaluation (that is not purely a one-way reporting system) is also recommended to gauge progress and to provide updated and reliable information on project impacts.

- Continuous capacity building is recommended for health professionals and health volunteer workers. They felt the need to know the state of the art of FP/MCH in order to have confidence in the performance of their functions.

- Basic equipment (provided by the project) to handle cases/patients and facilities need to be maintained by LGUs. Together – training and facilities and

equipment – ensures quality service delivery. As a midwife from Tarlac said, " *trainings plus new facilities and equipment give me self-confidence, especially in handling deliveries."*

- Aside from recommending budget allocation, increases from LGUs, fund/supply/material augmentation between national and local government is suggested. Such resource augmentation will help match the increasing number of clients/patients with budget scarcity. Along this line, pooling of resources (public, private and NGO partnership) in support of a common program should also be initiated by DOH-Regional office and LGUs.

- Innovative IEC need to be introduced to generate and sustain project impacts. IEC that move people, that market FP/MCH to political leaders are recommended. Strengthening of BHW associations and federations is also recommended. Aside from providing assistance in project implementation, they can advocate and exert community pressure to ensure that the project is sustained.

- DOH should recognize best practices in FP/MCH and continue to certify and reward good performance. Sentrong Sigla and PhilHealth accreditation motivates LGUs to maintain facilities, equipment and services on a given standard.

- The Philippines should also enact and implement an aggressive FP policy that will increase CPR and attain a population growth at a reasonable level. Without this policy, pushing FP is hard and reproductive health improvement becomes difficult.

- Project evaluation studies (ex-ante to ex-post evaluation) should be made an integral part of a recipient country commitment and such tasks should be done by the concerned department or ministry and/or by a national planning agency

For JICA

- In future project cycle management, the involvement of political leaders is suggested to JICA. As primarily responsible for delivering health services, political leaders should be in the driver's seat of this effort. Putting them on board from the planning stage is necessary.

- Aftercare support, five to seven years after program completion, small grants could be made available to replace vital equipment. Replacement of equipment (beyond the capacity of some LGUs) that will need a relatively small amount but generate more project impact is a reasonable investment

- Measures to enhance institutional, financial and technical sustainability should be integrated in the PCM as early as the design stage.

These recommendations are summarized in the table below.

Table 21. Summary of recommendations.

RECOMMENDATIONS	D O H		LGU Officials	LGU-Health Offices	JICA
	Central	Regional			
• Conduct more training/ refresher courses	X	X		X	
• Make FP/MCH a priority concern			X		
• Enhanced work commitment of health workers		X	X	X	
• Increase budget allocation	X		X		
• Proper maintenance and acquisition of new equipment		X	X		
• Promote cooperation of all sectors/networking and collaborative work				X	
• Information and Extension Communication materials	X	X		X	
• Institutionalization of BHW Federation		X		X	
• Conduct strict monitoring and evaluation	X	X			X
• Formulate local policies (ordinance/resolutions) in support of the project			X		

RECOMMENDATIONS	D O H		LGU Officials	LGU-Health Offices	JICA
	Central	Regional			
• Recognition/certification/ awards for service delivery	X	X			
• Mobilize barangay				X	
• Fund/Supply and Material augmentation	X	X	X		
• Explore other sources of funds			X		
• Advocate/market FP/MCH to LCEs		X		X	
• Aftercare support					X
• More involvement of LCE in FP/MCH project planning and management		X			X
• More participatory process throughout the project cycle management		X			X
• Definite and aggressive national FP policy	X				

C. Lessons Learned

Several lessons are offered by the project. Some of them are already integrated in the discussion about recommendations. In addition, the following lessons are learned: Putting local political leaders in the forefront of health service delivery could ensure generation of project impact and sustainability. At the early stage of the PCM, put them on board, to increase their awareness and eventually to make them service delivery champions. Interventions that will address political leaders and impress upon them the role of political leaders in FP/MCH should be a component of a similar project. A project should balance the involvement of political leaders and technical staff to ensure sustainability.

Another lesson is that an accreditation and reward system that recognizes quality performance should be installed parallel to projects like FP/MCH. An accreditation and certification mechanism working in the project areas at the moment is the Sentrong Sigla and the PhilHealth accreditation system. Quality of performance, facilities and services are regularly evaluated that facilitates sustainability beyond donor's life. Champion mayors and best practices can provide model for

sustainability and impact generation. They offer also inspiration and road map for replication. Other lessons learned are already integrated in the discussion about recommendations.

ANNEXES

Annex A

Detailed Questionnaire Survey Result

Questionnaire

Questionnaire for the Ex-post Evaluation of the Family Planning/Maternal and Child Health Project

Dear Respondents,

The Shifield Consultancy Phils. Inc. has been commissioned by the Japanese International Cooperation Agency (JICA) to undertake a post-evaluation of the Family Planning/Maternal and Child Health Project (FP/MCH).

This Project was undertaken with the assistance of the Government of Japan in March 1992. It was first implemented as a Project-Type Technical Cooperation (PTTC) on Family Planning/Maternal and Child Health (FP/MCH) Project with Tarlac as the pilot province. The project was focused on the improvement of service delivery system of FP/MCH in the pilot area, building the capability of health workers and enhancement of community participation in health-related activities.

When the PTTC ended in 1997, the GOJ and GOP noted the positive achievements of the FP/MCH in Tarlac and, on this basis, agreed to extend the project cooperation for another five years, from April 1997 to April 2002. With lessons learned from the pilot phase, FP/MCH II was designed to promote a region-wide improvement in reproductive health status in all provinces in Region III (Central Luzon). The Project sought to contribute to the overall goal of improving the health status through the DOH's Reproductive Health Strategy in Region III. To achieve the goal stated above, FP/MCH-II implemented various training programs for health workers, upgraded the facilities and equipment of field health units, conducted health related partnership activities and developed and disseminated FP/MCH-related IEC materials.

The Project ended in March 2002 and its impact, sustainability and lessons learned need to be evaluated as input to the development and management of similar or related undertakings.

Objectives of the Ex-post Evaluation Study

This ex-post evaluation study seeks to assess the impact and sustainability of the project, two years after its completion. In addition, the evaluation exercise seeks to:
(a) draw lessons and formulate recommendations for the improvement of planning and implementation of similar projects; and

(b) promote greater accountability and transparency by disseminating the evaluation results to the project stakeholders and the Japanese public.

This evaluation study covers impact (achievement of desirable change/s) and sustainability (to determine whether effects of the project are sustained even after the project is completed).

Goal

To what extent was the overall goal of "improving the health status in Region III through the DOH's Reproductive Health Strategy" being achieved?

To what extent has the project contributed to the achievement of the overall goal?

What are the changes in health status?

What are the improvements in socio-economic condition?
Are there external factors that influenced the achievement of the overall goal?

Are there other impacts (positive, negative or unintended) that can be attributed to the project?

Project Purpose

Did FP/MCH-II attain its Project Purpose of "achieving region-wide improvements in reproductive health status among all provinces in Region III through the dissemination of the gains from FP/MCH-I Project in Tarlac?

Was there a reduction in Infant Mortality Rate (IMR)? Maternal Mortality Rate in the Project area.

Was there an increase in Contraceptive Prevalence rate (CPR) in the project area?

Was there an increase (%) attendance in for Prenatal and Postnatal Check-ups?

What were the factors that affected the achievement of the project purpose?

Sustainability

To what extent has the implementing agency been able to sustain the outcomes/effects of the Project?

Are the activities being continued after donor funding has been withdrawn?

Are the outcomes/effects sustained after donor funding has been withdrawn?

How likely are the outcomes/effects of the Project to be sustained?

What are the factors that contribute/inhibit the sustainability of Project outcomes/effects?

Institutional sustainability

What measures has the (1) provincial offices, (2) the regional unit and (3) the DOH central office taken in order to sustain Project's output (changes might be organizational mission, personnel reform, staff training, stable provision of inputs, etc.)?

Is the external environment, like support from the LGU, regional office DOH and DOH central favorable to sustain the project?

Financial sustainability

Is the funding source sufficient to carry out the necessary activities and input into the future?

How strong is the dependence on outside revenue?

Are revenue sources stable?

Technical sustainability

Is the skill and knowledge transferred during the project firmly established within the institution?

Is the transferred technology used as a foundation for further adaptation?

Is there access to new technology?

Is there a mechanism to share the individual knowledge and skill among staff members?

Is there necessary and sufficient equipment to practice the knowledge and skill?

Is the maintenance of the equipment properly done?