付　属　資　料

ミニッツ及び終了時評価調査報告書（英文）

ANNEX 1：Project Design Matrix (PDM3)

ANNEX 2：評価グリッド

ANNEX 3：聞き取りを実施した関係者リスト

ANNEX 4：評価団の日程詳細

ANNEX 5：日本人専門家リスト

ANNEX 6：本邦研修参加者リスト

ANNEX 7：供与機材リスト

ANNEX 8：フィリピン側カウンターパートリスト

ANNEX 9：フィリピン側コストシェア

ANNEX10：活動実績

ANNEX11：プロジェクトで実施した研修の概要

ANNEX12：自治体間で異なる施設分娩の推移

ANNEX13：PhilHealthと妊産婦ケア・パッケージ

MINUTES OF MEETINGS
BETWEEN
THE JAPANESE TERMINAL EVALUATION TEAM
AND
THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE REPUBLIC OF THE PHILIPPINES
ON THE JAPANESE TECHNICAL COOPERATION FOR MATERNAL AND CHILD HEALTH PROJECT

The Japanese terminal evaluation team organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Ms. Harumi Kitabayashi conducted evaluation study from October 5 through 27, for the purpose of reviewing the progress of the technical cooperation project for Maternal and Child Health.

The evaluation team conducted interviews of various stakeholders, group discussions, document review and ocular survey of participating health facilities in Ifugao and Biliran Provinces. The team also attended the Executive Committee/Technical Working Group meetings of the both provinces and presented their findings.

As the result of the exercises above, the terminal evaluation report was prepared and presented at the Joint Coordination Committee of the Project. The both sides agreed upon the matters described in the report which is attached hereto.

Manila, October 27, 2009

北林 春美

Ms. Harumi Kitabayashi
Team Leader
Terminal Evaluation Study Team
Japan International Cooperation Agency

Dr. David J. Lozada
Undersecretary
Department of Health
The Republic of the Philippines

TERMINAL EVALUATION REPORT
ON JAPANESE TECHNICAL COOPERATION
FOR
THE MATERNAL AND CHILD HEALTH PROJECT

Japan International Cooperation Agency

and

Department of Health

The Republic of the Philippines

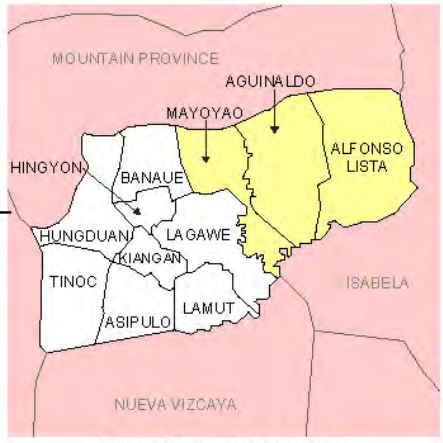
October 2009

Table of Contents

List of Tables and Figures

Annexes

Outline of the Project Area



Province of Ifugao

Province of Biliran

Province of Ifugao	
Area (km²)	2,517.8
Population	180,711
Households*	31,346
Density (/km²)	72
Municipalities	11
Barangays	175

	Population	Households*	Barangays
Mayoyao	16,722	2,917	27
Aguinaldo	17,231	3,341	16
Alfonso Lista (Potia)	25,323	4,275	20
Sub-total	**59,276**	**10,533**	**63**
Banaue	21,448	3,952	18
Hungduan	9,601	1,699	9
Kiangan	15,448	2,692	14
Lagawe (Capital)	17,373	2,944	20
Lamut	22,109	3,654	18
Hingyon	10,071	2,063	12
Tinoc	12,045	1,680	12
Asipulo	13,340	2,129	9

Province of Biliran	
Area (km²)	555.4
Population	150,031
Households*	27,907
Density (/km²)	270
Municipalities	8
Barangays	132

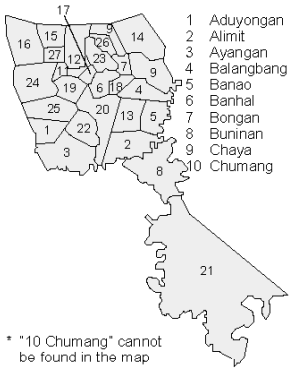
	Population	Households*	Barangays
Almeria	14,420	2,886	13
Biliran	14,947	2,619	11
Cabucgayan	18,799	3,372	13
Caibiran	20,616	3,597	17
Culaba	10,962	2,193	17
Kawayan	19,053	3,688	20
Maripipi	6,946	1,562	15
Naval (Capital)	44,288	7,990	26

Source: "2007 Census" and "2000 Census" for only "households" (http://www.census.gov.ph/). : Project target areas

Maps of Project Area by Barangay

Province of Ifugao

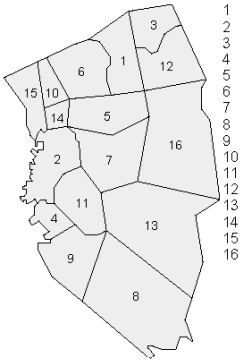
Mayoyao



1 Aduyongan
2 Alimit
3 Ayangan
4 Balangbang
5 Banao
6 Banhal
7 Bongan
8 Buninan
9 Chaya
10 Chumang
11 Guinihon
12 Inwaloy
13 Langayan
14 Liwo
15 Maga
16 Magulon
17 Mapawoy
18 Mayoyao Proper
19 Mongol
20 Nalbu
21 Nattum
22 Palaad
23 Poblacion
24 Talboc
25 Tulaed
26 Bato-Alatbang
27 Epeng

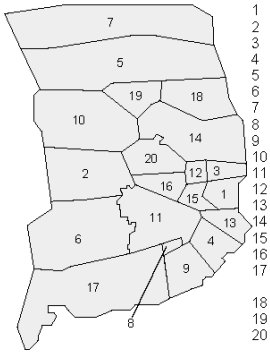
* "10 Chumang" cannot be found in the map

Aguinaldo



1 Awayan
2 Bunhian
3 Butac
4 Chalalo
5 Damag
6 Galonogon
7 Halag
8 Itab
9 Jacmal
10 Majlong
11 Mongayang
12 Posnaan
13 Ta-ang
14 Talite
15 Ubao
16 Buwag

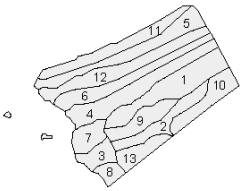
Alfonso Lista (Potia)



1 Bangar
2 Busilac
3 Calimag
4 Calupaan
5 Caragasan
6 Dolowog
7 Kiling
8 Namnama
9 Namillangan
10 Pinto
11 Poblacion
12 San Jose
13 San Juan
14 San Marcos
15 San Quintin
16 Santa Maria
17 Santo Domingo (Cabicalan)
18 Little Tadian
19 Ngileb
20 Laya

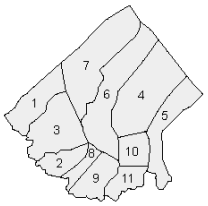
Province of Biliran

Almeria



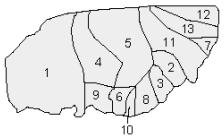
1 Caucab
2 Iyosan
3 Jamorawon
4 Lo-ok
5 Matanga
6 Pili
7 Poblacion
8 Pulang Bato
9 Salangi
10 Sampao
11 Tabunan
12 Talahid
13 Tamarindo

Biliran



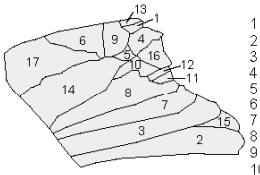
1 Bato
2 Burabod
3 Busali
4 Hugpa
5 Julita
6 Canila
7 Pinangumhan
8 San Isidro (Pob.)
9 San Roque (Pob.)
10 Sanggalang
11 Villa Enage (Baras)

Cabucgayan



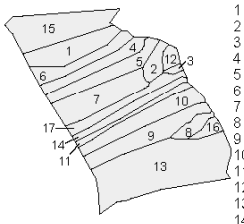
1 Balaquid
2 Baso
3 Bunga
4 Caanibongan
5 Casiawan
6 Esperanza (Pob.)
7 Langgao
8 Libertad
9 Looc
10 Magbangon (Pob.)
11 Pawikan
12 Salawad
13 Talibong

Caibiran



1 Alegria
2 Asug
3 Bari-is
4 Binohangan
5 Cabibihan
6 Kawayanon
7 Looc
8 Manlabang
9 Caulangohan (Marevil)
10 Maurang
11 Palanay (Pob.)
12 Palengke (Pob.)
13 Tomalistis
14 Union
15 Uson
16 Victory (Pob.)
17 Villa Vicenta (Mainit)

Culaba

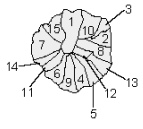


1 Acaban
2 Bacolod
3 Binongtoan
4 Bool Central (Pob.)
5 Bool East (Pob.)
6 Bool West (Pob.)
7 Calipayan
8 Guindapunan
9 Habuhab
10 Looc
11 Marvel (Pob.)
12 Patag
13 Pinamihagan
14 Culaba Central (Pob.)
15 Salvacion
16 San Roque
17 Virginia (Pob.)

Kawayan

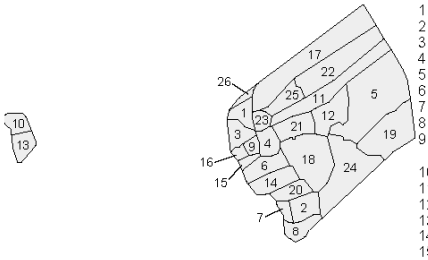
1 Baganito
2 Balacson
3 Bilwang
4 Bulalacao
5 Burabod
6 Inasuyan
7 Kansanok
8 Mada-o
9 Mapuyo
10 Masagaosao
11 Masagongsong
12 Poblacion
13 Tabunan North
14 Tubig Guinoo
15 Tucdao
16 Ungale
17 Balite
18 Buyo
19 Villa Cornejo (Looc)
20 San Lorenzo

Maripipi



1 Agutay
2 Banlas
3 Bato
4 Binalayan West
5 Binalayan East
6 Burabod
7 Calbani
8 Canduhao
9 Casibang
10 Danao
11 Ol-og
12 Binongto-an (Poblacion Norte)
13 Ermita (Poblacion Sur)
14 Trabugan
15 Viga

Naval (Capital)



1 Agpangi
2 Anislagan
3 Atipolo
4 Calumpang
5 Capiñahan
6 Caraycaray
7 Catmon
8 Haguikhikan
9 Padre Inocentes Garcia (Pob.)
10 Libertad
11 Lico
12 Lucsoon
13 Mabini
14 San Pablo
15 Santo Niño
16 Santissimo Rosario Pob. (Santo Rosa)
17 Talustusan
18 Villa Caneja
19 Villa Consuelo
20 Borac
21 Cabungaan
22 Imelda
23 Larrazabal
24 Libtong
25 Padre Sergio Eamiguel
26 Sabang

List of Acronym

ABC	Association for Barangay Captain
AMADHS	Alfonsolista-Mayoyao-Aguinaldo District Health System
AMMA	Active Male's Movement against Violence and for AYOD
APM	Assistant Project Manager
BEmOC	Basic Emergency Obstetric Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Barangay Health Station
BHW	Barangay Health Worker
BIHC	Bureau of International Health Cooperation
BNS	Barangay Nutrition Scholar
BPH	Biliran Provincial Hospital
CEmOC	Comprehensive Emergency Obstetric Care
CHD	Center for Health Development
CMMNC	Community Managed Maternal and Newborn Care
DH	District Hospital
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EC	Executive Committee
EC	European Commission
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
F1	FOURmula One for Health
FHSIS	Field Health Services Information System
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit
ILHZ	Inter-Local Health Zone
JCC	Joint Coordination Committee
LGU	Local Government Unit
LSS	Life Saving Skills
MCH	Maternal and Child Health
MCP	Maternal Care Package
MDG	Millennium Development Goals
MDR	Maternal Death Review
MHO	Municipal Health Office
MMR	Maternal Mortality Ratio
MNCHN	Maternal newborn child health and nutrition
NCDPC	National Center for Disease Prevention and Control
NDHS	National Demographic and Health Survey
NEDA	National Economic and Development Authority
NMR	Neonatal Mortality Rate
PCPNC	Pregnancy, Childbirth, Postpartum and Newborn Care
PDM	Project Design Matrix
PHDPF	Public Health Development Program Fund

PHO	Provincial Health Office / Provincial Health Officer
PhP	Philippine Peso
PIPH	Provincial-wide Investment Plan for Health
PO	Plan of Operation
PPDO	Provincial Planning and Development Office
PSWDO	Provincial Social Welfare Development Office
RHM	Rural Health Midwife
RHU	Rural Health Unit
SBA	Skilled Birth Attendant
TBA	Traditional Birth Attendant
TCL	Target Client List for Prenatal Care
TWG	Technical Working Group
UNFPA	United Nation's Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHT	Women's Health Team

1 Outline of the Evaluation Study

1.1 Background of the Evaluation Study

The Maternal and Child Health Project (here after referred to as the Project) to improve the quality of health care of the mothers and babies and to reduce maternal and neonatal deaths in Biliran and Ifugao provinces was launched on March 16, 2006 for the period of four (4) years. In the 6 months before the project termination, the Terminal Evaluation Team (here after referred to as the Team) was formed in accordance with the JICA evaluation guidelines for the purpose of reviewing the performance of the Project and the final evaluation. The terminal evaluation has been undertaken by the Evaluation Team with the involvement of national and provincial authorities of the Philippines.

1.2 Objectives of the Evaluation Study

Objective of the terminal evaluation study are as follows:

(1) To review the inputs, activities and achievements of the Project against the initial plan, and the implementation process as well as to clarify the problems and issues to be addressed for the successful implementation of the Project;

(2) To evaluate the Project using the five evaluation criteria (Relevance, Effectiveness, Efficiency, Impact and Sustainability);

(3) To make suggestions for sustaining the Project results after the Project termination, and to draw useful lessons learned for future similar projects.

1.3 Methodology of the Evaluation Study

1.3.1 Flow of Evaluation Study

The Terminal Evaluation of the Project was conducted following the process shown below, as per the JICA Project Evaluation Guideline of January 2004:

Step 1: Based on the Record of Discussions (January 2006), the third version of the Project Design Matrix (PDM ver.3: See Annex 1) as of August 2007 was adopted as the framework of the Terminal Evaluation exercise, and the Project's achievement was assessed in reference to the Objectively Verifiable Indicators in the PDM ver.3.

Step 2: Analysis was conducted on the factors that promoted or inhibited the achievement levels including factors relating to both the project design and the project implementation process.

Step 3: An assessment of the Project results was conducted based on the five evaluation

criteria: "relevance," "effectiveness," "efficiency," "impact" and "sustainability" (See "Table 1-1 Criteria for Evaluation" for the definition of each criterion"). (For the assessment tool used, see Annex 2: Evaluation Grid."

Step 4: Preliminary results are shared among the Provincial Executive Committees and the Technical Working Groups both in Ifugao and Biliran. Contents of the discussions are reflected in the recommendations.

Step 5: Recommendations for the Program stakeholders for the remaining implementation period and lessons learned were formulated for similar projects to be implemented by both Philippine and Japanese stakeholders.

1.3.2 Data Collection Methods of the Evaluation Study

Both quantitative and qualitative data were gathered and/or utilized for analysis. Data collection methods used by the Team were as follows:

(1) Literature/Documentation Review
- Record of Discussions signed on January 10, 2006
- Mid-term Evaluation Report 2007
- MCH Project Annual Report (2006, 2007, 2008)
- Project Biannual Reports (in Japanese)
- Province-wide Investment Plan for Health (Biliran and Ifugao Provinces)
- FHSIS Annual Health Reports (2005, 2006, 2007)
- Provincial FHSIS Reports (Biliran and Ifugao) (2005, 2006, 2007, 2008)
- Policy related documents
- Documents produced by the Project
- Other relevant documentations

(2) Interviews to Stakeholders (See Annex 3: Persons to be interviewed)
- Joint Coordination Committee (JCC) members (BIHC, NCDPC, CHDs, PHOs)
- Executive Committee members (PHOs, Provincial Governors, Municipal Mayors)
- Technical working groups/ Technical management groups (PHOs staff, Municipal Health Office staff, PHNs, RHMs)
- Technical staff from Provincial Hospital, DHs, RHUs, BHSs
- Members of Women's Health Teams
- Japanese Experts and Assistant Project Managers
- Development partners (UNFPA, EC/GTZ)

(3) Direct Observations at Project Implementation Site
- District Hospitals in Ifugao and Provincial Hospital
- RHUs in Ifugao (3) and Biliran (3) Provinces, respectively
- BHSs in Ifugao (2) and Biliran (2) Provinces, respectively

1.3.3 Criteria of Evaluation

Definition of the five evaluation criteria that were applied in the analysis for the terminal evaluation is given in Table 1-1 below.

Table 1-1: Definition of the Five Evaluation Criteria for the Final Evaluation

Five Evaluation Criteria	Definitions as per the JICA Evaluation Guideline
1. Relevance	Relevance of the Project is reviewed by the validity of the Project Purpose and Overall Goal in connection with the Government development policy and the needs of the target group and/or ultimate beneficiaries in the Philippines
2. Effectiveness	Effectiveness is assessed to what extent the Project has achieved its Project Purpose, clarifying the relationship between the Project Purpose and Outputs.
3. Efficiency	Efficiency of the Project implementation is analysed with emphasis on the relationship between Outputs and Inputs in terms of timing, quality and quantity.
4. Impact	Impact of the Project is assessed in terms of positive/negative, and intended/unintended influence caused by the Project.
5. Sustainability	Sustainability of the Project is assessed in terms of institutional, financial and technical aspects by examining the extent to which the achievements of the Project will be sustained after the Project is completed.

Source: JICA Project Evaluation Guideline (revised, January 2004), JICA

1.4 Members of the Evaluation Team

Members for the Terminal Evaluation Team are shown below.

Leader	Harumi Kitabayashi	Visiting Senior Advisor (Public health), JICA
Cooperation Planning	Yuko Ishida	Associate Expert, Reproductive Health Division, Health Systems and Reproductive Health Group, Human Development Department, JICA
Evaluation Analysis	Makiko Komasawa	Specialist in International Health, Earth and Human Corporation

1.5 Schedule of the Evaluation Study

Overall process of the Evaluation Study is shown in Figure 1-1 below. Detailed schedule of the Evaluation Team is attached in Annex 4.

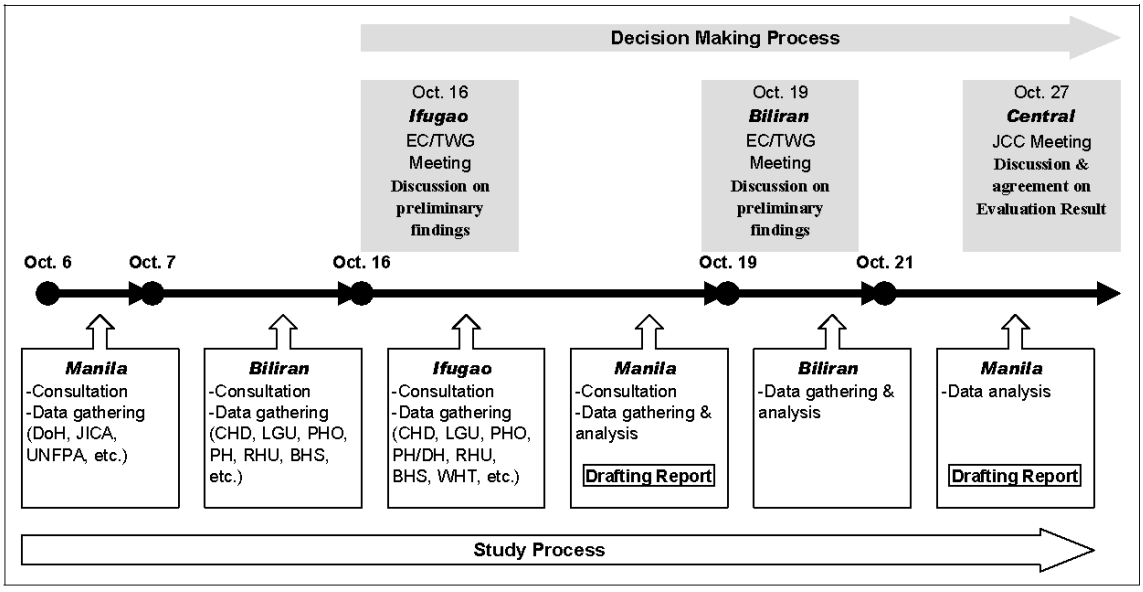


Figure 1-1: Schedule of the Evaluation Study

2 Outline of the Project

2.1 Background of the Project

Despite previous efforts and improvement in general health status in indicators, the rates of decline in maternal and neonatal mortality have decelerated in the past decade to a point where Philippine commitments to the Millennium Development Goal (MDGs) of lowering Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR) may not be achieved. However, with pregnancy and childbirth continuing to pose risks to Filipino mothers and their newborns, rapid reduction in these risks must be realized as quickly as possible[1].

In pursuit of this goal, DOH adopted series of policies and guideline for implementation of programs for provision of high quality care for mothers and newborns, especially EmOC services[2].

With the above considered, a technical cooperation project supported by JICA was developed, focusing on care integration at service delivery points, as well as enhancement of intuitional integration among three foci of responsibilities (DOH at the national and regional levels, the Inter-Local Health Zone (ILHZ), and the family and community). In March 2006, the Maternal and Child Health Project was launched for the implementation period of four (4) years. These project areas are Biliran province (Region VIII) and AMADHS-ILHZ in Ifugao province (CAR Region) with populations of 155,000 and 52,000, respectively.

2.2 Summary of the Project

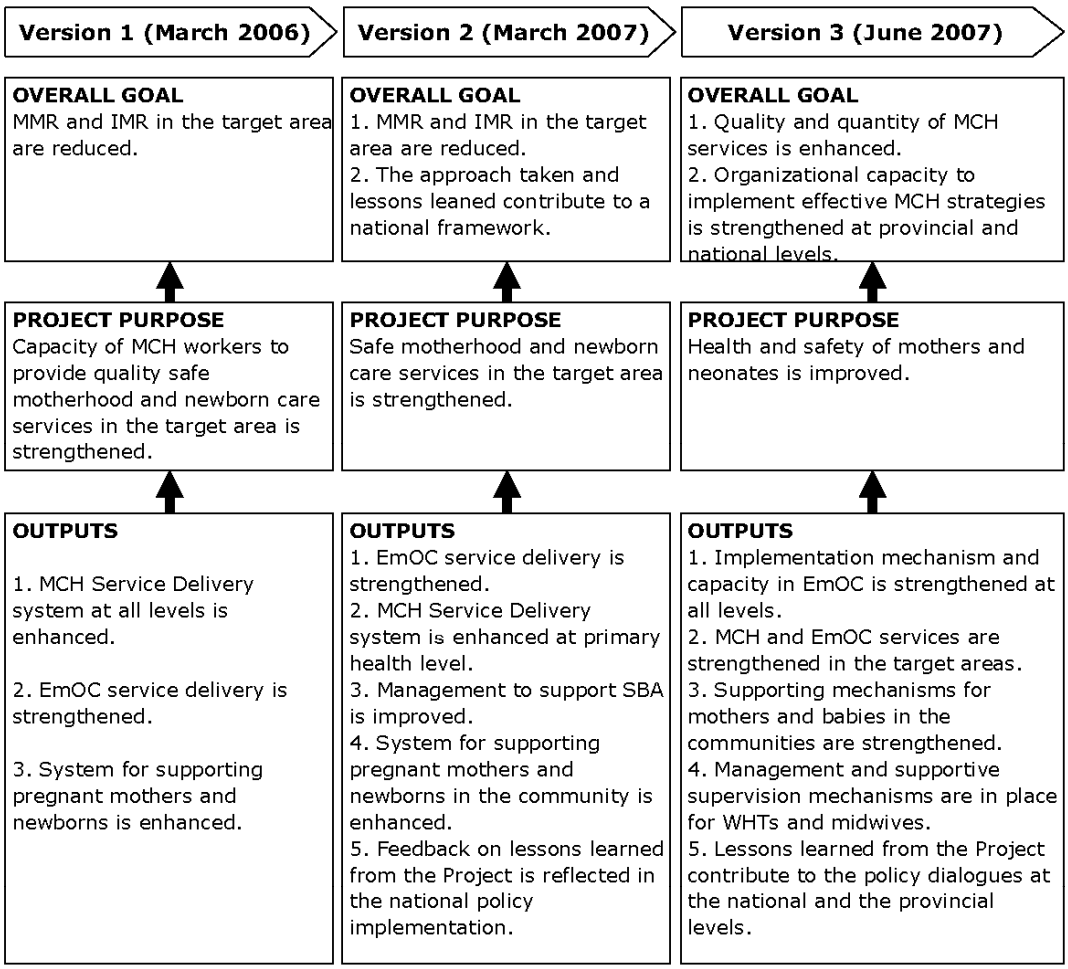
2.2.1 Change in Project Design Matrices (PDMs)

The Project Design Matrix (PDM) was reviewed and revised twice between January 2006 and September 2007. The third version of PDM (PDM 3, see Annex 1) is effective at the terminal evaluation period. Transitions of the narrative summary (Overall Goal, Project Purpose, Outputs) are summarized in the diagram below. Narratives are simplified from their original form for easier reference and comparison.

---

[1] The Department of Health (DOH) adopted the Administrative Order No. 2008-0029 in September, 2008. Its goal is "Rapid reduction maternal and neonatal mortality through local implementation of an integrated "Maternal Neonatal and Child health and Nutrition (MNCHN) strategy." The MNCHN strategy targets increase percentage of pregnant women having at least four antenatal care visits form 70% (National Demographic and Health Survey [NDHS], 2003) to 80% and increase percentage of skilled birth attendance and facility-based births from 40% (NDHS, 2003) to 80% by 2010.

[2] EmOC was revised into Emergency Obstetric and Newborn Care (EmONC) by A.O. No. 2008-0029 in September, 2008.



Source: Project Monitoring Report,2007; PDM 1, PDM 2, PDM 3.

Figure 2-1: Revisions Made to the Narrative Summary of PDM

2.2.2 Outline of the Project Design

As per the PDM 3, a narrative summary of the Project is described as follows.

(1) Overall Goal

In the framework of National Goal of Improving Women and Child Health, the central and provincial levels of organizational capacity to implement effective MCH strategies are strengthened and the quality and quantity of MCH services is enhanced.

(2) Project Purpose

In the project target areas, the health and safety of mothers and neonates in prenatal, during delivery and post partum period is improved through improving the quality of care and increasing the utilization of service provided.

(3) Outputs and Main Activities of the Program

The level of intervention, targets, the type of intervention and main activities for each Project Outputs are summarized in the Table 2-1.

Table 2-1: Summary Table of Project Outputs

Project Outputs	Level/Targets	Intervention Type	Main Activities
Output 1: Implementation mechanism and capacity of the central level to enhance Emergency Obstetric Care: EmOC in all levels is strengthened	Central/ DOH,CHD and training institution	Capacity building	▪ Enhance training capacity of EmOC and neonatal care at the central level training institution ▪ System formulation for monitoring
Output 2: The MCH services and EmOC are strengthened in the project target areas	Province and municipality/ PHs, DHs, RHUs/BHSs and SBAs working in such medical facility	Facility development and capacity development of health personnel	▪ BEmOC Training ▪ CMMNC Training ▪ LSS Training ▪ Provision of medical equipment
Output 3: Supporting mechanism for mothers and babies in the communities are strengthened	Municipality/ SBAs in RHUs and Barangay health volunteers, mothers, and community people	Community mobilization and organization, education and awareness building	▪ Formulation of WHTs ▪ Formulation of multi-sectoral community supporting group for emergency transportation
Output 4: Management and supportive mechanism are in place for WHTs and midwives to improve quality of service and their work environment in the project target areas	Municipality/ SBA s in RHUs and Barangay health volunteers, and community people	Capacity building through supportive supervision, formulation of financial mechanism for sustainability	▪ Supportive supervision for SBAs and WHTs ▪ Improvement of managerial capacity of RHUs ▪ Monthly meetings and Case Conference ▪ Maternal Death Review
Output 5: Lessons learned from the MCH project implementation contribute to dialogues at the national and the provincial levels and MCH policy discussions, and is reflected to the MCH policy formulation	Central /MCH Technical Working Group	Policy dialogues/ discussions	▪ Reactivate MCH TWG ▪ Discussion and revision of MCH policy ▪ Dissemination of MCH training materials

Source: MCH Project Annual Report 2007 with revision.

3 Achievement and Implementation Process

3.1 Achievement of the Project

3.1.1. Inputs

Table 3-1 shows the comparison of the planned (as per R/D of January 2006) and actual Inputs from the Japanese side as of September 2009.

Table 3-1: Inputs by the Japanese Side, Planned and Actual

Plan (as per R/D of January 2006)	Actual (as of September 2009)
[Japanese Experts] ■ One (1) Chief Adviser, Maternal and Child Health Planning	■ One (1) Chief Adviser/ Maternal and Child Health Planning

Plan (as per R/D of January 2006)	Actual (as of September 2009)
■ Two (2) Maternal and Child Health Experts ■ Other Expert (s) when necessity arises	■ One (1) Long-term Public Health/ Program Coordinator ■ One (1) Long-term Project Coordinator/ Training Monitoring ■ One (1) Long-term Project Coordinator (MM) **(Total: 121.2MM)** ■ Three (3) visits by Short-term Experts in the area of Maternal and Child Health ■ Two (2) visits by Short-term Experts in the area of Monitoring **(Total: Five (5) Short-term experts)** ■ Three (3) local staff as an assistant project mangers assigned in Biliran PHO, Ifguao PHO, and AMADHS office (see Annex-5 for details)
[Counterpart Training in Japan] ■ Not specified.	■ JFY2006: Six (6) persons ■ JFY2007: Ten (10) persons ■ JFY2008: Two (2) persons **(Total: 18 persons, including 7 participants for group training courses)** (see Annex-6 for details)
[Equipment] 1. Equipment for Emergency Obstetric Care 2. Equipment for other MCH care 3. Equipment for health education 4. Ambulances 5. Other equipment necessary for technical cooperation	1. Equipment for Emergency Obstetric Care 2. Other Equipment for MCP Accreditation 3. Equipment for health education and trainings 4. Ambulances 5. Monitoring vehicles **FY 2005 3,203,900 PhP** **FY 2006 9,266,408 PhP** **FY 2007 8,72,553 PhP** **FY 2008 2,363,960 PhP** **FY 2009 578,000 PhP** (As of August 2009) **Total: 24,133,821 PhP** (As of August 2009) (see Annex-7 for details)
[Operation Costs] ■ Not mentioned.	Cost sharing for local trainings, community orientation and production and reprinting for education and IEC materials. **FY 2005 3,546,046 PhP** **FY 2006 11,462,932 PhP** **FY 2007 12,194,411 PhP** **FY 2008 11,097175 PhP** **FY 2009 2,880,436 PhP** (As of August 2009) **Total: 41,181,000 PhP** (As of August 2009)

Source: Record of Discussion for the Project, January 2006; Project Monitoring Report, 2007; Information gathered by the Terminal Evaluation Team, October 2009

Table 3-2 shows the comparison of the planned and actual Inputs from the Philippine side as of September 2009.

Table 3-2: Inputs by the Philippine Side, Planned and Actual

Plan (as per R/D of January 2006)	Actual (as of September 2009)
[Philippine Counterpart] ■ Project Director: Director of National	■ Project Director: Director of National Center for

Plan (as per R/D of January 2006)	Actual (as of September 2009)
Center for Disease Prevention and Control (NCDPC) ■ Project Deputy Director: Governor of Ifugao and Biliran Provinces ■ Project Manager: Provincial Health Officers in Ifugao and Biliran; and/or Chairperson of the ILHZ of Ifugao ■ Project Staff: Medical Specialist II, DOH; Municipal Health Officers, Ifugao and Biliran Provincials; Center for health Development Officers, CAR and Region VIII ■ Administrative Personnel	Disease Prevention and Control (NCDPC) ■ Project Deputy Director: Governor of Ifugao and Biliran Provinces ■ Project Manager: Provincial Health Officers in Ifugao and Biliran; and/or Chairperson of the ILHZ of Ifugao ■ Project Staff: Medical Specialist II, DOH; Municipal Health Officers, Ifugao and Biliran Provincials; Center for health Development Officers, CAR and Region VIII ■ Administrative Personnel: Driver of the vehicles for monitoring and Secretary in Provincial Health Offices (See Annex-8 for details)
[Administration] ■ Technical Coordination Group of Health Sector Reform Agenda (TCG-HSRA) shall be the National Project Management Committee.	■ Cost of organization of JCC meetings were provided by the Philippine side. (see Annex-9 for details)
[Executive Committees at the Provincial Level] ■ Executive Committees at Provincial level to meet at least twice a year to formulate annual work plan, review the overall progress and achievement of the work plan, and review and exchange views on major issues arising from or in connections with the Project	■ Cost of organization of Executive Committee (EC) meetings were provided by the Philippine side.
[Land, Buildings and Facilities] ■ Office space and facilities at DOH and Provincial Health Office ■ Other spaces as mutually agreed upon as necessary	■ Office space and facilities at DOH, Provincial Health Offices and Mayoyao District Hospital ■ Venues for various training activities have also been provided. (see Annex-9 for details)
[Cost-sharing] ■ Not mentioned particularly.	■ **Administrative expenses:** Funds for JCC meeting; Travel expenses for Project site visits and monitoring; electricity; telephone; Use of office equipment; Travel allowances for staff training ■ **Personnel:** Salary for drivers and secretaries in provinces ■ **Cost sharing for conducting activities:** Financial and in-kind contributions are made by DOH-CHDs and provincial, municipal and baranga LGUs (see Annex-9 for details)

Source: R/D (January 2006); Report prepared by the Project for the Terminal Evaluation, September 2009.

3.1.2 Achievement of Activities

In general, Project activities have been implemented based on the PDM3 (See Annex 1).

Some activities were added, such as development and dissemination of Family Health Diary in CAR (localized version of MCBook in CAR) and reactivation of function of ILHZ in both Ifugao and Biliran in consultation with CHDs and the provincial governments. The detail achievements of activities are described in Annex 10.

3.1.3 Achievement of Outputs

PDM 3 consists of five (5) Outputs to achieve the Project Purpose. The following tables show indicators that measure the level of achievement of the Project Outputs. Extents of achievements as well as remaining challenges of each Output are described by analyzing the indicator results as well as observations made through interviews and field visits.

Output 1: Implementation mechanism and capacity of the central level (DOH central and Region) to enhance Emergency Obstetric Care (EmOC)

Under Output 1, series of training materials on Basic Emergency Obstetric Care (BEmOC), "Community-Managed Maternal and Newborn Care (CMMNC)" and "Life Saving Skill (LSS)" were developed and became ready to be used in order to improve clinical skill of MCH service providers and introduce the community based MCH care just before and after the project commencement. Development of these materials was initiated by DOH and collaboratively supported by UNFPA, UNICEF, WHO, Plan International and the Philippine Obstetrics and Gynecology Society as well as JICA. By using the developed materials, trainers for BEmOC and CMMNC trainings were trained nationwide.

The project also supported the set-up of a core national training institute, which was "Dr. Fabella Memorial Hospital" in Manila, in order to secure provision of quality trainings by providing equipment and educational tools. These developed training materials have widely been utilized by DOH and the other development partners and the training module became the national standard[3].

Regarding the monitoring and supervision tools, the Project paid attention to effective utilization of existing tools, such as "Field Health Services Information Statistics (FHSIS)" and "Target Clients List."

---

[3] The MNCHN Task Force is currently reviewing the training module to include newborn care.

Table 3-3: Achievement of Project Output 1 (As of September 2009)

Narrative Summary	Indicators	Achievement
Output 1 Implementation mechanism and capacity of the central level (DOH central and Region) to enhance Emergency Obstetric Care (EmOC) at all levels is strengthened.	1) Availability of EmOC and CMMNC training manuals	-BEmOC textbook named "Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC) : A Guide for essential practice in Philippine setting" for BEmOC textbook was developed with collaboration of DOH and other development partners and printed by JICA in 2005, before the project commencement. -BEmOC TOT was conducted in 2005. -A trainer's guide titled "Community-Managed Maternal and Newborn Care" (CMMNC) and a guide for Primary Health Care Professionals titled "Community-Managed Maternal & Newborn Care" have been developed in 2006 through the assistance of UNFPA, UNICEF, WHO and Plan International. -LSS training textbook was developed for medical improving normal delivery skill for midwifes in corporation with the Philippine OB-Gyen Society in 2007.
	2) Number of trainers received TOT of CMMNC	- CMMNC training of Trainers (4 days): participants were 184 trainers from 15 CHDs and 19 FI targeted provinces as regional trainers in collaboration with UNFPA, UNICEF, Care International in Nov. 2006. Out of these, 91 were funded by JICA project.
	3) Availability of monitoring and supervision tool for EmOC	-To strengthen the supervision mechanism, newly introduced "Target Client List for Prenatal Care" by DOH was used at RHU. -Referral card for BHS and RHU were used. -In addition, to strengthen the Information management system (IMS), trainings for Biliran province in Sep. 2006 were conducted: participants were 16 SBAs from RHU.

Source: MCH Project Annual Reports, 2006-2008, Report prepared for the Terminal Evaluation by the Project, September 2009.

Output 2: The MCH services and EmOC are strengthened in the project target areas

Under Output 2, to strengthen the MCH services and EmOC at municipal and barangay levels, Skilled Birth Attendants (SBAs) at the district hospital and RHU levels in the target areas were trained for both BEmOC and CMMNC. Then, Rural Health Midwives (RHMs) of BHSs in target areas were also trained to upgrade their midwifery skills in local settings.

To start BEmOC services and increase the accessibility of facility-based delivery in rural areas, both RHUs and BHSs which were selected by the DOH Facility Mapping in 2007, have been equipped with the obstetric equipment in accordance with the PhilHealth Guideline for Maternity Care Package (MCP) accreditation. As a result, all designated facilities (8 RHUs in Biliran and 3 RHUs in Ifugao) obtained PhilHealth MCP accreditation. Seven (7) BHSs were accredited in Biliran, and 8 BHSs in Biliran are 1 BHS in AMADHS are in the process of accreditation.

Some municipalities adopted ordinances or resolutions which decided introduction of user fees, creation of trust fund and how to use of the fund[4]. Improved skills, working environment, and incentives from LGUs and the trust funds motivated the staffs and enabled them to offer better services on 24 hour-basis.

Table 3-4: Achievement of Project Output 2 (As of September 2009)

Output 2 The MCH services and EmOC are strengthened in the project target areas	1) Number of SBAs received BEmOC training	-2006, 2007 and 2008: Basic Emergency Obstetric Care (BEmOC) training: 60 (33 in Ifugao, 27 in Biliran)
	2) % of SBAs received CMMNC training	-2006: CMMNC trainngs for SBAs : 70 in Birilan and 73 in Ifugao (including 25 from other than AMADHS)
	3) Number of midwives trained on LSS	-2007 and 2008: Life Saving Skills (LSS) Training for midwife: 62 (24 from Ifugao and 38from Biliran)
	4) % of number of RHUs accredited PhilHealth Maternity Care Package (MCP)	Biliran: -2007: 8 out of 8 RHUs accredited in Biliran for MCP (coverage: 100%) -2009: 7 out of 15 BHS also accredited AMADHS: -2008: 3 out of 3 RHUs accredited (coverage:100%) -2009: 1 out of 6 BHSs is in the process of accredited
	5) Number of health facilities offering BEmOC services	-2006: 8 RHUs in Biliran -2006: 3 RHUs and 3 district hospitals in AMADHS
	6) Number of BHSs working as birthing stations	According to Facility Mapping of DOH -2007: 15 out of 15 targeted BHSs functional in Biliran -2008: 6 out of 6 targeted BHSs functional in Ifugao
	7) % of deliveries by SBA[5]	-AMADHS: 54% (2005), 59% (2006), 57% (2007), 71% (2008) -Biliran: 44% (2005), 49% (2006), 83% (2007), 92% (2008)
	8) % of facility-based deliveries	-AMADHS: 19% (2005), 17% (2006), 23% (2007), 34% (2008) -Biliran: 25% (2005), 24% (2006), 79% (2007), 89% (2008)

Source: Report prepared for the Terminal Evaluation by the Project, September 2009, National FHSIS 2005-2007 and Provincial PHSIS 2005-2008 for Ifugao and Biliran.

[4] Majority of these municipalities decided that 30% of income should go to performance-based personnel reward.
[5] Given the conditions in Ifugao Province where access to birthing and EmOC facility is extremely limited, the Project suggested the use of "% of deliveries by SBAs" as supplementary indicator to "% of facility deliveries," in order to bridge the huge gap between home delivery with TBAs and facility delivery, so far as in the transitional period. This indicator has been endorsed by JCC of the Undersecretary, DOH and the Project Director (NCDPC, DOH) in September 2007.

Output 3: Supporting mechanism for mothers and babies by community members in the project target areas is enhanced

Regarding Output 3, under the concept of enhancement of community participation in maternal and child health care, the Project supported establishment and strengthening of Women's Health Teams (WHTs). The WHTs were formed of the existing barangay human resources in health field, including barangay health workers, barangay nutrition scholars, and hilots (traditional birth attendants). In Biliran, 374 WHTs were organized and 1,122 persons joined from all 132 barangays. In AMDHS, 96 WHTs were organized with 321 members from all 63 barangays. Not only the women's but also men's involvement in volunteer activities was observed for supporting pregnant women and educating community people in various health issues.

It was observed though the study team observations in the field of Biliran, the WHTs became important actors to track pregnant women in their community, to educate community people necessity of pre/post natal care and to encourage facility-based delivery for safe-motherhood.

In Ifugao, the WHTs have evolved into AYOD community health teams which assume expanded tasks on health program with active male participation. Since 2008, new training program named "Active Male's Movement against Violence and for AYOD"(AMMA) was introduced in Ifugao province with collaboration of the Department of Social Welfare and Development (DSWD) under the UNICEF support. Some of AYOD members were trained as peer male trainers and are enthusiastically providing trainings on various health and social welfare issues for local men in their communities.

These community-based health activities led to community people's awareness towards healthy motherhood and further supporting environment for pregnant women in communities.

Table 3-5: Achievement of Project Output 3 (As of September 2009)

Output 3 Supporting mechanism for mothers and babies by community members in the project target areas is enhanced	1) Number of established WHTs; WHTs (>1/Brg)	-In AMADHS: 96 WHTs (321 members): up to 2008 June (All 63 barangay covered) -In Ifugao province, 182 AYOD Team (2436 members in 11 municipalities) -In Biliran: 374 WHTs (1,122 members in) (All 132 barangay covered)
	2) Number of mother's class per WHT per month	-In discussion with CHD/Region VIII, "Parent's class manual" for WHT was developed in Jan. 2008 and printed 1100 copies for Region VIII. Using this manual, WHTs and RHM offered the parent class at almost BHSs every week. -In Ifugao province, AMMA training has been conducted and 33 trained advocates provided 9

		male education classes in Aguinaldo and 2 in Alfonso Lista.
	3) Availability of community plan for birth preparedness and emergency readiness	-AMADHS: All 63 barangays made their emergency preparedness plan with AYOD and submitted to PHO office. Ifugao developed Manual for AYOD Implementation and Manual for AMMA for Male TOT and printed in 2009, which includes birthing plans for all pregnant women. -Biliran: All 132 barangays made their emergency preparedness plan and submitted to PHO. All pregnant women made birthing plans for their emergency.
	4) Satisfaction of mothers	According to the provisional result of the Project Survey in 2009, 89% of expectant mothers in AMADHS (N=90) and 86% of them in Biliran (N=160) recommended to receive WHT consultation to other pregnant women.

Source: Report prepared for the Terminal Evaluation by the Project, September 2009, the provisional results of the Surveys for the Terminal Evaluation, September 2009, Interviews at field study2009.

Output 4: Management and supportive supervision mechanisms are in place for WHTs and midwives to improve quality of service and their work environment in the project target areas

Output 4 aims to improve quality of services and encourage community's supporting activities. Under Output 4, relationship between midwives in BHSs and WHTs (or AYOD in Ifugao) in communities have been tightened. Based on the series of the field interviews, nearly 100% of teams set a weekly or monthly meeting at BHSs with RHMs to share the pregnant women's tracking results and discuss issues they are facing. At the same time, a MHO hold a monthly meeting with all staff including midwives who work at BHSs. According to the provisional results of the survey conducted for the terminal evaluation in May to July in 2009, almost all WHT members are satisfied with working as a member and had wills to continue to work in both target areas.

Besides, it seems like that introducing user fees system for MCH services created monetary incentive for both health staff and WHT members. Indeed the incentives accelerated increase of facility-based deliveries. However, it should be noted that there were some arguments that the user fees system might discourage poor people to come to facilities for receiving necessary services.

Table 3-6: Achievement of Project Output 4 (As of September 2009)

Output 4 Management and supportive supervision mechanisms are in place for WHTs and midwives to improve	1) Number of monthly meetings with WHTs at BHS/RHUs as well as number of case conferences	-Biliran: MHO hold monthly or weekly meeting with all staff including RHMs who work at BHSs. RHMs hold meeting with WHT weekly. -Ifugao: MHO hold a monthly meeting with all staff including RHMs who work at BHSs. RHMs hold meeting with WHT weekly.

quality of service and their work environment in the project target areas		-In addition, for WHTs in Biliran, the supervision sheet was developed at the BHS's RHMs workshop facilitated by CHD/Region VIII in 2009 and now RHMs are orientating to their WHTs and formally introduced from January 2010. -For WHTs in CHD/CAR, the CHD decided to use Mather and Child Book (Family Health Diary) as monitoring tools for WHTs from January 2010.
	2) Number of maternal deaths review meetings	Both province are conducting MDR soon after incidence (in Biliran within a month) with all the related personnel and community based meetings. Total of 2 MDR conducted (in 07, 08 no maternal death, 2 in 09) in Ifugao and 10 MDR conducted (6 in 08, 4 in 09) in Biliran. In Biliran, MDR traininga for SBA of RHU in 06 and 07 were held using DOH mojule. Then, MDR case conferences were held with SBAs, PH, PHO and MCH coordinator, EVRMC doctors and CHD/Region VIII after 2 incidences.
	3) Number of supportive supervision by PHO/MHO offices	-Biliran: MCH coordinator of PHO visits all RHU quarterly and supervise their performance, mainly health statistics. MHO holds monthly or weekly meeting with all staff including RHMs who work at BHSs. RHMs at MHS hold meeting with all WHT at BHS weekly. Or one BHS assigned WHT to come and work at BHS in turn. -Ifugao: PHO made supervision twice a year to RHU and some BHS. MHO hold a monthly meeting with all staff including RHMs who work at BHSs. RHMs hold meeting with WHT weekly. Alfonso Lista PHN developed "Monitoring Check-list for BHS" and occasionally visit BHS and check it with the list. - In both areas, Target Client List (TCL) were utilized to track the pregnant women through BHS' RHM and WHTs, which gave MHO to monitor RHM and WHT performances.
	4) Satisfaction of WHT members and RHWs	According to the provisional Survey conducted by PHOs and the project on June to Aug 09, 100% of WHT were satisfied with being the WHT in Biliran (N=841) and 94% in AMADHS (N=683).

Source: Report prepared for the Terminal Evaluation by the Project, September 2009, the provisional results of the Surveys for the Terminal Evaluation, September 2009, Interviews at field study2009.

Output 5: Lessons learned from the MCH project implementation contribute to dialogues at the national and the provincial levels and MCH policy discussions; and is reflected to the MCH policy formulation

The Project shared its experiences in successful establishment of WHTs and AYODs in

all barangays with other provinces in Region VIII and CAR, through the Centers for Health Development (CHDs). Various textbooks and teaching materials developed were provided to provinces and municipalities outside the Project target areas for replication of activities.

A document titled "TEAMING UP for Safe Motherhood" was produced, which described step-by-step process of Project implementation including actions taken by the various stakeholders such as DOH-central, LGUs, PHOs, and the communities. This document was distributed to all PHOs and MHOs of CAR and Region VIII at the occasion of regional meeting organized by CHDs. It was also shared with development partners active in health sector reform at the launching ceremonies held in Ifugao and Biliran in 2008.

Overall, it is acknowledged by DOH as an effective translation of the MNCHN policy into practices.

Table 3-7: Achievement of Project Output 5 (As of September 2009)

Output 5 Lessons learned from the MCH project implementation contribute to dialogues at the national and the provincial levels and MCH policy discussions; and is reflected to the MCH policy formulation	1) Number of MCH Technical Working Group meetings (at DOH)	Attended MCH taskforce 2 times in 06, 2 times in 07, 1 time in 08 at DOH.
	2) Number of MCH training manuals provided	▪ Three-hundred (300) sets of CMMNC Trainers Guide, and Training Kit to 19 FOURmula-one target provinces and 17 CHD Regions, its CD version proved to the Philippine Midwife Association and USAID- affiliated NGOs ▪ WHT Guide: 600 copies (Ayagan & English version, Ilocano & English version), AYOD Guide: 3000 to Ifugao Province;700 copies (Wray-Wray & English, Cebuano & English) ▪ CMMNC textbook was reprint: 3000 to CHD/CAR, 2000 to CHD/Region VIII in March 2009. ▪ Published " TEAMING UP for Safe Motherhood"
	3) Number of other MCH related meetings conducted or participated in by the Project	Major meetings involved by the Project were at least 12 times by October 2009: ▪ At central level: 2 times ▪ At CHD/CAR region level: 5 times ▪ At CHD/Region VIII level: 4 times ▪ At Mindanao region: 1 time

Source: MCH Project Annual Reports, 2006-2008, Report prepared for the Terminal Evaluation by the Project, September 2009, the provisional results of the Surveys for the Terminal Evaluation, September 2009, National FHSIS 2005-2007 and Provincial PHSIS 2005-2008 for Ifugao and Biliran..

3.1.4 Achievement of the Project Purpose

Project Purpose: In the project target areas, the health and safety of mothers and neonates in pre-natal, during delivery, and postpartum period is improved.

Following tables illustrate the status of indicators that measure attainment level of the Project Purpose based on PDM 3.

Table 3-8 shows that deliveries assisted by the SBAs in target areas have rapidly increased from 44% in 2005 to 92% in 2008 in Biliran and 54% in 2005 and 71% in 2008 in AMADHS.

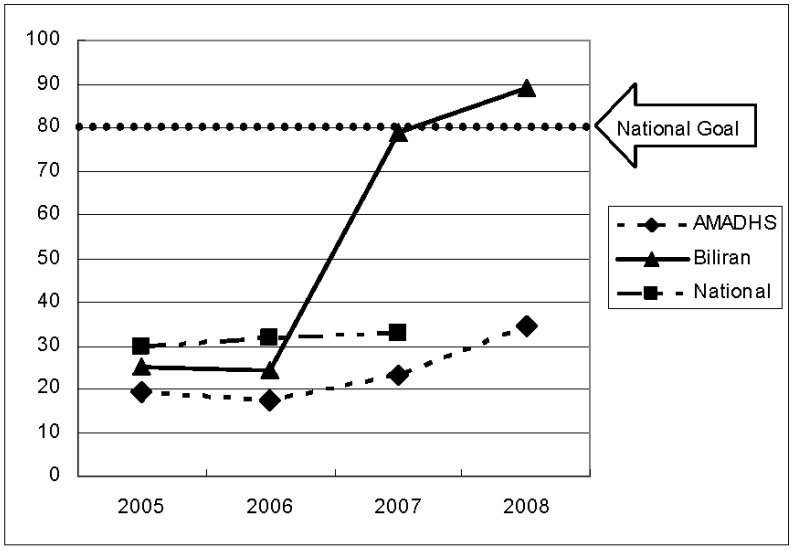
Table 3-8: Trends in Deliveries (As of December 2008)

Indicators for the Project Purpose	Benchmark		Achievement			Means of Verification
	2005		2006	2007	2008	
% of deliveries assisted by the SBAs in the target areas	**Biliran**	44%	49%	83%	92%	Provincial FHSIS
	Ifugao	68%	68%	63%	73%	
	AMADHS	54%	59%	57%	71%	
% of facility-based deliveries in the target areas	**Biliran**	25%	24%	79%	89%	Provincial FHSIS
	Ifugao	37%	37%	32%	49%	
	AMADHS	19%	17%	23%	34%	

Source: Provincial FHSIS 2005-2008.

Figure 3-1 shows that facility-based deliveries have drastically increased in Biliran from 25% (2005) to 89% (2008), and moderately increased in AMADHS, 19% (2005) to 34% (2008). The national goal stated in the Administrative Order 2008-0029 (A.O. 2008-0029) is aiming to attain the percentage of skilled birth attendance and facility-based delivery to 80% by 2010. Biliran almost reached the goal in 2007 after only one year from the Project start.

Share of facility-based deliveries in AMADHS starting from 19%, lower than the national average, reached to 34% in 2008 with 15% points increase in three years.



Source: National FHSIS 2005-2007 and Provincial FHSIS 2008 for Biliran and AMADHS.
Note: Data of 2005 & 2006 include only hospitals and, data in 2007&2008 include hospitals, RHUs, and BHSs, according to the FHSIS source.

Figure 3-1: Trends in Facility-based Deliveries

Table 3-9 shows the trends in receiving prenatal care. First of all, it should be pointed out that there are huge differences between the number of the national FHSIS and the provincial FHSIS. Inconsistency was observed in terms of frequency of visits (3 or 4) in national statistic for Ifugao. Thus, the Evaluation Team concluded these data in Table 3-9 are likely less reliable. However, if we assume the numbers in 2008 are reliable, they are considerably lower than the national goal (2010) of 80% set by A.O.2008-0029. Further effort to increase prenatal visit starting from the 1st trimester is required.

Table 3-9 also shows trends in receiving prenatal care in the first trimester in Biliran. Gradual increases have been seen from 2006 to 2008 in Biliran based on the RHU statistics. Data is not available for Ifugao. FHSIS does not require separate reporting of data regarding pregnant women who received prenatal care in the 1st trimester.

Table 3-9: Trends in Prenatal Care (As of December 2008)

Indicators for the Project Purpose	Benchmark		Achievement			Means of Verification
		2005	2006	2007	2008	
% of pregnant women who received prenatal care more than 3 or 4 times	**Biliran**	67%*3 (65%)*3	59%*3 (64%)*3	59%*3 (22%)*3	69%*3	Provincial FHSIS, ( ) indicates data from the National FHSIS
	Ifugao	99%*4 (36%)*4	96%*4 (64%)*3	90%*4 (64%)*4	65%*4	
	AMADHS*	88%*4	93%*4	91%*4	65%*4	
% of pregnant women who received prenatal care in the 1st trimester	**Biliran**	N/A	20%	26%	31%	Data were collected from each RHU by the Project team
	Ifugao	Data are not available				

Note: *3 indicates data presenting "3 or more" prenatal care received and *4 indicates data presenting "4 or more." DOH definition of % of women who received Prenatal care was changed in 2008, from "three times or more" to "four times or more" in 2008. However, the evaluation team recognized the front line staff are still confused in applying new system.

It is not possible to say from the figures in Table 3-10 that there is any significant change in mortality rates because the number of death is so small.

Table 3-10: Trends in Maternal and Neonatal Mortality (As of December 2008)

Indicators for the Project Purpose	Benchmark		Achievement			Means of Verification
		2005	**2006**	**2007**	**2008**	
Maternal mortality ratio (per 1000 livebirths) of project	**Biliran**	2.89 (#: 10)	2.80 (#: 10)	1.15 (#: 4)	1.57 (#: 6)	Provincial FHSIS
	Ifugao	0.85 (#: 1)	1.20 (#: 5)	1.32 (#: 3)	0.67 (#: 3)	
	AMADHS*	0.85 (#: 1)	0.87 (#: 1)	0 (#: 0)	0 (#: 0)	
Neo-natal mortality rate (per 1000 livebirths) of project area	**Biliran**	4.3 (#: N/A)	7.43 (#: N/A)	3.8 (#: 13)	9.4 (#: 36)	Data collected from MHO by the Project
	Ifugao	5.1 (#: 34)	3.92 (#: 40)	- (#: 12)	- (#: 11)	
	AMADHS*	5.12 (#: 6)	4.34 (#: 5)	- (#: 8)	- (#: 7)	

<Only References> Infant mortality rate (per 1000 livebirths)	**Biliran**	16.8 (#: 58)	19.0 (#: 68)	13.3 (#: 49)	19.1 (#: 73)	Provincial FHSIS
	Ifugao	8.5 (#: 34)	10.3 (#: 40)	10.9 (#: 35)	12.9 (#: 53)	
	AMADHS*	9.0 (#: 11)	9.6 (#: 12)	11.8 (#: 11)	11.8 (#: 12)	

Source: Provincial FHSIS 2005-2008, Neonatal data were collected from each RHU by the Project team.
Note: # indicates number of deaths.

3.1.5 Achievement of the Overall Goal

Overall goal: In the framework of National Goal of Improving Women and Child Health, the central and provincial levels of organizational capacity to implement effective MCH strategies is strengthened and the quality and quantity of MCH services is enhanced.

According to the JICA evaluation guideline, an overall goal is defined as a goal to be achieved in three to five years after the Project termination.

Table 3-11 shows the status of indicators that measure achievement level of the Overall Goal (as per PDM 3). Between 2005 and 2007, there is slow but steady increase in facility-based delivery and deliveries assisted by SBAs at national level. To achieve the national goal of 80 percent facility-based deliveries, intensified nationwide implementation of MNCHN strategy (A.O. 2008-0029) is required. The FHSIS data for maternal and neonatal mortalities are considered to be underestimating compared to the National Demographic and Health Survey (NDHS), which is conducted only every five years. The newest data from NDHS 2008 will be released soon.

Table 3-11: Achievement of the Overall Goal at National Level (2005-2007)

	2005	**2006**	**2007**
% of health facility deliveries	30%	32%	33% (44%)***
% of deliveries assisted by a skilled birth attendant (SBA)	68%	70%	73% (62%)***
% of pregnant women who received prenatal care 4 or more	61%	59%	58%
Maternal Mortality Ratio (100,000 live births)	-	(162)**	-
Neonatal Mortality Rate (1000 live births)	(17: 1998 -2003)*	-	-
Infant Mortality Rate (1000 live births)	-	(24)**	(25)***

Source: FHSIS 2005-2007, *National NDHS report 2003, **2006 Family Planning Survey,*** National DHS preliminary report 2008.
Note: National FHSISs are only available up to 2007 which was the second year of the Project. * includes all health facilities.

3.2 Implementation Process

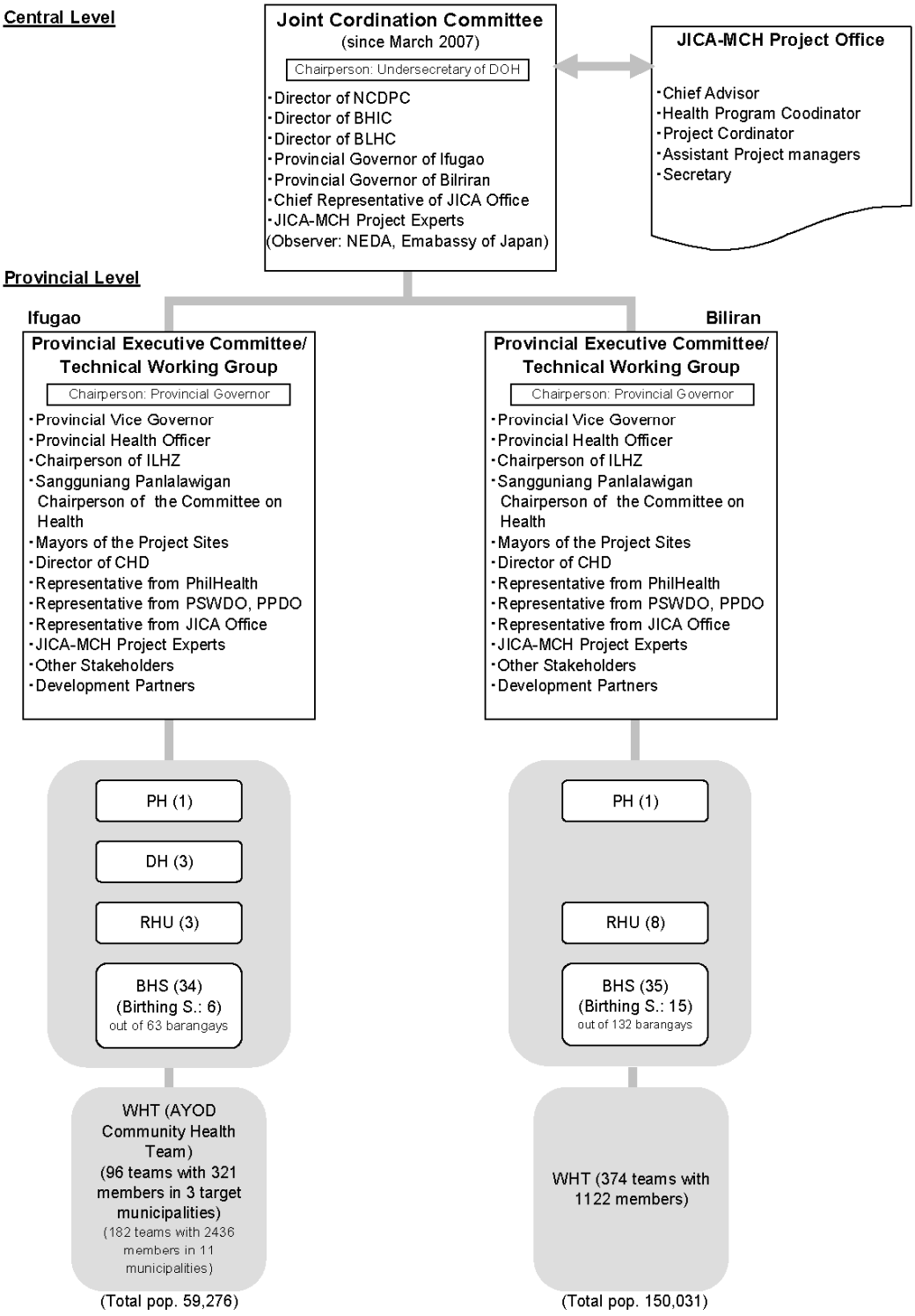
3.2.1 Progress of the Project activities and Monitoring

Most of the activities related to conducting trainings and providing equipment have been completed by the time of mid-term evaluation. At the mid-term evaluation, percentage of facility delivery in Biliran increased to around 80% in only 18 months from the start of Project. Then, activities related to Output 3 and 4, especially formation and encouragement of WHT in Biliran and AYOD in Ifugao have been accelerated since 2007. These rapid formations drew attention nationwide and the local stakeholders become more motivated. Since then, various approaches become integrated into one comprehensive mechanism and more accelerated under the strong commitment of health workers and LGUs. As a result, those good practices were taken up by the CHDs (Region VIII and CAR) and were expanded to the other areas.

The Project activities are aligned with the Province-wide Investment Plan for Health (PIPH) and its annual operation plans, and planning and monitoring of the Project is fully integrated into provincial exercises. Regular monitoring by the Executives Committee and the Technical Working Groups (TWGs) uses indicators of PDM and the progresses are shared among all stakeholders and development partners.

3.2.2 Project Management Structure

The Project was implemented under the management structure from the central to the barangay levels as shown in Figure 3-2. The integrated structure made effective the Outputs for achieving the project goals.



Source: MCH Project Annual Report 2008, 2007 Census, and TEAMING UP for Safe Motherhood 2008.

Figure 3-2: Project Implementation Structure

4 Evaluation Results

4.1 Evaluation by Five Criteria

The Project was evaluated along with the Five Criteria (Relevance, effectiveness, efficiency, impact and sustainability). Evaluation results are shown below.

4.1.1 Relevance

Project design is relevant in view of consistency with national and local policies, Japan's cooperation policies and the needs of the target groups. It can also be justified as relevant as means to reduce maternal and neonatal deaths. Specific arguments are made as the following.

1) Consistency with the Policies of the Philippine government and DOH

The Government of the Philippine committed to attain its Millennium Development Goals (MDGs). Reductions of maternal and neonatal mortality are targeted in the Goal 4 and 5. To reduce the maternal and neonatal mortality, DOH adopted the Administrative Order (No. 79 s. 2000) in July 2000 known as Safe Motherhood Policy set general objective of reducing maternal and prenatal mortality and morbidity.

During the project period, DOH updated the previous maternal and child policy to a new Administrative Order (No. 2008-0029) titled "Implementing Health Reform for Rapid Reduction in Maternal and Neonatal Mortality (MNCHN strategy)" in September 2008. It aimed at achieving the twin goals of maternal mortality reduction and neonatal mortality reduction[6], applying the FOURmula One for Health (F1) approach for the local implementation. MNCHN strategy emphasized its community-based approach including enhancement of conveniently located health facilities as birthing place.

The Project is designed based on the framework of these governmental policies and strategies.

2) Consistency with the Japanese cooperation policies and JICA's plan

The Japan's Country Assistance Program (2008) for the Philippines prioritizes supports for maternal and child health aiming at improvement of maternal mortality ratio and infant mortality rate, which are especially problematic in the Philippines, among the MDGs. The JICA's Country Assistance Strategy (2009) sets "Enhancement of Basic Social Services" as one of the development subject

[6] Page 7, DOH, "Implementing Health Reform for Rapid Reduction in Maternal and Neonatal Mortality," 2009.

and "Maternal and Child Health" is one of the priority issues under the health program. The project concept and strategy are consistent with these Japanese cooperation policies and JICA's strategy.

3) Appropriateness of selection of Project sites

The Project target areas (AMADHS and Biliran ILHZ) were selected from 16 F1 convergence provinces as a first stage of the Health Sector Reform implementation. Regarding socio-economic and health status, they were also suffering from higher maternal mortality ratio and poverty incidence than the national averages. Thus, the selection of the Project sites is appropriate.

4.1.2 Effectiveness

The Project was effective because it produced the aimed result which is represented as the increase of facility-based deliveries, through the integrated and coordinated implementation of multi-sector and multi-layer interventions and initiatives;

1) Development and standardization of training courses, and instruction materials which gave clear direction and technical backstop for service delivery.

Contribution of Dr. Jose Fabella Memorial Hospital and Philippines Obstetrics and Gynecology Society in development and provision of quality clinical training should be commended, for the BEmONC training conducted for a team of doctors, nurses and midwives who work in BEmONC facilities as well as the LSS training for rural midwives stationed at the BHSs proved to be very effective to prepare them to provide quality services.

2) Enhancement of service delivery at primary health care facilities

MNCHN services are defined by A.O.2008-0029 as package of services for women, mothers and children that cover the continuum of i) known appropriate clinical case management services, and ii) known cost effective public health measures.

SBAs working at district hospitals and RHUs received appropriate training on clinical care (BEmONC) and public health activities such as community organization, referral, planning and monitoring, and community financing (provided in the CMMNC). Later on, training needs of rural midwives working at BHSs were identified and the basic midwifery training (LSS) was developed and training courses conducted. It was confirmed that majority of the health

workers who participated in the training are now applying the skills to their routine maternal and neonatal care services.

Capacity development of health personnel (SBAs) was accompanied with improvement of equipment at the health facilities which enabled SBAs to apply their skills and provide quality care for mothers and newborns. District hospitals and RHUs are now providing 24-hour BEmONC services which became well-known to the community. Doctors are on call, and in Biliran province midwives attached to BHSs rotate to work at RHUs for attending deliveries. Increased workload of health workers were one of the concerns expressed by some staff of RHUs and BHSs at the time of mid-term evaluation in 2007. This problem was addressed by the municipalities in Biliran by employing additional workforces (9 midwives and 2 nurses) on contractual or casual basis.

3) Community mobilization and participation at the barangay level and linkages between the communities and primary care facilities

Rigorous mobilization of communities at barangay level through organization of the WHT strengthened the cooperative relationship between communities and primary health care facilities (RHUs and BHSs). Orientation and monitoring by staff of RHUs together with active involvement of local chief executive officers promoted rapid launching of WHTs. Members of WHT facilitated behavioral change of mothers and utilization of services through pregnancy tracking, birth plan, personal support and assistance to pregnant women such as escorting them to health facilities.

4.1.3 Efficiency

Harmonization with Other Development Partners

Under the FOURmula One (Health Sector Reform Agenda) and based on the discussion on the MCH program with other development partners (UNFPA, UNICEF, WHO, EU, GTZ), JICA designed and developed the project. Even before the Project launching, JICA and other development partner assisted DOH to develop the BEmOC training module in 2005 as a national training program. Training tools were provided to the Febella hospital in Manila as one of the national training centers. Established BEmOC training program as national standard enabled the Project to start the immediate and smooth activities right after the launching.

4.1.4 Impact

1) Prospect of Achievement of Overall Goal as Expected Positive Impacts

As discussed in 3.1.5, there is slow but steady increase in facility-based delivery and skilled birth attendance at the national level. To achieve the national goal of 80 percent facility-based deliveries, intensified nationwide implementation of MNCHN strategy (A.O. 2008-0029) is required. Even though it is widely accepted that MDG 4 (reduction of infant mortality rate by 2/3) and MDG 5 (reduction of maternal mortality ratio by 3/4) may not be achieved by 2015[7], reduction of risks Filipino mothers and their newborns by means of comprehensive maternal and child health package may contribute to decreased mortalities.

Indicators could not tell that the overall goal can be achieved within the three years after the Project termination. The project provided good practices in both project sites, improving mother and family health status, which will influence the national MCH program.

2) Positive Impacts

Good practices such as WHT, AYOD community health teams, Family Health Diary, were taken up by the CHDs (Region VIII and CAR) and were expanded to the other areas outside target Project areas. For example, officers of the Mountain Province in CAR who were inspired by the successful implementation of AYOD in Ifugao Province launched their own WHT in 2008.

3) Negative Impacts

No negative impact has been observed.

4.1.5 Sustainability

1) Political aspect

Political commitment at all levels towards achieving MDGs on maternal and infant deaths is likely to be sustained irrespective of administration changes. Some concerns remain regarding continuing commitment and support to MNCHN programs by the LGUs if there is change in political leaderships.

2) Organizational Aspect

The Project was implemented by the existing local health system at region and

[7] Page 1, A.O. 2008-0029.

province levels. Through the implementation of the Project to provide the quality MNCHN services, coordination mechanism of stakeholders became functional, and the capacity of the respective members engaged in the Project was enhanced for coordination of complex structure of DOH-CHD-PHO-public health service providers-community as well as the LGUs.

At the moment of the Project terminal evaluation, this integrated mechanism is effectively working. The mechanism will be sustainable with the encouragement from DOH central.

3) Financial Aspect

As for the financial sustainability, the Public Health Development Program Fund (PHDPF) and "Health Facilities Enhancement Program" budget of DOH are expected to add a major capital contribution to implement the PIPH (2005~2010), and significantly boost the expansion and upgrading of facilities and equipment.

PhilHealth MCP reimbursement and user fees, if enforced appropriately, would contribute to sustaining operation and maintenance of facilities and motivating health workers and communities.

4) Technical Aspect

Knowledge and skills required to provide MNCHN service package were well standardized in the training modules (BEmONC, CMMNC and LSS), and proven effective in the rural settings of the Philippines. Technical sustainability will be high with systematic implementation of continuous re-training and supportive supervision by PHOs/CHDs.

4.1.6 Promoting and Inhibiting Factors

1) Promoting factors

Integrated coordination mechanism of complex stakeholders can be considered as one of the promoting factors of the project success. There are two important players, namely health care providers and political leaders. Coordination of these two players made synergetic effects and maximized outcomes.

Regarding the LGU side, the Project activities have been promoted by various political commitments. Their most outstanding commitment is adoption of political decisions as follows.

- **Biliran Provincial Resolution No.166:** Regulating the practice of trained birth

attendants on safe motherhood/maternal and child health program of the province Biliran, in August 2006.

- **Almeria Municipal Resolution Order No.15, S-2007**: Prescribing the rate on service charges rendered by the RHU of Almeria maternity care and child health clinic and mandating further that the income generated by its service charge shall accrue to a trust fund to be devoted solely to the maternity clinic operations and incentives to women's health team in municipality, in February 2007. Other seven municipalities in Biliran also adopted the same regulation in 2007
- **Ifugao Provincial Executive Order No.22**: Ameding executive order No. 19 on organization of community health teams to be known as Ifugao AYOD community health team and institutionalizing the same all over the provinces, in April 2008. The Ifugao province made amendment of the executive order again in 2009 to include the strengthening maternal and child care services based on lesson learned from the project experiences.
- **Brangay Resolutions**: Two barangay governments in Alfonso Lista municipality, namely San Marcos and Pinto, adopted the resolution on encouragement of facility deliveries in 2009. In addition, Alfonso Lista municipality is preparing the municipal resolution which is expected to be adopted by the end of October 2009.

It can be said that the successful project achievements triggered those political commitments in LGUs in target areas.

2) Inhibiting factors

In the municipalities where the increase of SBA-assisted deliveries and facility-based deliveries were not significant (See Annex 12), there was frequent change of health workers at the district hospitals, RHUs and BHSs. The reasons for such change were i) resignation of doctors and nurses due to personal reasons, ii) non-rehiring of contractual midwives by LGUs, or iii) regular shuffling of staff within a LGU[8]. Opportunities for strengthened liaison with the communities and monitoring of the WHTs were missed by short-term assignment of health workers in the same community. Attrition of trained workers also means that acquired skills for sustained BEmONC service delivery are lost unless the newly posted workers are provided with training. Concerns were expressed by some LGUs officers that non-regular health workers may not be able to have training opportunities. The short-term retention of health workers in addition to shortage of absolute number of them lessened the effectiveness of the Project.

4.2 Conclusion

In general, the Project accomplished its objectives. It is acknowledged as an effective translation of MNCHN policy into practice. Various good practices produced in the

[8] In AMADHS ILHZ of Ifugao Province, out of 33 SBAs trained since 2006, 10 SBAs were no longer working in the target area; Two doctors were transferred, five resigned, two nurses went abroad, and one midwife was not awarded renewed contract.

target areas were disseminated nationwide. Considering that high sustainability can be expected, the Evaluation Team concluded the Project can be successfully terminated as planned.

5 Recommendations and Lessons Learned

5.1 Recommendations

The Team recommends the followings towards improvement of quality of services, and sustainability of activities after the project termination.

1) Governance

   To LGU Executives: Continuous political supports are urged to sustain the Project outcomes in LGUs. Even if the executives are changed the supports should be taken over by new administration.

2) Service delivery

   To LGU Executives: To provide effective services and create closer relationship with community, it is recommended LGUs make efforts to recruit midwives, preferably from the assigned community. Furthermore, assigning one midwife per BHS is desirable.

   To PHOs and MHOs: Maintaining facility and equipment is essential for keeping better EmONC services. To do so, maintenance systems should be established under the supervisions of PHOs from the technical and financial view points.

   Increasing facility-based deliveries were successfully achieved, but more attention should be paid to enhancing other MNCHN services, such as promotion of prenatal care, postnatal care, nutrition and family planning.

   To DOH and CHDs: For strengthening the monitoring and evaluation function, existing tools, such as FHSIS and TCL, should be improved and effectively utilized. The process of data collection and analysis at BHSs and RHUs and compilation at PHOs should be supervised, and appropriate and timely feedback should be provided when the weakness is found in order to formulate better evidence-based action plans.

   To PHOs and CHDs: Regarding maternal death reviews, even though it was strengthened in the Project target areas, there still remains some weakness in the following aspects: holding a quick review session, documentation of medical

records and the findings, and feedback of the results to community members.

The Evaluation Team recommends PHOs with the CHD technical assistance enforce the DOH procedure of MDR thoroughly and utilize the analysis for continuous improvement of services to prevent further maternal mortality.

3) Finance

To CHDs: One of the important strategies the Project took was promoting MCP accreditation of facilities and health personnel under the PhilHealth scheme in order to accelerate access to better facility based-services, including prenatal care, delivery and newborn care. However, at this evaluation moment women and even health facility staffs were not enough aware of the benefits, and the utilization rate was quite low in the target sites. There might be fundamental problems behind such circumstances. Thus, it is recommended that CHDs with DOH assistance should conduct a study to explore reasons for low usage of PhilHealth MCP (See Annex 13 for details).

To PhilHealth: PhilHealth offices are strongly recommended, i) to raise awareness of health workers and communities about PhilHealth membership and MCP benefits, ii) to facilitate MCP claims to be made by health facilities, iii) to fast-track reimbursement procedures for RHUs and BHSs.

To LGUs: To increase MCP utilization, sustained enrollment of indigent families in PhilHealth needs to be ensured by LGUs.

To sustain and encourage the activities by community actors, especially WHT/AYOD members, some kinds of compensation for transportation expenses related to WHT activities should be taken into consideration.

5.2 Lessons learned

Through the experiences of the Project, active involvement of LGUs in project implementation was proved effective in mainstreaming the maternal and child health in local development agenda.

Rigorous interaction and mutual learning by health officers at all levels streamlined local health service deliveries responding to community needs in a consistent manner with the national strategy.

Under the decentralized health systems of the Philippines, a project which aims at improvement of health status of the rural population should be designed taking into consideration coordination of multi-layer and multi-sector stakeholders.