USAID/PHILIPPINES HEALTH PORTFOLIO EVALUATION

August 2016

This publication was produced at the request of the U.S. Agency for International Development. It was prepared independently by Constance Carrino, Ph.D., Dr. Fabio Luelmo, Dr. Esperanza A. Icasas-Cabral, Ms. Eleanora de Guzman, Governor Victor E. Agbayani and Elma Laguna, Ph.D.
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Any errors and omissions are, of course, our own.

Cover photo: Using a USAID-developed community health worker’s tool kit, a community health worker visits a household in a conflict-affected village in Basilan to discuss maternal and child health with a mother. Source: Resurreccion/Jhpiego
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August 2016
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<th>Description</th>
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<tr>
<td>4Ps</td>
<td><em>Pantawid Pamilyang Pilipino</em> Program</td>
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<td>ARMM</td>
<td>Autonomous Region in Muslim Mindanao</td>
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<tr>
<td>BEmONC</td>
<td>Basic emergency obstetric and newborn care</td>
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<td>BEST</td>
<td>Best Practices at Scale for the Home, Community and Facilities</td>
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<td>BHW</td>
<td>Barangay health worker</td>
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<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<td>CDACS</td>
<td>Country Development Cooperation Strategy</td>
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<td>CHANGE</td>
<td>Communication for Health Advancement through Networking and Governance Enhancement Project</td>
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<td>CHT</td>
<td>Community Health Teams</td>
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<td>CMSU</td>
<td>Community Maternal, Neonatal, Child Health and Nutrition Scale Up Project</td>
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<tr>
<td>CSO</td>
<td>Civil society organization</td>
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<tr>
<td>DO</td>
<td>Development objective</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DOH-RO</td>
<td>Department of Health regional office</td>
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<td>EU</td>
<td>European Union</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>FHSIS</td>
<td>Field Health Surveillance and Information System</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FP2020</td>
<td>Family Planning 2020</td>
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<td>FPCBT</td>
<td>Family planning competency-based training</td>
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<tr>
<td>Hi-5</td>
<td>Universal Health Care High-Impact Five Plan</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HLGP</td>
<td>Health Leadership and Governance Project</td>
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<td>HPDP</td>
<td>Health Policy Development Program</td>
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<tr>
<td>ID</td>
<td>Infectious disease</td>
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<td>IMPACT</td>
<td>Innovations and Multisectoral Partnerships to Achieve Control of TB</td>
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<tr>
<td>IPC/C</td>
<td>Interpersonal communication and counseling</td>
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<td>IR</td>
<td>Intermediate result</td>
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<td>IUD</td>
<td>Intrauterine device</td>
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<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<tr>
<td>LAM</td>
<td>Lactational amenorrhea method</td>
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<tr>
<td>LAPM</td>
<td>Long-acting and permanent methods</td>
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<tr>
<td>LARC</td>
<td>Long acting reversible contraceptives</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, gay, bisexual and transgender</td>
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<tr>
<td>LGU</td>
<td>Local Government Unit</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<tr>
<td>MCHIP</td>
<td>Maternal and Child Health Integrated Program</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>mCPR</td>
<td>Modern contraceptive prevalence rate</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MDR-TB</td>
<td>Multidrug-resistant TB</td>
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<td>MMR</td>
<td>Maternal mortality ratio</td>
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<tr>
<td>MNCHN/FP</td>
<td>Maternal Neonatal, Child Health, Nutrition and Family Planning Project</td>
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<tr>
<td>NDHS</td>
<td>National Demographic and Health Survey</td>
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<td>NGO</td>
<td>Non-governmental organization</td>
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<td>NHTS PR</td>
<td>National Household Targeting System for Poverty Reduction</td>
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<td>NIT</td>
<td>National Implementation Team</td>
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<td>NTP</td>
<td>National TB Control Program</td>
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<tr>
<td>PhilHealth</td>
<td>Expanded National Health Insurance Program</td>
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<td>PhilPACT</td>
<td>Philippine Plan of Action to Control TB</td>
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<td>PopCom</td>
<td>Commission on Population</td>
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<tr>
<td>PRISM</td>
<td>Private Sector Mobilization for Family Health Project</td>
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<tr>
<td>PSA</td>
<td>Philippine Statistics Authority</td>
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<td>PSPI</td>
<td>Population Services Pilipinas, Inc.</td>
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<tr>
<td>RA</td>
<td>Republic Act</td>
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<tr>
<td>RH</td>
<td>Reproductive health</td>
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<td>RHU</td>
<td>Rural Health Unit</td>
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<td>RPRH</td>
<td>Responsible Parenthood and Reproductive Health Act</td>
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<tr>
<td>SDN</td>
<td>Service Delivery Network</td>
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<tr>
<td>SIAPS</td>
<td>Systems for Improved Access to Pharmaceuticals and Services</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TB-DOTS</td>
<td>Tuberculosis Directly Observed Treatment Short-course</td>
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<tr>
<td>TFR</td>
<td>Total fertility rate</td>
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<tr>
<td>UHC</td>
<td>Universal Health Care (also known as Universal Health Coverage)</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UPecon</td>
<td>University of the Philippines Economic Foundation</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>XDR-TB</td>
<td>Extensively drug-resistant TB</td>
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<td>ZFF</td>
<td>Zuellig Family Foundation</td>
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EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The U.S. Agency for International Development in the Philippines (USAID/Philippines) contracted for an independent team of health and policy experts to conduct a portfolio-wide evaluation of its assistance in health. The evaluation comes as USAID begins to develop its strategy for future engagement in the health sector in the Philippines. It coincides with elections for a new president and comes as health budgets continue to grow and increasing numbers of low-income families are being covered by social insurance. There is also both fluidity and some clarity in legislative intentions in the fields of reproductive health, tuberculosis (TB) and HIV at this time.

The evaluation covers projects in maternal, neonatal and child health and nutrition, and family planning (MNCHN/FP), infectious diseases (ID), with an emphasis on tuberculosis (TB) and, more recently, multidrug-resistant TB (MDR-TB), and crosscutting projects in policy, governance and communication. The expectation is that this higher-level look at the entire portfolio will widen USAID’s options for consideration as it plans for new programs and engagements.

Evaluation questions cover the portfolio’s relevance, best practices, strategic implementation, sustainability, institutionalization and USAID’s comparative advantages. They are:

1. Were the two major projects in the portfolio—MNCHN/FP and ID—relevant to the challenges identified in the design of the current USAID health strategy and the results of the evaluations completed under the previous project cycle? Are they relevant to current developments in the health sector? Why or why not?
2. What are the best practices or interventions emanating from the portfolio as a whole? What interventions are not working? Why not?
3. Is the portfolio implemented in a strategic manner? Why or why not?
4. Are the institutionalization and sustainability objectives of the MNCHN/FP and ID projects being met? Why or why not?
5. What are USAID’s comparative advantages in health in comparison to other donors, private sector and civil society, vis-à-vis local and national government?

The evaluation team answers the questions within the Findings section of this report and based on those answers, provides a series of conclusions and recommendations for USAID.

PROJECT BACKGROUND

USAID/Philippines’ health goal is to improve family health through increased utilization of health services, to be accomplished by: (1) increased access to and availability of integrated health services (supply), (2) strengthened demand for services and (3) improved policies and systems for health.

The health portfolio currently comprises two five-year projects—MNCHN/FP and ID (mainly dedicated to TB)—and three crosscutting activities focused on health policy, governance and communication.

The MNCHN/FP project supports region-wide service delivery agreements in Luzon, Visayas and Mindanao, covering provinces and cities/municipalities with large unmet need for FP and high maternal mortality, with a life-of-project budget of approximately $107.1 million. A grant to the Integrated Midwives Association of the Philippines, Inc., recently ended, and field support from the Maternal and Child Health Integrated Program (MCHIP) and USAID’s Private Sector Mobilization for Family Health 2 (PRISM2) ended in 2014.
The ID project covers selected provinces nationwide with a service delivery activity—Innovations and Multisectoral Partnerships to Achieve Control of Tuberculosis (IMPACT)—that targets high TB-burden areas, and two supporting agreements, Systems for Improved Access to Pharmaceuticals and Services (SIAPS) and Promoting the Quality of Medicines. There is technical assistance provided to the National TB Program through an Umbrella grant in the Global Health Bureau. In December 2015, a cooperative agreement: Reaching Out to Most-at-Risk Populations (ROMP) ended. The total budget for this project is approximately $40.1 million.

The three crosscutting activities—Health Policy Development Program 2 (HPDP2), Health Leadership and Governance Project (HLGP), and Communication for Health Advancement through Networking and Governance Enhancement (CHANGE)—support the goal of the portfolio, and work with the service delivery activities both directly and indirectly. Their budgets total approximately $36.8 million.

The agreements that make up the health portfolio total approximately $224.1 million and are scheduled to end between 2016 and 2018, depending on the agreement.

**EVALUATION DESIGN, METHODS AND LIMITATIONS**

This evaluation began with a document, data and literature review and briefings from the USAID cooperating agencies implementing the projects that make up the portfolio. The evaluation team held interviews and focus group discussions (FGDs) with clients and health, government and donor stakeholders at the national, regional and local levels, and it asked USAID cooperating agencies to answer a few questions in writing.

Discussions were held in Metro Manila with various parts of the Department of Health (DOH) and donor representatives at headquarters, as well as health experts. Evaluation team members attended key policy, TB and communication meetings held during the evaluation. They conducted field visits in Luzon, Visayas, and Mindanao, where they interviewed representatives of local government units (LGUs), the DOH, Philippine Health Insurance Corp. (PhilHealth), Commission on Population (PopCom), private facilities, private practitioners and donor representatives in the field. The team held FGDs with young women who are FP acceptors, women of reproductive age who are not FP acceptors, husbands who received reproductive health counseling, and community health workers involved in TB. Open-ended discussions were held with medical health officers, nurses, midwives and community health workers. Instruments for interviews, FGDs and group discussions were used in the field. The evaluators visited facilities and reviewed service delivery data. Project cooperating agencies provided answers to a series of questions asking what was working in the portfolio and what was not, and projects were asked to characterize USAID’s comparative advantages. The evaluation team reviewed findings on a regular basis and held team discussions concerning the policy context and challenges facing the health system.

Four hundred sixty-six respondents provided input, including 194 individuals who participated in 28 FGDs. The team conducted this work from February 26 to April 21, 2016.

The evaluation team was led by Constance Carrino, Ph.D., and included Dr. Fabio Luelmo, Dr. Esperanza A. Icasas-Cabral, Ms. Eleanora de Guzman, Governor Victor E. Agbayani and Elma Laguna, Ph.D. Five researchers, under the direction of Dr. Laguna, assisted in the conduct of field research, and one logistics specialist assisted the entire team.

**FINDINGS**

**Relevance when designed?**

Were the two major projects relevant to the challenges identified in the current USAID health strategy and the evaluations completed under the previous project cycle? The evaluators found that they were.
The two flagship projects were designed in 2012, when DOH budgets were increasing after a long period of being flatlined (PhP18B in 2008; PhP 42B in 2012), PhilHealth was increasing coverage for the poor, couple-years of protection were virtually flat with some increase in the use of pills over intrauterine devices (IUDs), maternal mortality was too high to meet United Nations (UN) Millennium Development Goals (MDGs), the country was in the top 10 countries for TB burden, and HIV rates were low but increasing.

Recent and upcoming policy issues affecting health programs in 2012 included the passage and rollout of the Responsible Parenthood and Reproductive Health (RPRH) Act of 2012, increased leniency for midwives to provide lifesaving drugs (2010), the Cheaper Medicines Act that reduced the price of branded drugs and opened the door for more generics (2008), lifting of the ban on drug donations (2010), and the soon-to-be-passed “sin tax” that would bring tax revenue into the public sector health budget. A Joint TB Program Review in 2013 advanced the WHO recommendations (mainly regarding rapid diagnostic tests), and a midterm evaluation of the Plan of Action 2010-2016 contributed to the information and policy base. The 2012 USAID/Philippines: Performance Evaluation of the Family Planning and Maternal and Child Health Portfolio and the 2012 USAID/Philippines: External Evaluation of the Tuberculosis Portfolio contributed to a design that continued support for MNCHN/FP and TB service delivery.

Both the MNCHN/FP and ID projects were focused on demand, quality and access to services, and were closely aligned with national strategies that were giving special attention to the expansion of PhilHealth services for the poor. Had the windfall of funding from the sin tax been anticipated, both the DOH and USAID might have moved more into initiatives to improve the management systems within the DOH, PhilHealth and LGUs; however, on balance, the portfolio was relevant to the information considered by USAID and USAID’s field experience at the time.

**Relevance in 2016?**

In its present configuration, the health portfolio strategy is not relevant in 2016. Health budgets continue to rise (PhP 83.7B in 2014, PhP 86.0B in 2015, PhP 122.0B in 2016), assisted by funds made available by the sin tax, and PhilHealth continues to expand services, with different levels of progress. Learning to spend has been a challenge; for the last five years, the DOH returned funds to the National Treasury. Evidence that the poor can be served through social insurance is mounting. In 2015, over PhP12 billion was paid out by PhilHealth covering more than a million claims for the six reproductive health packages offered.

Key TB and HIV policies are in flux. The WHO-recommended nine-month regimen for MDR-TB and the general use of the rapid GeneXpert test for identifying TB or MDR-TB, which eliminated the need for TB Diagnostic Committees, are expected to result from a new TB law signed by President Aquino in April 2016. In December 2015, the White House announcement addressing “the core domestic and global challenges posed by MDR-TB and extensively drug-resistant TB (XDR-TB)” lists the Philippines as a priority country. In HIV, DOH is expected to accept a test-and-treat policy for HIV as part of a new

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3. Continuing appropriations that lapse are eventually returned to the National Treasury. The DOH has had to return an average of PhP 1 billion per year from 2011 to 2013. In 2014, the DOH returned P 400 million in unspent funds.

HIV strategy to be developed this fall and expected to be unveiled as early as December 2016.5 A ramp-up of work in these ID areas will be necessary.

More broadly, the public health system has an outdated supply chain system for medicines and commodities, poor data management systems and data utilization, and dependence on outside training. USAID’s work under the present portfolio has helped define the extent of these weaknesses at the regional level and provides assistance to the DOH to develop alerts for stock-outs, link providers with PhilHealth, collect field data and train DOH personnel in state-of-the-art MCH, FP and TB interventions until DOH systems can be strengthened and institutionalized, which needs to occur. A more relevant approach for the coming years, especially considering USAID’s very long field-level expertise in these areas, would be to move from a support function assisting with workarounds toward assistance that strengthens the systems themselves and institutionalizes training.

Maternal mortality, TB, MDR-TB and HIV remain critical challenges. While a more sustainable, systems-strengthening approach is suggested, USAID experience in policy development, system strengthening, communication, technical leadership, management and how to deliver services remains relevant to future health system needs. Highlights of that experience from the present portfolio in a discussion of what is working and what challenges are being faced are discussed below.

What is working?

USAID implementing partners include a large number of talented and experienced individuals and trusted organizations. USAID’s support for the DOH’s efforts to meet health objectives focuses on direct partnering with the DOH on training and service delivery at the facility and community levels, as well as the expansion of services in the private sector, e.g., midwives, TB doctors. The evaluation team defined “what worked” as how the portfolio met its intended outcomes, including the expectation that projects would develop approaches to service delivery that showed potential for scale-up. Important issues related to sustainability and the institutionalization of DOH training are discussed in a separate section below.

At the site level, the number of acceptors of permanent FP methods increased, as did the number of facility-based deliveries and TB case detection rates.

Based on evidence from the project reports, site visits and discussions with stakeholders and beneficiaries, there are numerous signs of success and possibility of replication. Highlights in the present portfolio span a wide range of activities. In MNCH/FP, the highlights are:

- Integration of FP into antenatal care
- Training to expand state-of-the-art skills, including emergency obstetrical and neonatal care, and long-acting and permanent FP methods
- MNCHN/FP follow-up on training, especially in areas where DOH programs did not have the staff to reach
- Various well-thought-out programs for adolescents, young mothers and young parents in hospital settings
- A mentoring program by midwives for midwives that has increased the number of midwives trained
- Promising initial assistance in the creation of Service Delivery Networks (SDNs)

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5 This schedule may change, but it is what was envisioned by the Country Coordinating Mechanism at the time of this evaluation.
Collaboration with the DOH and others on background research and drafting of the Implementing Rules and Regulations of the RPRH law

On the TB side, there is:
- Increased detection of patients with symptoms to undergo microscopy
- Integrated TB communication/mass media social mobilization, credited by facility-based providers, patients and others interviewed as reducing stigma and bringing more people in for testing
- Stable treatment and cure rates for TB, despite the increased incidence
- Local policy advocacy on TB to reinforce active case-finding and continued treatment
- Collaboration with the DOH on background research and drafting of the TB law approved in April 2016, which includes laboratory services and TB drugs for patients, regulation of TB drug sales, and mandatory notification

Overall highlights for the entire portfolio include:
- Training for public and private providers that has led to PhilHealth certification and accreditation of public and private health facilities
- Leadership training and tools: joint work with political leaders and their health counterparts and the health dashboard for LGU leaders to track progress
- Initial work on pharmaceutical systems and assisting with quality assurance
- Expansion of access to FP/MNCHN and TB services through the private sector

What is not working, and why?

The evaluation team defined “what did not work” as project interventions that were not adequately designed or implemented, and includes existing public-sector personnel structures on which the evaluators find USAID initiatives cannot rely.

Implementation challenges for both MNCHN/FP and ID projects include:
- Community Health Teams (CHTs) were established in 2011 as a component of the DOH’s “Big Push” to accelerate the achievement of the MDGs. USAID set out to strengthen them and use them for demand generation and referrals within the MNCHN/FP and ID projects. Two in-depth studies found that CHTs were not functioning: In 2013, the DOH revealed many weaknesses in the CHT system, and a subsequent evaluation by LuzonHealth and DHO Region II corroborated the findings. In 2015, as the DOH shifted to the UHC High Impact Five (Hi-5) Plan, the new Secretary acted upon these assessments by defunding the CHTs in favor of establishing a cadre of “public health assistants” and “UHC implementers” composed mainly of underboard nurses and doctors. Local areas that wish to continue using the CHT model will need LGU support.

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6 Reduction of duration of MDR treatment is not mentioned in the law, although it may be included in the new Comprehensive Plan of Action.

7 Weaknesses included ineffective training, teams with only a single member, poor utilization of information collected by CHTs about communities, and some technical requirements beyond the capabilities of team members.

8 The Hi-5 high-impact UHC interventions include maternal care, infant care, child care, HIV/AIDS, and SDNs. An SDN, as defined by the RPRH law, refers to the network of health facilities and providers within a province or city health system, organized by the LGU in coordination with the DOH to offer core packages of services to priority populations in an integrated manner. DOH. Guidelines for Establishing Service Delivery Networks. www.doh.gov.ph. MindanaoHealth reports using an SDN model that can cross LGU lines.
Implementation challenges on the MNCHN/FP side include:

- Too many groups are identifying unmet need for FP, and linkages between this identification and service delivery is weak. PopCom was tasked with identifying unmet need, USAID service delivery projects tried their own approaches and developed their own tools, and, in a few areas, civil society organizations (CSOs) use some of the same barangay health workers (BHWs) to identify potential clients for their own programs. This compartmentalization is inefficient.

- More importantly, there are thousands of potential clients informed and involved through a variety of demand-generation activities, including Usapan sessions, but no causal links to services or way to track whether the activities work to improve knowledge, attitudes and practices. The portfolio lacks a process to understand the effectiveness of interpersonal communication and counseling (IPC/C) activities and how they relate to the uptake of services.

- Unlike the TB case discussed above, to date, MNCHN/FP national communication campaigns are not very effective. Mass media messages did not communicate information on available methods or the availability of services; print materials developed for health facilities and communities were not linked to the mass media campaigns, and in many cases, service projects are using old off-the-shelf materials.

- Exclusive breastfeeding promotion has been very difficult, due to the inability to track exclusivity despite breastfeeding support groups, women’s role in the workforce, and cultural mores that do support breastfeeding, but not for six months.

Challenges in TB:

- Detection of infectious cases is weakened because facility protocols generally do not focus on all patients entering a facility with a cough, there are low levels of microscopy testing despite an existing laboratory network, and there is little use of Xpert testing to identify additional pulmonary cases and confirm TB in persons with signs such as abnormal X-rays.

- Active TB community case-finding is compromised because frontline BHWs lack incentives and adequate supervision and are overloaded with information, much of which is not necessary for active case-finding. (Moving this role to public school teachers is being tested.)

- For MDR-TB, the current 24-month treatment regimen causes a large proportion of patients to abandon treatment.

**Is the portfolio implemented in a strategic manner?**

USAID’s strategy to partner with the DOH in the field and assist with policy development, while helping to introduce new approaches to MNCHN/FP and TB programs, continues well through implementation of the entire portfolio. Highlights of the relationship include a technical relationship that led to research to shorten the MDR-TB treatment and introduce the change through the new TB law, and the USAID and DOH’s ability to weather the temporary restraining order that pulled implants from DOH shelves and led to informal referrals of clients to private sector sources.

However, in some ways, the portfolio is not implemented in a strategic manner. For example, the three regional MNCHN/FP activities and the TB service delivery activities are not managed to collaborate with

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9 Usapan sessions are group discussions on FP or other MNCHN topics led by a trained facilitator using the GATHER approach of “Greet, Ask, Tell, Help, Explain, Repeat/Recommend,” which is designed to increase interaction between providers and clients with unmet need and help the latter arrive at a decision to accept FP/MCH practices.

10 Subsequent to this evaluation, a TV campaign was launched after the May 2016 election that refers to specific methods and includes testimonials by users. CHANGE tracking reports show the TV spot reaching 74 percent of its target audience. CHANGE has print materials developed for health facilities and communities that are linked to the TV messages. Coordination with the three regional FP/MNCHN activities was not evident during the evaluation.
the leadership development work of the Health Leadership and Governance Project (HLGP) when operating in the same political and geographic space. Design and implementation of these activities are not integrated, and synergies are not found. Such integration could improve LGU absorption and institutionalization of the service delivery. For the MNCHN activities, integration at the local level in areas such as demand generation is especially difficult due to the large number of technical objectives and provinces these activities are trying to cover.

**Sustainability and institutionalization**

Experience indicates that moving toward sustainability was easiest within the private sector in both the MNCHN/FP and ID projects (e.g., private midwives and private practitioners), but that large or motivated public and private facilities, and even smaller facilities with strong networking skills, should be able to absorb the USAID investments and continue without further assistance. Yet regional and facility beneficiaries do not feel any urgency to continue without assistance from the USAID projects, and USAID project monitoring continues to focus on indicator tracking and not measures of progress toward sustainability.

At the national level, the DOH is identifying what could be important priorities for institutionalization (e.g., training, tracking field resources), and other needs are apparent, such as strengthening the supply chain, data management and utilization. In the present portfolio, USAID’s work on supply chain and data management and utilization has focused on stop-gap assistance measures to bolster weak systems, but both systems need to meet the increased coverage expected to come with higher budget levels and the expansion of social insurance.

**USAID’s comparative advantage**

The evaluation team asked what comparative advantages USAID had that could assist the health sector in the Philippines. Respondents from government, cooperating agencies and donors tended to begin by saying that FP and the National Demographic and Health Survey (NDHS) are USAID strengths and important comparative advantages. They are also USAID’s longest-running health activities. Within the TB community, USAID and its partners are respected for what they have accomplished (e.g., expanding DOTS to private sector providers, national and regional policy development) and considered to be very much needed. Both within and outside of the DOH, USAID is seen as having a strong working relationship with the DOH.

Government and beneficiaries said USAID is good at training and the development of training documentation and protocols, preparation of policy guidelines and assistance in policy development, field-level operations research, behavior change communication, experience with the transfer of technology and with the private sector.

Operationally, respondents noted that USAID had the ability to work with the private sector, the technical capacity to address complicated systems and diseases, expertise in developing programs at the national, regional and local levels, the capacity to train national trainers on monitoring and evaluation (M&E) and data for decision-making, and the ability to respond rapidly at the program level.

Respondents within and outside of USAID noted that the health sector has a strong partner group, and that the country has an effective Global Fund Country Coordinating Mechanism (CCM). While the evaluation schedule did not overlap with meetings of either group, interviews with individual donor representatives regarding health assistance indicate that, generally, the UN agencies and the European Union favor assistance that strengthens systems, noting that the Philippines falls in the World Bank’s lower middle income category, obviating the need for direct service delivery except in cases of disease outbreaks or natural disasters. The UN agencies expect to continue their work in emergency services and commodities and HIV, and will have a consolidated effort in Mindanao. Japan International Cooperation Agency (JICA) and the Korea International Cooperation Agency are involved with public-
private partnerships, and JICA continues its work in MCH training. Continued Global Fund support for HIV and TB is expected. USAID is seen as a good partner that can bring added value and resources to shared objectives.

The challenge for the coming years will be to combine USAID’s many comparative advantages in concert with those of government and other donors to develop a portfolio that is relevant to the systemic needs of the public sector during this period of increased budgets, and to meet the sustainability and institutionalization objectives of USAID’s assistance program. The following conclusions and recommendations are offered as an avenue to meet that challenge.

**CONCLUSIONS AND RECOMMENDATIONS**

Key elements of the conclusions and recommendations, some of which could begin before the end of the present set of portfolio agreements, are summarized as follows:

- **DOH systems strengthening in data, supply chain and training**: Given the enhanced policy and budgetary environment the DOH enjoys the gaps evident in the public sector supply chain, data management and utilization system, and the DOH’s ability to reach LGUs with technical systems and leadership training, this would be an opportune time to reposition USAID’s portfolio from being an extension of DOH services and training to one that partners with the DOH to strengthen government systems and develop the systems needed to contract out for technical services. Work on these initiatives will require development of or improvements in DOH procurement mechanisms to engage third-party technical assistance and training.

- **PhilHealth** is an integral part of moving toward universal health care (UHC) in the Philippines. USAID has enabled facilities and individuals to enter the PhilHealth system, and despite policies aimed at meeting the needs of the poor and an exemplary showing, PhilHealth experience in moving social insurance to clients in a decentralized health system demonstrates a need for better clarity and evidence-based expansion of the packages. USAID is well positioned to explore a direct working partnerships with PhilHealth at both the national and regional levels, focused on increasing access to quality MNCHN/FP and ID packages, and better linking of PhilHealth and providers at regional and local levels.

- **Policy development**: The University of the Philippines Economic Foundation (UPecon) and others have helped developed laws and guidance and conducted studies on a wide range of topics, the Zuellig Family Foundation (ZFF) program has raised awareness and skills among LGU leaders to address health issues and track progress, and both the ID and MNCHN/FP projects have contributed to policy development. This work needs to be conducted under a unified strategy, especially if it is going to ensure that the health sector has the approaches and skill set necessary to address future policy challenges. USAID will need an in-house leader responsible for the strategic direction, design and management of all policy activities in the portfolio. Recommended policy activities for the future include: capacitating the DOH’s Health Policy Development and Planning Bureau; improving the flow of information about government policies (especially those of PhilHealth); tapping CSOs, the media and other institutions to improve accountability of government or as a watchdog for the private sector; and a plan for policy analysis for specific audiences that addresses timely issues, based on USAID’s experience at the national and regional levels, such as health services and rights of minors, women’s health as a human right, and role of medicines in UHC.

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11 The 2012 concept note for the Global Fund TB grant is clearly delineated and calls for 78 percent of the grant to be used for MDR-TB.
- **Reproductive health (MNCHN/FP):** As USAID continues to support implementation of the RPRH law, it is important to move away from complementing DOH training and service delivery and toward more institutionalization and systems strengthening within the public sector (e.g., MNCHN training). In FP, where USAID’s work began in the 1960s and is still highly respected, it is now important to step away from “filling the gaps” in the public sector program and choose a few, discrete, time-limited operational research/demonstration activities in MNCHN/FP at the regional level and below. Examples of such activities include support for the expansion of sustainable FP services in the private sector, or clinic- or school-based adolescent programs for teens, or even an operations research program for FP innovations. Additionally, for a very limited number of service delivery activities in high-need areas, locally based planning with LGUs and coordination with policy development initiatives operating at the local level should be considered.

- **Tuberculosis:** The new TB law and subsequent strategy are expected to significantly update programmatic and technological approaches to TB and MDR-TB control, and the new White House plan for MDR-TB, which includes an international component (albeit unfunded), USAID is well positioned to assist the National TB Program (NTP) to expand integrated access to TB care, the use of rapid tests for diagnosis, mandatory notification, quality communication programs and shorter treatment of MDR-TB. USAID could assist with the establishment of a national managerial team, training NTP staff and TB-DOTS providers (including laboratories), operational research and programming for co-morbidities.

- **Autonomous Region in Muslim Mindanao (ARMM):** MindanaoHealth, IMPACT, and HLG are providing ARMM with training and service support for basic emergency obstetric and newborn care (BEmONC), essential intrapartum and newborn care, breastfeeding, TB, FP, data management, and leadership training. These USAID projects have worked effectively with political, medical officers and populations in the region to bring in lifesaving neonatal and delivery approaches. Given the region’s difficult geography and political volatility, and the fact that ARMM has some of the worst education and health indicators nationwide, this work should continue, with possible enhancements such as assistance in acute respiratory infections (ARI) and water, sanitation and hygiene. Recently, the UN developed a convergent strategy in Mindanao and expects to co-locate UN agencies there soon. USAID should consider a focused, integrated program for ARMM, and, of course, coordinate with UN counterparts.

- **HIV:** The rate of HIV continues to increase, and the DOH is being well served by international experts and their own HIV Centers around the country. Given its successful experience internationally and in the Philippines with programs that reach out to high-risk groups, USAID should offer the DOH and UNAIDS technical assistance in preparing the national HIV plan, and consider with other stakeholders the desirability of further USAID advice and support to implement the plan.
1. INTRODUCTION

EVALUATION PURPOSE

This evaluation is intended to answer key program-wide questions about USAID/Philippines’ Health Portfolio, made up of two five-year service delivery projects—Maternal Neonatal, Child Health, Nutrition and Family Planning (MNCHN/FP) and Infectious Disease (ID), which presently focuses on tuberculosis (TB)—as well as three crosscutting projects focused on health policy, governance and communication. USAID/Philippines is the primary audience for this evaluation; other stakeholders within USAID, the Philippines Department of Health (DOH) and the USAID partner community may find it useful.

USAID/Philippines decided to conduct a program evaluation instead of project- or agreement-specific evaluations to take stock of the relevance of its overall strategy, investigate issues of institutionalization and sustainability, and see trends across projects in terms of what is working well and what challenges exist. The expectation is that this portfolio approach will widen USAID’s options for consideration as it plans new programs and engagements. (See Annex I for the evaluation’s complete scope of work.12)

The evaluation team was led by Constance A. Carrino, Ph.D., and included Dr. Fabio Luelmo, Dr. Esperanza A. Icasas-Cabral, Ms. Eleanora de Guzman, Governor Victor E. Agbayani, and Elma Laguna, Ph.D. Five researchers, under the direction of Dr. Laguna, assisted in the conduct of field research, and one logistics specialist assisted the entire team.

EVALUATION QUESTIONS

The evaluation answers the following specific questions:

1. Were the two major projects in the portfolio—MNCHN/FP and ID—relevant to the challenges identified in the design of the current USAID health strategy and the results of the evaluations completed under the previous project cycle? Are they relevant to current developments in the health sector? Why or why not?

2. What are the best practices or interventions emanating from the portfolio as a whole? What interventions are not working? Why not?

3. Is the portfolio implemented in a strategic manner? Why or why not?

4. Are the institutionalization and sustainability objectives of the MNCHN/FP and ID projects being met? Why or why not?

5. What is USAID’s comparative advantage in health in comparison to other donors, private sector and civil society, vis-à-vis local and national government?

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12 This is not an evaluation of the Philippines’ progress in specific USAID/Philippines or international initiatives, such as USAID’s Best Practices at Scale for the Home, Community and Facilities (BEST) strategy in MNCHN/FP, Philippine’s progress in meeting Family Planning 2020 (FP2020), or MDG goals, or the Global Fund grant for TB.
II. PROJECT BACKGROUND

Annex VI provides an expanded version of this section. It covers recent changes in FP; maternal and child health (MCH); TB and HIV indicators; the health policy and finance environment in the Philippines; and a description of the decentralized governance structure in which the public health sector operates.

HEALTH PORTFOLIO: OCTOBER 2012–SEPTEMBER 2017

USAID’s health portfolio focuses on addressing persistent problems that have kept the Philippines from achieving the United Nations (UN) Millennium Development Goals (MDGs) in maternal/child mortality and TB, namely, high unmet need for FP and MCH services, large TB disease burden and increasing multidrug-resistant TB (MDR-TB). Until recently, it responded to the growing threat of HIV.

The health portfolio’s goal is to improve family health through increased utilization of health services to be accomplished through: (1) increased access to and availability of integrated health services (supply); (2) strengthened demand for services; and (3) improved policies and systems for health. The portfolio is made up of two projects, one for MNCHN/FP and another for ID, which presently focuses on TB, with three crosscutting projects in policy, governance and communication. Some agreements in the portfolio have ended, and all will be completed by the end of 2018. MNCHN/FP has a total budget of $107.1 million, ID’s budget is $40.1 million, and the crosscutting projects total $36.8 million.

The MNCHN/FP project is presently made up of three regional service delivery agreements—LuzonHealth, VisayasHealth and MindanaoHealth—covering provinces and cities/municipalities with large unmet need for FP. A grant to Community Maternal, Neonatal, Child Health and Nutrition Scale Up (CMSU) recently ended, and the Private Sector Mobilization for Family Health—Phase 2 (PRISM2) ended in 2014.

The ID project includes one service delivery activity for TB, IMPACT, which targets areas with high TB burden; two supporting agreements, Systems for Improved Access to Pharmaceuticals and Services (SIAPS) and Promoting the Quality of Medicines; and recently completed field support to the World Health Organization (WHO) Consolidated Grant. The ID project also included an HIV/AIDS activity to test models for assisting high-risk groups, which ended last year.

All four service delivery activities have supply, demand-generation and policy components. For MNCHN/FP, this includes expanding limited services for long-acting and permanent methods (LAPM), basic emergency obstetric and newborn care (BEmONC), active management of the third stage of labor and integrating MNCHN/FP. For ID, it includes scaling up TB-DOTS services and, more recently, research on MDR and extensively drug-resistant (XDR) TB treatment.

Four crosscutting national activities support the three service delivery projects. CMSU is a mentoring program for midwives on MNCHN and FP that ended just prior to this evaluation. Health Policy Development Program-Phase 2 (HPDP 2) assists national-level policy formulation, regulation and financing concerns. The Health Leadership and Governance Project (HLGP) builds capacity of local chief executives, health managers and decisionmakers to develop their local health systems. Communication for Health Advancement through Networking and Governance Enhancement (CHANGE) reinforces regional demand-generation efforts for MNCHN/FP and TB through mass media campaigns, “below the line” materials development, and service provider/health volunteer capacity building for behavior change communication.
GOVERNANCE CONTEXT

The country has 81 provinces administered by elected governors. Within the territorial boundaries of provinces are municipalities and cities administered by elected mayors. The smallest province has five municipalities; the largest has 44 municipalities and nine cities. There are a total of 1,489 municipalities and 145 cities across the country. Proximate provinces with similar ethnicity are clustered into the country’s 18 regions. National programs of the various departments, including the DOH, are administered through their regional offices.

While municipalities and component cities fall under the territorial jurisdiction of a province, the municipal or city chief executive and the local legislature have relative autonomy in determining their development plans and priorities, and corresponding budgets. The Autonomous Region in Muslim Mindanao (ARMM) has the same powers and functions as those of departments of the national government, except when national sovereignty or territorial integrity are involved.13

In the public health sector, local government units (LGUs) assume the responsibility for the delivery of health services and the maintenance and supervision of local health facilities and personnel, while the DOH maintains national programs on FP, MNCHN and TB. While the term LGU usually refers to provinces, municipalities and cities, there are also more than 42,036 smaller political, geographic subdivisions called barangays.14 However, for the implementation of national health programs, the critical interface is among the regional office of the DOH, the LGU or local chief executive and the local health officer.15

The effectiveness of the interface between the two is affected by the local chief executive’s priorities. To a significant extent, an LGU’s performance in the delivery of its development plans and objectives depends on the competencies and priorities of the local chief executive. By and large, the local chief executive determines policies, budget, directions, priorities and development plans in general, and consequently the strength and level of priority of health programs in the LGU. Under RA 7160, local elective officials have three-year terms and a three-term limit. Thus, a local chief executive may have either a limited influence or an enduring presence if his or her proxies are elected after the term limit.

A recent political-economic analysis of the Philippine health sector noted various lessons learned in operating in this environment as a donor. Specifically, the report noted that it was important to understand the country’s political environment, but to be distant from it; both planning and implementation are important; conditionality is seldom enough without help in how to reform; good data are key; and, while local government executives are important for health programs, they have short terms in office.16

Geographically, USAID-supported programs in the health portfolio work with DOH and the LGUs as shown in Figure 1 below.

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13 RA 6734; ARMM has an elected regional governor, a cabinet and a Regional Assembly.
15 The Philippine Standard Geographic Code classifies cities as highly urbanized, component and independent component. Of the 145 cities, 143 are classified as highly urbanized, while Isabela City in Region IX is a component city and Cotabato City in Region XII is an independent component city. (Source: Philippine Standard Geographic Code. In http://nap.psa.gov.ph/activestats/psgc/articles/con_cityclass.asp) The relative autonomy in self-governance given to component or chartered cities is about the same. I believe that their basic differences (such as constituents of chartered cities do not vote for provincial officials) will not significantly matter in the establishment and manner of this interface or engagement.
Figure 1. USAID health portfolio activities map for MNCHN and ID projects and crosscutting mechanisms
RECENT CHANGES IN FP, MCH, TB AND HIV INDICATORS

Family planning

In the Philippines, fertility remains one of the main contributors to population growth. Based on the 2013 National Demographic and Health Survey (NDHS), total fertility rate (TFR), or the average number of children that a woman can have in her reproductive life, is three. This is still high, especially compared to other Southeast Asian countries that achieved replacement fertility (TFR=2) decades ago.

There are disparities in fertility based on women’s education, economic status and place of residence. The TFR difference between women attaining the highest and lowest education levels is 2.1 vs. 4.6, respectively; the difference between the highest and lowest wealth quintiles is 1.7 vs. 5.2. While the median age at first birth is creeping up, teenage pregnancy is increasing; high-fertility regions like the ARMM and Eastern Visayas are demonstrating high proportions of young women who already have three or more pregnancies. Among currently married women aged 15-49, 55 percent are currently using a contraceptive method, slightly higher than rates found in the 2008 NDHS, continuing a 30-year progression.

DOH 2015 program data place the use of modern family planning methods (measured as modern contraceptive prevalence rate or mCPR) among women of reproductive age at 44 percent, slightly higher than in 2013. The most frequently used modern contraceptive method remains the pill. However, the CPR for IUDs, which was estimated to be 9.2 in 2013 and 10.9 in 2014, dropped to 8.0 in 2015, reportedly associated with the greater availability and lower cost of pills. Implants were gaining headway until the Supreme Court order took them off public sector shelves in mid-2015.

The disparities in fertility translate to similar ones in FP use. Barriers to FP services are traced to poverty, religious and cultural practices; lack of education and information; and poor access to services and supplies. The DOH Regional Offices (DOH-ROs) reported wide regional disparities in mCPR, from as high as 60 to under 30.

The 2013 NDHS showed that an estimated 18 percent of women of reproductive age have unmet need for FP. Women belonging to the lowest economic quintile have the highest proportion with unmet need at 21.3 percent. This translates to approximately 5.5 million women of reproductive age who have indicated, through their desired family size or desire to space births, an unmet need for FP. If accurate analysis of spontaneous vs. induced abortion were available, further information on unmet need may be available. In 2015, PhilHealth reports payouts totaling PhP 400 million covering 278,000 claims for post-abortion care.

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18 Demographic Research and Development Foundation and University of the Philippines Population Institute. 2014. *2013 Young Adult Fertility and Sexuality Study Key Findings.* Quezon City: Demographic Research and Development Foundation and University of the Philippines Population Institute.

19 A similar drop in IUD use attributed to stock-outs at the time occurred prior to the development of the present USAID portfolio. As noted in the Findings section, public sector stock-out may be an issue as well; pills can be purchased in pharmacies.

20 PhilHealth, Top Ten Procedures Paid as of 2015.

21 Clearer information on abortion may also be useful in analyzing causes of maternal mortality, as WHO estimates that approximately 13 percent of maternal mortality is caused by unsafe abortions. WHO, Human Reproduction Programme Research for Impact, 2008. [http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/](http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/)
**Maternal health**

The reduction in maternal mortality ratio (MMR) from 209 in 1990 to 52 in 2015 is one of the MDGs. However, the 2011 Family Health Survey reported that MMR was 221 per 100,000 births, making the MDG 5 target (to improve maternal health) not achievable by the end of 2015.22

Initial estimates from the 2015 Updating National Nutrition Survey revealed an MMR of 204 per 100,000 live births. A similar stagnation in MMR was observed with administrative data (i.e., Field Health Surveillance and Information System, FHSIS) from the DOH covering only public facilities. The 2015 DOH report reveals an MMR of 78 per 100,000 live births. There is still a wide variation in MMR levels among regions, with ARMM having the highest rate at 153 per 100,000, followed by Regions V and XI, at 128 and 122 per 100,000 live births, respectively. The lowest 2015 estimate of MMR is observed in Cordillera Autonomous Region at 42 per 100,000 live births.

Despite the level of MMR, there is improvement in antenatal care among women. The 2013 NDHS show that almost all women (95 percent) with a live birth in the past five years before the survey received antenatal care from skilled providers. However, the disparity across economic status and educational attainment continues: More than a third of women with low education did not receive antenatal care from skilled providers, compared to only 1.5 percent among women with college education. In ARMM, 35 percent of women did not see a skilled provider during antenatal care.

While one of the guiding principles of the DOH Integrated MNCHN Service Package is to ensure that every delivery is facility-based and managed by skilled health professionals, results of the 2013 NDHS show that only 61 percent of all live births in the past five years occurred in a health facility. More women from urban areas delivered in a health facility, compared to those in rural areas (72 percent vs. 51 percent). Only 12 percent of births in ARMM were facility-based.

The DOH FHSIS data on health program coverage, on the other hand, show that pregnant women attended by professional health workers during delivery remain close to 80 percent, while women giving birth in health facilities increased from 75 percent in 2014 to 80 percent in 2015.

**Tuberculosis**

Tuberculosis is the sixth leading cause of morbidity and the eighth leading cause of mortality in the Philippines, and the Philippines is one of world’s high-burden TB and MDR-TB countries. The TB smear-positive prevalence found in population surveys decreased from 3.1 per 1,000 in 1997 to 2 per 1,000 in 2007 (28 percent), and from 8.1 to 4.7 per 1,000 for culture-positive pulmonary tuberculosis (38 percent).23,24 Incidence is probably underestimated at 290 per 100,000, as new and relapse cases reported by the National TB Program (NTP) already reach that level25 in spite of limited reporting of patients by the private sector.

Figure 2 shows the number of TB cases reported from 2011 to 2014. The country achieved national coverage of the TB-DOTS strategy in 2003. Cases reported are mainly pulmonary (98 percent in 2014), with 40 percent of new cases confirmed by bacteriology, and the majority of patients are still clinically

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22 Philippine Statistics Authority. 2013. *2011 Family Health Survey*. Manila: PSA. Beyond the issue of not meeting the MDG percentage target, the survey report notes that “Even though the point estimates for the 2006 and 2011 surveys imply an upward trend, because the 95 percent confidence intervals around the point estimates (162 and 221 maternal deaths per 100,000 live births) from the two surveys encompass the point estimate from the other survey, the apparent increase cannot be considered statistically significant.”


diagnosed without lab confirmation. Reporting includes cases diagnosed by the public system, plus a limited but growing number reported by private providers. Very few are children, and few of the reported cases are extrapulmonary (4 percent), probably a result of limited reporting by hospitals and pediatricians.

![Graph of reported TB cases, Philippines 2011-2014](image)

**Figure 2. Reported number of TB cases, Philippines 2011-2014**

*Source: WHO TB Data, 2015*

Although the detection of adults with respiratory symptoms suggestive of TB has doubled from 2010 to 2014 (411,000 to 760,000), it is still low—under 1 percent of the population per year—with a very high proportion of them highly infectious (13 percent smear-positive). HIV co-infection is low (under 1 percent in new TB patients with known HIV status), although both HIV infection and co-infection are increasing.

**MDR-TB**

Identification of MDR cases is low. In 2014, 27,287 cases were tested for MDR (28 percent of the confirmed reported cases); 3,000 were diagnosed with MDR and 2,680 of them (90 percent) started on treatment. In 2015, 75,249 Xpert tests identified 19,704 TB cases (26 percent positivity). Six percent of the tests and 24 percent of the confirmed TB cases were rifampicin-resistant. Eighty-eight percent of the resistant cases were enrolled for treatment.

While the proportion of detected MDR cases that started treatment is high, treatment outcomes are poor (less than 50 percent success). In the cohort of 2012, 36 percent of the MDR cases were lost from control and 14 percent died. Pre-XDR and XDR TB cases do exist and were summarized in the 2016 Joint Programme Review, along with information on MDR cases. The number of GeneXpert machines for rapid diagnosis has increased to 84 by 2014, 138 in 2015, and 158 currently, but they are underused, as they are not used routinely to confirm clinical TB diagnosis and are not always accessible.

**Policy and finance context**

In 2010, the Achieving Universal Health Care (UHC) for All Filipinos Administrative Order resulted in a strategy that included financial risk protection through the Expanded National Health Insurance Program (PhilHealth) enrollment and benefit delivery, and improved access to hospitals and health facilities. In 2011, to pursue the goals of the Aquino Administration’s Universal Health Care Program (Kalusugang Pangkahalatan), DOH launched the “Big Push,” a community-based approach to accelerate the achievement of the MDGs. The MDG targets were used to measure the strategy’s success, and this

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agenda and subsequent policy actions supporting it became the foundation for the USAID programmatic partnership with the DOH.

After a stagnant budget of PhP 9-10 billion for almost two decades, DOH budgets began to increase in 2008, reaching approximately PhP 122 billion today, including approximately PhP 40 billion increments from “sin taxes” on tobacco and alcohol. The DOH budget was flat, at about PhP 9 billion a year from 1991 to 2007, but increased steadily during the latter part of the administration of President Gloria M. Arroyo. The 2009 budget was twice that of 2007. As shown in Figure 3 below, this trend continued during the term of President Benigno Aquino, as UHC, especially for the poor, became a key objective for the health sector. By 2015, the DOH budget had grown to more than three times the 2010 budget level. In 2016, it rose to PhP 122 billion, or five times the 2010 level. These increases can be attributed to the expanded fiscal space and priority given to social services during the terms of the previously mentioned presidents. The Philippine Statistical Authority (PSA) and DOH estimate that, since 2014, the budget benefited from an annual increment of approximately PhP 40 billion, funded by the sin taxes that the national government allot mostly to PhilHealth to pay for insurance premiums of the poor and elderly.

However, learning to spend this ever-increasing budget has been a challenge. The DOH is able to obligate only about 90 percent of its budget every year. Unobligated funds are then passed on to the following budget year as continuing appropriations. These unobligated budgets further add to the increasing amounts that the DOH has to use the next year. Continuing appropriations that lapse are eventually returned to the National Treasury. The DOH has had to return to the National Treasury an average of PhP 1 billion per year from 2011 to 2013. In 2014, the DOH returned PhP 400 million in unspent funds.

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28 Department of Budget and Management, April 2016, Department of Health website.
29 Department of Budget and Management, April 2016, Department of Health website.
At present, total health spending as a percentage of GDP is more than 4 percent, of which 11 percent is from the national budget and 13 percent from local budgets.\textsuperscript{30} LGUs are required to spend a fixed percentage of the internal revenue allotment\textsuperscript{31} that they receive as their share of the taxes collected by national government on social services including health. Best estimates show that from 1993 local government spending increased but then stagnated at about 13 percent of total health spending beginning in 1998.\textsuperscript{32}

In terms of sources of health system funding, the National Statistical Coordination Board estimates that in 2013, the central government provided 11.9 percent of health spending, local government units provided 7 percent, and an additional 11.5 percent came from social insurance, for a total of 30.4 percent for all three spigots.\textsuperscript{33,34} Public health expenditure as a percent of total health expenditure was estimated by the World Bank to be 34.3 percent in 2014.\textsuperscript{35} Out-of-pocket health expenditures, especially those for medicines, remain a financial burden for the poor. A World Bank study recently estimated that “By 2012, out-of-pocket spending on health added 1.5 percentage points to the poverty rate . . . The main driver of health spending is medicines, accounting for almost two-thirds of total health spending, and as much as three-quarters among the poor.”\textsuperscript{36} In 2015, the DOH shifted to the UHC High-Impact Five (Hi-5) Plan, with the theme of “Kalusugang Tuloy-tuloy Para sa Pamilyang Pinoy.” Hi-5 is a catch-up strategy that aims to identify health needs of the vulnerable populations in the National Household Targeting System to be provided with appropriate health services (community-based, facility-based or outreach-based). It is focused on five high-impact UHC interventions: maternal care, infant care, child care, HIV/AIDS, and Service Delivery Networks (SDNs).\textsuperscript{37}

**National health insurance program (PhilHealth)**

PhilHealth estimates it has reached 92 percent coverage of the projected population in 2015, including all of the 15.3 million indigent members from the National Household Targeting System for Poverty Reduction (NHTS PR) households. The total benefit payment related to the Responsible Parenthood and Reproductive Health Act (RPRH) in 2015 is 13 percent higher than in 2014. Among the top 10 procedures paid by PhilHealth in 2015, five were for reproductive health issues,\textsuperscript{38,39} and these packages comprised 13 percent of the total claims paid.


\textsuperscript{31} Local Government Code.


\textsuperscript{34} Out-of-pocket funding was 56.3 percent for the same period, and grants to the health system were approximately 1.5 percent. Total health spending includes money spent on conventional treatment as well as spending on over-the-counter drugs, food supplements and even non-evidence-based types of health care that are becoming increasingly fashionable. Most are counted as out-of-pocket expenses and are not paid for by government, the NHIP, private insurance and HMOs.

\textsuperscript{35} http://data.worldbank.org/indicator/SH.XPD.PUBL/countries


\textsuperscript{37} SDNs, as defined by the RPRH law, refer to the network of health facilities and providers within a province or city health system, organized by the LGU in coordination with DOH to offer core packages of services to priority populations in an integrated manner. DOH, Guidelines for Establishing Service Delivery Networks. www.doh.gov.ph


\textsuperscript{39} These packages include FP, MNCHN, post-abortion care, STI and HIV, breast gynecologic conditions, men’s reproductive health.
As of 2015, 45 million indigent PhilHealth members and their families are the largest single category of the population covered, representing close to 49 percent of all beneficiaries.

Premium collection for PhilHealth amounted to PhP 96.69 billion in 2015, and reimbursement totaled PhP 97.03 billion. Of that premium collection, PhP 36.26 billion came from the national government, as appropriated in the General Appropriation Act for PhilHealth’s poor members. Government-sponsored members received 26 percent (PhP 25 billion) of the reimbursements. Of the total benefit payment, at least PhP 12.8 billion was paid for RPRH-related claims.

Among LGUs with the facilities and personnel to provide primary care benefits, the maternal care package and TB DOTS, 83 percent were accredited in 2015. The number of accredited outpatient clinics in 2015 for public health included 2,553 providing the primary care benefit package, 2,981 providing the maternity care package, and 1,739 providing the DOTS package.

Reproductive health

The RPRH Act of 2012\(^{42}\) provides umbrella legislation for a series of new and revised policies by the DOH and other government agencies. Policies focus on a host of issues, from technical guidelines for the use of drugs and reagents to ensuring access to services and commodities, informed choice and voluntarism, adolescent education, provisions on gender-based violence, financing through national health insurance, and special integrated programs for the poor.

Of recent concern is a temporary restraining order issued on June 17, 2015 (which remains in effect) by the Supreme Court: It prohibits registration of new contraceptives or the promotion, purchase, distribution or provision of subdermal implants by the DOH or its agents (e.g., USAID projects).

Significant amounts of the DOH budget are allocated to the implementation of programs for elements of the RPRH. In 2015, a total of PhP 21.74 billion was budgeted for: Family Health and Responsible Parenting (PhP 3.267 billion), Expanded Program on Immunization (PhP 6.892 billion), Health Facilities Enhancement Program (PhP 11.254 billion), and National STI and HIV Program (PhP 324 million).

Multilateral and bilateral donors provide approximately PhP 5.93 billion, and civil society organizations (CSOs) provide approximately PhP 238 million.\(^{43}\)

Tuberculosis

The DOH updated the Plan of Action to Control TB (PhilPACT) 2010-2016 in 2014,\(^{44}\) and it is now designing a new five-year TB plan of action. A new TB law\(^{45}\) was approved in April 2016. The strategy is intended to expand access to diagnostic facilities, mainly in private practice, and use of rapid tests; and to improve human resource capacity, logistics and capacity for program management.

During the PhilPACT period, both domestic and Global Fund resources increased, and funding from other sources began. Out-of-pocket spending through the private sector shows a high expenditure on TB drugs in private pharmacies, estimated at over US$20 million in 2011.\(^{46}\)

\(^{40}\)PhilHealth has reserves of PhP 122 billion as of 2014, exclusive of premium collection.

\(^{41}\)PhilHealth 2015 reporting.

\(^{42}\)With amendments made in March 2013; also referred to as the RPRH Act.

\(^{43}\)DOH, 2015.

\(^{44}\)DOH/NTP. 2014. Updated 2010-2016 Philippine Plan of Action to control Tuberculosis (PhilPACT).

\(^{45}\)Republic Act No 10767, April 26, 2016: establishing a comprehensive Philippine plan of action to eliminate tuberculosis as a public health problem and appropriate funds.

The TB law calls for demonstration projects to generate evidence for policy and develop regional capacity; nationwide public information and education campaigns (in collaboration with the Philippine Information Agency; the improvement of training and technical skills; and collaboration with local and foreign organizations. The TB law tasks the Food and Drug Administration to regulate the sale and use of TB drugs in the market and ensure their quality. All public and private health centers, hospitals and facilities will notify all TB cases, and PhilHealth will expand its benefits package for TB patients and make the DOTS package more responsive to patient needs.
III. EVALUATION METHODS AND LIMITATIONS

This process evaluation focuses on a portfolio of projects with specific questions about relevance and strategic approach, and more standard questions about what is and is not working and whether services, training and other contributions from the projects’ work would continue beyond the life of the project.

The evaluation involved several methodologies, including:

- A review of project documents, data on health indicators, and recent literature on health and related topics (see Annex IV for bibliography)
- Project orientation and briefings from USAID Office of Health staff and cooperating agencies
- Interviews and group meetings with government agencies and donor stakeholders at the national, regional and local levels
- Field visits to government and private health facilities and project sites in Luzon, Visayas and Mindanao
- Focus group discussions (FGDs) and group discussions

Meetings and interviews, particularly among international donor agencies and central office of the DOH, PopCom, PhilHealth and the project implementing teams, were held in Metro Manila, as were initial meetings with chiefs of party. The identification of areas for site visits was finalized in coordination with USAID and the project components, namely, LuzonHealth, VisayasHealth and MindanaoHealth. The main consideration for the choice of area is the presence of both MNCHN/FP and ID, especially TB projects. For Luzon, Quezon City and Cavite (Trece Martinez and Tanza) were chosen, in Visayas, Cebu City and Tacloban City, and in Mindanao, Cagayan de Oro City, Bukidnon, Davao City and Digos City.

Field visits included interviews and group meetings with staff of the different projects; local chief executives; planning officers; health officials and representatives of the DOH, PhilHealth and PopCom; community health workers; midwives, nurses and private practitioners; and donor representatives in the field. With the help of LuzonHealth, VisayasHealth and MindanaoHealth, FGDs were held with young women who were FP acceptors, women of reproductive age who were not FP acceptors, husbands who received reproductive health counseling and community health workers involved in TB. In Cagayan de Oro, an FGD with TB patients was also conducted. Guides were prepared for the FGDs, and five local researchers served as FGD moderators.

The evaluators visited facilities and reviewed service delivery data. Project cooperating agencies provided answers to written questions from the evaluation team about what was working in the portfolio and what was not, and projects were asked to characterize USAID’s comparative advantages. The evaluators held team discussions concerning the policy context and challenges facing the health system and attended key policy, communications and TB meetings in Manila.

Input was received from 466 respondents (see Annex III), including 194 FGD participants whose names are not included in Annex III. This work was conducted from Feb. 26 to April 20, 2016.

The team conducted qualitative analysis of the data collected, following a two-step process developed by (and with input solicited from) USAID: (1) data and document review, then (2) finalization of questions and instruments. The evaluators held periodic meetings to reach consensus on major trends in the findings and worked together and in pairs to fill in gaps in knowledge.

Annex II provides further additional information on the methodology, Annex V provides copies of the instruments used, and Annex VII provides consolidated reports from the FGDs.
IV. FINDINGS

In this section of the report, the evaluators answer the five questions posed in the scope of work and then use those responses to inform conclusions and recommendations in section V, below.

WERE THE TWO MAJOR PROJECTS RELEVANT?

Specifically, the evaluation team was asked whether the two major projects were relevant to challenges identified in the current USAID health strategy and the evaluations completed under the previous project cycle. The evaluators found that they were.

The two flagship projects and the three crosscutting activities directed at policy development, improving health governance and communication, were designed around 2012 when DOH budgets were increasing after a long period of being flatlined (PhP 18B in 2008, PhP 42B in 2012). PhilHealth was increasing coverage for the poor, FP was flat, maternal mortality was too high to meet MDGs, the country was in the top 10 countries for TB, and HIV rates were low but increasing. The RPRH was rolling out with a host of supporting policy actions, including the soon-to-be-passed sin tax that would bring revenue into the health budget. A Joint TB Program Review in 2013 advanced WHO recommendations regarding rapid diagnostic tests, as did a midterm evaluation of the Plan of Action 2010-2016 that led to revised a plan approved in 2014.

The 2012 USAID/Philippines: Performance Evaluation of the Family Planning and Maternal and Child Health Portfolio was designed to evaluate and identify how to improve upon USAID’s service delivery programs. Among its many recommendations, there were several that the evaluators could see are being pursued in the present portfolio, such as the recommendations that USAID:

- Support the DOH in standardizing and expanding its training capacity, especially for BEmONC.
- Position FP as an input to improved MCH, including the expansion of postpartum FP.
- Encourage demand creation that provides information on FP methods and dispels myths, misconceptions and fear of side effects.
- Enhance inter-pregnancy care through counseling and group discussions.
- Increase focus on information and FP services to youth.

The evaluation also noted a lack of program integration among activities and recommended that, beyond normal partner coordination meetings, USAID projects should undertake joint planning to integrate activities, and it recommended “strengthening coordination among projects not only for information sharing but also for joint planning in order to integrate implementation of interventions. In order to better achieve this, USAID Contracting/Agreement Officer’s Representatives (C/AORs) should work as a team or a steering committee to oversee not only the individual implementation but also functional integration of the projects.”

Further, instead of working in 30 provinces around the country, the evaluation recommended that future projects “be designed to focus on more municipalities and cities in fewer provinces clustered in fewer regions, to maximize synergies and logistical efficiencies and in turn lead to greater impact,” with

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48 Ibid. p. 15; a similar concern is raised in this evaluation.

49 Ibid. p. 18.
caveats regarding consideration for absorptive capacity, political commitment, population size and need, especially for women and youth.  

USAID developed a strong relationship with local DOH programs and personnel in the areas of technical training and service delivery. Similar relationships with PhilHealth to expand the reach of social insurance at the regional level did not occur, nor was there formal partnering with PopCom, which by 2013 was conducting classes under the family development sessions of the Conditional Cash Transfer Program that resulted in long lists of women and couples who expressed unmet need for spacing or limiting births. Also during this period, what soon became a windfall of funds from the sin tax was not anticipated.

The 2012 USAID/Philippines: External Evaluation of the Tuberculosis Portfolio (2006–2011) recommended that USAID continue its support for TB prevention with:

- A focused strategic plan that addresses local needs
- A greater effort to identify activities that have the highest impact and could be continued
- A transfer of national policies and tools to lower levels of the health system

This evaluation emphasized that activities be closely aligned with national strategies and plans and that USAID support existing and emerging national approaches to delivering care, such as PhilHealth and the CHTs.

Both the MNCHN/FP and ID projects gave special attention to the expansion of PhilHealth services to the poor. On balance, the portfolio was relevant to the information USAID considered and its field experience at the time.

**IS THE STRATEGY RELEVANT TODAY?**

The present health portfolio strategy would not be relevant today. By 2016, health budgets continued to rise (PhP 83.7B in 2014, PhP 86.0B in 2015), assisted by funds made available by the sin tax.

PhilHealth continued to expand services, with different levels of progress. In 2015, for example, PhilHealth paid over PhP 12 billion for more than a million claims under the six reproductive health packages offered, demonstrating that financing health for the poor would depend considerably on social insurance. Respondents within the DOH and PhilHealth reported either advocating for or working to develop new packages for PhilHealth. Also in 2015, the DOH shifted to its Hi-5 Plan, a health-facility-based model that aims to match vulnerable families in the NHTS with appropriate health services (community-, facility- or outreach-based.)

Key MNCHN/FP, TB and HIV policies are in transition:

- In June 2015, a temporary restraining order issued by the Supreme Court prohibited the registration of new contraceptives and prohibited the DOH and its agents (including USAID) to purchase and provide contraceptive implants and any new contraceptive.

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50 LuzonHealth, VisayasHealth and MindanaoHealth work in 48 provinces.
52 These packages include FP, MNCHN, post-abortion care, STI & HIV, breast gynecologic conditions and men’s reproductive health.
53 For example, a TB-DOTS package exists but one for MDR-TB as yet. A youth package has been discussed in PhilHealth but as yet lacks a sufficient evidence base to proceed.
• The new TB law includes provision of free laboratory diagnosis and TB drugs, regulation of the sale of TB drugs of assured quality, training of public and private hospital health providers, monitoring of TB cases, education programs and development of technologies. There is also a move to reduce the duration of treatment of MDR-TB and expand the use of GeneXpert as a TB diagnostic tool.

• The DOH is expected to accept a test-and-treat policy for HIV as part of a new HIV strategy to be developed this fall and unveiled as early as December 2016. This will dramatically increase the HIV budget for the next two decades but is expected to stem the progress of the disease and eventually eliminate it as a major health concern.

Additionally, the UN agencies are transitioning toward technical assistance that focuses on systems strengthening and away from services. And in TB, in December 2015 the White House announced a plan for addressing MDR- and XDR-TB,\textsuperscript{54} as the Philippines continues to be in the top 10 countries for numbers of people with TB and MDR-TB.

Despite increased budgets and strong government commitment to move toward universal health coverage, various existing public health systems are weak. For example, USAID projects and others have attempted to address supply chain failures from an outdated system where drugs and contraceptives are pushed to the field without local forecasting or integrated procurement planning. In 2015, HPDP2 assisted the DOH to develop a new logistics solicitation, which unlike earlier contracts, carried penalties and called for medicines to be delivered directly to rural health units (RHU) as opposed to centralized points used in the past. HPDP2 also helps with performance monitoring to ensure delivery of reproductive health goods in a more complete and timely manner.

In interviews and facility visits, the evaluators heard that FP programs go to the United Nations Population Fund (UNFPA) or CSOs when they have stock-outs, and USAID projects provide IUDs for training programs so students will have enough to pass their practicum. TB programs use a text alert system to warn of stock-outs, PopCom does the same with an FP logistics hotline, and USAID projects all have examples of facilities needing to swap out product among health units to fill gaps. In the focus group with TB workers, the evaluators heard there were stock-outs of children’s drugs everywhere except in Javier,\textsuperscript{55} Leyte and with category II drugs (i.e., streptomycin). Some facilities rely on LGUs or patients to buy drugs in the private sector. As programs expand in this PhilHealth era, the antiquated push system of providing set numbers of medicines per facility does not work; it leads to over- and under-stock and wastes scarce resources. The stock-out problem is only periodic in any one site that the evaluation team visited, but prevalent enough to question whether the stock-outs are a factor in drop-outs from the TB program or contraceptive choices in the FP program. They were discussed in the 2012 evaluation of the USAID/Philippines MCH/FP project as well, but the decentralized system apparently makes it difficult.

Similarly, weak data collection, analysis and use are being buttressed by USAID support, but the systems themselves have not been strengthened or institutionalized within the DOH. All four service delivery agreements help with quality control of MNCHN, FP and TB data in their regions. Respondents, including those from the TB workers FGD see data as a job requirement as opposed to a tool for decision-making. Facilities have their own data but do not appear to receive consolidated data that allow for trends and comparisons with other facilities.


\textsuperscript{55} FGD respondents from Javier, Leyte said their LGU can purchase TB drugs. There is a TB capitation fund from the PhilHealth benefit claims. The LGU has a PhilHealth Trust fund, where the municipal health officer approves the release of the funds. For any purchase less than P50,000, no bidding is needed so the funds can be easily released to purchase TB drugs.
It is also hard for the public sector to cover training needs, especially at the regional level, for both public and private sector providers and local governments. USAID supported training of health care providers has helped expand DOH reach and PhilHealth coverage, and training of LGU leaders has forged better understanding of and support for health needs at the local level, but institutionalization of training within the DOH has not occurred. Recently the DOH has raised concerns that donor-supported training programs, where USAID leads in support, are taking public sector health workers away from their jobs. USAID cooperating agencies are concerned with training public health providers in isolated areas where the absence of the single health provider means services cannot be provided, and more generally that the DOH may be getting too used to the outside support to staff up and take on the responsibility.

While USAID assistance in all these areas is highly valued by central and local DOH respondents and by LGUs, the lack of strong, permanent systems concerns stakeholders and leaves the DOH vulnerable as a steward of the health sector at a time when services are expanding.

BEST PRACTICES AND INTERVENTIONS

A best practice, strictly defined, is an intervention that has shown positive outcomes as evidenced by quantitative and qualitative research. For this evaluation, the team focused on interventions that “are working” in the portfolio that show progress toward meeting intended outcomes. Evidence that demonstrated results or early signs of success in meeting objectives and possibility of replication came from project reports, site visits and discussions held with stakeholders and beneficiaries.

What is working in MNCHN/FP

Integration of FP in antenatal care

Pregnancy tracking, incorporating FP counseling in antenatal care, and expanding health facilities providing postpartum FP are helping increase acceptance of long-acting and permanent methods (LAPM) postpartum. Health center staff revealed that FP is usually discussed during the third antenatal visit. In LGUs visited, the PhilHealth maternal care package has motivated barangay health workers (BHWs) to better track pregnancies in their communities and mothers to complete four antenatal care visits, give birth in a health facility, and complete two postpartum visits. In one location visited, safe motherhood incentives were being provided through an Executive Order issued by the Tacloban City Mayor’s Office that gives PhP 500 to a BHW for referring a pregnant woman and PhP 1500 to the mother for completion of four antenatal visits, facility-based delivery and two postnatal visits. The seven FGDs of young FP acceptors conducted for this evaluation found that the main and most credible sources of awareness are the health center/institution and the health workers/midwives and doctors. Catching mothers during prenatal visits and when they go for their baby’s regular immunization seems to be the ideal opportunity to discuss FP.

As a result, based on health service information, there has been an accelerated uptake of long-acting reversible contraceptives (LARC) and LAPM in all regions within the last three years (2013-2015), much higher than the small increases within five-year periods reported by NDHS surveys in the past:

- Mindanao Health reported a 16 percent increase in modern FP users (174,108 acceptors) from Year 1 to Year 3, of which 41 percent use LARC and 41 percent bilateral tubal ligation.
- Luzon Health reported a 7 percent increase in modern FP users (103,050 acceptors) from Year 1 to Year 3, of which 39 percent use pills, 18 percent injectables, 15 percent bilateral tubal ligation, 11 percent lactational amenorrhea method (LAM), 7 percent condoms, 6 percent IUDs, 2 percent progestin-only subdermal implants, and 0.7 percent natural family planning.
- Visayas Health had to focus on emergency and rehabilitation efforts when a 7.5 magnitude earthquake hit Bohol province in October 2013 and typhoon Yolanda (Haiyan) struck the region in November 2013, thus disrupting activities. By December 2014, the project reported 11,057...
new Patient Specific Implant acceptors (before the ban on implants for the public sector) and 3,489 new postpartum IUD acceptors. By the end of Year 3 (September 2015), the project reported a 47 percent increase in couple-years of protection compared to Year 2 due to LAPM, by noting that “Clients are opting for more permanent methods.”

Based on these changes, an increase in modern FP use should be evident in the next NDHS.

**Training for MNCHN/FP accreditation**

Expanding availability of MNCHN/FP services by increasing the number of trained health service providers in basic MNCHN/FP and LAPM is a major objective of the regional projects. Based on key informant interviews and discussions held by the evaluation team, training in LAPM and BEmONC were the most valued interventions by project staff, government and private providers and LGU counterparts. It led to PhilHealth certifications of both public and private providers for FP service provision and accreditation of health facilities for the maternal/newborn care packages.

LuzonHealth provided FP competency-based training (FPCBT1) to 1,666 health service providers and FPCBT2 to 632 from 2013 to 2015, expanding the number of RHUs providing FP services from 81 to 93 percent. During the same period, 367 providers were trained in BEmONC. The number of facilities accredited in the maternal care package increased from 51 percent (148/290) to 75 percent (252/334). VisayasHealth training resulted in more health facilities (hospitals, RHUs and urban-based health centers) providing LAPM—from 185 (38 percent) prior to the project to 426 (77 percent) currently. The number of PhilHealth facilities accredited for the maternal care package increased from 42 percent to 66 percent. MindanaoHealth trained 2,409 providers in FPCBT1, 670 in subdermal implants and 744 in postpartum IUD. It has trained 332 providers on caring for mothers and newborns in the community and 890 on essential intrapartum newborn care/BEmONC. Health facilities accredited for maternal/newborn care packages increased from 13 percent prior to the project to 44 percent as of end 2015.

**Projects’ inputs to training**

While training is normally organized by DOH regional offices (DOH-ROs), courses are not currently offered on a regular basis. Without USAID support, trainees admitted that they would not have had the opportunity to be trained in the MNCHN/FP skills required.

The projects initiated trainings, provided resource persons/trainers, supported lodging and per diem of participants, reproduced modules and materials, and conducted post-training follow-up. In some cases, (e.g., Luzon), a hospital was contracted to conduct training (BEmONC), with the project paying participants’ tuition fees and the DOH-ROs paying for board and lodging. Upon successful completion of the training and practicum requirements, the DOH-ROs issue training certificates and the DOH recommends them for PhilHealth accreditation.

Health service providers interviewed said that USAID project staff have been diligent in conducting post-training follow-up. They added that training in LAPM (postpartum IUD, interval IUD, bilateral tubal ligation), active management of the third stage of labor and FP/MCH integration, has enabled them to deliver more effective services, obtain PhilHealth accreditation and receive additional income from PhilHealth for services provided.

The intent of this USAID assistance was to provide assistance in developing state-of-the-art training modules, training follow-up and the implementation of training programs as a contribution to strengthening the DOH’s technical and training capacity, and that has occurred. Central and regional DOH personnel shortfalls and the lack of a tenable plan to cover training needs without creating a burden translates into a continued need for USAID support.

**Midwife monitoring and mentoring**

Later in this report, it is noted that individuals and facilities that demonstrate good networking skills demonstrate stronger potential for sustainable programs. Within the MNCHN/FP project, the
Integrated Midwives Association of the Philippines program for their members is a positive example of both using and teaching networking to improve technical and operational skills. This activity was part of the CMSU activity, which ended earlier in 2016, with antecedents in the PRISM and PRISM2 projects, to improve the skills of individual midwives, many of whom work in both the public sector and privately. Initially the plan was to train midwives in essential intrapartum and newborn care, antenatal care, FP, IUD insertion and removal, and infant and young child feeding, with two supervisory visits as a check on the training. As it evolved, the principles of adult learning, building mentor-mentee relationships and coaching, and the use of standard checklists were added.

USAID/Philippines’ Portfolio Review for FY 2015\(^5\)\(^6\) reported that 438 midwives had been validated to be correctly practicing essential intrapartum newborn care, while 608 were proficient in IUD insertion, counseling on essential intrapartum newborn care, FP and breastfeeding. By applying what they have learned, the standards become routine in both public and private practice, with the midwives becoming more skilled in the process in which complications are detected early and addressed appropriately. As CMSU ended, the regional MNCHN/FP projects were asked to absorb the mentoring activity.

Beyond these excellent program statistics, in Digos City, the team observed how a midwife mentor stayed in contact with a mentee she had worked with for some time. They worked in different private hospitals but kept in contact. On the day the team was there, the pair discussed how to find technical update opportunities and how the local government was reacting to progress toward maternal mortality indicators.

Adolescent programs in hospital settings

To address the high rates of teen pregnancy noted above, the projects have initiated and encouraged various adolescent and youth reproductive health programs. These programs are basically of three types: community-, school- and health-facility-based, Feedback from interviews by the team showed that teenagers are not too keen to avail of community-based programs because of privacy concerns. School-based peer educator programs, though popular with students and administrators, need continuous training of new peer educators to replace those who have graduated, so they are more challenging to sustain and lack the immediate medical attention possible at a health facility. And unfortunately, as indicated in the FGDs conducted in regions with the highest teen pregnancy rates, the teenage mothers were out-of-school youth when they got pregnant.

Based on site visits and interviews with project, LGU and health facility staff, hospital-based teen programs are working most effectively since they can provide counseling on a wide range of issues facing adolescents as well as FP services, and they can readily be integrated within facilities, usually ob-gyn departments, without significant additional resources. Although most of these centers cater to teenagers who are already pregnant (high-risk teenage pregnancies are referred to them), they do capture those with unmet need for spacing and help prevent successive teenage pregnancies, and some offer hotlines and teen events.

Starting in 2014, MindanaoHealth has supported the private Brokenshire Hospital in Davao City to prepare for what became the hospital’s program for teens through training of obstetrician-gynecologists, and assistance in developing operational guidelines. Today, Brokenshire has a fully functioning teen program that is networked with the Department of Social Welfare and Development to conduct youth development sessions; City Health Council for youth events; public/private schools; barangay health stations for outreach; and the Southern Philippines Medical Center, a DOH-retained hospital, for referral of cases of domestic violence. The program provides a teen hotline, FP counseling and services--

\(^5\)\(^6\) November 5, 2015.
pills, IUDs and implants. The hospital is PhilHealth-accredited and offers No Balance Billing.57 Brokenshire teen program staff reported that the hospital’s board has agreed to integrate adolescent services into the ob-gyn department.

Another fully functioning adolescent program is the VisayasHealth-assisted Program for Young Parents at the Eastern Visayas Regional Medical Center in Tacloban City, launched in September 2014. A core team of five doctors and nurses from the ob-gyn department is involved in the program. Staff has been trained on counseling, dealing with adolescents, and conduct of Usapan sessions.58 The Eastern Visayas Regional Medical Center has launched a “champions” activity under the program, composed of those teen parents who have accepted contraception. These champions are trained to speak to other teenagers in the hospital and in their communities about the difficulties of early pregnancies, the benefits of delaying sexual activity, and FP. Every Wednesday, the program holds Usapan sessions on antenatal care, breastfeeding, baby care, hygiene and FP. Of the more than 5,000 deliveries in the Eastern Visayas Regional Medical Center in 2015, 15 percent were by teenagers. In 2015, the program recorded 179 acceptors of modern methods (24 percent of teenage deliveries), of which 144 were postpartum IUDs. According to the medical staff interviewed, few additional resources are needed to continue with the program, and they expect more referrals in the future.

*Service Delivery Networks (SDNs)*59

The regional projects’ efforts to support the DOH-ROs to strengthen establishment of SDNs, envisioned as key to ensuring sustainability, are promising. Founded on the DOH Interlocal Health Zones concept, the SDN is an initiative that builds partnerships among public and private health facilities to optimally deliver MNCH, FP and other reproductive health services. While SDNs are not fully functional or sustaining, USAID has helped with start-up of the SDN work in the three MNCHN/FP service regions and should be able assist in identifying how SDNs can be rolled out and sustained.

- LuzonHealth helped the DOH of Cordillera Autonomous Region and DOH-RO II develop tools—one for digital mapping of health facilities, and another for SDNs to assess competencies of health providers in the mapped health facilities and identify gaps in service delivery. Results were used to identify levels of health services available and capacity-building needs. LuzonHealth supported meetings among identified health providers to obtain agreement on participation in the SDN, referrals, procedures and process flow. In Region III, LuzonHealth led discussions to plan for the operationalization of SDNs in each province. In the National Capital Region and CALABARZON, it supported assessment workshops and meetings to strengthen or reactivate existing SDNs.

- MindanaoHealth helped develop an SDN Operational Guide and supported training of six DOH-ROs and 53 LGUs on its use. As a result, 18 SDNs across 53 LGUs are using the SDN maps that indicate referral pathways for MNCHN/FP services, and eight public-private partnerships for MNCHN/FP have been initiated. MindanaoHealth is encouraging an SDN concept that has no political boundaries, (i.e., crossing LGU lines) as a way to improve SDN quality and efficiency.

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57 No Balance Billing is available to sponsored (indigent household members) in public facilities. Selected accredited private facilities mandated to implement No Balance Billing are providers for the Z package (for cancer and other serious diseases), ambulatory surgical package, free-standing dialysis, TB-DOTS, birthing homes, maternity and newborn care package

58 Usapan sessions are a unique interactive approach designed to reduce the FP knowledge gap through facilitated group discussion. They include group discussions on FP or other MNCHN topics led by a trained facilitator using the GATHER approach of Greet, Ask, Tell, Help, Explain, Repeat/Recommend that is designed to increase interaction between providers and clients with unmet need and help the latter arrive at a decision to accept FP/MCH practices.

59 SDN, as defined by the RPRH law, refers to the network of health facilities and providers within a province or city health system, organized by the LGU in coordination with DOH to offer core packages of services to priority populations in an integrated manner. DOH, *Guidelines for Establishing Service Delivery Networks*. www.doh.gov.phs. MindanaoHealth reports using an SDN model that can cross LGU lines.
In Tacloban City in 2015, VisayasHealth supported a strategic planning workshop with the City Hospital and City Health Office staff to develop a business plan to establish an SDN there, which was subsequently approved by the city government.

Sustaining the RPRH law
The process to pass the RPRH Act of 2012 was arduous and protracted. When finally, the bill reached the point of plenary debate in both houses of Congress, evidence supporting its passage and answering what were often spurious questions and arguments by groups against the bill required response. The DOH and the sponsor legislators relied heavily on UPecon and scientists and doctors from academia and the private sector to provide the evidence and analysis necessary. HPDP2 also assisted, through the DOH, the Office of the Solicitor General and the legislative interveners, with evidence to support the constitutionality of law when it was put under status quo ante by the Supreme Court, and a petition to declare the law unconstitutional was subjected to written and oral arguments before the court.

Best practices from the TB side

Increased detection of persons with symptoms for microscopy
In 2010, 411,000 persons with symptoms were examined (0.6 percent of the population), with a positivity of 17 percent; in 2014, 760,000 were examined (0.8 percent), with a positivity of 13 percent. This shows a significant improvement in the detection of sources of infection and a reduction in the prevalence. The strategy is effective and sustainable with national resources.

Integrated TB communication/mass media social mobilization
A TB communication campaign aimed to reduce stigma and motivate people with a cough to go to a health center for testing and treatment succeeded in getting people to the health centers and helped to reduce stigma. The TNS Global tracking study on the mass media campaign showed a “softening” of TB stigma by the public. The proportion of respondents who agreed to the statement that “TB is very contagious and we should keep away from people with TB” decreased from 42 percent prior to the campaign to 34 percent at its end. Health providers interviewed in Cavite and Leyte said that the material and tarps in their centers showing the same images and messages as the TV campaign reassured concerns of patients and family members regarding stigma surrounding the disease, and primed some to come to facilities. TB patients in FGDs were able to recall the campaign messages and said that it helped reduce stigma. BHW respondents in FGDs conducted in Davao, Batangas, Cagayan de Oro and Quezon City voluntarily stated that the TV ad “with Mitch Valdez” has been able to increase awareness that TB is curable and reduce stigma in their areas of coverage.

The campaign succeeded because the national and regional messages were integrated. It used mass media to provide umbrella support to local communication efforts by community volunteers in the barangays and health service providers in health centers. A single brand–celebrity endorser Mitch Valdez–was used in both mass media messages and print materials used for interpersonal communication (IPC) in a two-phase campaign. Phase I provided correct information and attempted to reduce stigma, while Phase II promoted DOTS compliance. IMPACT and CHANGE jointly developed the campaign strategy and creative concept and discussed these with the NTP and National Center for Health Promotion (now Health Promotion and Communications Service) at the DOH. CHANGE planned and executed the mass media campaign and developed the below-the-line materials, and with IMPACT managed the ground-level campaign (community mobilization, reproduction and distribution of below-the-line materials, group and individual face-to-face communication). The NTP was part of the collaboration, so their approvals were on time and they provided additional funds beyond those from USAID for media placements, resulting in a much wider reach and higher airing frequency.

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60 Much of UPecon’s work at this stage was USAID supported via HPDP.
Participation of private providers in diagnosis, referral and reporting of TB cases

Initial work on referral by pharmacies and increased referral or reporting of TB cases by private practitioners and hospitals is evidenced by the number of TB cases reported, mainly pulmonary with clinical diagnosis and extra-pulmonary cases beginning in 2010 (see Figure 2 above). It is estimated that private providers contribute 13 percent of the notified TB cases, but available data are incomplete, and some private clinics and hospitals do not document or notify their TB cases. Mandatory notification (TB law) will improve the information and coverage of reporting. Availability of Xpert tests to private practice would improve the quality of diagnosis.

Maintaining treatment and cure in spite of increased reported incidence

The treatment success and cure rates have been maintained at or increased over the established targets (90 percent success in the 2013 cohort). This is in spite of occasional irregular TB drug supplies at the peripheral level and a substantial increase in the number of cases reported, from 166,000 in 2010 to 243,000 in 2014.

Local policy advocacy and local incentives

IMPACT has influenced the issuance of 372 local policies designed to increase case detection and overcome barriers to continued treatment and care for TB. For example:

- In Javier, Leyte, when a TB patient has undergone complete treatment and is cured, the Municipal Health Office gives PhP 1,000 to the BHW and PhP 1,000 to the patient. Taken from PhilHealth’s PhP 4,000 TB outpatient benefit package, this incentive is credited with improving case detection from 85 to 100 percent between 2014 and 2015. In Leyte, barangay officials cover transportation expenses of their constituents in need.
- In Tacloban City, Executive Order 15-12-015 gives PhP 1,000 to private providers who refer cases for TB-DOTS. If referral is not from a private source, PhP 500 is given to the patient for completion of the six-month course.
- In Batangas City, PhP 1,000-3,000 is given to each BHW for every 10 TB patients referred monthly. BHWs are also awarded certificates by the City Health Office to recognize outstanding performance.
- In Consolacion, Cebu, BHWs are given a monthly quota of TB patients to be referred to RHUs.

Collaboration with the DOH to draft the TB law

The TB law approved in April 2016 includes the key elements of policy, finance, management, technical interventions and monitoring/evaluation to strengthen TB control in the country. It is a powerful policy instrument with concrete mandates to the Secretary of Health and will result in a comprehensive plan of action in consultation with public and private entities, including the Department of Education, Commission on Higher Education, Philippine Information Agency, LGUs and NGOs. Funding will be charged under the General Appropriations Act. Implementation of the law will require support to modify some technical guidelines, create an NTP managerial team, train staff and monitor results, both in the public and private health systems, and USAID should have a major role.

WHAT IS NOT WORKING? AND WHY?

The evaluation team defined “what did not work” as project interventions that were not adequately designed or implemented, and includes existing public sector personnel structures on which the evaluators find USAID initiatives cannot rely.

Challenge for both MNCHN/FP and ID

Community Health Teams (CHTs)

The CHT, composed of BHWs, midwives and informal community leaders, was established in 2011 by the DOH as the driving force for social mobilization efforts of the Universal Health Care (Kalusugan
**Pangkahalatan** Program of the Aquino Administration. In 2011, the CHT community-based approach was presented as an essential component of the DOH’s “Big Push” to accelerate the achievement of the MDGs. The MNCHN/FP and ID projects depended on the CHTs for demand generation and referrals.

Indications that CHT was not a viable model began to emerge in 2013. An assessment conducted by the DOH in 2013 revealed many weaknesses in the CHT system and various factors hindering the teams’ functionality. A separate evaluation by LuzonHealth and DOH-RO II found that CHT partners did not deliver key messages due to their complexity or partners’ unfamiliarity with them, though CHTs in areas with strong local support, such as Tacloban and Javier (both in Leyte Province) were functioning during that period. Generally, CHTs were unable to correctly prepare household profiles or health use plans. They inaccurately recorded services provided, or did not record them at all, and they lacked financial assistance to reach all their assigned households.

In 2015, a new Secretary acted upon these assessments by defunding the CHTs in favor of establishing a cadre of “public health assistants” and “universal health care implementers,” composed mainly of under board nurses and doctors. Thus, local areas that wish to continue the CHT model will require LGU support.

On the reproductive health side, the defunding of CHTs was concurrent with a shift to the UHC Hi-5 Plan, with the theme of “Kalusugang Tulyo-tulyo Para sa Pamilyang Pinoy.” Hi-5 is a catch-up strategy that aims to identify health needs of the vulnerable populations in the NHTS to be provided with appropriate health services (community-, facility- or outreach-based). It is focused on five high-impact UHC interventions—maternal, infant and child care, HIV/AIDS, and SDNs. The DOH expects to achieve outputs of Hi-5 within a “breakthrough” period of 15 months.

In the 17 sites visited, the evaluation team was not presented with functioning CHT teams. In Luzon, key informants explained that the CHT is actually the BHW working alone or helped by one or two more volunteers (Barangay Nutrition Scholar, Barangay Service Point Officer).

**Challenges for MNCHN/FP**

**Too many groups identifying unmet need for FP**

PopCom, through its regional offices and officials, is identifying unmet need as part of demand generation for FP/RH under the RPRH law. PopCom’s regional offices conduct responsible parenthood/family planning classes (sub-module 2.2) of the family development sessions for the *Pantawid Pamilyang Pilipino* Program (4Ps) beneficiaries. Attendance of these sessions is a requirement for continued receipt of 4Ps benefits. These sessions result in extensive lists that require follow-up.

However, without collaboration with PopCom, the three projects are identifying couples or women with unmet need using different tools. LuzonHealth uses Community Health and Service Records, VisayasHealth has its Unmet Need Tool based on the 4Ps, while MindanaoHealth relies on RHU unmet need data and inputs them in their data tracking system. If three USAID parallel systems have successful experience to scale up or share with PopCom, experimentation with these three approaches would have been more useful had they been conducted in concert with or for PopCom to consider.

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61 SDNs, as defined by the RPRH law, refer to the network of health facilities and providers within a province or city health system, organized by the LGU in coordination with the DOH to offer core packages of services to priority populations in an integrated manner. DOH, *Guidelines for Establishing Service Delivery Networks*. www.doh.gov.ph. MindanaoHealth reports using an SDN model that can cross LGU lines.


63 This is also documented in LuzonHealth’s *Project Year 2 Annual Performance Report*, p. 54.

64 4Ps is a conditional cash transfer program of the Philippine government that provides cash grants to families to enable them to send their children to school and to access health services, particularly mothers and young children.
There is also evidence that it would have been worthwhile to coordinate with PopCom. In 2015, PopCom reports conducting 35,697 Responsible Parenthood/Family Planning sessions in all regions. These sessions reached 599,310 couples/individuals of reproductive age, of whom 208,654 were identified with unmet need. PopCom reported that 47.8 percent (99,777) of those with unmet need were served, i.e., referred to RHUs or private providers like Population Services Pilipinas, Inc. (PSPI) or FriendlyCare and provided service. Of those served in 2015, the most popular methods accepted were pills (49,051), injectables (20,968) and LAM (10,253) followed by implants (5,857), IUDs (4,289), condoms (3,720) and bilateral tubal ligation (3,106) (from data provided by PopCom to the team). There is opportunity to coordinate with PopCom in unmet need identification. With PopCom’s budget and personnel resources to identify unmet need, a useful avenue for assistance would be to strengthen the conduct of their Responsible Parenthood/Family Planning classes, more effectively refer unmet need identified to health services, and increase acceptance rates to nearly 100 percent.

**Demand generation not systematically linked to service delivery**

The regions’ demand-generation strategy is IPC through small or large group approaches like Usapan, community-level health events, and individual FP counseling in health facilities. LuzonHealth and MindanaoHealth conduct community-level group activities, while VisayasHealth restricts its Usapan sessions to health facilities. By the end of Year 3, numbers reached by the three projects were staggering. Project reporting show LuzonHealth reached 487,341 women and/or partners individually or in groups. VisayasHealth reached 273,604 pregnant women during antenatal care and 144,846 women during postpartum visits, and MindanaoHealth reached 23,346 women.

These data do not provide information on whether those who received or participated in IPC activities had improved knowledge, attitudes or desires to practice FP, and, more importantly, whether they became FP acceptors. Projects do not gather this information, though some have started doing so on a pilot basis. Within the present set of projects USAID has not undertaken empirical assessments of the effectiveness of IPC, e.g., how many of what types of IPC, or IPC in combination with mass media, led to improvements in knowledge, attitudes and practice.

**Weaknesses in FP mass media campaign**

USAID envisioned that CHANGE would develop an umbrella national TV campaign, reaching a wide audience and harmonized with a local-level demand-generation IPC campaign by the regional projects. TV is still the most popular mass medium, reaching a majority of urban and rural women with FP information, and there is little recollection of IPC at health facilities and in communities. During field visits, many facilities, both private and public, had video screens in operation; some showed technical content, and others were showing local TV.

For the Phase 1 of the FP communication campaign, in 2014, CHANGE produced and aired the TV ad “A planned life is a good life,” which depicted the hardships of a poor family with 10 children and the need to plan one’s family. The ad showed deference to the conservative culture but did not address unmet need for FP. It was not linked to the training and service delivery activities on LAPM implemented by the regional projects, and due to delays, prototype print materials developed for health facilities and communities were not produced on time, resulting in the regional projects’ having to adapt and

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65 Identification of women with unmet need started in 2013, but up until 2014, only 2 percent of these women received FP services. It was only in 2015 when PopCom started to seriously link these women to service providers, public or private.

66 The Usapan was developed by PRISM2 and adopted by the DOH. It was supposed to be different from the usual education/demand-generation sessions in that every Usapan was supposed to have ready FP service providers available to supply methods and referrals to LARC or LAPM methods.

67 NDHS 2013.

68 NDHS 2013 reports that only a small portion of urban and rural women reported having been visited by a field worker who discussed FP or discussed FP during their health facility visit.
reproduce their own materials on modern FP methods from previous projects like HealthPro. Without a communication strategy linking national TV campaigns with regional communication and service delivery, this activity had limited impact. During the evaluation, coordination among CHANGE and the three regional FP/MNCHN communication activities was not apparent, despite regular harmonization meetings among these projects.

In early May 2016, following the end of fieldwork on this evaluation, the method-specific FP mass media campaign (or Phase 2) was launched. The campaign uses testimonials from users of ligation, pills and the Standard Days Method (though not IUDs.) The airing was moved after the election campaign to avoid the high costs for TV time and avoid the media clutter during the election season. Based on a tracking study, CHANGE reports that this Phase 2 TV ad, “Planadong Pamilya,” is reaching 74 percent of its target audience.  

Exclusive breastfeeding promotion
The exclusive breastfeeding program is difficult to implement, and results are elusive. The projects already have many MNCHN/FP practices to promote and monitor. VisayasHealth notes that exclusive breastfeeding interventions are both labor- and resource-intensive, ranging from policy and regulatory reforms to enforcement of regulations in health facilities to community-based interventions. Even in ARMM, where LAM is popular with Muslim mothers and Islam requires that the baby be put to the breast immediately after birth, there is a high dropout rate, and babies are weaned as early as one month of age. These interventions require considerable funding and compete with efforts and resources to address program gaps in FP and MCH. MindanaoHealth avers that exclusive breastfeeding and infant and young child feeding are not within USAID’s area of expertise in the Philippines and put a strain on its MNCHN budget, which is only about 10 percent of its total budget.

Key informants (e.g., in Cavite) said that the breastfeeding support groups are difficult to sustain and may not be a viable approach to ensure that breastfeeding is exclusive for six months. Most of these groups are coordinated by the BHW, who has many programs to cover. As a child health and nutrition intervention, USAID may be better off leaving exclusive breastfeeding programs to agencies such as UNICEF and focus resources on areas in MNCHN where it can be more effective.

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It is very difficult to determine and track exclusive breastfeeding practice as an FP intervention. The projects report on LAM acceptors, most of whom are probably not exclusively breastfeeding, so they are at high risk of getting pregnant within a short a time after giving birth.

Challenges for TB DOTS and MDR-TB

Detection of infectious cases
Identification and treatment of the most infectious cases (smear-positive pulmonary TB) is the most effective intervention to reduce TB transmission and prevalence. The most efficient strategy is to identify persons with persistent cough among the adults attending public or private health facilities for any reason, in addition to those spontaneously declaring signs or symptoms of TB, and carry out sputum microscopy. The laboratory network has sufficient capacity and organization to increase microscopy, as the workload of the microscopy units is, on average, less than 10 smears per day.

Xpert testing can identify additional pulmonary cases and confirm TB in persons with signs such as abnormal X-rays. Most extra-pulmonary cases are not infectious and have a lower public health priority.

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69 The Planned Family.  
70 AC NIELSEN PHINTA (Philippine National Television Audience Measurement), as presented in an undated DOH/USAID overhead.  
71 USAID also notes that it is not highly effective among various interventions, given current level and age breakdown of childhood mortality.
Although detection and sputum microscopy have increased, coverage of the outpatient health facilities, particularly hospitals and private providers, is still incomplete. This is a major priority because the intervention is sustainable and the data can be used as a key indicator of case detection.

**Active TB community case-finding by CHTs/community-based organizations/BHWs**

Community case-finding, anchored on a functional BHW and CHT, is an important intervention to detect TB cases. So far, this strategy is not working. IMPACT’s target is 15 percent of notified TB cases referred by community-based organizations/CHTs/BHWs, and by September 2015 only six percent were reached.

In 2015, IMPACT monitored BHWs, community-based organizations and community volunteers who were trained in TB/IPC and supervision of treatment partners in four cities of the National Capital Region and several municipalities in eight provinces nationwide. They found that BHWs trained in IPC have not yet referred presumptive TB to the RHU nor used the planning, referral and monitoring tools given them. BHWs cited lack of supervision and their being saddled with many health programs in the community as reasons for non-performance. IMPACT has since undertaken efforts to provide further mentoring support to BHWs and supervisors to enhance their performance. Whether the volunteer BHWs are the most effective workers to detect TB cases, given the many tasks they are expected to perform, is open to question. However, in LGUs, incentives for BHWs have motivated them to actively look for TB cases.

One reason active case-finding is not working as expected is that the BHW/community volunteer is expected to provide information that is not necessary for active case-finding. The IPC flipchart being used contains messages that place an unnecessary burden on the BHW. Different communication materials with very simple messages and tasks need to be given to the BHW. The more comprehensive information can be provided by the health service provider to the TB patient once in the health facility.

A confounding issue is that, while active case detection by BHWs is not working well, there is a perception by health workers that it is. TB health workers have a positive outlook on what they are accomplishing. In FGDs, they report that active community case-finding by BHWs and TB task forces has increased case detection and continued treatment. TB workers say that BHWs conduct house-to-house visits or lectures in the barangays, and Quezon City, Misamis Oriental and Leyte report active TB task forces. TB patients in one FGD stated that they received TB information from the BHWs during home visits and were given bond-paper-sized posters.

The discrepancy between perceived benefits in case detection and information to patients and the community at the field level, and the poor results of referral and detection from actual data collected is due to excessive expectations of the role of community case-finding. Community case-finding is a complementary activity, which is labor-intensive and less effective than screening for respiratory symptoms in congregated settings, such as hospitals and outpatient health facilities or in high-risk groups, such as contacts. The level of information and access to services influence how well a community identifies and refers cases over time.

**Long duration of the MDR-TB treatment regimen**

The current treatment regimen for MDR-TB is 24 months. As a result, a large proportion of patients abandon treatment, and the outcomes are not satisfactory. The WHO has just recommended regimens of 9-12 months’ duration already used in multiple countries.\(^2\) These regimens do not include the most recently developed drugs and cost under US$1,000 per patient, with significant savings in money, human resources and patient hassle.

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IS IMPLEMENTATION STRATEGIC?

Is the portfolio implemented in a strategic manner? Why or why not? No one sets out to implement a portfolio in a manner that is not strategic, and the managers of the USAID health portfolio were no exception.

USAID/Philippines’ Country Development Cooperation Strategy (CDCS) for 2012-2016, with its goal of a “more stable, prosperous and well-governed nation,” includes intermediate result (IR) 1.3: “improving health to create a healthier workforce,” as part of the strategy’s development objective (DO) 1: “Achieve broad-based and inclusive growth accelerated and sustained.”73 Reductions in TB and improvements in FP and maternal health are presented as key elements to meet IR 1.3, and movement toward UHC and meeting the MDGs’ important objectives is seen as both important and feasible.74 Nutrition and HIV/AIDS were left off of this strategy.75 Three IR 1.3 sub-IRs focus on supply of services (supply of quality services for FP and maternal health, and both services and drugs for TB), demand, and policy development, providing the resulting FP/MNCHN and ID projects with a very wide choice of activities to choose from. USAID placed a geographic focus on areas with high unmet need for FP and MCH and high burden of TB for implementing IR 1.3,76 which provides a more defendable, though not immediate, impact on the health of the workforce than one might expect for a focused strategy.

The CDCS for 2012–2016 also includes health–implemented with the same focus on FP, MCH and TB access, demand and policy–in DO 2: “Peace and stability in conflict-affected areas in Mindanao improved.” Under this DO, health is part of IR 2.1: “local governance strengthened,” sub-IR 2.1.2.: “service delivery by local governments.” Here, the CDCS makes a direct strategic link between the DO and the health portfolio work with local government, and the strategy calls for a focus on the most vulnerable, youth and male-friendly services.77 This focus mirrors the health activities being undertaken in Mindanao.

As this strategy moved to implementation, the FP and MCH, and ID Project Narratives based success on the achievement of internationally accepted indicators used by the DOH (e.g., confirmed cases of TB, CPR), and used DOH-accepted approaches (e.g., BEmONC, DOTS). The FP and MCH project focuses on regions showing the most need based on those indicators. The ID project focuses exclusively on TB.

Both projects are designed to assist the DOH to engage at the provincial level, which allows for province-wide implementation and acceptance of programs, in contrast to engagement and acceptance in scattered and dispersed municipalities. In this approach, receptiveness of the LGU and the local chief executive is key. If the provincial government and its local chief executive are not keen to champion or accept the programs and reforms, municipal engagement is the next option. Again, the number of municipalities that can be engaged successfully (and consequently, the extent of coverage in the entire province) will depend on the receptiveness of municipal governments and local chief executives, the number of interventions in the assistance package, and the resources USAID is able to bring.

Strategic implementation–having an articulated strategy and implementing it for the desired effect–is evident in some parts of the portfolio, and not in others.

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74 Ibid. p. 22-23.
76 Ibid. p. 23.
Solid strategic partnership with DOH

On the FP side, this strategic approach is used with the DOH, yet the continued sensitivity surrounding permanent FP methods is a formidable issue. The temporary restraining order issued in June 2015 by the Supreme Court that prohibits the DOH or its agents (e.g., USAID) to register new contraceptives and the promotion and use of subdermal implants resulted in USAID-supported programs in both the public and private sector cutting implants from their contraceptive choices virtually overnight. No movement toward reversal of this order is evident at this time. To date, no other contraceptives (e.g., new IUD models) have been considered for the DOH program due to the order. DOH programs, including those receiving technical assistance from USAID, are using referrals to NGOs to meet the demand for implants, and private providers are finding other sources. USAID and DOH partnership continues, women continue to receive MNCHN/FP services, and USAID projects stand ready to address a change in the order if it occurs.

Other strategic approaches in the health portfolio were not as clearly defined, and thus harder to evaluate in implementation. The difficulty in finding and assessing strategic implementation begins with a very broad and unfocused statement of strategy: “demand for services, the supply of services (quantity and quality), and health systems strengthening and health policy reforms.”

Integrating services and leadership activities

As noted above, USAID’s programmatic strategy in the present portfolio is to lead with two large service delivery projects supported by crosscutting activities in policy, communication and leadership. One would expect the projects to be designed and managed with in close coordination with the crosscutting activities in the same geographic areas. For example, such integration could improve LGU absorption and institutionalization of the service delivery. Yet the three regional MNCHN/FP activities and the TB service delivery activities are managed and work independently from HLGP, though they operate in the same geographic space and ultimately under the direction of the same local political and health leaders in their respective areas. There is no evidence from interviews with local health leaders and partner staff that that the awareness-raising and positive support for key health issues emanating from the HLGP program is affecting how the USAID services activities are programming for expansion or sustainability. HLGP work supported by USAID began after the service delivery activities were launched, and the interface between the services and leadership activities were not clear to the USAID partners.

Strategic implementation difficult for MNCHN/FP

In MNCHN/FP, USAID’s all-encompassing strategy statement led to the development of a plan with many approaches to increase modern CPR and reduce unmet need for spacing and limiting the number of children a woman has by implementing interventions to increase demand for and expand access to LAPM, as well as creating a policy environment that would support increases in demand and services. The plan assumed that communication would increase demand; training and a steady supply of commodities would improve and expand service delivery; education and advocacy with LGUs would build a more supportive policy environment; and, by its absence in the plan, that the availability of

78 Nevertheless, in November, 2015, the Office of the Solicitor General submitted to the Supreme Court its reply to the petition for temporary restraining order and asked the Supreme Court to lift it. In March, 2016, the Human Development and Poverty Reduction Cabinet Cluster and the Social Development Cluster (Cabinet-level also) of the National Economic and Development Authority issued a joint resolution asking the Supreme Court to lift the order. A second motion to lift the order was submitted by the Office of the Solicitor General to the Supreme Court in June 2016. The newly appointed Health Secretary by President Duterte, expressed support for implementation of RPRH and has announced that the DOH will work for the reversal of this ban and, in his first State of the Nation address, expressed support for implementation of the RPRH law.

79 USAID, Infectious Disease Project Narrative, February, 18, 2015, p. 4; USAID Family Planning/Maternal and Child Health Project Narrative, February 18, 2015, p. 4.
contraceptives and other supplies was assured through the DOH. A strategic, geographic focus on Luzon, Visayas and Mindanao had USAID programs working in areas that had demonstrated high levels of need for a long time, as well as USAID involvement. Separate agreements were set up for each region and, in total, more provinces were covered by the project than in the earlier nationwide program.

A critical strategic implementation issue facing the MNCHN/FP project, with operations at the sub-national level, is the integration of USAID-assisted demand-generation, service delivery, and policy interventions at the city/municipality level. Based on interviews with government officials and partners, such integration, and the synergies expected from it, are not evident. As noted above, the services activities were designed to assist the DOH to engage at the provincial level, and their points of contact are the Municipal Health Officers. Interviews with city and barangay health officials demonstrate that it is at the city/municipality where plans for demand generation, service delivery and interpreting DOH policy occur. This leaves the services activities assisting demand generation, service expansion and policy development in as many cities/municipalities as possible. The result has been a focus on quantity rather than quality and effectiveness. The project reports narrate the number of communication activities and people reached, service providers trained in various skills, and policy initiatives undertaken. It is difficult to tell whether those reached were referred/served and those trained are performing adequately. It is hard to determine the mix of interventions undertaken in a particular city/municipality and the impact of this mix in reducing unmet need, and to track how each city/municipality is progressing. In short, some excellent approaches are being pursued, but not strategically.

Drilling down into technical approaches, the lack of carrying out a strategy is evident as well. Some strategic approaches were never fully articulated, for example, no overarching communication strategy, or evaluation strategy for determining the impact of approaches. Other technical strategies were developed, but not always pursued to their logical conclusion. For example, the integration of FP into antenatal care and immediate postpartum services was, as discussed above, a positive contribution. However, without a strategic underpinning on the specific issue of integration into antenatal care, it is not clear what USAID expects the DOH to do with the experience. An example of disconnect is found in the demand-generation strategy where IPC through small- or large-group approaches like Usapan and other health events at the community level and individual FP counseling in health facilities led to thousands of potential clients reached by the end of Year 3, yet there was no systematic link between this demand-generation and who actually became an FP acceptor. For example, FGD with young FP acceptors revealed that a number of the acceptors chose an FP method on their own without receiving any information and counseling from health providers.

**INSTITUTIONALIZATION AND SUSTAINABILITY**

Sustainability and institutionalization are USAID principles regularly addressed in USAID programs. The USAID/Philippines health portfolio is no exception. Experience indicates that moving toward sustainability was easiest to see within public-private partnerships in both the MNCHN/FP and ID projects, but that large or motivated public and private facilities, especially those with strong networking skills, should be able to absorb the USAID investments and continue without further assistance.

At the national level, the DOH is identifying important priorities for institutionalization, one of which is to develop some sort of semi-autonomous training institute in response to high demand for technical and managerial training. USAID has provided technical assistance to improve the technical quality and implementation of the DOH’s training program in key regions, but is not, under the present portfolio, working to institutionalize that training. Similarly, while the MNCHN/FP and ID projects have identified and attempted to assist regions when the DOH supply chain and data collection and utilization programs were found lacking, strengthening of those systems at the central and regional levels is not a project objective of the present portfolio.
USAID calls for sustainability

According to the cooperative agreements for the service delivery projects, efforts at institutionalization and sustaining good practices are built into the projects, following USAID principles. The following are examples of the language USAID used in the MNCHN/FP cooperative agreements to indicate what USAID expects to be sustained at the end of a project:

**Capacity Building and Integration of Maternal and Neonatal Health with Family Planning: VisayasHealth, Cooperative Agreement No. AID-492-A-13-00007**

- Help LGUs establish, operate and **sustain the network for SDNs** (p. 28 of 79)
- (d) work with LGU staff to strengthen their ability to improve their own systems . . . (e) **address sustainability issues immediately as they occur** during project implementation and progress toward their resolution should be monitored periodically (p. 29 of 79)
- **Sustainability:** . . . **Recipient identifies activities and interventions that have a high probability of sustainability** and plans for the continuity of these activities (p. 32-33 of 79)

**Capacity Building and Integration of Maternal and Neonatal Health with Family Planning: MindanaoHealth, Cooperative Agreement No. CA-AID-492-A-13-00005**

- The Integrated MNCHN/FP Regional Projects seek to ensure adequate and quality MNCHN/FP services that can be provided in a sustainable manner. **Sustainability should be a primary concern** of the Recipient in all activities to be implemented. (p. 24 of 86)
- (e) **address sustainability issues immediately** as they occur during project implementation and progress toward their resolution should be monitored periodically. (p. 29 of 86)
- Component 3: . . . As the project strengthens LGUs in the service provision of MNCHN/FP, CHTs should be concurrently enhanced to ensure that they are able to steward the local health offices, monitor their performance, and **institutionalize the training, TA [technical assistance], and other project inputs.** (p. 28 of 86)

While the bolded language above calls for a strong focus on sustainability, subsequent work plans and indicators in the regional MNCHN/FP agreements emphasized more immediate service delivery outcomes and indicators that tracked achievement toward MDG goals.

As noted above, the FP/MNCHN projects did, primarily through training, improve the ability of providers to offer important services, especially in postpartum FP and emergency obstetrical care. Where training-of-trainers programs operate well, a certain amount of technical sustainability is possible. While the HLGP project engaged, educated and enthused LGU leaders in MCH and other health priorities in their areas, and services projects supported the work of LGUs, there was no systematic strategy in place for the HLGP and the services projects to work together. Thus, if an LGU leader was inspired (this was evident in Tacloban), service provision and necessary inputs, such as incentives for BHWs and commodities, could be sustained. In the likely cases where leaders changed or did not take up the health cause, there was no alternative approach to developing sustainability.

Public-private partnerships, through the expansion of training, licensing and certification of private midwives, and the enhancement of MNCHN/FP services, including the Program for Young Parents and adolescent programs, did successfully strengthen and sustain the available MNCHN/FP services in all three regions. These are the most likely initiatives to be sustained within the health system.

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80 This and other examples in this section are intended as examples of how USAID asks cooperating agencies to work on sustainability; other agreements in both projects have similar examples.
As noted above, while assistance to develop and start up SDNs is promising, these networks have not been completely rolled out or sustained.

For TB, the IMPACT agreement (AID-492-A-12-00014) includes the following, less definitive, language when referring to sustainability:

- Wherever feasible, TB training courses shall be embedded in existing DOH capacity building program and **assist the NTP in institutionalizing the training program.** (p. 27 of 86)

- **Ensure sustainability by engaging organizations . . .** explore public-private partnerships in the process. (p. 15 of 86)

- The project will coordinate with HPDP 2 and assist NTP **developing MDR-TB plan and financing that addresses sustainability beyond the GF [Global Fund] grant.** (p. 28 of 86)

IMPACT and SIAPS/USAID work was integrated into the concept note to the Global Fund for the current $93 million TB grant, and both agreements worked in close collaboration with the NTP. IMPACT is responsible for technical assistance and training in 43 cities/provinces; the plan is to reach 90 percent of public providers and 65 percent of private providers by end of 2016.81 The Global Fund documents do not discuss post-grant sustainability; the government commits only to support testing, all first-line drugs, and limited amount of MDR treatment. The major sustainability concern for TB is not as much funding or the technical capability being built within the regions, but the very small staff capacity of the NTP, which is both too small and too dependent on embedded international personnel.

**No urgency among beneficiaries**

Again, public/private approaches were key to meeting IMPACT’s sustainability requirements. The expansion of DOTS among private providers not only expanded the NTP’s reach, but also began to address quality improvements of private prescribers. That said, mandatory notification and access to new diagnostic methods (GeneXpert) would reduce the number of false clinical diagnosis and facilitate confirmation of TB cases. Yet when project beneficiaries—DOH national and regional personnel, LGU leaders and providers, private providers—are asked if they can institutionalize and sustain the good practices that the project has introduced, the following range of tentative responses are given:

- They are hoping the project will continue indefinitely.

- If the project is to be terminated, they are hoping it will not be right away and that a transition period can be provided.

- Should the project be terminated abruptly at the end of the current project’s life, they will do what they can to sustain the good practices that were introduced and implemented.

None of the beneficiaries reported understanding that the technical assistance they were receiving was time-limited, nor did they say that plans were underway for the end of the USAID assistance to their program.

**Signs favoring sustainability**

Some LGUs (e.g., Leyte, areas of Luzon) and larger facilities (e.g., South General Hospital in Cebu, Southern Philippines Medical Center in Davao, and Brokenshire Hospital) express interest in continued technical cooperation but are visibly able to survive on their own resources. And once private midwives and TB doctors, some of whom are already financially sustainable, receive technical training and advice

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81 This work remains on track; IMPACT completed planned training of approximately 3,600 community volunteers, involved approximately 365 private hospitals in TB-DOTS, and trained personnel in 4,067 pharmacies.
on registration and certification from the DOH and PhilHealth, respectively, quality services can be maintained.

USAID’s experience with Well Family Midwife Clinics\(^{82}\) and other private midwife clinics under a previous USAID project gives credence to the possible success of present efforts to move toward sustainability by engaging the private sector. During field visits, the evaluation team was told that six of the 20 clinics established in Davao were still operating and that some were sustained in Luzon.\(^{83}\) As noted in the section on mentoring of midwives, above, this thread to focus on midwives via private sector projects continued in the two later PRISM projects.

At present, the financial support to the population covered by PhilHealth and the facilities accredited to provide PhilHealth insurance packages bodes well for entities assisted by the present portfolio. Further, the enthusiasm and low costs of programs such as the Program for Young Parents and adolescent programs make it likely for established facilities to continue these programs if their use continues to be valued.

**Networking**

The successful providers the evaluation team met with were good networkers. Examples include large health facilities that bring in small CSOs for special work in TB or HIV, local businesses for a Program for Young Parents or teen days; midwives who keep in touch with CMSU or learn what the PhilHealth rules are; and small government facilities who refer out patients who want implants.

This is an important implementation issue for USAID projects because the assistance provided through the services activities can impede networking. When the evaluation team was told that a USAID activity provided contraceptives when there was a stock-out, it was because the activity went to UNFPA or PSPI for the facility needing commodities, instead of the facility making that link itself. In one RHU that provides FP, MCH and TB services, for example, the nurse gave a presentation that noted that they had not received PhilHealth funding on time and appreciated the USAID activity’s assistance in securing their funds. This RHU had had stock-outs and received supplies from UNFPA and PSPI, but it did not consider the two organizations partners because the USAID activity had secured the drugs for the RHU. Developing the networking skill in this RHU and others will be necessary to sustain its work.

**Institutionalization within DOH**

The expectation is that much of the assistance USAID provides will be taken over by the DOH. In interviews with government officials, primarily in Manila, the evaluation team heard that the DOH expects to develop the DOH Academy, which will tap expertise from around the country and the world to ensure that both medical and systems aspects of DOH work benefit from continuous updates and improvement. PhilHealth continues to develop public health packages and to expand coverage of the poor and underserved (e.g., indigenous populations) in an effort to provide health care for the poor. PopCom was relatively recently tasked with focusing on expanding FP information to poor and underserved families who are part of the 4Ps.

USAID projects assist with the content of what will be institutionalized in the field, i.e., training, expanding PhilHealth coverage, and FP education. At the national level, USAID is involved with both the implementation of RPRH law and the expansion of the NTP. It works through HPDP2 with the EU on budget issues related to PhilHealth, and USAID health officers stay aware of PopCom’s work under 4Ps. However, there is no direct programmatic engagement on institutionalization of field-level needs that

\(^{82}\) 190 clinics were set up in 1997 under the USAID-supported TANGO II project managed by John Snow (JSI).

\(^{83}\) This finding highlights how investigating sustainability in a program is often easier and more valid after the assistance investment has ended.
USAID projects support or assist with—technical training, social insurance through PhilHealth, data collection and utilization, LGU leadership development in health, or supply chain.

**International initiatives and institutionalization**

Both projects are assisting the DOH to meet its objectives as part of international initiatives, or in the case of the Global Fund, an international financing mechanism.

As noted above, in TB, work by IMPACT and SIAPS are specifically delineated within the Global Fund grant as part of a partnership with government designed to strengthen the DOH’s TB program and expand coverage through the private sector. The Global Fund’s Country Coordinating Mechanism (CCM)\(^4\) structure—which includes the government, UN, USAID and other donors—engages with the DOH in continuous dialog on progress. Additionally, the TB Joint Programme Reviews, led by the WHO and including experts from WHO, CDC, USAID and other U.S., bilateral and international agencies, are conducted on a regular basis. These in-depth visits throughout the country provide an outside look at what the government is doing and provides a respected, third-party critique of what the government and in-country donors are partnering to achieve. Both the CCM and the Joint Programme Reviews are able to give relevant input on the progress of what the government is achieving (as opposed to what donors are achieving). By design, both can keep government focused on its responsibilities related to sustainability (e.g., expanding services through the private sector), and institutionalization (e.g., expanding the size and strengthening management in the NTP), giving the USAID-DOH partnership third-party input.

For MNCHN/FP, there are international initiatives that hold the Philippine government accountable for progress; however, project documentation and interviews indicate that those initiatives are a step removed in comparison with what occurs for TB. The MDGs call for improvements in maternal health and FP, and the Philippines was tasked during the FP2020 meeting in Bali, Indonesia to continue implementation of the RPRH law. The government is required to report back, and it does so. The RPRH Secretariat, chaired by the DOH and including representatives from USAID implementing partners and other donor representatives, is the oversight mechanism for the RPRH law. There is no direct counterpart to the CCM or the Joint Programme Reviews that operates within the country on an ongoing basis.

**USAID’S COMPARATIVE ADVANTAGE**

What are USAID’s comparative advantages in health in comparison to other donors, the private sector and civil society, vis-à-vis local and national government?

Donor representatives and both public and private sector partners see USAID as having specific technical capabilities, including training and the development of training documentation and protocols, preparation of policy guidelines and assistance in the development of policy, field-level operations research, behavior change communication, experience with the transfer of technology and experience with the private sector.

Family Planning and the NDHS are mentioned universally as USAID strengths and important comparative advantages, and within the TB community, USAID and its partners are respected for what they have accomplished. NDHS data are used by other donors, the DOH and PhilHealth, and some want more information from it. As one donor representative noted, “Give up family planning if you need the money to fund DHS... but needs to be more granular.”

\(^4\) CCMs are country-level multi-stakeholder partnerships that develop and submit grant proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation.
Donor partners, LGUs, providers and beneficiaries note a comparative advantage of USAID is the Agency’s greater financial resources. The 2nd Consolidated Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012 reports that USAID contributes 64 percent of the approximately PhP 5.92 billion provided by donors to meet the objectives of the Act. Similarly, USAID is the leading technical assistance provider for the NTP.

USAID has a long history of development cooperation with the Philippines. In health, USAID began working on FP in the early 1960s, first with PopCom and later with the DOH. During this evaluation, the evaluation team heard about and witnessed USAID’s good working relationship with the DOH at the central, regional and facility levels. Whether an issue was contentious (e.g., too much time of staff away from work on training) or positive (e.g., DOH clearance for accreditation of a facility by PhilHealth), USAID and the DOH are able to achieve results together.

Operationally, respondents noted some important comparative advantages they saw for USAID, including: the ability to work with the private sector, including for-profits, to contract directly with CSOs and faith-based organizations, the technical capacity to address complicated systems and diseases, international field expertise, the capacity to train national trainers on M&E and data for decision-making, and, because most of its assistance is provided through grants and contracts, the ability to respond rapidly at the program level.

Respondents within and outside of USAID noted that the health sector has a strong partners group, and that the country has an effective CCM. USAID leads the health partners group and holds membership in the CCM. While the evaluation schedule did not overlap with meetings of either group, interviews with individual donor representatives indicate that USAID is an effective and well-respected partner within the health sector.

Present objectives of other donors support the Philippines as a country committed to and capable of meeting its Sustainable Development Goals. The UN agencies and EU favor assistance that strengthens systems. As one donor representative noted, “We want to move away from any direct assistance given that the Philippines is lower middle income... The Philippines needs to embrace its normative role and needs to set up pillars of accountability.”

UN agencies expect to continue their work in emergency services and commodities and HIV, and will have a consolidated effort in Mindanao. The EU and USAID coordinate closely on their analysis and technical assistance on various elements of medicines regulation and oversight, including technical assistance to the Food and Drug Administration on pharmacovigilance. JICA and the Korea International Cooperation Agency are involved with public-private partnerships. JICA continues to support MCH training, noting that it appreciates training modules developed by USAID projects (e.g., for BEmONC). Continued Global Fund support for HIV and TB is expected, and implementation of the RPRH law continues and was highlighted at the key action for the Philippines in January 2016 FP2020 conference in Bali, attended by most representatives of the partners group.

The challenge for the coming years will be to combine USAID’s many comparative advantages in cooperation with the government and other donors to develop a portfolio that is relevant to the

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86 For the UN system and the EU, the fact that the Philippines is a lower middle-income status in the World Bank indicators leads them to move from service delivery assistance to system strengthening; however, both have worked with selected poorer populations such as the indigenous peoples in Mindanao.

87 Similarly, though not within the health sector, the Millennium Challenge Corp.—an independent foreign aid agency of the United States government—agreed in December 2015 to fund a second large-scale (~ $434 million) five-year development grant for the Philippines, speculated to focus on rural agriculture. Naki B. Mendoza, Devex, July 19, 2016.
systemic needs of the public sector during this period of increased budgets. The conclusions and recommendations in the following section are offered as an input into that process.

**To summarize these findings:**

**Question 1:** The health portfolio was relevant to needs in 2012, but in its present configuration is not relevant for the policy, technological, program and finance environment today.

**Question 2:** The present portfolio resulted in several important accomplishments, and some failures, which can be traced to weak strategy or attempts to do too much.

**Question 3:** Strategic implementation as a partner with the DOH has stood the test of time, but others, especially the integration of portfolio activities at the local level, have not.

**Question 4:** USAID is committed to sustainability, and some successes at the local level, especially in the private sector, are evident, but projects have not made working themselves out of job a priority and they are not managed to do so; there is no movement away from direct support and toward institutionalization.

**Question 5:** USAID is very well positioned to continue to make significant contributions toward assisting the Philippines to meet its health objectives.
V. CONCLUSIONS AND RECOMMENDATIONS

USAID/Philippines has provided important, expert assistance to the MNCHN/FP and ID programs in the Philippines, and it is well appreciated by stakeholders and has made a difference. The following conclusions and recommendations are offered as suggestions for a future USAID health response that is relevant, strategic, effective and sustainable within the public and private sectors.

DOH SYSTEMS STRENGTHENING–DATA, SUPPLY CHAIN AND TRAINING

Conclusions

As USAID projects work in data collection, training and increased delivery of services in MNCHN/FP and ID (TB), it has become apparent that local and other temporary fixes, including some supported by USAID, cannot replace DOH system development and rollout in three major areas: data collection and utilization, supply chain for medications and related commodities, and the DOH Academy. In all three, USAID has the experience in other settings to assist DOH with the development and strengthening of these systems.

Data management and utilization: USAID service projects have trained and supported government units in their geographic areas to collect, report and evaluate health information for the DOH. Projects go about this work in different ways, and, while they all have strong M&E teams, as a group, the teams have no control over the data collection plan itself nor over the indicators they are told to include. The DOH would benefit from dedicated technical assistance to help it review data objectives, standardize the data management system across locations and ensure that processes are user-friendly for suppliers and users of data. USAID has experience assisting countries to develop national data systems linked to regional and local sites, training and data quality programs and developing tools to enhance data transparency, such as dashboards in government websites.

Public sector supply chain: Small but widespread stock-outs of FP, TB and other drugs that the DOH provides are too big a problem for short-term solutions. Family planning programs go to UNFPA or CSOs when they have stock-outs, USAID projects provide IUDs for training programs so students will have enough to pass their practicum, TB programs use a text alert system to warn of stock-outs, PopCom does the same with an FP logistics hotline, and USAID projects all have examples of facilities needing to swap out products among health units to fill gaps. Some facilities rely on LGUs or patients to buy drugs in the private sector. As programs expand in this PhilHealth era, the antiquated push system of providing set numbers of medicines per facility does not work: It leads to over- and under-stock and wastes scarce resources. There is wide agreement within and outside the DOH that there needs to be an overhaul of the public sector’s supply chain for medicines.

Additionally, while some other parts of the pharmaceutical management system are receiving attention, such as Promoting the Quality of Medicines and SIAPS’s work with the Food and Drug Administration on medicine quality-assurance and pharmacovigilance, respectively, little outside involvement is evident with the development of the essential drugs lists that feed into the selection and procurement side of the supply chain, which should be aligned with standard treatment guidelines and impact medicines budgets. However, the evaluators limit the recommendations below to the supply chain as an important entry point into pharmaceutical systems strengthening because at this time, the weak public sector system is affecting access to services for the poor. USAID has experience in helping countries develop modern supply chain programs as well as broader work in pharmaceutical system strengthening that affects both public and private sectors, including regulations and licensing for those providing commodities to the public sector system or planning to sell them in the private sector. Future work or
work later in the next cycle of assistance may want to address the function of medicines in the health system in its entirety; however, given the immediacy of the need for reliable availability of medicines at the local level, the evaluators suggest starting with supply chain.

**DOH Academy:** Finally, as one respondent noted, “It is time to assist in making the DOH Academy a reality.” Yet curriculum development and technical training for health care administrators, midwives, nurses, doctors and pharmacists in both the public and private sectors continue to be an integral part of USAID’s MNCHN/FP and TB activities. Demand for trained professionals continues to increase, especially with the advent of PhilHealth’s expansion of coverage, and as new cadres of professionals enter the market. The DOH recognizes the need and has considered ways to institutionalize training within the DOH for quite some time. More recently, it has noticed that too much staff time is spent in training, adding an additional burden to getting people trained. Many respondents close to this issue see a DOH Academy as the best option and note that it will be important for the DOH to contract out for training to ensure the requisite technical offerings can continue to evolve to meet the needs of the DOH and its clients. Several past and present USAID technical assistance and service providers are certified as institutional trainers in selected areas, as are several Philippine institutions and CSOs. Similarly, the DOH could use an institute model to sustain the work of the HLGP, and to strengthen DOH skill levels in communication, supportive supervision and drug management.

Along with the requisite experience and technical capacity to take on these complicated challenges, there is trust and a working relationship between USAID and the DOH that allows the two partners to tackle systemic problems. The entree will need to come from senior levels of USAID, as opposed emanating from implementing partners or during the implementation of a particular technical activity.

**Recommendations**

- Support the DOH to further develop and strengthen a data system where health and government leaders as well as health care providers can report on and use relevant and accurate data to track progress toward meeting national goals in a transparent manner. This assistance could take the form of technical assistance in data systems management for a multi-level health system, including communication among those levels, training-of-trainers in data collection and management, the development and launch of work plans for the use of data in decision-making at various levels of government and advocacy in the CSO and private sectors, and developing simple, transparent systems for sharing data with the public (e.g., data dashboards on the DOH web page).

- Support the development of an updated supply chain management system that includes local-level planning and forecasting, tracking product to the community level and sufficient expertise within DOH—including PhilHealth—in pharmaceutical management. Continue analytical work on broader elements of pharmaceutical systems strengthening, (e.g., licensing, regulation, pharmacovigilance, drug choices) affecting the public and private sectors.

- Support the development of and operational plan for the DOH Training Academy, including the legal, management and contracting structure necessary for contracting out for training and evaluation. Beyond basic technical and managerial skills for public and private providers of medicines or services, encourage the inclusion of LGU leadership training, training PhilHealth representatives in the field on current DOH technical approaches, and training in the design and management of third-party contracts for relevant DOH staff.

- Introduce the transfer of the HLGP health leadership program into the DOH.
PHILHEALTH

Conclusions

PhilHealth provides the opportunity for LGUs to strengthen and sustain operations of their health systems and health facilities. The evaluators heard heartwarming stories of health facility services in provinces, cities and municipalities that have been improved and systems upgraded because they were able to successfully access PhilHealth reimbursements (Cagayan de Oro City, Bukidnon, Tacloban City, Leyte, Cebu City, Davao City). USAID project assistance to LGUs has increased the number of hospitals, city health units and RHUs accredited for various MNCHN/FP packages.

However, not all LGUs understand the system. According to senior PhilHealth staff, while all LGUs have at least one public health facility or outpatient health service (e.g., TB-DOTS, animal bite center) accredited by PhilHealth, many LGUs do not know how to manage the system to facilitate claims, or even provide figures on use. Both LGUs and facilities lack knowledge and skills on how to obtain health provider certifications and facility accreditations, and once obtained, how to manage the system to facilitate payment of claims. Both the public and many health facilities in municipalities and barangays are not fully cognizant of the PhilHealth benefits that are now available and how they can be accessed. With a few exceptions, local PhilHealth staff process claims with little interaction with the delivery of health care. In several areas, the evaluators heard of long delays in getting PhilHealth reimbursements (e.g., Cavite, Cebu). Providers get frustrated and confused when PhilHealth withholds payments without explaining it was in reaction to a DOH licensing or renewal requirement. In many locales, the PhilHealth officials do not know their governors, mayors or health facility heads, and vice versa.

For those receiving assistance, facilities and LGUs appreciate USAID project assistance in liaising with PhilHealth, but that leaves USAID projects in the middle of what should be a direct relationship between the insurer and providers or beneficiaries. If USAID and PhilHealth had a closer and more formalized working relationship, policies and opportunities would not have to be relearned every time there was a bottleneck, and the two could move on to addressing effectiveness and quality needs at the local level.

At the national level, HPDP2 is working with the EU and PhilHealth to analyze budget flows of the DOH and PhilHealth and have found a key anomaly: The DOH purchases drugs for MNCHN/FP programs, but then PhilHealth covers the costs of drugs in the various reproductive health packages. Work continues on presenting solutions.

Another concern raised by the USAID health team is that, given the high out-of-pocket spending on medicines in the country, attention should be given to analyzing medicines benefits policies and strategies with a view to optimizing the use of PhilHealth resources for maximum public health benefit and reducing household out-of-pocket spending on medicines by the poor.

Recommendations

- Develop a formal partnership with PhilHealth to assist in addressing key issues in the expansion and use of social insurance, as well as to support PhilHealth’s package development in the areas of MNCHN/FP and ID, especially at the regional level.
- Develop and strengthen transparent and standardized approaches within PhilHealth to assist LGUs and private clinics to obtain certifications and to manage claims.
- Support proactive communication interventions and outreach that will improve knowledge and understanding of providers and beneficiaries about PhilHealth benefits and certification procedures and how they can be accessed.
- Where needed, develop LGU support for and capacity to optimally and transparently access and use PhilHealth funding for health objectives; involve governors and mayors.
• Include local PhilHealth officials in future capacity-building efforts for local chief executives and local health officials.

POLICY DEVELOPMENT

Conclusions

The health portfolio supports a substantial amount of policy development assistance.

USAID has a long-standing relationship with UPecon, whereby the university provides legal, administrative, financial and technical advice to the DOH and other parts of government and conducts field research and experimentation. Among its many activities, UPecon provides technical assistance to the National Implementation Team (NIT) of the RPRH law, works with the EU and PhilHealth on examining the relationships between budgeting within PhilHealth and the rest of the DOH, coordinates the inputs of the MNCHN/FP work to help LGUs strengthen data management and quality checks, and helped PopCom develop a FP logistics hotline to monitor commodity stocks and send information to the DOH. In April 2016, the project convened government, private sector and academic experts for the 9th Ayala-UPSE Economic Forum, where many of their publications were disseminated.

USAID funds a ZFF initiative for health leaders—also supported by UNFPA and UNICEF, Merck, Sharpe and Dohme’s Merck for Mothers program and the DOH—that links government local chief executives with their health counterparts and creates a space for them to work through real-world health challenges, primarily in maternal health. ZFF has also developed an MDG matrix that local governments are using as a dashboard to track progress. Both approaches are used internationally in policy development.

UPecon’s policy development work and evidence-based engagement with government is similar to that of universities around the world (e.g., University of Cape Town, Harvard School of Public Health, University of Washington, London School of Tropical Medicine), and the ZFF approach to engaging while educating leaders is similar to that of the Aspen Institute and the UK’s Children’s Investment Fund Foundation for national health and development leaders.

In TB, the USAID ID project helped develop national guidelines and policies, many of which fed into the new TB law, including the policy for rapid testing, and is presently completing a formal study of the nine-month treatment regimen for MDR-TB. In MNCHN/FP, representatives from the services projects advise on RPRH implementation.

Locally, IMPACT reports influencing the issuance of 372 local policies that increase case-detection rates and overcome barriers, like transportation costs, to continued treatment and care. MNCHN/FP policy initiatives focus on PhilHealth accreditations, and VisayasHealth used its analysis of common factors for success in removal of financial barriers to access by pregnant women to antenatal care and facility-based delivery for advocacy work in LGUs. Beyond USAID project involvement, local policies exist that address barriers to health care (e.g., in Tacloban City, Valencia City, Bukidon). These policies need to be analyzed for impact and moral hazard.

USAID leaders themselves serve on key reproductive health policy initiatives, including participation in FP2020, the secretariat of the NIT of the RPRH law, and the Global Fund CCM, as well as playing a lead role among development partners in the health group.

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88 This work helped identify an important budgetary issue: Medicines and health commodities are budgeted for in the DOH budget but then paid for by the PhilHealth budget. This leads HPDP2 to suggest rationalization or consolidation of the two public sector budgets.
Beyond what is being addressed on the policy side by USAID health cooperating agencies, there are directions that USAID has not taken but perhaps should be considering, for example:

- The policy unit (Health Policy Development and Planning Bureau) in the DOH is not capacitated to operate on its own.
- Policy work includes engagement of CSOs, the media or other organizations as third parties to encourage transparency in government and serve as watchdogs for the expansion of the private sector or key concerns (e.g., medicine stock-outs, maternal mortality ratios) in select regions.
- International policy development advice or approaches are seldom sought, yet welcome. UPecon reports being paired with the Harvard School of Public Health in its early years of policy development work with USAID, but the relationship was not seen as useful. Yet on the technical side, useful international input is evident, for example in the Joint Programme Reviews in TB and the MNCHN/FP implementing partners’ (EngenderHealth, RTI and Jhpiego) input to the NIT for the RPRH law.

To implement its policy development program, USAID is partnering with established organizations to contribute to policy development (UPecon and ZFF) and working on policy through MNCHN/FP and ID projects. These policy initiatives were designed separately, often in reaction to DOH or LGU needs and opportunities. Each implementing partner is managed separately and in a compartmentalized manner, where each has a separate Office of Health manager and separate objectives. The result is that it is difficult to give direction to the whole set of policy actors working for USAID, and even more difficult to take on new policy challenges, such as some of the suggestions above. There is little indication that merely requesting better communication and coordination across the projects or across Office of Health staff will help streamline or update this policy work, and presenting the portfolio as if there is a single policy project does a disservice to the breadth of what USAID has in its arsenal.

**Recommendations**

- Consolidate the management of health policy activities in the portfolio under a single senior manager with a team of one or two other officers to design and manage the Office of Health’s policy portfolio.
- Develop a plan to strengthen the role of the DOH’s Health Policy Development and Planning Bureau.
- Develop a plan to integrate the HLGP into the DOH Academy.
- Document and disseminate successful local policy initiatives on TB and MNCHN/FP in provinces, cities and municipalities, and include these as case studies in HLGP capacity-building efforts as well as advocacy targeting other LGU leaders and local health officials. Evaluate selected initiatives for effectiveness and moral hazard.
- Develop a focused plan for policy analyses, with clarity of who the audiences are. Address specific, timely issues, based on USAID and DOH priorities at the national and regional levels, for example, health services and the rights of minors, women’s health as a human right and the role of medicines in UHC.
- Review examples of CSO and media engagement within policy initiatives in other USAID-assisted countries to consider how a broader base of information, education and oversight might assist with the rollout of key policy actions (e.g., TB and HIV strategies, PhilHealth expansion of coverage for the poor) and USAID’s work to encourage the private sector.89

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89 Examples might include strengthening the skills of women’s groups supporting the RPRH law to disseminate information on PhilHealth packages and policies, educating local media that report on health issues or how to track medicine stock-outs, or expanding the skill set of ID advocacy groups to participate in policy development and progress tracking.
REPRODUCTIVE HEALTH (MNCHN/FP)

Conclusions

Increased use of antenatal care, facility-based delivery and LAPM/LARC in project sites is evident. Of special note in the present portfolio is the assistance provided to develop programs for adolescents, young mothers and young couples, and USAID’s role in the expansion of public and private service providers trained and accredited to provide BEmONC, active management of the third stage of labor, and LAPM/LARC methods. USAID should be commended for this work.

Data and FGD responses support the notion that first pregnancies among youth occur prior to becoming a FP acceptor. Facility-based adolescent reproductive health programs have tapped an important population for MNCHN/FP and enjoy support from local officials who are concerned about the rise in teenage pregnancies. Most target pregnant teens and, thus, do not prevent first pregnancies, but some reach teen girls before pregnancy via events and hotlines. Facilities integrate these teen programs with other social issues such as education, job training and gender violence. Maintaining facilities’ commitment to these programs and evaluating them is worthwhile. A key advantage to the facility-based approach is the immediate ability to identify and serve young clients in an efficient and discrete manner (e.g., pregnancy testing, prenatal care, interaction with family members and follow-up with FP acceptors). This is especially important when dealing with pregnancy and pregnancy scares among minors.\(^\text{90}\)

For communication, there is no overarching strategy for demand creation and linking demand creation with services, or identifying access issues that are not related to communication (e.g., availability of medicines, motivation of providers). Other barriers to services (e.g., not knowing how to access PhilHealth services, client or BHW transport costs) are not being or cannot be addressed by communication programs. There is a serious disconnect between the mass media and local communication efforts in FP, mostly because the mass media program does not provide the type of information on FP methods necessary to link with and buttress IPC and services at the facility and community levels. The media campaign launched in May 2016 may close some of this disconnect if facility- and community-level materials can be effectively rolled out on time and if more effective coordination between CHANGE and the three regional FP/MNCHN activities is reached. USAID sees the cost of national TV and other national mass media as high for the impact on behavior change, and for FP, the evaluators agree. That said, the strengths of social media need to be tapped, and professionally produced videos should be considered along with IPC approaches at both the facility and community levels.

An even more important disconnect, especially from the standpoint of evidence, is that between the projects’ regional demand-generation activities–Usapan, community-level health events (congresses)–and whether those who participated became FP acceptors. Exceptions include a few facility-level initiatives, such as the Program for Young Parents and postpartum FP programs, where follow-up is easier to track. Data on the number of acceptors who attended Usapan or meetings do not provide a causal linkage. In general, young women acceptors in FGDs said they learned about FP methods from their mothers, other family members, friends and health care workers, but not until they were pregnant with or delivering their first child. However, Usapan sessions were mentioned in FGDs with male acceptors, along with other sources, and one of regional health projects reported a strong testimonial by a male acceptor who said he learned about vasectomy through a Usapan. A system is needed to link the positive results of local demand generation to service delivery in a timely manner; otherwise, lost

\(^\text{90}\) The MNCHN/FP program also supports popular communication and education programs in schools to prevent first pregnancies, which participating schools and regional health professionals in Luzon have found promising as a way to raise awareness among youth as they make key decisions about their behavior.
opportunities for FP acceptance will continue to be the norm. Additionally, PopCom needs support in increasing the rate of FP acceptance from the unmet need numbers identified in its family development sessions. In 2015, PopCom identified 208,654 couples with unmet need, of whom 47 percent (97,244) accepted modern FP methods, a rate that has much room for improvement.

USAID has given attention to helping midwives stand on their own, technically and financially, originally under private sector projects (e.g., TANGO II, PRISM, PRISM2) and continued under the present portfolio through the regional MNCHN/FP and CMSU agreements. The innovation of midwives mentoring midwives is a welcome element of networking that is worth institutionalizing and should prove useful when USAID support for this sub-activity ends or is taken up by LGUs.

USAID supports technical and policy guidance on the development and implementation of the RPRH law and continues to participate in the RPRH law NIT. In the field, implementation of the law would benefit from improved transparency in operation. Dissemination of specific policies to LGU officials, health providers and other stakeholders in the field remains a challenge, for example, what emergency drugs midwives can use, the full extent of the 2015 temporary restraining order contraceptive prohibition, and the reinvigorated role of PopCom in identifying unmet need under the law. Further, the three MNCHN/FP projects could better integrate with HLGP efforts in the field. The improved capacity of the local chief executive as a result of training with the HLGP could be a point of departure for sustaining project programming in some areas and thus better solidify LGU responsibility to keep programs on track and supported.

Continued support for the conduct of NDHS remains an important program of USAID; however, if NDHS is, as the evaluators heard from respondents, a key survey for program designers and implementers, it may need to be expanded to include more granularity or be better linked with other sources of information. However, since 1998, pregnancy-related cause of death among women was dropped from the NDHS; thus, maternal mortality data were based on estimates from the Family Planning Survey (2006) and Family Health Survey (2011). Worldwide, there has been an effort to use the Civil Registry and Vital Statistics as the basis for estimating maternal and child deaths, but this would entail strengthening the civil registration system in the country. In 2015, President Aquino issued Proclamation No. 1106, declaring the period 2015-2024 as the Civil Registration and Vital Statistics Decade. The Philippines also agreed to adopt the ASEAN Ministerial Declaration to "get everyone in the picture." However, the requisite improvements in the Civil Registry and Vital Statistics will need to occur before using it for estimating maternal and child deaths. The national Family Health Survey is not adequately standardized to be useful for trends analysis without considerable manipulation, and USAID no longer funds it.

While breastfeeding is popular, exclusive breastfeeding for six months has been an elusive objective for USAID programs in the Philippines. Project staff members do not see breastfeeding as a child health strategy in USAID's comparative advantage and, especially given the relatively low level of MNCHN funding, suggest that a CSO or UNICEF may make more progress. The evaluators agree.

It is not clear whether USAID was correct to break the MNCHN/FP project into three separate agreements. The initial rationale seemed fine; however, as it has become apparent that some areas in Mindanao such as the ARMM could have benefited from increased attention, and some areas such as Quezon City and Leyte were ready to graduate, further focus and concentration were not attempted

The ability to make trade-offs among regions and cut the number of areas covered could have enabled USAID contributions to have a stronger impact on future LGU operations.

It is also not clear that there should be a single group in the country that has the manpower and effective reach in all three island groups to implement a mega-project as one large DOH shadow activity with little chance of ever phasing out. At the field level, government and health officials and facility workers say they appreciate the projects’ ability to allow them to take advantage of opportunities (e.g., training, launching adolescent programs, Usapan, help with PhilHealth) and to receive help in “filling the gaps” (e.g., meetings, training venues, travel, commodities, or “whatever is needed”). While positive, these reactions do not demonstrate a concerted effort (or any effort) toward sustainability. Even separated into three, it is hard to adequately cover so much ground, and, unlike the ID agreements, the MNCHN/FP agreements have numerous objectives and activities.

**Recommendations**

- Use the final time of the existing MNCHN/FP agreements to implement sustainability plans for key project activities that can be absorbed by government (including PopCom), CSOs, the private sector (e.g., midwives) or other donors (e.g., breastfeeding). Focus end-of-project reports and presentations on how project activities will be sustained or institutionalized, and use the sustained activities as a foundation for LGUs.
- Continue providing policy support for the implementation of the RPRH law. Include focus on how to better disseminate (including a communication plan) and operationalize policy and implementing guidelines at the LGU, city and municipality levels.
- Continue leadership training for health at the LGU level, and include local PhilHealth leaders in that training. (As noted in the recommendation above, institutionalize this training within the DOH Institute.)
- Move away from the present service delivery and training assistance model to discrete, time-limited and highly visible operational research/demonstration projects on approaches to quality services that provide clear evidence on how to strengthen DOH delivery of services at the regional level and below, or, in the case of the private sector, how to expand quality services. Examples of such activities include support for the expansion of sustainable FP and MCH services in the private sector, facility-based programs reaching teens, or expansion and development of a sustaining model for midwife mentoring and other networking approaches to improving the quality and delivery of services. Allow for evaluation in consultation with stakeholders and dissemination.
- Limit any direct, generalized FP or MNCH assistance to a few (two to four), very needy municipalities where USAID, possibly with other donors, can support integrated health and development assistance. Transfer networking skills, and jettison “filling the gaps” and other approaches that engender dependency. USAID has years of experience identifying criteria to choose sites, such as USAID presence, high MMR, high poverty incidence or local leadership support, and the National Economic and Development Authority will have a list of priority LGUs. Limit the number of sites and have a clear exit plan up front.\(^93\)
- Assist PopCom to ensure that its demand-generation efforts are linked and integrated into service delivery on a sustainable basis, and help integrate any relevant elements of its FP logistics hotline into the DOH’s supply chain.
- Ensure that any new service delivery initiative in FP/MNCHN has a communications strategy guided by research into target audience behaviors and messages that are consistent across all

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\(^93\) If, for example, high MMR was chosen as the lead concern, areas now covered by VisayasHealth and MindanaoHealth may be candidates: Northern Samar, Western Samar, Compostela Valley, Davao del Sur, and Agusan del Norte.
channels, are linked to service delivery and have an impact evaluation component. Aside from IPC, the evaluators suggest using other local or regional channels, such as videos in facilities, radio, social media and local champions.

- Leave exclusive breastfeeding assistance to agencies with a stronger comparative advantage, such as CSOs or UNICEF.
- Continue support for the NDHS and, when appropriate, use linked methodology for smaller, interim or issue-specific data collection, for example, research that probes barriers to access and unmet need. Review what questions can and should be answered from the 2017/2018 NDHS prior to finalizing the modules.

**TUBERCULOSIS**

**Conclusions**

USAID supported the successful integration of TB control activities among private practitioners and hospitals. There was substantial progress in the reporting and referral of TB cases, as evidenced by increases of cases reported and extrapulmonary cases. The anti-stigma media campaign, linked with print materials and featuring a national sports star, attracted people into facilities to be tested. This work could be further strengthened by support to PhilHealth and information to health providers, including pharmacies and the community, as well as implementation of mandatory case notification, but on balance, the results of USAID work are very positive and widely appreciated in the TB community.

The April 2016 TB law is a significant step, and implementing the law will require changes in rules and regulations and in technical and operational guidelines. NTP staffing of the central unit is insufficient to sustain the TB program; it is run by a single program manager with a staff supported by the Global Fund and USAID, and the management of MDR-TB is fully dependent on Global Fund support.

Decentralization and a substantial increase in the number of TB cases reported and referred to the public sector contributed to irregular supplies at all levels, and the monitoring system is inadequate. The diagnosis of the situation and alternatives proposed by SIAPS\(^94\) can help the DOH to improve the system. Also, as discussed above, the drug supply system needs strengthening, preferably through standardization of procedures for distribution and establishing a strong monitoring system for commodities.

At the facility level, physicians ask about coughs only of patients who come in for respiratory symptoms, thus missing many opportunities to detect smear-positive infectious sources. Yet routine screening of outpatients is the most productive and cost-effective method to detect highly infectious pulmonary TB and reduce the prevalence of TB in the community. The question should be asked of all adults attending facilities for any reason.\(^95\) A systematic query regarding coughs at the moment of registration should be carried out for all adults, and then the administrative staff or nurse can decide whether to refer to the laboratory without the physician’s intervention.

Active case-finding by community workers is problematic because it has low sustainability without additional resources. The current indicators for case detection and diagnosis are inadequate to monitor the impact of TB interventions. The capacity of the program at all levels to interpret the data collected to evaluate impact and decide on priorities is very limited. The large amount of TB training carried out does not appear to include the use of data to evaluate the impact of training and other activities at facility and microscopy laboratory levels, such as the positivity of microscopy as an indicator of

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detection of TB sources and the trend of TB prevalence in the community. This problem needs a new systematic strategy.

In May 2016, WHO recommended regimens of 9-12 months’ duration, which will be less expensive without including newly developed drugs. Adoption by the country will result in reduction of costs, staff time and unnecessary drugs for patients, with better outcomes. MDR is a risk in a country with unregulated selling of TB drugs in the private market, with and without prescription. At present, the Programmatic Management of Drug-Resistant TB sites are few and have limited access by the patients. The use of GeneXpert can facilitate identification of MDR patients for appropriate treatment, as it can for TB patients. MDR patients identified are put on treatment, but the excessive duration of treatment and poor access results in large loss from control and low cure rates. Initial awareness and testing protocols for HIV/TB co-infection can be found, yet despite an increasing incidence and prevalence of diabetes, no attention is being given to the increase in diabetes in TB patients, and the role diabetes has in increasing TB incidence.

Recommendations

- Support the DOH and PhilHealth to implement the new policy, particularly integration to expand access to TB care, use of rapid tests for diagnosis, mandatory notification, regular drug supply and financing of shorter treatment of MDR-TB. For this and the remaining recommendations, allot additional USAID resources to TB and MDR-TB.
- Support the DOH to establish a national managerial team, as defined by the country’s TB/MDR-TB strategy, by creating posts, absorbing externally funded positions and offering staff training in planning, monitoring and supervision.
- Support the DOH to train NTP staff and DOTS and MDR-TB providers, including laboratories, in interpretation of data and regular use of selected indicators to self-evaluate the impact of their activities at all levels.
- Ensure that a new TB/MDR-TB project has a strong communication component with a strategy that is integrated and evidence-based, with messages that are consistent across all channels and linked to service delivery. Support strategic communication that will further reduce stigma and bring people with cough to health centers, using mass media and IPC channels.
- Review the role of BHWs and community-based organizations in case-finding and whether other alternative options, such as schoolteachers, produce better results.
- Conduct operations/demonstration research on the routine screening of general outpatients to identify the best procedures for each type of health facility.
- Support deployment of GeneXpert and training of staff to increase access to MDR treatment, and shorten the duration of treatment to nine months based on the already available international evidence.
- Provide technical assistance to the DOH to strengthen TB testing where co-morbidities are present, such as HIV and diabetes.

AUTONOMOUS REGION IN MUSLIM MINDANAO

MindanaoHealth, IMPACT and HLGP are providing ARMM (population over 4 million) provinces training and service support for BEmONC, essential intrapartum and newborn care, breastfeeding, TB, FP, data management and leadership training. The USAID projects have worked very effectively, considering the region’s difficult geography and political volatility.

As noted, ARMM provinces demonstrate some of the worst education and health profiles in the country, including high fertility, pregnancies at a young age, low CPR (and very low mCPR), low facility-based deliveries, low antenatal care by a skilled health provider and the poorest access to health facilities.\footnote{NDHS 2013} Government and project representatives also noted serious problems with water and sanitation and acute respiratory infections.

UN agencies and the EU have been working in other remote areas of Mindanao with small (populations of just a few hundred thousand), very isolated indigenous populations. This work included administrative development and health,\footnote{NCIP. Stakeholder Progress Report No. 6, January 1, 2015 to June 30, 2015. Indigenous Peoples Maternal, Neonatal and Child Health and Nutrition Project. EU, NCIP, DOH and UNFPA.} and members of the UNFPA and EU teams stressed the importance of an integrated approach to working with communities on their development needs. MindanaoHealth staff members who worked directly in the ARMM believe the same is true for them, and that an intensive, integrated approach would be most effective.

Recently, the UN agencies have developed a convergent strategy in Mindanao and expect to co-locate UN agencies there soon. They are looking to scale up an ARMM pilot into a peace and health program, with a humanitarian side. This work would include UNICEF, the WHO and UNHCR. PhilHealth officials working in Mindanao feel they need additional help to work with populations in both the indigenous population regions and ARMM.

**Recommendation**

- USAID should continue support for the ARMM, in consultation and coordination with UN partners, and, because of the low level of development indicators in the region, consider a focused, integrated approach to assistance that includes other health (e.g., acute respiratory infections, water, sanitation and hygiene) and relevant USAID assistance.

**HIV**

**Conclusions**

The Philippines is in the unfortunate position of being one of a very few countries where the rate of HIV is increasing, and, while the level is low, it continues to increase. At 7,829 newly diagnosed cases in 2015, rates were 30 percent more than in 2014, an average of 21 cases a day. The majority of reported cases are among men who have sex with men and people who inject drugs, but female sex workers and a small number of babies born to HIV-positive mothers are affected.

Sub-epidemics in areas such as Cebu City, Batangas and Davao are increasing faster. The largest government hospital in Davao reports having a single HIV patient in 1999, seven in 2006, 700 in 2010, and 1,600 as of March 2016. On average, the facility diagnoses two cases a day.

The DOH is allowing eight centers around the country to test and treat, and the one the evaluators observed was working well and receiving drugs. None are using pre-exposure prophylaxis for non-infected partners, but HIV doctors the evaluation team spoke to are well aware of the benefits and the WHO guidance.

Medical professionals working in HIV that the evaluators met with were well versed in international protocols and guidance in counseling and testing, treatment, care, prevention of mother-to-child transmission, and linking to TB, as well as where and how to work with high-risk groups and appropriate
options for screening minors. Sundown Clinics were developed as a meeting place for information and testing, local NGOs were engaged, and hotlines were set up.

UNAIDS leads the CCM and policy dialog with the government on HIV. At present, the test-and-treat protocol is a key issue being considered. Accepting the approach would require a high government outlay for a generation but would end the epidemic, and, if begun immediately, promises the chance that the epidemic will not become generalized. The CCM would welcome USAID’s international expertise in the development of the national HIV plan.

USAID’s HIV project, which ended in October 2015, assisted with setting up community outreach Sundown Centers, linking them with local CSOs working in LGBT, HIV and human rights, and strengthening case management. As the evaluators visited regional health offices, they learned many Sundown Clinics were still operating. That experience and USAID’s worldwide HIV expertise through PEPFAR make USAID a useful partner, yet USAID/Philippines has received no HIV funding since 2012.

Recommendations

- Offer assistance to UNAIDS and the DOH in the development of the National HIV Strategy.
- Prepare a request for PEPFAR funding for the Philippines, concentrating on sub-epidemic service delivery for high-risk groups. Include an option to research the relationship between HIV-positive groups and the general population, and to field test new guidance such as pre-exposure prophylaxis.

ENDNOTE

Several recommendations listed above involve activities that can be initiated or accomplished by USAID or the projects within the present portfolio over the coming year. Most involve initial steps toward a new strategic approach and can be done without significant disruption. However, based on the evaluators’ understanding of present work plans, the first three recommendations would require significant changes.

The recommendations that could begin now include:

- Use the final time of the existing MNCHN/FP agreements to implement sustainability plans for key project activities that can be absorbed by government (including PopCom), CSOs, the private sector (e.g., midwives) or other donors (e.g., taking on breastfeeding). Focus end-of-project reports and presentations by the three regional projects on which and how project activities will be sustained or institutionalized. Aside from beginning a transition to a new portfolio, this may help USAID begin to wean itself from the popular gap-filling and problem-solving role USAID projects have played in the regions.
- In continued planning for the 2017/2018 NDHS, review what information it will provide and how that information will be used within the Office of Health and, possibly through a meeting, with other donor and government stakeholders.
- Offer to conduct joint assessments with the DOH at the national and local levels to determine approaches and options to strengthening the DOH supply chain and data management and utilization. Similarly, offer to conduct joint observational visits to LGUs with PhilHealth to determine what a USAID/PhilHealth partnership might accomplish. While some outside assistance may be necessary via field support, this work could involve project and USAID staff members who have been involved in work on bolstering the supply chain and data management, linking providers to PhilHealth, and state-of-the-art training provided through the services and HLGP projects could assist with these initial efforts.
• For HLGP, begin discussions with the DOH, and possibly other donors, on how to scale up and sustain it and integrate it into the DOH Academy. The DOH Bureau for Local Health Development or the Health Human Resource Development Bureau may be useful starting points for the discussion.

• For PopCom, consider USAID assistance to link demand-generation activities with service delivery to leave clearer models in place. A possible first step would be a meeting to discuss the methodologies now used to identify unmet need by PopCom, USAID regional projects and CSOs, as well as the process and challenge of linking that demand with acceptance and services. (An objective here is to get USAID partners out of the business of identifying unmet need.)

• Continue and review HPDP2 work with PhilHealth and the EU regarding DOH and PhilHealth and budgets and how they relate, and more broadly discuss the possible ramifications of this work within the Office of Health and possibly within the partners group to develop a USAID position on how to proceed.

• Offer international expert assistance to the DOH and UNAIDS in the development of the new HIV strategy, and discuss HIV needs and opportunities in the Philippines with the PEPFAR team. (This is likely already done.)
ANNEX I. SCOPE OF WORK

Assignment #: 145 [assigned by GH Pro]

Global Health Program Cycle Improvement Project—GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK
Date of Submission: 08/04/2015
Last update: 2/26/2016

Refer to the USAID How-To Note: Developing an Evaluation Scope of Work and the Scope of Work Good Practice Examples when developing your scope of work.

I. TITLE: Philippines Health Portfolio Performance Evaluation

II. Requester / Client
USAID Country or Regional Mission
Mission/Division: Philippines

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
3.1.1 HIV
3.1.2 TB
3.1.3 Malaria
3.1.4 PIOET
3.1.5 Other public health threats
3.1.6 MCH
3.1.7 FP/RH
3.1.8 WSSH
3.1.9 Nutrition
3.2.0 Other (specify):
USAID/Philippines Mission FS

IV. Cost Estimate: (Note: GH Pro will provide a cost estimate based on this scope of work)

V. Performance Period
Phase 1 Expected Start Date (on or about): February 26, 2016
Phase 1 Anticipated End Date (on or about): June 30, 2016

VI. Location(s) of Assignment: (Indicate where work will be performed)

Philippines

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)
EVALUATION:

Performance Evaluation (Check timing of data collection)
Midterm Endline Other (specify): Portfolio Evaluation

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.
**PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)**

**Note:** If PEPFAR-funded, check the box for type of evaluation.

**Process Evaluation** *(Check timing of data collection)*

| Midterm | Endline | Other (specify): Portfolio Evaluation |

Process evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal and economic context that affects implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? *(PEPFAR Evaluation Standards of Practice 2014)*

**Outcome Evaluation**

Outcome evaluation determines if, and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? *(PEPFAR Evaluation Standards of Practice 2014)*

**Impact Evaluation** *(Check timing(s) of data collection)*

| Baseline | Midterm | Endline | Other (specify): |

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). They are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

**Economic Evaluation (PEPFAR)**

Economic evaluation identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

**VIII. BACKGROUND**

**Table 1: Identifying information of health implementing mechanisms by project**

*Note: USAID/Philippines has two primary health projects: (1) Family Planning/Maternal and Child Health (FP/MCH); and (2) Infectious Disease Control (IDC). Under each project it funds several mechanisms, also referred to as activities.*

<table>
<thead>
<tr>
<th>Implementing mechanism activity by project</th>
<th>Type of mechanism and award number</th>
<th>Start date</th>
<th>End date</th>
<th>LOP budget</th>
<th>Implementing partner</th>
<th>Name of AOR/COR</th>
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</thead>
<tbody>
<tr>
<td>FP/MCH project</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Project Description</td>
<td>Agreement Type</td>
<td>Start Date</td>
<td>End Date</td>
<td>Budget</td>
<td>Implementing Organization</td>
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<td>Ended in 2014; not covered by this evaluation</td>
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<td>10/30/2009</td>
<td>12/13/2014</td>
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<td>9/30/2017</td>
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99 An end-of-project evaluation was conducted for PRISM2 in 2013.
### Crosscutting mechanisms

<table>
<thead>
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<th>Activity</th>
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<th>End Date</th>
<th>Funding</th>
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<td>10/1/2012</td>
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#### Background of USAID/Philippines Health Program:

The health portfolio evaluation will cover the two health projects being supported by USAID/Philippines, which are:

1. Family Planning and Maternal and Child Health (FP/MCH); and
2. Infectious Disease Control (IDC).

It will investigate the various activities (mechanisms) under the FP/MCH and IDC projects to determine the contribution each is making in the achievement of Intermediate Result (IR) 1.3: Health Improved. Health Improved is one of three intermediate results under USAID/Philippines’ Development Objective (DO) 1: Broad-Based and Inclusive Growth Accelerated and Sustained. DO1 is one of the mission’s three development objectives to achieve the goal of making the Philippines a more stable, prosperous, well-governed nation. Please see the mission’s results framework below (Figure 1).

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100 The current HIV/AIDS activity is a small one ($2 million over three years) and focuses mainly on modeling. USAID/Philippines is no longer getting any HIV/AIDS funding; hence, there will not be any follow-on HIV/AIDS activity in the next project cycle.
The corresponding results frameworks for the two health projects are shown in Figures 2 and 3 below.
Figure 2: Results Framework for the FP/MCH Project

BROAD BASED AND INCLUSIVE GROWTH
ACCELERATED AND SUSTAINED
(Partnership for Growth)

Intermediate Result 1.3 Family Health Improved

Utilization of Quality FP/MCH Services Increased

Sub-IR 1.3.1 Supply of integrated FP/MCH services improved
  - Sub-IR 1.3.1.1 Availability of FP/MCH services increased
  - Sub-IR 1.3.1.2 Quality of FP/MCH services improved
  - Sub-IR 1.3.1.3 Affordable quality private sector FP/MCH services selectively expanded

Sub-IR 1.3.2 Demand for essential FP/MCH services strengthened
  - Sub-IR 1.3.2.1 Individuals' FP/MCH knowledge and awareness increased
  - Sub-IR 1.3.2.2 Communities mobilized to support healthy FP/MCH behaviors
  - Sub-IR 1.3.2.3 Advocacy for FP/MCH strengthened

Sub-IR 1.3.3 Health policies and systems on FP/MCH improved
  - Sub-IR 1.3.3.1 Policy barriers to FP/MCH service provision and financing resolved
  - Sub-IR 1.3.3.2 Financing of provision/consumption of FP/MCH services made more sustainable
  - Sub-IR 1.3.3.3 Critical health systems underpinning LGU FP/MCH services

Figure 3: Results Framework for the IDC Project

BROAD BASED AND INCLUSIVE GROWTH ACCELERATED AND SUSTAINED (Partnership for Growth)

Intermediate Result 1.3 Family Health Improved

Utilization of Quality Infectious Diseases (ID) Services Increased

Sub-IR 1.3.1 Supply of integrated ID services improved
  - Sub-IR 1.3.1.1 Availability of ID Services Increased
  - Sub-IR 1.3.1.2 Quality of ID Services Improved
  - Sub-IR 1.3.1.3 Affordable quality private sector ID services selectively expanded

Sub-IR 1.3.2 Demand for Essential ID Services Strengthened
  - Sub-IR 1.3.2.1 Individual's ID K & A Increased
  - Sub-IR 1.3.2.2 Communities mobilized to support healthy behaviors related to ID
  - Sub-IR 1.3.2.3 Advocacy for ID strengthened

Sub-IR 1.3.3 Health policies and systems on ID improved
  - Sub-IR 1.3.3.1 Policy Barriers to ID service provision and financing removed
  - Sub-IR 1.3.3.2 Financing of provision/consumption of ID services made more sustainable
  - Sub-IR 1.3.3.3 Critical health systems underpinning LGU ID services
The FP/MCH project is implemented through six FP/MCH activities, including one funded under field support, while the IDC project is carried out by two implementing mechanisms supported by three small activities funded under field support. In addition, there are three crosscutting mechanisms that cover both FP/MCH and IDC (see Table 1 above for a summary of all the mechanisms under USAID/Philippines’ current health portfolio). For the purposes of this evaluation, however, the HIV/AIDS activity and the PRISM2 project will not be included.

**Development Context**

**C.1 Problems Addressed**

**Family Planning.** Fertility and family planning indicators for the Philippines are unusually weak compared to its Asian neighbors. The TFR in the country has slightly declined from 3.3 (2008 DHS) to 3.0 (2013 Family Health Survey), but it remains among the highest in the Southeast Asian region, next to Laos. Moreover, the total wanted fertility rate for the Philippines is 2.2 children, 27 percent lower than the actual total fertility rate of 3 children (2013 NDHS). Its contraceptive prevalence rate of 38 percent (2013 DHS) is among the lowest in Southeast Asia. The mCPR, which was stagnating in the past decade, increased a little in the last five years from 34 percent in 2008 to 38 percent in 2013, and unmet need, both for spacing and limiting, dropped from 22 percent to 18 percent in the same period. Modern contraceptive use among women in the lowest economic quintile increased from 26 percent to 33 percent. The pace of improvement, though, appears not to be fast enough to achieve the CPR commitment under the 2012-2017 Development Objective Agreement (DOAg) between USAID and the Government of the Philippines, which is 45 percent by 2016. The passage of the Responsible Parenthood and Reproductive Health (RPRH) Law in 2013 is expected to deliver better results in reproductive health.

**Maternal and Child Health.** Trends in MCH indicators in the Philippines are mixed. A policy of facility-based births has been in place since 2008. The 2013 DHS results show that 60 percent of deliveries were facility-based (up from 44 percent in 2008), and 72 percent were assisted by a skilled provider (up from 64 percent in 2008). Despite these improvements, the country’s MMR is believed to be approximately 100-150, which places the Philippines in about the middle of the spectrum for Southeast Asia—below Cambodia and Indonesia, which are closer to 400, but above Vietnam (100), Malaysia and Thailand (both below 50). The rate of improvement is far below DOH expectations, since the MDG target for 2015 is 52 per 100,000 live births. Neonatal mortality is relatively low compared to some neighboring countries (13 per 1,000 births in 2013) but has not improved markedly over the five years (16 per 1,000 births in 2008). Infant (24) and under-5 (31) mortality rates show a similar picture: slow improvement but, in most instances, the Philippines has not kept up with neighboring countries. In 1960, the infant mortality rate was better than those in Indonesia, Korea, Malaysia, Sri Lanka and Thailand; now the Philippines ranks fifth out of the six countries (World Development Index, cited by the World Bank).

**Tuberculosis.** Since the Philippines adopted the DOTS strategy in all public facilities in 2012, significant progress has been achieved along TB control. The national-level indicators for TB case detection (84 percent) and treatment success rate (90 percent) show that the country is meeting global targets; however, the latest data show that the disease burden remains unacceptably high and TB continues to be the sixth leading cause of mortality in the Philippines. The country ranks seventh in the list of 22 high TB-burden countries worldwide, with an incidence of 265 per 100,000 population and a prevalence of 461 per 100,000 population. In 2013, this translated into 260,000 new cases of TB; 450,000 prevalent TB cases; and 23,000 TB-related deaths. Moreover, MDR-TB is increasing, and the estimated annual number in the Philippines is 13,000 cases, the fourth highest number of MDR-TB cases globally.
C.2 Target Areas and Groups

The main basis for site selection for the FP/MCH project is the number of women of reproductive age with unmet need for family planning. There are about 5.3 million women of reproductive age with unmet need in the Philippines. The country’s 82 provinces were ranked based on unmet need. Spread across all 17 regions in the country, the USAID-assisted sites consist of 14 provinces in Luzon, eight provinces in the Visayas and 19 provinces in Mindanao for a total of 41 provinces nationwide.

The project sites for the IDC project are the 26 provinces and 11 cities with the greatest TB burden in the country and with the lowest performance in both case detection rates and cure rates, and five provinces chosen as demonstration sites. The USAID-assisted sites coincide with the priority areas chosen by the Department of Health (DOH) to support the Philippine Plan of Action for TB (PhilPACT). The USAID HIV/AIDS prevention-to-care modeling activity focuses on men having sex with men in Quezon City and Metro Manila, and people who inject drugs in the metropolitan tri-city area of Cebu, Lapu-Lapu, and Mandaue in the Visayas.

C.3 Health Assistance Strategy for Family Health Improved (October 2012–September 2017)

The current USAID/Philippines health strategy is governed by a DOAg signed with the Government of the Philippines on September 28, 2012, for a period of five years, with a Development Objective of “Family Health Improved.” Since then, however, “Family Health Improved” has evolved into Intermediate Result 3 under USAID/Philippines’ Development Objective 1: Broad-Based and Inclusive Growth Accelerated and Sustained. The DOAG has been amended twice to reflect the changes, in both the U.S. Government and Government of the Philippines’ counterpart contributions. The latest amendment was signed on September 26, 2014. The FP/MCH project shares the same Development Objective with the IDC project and both have complementary results frameworks, goals and purposes (see Figures 2 and 3 on page 2). Both projects are funded under the current bilateral agreement between the U.S. Government and the Government of the Philippines.

C.4 FP/MCH Project Overview

The **FP/MCH project’s goal is “Family health improved.”** Key indicators of success are: total fertility rate reduced from 3.3 in 2008 to 2.96 in 2015; maternal mortality ratio reduced from 163 per 100,000 live births in 2010 to 50 in 2016; infant mortality reduced from 25/1000 live births in 2008 to 17 in 2016; and under-5 mortality rate reduced from 34 per 1,000 live births in 2008 to 25.5 in 2016.

The **FP/MCH project’s purpose is “Utilization of integrated family planning and maternal child health public and private services increased.”** Key indicators of achievement of the project purpose are: unmet need for FP reduced from 19 percent (2011) to 14 percent (2017); modern contraceptive prevalence rate increased from 37 percent in 2011 to 46 percent in 2017; couple-years of protection increased; facility-based delivery increased from 55 percent in 2011 to 90 percent in 2016; and percent of deliveries with skilled birth attendants in U.S. Government-assisted programs increased from 72 percent in 2011 to 90 percent in 2017. To contribute to inclusive growth, percent of NHTS including conditional cash transfer beneficiaries availing of the PhilHealth maternity care package and newborn care package is likewise targeted to increase.

There are three project sub-purposes that, taken together, will lead to achievement of the project purpose. These sub-purposes are: supply of integrated FP/MCH services improved; demand for essential FP/MCH services strengthened; and health policies and systems on FP/MCH improved. Each project sub-purpose has a number of intermediate results that will lead to achievement of the sub-purpose.
Sub-Purpose 1: Supply of integrated FP/MCH services improved
Sub-IR 1.1: Availability of FP/MCH services increased;
Sub-IR 1.2: Quality of FP/MCH services improved; and
Sub-IR 1.3: Affordable quality private sector FP/MCH services expanded.

Project Sub-Purpose 2: Demand for essential FP/MCH services strengthened
Sub-IR 2.1: Individuals' FP/MCH knowledge and awareness increased;
Sub-IR 2.2: Communities mobilized to support healthy FP/MCH behaviors; and
Sub-IR 2.3: Advocacy for FP/MCH strengthened.

Project Sub-Purpose 3: Health policies and systems on FP/MCH improved
Sub-IR 3.1: Policy barriers to FP/MCH service provision and financing resolved;
Sub-IR 3.2: Financing of provision/consumption of FP/MCH services made sustainable; and
Sub-IR 3.3: Critical health systems underpinning LGU FP/MCH services strengthened.

FP/MCH Project Activities
The FP/MCH project covers several different activities (implementing mechanisms) that, when combined, will produce the outputs needed to achieve the project purpose. The flagship activities are three regionally-based integrated MNCHN/FP activities that work in Luzon, the Visayas and Mindanao.

- **LuzonHealth, VisayasHealth and MindanaoHealth**

The LuzonHealth, VisayasHealth and MindanaoHealth are five-year (2013-2018) integrated family planning and maternal health service delivery strengthening activities in Luzon, the Visayas and Mindanao. The three regional activities support the DOH-led scale up of high-impact services and patient-centered information to improve MNCHN outcomes, and to reduce unmet need for FP, especially among the lowest wealth quintiles in the identified priority provinces and cities nationwide.

**LuzonHealth** is implemented by Research Triangle Institute (RTI) International and supports eight DOH Regional Offices, 14 provinces, 338 municipalities and 45 cities in Luzon.

**VisayasHealth** is implemented by EngenderHealth. The activity supports three DOH regional offices, eight provinces, 257 municipalities and 30 cities in the Visayas.

**MindanaoHealth** is implemented by Jhpiego—an affiliate of the Johns Hopkins University. It supports five DOH-ROs, the Autonomous Region in Muslim Mindanao, 19 provinces, 336 municipalities and nine cities in Mindanao.

The LuzonHealth, VisayasHealth and MindanaoHealth activities aim to improve the health of Filipino families in targeted provinces by significantly increasing the quality and uptake of integrated FP/MCH services at household level, in communities and at both public and private facilities. Working with the DOH, DOH-ROs, local government units (provincial/municipal/city health offices), and other related government agencies, the activities address the distinct service delivery needs of priority populations, which include men and women of reproductive age, adolescents/youth, children under 5 years of age, the displaced in conflict-affected areas and poor families covered by the Government of the Philippines' NHTS PR.

Key operating principles are to: (1) target resources for maximum impact; (2) build on existing resources and opportunities; and (3) scale up proven innovations. Activity interventions are intended to:
Increase supply of MNCHN/FP services
- Improve provider knowledge and skills in integrated FP/MCH clinical and non-clinical areas, and in supportive supervision through on-the-job mentoring
- Identify and develop local technical assistance providers to serve as pool of trainers and mentors for FP/MCH services
- Extend services to geographically isolated and disadvantaged areas and conflict-affected areas through integrated outreach service delivery events
- Expand MNCHN/FP services through private sector and hospital engagement
- Strengthen and converge services addressing the health needs of adolescents and youth

Increase demand for FP/MCH services
- Increase the number and quality of CHTs or their equivalent and enhance their ability to effectively link families to the health care system
- Increase the demand and avoid missed opportunities at the SDN by improving health care workers’ ability and motivation to introduce strategic FP/MCH counseling messages at all possible points of contact
- Improve targeted communication to women, men, adolescents and youth for FP/MCH information and services

Remove local policy and health systems barriers for FP/MCH
- Increase the capacity of the local government units to enact and monitor compliance to key policies supportive of FP/MCH program implementation
- Strengthen SDN’s capacities by improving the quality of the referral network and the number of health facilities accredited by PhilHealth to provide high-quality, high-impact services
- Strengthen capacities of SDN stewards like the DOH-ROs and PHOs/City Health Offices to make decisions based on timely and accurate patient-based information.
- Strengthen logistics management to ensure availability of quality medicines and commodities

The integrated FP/MCH regional activities work jointly with other USAID health activities to capitalize on the different strengths, efforts and networks of these activities, which include the following:

- Community Maternal, Neonatal, Child Health and Nutrition Scale Up (CMSU)

The CMSU activity supports the implementation of USAID’s FP/MCH Strategy and the Philippine Government strategy to achieve its 2015 MDGs to reduce maternal and under-5 mortality. It aims to strengthen the skills and practices of public and private sector midwives as providers of FP and of maternal and neonatal health services. It supports the enhancement of midwives’ capacity to organize, coordinate, train and support the effective functioning of MCH SDNs, particularly the CHTs. The activity assists in strengthening the national and local midwives associations’ capacities in mentoring, performance management and monitoring using the quality improvement collaborative approach, and establishing quality assurance in public and private birthing homes. The activity collaborates with local government units, national government agencies and other health professional associations to secure policy support for sustained quality of midwives services. The activity is implemented by the Integrated Midwives Association of the Philippines. It is being implemented in 11 provinces and 6 cities.
The major activity components are:

- **Component 1:** Mentoring and monitoring of midwives on the correct practice of essential intrapartum and newborn care, antenatal care, FP counseling and services, and counseling on exclusive breastfeeding
- **Component 2:** Expanding midwives’ reach through participation at various levels in the SDN and CHTs
- **Component 3:** Strengthening the national and local midwives associations’ organizational and management capacities

**The Private Sector Mobilization for Family Health activity–Phase 2 (PRISM2)**

(Note: The activity description for PRISM2 is included for information purposes only. The activity will not be included in the evaluation.)

PRISM2 is part of USAID’s continuing initiative to build enduring public-private partnerships that would assure Filipinos the availability of and access to quality modern FP and MCH products and services. Specifically, PRISM2 provides support to the DOH, LGUs and other national and local partners in their provision of technical assistance to the private sector and strengthening its role in the delivery of FP and MCH products and services. PRISM2 is implemented by Chemonics, a U.S. consulting firm. PRISM2 started in 2009 and ended in 2014. PRISM2 expanded the gains of PRISM. It supported crosscutting efforts such as alliance building, advocacy and institutional development. It was initially implemented in 77 provinces/independent cities nationwide and was more narrowly focused to 36 provinces/independent cities starting 2012. Its objective was to assist the DOH and the LGUs to engage and mobilize private sector resources in the delivery of FP/MCH services and products. PRISM2 sought to:

- increase the number of private sector providers providing services to poorer segment of the population and the coverage of the poor
- increase financing of the private sector delivery of services and products
- improve marketing of FP and MCH services and products as means to generate demand for FP and MCH services
- improve private practice providers’ effectiveness in communicating and encouraging clients to seek FP and MCH services from trained providers and deliver in birthing facilities
- facilitate the creation of clear, specific and formal local and national policies and regulations for mobilizing the private sector in the provision of FP and MCH services and products.

Upon the project’s completion in December 2014, the integrated FP/MCH regional activities continued the work with the private sector.

**Maternal and Child Health Integrated Program (MCHIP)**

In 2012, USAID/Philippines began to support MCHIP, a USAID global project mechanism, through field support funding to: (1) build the capacity of health care providers to offer long-acting and permanent FP methods in the postpartum period, including intrauterine contraceptive devices; (2) scale up interventions for postpartum hemorrhage; and (3) strengthen FP and MCH integration. MCHIP assistance contributes to the overall measurable goal of the existing U.S. Government-assisted FP/MCH portfolio and help demonstrate the improvement of current practices through high-impact and evidence-based interventions. MCHIP was able to establish nine centers of excellence on postpartum FP services. These nine hospitals serve as the training institutions for postpartum FP services to reduce missed opportunities for FP services. It also conducted rapid facility assessments and observations of the delivery of high-impact interventions for postpartum FP. This assessment aids in the development of
FP interventions. MCHIP is implemented by Jhpiego, an affiliate of Johns Hopkins University. The activity ended in September 30, 2014.

The health portfolio supports three crosscutting implementing mechanisms that carry both FP/MCH and TB components, and these will be described at the end of this sub-section.

C.5 Infectious Disease Control (IDC) Project Overview

The IDC project's goal is “Family health improved.” Key indicators of success are TB prevalence rate reduced, and HIV prevalence in the general population maintained at 1 percent.

The IDC project's purpose is: “Utilization of quality services for high priority infectious diseases increased.” Key indicators for this include case notification rate, all forms, in U.S. Government-assisted sites; treatment success rate, all forms, in U.S. Government-assisted sites; TB cure rate, new bacteriologically confirmed; and TB case detection rate, all forms.

There are three project sub-purposes that, taken together, will lead to achievement of the project’s purpose. These sub-purposes are: supply of integrated ID services improved; demand for essential ID services strengthened; and health policies and systems on ID improved. Each project sub-purpose has a number of IRs that will lead to achievement of the sub-purpose.

Sub-Purpose 1: Supply of integrated ID services improved
Sub-IR 1.1 Availability of ID services increased
Sub-IR 1.2 Quality of ID services improved
Sub-IR 1.3 Affordable quality private sector ID services selectively expanded

Sub-purpose 2: Demand for essential ID services strengthened
Sub-IR 2.1 Individuals’ ID knowledge and attitudes increased
Sub-IR 2.2 Communities mobilized to support healthy behaviors related to ID
Sub-IR 2.3 Advocacy for ID strengthened

Sub-Purpose 3: Health policies and systems on ID improved
Sub-IR 3.1 Policy barriers to ID service provision and financing removed
Sub-IR 3.2 Financing of provision/consumption of ID services made more sustainable
Sub-IR 3.3 Critical health systems underpinning LGU ID services strengthened

IDC Project Activities

The IDC project's outputs are currently achieved through two major implementing mechanisms: a cooperative agreement with Philippine Business for Social Progress for the control of TB, called IMPACT, which will run from 2012 to 2017; and a cooperative agreement with Family Health International 360 (FHI 360) to implement the HIV/AIDS activity, named Reaching Out to Most-at-Risk Populations (ROMP), from 2012 to 2015.

Tuberculosis

- Innovations and Multi-Sectoral Partnerships to Achieve Control of Tuberculosis (IMPACT)

IMPACT, the main activity for TB control, engages both the public and private sectors nationally and in the project sites in detecting and successfully treating drug-susceptible TB and MDR-TB cases. Project sites are the 26 provinces and 11 cities with the greatest TB burden in the country and with the lowest performance in both case detection rates and cure rates, and five provinces chosen as demonstration
sites. These sites coincide with the priority areas chosen by the DOH to support PhilPACT. The activity strengthens demand for TB services through the adoption of healthy behaviors within families; improves supply of TB services, including the availability and quality of public sector services and selective expansion of private sector providers; and removes policy and systems barriers to support supply and demand for TB services.

The IMPACT activity is reinforced by these field support activities:

- SIAPS Project provides technical leadership and assistance to strengthen the pharmaceutical system and local laboratory capacity, which will support the scale-up of TB control interventions. It focuses on long-term forecasting, procurement, and logistical processes and outcomes for pharmaceuticals for the TB DOTS and Programmatic Management of Drug-Resistant TB programs. It also supports the development of the National TB Reference Laboratory and expands the application of an integrated TB information system (ITIS). This is a field support activity implemented by Management Sciences for Health (MSH).

- Promoting the Quality of Medicines Project helps USAID-supported countries strengthen their quality assurance and quality control systems to better ensure the quality of medicines that reach patients. This is done by enhancing local quality control systems, increasing the supply of quality-assured medicines, combating the availability of substandard or counterfeit medicines and providing technical leadership and global advocacy. In the Philippines, the activity works very closely with the Food and Drug Administration to ensure the availability of quality-assured TB medicines. This is a field support activity implemented by the United States Pharmacopeia.

- WHO Umbrella Grant. USAID supports the position of the WHO TB Technical Officer to the NTP.

- Partnerships for Enhanced Engagement in Research (PEER) Health. Two research studies on childhood TB led by Filipino investigators are being supported through the PEER Health mechanism, implemented by the National Academy of Sciences. Childhood TB is an area where there are major gaps in knowledge and program implementation in the Philippines.

In addition to the above, the position of a TB Technical Advisor assigned to the NTP provides additional technical support to TB Global Fund grant implementation. It is funded through the centrally managed TB In-Country Advisors Activity.

**HIV/AIDS**

- Reaching Out to Most-at-Risk Populations (ROMP)

  (Note: The description for this activity is included for information purposes only. The activity will not be covered in this evaluation.)

ROMP is a three-year (2013-2015) USAID HIV/AIDS prevention-to-care modeling activity implemented by FHI 360, in support of the National AIDS-STI Prevention and Control Program of the Philippines’ DOH and the 5th Philippine AIDS Medium-Term Plan. ROMP aims to demonstrate evidence-based models for broadly reaching key populations at highest risk, specifically men who have sex with men, and people who inject drugs, and providing a continuum of prevention-to-care intervention package that the DOH can recommend to local governments for programming. ROMP improves the quality and coverage of prevention programs for most-at-risk populations by building the capacity of stakeholders in both the public and private sectors to maintain low HIV prevalence among most-at-risk populations. ROMP aims to increase the demand for services and strengthen the comprehensive prevention model.
for men who have sex with men in Quezon City and with people who inject drugs in the metropolitan tri-city area of Cebu, Lapu-Lapu, and Mandaue.

C.6 Crosscutting Project Activities

The two major projects, FP/MCH and IDC are supported by several crosscutting activities aimed at improving health governance, strengthening policies and promoting behavior change.

Crosscutting supportive activities are implemented by HLGP, HPDP 2, and CHANGE.

- Health Leadership and Governance Program (HLGP)

The HLGP activity is a Global Development Alliance between USAID and the Zuellig Family Foundation (ZFF), a Philippine NGO. The overarching objective is to improve health outcomes in FP, MCH and TB in USAID-assisted areas. This is done by enhancing leadership and governance capabilities of local chief executives and local health officers to improve local health systems and make them more responsive to the needs for MCH, FP and TB prevention and control, as well as neglected tropical diseases and other infectious diseases. It also aims to increase community participation and health-seeking behaviors in target areas through better managed local health systems and local health leadership.

The ZFF strategy uses a health change model, which is premised on the assumption that local leadership is the key to changing systems and innovating health programs for better health outcomes, and it focuses on creating a more responsive health leadership that can institute reforms at the provincial, municipal and city levels. The two- to three-module programs (Provincial/Municipal/City Leadership and Governance Programs) involve two to four days of didactic and six months’ practicum to implement action plans formulated during the conduct of the leadership and governance program. Requisite to the conduct of the first module is the participation of the health officers and health technical officers in a preparatory workshop for an initial situation analysis and ensuring the commitment of the local chief executive. The HLGP-USAID partnership intends to cover about 100 municipalities and cities. HLGP is operating in more than 600 LGUs with support from the DOH and other development partners.

- Communication for Health Advancement through Networking and Governance Enhancement (CHANGE)

CHANGE is a five-year activity that addresses the need for strategic and sustainable communication interventions in order to generate increased demand for FP/MCH and TB services in the Philippines. CHANGE supports the FP/MCH and TB communications programs of the Philippines DOH and the communications component of the various USAID/Philippines health projects involved in the delivery of FP/MCH and TB services. CHANGE develops and delivers national communication campaigns, messages, standards, modules, tools and templates on FP/MCH and TB. The CHANGE approaches, models and templates on all communications initiatives are then utilized at the local level by program implementers and service providers. CHANGE continuously monitors coverage and impact on behavior change. The activity strengthens national and regional capacity for improved health promotion and increases the demand for and utilization of quality health services. It works toward institutional strengthening in health promotion and communication of the DOH-National Center for Health Promotion, PopCom, PhilHealth and their respective regional offices; intensifies promotion of health-seeking behaviors and healthy behaviors of targeted audiences through mass media campaigns and support to IPC/C of health workers and service providers; and supports advocacy and service marketing to scale up proven program interventions, and management of initiatives for electronic and mobile phone-based technologies, especially focusing on adolescents and youth. CHANGE assists the DOH develop new set of social and behavior change communication materials for adoption and adaptation at the local levels. It also develops programs and tools to change the mindset and behavior of
the health communicators themselves—to “sell” healthy behaviors and create a demand for health services in a targeted and creative manner.

- **Health Policy Development Project 2 (HPDP 2)**

HPDP 2 is a five-year (2012-2017) health policy activity implemented by the UPEcon Foundation. It supports the DOH-led policy formulation process for scaling up UHC. Most FP/MCH and TB policies and guidelines are in place. However, the issuance of critical policies for FP/MCH and TB implementation under UHC and the significant increases in budgets of the DOH have yet to significantly improve overall health outcomes. This gap can be attributed to difficulties in implementing interventions at scale. HPDP 2 supports the DOH in scaling up implementation of FP/MCH and TB interventions. The activity provides assistance to:

  0 Establish an institutional platform to help the DOH design, implement, monitor and evaluate the UHC agenda; and improve policies and health systems to remove policy and systems barriers to improved supply and demand for FP/MCH and TB services;

  0 Improve policies and regulations on service delivery of priority interventions that impact on FP/MCH and TB outcomes; ensure sustainable health care financing, particularly for FP/MCH and TB; strengthen policy and national program monitoring and evaluation; and build capacity for more vigorous implementation of health reforms.

USAID’s implementing partners collaborate closely with HPDP 2 in working with partner DOH-ROs, LGUs, and provincial, city and municipal health offices for any policy-related issues on FP/MCH and TB that may arise in the course of policy implementation or enforcement. Complementing each other based on a synchronized policy agenda, HPDP 2 efforts focus at the national and regional levels, while the regional activities sustain local policy advocacy in support of their service delivery agenda.

HPDP 2 organizes and delivers technical assistance through four channels:

  0 Technical assistance on policy, regulation and financing concerns to the DOH operations clusters and regional health offices to address scale-up problems of FP/MCH and TB interventions.

  0 Support to policy, regulation and financing to the DOH central office, including technical clusters, bureaus, PhilHealth and other attached agencies in removing policy, regulatory and financial barriers that impede the flow of resources for FP/MCH and TB interventions.

  0 Implementation of research, monitoring, and evaluation assistance to the DOH to monitor the progress and measure the impact of interventions aimed at improving FP/MCH and TB outcomes, and to conduct operations research on possible solutions to scale-up problems.

  0 Support to capacity building and knowledge management to assist the DOH in managing interventions designed to build up and sustain capacity to manage information, scale up reform implementation, and address future strategic policy issues of the health sector. This includes assisting the DOH in establishing an institutional platform for UHC.

**Coordination Mechanisms.** USAID/Philippines has a synchronized and integrated approach among its activities in dealing with LGUs, DOH-ROs and other local stakeholders participating in project-funded activities. To realize this objective, USAID/Philippines has mandated the integrated FP/MCH regional activities to exercise the function of being a physical and virtual regional field coordination office to all cooperating agencies that will be involved in field activities in Luzon, Visayas and Mindanao, i.e., PRISM2, HPDP 2, CHANGE, HLGP and MNCHN Scale Up, IMPACT TB, ROMP and other related USAID activities. This will be done through a variety of mechanisms including (a) joint planning and programming of all activities in the field; (b) joint supervision, monitoring and evaluation visits; (c) creation of interagency technical working groups; and (d) informing in advance the field coordination office of all trips and activities to be made in the field. This function is intended to improve coordination.
and to lessen the transaction costs incurred by LGUs, DOH-ROs and other local stakeholders in having to know and to frequently deal with a multiplicity of cooperating agencies’ staff; and understanding USAID policies and procedures, or those of other donors.

Theory of change of the program

The Program Hypotheses\(^{101}\)

1. If USAID improves the supply of and demand for FP and MCH services and strengthens policies and systems to remove barriers in supply of and demand for services, utilization of FP and MCH services will increase and this will lead to improved family health.

2. If USAID improves the supply of and demand for TB services and strengthens policies and systems to remove barriers in the supply of and demand for services, utilization of TB services will increase and this will lead to improved family health.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Philippines: Luzon, Visayas and Mindanao

IX. SCOPE OF WORK

A. **Purpose**: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

This performance evaluation of USAID/Philippines’ health portfolio, for the period FY 2013 to FY 2018, including FP/MCH and IDC projects, aims to:

1. Inform the future strategic direction and approach of the USAID/Philippines health portfolio. Identify key aspects of the political, economic and social context that have influenced and will influence health programming in the future. Recommend strategic shifts in light of these realities.

2. Determine whether current USAID-supported activities on improving supply of and demand for FP/MCH, and TB services, as well as interventions to strengthen policies and systems, are contributing to output and outcome indicators in FP/MCH and TB projects. Recommend modifications in the design and implementation of current approaches and interventions to improve their effectiveness in the remaining two years of the current project cycle. Likewise, recommend areas to focus on in the future for optimum results.

3. At the project level, determine factors that contribute to or hinder the achievement of FP/MCH and IDC outcomes and impact indicators. Identify packages of interventions for FP/MCH and TB control that maybe recommended for replication and scaling up in the next health strategy, taking into consideration the factors required for the interventions to work optimally. Identify gaps in current USAID health portfolio programming to inform the design of the health strategy for FYs 2018-2022.

B. **Audience**: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

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\(^{101}\) These hypotheses are based on the FP/MCH and IDC project results frameworks and were defined at the strategy design stage.
In addition to USAID/Philippines, results of the evaluation will be disseminated and discussed with the DOH, Commission on Population, PhilHealth, implementing partners, other development partners, LGUs and other organizations/agencies involved in implementing FP/MCH and IDC programs and activities in the country.

C. Applications and use: How will the findings be used? What future decisions will be made based on these findings?

Findings and recommendations shall be used to make adjustments in the design of current projects and activities, if needed, for implementation in the last two years of the current project cycle. They will be used to enhance the way specific approaches and interventions are currently designed and implemented at the LGU level as well as define the technical assistance and support mechanisms required for an intervention to work optimally. Good practices identified based on evidence will be considered for replication and scaling up. Recommendations will be shared with relevant agencies to enhance their existing operational plans and inform the design of future strategies and projects of USAID on FP/MCH and IDC. Furthermore, results shall be used to inform the design of the health strategy for FYs 2018-2022.

D. Evaluation/Analytic Questions & Matrix:

a) Questions should be: (a) aligned with the evaluation/analytic purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.); they must be incorporated into the evaluation/analytic questions. USAID policy suggests 3 to 5 evaluation/analytic questions.

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements toward answering the evaluation questions; for example, (i) ratings of quality of services, (ii) magnitude of a problem, (iii) number of events/occurrences, (iv) gender differentiation, (v) etc.

The list of illustrative evaluation questions below will be reviewed and revised (if needed) by the evaluation team, to inform reasonable data collection tools.

<table>
<thead>
<tr>
<th>Evaluation/analytic question</th>
<th>Research methods</th>
<th>Application or data use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   Are project/activity interventions on increasing supply of and demand for FP/MCH and TB services, as well as strengthening policies and systems, relevant given the development challenges identified in the design of the current health strategy (DAAD) and results of the FP/MCH and TB evaluations under the previous project cycle? (Relevance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2   How do governance, health, civic and other MCH/FP/ID-related systems operate, and how have these factors influenced USAID-supported achievements? (Context/Strategy)</td>
<td></td>
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<tr>
<td>3   Are the two health projects and corresponding activities implemented in the most efficient manner compared to an alternative approach? (Efficiency)</td>
<td></td>
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<tr>
<td>● national vs. regional configuration</td>
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<tr>
<td>● integrated private sector engagement or stand-alone</td>
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<td></td>
</tr>
<tr>
<td>● what element(s) of MCH should be given focus/priority given limited MCH funds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- management mechanisms in place to ensure effective coordination and synergies among USAID implementing partners
- coordination with public and private sector partners and other donor agencies at all levels

<table>
<thead>
<tr>
<th>4</th>
<th>How and to what extent are the projects’ and activities’ institutionalization and sustainability objectives being met? (Institutionalization/Sustainability)</th>
</tr>
</thead>
</table>
|   | - presence and implementation of exit and sustainability plans
|   | - policy and systems improvements
|   | - capacity enhancements (national, regional and local levels)
|   | - knowledge and best practices documentation and sharing for advocacy, replication and scaling-up
|   | - host-country ownership (national, regional, local)

<table>
<thead>
<tr>
<th>5</th>
<th>What are the three best/most promising packages of interventions for FP/MCH and the three best/most promising packages of interventions for ID/TB interventions that are currently implemented, which maybe recommended for replicating and scaling-up in the next project cycle? (Portfolio/Project Design)</th>
</tr>
</thead>
</table>
|   | - strategic shifts needed in light of the current context
|   | - remaining gaps in programming of USAID assistance for FP/MCH and ID/TB in the Philippines that should be addressed in the next USAID health strategy

E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

**General comments related to methods:**

The evaluation team will recommend the methods to be used.

This evaluation, by design, is essentially a project performance evaluation, not an impact evaluation. However, as much as possible, this evaluation will measure the effects of USAID-assisted FP/MCH and TB interventions between 2008 and 2013, primarily based on a review of and secondary analysis of Philippines NDHS, NTP and WHO data. It shall also measure the performance of current activities for FP/MCH and TB from the start of current activities to December 2015.

This evaluation will be carried out in two phases. **Phase 1** focuses on reviewing existing information (documents and data) related to FH/MCH and ID/TB, resulting in methodology and protocols for Phase 2. The evaluation team will prepare a report for Phase 1. **Phase 2** is a more in-depth and comprehensive evaluation of the USAID/Philippines health portfolio, focused on existing FP/MCH and ID/TB projects, that includes primary data collection (quantitative and qualitative) that evaluates the performance of the projects against their objectives, and also serves as an opportunity to take a much closer and rigorous look at why or why not, and how the results were achieved.

**Phase 1 work:**

- Document and data review to inventory
  - FP/MCH key interventions
    - Coverage and reach
- Outcomes associated with U.S. Government support
- Findings and recommendations

0 ID/TB key interventions
- Coverage and reach
- Outcomes associated with U.S. Government support
- Findings and recommendations

0 Findings and Recommendations
- Conduct secondary data analysis of NDHS, NTP and WHO data
- Develop an inventory of key interventions along supply, demand, and policy and systems in FP/MCH and ID/TB in USAID-assisted and non-USAID project sites by province
- Prepare a report for Phase 1 with separate sections for FP/MCH and IDC projects
- Present Phase 1 report to USAID/Philippines upon arrival in the Philippines for Phase 2 work
- Draft with more specifications Phase 2 scope of work, with refined methods and protocols for more in-depth rigorous evaluation of USAID/Philippines health portfolio, including timeline

**Phase 2** work (in-country):
- Additional document review, as needed
- Further secondary analyses of existing data (e.g., NDHS, NTP and WHO)
- Collection and analysis of primary data (see methods below)
  - Key informant interviews (individual and group)
  - Focus group discussions
  - Field observations
- Prepare a PowerPoint presentation of evaluation findings/conclusions and recommendations, with separate sections for FP/MCH and IDC projects
- Conduct a findings review workshop with stakeholders
- Present findings and recommendations to USAID/Philippines and the DOH

Upon completion of in-country fieldwork:
- Prepare a draft and final report with separate sections for FP/MCH and IDC projects

**Document and Data Review** *(list of documents and data recommended for review)*

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

**Phase 1**

Review the following documents:
- Existing project documents, including:
  - RFP/A and corresponding proposals/applications
  - Current contracts and cooperative agreements with USAID cooperating agencies, including modification documents and project budgets
  - Annual reports
  - Performance monitoring plans and performance indicator data
  - Project annual implementation plans, work plans, and similar related documents
  - Project special reports
- NDHS Reports (2013, 2008)
- Family Health Survey (2011)
- Philippine Plan of Action to Control Tuberculosis (PhilPACT) 2010-2015

Other Documents:
- Research studies, surveys, evaluation reports and similar documents and literature related to (i) demand generation, (ii) provision of FP/MCH and ID/TB services and (iii) policy, systems and financing support to FP/MCH and ID/TB
- Project strategy papers, concept paper of project approaches
- Evaluation reports and other relevant reports of similar nature
- TB-related surveys

Data:
- NDHS
- WHO/WPRO ([http://hiip.wpro.who.int/portal/Dataanalytics.aspx](http://hiip.wpro.who.int/portal/Dataanalytics.aspx))
- NTP database
- Data on coverage of project interventions/activities generated from customized inventory sheets/checklists/brief questionnaires developed to gather data on project coverage/reach
- TB-related surveys

USAID/Office of Health shall ensure that all of the survey results, project reports and summaries of the relevant service statistics and project performance data are available prior to the field deployment of the evaluation team.

**Phase 2**
Additional review of Phase 1 documents and data, as needed, plus any additional documents and data not yet reviewed that are identified during Phase 1

**Secondary analysis of existing data** *(This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)*

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<table>
<thead>
<tr>
<th>Data source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDHS 2013 &amp; 2008</td>
<td>National survey among women aged 15-49 to collect data on data on key demographic, family planning and health indicators, particularly data on household characteristics and practices; health</td>
<td>Statistically significant changes across time (between 2008 and 2013) of selected FP and MCH indicators. Specifically, the performance in U.S. Government-assisted provinces and non-assisted provinces</td>
</tr>
</tbody>
</table>
insurance coverage; awareness of common noncommunicable and infectious diseases; health-seeking behavior; utilization of health facilities; fertility levels; fertility preferences; marriage and sexual activity; knowledge and use of FP methods; childhood mortality; maternal and child health; knowledge on AIDS and HIV prevention; and extent of violence against women in the Philippines.

using data from the 2008 NDHS (as baseline) and the 2013 DHS will be determined using the following indicators: (i) modern CPR; (ii) modern CPR in the two lowest economic quintiles; (iii) unmet need for FP; (iv) percentage of deliveries assisted by skilled birth attendants; and (v) percentage of facility-based delivery.

<table>
<thead>
<tr>
<th>NTP data</th>
<th>National data on TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statistically significant increases across time of selected TB indicators. Specifically, the performance in U.S. Government-assisted provinces and non-U.S. Government-assisted provinces on the following indicators, among others: (i) treatment success rate; (ii) case notification rate; (iii) percent of successfully treated MDR-TB cases.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>WHO database</th>
<th>TB data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statistically significant increases across time of selected TB indicators. Specifically, the performance in U.S. Government-assisted provinces and non-U.S. Government-assisted provinces on the following indicators, among others: (i) treatment success rate; (ii) case notification rate; (iii) percent of successfully treated MDR-TB cases.</td>
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</tr>
</tbody>
</table>

**Key informant interviews (list categories of key informants, and purpose of inquiry)**

Interviews will be conducted to identify strengths, best practices, gaps, obstacles to health program and project efficiency, management, coordination, institutionalization and sustainability. Key informants will include, but not limited to:

- USAID/Philippines Health Office staff
- MCH and TB implementing partner staff, including subcontractors
- DOH, LGU and NTP representatives
- Local NGOs that have been engaged through the USAID health projects
- Local service providers that have been engaged through the USAID health projects
- Development agencies supporting FP/MCH and IDC/TB programs, and health systems activities

**Focus Group Discussions (list categories of groups, and purpose of inquiry)**

Focus group discussions will be conducted to gain further insight into the relevance and context of these projects. Participants in these discussions can include, but are not limited to:

- Parents with children less than 5 years
- Community members who are targets for project demand creation activities
● Women of reproductive age (to include groups of young mothers: 15-19 and 20-24 years old)
● Males

**Group interviews (list categories of groups, and purpose of inquiry)**

Some key informants (see above) can be clustered into groups for their interview. The evaluation team will be cognizant to avoid any power differentials within a group, to ensure that all participants in a group feel comfortable sharing their opinions.

**Survey (describe content of the survey and target responders, and purpose of inquiry)**

Due to the vast number of projects and persons involved in these projects, a mini-survey will be conducted, where appropriate, to gather standardized information across a wide array of individuals involved in the project, using a structured survey questionnaire. The survey will be loaded as a web-based survey, using SurveyMonkey or a similar platform. For those respondents for whom a web-based survey is not practical, hard copies of the survey will be distributed, and the evaluation team will enter these responses into the online version for analyses. This survey will collect information on relevance, context, efficiency, institutionalization, sustainability, management and coordination. Respondents for the survey may include, but are not limited to:

- USAID/Philippines Health Office staff
- MCH and TB implementing partner staff, including subcontractors
- DOH, LGU and NTP representatives
- Local NGOs that have been engaged through the USAID health projects
- Local service providers that have been engaged through the USAID health projects
- Development agencies supporting FP/MCH and IDC/TB programs and health systems activities

**Observations (list types of sites or activities to be observed, and purpose of inquiry)**

Field visits shall be undertaken to validate project reports and data gathered from inventories. Data will be collected using an observation checklist and field notes.

**X. HUMAN SUBJECT PROTECTION**

The analytic team must develop protocols to ensure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.
XI. ANALYTIC PLAN
Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data are to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program’s achievements against its objectives and/or targets.

Whenever the data allow, samples from U.S. Government-assisted and non-assisted areas will be aggregated for the three island groups (Luzon, Visayas and Mindanao) to generate valid estimates.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age and location, whenever feasible. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances, and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, NTP, WHO, HMIS data, etc.) will allow the team to triangulate findings to produce more robust evaluation results.

The evaluation report will describe analytic methods and statistical tests employed in this evaluation.

XII. ACTIVITIES
List the expected activities, such as team planning meeting, briefings, verification workshop with implementing partners and stakeholders, etc. Activities and deliverables may overlap. Give as much detail as possible.

Background reading—Several documents are available for review for this analytic activity. These include USAID FP/MCH and ID/TB proposals, annual work plans, M&E plans, quarterly progress reports and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and NTP). This desk review will provide background information for the evaluation team and will also be used as data input and evidence for the evaluation.

Team planning meeting (TPM)

Phase 1
A two-day virtual TPM will be held at the initiation of this assignment. As this will be held virtually, the team leader may decide to break up the TPM into smaller chunks of time over a wider span of days. The TPM will:

- Review and clarify any questions on the evaluation scope of work
- Clarify team members’ roles and responsibilities
- Establish a team atmosphere, share individual working styles and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and revise the evaluation timeline, as needed
● Develop an analytical plan for the Phase 1 secondary data analyses
● Develop a template to inventory of key interventions
● Review and clarify any logistical and administrative procedures for the assignment
● Draft the Phase 1 work plan for U.S. Government’s approval
● Review the requirements for the scope of work
● Assignments of team members for and format of Phase 1 report

Phase 2

A three-day TPM will be held in the Philippines to prepare for more in-depth data collection. It will:

● Review and clarify any questions on the Phase 2 evaluation scope of work
● Clarify team members’ roles and responsibilities for Phase 2
● Review and finalize evaluation questions with the evaluation matrix
● Review and finalize the Phase 2 timeline
● Develop Phase 2 data collection methods, protocols, instruments, tools and guidelines
● Review and clarify any logistical and administrative procedures for the assignment
● Develop a Phase 2 data collection plan
● Develop a data management and analysis plan
● Present a Phase 2 work plan for U.S. Government’s approval
● Develop a preliminary draft outline of the evaluation report
● Assign drafting/writing responsibilities for the final report

Briefing and debriefing meetings—Throughout the evaluation the team leader will provide briefings to USAID. The in-briefing and debriefing are likely to include all evaluation team experts, but will be determined in consultation with the mission. These briefings are:

● Evaluation launch, a call/meeting among GH Pro and the key staff on the evaluation team to initiate the evaluation activity and review the schedules, expectations and procedures. GH Pro will hand over the lead of this activity to the team leader and review other management issues.

● Phase 1 in-briefing with USAID, as part of the Phase 1 TPM. These briefings are broken into two meetings: (a) at the beginning of the TPM, so the evaluation team and USAID can discuss expectations and intended plans; and (b) at the end of the TPM when the evaluation team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-briefing will be the format and content of the key intervention inventory and the Phase 1 evaluation report. The time and place for this in-briefing will be determined between the team leader and USAID prior to the TPM for Phase 1. This will be a virtual in-briefing conducted via phone or video conferencing.

● Phase 1 debriefing will be conducted virtually by phone or video conferencing. During this meeting the evaluation team, using a PowerPoint presentation, will present the inventory of key interventions, findings from Phase 1 review and analysis, and revised scope of work for Phase 2. During this meeting, the team will also discuss next steps for Phase 2 with the mission.

● Phase 2 in-briefing with USAID, as part of the Phase 2 TPM convened in Manila. These briefings are broken into two meetings: (a) at the beginning of the TPM, so the evaluation team and USAID can review the Phase 2 scope of work, and any comments from Phase 1 that affect the Phase 2 work; and (b) at the end of the TPM, when the evaluation team will present an outline and explanation of the evaluation design, protocols and tools for the evaluation.
● In-briefing with projects during Phase 2 to review the evaluation plans and timeline with the implementing partners, and if time allows, for the projects to give a brief overview of their activity to the evaluation team.

● The team leader will brief the USAID weekly to discuss progress on the evaluation. As preliminary findings arise, the team leader will share these during the routine briefing, and in an email. These weekly briefings will be primarily via email, but at critical points in the evaluation process USAID may request phone briefings as well.

● A final debriefing between the evaluation team and USAID will be held at the end of the evaluation (Phase 2) to present preliminary findings to USAID. During this meeting, a summary of the data will be presented, along with high-level findings, conclusions and draft recommendations. For the debriefing, the evaluation team will prepare a PowerPoint Presentation of the key findings, issues and recommendations. The evaluation team shall incorporate comments received from USAID during the debriefing in the evaluation report. (Note: preliminary findings are not final and as more data sources are developed and analyzed these findings may change.)

● Debrief between the evaluation team and the DOH using PowerPoint presentation

● Stakeholders’ debriefing/workshop will be held with the implementing partners’ staff and other stakeholders identified by USAID. This will occur following the final debriefing with the mission and will not include any information that may be deemed sensitive by USAID. This is an opportunity present the preliminary findings and to discuss the interpretation of these findings and recommendations.

Fieldwork, site visits and data collection—During Phase 2, the evaluation team will conduct site visits for data collection. The selection of sites to be visited will be finalized during the TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Phase 1 report—At the close of Phase 1, this report will have three parts:
   1. Key intervention inventory
   2. Phase 1 evaluation findings
   3. Phase 2 revised scope of work, including draft data collection tools

This report is not a public document and is meant for USAID/Philippines’ use. It will be submitted to USAID prior to the Phase 1 debrief.

Evaluation/analytic report—At the close of Phase 2, the evaluation team under the leadership of the team leader will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:
   1. The team leader will submit the draft evaluation report to GH Pro for review and formatting.
   2. GH Pro will submit the draft report to USAID.
   3. USAID will review the draft report in a timely manner and send their comments and edits back to GH Pro.
   4. GH Pro will share USAID’s comments and edits with the team leader, who will then do final edits, as needed, and resubmit to GH Pro.
   5. GH Pro will review and reformat the final evaluation report, as needed, and resubmit to USAID for approval.
   6. Once evaluation report is approved, GH Pro will reformat it for 508 compliance and post it to the DEC.
The evaluation report excludes any procurement-sensitive and other sensitive but unclassified (SBU) information. This information will be submitted in a memo to USAID separate from the evaluation report.

XIII. DELIVERABLES AND PRODUCTS
Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

DELIVERABLES (Summary):

<table>
<thead>
<tr>
<th>Deliverable/product</th>
<th>Timelines &amp; deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 (Virtual)</strong></td>
<td></td>
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<tr>
<td>Launch briefing</td>
<td>On/or about March 1, 2016</td>
</tr>
<tr>
<td>Team planning meeting</td>
<td>March 1-2, 2016</td>
</tr>
<tr>
<td>Phase 1-Virtual review of documents</td>
<td>Feb 26-27, 29; March 3-4, 2016</td>
</tr>
<tr>
<td>Phase 1 draft report and Phase 2 draft work plan</td>
<td>March 5, 2016</td>
</tr>
<tr>
<td><strong>Phase 2 (In-country)</strong></td>
<td></td>
</tr>
<tr>
<td>Consolidated Phase 1 report and PowerPoint presentation; Draft Phase 2 work plan and PowerPoint presentation</td>
<td>March 7-9, 2016</td>
</tr>
<tr>
<td>Phase 1 report in-briefing with mission (Includes inventory of key interventions)</td>
<td>March 10, 2016</td>
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<tr>
<td>Phase 2 work plan in-briefing with mission</td>
<td>March 10, 2016</td>
</tr>
<tr>
<td>Briefing on key activities/projects</td>
<td>March 11-12, 2016 (for key eval personnel)</td>
</tr>
<tr>
<td>Pre-test protocol and data collection tools</td>
<td>March 11-12, 2016 (by evaluation field coordinator and selected local evaluators)</td>
</tr>
<tr>
<td>Final analytic protocol and data collection tools in-briefing with mission</td>
<td>March 14, 2016</td>
</tr>
<tr>
<td>Fieldwork for 4 weeks</td>
<td>Begin March 17-April 8, 2016 (15 days)</td>
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<tr>
<td>Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>PowerPoint presentation for mission</td>
<td>April 11, 2016</td>
</tr>
<tr>
<td>Out-briefing with DOH with PowerPoint presentation</td>
<td>April 12, 2016</td>
</tr>
<tr>
<td>Findings review workshop with stakeholders with PowerPoint presentation</td>
<td>April 13, 2016</td>
</tr>
<tr>
<td>Draft report</td>
<td>May 13, 2016</td>
</tr>
<tr>
<td>Mission comments on final report</td>
<td>June 13, 2016</td>
</tr>
<tr>
<td>Final report</td>
<td>July 5, 2016</td>
</tr>
<tr>
<td>Raw data</td>
<td>July 5, 2016</td>
</tr>
<tr>
<td>Report posted to the DEC</td>
<td>July 20, 2016</td>
</tr>
</tbody>
</table>

Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval: ______ 20 ______ business days

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

**Evaluation/analytic team:** When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team leader experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with related methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

**Team qualifications:** Please list technical areas of expertise required for this activities.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, as well as for the individual team members.

<table>
<thead>
<tr>
<th>USAID suggests a small, core team of 3-4 individuals conduct Phase 1 of the evaluation, and a larger team with more technical specialists conduct Phase 2. The competencies for the teams are listed below. Multiple competencies are likely to be filled by one individual.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Senior evaluation specialist (team leader)</td>
</tr>
<tr>
<td>• Political economist</td>
</tr>
<tr>
<td>• Strategic planning specialist</td>
</tr>
<tr>
<td>• Technical program expert–FP</td>
</tr>
<tr>
<td>• Technical program expert–MCH technical program expert–senior ID/TB specialist</td>
</tr>
<tr>
<td>• Technical program expert–TB/laboratory and diagnosis</td>
</tr>
<tr>
<td>• Technical program expert–health policy and systems</td>
</tr>
<tr>
<td>• Technical program expert–communication and demand generation</td>
</tr>
<tr>
<td>• Technical program expert–private sector</td>
</tr>
<tr>
<td>• Statistical analyst</td>
</tr>
<tr>
<td>• Logistics/administrative coordinator</td>
</tr>
</tbody>
</table>

**Team leader:** This person will be selected from among the key staff and will meet the requirements of both this and the other position. The team leader should have significant experience conducting project evaluations/analytics.

**Roles and responsibilities:** The team leader will be responsible for (1) providing team leadership; (2) managing the team’s activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team and (5) leading briefings and presentations.
Qualifications:

- Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods
- Excellent skills in planning, facilitation and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the Philippines and/or the Asia/Pacific region
- Familiarity with USAID and the Program Cycle
- Familiarity with USAID policies and practices
  - Program Cycle
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 1 Title: MCH-FP/RH specialist

Roles and responsibilities: Serve as a member of the evaluation team, providing expertise in MCH and FP/RH. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, development of the key interventions inventory and writing of the evaluation report.

Qualifications:

- At least 8 years’ experience with MCH and FP/RH projects; USAID project implementation experience preferred
- Expertise in supply and demand for MCH and FP services at the community and clinical level
- Familiarity with USAID project implementation and the Program Cycle, is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the Philippines and/or the Asia/Pacific region

Key Staff 2 Title: Infectious disease/TB specialist

Roles and responsibilities: Serve as a member of the evaluation team, providing expertise in ID and TB. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, development of the key interventions inventory and writing of the evaluation report.
Qualifications:
- At least 8 years’ experience with ID/TB projects; USAID project implementation experience preferred
- Expertise in supply and demand for ID/TB services at the community and clinical level
- Familiarity with USAID project implementation and the Program Cycle, is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the Philippines and/or the Asia/Pacific region

Key Staff 3 Title: Health systems and policy specialist

Roles and responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate organizational effectiveness, including institutionalization, sustainability, management and coordination. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:
- Background and at least 8 years’ experience in health systems strengthening and/or health policy
- Experience assessing and/or evaluating health policy and/or health systems
- Experience working with USAID, as well as governmental and non-governmental entities in developing country settings to strengthen health policies and programs/activities
- Experience in strengthening leadership and management on health programs, projects and/or activities.
- Familiarity with supply chain management in desirable
- Experience in implementing and/or evaluating MCH-FP and/or ID/TB programs/projects
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the Philippines and/or the Asia/Pacific region

Key Staff 4 Title: Social and behavior change communication specialist

Roles and responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate social and behavior change communications activities. S/he will provide technical expertise on social and behavior change communication, including demand creation for health products and services, adopting healthy behaviors, and gender issues. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:
- At least 8 years of experience working with social and behavior change communications programs in developing country settings
- Experience should include mass media, community-based interventions, and IPC
- Experience working with formal and non-formal private and public sector networks
- Experience in social marketing and demand generation for FP-MCH and IDC commodities
- Familiar with supply chain management for FP-MCH and IDC commodities is desirable
- Experienced and knowledgeable on evaluation methodologies related to social and behavior change communication
- Proficient in written and spoken English
- Good writing skills, with experience producing evaluation and/or technical reports
- Experience in implementing and/or evaluating MCH-FP and/or ID/TB programs/projects
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the Philippines and/or the Asia/Pacific region

**Key Staff 5** Title: *Evaluation specialist*

**Roles and responsibilities:** Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, ensuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, ensuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection and data analysis to report writing.

**Qualifications:**
- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating others to implement surveys, key informant interviews, focus groups, observations and other evaluation methods that ensure reliability and validity of the data
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in English
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health MCH-FP and/or ID/TB programs/projects is desirable
- Familiarity with USAID and PEPFAR M&E policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans
- Experience working with MCH-FP and/or ID/TB project is desirable
- Experience working in the Philippines and/or the Asia/Pacific region
**Key Staff 6** Title: **Evaluation field coordinator** (local consultant)

**Roles and responsibilities:** Serve as a member of the evaluation team, assisting the team leader and evaluation specialist with data collection protocols, oversight of field operations and data collection sub-teams, adherence to data collection protocols and data management. S/He will participate in all aspects of the evaluation, from planning, data collection and data analysis to report writing. Additionally, s/he will actively assist in the recruitment of other local consultants to work on this evaluation.

**Qualifications:**
- At least 5 years in field based evaluation and/or research
- Experience implementing qualitative and quantitative data collection
- Experience coordinating and/or supervising on-the-ground data collection efforts related to evaluation and/or research in the Philippines
- Experience in data management
- Good organizational skills
- Experience planning data collection activities, including logistics
- Able to analyze quantitative, primarily using descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Proficient in English
- Familiarity with USAID health MCH-FP and/or ID/TB programs/projects is desirable
- Familiarity with health programs and services in the Philippines

**Other staff titles with roles and responsibilities (include number of individuals needed):**

| Local **evaluation logistics/program assistant** (one local consultant) | will support the evaluation team with all logistics and administration to allow them to carry out this evaluation. The logistics/program assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations including the MOH, donors and other stakeholders. To support the team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and ensure business center support, e.g., copying, internet and printing. S/he will work under the guidance of the team leader to make preparations and arrange meetings and appointments. S/he will conduct programmatic, administrative and support tasks as assigned and ensure the processes move forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed. |
|---|
| Local **evaluators** (six local consultants) | to assist the evaluation team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys, interviews and focus group discussions, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The local evaluators will have a good command of English and local language(s). They will also assist the team and the logistics coordinator, as needed. They will report to the team leader. |

**Will USAID participate as an active team member or designate other key stakeholders as an active team member? This will require full time commitment during the evaluation or analytic activity.**

Yes—If yes, specify who:
**No**

**Staffing level of effort (LOE) matrix (optional):**

This optional LOE matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table, total the LOE days for each consultant title in the ‘sub-total’ cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Estimated level of effort in days for each evaluation/analytic team member—*This is illustrative and will be revised based on the actual start-up dates for Phase 1 and Phase 2.*

<table>
<thead>
<tr>
<th>Activity/deliverable</th>
<th>Evaluation/analytic team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons</td>
<td>Team leader/Key staff 1</td>
</tr>
<tr>
<td></td>
<td>Key staff 2</td>
</tr>
<tr>
<td></td>
<td>Key staff 3</td>
</tr>
<tr>
<td></td>
<td>Key staff 4</td>
</tr>
<tr>
<td></td>
<td>Key staff 5</td>
</tr>
<tr>
<td></td>
<td>Evaluation specialist</td>
</tr>
<tr>
<td></td>
<td>Evaluation field coordinator</td>
</tr>
<tr>
<td></td>
<td>Local evaluators</td>
</tr>
<tr>
<td></td>
<td>Logistics/Program Assistant</td>
</tr>
<tr>
<td>Launch briefing</td>
<td>1</td>
</tr>
<tr>
<td>Phase 1 virtual TPM</td>
<td>2</td>
</tr>
<tr>
<td>In-briefing with USAID</td>
<td>0.5</td>
</tr>
<tr>
<td>Document review and secondary data analysis</td>
<td>10</td>
</tr>
<tr>
<td>Inventory of key interventions</td>
<td>1</td>
</tr>
<tr>
<td>Phase 1 analysis/report preparation (virtual)</td>
<td>2</td>
</tr>
<tr>
<td>Phase 1 report finalization (in-country)</td>
<td>1</td>
</tr>
<tr>
<td>Phase 1 debriefing with USAID with preparation (virtual)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Description</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Preparation for team convening in-country</td>
</tr>
<tr>
<td>8</td>
<td>Travel to country</td>
</tr>
<tr>
<td>9</td>
<td>Phase 2 TPM</td>
</tr>
<tr>
<td>10</td>
<td>Phase 1 report in-briefing with mission with preparation</td>
</tr>
<tr>
<td>11</td>
<td>In-briefing Phase 2 work plan and field activities with preparation</td>
</tr>
<tr>
<td>12</td>
<td>Data collection quality assurance workshop (protocol orientation for all involved in data collection)</td>
</tr>
<tr>
<td>13</td>
<td>Preparation/logistics for site visits</td>
</tr>
<tr>
<td>14</td>
<td>Data collection/site visits (including travel to sites)</td>
</tr>
<tr>
<td>15</td>
<td>Data consolidation analysis</td>
</tr>
<tr>
<td>16</td>
<td>Debriefing with mission/DOH with preparation</td>
</tr>
<tr>
<td>17</td>
<td>Stakeholder debriefing workshop with preparation</td>
</tr>
<tr>
<td>18</td>
<td>Depart country</td>
</tr>
<tr>
<td>19</td>
<td>Draft report(s)</td>
</tr>
<tr>
<td>20</td>
<td>GH Pro Report quality control review and formatting</td>
</tr>
<tr>
<td>21</td>
<td>Submission of draft report(s) to mission</td>
</tr>
<tr>
<td>22</td>
<td>USAID report review</td>
</tr>
</tbody>
</table>
23. Revise report(s) per USAID comments

24. Finalize and submit report to USAID
   4  3  3  3  3  3  2

25. 508 compliance review

26. Upload evaluation report(s) to the DEC

| Sub-total LOE | 78 | 69 | 73 | 69 | 69 | 73 | 70 | 47 | 51 |

If overseas, is a 6-day workweek permitted

Yes          No

Travel anticipated: List international and local travel anticipated by what team members.

XV. LOGISTICS

Note: Most evaluation/anlytic teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain Facility Access only. Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

USAID Facility Access
   Specify who will require Facility Access: ______________________

Electronic County Clearance (ECC) (International travelers only)

GH Pro workspace
   Specify who will require workspace at GH Pro: ______________________

Travel—other than posting (specify): ________________________________

Other (specify): ___________________________________________________

XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/anlytic team and provide quality assurance oversight, including:

- Review scope of work and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/anlytic team, with USAID point-of-contact approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
● Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
● Report production—If the report is *public*, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is *internal*, then copy editing/formatting for internal distribution.

**XVII. USAID ROLES AND RESPONSIBILITIES**
Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>USAID</strong> will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
<tr>
<td><strong>Before fieldwork</strong></td>
</tr>
<tr>
<td>● <strong>Scope of work</strong></td>
</tr>
<tr>
<td>○ Develop scope of work.</td>
</tr>
<tr>
<td>○ Peer review scope of work.</td>
</tr>
<tr>
<td>○ Respond to queries about the scope of work and/or the assignment at large.</td>
</tr>
<tr>
<td>● <strong>Consultant conflict of interest</strong>: To avoid conflicts of interest or the appearance of one, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential conflict of interest with the project contractors evaluated/assessed and information regarding their affiliates.</td>
</tr>
<tr>
<td>● <strong>Documents</strong>: Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.</td>
</tr>
<tr>
<td>● <strong>Local consultants</strong>: Assist with identification of potential local consultants, including contact information.</td>
</tr>
<tr>
<td>● <strong>Site visit preparations</strong>: Provide a list of site visit locations, key contacts and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.</td>
</tr>
<tr>
<td>● <strong>Lodgings and travel</strong>: Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).</td>
</tr>
<tr>
<td><strong>During fieldwork</strong></td>
</tr>
<tr>
<td>● <strong>Mission point of contact</strong>: Throughout the in-country work, ensure constant availability of the point of contact person and provide technical leadership and direction for the team’s work.</td>
</tr>
<tr>
<td>● <strong>Meeting space</strong>: Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).</td>
</tr>
<tr>
<td>● <strong>Meeting arrangements</strong>: Assist the team in arranging and coordinating meetings with stakeholders.</td>
</tr>
<tr>
<td>● <strong>Facilitate contact with implementing partners</strong>: Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.</td>
</tr>
<tr>
<td><strong>After fieldwork</strong></td>
</tr>
<tr>
<td>● <strong>Timely reviews</strong>: Provide timely review of draft/final reports and approval of deliverables.</td>
</tr>
</tbody>
</table>

**XVIII. ANALYTIC REPORT**
Provide any desired guidance or specifications for the final report. (See How-To Note: Preparing Evaluation Reports)

The **evaluation/analytic final report** must follow USAID’s *Criteria to Ensure the Quality of the Evaluation Report* (found in Appendix I of the *USAID Evaluation Policy*).

a. The report must not exceed XX pages (excluding executive summary, table of contents, acronym list and annexes).
b. The structure of the report should follow the evaluation report template, including branding, found here or here.

c. Draft reports must be provided electronically, in English, to GH Pro, who will then submit it to USAID.

d. For additional guidance, please see the How-To Note on Preparing Evaluation Draft Reports found here.

**Reporting guidelines:** The draft report should be a comprehensive, analytical, evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints and lessons learned, provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive summary: Concisely state the most salient findings, conclusions and recommendations (not more than 4 pages)
- Table of contents (1 page)
- Acronyms
- Evaluation/analytic purpose and evaluation/analytic questions (1-2 pages)
- Project [or program] background (1-3 pages)
- Evaluation/analytic methods and limitations (1-3 pages)
- Findings
- Conclusions
- Recommendations
- Annexes
  - Annex I: Evaluation/analytic statement of work
  - Annex II: Evaluation/analytic methods and limitations
  - Annex III: Data collection instruments
  - Annex IV: Sources of information
    - List of persons interviewed
    - Bibliography of documents reviewed
    - Databases
    - [etc.]
  - Annex V: Disclosure of any conflicts of interest
  - Annex VI: Statement of differences (if applicable)

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports.

--------------------------------

The evaluation report should exclude any potentially procurement-sensitive information. As needed, any procurement-sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID, separate from the evaluation report.

--------------------------------
All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the program manager. All data will be in an unlocked, editable format.

XIX. USAID CONTACTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Primary contact</th>
<th>Alternate contact 1</th>
<th>Alternate contact 2</th>
<th>Alternate contact 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID office/mission</td>
<td>Albert Aquino</td>
<td>Reynalda Perez</td>
<td>Chen, Judy</td>
<td>Karen Klimowski</td>
</tr>
<tr>
<td>USAID office/mission</td>
<td>M&amp;E Specialist</td>
<td>Philippines/Program Office</td>
<td>Philippines/OH</td>
<td>Philippines/OH</td>
</tr>
<tr>
<td>USAID office/mission</td>
<td>Philippines/Program Office</td>
<td>Philippines/OH</td>
<td>Philippines/OH</td>
<td>Philippines/OH</td>
</tr>
<tr>
<td>USAID office/mission</td>
<td><a href="mailto:aaquino@usaid.gov">aaquino@usaid.gov</a></td>
<td><a href="mailto:rperez@usaid.gov">rperez@usaid.gov</a></td>
<td><a href="mailto:juchen@usaid.gov">juchen@usaid.gov</a></td>
<td><a href="mailto:kklimowski@usaid.gov">kklimowski@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell phone:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List other contacts who will be supporting the requesting team with technical support, such as reviewing the scope of work and report (such as USAID/W GH Pro management team staff)

<table>
<thead>
<tr>
<th>Name</th>
<th>Technical Support Contact 1</th>
<th>Technical Support Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Diana Harper</td>
<td></td>
</tr>
<tr>
<td>Title:</td>
<td>Senior Evaluation and Program Advisor</td>
<td></td>
</tr>
<tr>
<td>USAID office/mission</td>
<td>Office of Policy, Planning and Programs</td>
<td>USAID Bureau for Global Health</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:dharper@usaid.gov">dharper@usaid.gov</a></td>
<td></td>
</tr>
<tr>
<td>Telephone:</td>
<td>571-551-7086</td>
<td></td>
</tr>
<tr>
<td>Cell phone (optional)</td>
<td>571-228-3619</td>
<td></td>
</tr>
</tbody>
</table>

XX. REFERENCE MATERIALS
Documents and materials needed and/or useful for consultant assignment, that are not listed above
Annex A-Checklist for Assessing USAID Evaluation Reports

GOOD PRACTICE ELEMENTS OF AN EVALUATION REPORT

<table>
<thead>
<tr>
<th>EVALUATION REVIEW FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the evaluation report have a cover sheet attached indicating the type of evaluation conducted (e.g., performance evaluation or impact evaluation) and general design?</td>
</tr>
<tr>
<td>2. If a performance evaluation, does the evaluation report focus on descriptive and normative evaluation questions?</td>
</tr>
<tr>
<td>3. If the evaluation report uses the term “impact evaluation,” is it defined as measuring the change in a development outcome that is attributable to a defined intervention (i.e., impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual)?</td>
</tr>
<tr>
<td>4. Regardless of the type of evaluation, does the evaluation report reflect use of sound social science methods?</td>
</tr>
<tr>
<td>5. Does the report have a table of contents?</td>
</tr>
<tr>
<td>6. Do lists of figures and tables follow the table of contents?</td>
</tr>
<tr>
<td>7. Does the report have a glossary of terms?</td>
</tr>
<tr>
<td>8. 7.1 Are abbreviations limited to the essential?</td>
</tr>
<tr>
<td>8. Is the date of the report given?</td>
</tr>
<tr>
<td>9. Does the body of the report adhere to the 20-page guide?</td>
</tr>
<tr>
<td>10. Is the report well-organized (each topic is clearly delineated, subheadings used for easy reading)?</td>
</tr>
<tr>
<td>11. Does the report’s presentation highlight important information in ways that capture the reader’s attention?</td>
</tr>
<tr>
<td>12. Is the report well written (clear sentences, reasonable length paragraphs, no typos, acceptable for dissemination to potential users)?</td>
</tr>
<tr>
<td>13. Does the evaluation report focus on the essential issues concerning the key questions, and eliminate the “nice to know,” but not essential information?</td>
</tr>
<tr>
<td>14. Does the evaluation report discuss any issues of conflict of interest, including the lack thereof?</td>
</tr>
<tr>
<td>15. As applicable, does the evaluation report include statements regarding any significant unresolved differences of opinion on the part of funders, implementers and/or members of the evaluation team?</td>
</tr>
<tr>
<td>16. Does the evaluation report begin with a 3- to 5-page stand-alone summary of the purpose, background of the project, main evaluation questions, methods, findings, conclusions, recommendations and lessons learned (if applicable) of the evaluation?</td>
</tr>
<tr>
<td>17. Does the executive summary concisely state the main points of the evaluation?</td>
</tr>
<tr>
<td>18. Does the executive summary follow the rule of only saying what the evaluation itself says and not introducing new material?</td>
</tr>
<tr>
<td>19. Does the report introduction adequately describe the project?</td>
</tr>
<tr>
<td>19.1. Does the introduction explain the problem/opportunity the project was trying to address?</td>
</tr>
<tr>
<td>19.2. Does the introduction show where the project was implemented (physical location) through a map?</td>
</tr>
<tr>
<td>19.3. Does the introduction explain when the project was implemented?</td>
</tr>
<tr>
<td>19.4. Are the “theory of change” or development hypotheses that underlie the project explained? (Does the report specify the project’s inputs, direct results (outputs), and higher-level outcomes and impacts, so that the reader understands the logical structure of the project and what it was supposed to accomplish?)</td>
</tr>
<tr>
<td>19.5. Does the report identify assumptions underlying the project?</td>
</tr>
<tr>
<td>19.6. Does the report include sufficient local and global contextual information so that the external validity and relevance of the evaluation can be assessed?</td>
</tr>
<tr>
<td>19.7. Does the evaluation report identify and describe any critical competitors to the project that functioned at the same time and in the project’s environment?</td>
</tr>
<tr>
<td>19.8. Is USAID’s level of investment in the project stated?</td>
</tr>
<tr>
<td>19.9. Does the evaluation report describe the project components funded by implementing partners and the amount of funding?</td>
</tr>
<tr>
<td>20. Is the purpose of the evaluation clearly stated?</td>
</tr>
<tr>
<td>21. Is the amount of USAID funding for the evaluation indicated?</td>
</tr>
<tr>
<td>22. Are all other sources of funding for the evaluation indicated as well as the amounts?</td>
</tr>
<tr>
<td>23. Does the report identify the evaluation team members and any partners in the evaluation?</td>
</tr>
<tr>
<td>24. Is there a clear statement of how the evaluation will be used and who the intended users are?</td>
</tr>
<tr>
<td>25. Are the priority evaluation questions presented in the introduction?</td>
</tr>
<tr>
<td>26. Does the evaluation address all evaluation questions included in the statement of work?</td>
</tr>
<tr>
<td>26.1. Are any modifications to the statement of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline indicated in the report?</td>
</tr>
<tr>
<td>26.2. Is the statement of work presented as an annex?</td>
</tr>
<tr>
<td>26.3. If so, does the annex include the rationale for any change with the written sign-offs on the changes by the technical officer?</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>27. Does the report provide a clear description of the evaluation’s design?</td>
</tr>
<tr>
<td>28. Does the report state the period over which the evaluation was conducted?</td>
</tr>
<tr>
<td>29. Does the report state the project time span (reference period) covered by the evaluation?</td>
</tr>
<tr>
<td>30. Does the evaluation report indicate the nature and extent of consultation on the evaluation design with in-country partners and beneficiaries?</td>
</tr>
<tr>
<td>31. Does the evaluation report indicate the nature and extent of participation by national counterparts and evaluators in the design and conduct of the evaluation?</td>
</tr>
<tr>
<td>32. Does the report address each key question around which the evaluation was designed?</td>
</tr>
<tr>
<td>33. Is at least one of the evaluation questions directly related to gender analysis of outcomes and impacts?</td>
</tr>
<tr>
<td>34. In answering the questions, does the report appropriately use comparisons made against baseline data?</td>
</tr>
<tr>
<td>35. If the evaluation is expected to influence resource allocation, does it include information on the cost structure and scalability of the intervention, as well as its effectiveness?</td>
</tr>
<tr>
<td>36. Is there a clear description of the evaluation’s data collection methods (summarized in the text with the full description presented in an annex)?</td>
</tr>
<tr>
<td>36.2. Does the evaluation report include information, as appropriate, on the pilot testing of data collection instruments?</td>
</tr>
<tr>
<td>37. Are all sources of information properly identified and listed in an annex?</td>
</tr>
<tr>
<td>38. Does the evaluation report contain a section describing the limitations associated with the evaluation methodology (e.g., selection bias, recall bias, unobservable differences between comparator groups, small samples, only went to villages near the road, implementer insisted on picking who the team met with, etc.)?</td>
</tr>
<tr>
<td>39. Does the evaluation report indicate the evaluation methodology took into account the time, budget and other practical considerations for the evaluation such as minimizing disruption and data burden?</td>
</tr>
<tr>
<td>40. Does the report have sufficient information to determine if the evaluation team had the appropriate methodological and subject matter expertise to conduct the evaluation as designed?</td>
</tr>
<tr>
<td>41. If an impact evaluation was designed and conducted, does the evaluation report indicate that experimental methods were used to generate the strongest evidence? Or does the report indicate that alternative methods for assessing impact were utilized and present the reasons why random assignment strategies were not feasible?</td>
</tr>
<tr>
<td>42. Does the evaluation report reflect the application and use to the maximum extent possible of social science methods and tools that reduce the need for evaluator-specific judgments?</td>
</tr>
<tr>
<td>43. Does the evaluation scope and methodology section address generalizability of the findings?</td>
</tr>
<tr>
<td>44. Are percentages, ratios, cross-tabulations, rather than raw data presented, as appropriate?</td>
</tr>
<tr>
<td>45. When percentages are given, does the report always indicate the number of cases used to calculate the percentage?</td>
</tr>
<tr>
<td>46. Are whole numbers used or rounding-off numbers to 1 or 2 digits?</td>
</tr>
<tr>
<td>47. Are pictures used to good effect?</td>
</tr>
<tr>
<td>47.2. Called out in the text and placed near the call-out</td>
</tr>
<tr>
<td>48. Are charts and graphs used to present or summarize data, where relevant?</td>
</tr>
<tr>
<td>48.2. Are they consistently numbered and titled?</td>
</tr>
<tr>
<td>48.4. Is the source of the data identified?</td>
</tr>
<tr>
<td>48.6. Are the scales honest (proportional and not misleading by virtue of being “blown-up”)?</td>
</tr>
<tr>
<td>49. Are FINDINGS specific, concise and supported by strong quantitative and qualitative evidence?</td>
</tr>
<tr>
<td>50. Are adequate data provided to address the validity of the “theory of change” or development hypothesis underlying the project, i.e., cause-and-effect relationships?</td>
</tr>
<tr>
<td>51. Are alternative explanations of any observed results discussed, if found?</td>
</tr>
<tr>
<td>52. Are unplanned results the team discovered adequately described?</td>
</tr>
</tbody>
</table>
### Definitions:

**Performance evaluation** focuses on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision-making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

**Impact evaluation** measures the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

**Theory of change**: A tool to design and evaluate social change initiatives. It is a blueprint of the building blocks needed to achieve long-term goals of a social change initiative.

**Development hypothesis**: Identifies causal linkages between USAID actions and the intended Strategic Objective (highest level result).

**External validity**: The degree to which findings, conclusions and recommendations produced by an evaluation are applicable to other settings and contexts.

**Findings**: Empirical facts collected during the evaluation

**Conclusions**: Interpretations and judgments based on the findings

**Recommendations**: Proposed actions for management

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| 53. | Are opinions, conclusions and recommendations kept out of the description of FINDINGS? |
| 54. | Is there a clear distinction between CONCLUSIONS and FINDINGS? |
| 55. | Is every CONCLUSION in the report supported by a specific or clearly defined set of FINDINGS? |
| 56. | Are the CONCLUSIONS credible, given the FINDINGS the report presents? |
| 57. | Can the reader tell what CONCLUSIONS the evaluation team reached on each evaluation question? |
| 58. | Are RECOMMENDATIONS separated from CONCLUSIONS? (Are they highlighted, presented in a separate section or otherwise marked so that the reader sees them as being distinct?) |
| 59. | Are all RECOMMENDATIONS supported by a specific or clearly defined set of FINDINGS and CONCLUSIONS? (Clearly derived from what the evaluation team learned?) |
| 60. | Are the RECOMMENDATIONS practical and specific? |
| 61. | Are the RECOMMENDATIONS responsive to the purpose of the evaluation? |
| 62. | Are the RECOMMENDATIONS action-oriented? |
| 63. | Is it clear who is responsible for each action? |
| 64. | Are the RECOMMENDATIONS limited/grouped into a reasonable number? |
| 65. | Did this evaluation include lessons that would be useful for future projects or programs, on the same thematic or in the same country, etc.? |
| 66. | Are the LESSONS LEARNED highlighted and presented in a clear way? |
| 67. | Does the report indicate whom the lessons are for? (e.g., project implementation team, future project, USAID and implementing partners, etc.) |
| 68. | Does the evaluation report give the appearance of a thoughtful, evidence-based and well-organized effort to objectively evaluate what worked in the project, what did not and why? |
| 69. | As applicable, does the evaluation report include statements regarding any significant unresolved differences of opinion on the part of funders, implementers and/or members of the evaluation team? |
| 70. | Is the evaluation report structured in a way that will promote its utilization? |
| 71. | Does the evaluation report explicitly link the evaluation questions to specific future decisions to be made by USAID leadership, partner governments and/or other key stakeholders? |
| 72. | Does the evaluation report convey the sense that the evaluation was undertaken in a manner to ensure credibility, objectivity, transparency and the generation of high-quality information and knowledge? |

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**REPORT DISSEMINATION**

| 73. | Have all evaluation team members signed a statement attesting to a lack of conflict of interest, or describing any existing conflict of interest relative to the project being evaluated? |
| 74. | Was the report submitted to the Development Experience Clearinghouse (DEC)? |
| 75. | Has a dissemination plan been developed for this report? |
| 76. | Is the report widely shared to interested stakeholders? |
ANNEX II. EVALUATION METHODS AND LIMITATIONS

Following the scope of work, the evaluation involved two phases. Phase 1 focused on reviewing existing documents and data related to MCH/FP and ID/TB projects, such as cooperative agreement documents, progress reports, indicators and recent literature on health and related topics. Based on the results of Phase 1 and discussion with the USAID/Philippines Office of Health staff, the team finalized the main research questions that will be answered by the performance evaluation, as well as the methodology and protocols for Phase 2.

The five research questions center on the current health portfolio’s relevance, whether the projects are being implemented in a strategic manner, whether they address institutionalization and sustainability, the best practices that emanate from the projects and which can be scaled up, and the identification of USAID’s comparative advantage in health in comparison with other donors and stakeholders. To answer these questions, the evaluators used the following methodologies:

- A review of project documents, data on health indicators and recent literature on health and related topics (see Annex IV for bibliography)
- Project orientation and briefings from the USAID Office of Health staff and USAID cooperating agencies
- Interviews and group meetings with government agencies and donor stakeholders at the national, regional and local levels
- Field visits to government, health facilities and project sites in Luzon, Visayas and Mindanao
- FGDs and group discussions with clients and service providers
- Written questions to cooperating agencies

A. Document and literature review

The evaluators reviewed several types of documents. General literature on health, results from recent national surveys—such as the 2013 Demographic and Health Survey, 2011 Family Health Survey and 2013 Young Adult Fertility and Sexuality Survey—and the HIV registry and NTP database provided updates on the latest trends and patterns in maternal health, family planning, teenage pregnancy, youth sexual behavior, tuberculosis and HIV/AIDS incidence in the country. Project-related documents, such as project briefs and annual progress reports, were also reviewed to identify accomplishments and gaps. Equally important in the review were governmental laws, administrative orders and ordinances that either facilitated or hindered the achievement of MNCHN/FP and ID/TB projects. Finally, administrative data, such as budget allocation and PhilHealth expenditures, were accessed by the team online.

B. Project orientation and briefing

At the start of the portfolio evaluation, USAID/Philippines organized a meeting with all chiefs of party. The meeting facilitated initial work on the project and validated what the team found from document review. The chiefs of party, particularly for the MNCHN/FP activities (Luzon Health, Visayas Health and Mindanao Health) helped the team in the identification of areas for site visits. They also helped arrange most interviews with local chief executives and health officials and coordinated the recruitment of participants for the FGDs. The main consideration for the choice of area was the presence of both MNCHN/FP and IDC, especially TB, activities. For Luzon, Quezon City and Cavite (Trece Martirez and Tanza) were chosen; for Visayas, Cebu City and Tacloban City; and for Mindanao, Cagayan de Oro City, Bukidnon, Davao City and Digos City.

The evaluators also met other project staff in their respective field offices.
Project cooperating agencies answered questions about what was working or not working in the portfolio, and projects were asked to characterize USAID’s comparative advantages.

C. Interviews and group meetings with government agencies and donor stakeholders at the national, regional and local levels

The evaluators interviewed representatives from eight international donor agencies, as well as heads of the main government agencies for health: the DOH, PopCom and PhilHealth. Most of the meetings and interviews, particularly those among international donor agencies and the central office of the DOH, PopCom and PhilHealth, were held in Metro Manila. During site visits, meeting with the regional and local counterparts of the DOH, PopCom and PhilHealth allowed for a more focused discussion on local implementation of the projects. A range of private providers were visited during field visits as well.

D. Field visits to government, health facilities and project sites in in Luzon, Visayas and Mindanao

Field visits included interviews and group meetings with project staff, local chief executives, planning officers, health officials, community health workers, midwives, nurses and private practitioners, as well as donor representatives in the field. Interview guides were prepared for local chief executives and health officials and service providers. The evaluators visited 12 public and 6 private health facilities across Luzon, Visayas and Mindanao and reviewed service delivery data.

E. Focus group discussions

With the help of LuzonHealth, VisayasHealth and MindanaoHealth, FGDs were held with young female FP acceptors, women of reproductive age who are not FP acceptors, husbands who received reproductive health counselling and community health workers involved in TB. In Cagayan de Oro, an FGD with TB patients was also conducted. Guides were prepared for the five FGDs, and five local researchers served as moderators. The evaluation team jointly prepared the instruments. Moderators and note-takers were briefed on the protocols and the expected analysis.

In the analysis of the FGDs, highlights were summarized per focus group per study area. Usually, it presented common points raised and also interesting counterarguments. These summaries were consolidated to come up with an FGD report per group. The consolidated report, to an extent possible, compares and contrasts main discussion points on certain issues across study sites. (See Annex VII).

The table below summarizes the number of FGDs conducted and the participants per group across the study sites.

**Table II-1: FGDs and number of participants by study site**

<table>
<thead>
<tr>
<th></th>
<th>Young Acceptors</th>
<th>Non-FP users</th>
<th>Males with RH counseling</th>
<th>TB BHWs</th>
<th>TB Patients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cavite</td>
<td>4</td>
<td>7</td>
<td>-</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Davao/Davao del Sur</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cebu</td>
<td>8</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tacloban/Javier, Leyte</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cagayan de Oro/Bukidnon</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Batangas City</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quezon City</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total FGDs conducted</strong></td>
<td><strong>7</strong></td>
<td><strong>7</strong></td>
<td><strong>6</strong></td>
<td><strong>7</strong></td>
<td><strong>1</strong></td>
<td><strong>28</strong></td>
</tr>
<tr>
<td><strong>Total FGD participants</strong></td>
<td><strong>46</strong></td>
<td><strong>49</strong></td>
<td><strong>39</strong></td>
<td><strong>54</strong></td>
<td><strong>6</strong></td>
<td><strong>194</strong></td>
</tr>
</tbody>
</table>
The evaluation team held discussions among themselves concerning the policy context and challenges facing the health system, and attended key policy, communications and TB meetings in Manila.

Input was received from 466 respondents (see Annex III for list), including 194 who participated in FGDs. This work was conducted from February 26 to April 21, 2016.

Limitations

One limitation of the evaluation is the short time allotted to conduct all the evaluation activities. Thus, efforts were focused on selected study areas that may not have been representative of the whole project sites. The timing was also crucial, as the evaluation period coincided with the campaign period for national elections. The team was not able to interview local chief executives at the provincial level (governor) and had a hard time scheduling interviews with those at the municipal/city level.
ANNEX III. PERSONS INTERVIEWED

USAID/Philippines Contacts
Dr. Susan Brems, Mission Director
Karen Klimowski, Director, Office of Health
Judy Chen, Deputy Chief, Office of Health
Reynalda Perez, Program Management Specialist, Office of Health
Albert Aquino, M&E Specialist, Program Office
Bernadette Cariaga, Gender and Development Specialist, Program Office
Helen Hipolito, Project Development Specialist, Office of Health
Teresa Carpio, Project Development Specialist, Office of Health
Consuelo Anonuevo, Project Development Specialist, Office of Health
Ma. Paz de Sagun, Program Management Specialist, Office of Health
Derrick Golla, Communication Specialist
Kathryn Roa, Infectious Disease Specialist, Office of Health

USAID/Washington
Micaela Arthur, Health Advisor, Asia Bureau
Kristina Yarrow, Senior Health Technical Specialist, Asia Bureau
Jasmine Baleva, PHN Country Team Lead
Sara Swift, Cross-Sectoral Program Team, Political Economy Analysis
Josephine Francisco, Program Officer, USAID/Philippines

USAID Partners
Communication for Health Advancement through Networking and Governance Enhancement (CHANGE)
Marilyn Villapando, Chief of Party
Mr. Boboy Consunji, CEO
Mr. Juan Borjd, M&E, Writer
Ms. Eliza Joy N. Dimaano, Creative Director
Ms. Yolly Ong, Former COP

Community Maternal, Neonatal, Child Health and Nutrition Scale Up (CMSU)
Patricia Gomez, Chief of Party
Janet Malala, Program Manager for Luzon

Promoting the Quality of Medicines
Ms. Maria Kathrina G. Olivarez, Program Technical Manager

Health Leadership and Governance Project 2 (HLGP2)
Mr. Ramon Derige, Chief of Party
Mr. Jerry Jose, Program Manager
Ms. Sealdi Gonzales, Partnerships Associate
Ms. Pamela Bianca Mangilin, M&E Specialist

Health Policy Development Program (HPDP)
Dr. Carlos Panelo, Chief of Party
Dr. Carlos Tan, Deputy Chief of Party
Alejandro Herrin, School of Economics, University of the Philippines (former COP, LuzonHealth)
Orville Solon, School of Economics, University of the Philippines (former COP, HPDP)

Innovations and Multisectoral Partnerships to Achieve Control of Tuberculosis (IMPACT)
Dr. Belfrando A. Cangao, Chief of Party
Dr. Eduardo M. Gonzaga, Deputy Chief of Party
Dr. Florante P. Magboo, M&E and Management Specialist
Mr. Raul Caceres, Behavior Change Communication Specialist
Dr. Ted Yu, Regional Team Leader for Mindanao
Dr. Pilar Mabasa, Regional Team Leader Visayas
Ms. Geraldine Arreza, PTIS Subgrant, Visayas

Systems for Improved Access to Pharmaceuticals and Services (SIAPS)
Wehmood Anwar, Country Project Manager

Luzon Health
Dr. Easter Dasmarinas, Chief of Party
Dr. Rosario Benabaye, Deputy Chief of Party
Dr. Ingrid Magnata, FP/MCH Specialist
Ms. Jessamine Lei Generoso, M&E Officer
Ms. Noemi Bautista, Senior Policy and Health Systems Adviser
Mr. Jose Juan dela Rosa, Behavior Change Communication Specialist

Mindanao Health
Dr. Dolores Castillo, Chief of Party
Mr. Fidel Bautista, M&E Specialist
Dr. Roy Gavino, Regional Team Leader for Northern Mindanao
Dr. Averdin Bucad, Program Manager
Edgardo B. Catalan, Policy and Health Systems Specialist
Rey Soriano, Behavior Change Communication Specialist
Maharlika F. C. Gomez, Communication Specialist, Northern Mindanao
Al-Zadat Amilassan, M&E Officer SOCCSKSARGEN
Nayda Julkarnain, M&E Officer ARMM
Keane Agravante, M&E Officer North Min and CARAGA
Dr. Henry Plaza, FP/MCHN Specialist

Visayas Health
Dr. Jose Rodriguez, Chief of Party
Dr. Susana Madarieta, Deputy Chief of Party
Alicia Lourdes de Guzman, Behavior Change Communication Specialist
Ms. Merlyn Rodriguez, Policy and Advocacy Officer

**Government of the Philippines–Department of Health**

Dr. Janette Garin, Secretary of Health
Dr. Celine Garfin, National TB Coordinator
Dr. Marwynn Bello, Director III, Health Promotions & Communications
Ms. Brenda Panganiban, Senior Health Program Officer, BIHC
Ms. Georgina Romero, Chief Health Program Officer, BIHC
Dr. Yolanda E. Oliveros, Office of the Secretary (USAID)

**National Implementation Team for RPRH Law Secretariat**

Dr. Junice Melgar, Chief, Family Health Office
Dr. Diego Danila, FP Coordinator, Family Health Office
Dr. Joyce Ducusin, Family Health Office
Zenaida Recidoro, Chief, Health Program Officer, Family Health Office
Anthony Escobier, Legal Advisor
Dr. Bernabe Marinduque, Jhpiego

**Department of Health–Regional Health Office NCR**

Dr. Ariel Valencia, Director IV
Dr. Corazon Flores, Assistant Director
Dr. Reinhard Dalumpines, FP/MCH Coordinator
Dr. Amelia Median, Medical Specialist, Local Health Support
Mr. Robert Belchez, RN, TB Program Coordinator
Jeff Carl Estioco, RN, TB Program Coordinator

**Department of Health–Regional Health Office 4A**

Dr. Rio Magpantay, Director IV
Dr. Eva Marie Torio, NTP Medical Coordinator
Ms. Malou Balena, FP Coordinator

**Department of Health–Regional Health Office 7**

Dr. Jaime S. Bernadas, Director IV
Dr. Jera Almendarez, Family Planning Officer

**Department of Health–Regional Health Office 8**

Dr. Theresa Caidic, NTP Regional Coordinator
Dr. Milagros Bolito, Head, Family Health Cluster

**Department of Health–Regional Health Office 11**

Dr. Abdullah B. Dumama, Director IV
Philippine Health Insurance Corporation
Dr. Mary Antonette Y. Remonte, Medical Specialist III, MDG Benefit Team Leader
Ms. Rosanna Martinez, Senior Social Insurance Specialist
Ms. Pura Carino, Division Chief, International and Local Engagement Department
Dr. Francis Javier, Visayas, Region 7
Mr. Walter Bacareza, AVP, Region 8
Laarni Decena, Davao de Sur, Region XI
Chris Molina, Compostela Valley, Region XI

Population Commission (PopCom)
Dr. Juan Antonio Perez III, Executive Director
Lydio Espanol, Regional Director, Region IVA/B
Ms. Josephine Santos, Behavior Change Communication Specialist, Region IVA/B
Ms. Elnora Pulma, Director Region 8
Mr. Niel Aldrin Omega, PopCom, Region X
Mr. Madu Damsani, Director, Region XI
Ms. Ching Amor, Information Officer, PopCom Region XI
Jony Mae Catalan, Project Evaluation Officer, PopCom Region XI

Regional Contacts
Province of Cavite
Dr. Gilbert P. Ilog, Provincial Health Officer I
Ms. Hazel V. Creencia, MCH Coordinator
Dr. Maria Hilda Bucu, Coordinator, TB Program, Infectious Disease Cluster Head
Ms. Minda Lingan, NTP Nurse Coordinator

LGU-Municipality of Tanza
Dr. Ruth Punzalan, Tanza Municipal Health Officer
Jingle Alcantara, FP/MCHN, Tanza RHU
Evangeline Fojas, PHN, Tanza RHU
Yolanda Jabonilla, TB Nurse Coordinator, Tanza RHU

LGU-Trece Martires City, Cavite
Dr. Marina Pagao, Trece Martires City Health Officer
Trece Martires City Population Office

Batangas City
Mayor Eduardo B. Dimacuha
Atty. Victor Reginald A. Dimacuha, Chief of Staff, Mayor’s Office
Dr. Rosanna Carmelita A. Barrion, City Health Officer
Maria Elena B. Elepano, Nurse VI

Marikina City
Mr. Wilfredo Reyes, Executive, Assistant of City Mayor
Dr. M.G. del Rosario, RH Physician & MNCHN Coordinator
Mrs. R. R. Santiago, Planning Officer
Dr. Charie Salvador, Rural Health Physician and Head, TB DOTS Clinic

Quezon City
Mr. Aldrin Cuna, City Administrator
Dr. Ramona Abarquez, MCHN Coordinator, Health Department
Ms. Victoria Bravo, PHN

Province of Cebu
Dr. Sharon Azenith Laural, Regional NTP Medical Coordinator
Ms. Yolanda Garces, Medical Technologist and NTP Coordinator
Carlo Wyne Brillantes, RN, Regional NTP Assistant for Cebu Province
Mabel J. Amarga, NTP Coordinator, PHO
Buel Espinas, Regional NTP Nurse Coordinator

Local Government Units
LGU-Municipality of San Remigio, Cebu
Hon. Mariano Martinez, Mayor

LGU-Municipality of Asturias, Cebu
Hon. Alan Aldawan, Mayor

LGU-Municipality of Consolacion, Cebu
Dr. Fe Eleanor Padillo, Municipal Health Officer
Paul Pangatungan, NTP Nurse Coordinator
Virgilia Senining, Medical Technologist

LGU-Cebu City, Cebu
Dr. Daisy Villa, City Health Officer
Jules Cortes, TB Medical Coordinator

LGU-City of Naga, Cebu
Dr. Andres E. Gestopa, City Health Officer
Wilma C. Abangam, Medtech II
Maria Eden B. Cruda, Nurse III
Raycel Mae Vianca S. Buot, City TB Health Aide
Dr. Porferia Daclan, City Population Officer

Province of Leyte
Dr. Edgardo Daya, PHO I

Tacloban City, Leyte
Atty. Jenelyn Manibay, City Administrator
Dr. Jaime Opinion, Chief of Hospital, Tacloban City Hospital

Valencia City, Bukidnon
John Lancelot C. Rasonabe, LGU Adviser, Valencia City
Gouvo Cadigal, City Administrative Officer
Bernaldo L. Obuta, Acting City Planning Officer
Myrna San Juan, Nurse III
Marilyn Macota, Nurse IV

**Province of Davao Sur**
Robert Bellarmine Bajo, Provincial Planning and Development Officer
Hon. Joseph Penas, Mayor, Digos City

**Province of Davao Oriental**
Dr. Joy Sanico, Provincial Health Officer
Jelly Joy Caipang, NTP Nurse Coordinator

**Province of Compostela Valley**
Alen Vee Vermont, NTP Nurse
Desiree Rasonable, NTP Nurse
Abegail Antonio, NTP Med Tech

**City of Davao**
Atty. Melchor Quitain, City Administrator
Dr. Mary Joselle D. Villafuerte, City Council Chair on Health
Dr. Josephine Villafuerte, City Health Officer
Johore A. Agustin, Assistant Health Officer
Jeff Fuentes, City Population Officer
Ms. Mary Beth Andrade, Population Program Worker, CPO Davao City
Ms. Norie Mae David, Population Program Officer, Davao City
Ms. Joseliedelos Santos, Population Program Officer, Davao City

**Province of Misamis Oriental**
Dr. Jerie Calingasan, Provincial Health Officer
Hazel Ganas, FP Coordinator
Rosette Cervantes, Administrative Officer
Ma. Carmela Ditona, Medical Technologist (TB)
Prasadas Obsioma, PHO Consultant

**City of Cagayan de Oro**
Oscar S. Moreno, Mayor, Cagayan de Oro City
Dr. Fe Bongcas, City Health Officer
Dr. Richell Dillas, FP Coordinator
Dr. Mercedes Barba, MCHN Coordinator

**Public Health Facility Visits**
*General Emilio Aguinaldo Memorial Hospital, Cavite*
Maria Jaime, Nurse

*Batangas RHU1, Batangas City*
Dr. Allen Evangelio Santos, Medical Office IV
Tarcila Ceraday, Nurse IV
Vicky Matienza, NTP and HIV/AIDS Coordinator
Gloria Garcia, Midwife
Diane Jean Panlaqui, Admin Aide III

Cebu Provincial Hospital, Danao City
Dr. Prudencio Manubag, Chief of Hospital
Southern General Hospital, Cebu City
Marlon Hermosada, PPMD Nurse

Eversley Child Sanitarium & General Hospital, Cebu City
Dr. Alimar I. Nassae, TB Lead Staff
Arnufo L. Jarancey, Training Director
Joseph Dennis Adlawan, Health Education Promotion Officer
Lewelyn C. Cabrera Nurse II, OPD/PPMP Nurse
Mar. Fe. Gocodano, Nursing Attendant

Inayawan Health Center, Cebu City
Ted Gaspe, Public Health Nurse

Social Hygiene Clinic, Cebu City Health Office
Dr. Ilya Abellanosa Tac-an Program Manager, Social Hygiene Clinic, Cebu City Health Office

Eastern Visayas Medical Center, Tacloban City
Dr. Gerardo M. Aquino, Chief of Hospital
Dr. Realino Molina, Head, Ob-Gyn
Dr. Jenny Lind Lesigues, In-charge, Program for Young Parents Center

Davao del Sur Provincial Hospital
Dr. Glinard Quezada, Chief of Hospital

Southern Philippines Medical Center, Davao City
Dr. Lopoldo J. Vega, Chief I
Dr. Molia Carrias-Llaya, Chief OBGYN Section (MCH/FP/HIV)
Dr. Je Loren
Alicia Layeeg
Angelina Pastolen
Emmanuel Lopez, M&E Specialist/IP-MCHN Mindanao

Northern Mindanao Medical Center, Cagayan de Oro City
Dr. Sarah Pingol, Ob-Gyn Head
Dr. Carol Orimaco, FP/MCH Specialist

SIR Talomo North RHU (DOTS)
Dr. Carmela Cunara, District Medical Officer
Nelia Sarona, Midwife
Private Health Facilities

*Paanakan SaMandaue Lying-in Clinic, Cebu City*
Ms. Lisa Prudenciado, Head Midwife

*Mendez Medical Center (Cebu City)*
Hazel Medillo, Nurse
Peter Arnold Tubayan, Nurse

*Brokenshire Hospital, Davao City*
Dr. Darleen Estuart
Dr. Rosemarie Buenaventura
Dr. Mae Bonguyan
Dr. Krislyn Kate Dublin
Ms. Rhoda Payumo, Branch Manager, Southern Mindanao

*Wellfamily Clinic, Davao City*
Ms. Anita Alojado, Owner

*Digos Maternity Clinic, Digos City*
Dr. Armie Monarca, Owner and Physician
Jonalyn Sabejon, Midwife
Lady Mae Rocacorba, Midwife

Donor Partners

Mr. Klaus Beck, Country Representative, UNFPA
Dr. Elizabeth Sabay, UNFPA Mindanao

Nino Rocamara, Office of the Resident Coordinator, UNDP
Mr. Fernando Antolin, UNDP

Mariella Castillo, Health Specialist, Health and Nutrition Section, UNICEF
Ms. Kathleen Solis, C4D Specialist, UNICEF
Ms. Teresita Marie Bagasao, Country Coordinator, UNAIDS

Dr. Gundo Aurel Weiler, WHO Representative
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Rajendra Yadav, Medical Officer, WHO
Jacqueline F. Kitong, Technical Officer, MNCHN, WHO

Fabia Lonquist, External Relations, WHO, WPRO
Ruth Macapagal, External Relations, WHO, WPRO
Dr. Roberto Rosadia, Health Specialist, WB

Diana Van Daele, Program Manager Health, Operations Section, EU
John Izard, Technical Assistance Team Leader, IP MNCHN Project, Mindanao (EU)

Flerida Chan, Section Chief, Poverty Reduction Section, Human Security Group, JICA
Teresa Mendoza, Program Officer, Human Security Group, JICA

Others

Dr. Virgillo Pernito, COO, Population Services of the Philippino International (PSPI)
Mr. Rostom Deiparine, CEO, PSPI
Dr. Oscar Picazo, Health Finance Consultant
ANNEX IV. BIBLIOGRAPHY

General References


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**Philippine Government Laws/Administrative Orders**


**Online Resources**


ANNEX V. DATA COLLECTION INSTRUMENTS

Part of the data collection during field visits included the use of the following instruments and guidelines:

1. Facility Observational Checklist (1)
2. TB Data Collection Chart and Checklist (1)
3. Guidelines for Focus Group Discussion (5)
   a. Young women, new acceptors of temporary FP methods (pills, IUD, injectables, implant, condom). They should have at least one child, or be part of an adolescent and youth reproductive health program; age range 18-21.
   b. Women of reproductive age who are non-FP users (not currently using, but will also include those who have used any method before, discontinued/dropped out). They should have at least one child. Age: 18-35
   c. Husbands who received RH counseling (spouse is a new acceptor); Age range: 18-35
   d. Community health workers involved in TB (BHW, CHT members)
   e. TB patients
4. Guidelines for Key Informant Interviews (2)
   a. Local executives (Governor, mayor, or former executives)
   b. Provincial/Municipal/City Health Officer/others as appropriate
5. Open-ended discussions (1 each in Luzon, Visayas, & Mindanao)
   a. Nurses/midwives trained in IPC/C, Usapan
   b. Nurses + Municipal Health Offices (Supervisors). Include those trained and not trained on supportive supervision.
   c. BHWs trained in IPC/C, Usapan
6. Request for Information to USAID project partners

Copies of each follow.
## FACILITY OBSERVATION CHECKLIST

Name of Facility: __________________________________________________

(Encircle)
- RHU
- Hospital
  - Public
  - Private
- Birthing Facility

Name of Observer: ___________________________________________________

Date of Observation: ________________________________________________

Time of Observation: ________________________________________________

### A. Infrastructure and Facilities

1. Is there a:
   - [ ] Waiting area for clients with chairs
   - [ ] Waiting area for husbands/companions
   - [ ] Examination room
   - [ ] Storage room for TB drugs and contraceptive supplies
   - [ ] Signage announcing FP/IMCH and TB services
   - [ ] Sufficient number of beds (maternity)

2. Is there a separate room for TB?
   - [ ] yes
   - [ ] no

3. Microscopy room?
   - [ ] yes
   - [ ] no

<table>
<thead>
<tr>
<th>Remarks</th>
</tr>
</thead>
</table>

### B. FP/MCH/TB drug supplies (services)

- [ ] Provide pills
- [ ] Provide IUD
- [ ] Provide condoms
- [ ] Provide injectables

<table>
<thead>
<tr>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide implants</td>
</tr>
<tr>
<td>提供肉芽</td>
</tr>
<tr>
<td>Provide natural FP</td>
</tr>
<tr>
<td>提供自然避孕方法</td>
</tr>
<tr>
<td>Provide DOTS</td>
</tr>
<tr>
<td>提供DOTS</td>
</tr>
<tr>
<td>Provide tubal ligation</td>
</tr>
<tr>
<td>提供输卵管结扎术</td>
</tr>
<tr>
<td>Provide vasectomy services</td>
</tr>
<tr>
<td>提供绝育术</td>
</tr>
<tr>
<td>Is postpartum IUD being offered?</td>
</tr>
</tbody>
</table>

**C. IEC materials**
- On different FP methods
- On MCH
- On TB
- On TB
- On TB
- On TB
- On TB
- On TB

**D. Recording/Information system**
- On TB patient records
- On FP client record
- On MCH client record
- Are they updated?
  - Yes
  - No

Is there an unmet need list? _______

**E. Equipment**
- Weighing scales
- Sterilizing equipment
- Enough specula
- Enough tenacula
- Enough syringes
- Enough gloves
- Enough implant kits
- Others

**F. Staffing:**
- Number of midwives
- Number of med techs (microscopy in DOTS)
- Number of trained midwives FPCT1 only
- Number of trained midwives trained in FPCT1 and 2
- Number of HP providing IUD and implant
- Number of nurses
- Nurses trained in FPCT
- Nurses trained in supportive supervision
- Number of physicians (FP/IMCH/TB) in facility
- Physicians trained in FP/IMCH/HLGPI
### TB Data Collection Chart and Checklist

**EXAMPLE**

Region, municipality: Province of XXX

Name and type of facility: XXX Hospital DOTS

- Name of respondent, position: XXX—Nurse Microscopist; XXX: NTP Coordinator

<table>
<thead>
<tr>
<th>Period (year or quarter)</th>
<th>Number of outpatients (any reason)</th>
<th>Number of adults (M/F)</th>
<th>Number examined (persons or slides)</th>
<th>Number smear positive</th>
<th>%</th>
<th>Number TB</th>
<th>Number pulmonary TB S+</th>
<th>Percent S+</th>
<th>Number cured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not collected</td>
<td>---</td>
<td>1074</td>
<td>190</td>
<td>149</td>
<td>28</td>
<td>18%</td>
<td>18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Infection control, QA microscopy, MDR, availability and use of GeneXpert)

1. **Observations:**
   - Facility is clean. Microscopy lab is in a separate room.
   - They use GeneXpert in the public health MDR satellite facility.
   - Sputum induction done outside in open air and located close to the other hospital
   - Keep updated TB registers and information
   - Gives out weekly supply—nearest relative as treatment partner.

2. **What is the input of USAID support? Was it effective? How?**
Consists mostly of trainings. They find the training very useful and relevant.

Trainings attended:
- Informal Lab worker training (DOH)
- DSSM
- Basic DOTS
- Programmatic Management of Drug-Resistant TB
- Training on revised MOP
- Infection control (given by PBSP)
- Drug supply and logistics

What can be improved in support of TB control? More manpower.

Treatment partner are relatives. Patients given weekly supply.

Name of team member: Marilou Costello

Focus Group Discussion (FGD) Guide

Young women, new acceptors of temporary FP methods (pills, IUD, injectables, implant, condom). They should have at least one child, or in an adolescent and youth reproductive health program.

Age: 18-21

Objectives:
1. To find out how the project identified them
2. Did they participate in activities of the project that influence them to seek services?
3. Who were the service providers that assisted them in the community (CHT? BHW?), in the clinic/facility (SDP) (i.e., midwives, nurses)?
4. Did they see any IEC materials on FP/MCH? Did they see or hear any campaign on FP/MCHN over the radio or TV?
5. What method was chosen?
6. How was her experience, was the method readily available? Did she pay for the services?

FLOW/PROCESS OF THE FGD

Guide for Facilitators

1. Preliminary instructions (to be explained to all participants)
   1. Introduce yourself and the other members of the team.
   2. Thank the participants in advance for agreeing to participate in the FGD group.
   3. Explain the nature of the activity: In an FGD, the moderator/facilitator asks questions of mutual interest to the team and the participants. Please mention that participants DO NOT merely answer the facilitator’s questions, but instead engage in discussion with other participants.
   4. Explain the nature of one’s participation: Everyone is encouraged to engage in discussion. Encourage participants to share even ideas even if they are unsure about them. Participants may ask questions to other participants, and they may follow up on a point raised by another participant. Emphasize that there are no right or wrong answers.
   5. Explain confidentiality: Kindly remind participants that the discussions are confidential, especially if there are sensitive issues or points raised in the course of the FGD. They may not speak of what was
discussed to external parties. Give the assurance that their responses will only be used for the purpose of the study and will not be linked to them individually.

6. Ask permission to record the FGD.

II. Introducing the participants
1. The facilitator asks all participants to introduce themselves. This information is suggested: name and nickname, marital status, age, number of children
2. The facilitator reminds participants to use each one’s nickname to establish rapport.

III. Discussion proper
(The facilitator probes the following themes/questions,)

| Part 1 | Sexuality and fertility | How many children do you have now? How many children do you want to have? Explore: one’s fertility intention, age of sexual initiation. What FP method are you currently using? How did you learn about this method? When did you decide to use a family planning method? Explore: motivations for FP use, what method she tried to use, current method use, duration of current method use, misconceptions about FP, influenced by outreach worker, IEC materials, radio and TV campaigns, family, counselling or own choice. |
| Part 2 | Decision-making about FP | Why did you decide to use a family planning method? Who convinced or persuaded you to use this method (Probe: If you had contact with health center, did anyone talk to you about all the methods?) Explore: What are your considerations in choosing this method? Who in your family or community did you consult before using this method? Was parental/husband consent required by the facility? Did they support or object to your decision to use an FP method? Explore: the reasons for objection/support, whether these affected her decision in choosing a method. |
| Part 3 | Method use experience | Are you satisfied with your current method? Explore: Did she experience side effects? What are these? How did she deal with them and if she consulted someone about side effects? Explore logistic issues: Was supply readily available? If supply was not available in your facility, were you referred to other facilities? What about quality of care? Was the service provider helpful? Respectful? Did you have to wait long before you were attended to? Did you get the method that you preferred? Where did you get information about FP? Was this info enough to make a decision? Where did you get FP services? Were you satisfied with your service provider? What advice about FP was given? Until when do you plan to use this method? The last time you gave birth, were you counselled right away about family planning? What advice did you get? Did you accept this method at that time? While you pregnant with your last child, were you given information about FP? Who gave it to you? What information did you get? |
Additional guidelines:

- When the facilitator thinks that a question/issue has not been discussed thoroughly, s/he always invites other participants to share their ideas. Encourage the participants to talk to each other. If necessary, encourage participants to ask questions.
- Make sure that a question/topic is thoroughly discussed before moving to another topic. Facilitators should avoid moving to and from different topics too much, unless participants initiate it. If the facilitator thinks that a particular issue has already been discussed, s/he may gently shift to another topic. Do not be too abrupt in introducing new topics; you may connect them to other previously mentioned points.
- Facilitators should look out for participants who are quite vocal and might dominate the discussion. When there are such participants, it is all the more necessary to invite other participants to speak out, because others will tend to remain silent.
- Facilitators should note disagreements/divergences in thinking and explore them further. When opposing ideas are presented, facilitators should encourage other participants to weigh in on the discussion (i.e., to state their agreement/disagreement with a point and explain their reasons).
- In the event that the discussion becomes “too personal” and there is likelihood of conflict, the facilitator brings the discussion back to the issues at hand.

III. Summary of important points and conclusion

1. The facilitator (or secretary/documenter) summarizes key points made in the discussion.
2. The facilitator asks the participants if they have any questions.
3. The facilitator thanks all the participants and concludes the FGD.

**FOCUS GROUP DISCUSSION (FGD) GUIDE**

**Health Portfolio Evaluation**

Women of reproductive age who are non-FP users (not currently using, but will also include those who have used any method before, discontinued/dropped out). They should have at least one child.

Age: 18-35

Objectives:

1. Have they ever seen or heard an FP/MCHN campaign over the radio or TV?
2. Have they ever participated in any FP/MCHN(4,6),(998,988) communication activity?
3. Have they been contacted by an outreach worker?
4. Have they been counselled by service providers in the facility?
5. Do they have the need to use FP either to space or limit pregnancies?

**FLOW/PROCESS OF THE FGD**

**Guide for Facilitators**

I. Preliminary instructions (to be explained to all participants)

1. Introduce yourself and the other members of the team.
2. Thank the participants in advance for agreeing to participate in the FGD group.
3. Explain the nature of the activity: In an FGD, the moderator/facilitator asks questions of mutual interest to the team and the participants. Please mention that participants DO NOT merely answer the facilitator’s questions, but instead engage in discussion with other participants.
4. **Explain the nature of one’s participation**: Everyone is encouraged to engage in discussion. Encourage participants to share even ideas even if they are unsure about them. Participants may ask questions to other participants, and they may follow up on a point raised by another participant. Emphasize that there are no right or wrong answers.

5. **Explain confidentiality**: Kindly remind participants that the discussions are confidential, especially if there are sensitive issues or points raised in the course of the FGD. They may not speak of what was discussed to external parties. Give the assurance that their responses will only be used for the purpose of the study and will not be linked to them individually.

6. **Ask permission to record the FGD**.

**II. Introducing the participants**

1. The facilitator asks all participants to introduce themselves. This information is suggested: name and nickname, marital status, age, number of children

2. The facilitator reminds participants to use each one’s nickname to establish rapport.

**III. Discussion proper**

*(The facilitator probes the following themes/questions.)*

| Part 1 | Sexuality and fertility | How many children do you have now?  
Explore: one’s fertility intention, age of sexual initiation  
For those who want a child later or don’t want to have another child, are you doing anything to delay your next pregnancy or stop getting pregnant?  
If yes, what are you doing to prevent another pregnancy? How did you learn about this way of delaying or stopping pregnancy? What do you feel about this way of delaying or stopping your pregnancy? |
|---|---|---|
| Part 2 | Awareness of FP methods | Do you know of ways to limit or space births or pregnancies?  
Explore: Can you name any of these methods? Probe: Where did you hear about these methods? What do you know about these methods?  
If there is no mention of any method, ask: Have you heard about: pill, IUD, injectables, condom, implant, natural FP? What do you know about these methods? Where did you hear about these methods? What do you think about these methods? |
| Part 3 | Use of FP methods | Did you ever consider using an FP method?  
Explore: What method was it? Why did you not pursue using this method? Probe for fear of side effects or misconception. Where did they hear about it?  
For those who have ever used: Why did you stop using the method?  
Do you know of anyone in your family, community who use an FP method?  
Explore: Who is/are these people? Did you consult them about FP or did they talk to you about this? What did you discuss? |
| Part 4 | Information dissemination campaign on FP | Have you ever participated in an Usapan or group discussion or chat in your community or health center? What was the topic of this discussion? Who organized this discussion or Usapan? Were individual counseling and services (commodities/referral) provided after the group discussion session? (If 4Ps beneficiaries, ask whether PopCom organized the Usapan?) |
If participated, what are the key points you remember from this discussion? (PROBE FOR KEY MESSAGES). What do you think about this information? What did you like about this discussion? What did you not like? Would you like to participate in another discussion again? Do you plan to use a method in the future?

Additional guidelines:

- When the facilitator thinks that a question/issue has not been discussed thoroughly, s/he always invites other participants to share their ideas. Encourage the participants to talk to each other. If necessary, encourage participants to ask questions.

- Make sure that a question/topic is thoroughly discussed before moving to another topic. Facilitators should avoid moving to and from different topics too much, unless participants initiate it. If the facilitator thinks that a particular issue has already been discussed, s/he may gently shift to another topic. Do not be too abrupt in introducing new topics; you may connect them to other previously mentioned points.

- Facilitators should look out for participants who are quite vocal and might dominate the discussion. When there are such participants, it is all the more necessary to invite other participants to speak out, because others will tend to remain silent.

- Facilitators should note disagreements/divergences in thinking and explore them further. When opposing ideas are presented, facilitators should encourage other participants to weigh in the discussion (i.e., to state their agreement/disagreement with a point and explain their reasons).

- In the event that the discussion becomes “too personal” and there is likelihood of conflict, the facilitator brings the discussion back to the issues at hand.

III. Summary of important points and conclusion

1. The facilitator (or secretary/documenter) summarizes key points made in the discussion.
2. The facilitator asks the participants if they have any questions.
3. The facilitator thanks all the participants and concludes the FGD.

FOCUS GROUP DISCUSSION (FGD) GUIDE
Health Portfolio Evaluation

Husbands who received RH counseling (spouse is a new acceptor)

Age range: 18-35

Objectives:

1. How the various demand- and supply-side interventions of the project influence the use and non-use of FP by men
2. Whether they have opted for male-focused method or supported their partner’s method use

FLOW/PROCESS OF THE FGD
Guide for Facilitators

I. Preliminary instructions (to be explained to all participants)

1. Introduce yourself and the other members of the team.
2. Thank the participants in advance for agreeing to participate in the FGD.
3. **Explain the nature of the activity**: In an FGD, the moderator/facilitator asks questions of mutual interest to the team and the participants. Please mention that participants DO NOT merely answer the facilitator's questions, but instead engage in discussion with other participants.

4. **Explain the nature of one's participation**: Everyone is encouraged to engage in discussion. Encourage participants to share even ideas even if they are unsure about them. **Participants may ask questions to other participants**, and they may follow up on a point raised by another participant. Emphasize that there are no right or wrong answers.

5. **Explain confidentiality**: Kindly remind participants that the discussions are confidential, especially if there are sensitive issues or points raised in the course of the FGD. They may not speak of what was discussed to external parties. Give the assurance that their responses will only be used for the purpose of the study and will not be linked to them individually.

6. **Ask permission to record the FGD**.

---

**II. Introducing the participants**

1. The facilitator asks **all participants to introduce themselves**. This information is suggested:
   - Name and nickname, marital status, age, number of children

2. The facilitator reminds participants to **use each one’s nickname** to establish rapport.

---

**III. Discussion proper**

*(The facilitator probes the following themes/questions.)*

**Husbands who received RH counselling**

| **Part 1** | **RH Counselling** | Have you heard about FP? Where?  
Have you attended any discussion on FP? When? Where did you attend it (health center, community/barangay center, etc.)? Who organized this session?  
Who invited you to this discussion? Do you know why you were invited?  
What key information do you remember from this session? Probe—anything else?  
What did you think of this information? (like, did not like, applicable)  
What did you like/dislike about the discussion? Probe (too long, difficult to understand, speaker too strict-looking)  
Did you apply whatever advice was given during this discussion? Why or why not?  
Explore: Were you able to share this information to any male friend or relatives?  
Do you know of any male friends who you think can benefit from this kind of activity? Would you recommend this activity to them? What will you say to them? |
|---|---|---|
| **Part 2** | **Awareness and use of FP** | Do you know of any family planning method? If so, please enumerate all that you know.  
Are you and/or your partner using any of these FP methods?  
Explore: (if not male FP method) Do you think you can take responsibility for using standard days method, condom or undergoing vasectomy?  
What method is your wife using?  
What do you think of this method that your wife is using? |
Did your wife/partner seek your permission in order for her to use the pill, injectable, implants or IUD? Would you require your wife to seek your approval before using a method? Did she initiate the discussion on the method? What did you talk about?
Probes for fear of side effects/misconceptions?

Additional guidelines:

- When the facilitator thinks that a question/issue has not been discussed thoroughly, s/he always invites other participants to share their ideas. Encourage the participants to talk to each other. If necessary, encourage participants to ask questions.
- Make sure that a question/topic is thoroughly discussed before moving to another topic. Facilitators should avoid moving to and from different topics too much, unless participants initiate it. If the facilitator thinks that a particular issue has already been discussed, s/he may gently shift to another topic. Do not be too abrupt in introducing new topics; you may connect them to other previously mentioned points.
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III. Summary of important points and conclusion

1. The facilitator (or secretary/documenter) summarizes key points made in the discussion.
2. The facilitator asks the participants if they have any questions.
3. The facilitator thanks all the participants and concludes the FGD.

FOCUS GROUP DISCUSSION (FGD) GUIDE
Health Portfolio Evaluation

Community health workers involved in TB (BHW, CHT members).

Objectives:
1. How are TB cases identified?
2. How is treatment administered?
3. What are the challenges in the implementation of TB program?

FLOW/PROCESS OF THE FGD
Guide for Facilitators
I. Preliminary instructions (to be explained to all participants)
1. Introduce yourself and the other members of the team.
2. Thank the participants in advance for agreeing to participate in the FGD group.
3. **Explain the nature of the activity:** In an FGD, the moderator/facilitator asks questions of mutual interest to the team and the participants. Please mention that participants DO NOT merely answer the facilitator’s questions, but instead engage in discussion with other participants.

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6. **Ask permission to record the FGD.**

**II. Introducing the participants**

1. The facilitator asks **all participants to introduce themselves.** This information is suggested:
   - Name and nickname, marital status, age, number of years in as community health worker/BHW
2. The facilitator reminds participants to **use each one’s nickname** to establish rapport.

**III. Discussion proper**

*The facilitator probes the following themes/questions.*

<table>
<thead>
<tr>
<th>Part</th>
<th><strong>Diagnosing TB patients</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What are the main reasons for (general) patients to consult with a health worker or health center?</td>
</tr>
<tr>
<td></td>
<td>How do you identify TB cases?</td>
</tr>
<tr>
<td></td>
<td>Explore: Do you do active case-finding, such as going from house to house, have meetings in groups?</td>
</tr>
<tr>
<td></td>
<td>Where do you refer patients for diagnosis?</td>
</tr>
<tr>
<td></td>
<td>Explore: Is referral a problem? Does it involve cost? What are the costs? How far is the referral site from the barangay?</td>
</tr>
<tr>
<td></td>
<td>How do you convince them to go for diagnosis or treatment?</td>
</tr>
<tr>
<td></td>
<td>Explore: Do you use any IEC materials to help you in providing information? Where did you obtain these materials? How useful are they?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part</th>
<th><strong>Treatment of TB patients</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Do you care for TB in children, extra-pulmonary disease? How do you care for TB in children?</td>
</tr>
<tr>
<td></td>
<td>How do you obtain the drugs for treatment? How frequently? Does the patient have to pay for them? Do you have to go to the health center to get the drugs or they are delivered here? Do you need to pay for transport? Who much?</td>
</tr>
<tr>
<td></td>
<td>Explore: Have you experienced stock-out? How often?</td>
</tr>
<tr>
<td></td>
<td>How do you know or check that TB patients are taking the drugs regularly?</td>
</tr>
<tr>
<td></td>
<td>Explore: Do you observe each dose taken or provide drugs to the patient for several days? How do you check the progress of treatment and outcome (cure, completion, death, default, failure)?</td>
</tr>
<tr>
<td></td>
<td>Do you have a system of recording and monitoring cases? (Probe data collection system, use checklist.)</td>
</tr>
<tr>
<td></td>
<td>How do you report the results, and how often?</td>
</tr>
</tbody>
</table>
### Part 3: Satisfaction

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you like about the TB program in your facility?</td>
<td>What are the strengths of the TB program in your facility?</td>
</tr>
<tr>
<td>What are the strengths or areas for improvement?</td>
<td>What are the weaknesses or areas for improvement?</td>
</tr>
<tr>
<td>What are the main problems, and how do you think they should be addressed?</td>
<td>Who needs to address these weaknesses or problems?</td>
</tr>
<tr>
<td>Is there still stigma attached to TB in the community?</td>
<td>Explore: How do you know? Why do you think this stigma still persists?</td>
</tr>
<tr>
<td>Have you seen or heard the mass media campaign on TB lately?</td>
<td>What strategies do you use to address stigma?</td>
</tr>
<tr>
<td>When did you see or hear it, which channel (TV, radio, tarp or poster in health center)?</td>
<td>Have you remember from this campaign? Do you think these materials have helped in reducing stigma?</td>
</tr>
</tbody>
</table>

### Additional guidelines:

- When the facilitator thinks that a question/issue has not been discussed thoroughly, s/he always invites other participants to share their ideas. Encourage the participants to talk to each other. If necessary, encourage participants to ask questions.
- Make sure that a question/topic is thoroughly discussed before moving to another topic. Facilitators should avoid moving to and from different topics too much, unless participants initiate it. If the facilitator thinks that a particular issue has already been discussed, s/he may gently shift to another topic. Do not be too abrupt in introducing new topics; you may connect them to other previously mentioned points.
- Facilitators should look out for participants who are quite vocal and might dominate the discussion. When there are such participants, it is all the more necessary to invite other participants to speak out, because others will tend to remain silent.
- Facilitators should note disagreements/divergences in thinking and explore them further. When opposing ideas are presented, facilitators should encourage other participants to weigh in on the discussion (i.e., to state their agreement/disagreement with a point and explain their reasons).
- In the event that the discussion becomes “too personal” and there is likelihood of conflict, the facilitator brings the discussion back to the issues at hand.

### III. Summary of important points and conclusion

1. The facilitator (or secretary/documenter) summarizes key points made in the discussion.
2. The facilitator asks the participants if they have any questions.
3. The facilitator thanks all the participants and concludes the FGD.

---

**FOCUS GROUP DISCUSSION (FGD) GUIDE**

**Health Portfolio Evaluation**

**TB patients**

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**FLOW/PROCESS OF THE FGD**

**Guide for Facilitators**

1. **Preliminary instructions (to be explained to all participants)**
   - **Introduce yourself** and the other members of the team.
2. Thank the participants in advance for agreeing to participate in the FGD group.

3. Explain the nature of the activity: In an FGD, the moderator/facilitator asks questions of mutual interest to the team and the participants. Please mention that participants DO NOT merely answer the facilitator’s questions, but instead engage in discussion with other participants.

4. Explain the nature of one’s participation: Everyone is encouraged to engage in discussion. Encourage participants to share even ideas even if they are unsure about them. Participants may ask questions to other participants, and they may follow up on a point raised by another participant. Emphasize that there are no right or wrong answers.

5. Explain confidentiality: Kindly remind participants that the discussions are confidential, especially if there are sensitive issues or points raised in the course of the FGD. They may not speak of what was discussed to external parties. Give the assurance that their responses will only be used for the purpose of the study and will not be linked to them individually.

6. Ask permission to record the FGD.

II. Introducing the participants
1. The facilitator asks all participants to introduce themselves. This information is suggested:
   Name and nickname, marital status, age, occupation, DOTS treatment
2. The facilitator reminds participants to use each one’s nickname to establish rapport.

III. Discussion proper
(The facilitator probes the following themes/questions.)

<table>
<thead>
<tr>
<th>Part 1</th>
<th>Symptoms and treatment sought</th>
<th>What did you feel? What are the symptoms?</th>
<th>Where did you go for diagnosis and treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 2</td>
<td>Sources of information on TB</td>
<td>Where did you get information on TB?</td>
<td>What information was provided to you regarding diagnosis and treatment?</td>
</tr>
<tr>
<td>Part 3</td>
<td>Treatment</td>
<td>Do you have treatment partner? Who is your treatment partner?</td>
<td>Did you feel any side effects? Were you informed about the side effects of the medicines?</td>
</tr>
<tr>
<td>Part 4</td>
<td>Satisfaction with service</td>
<td>Did the health center advise your household members to have a check-up or undergo sputum microscopy?</td>
<td>Were you satisfied with the treatment or services provided by the health center?</td>
</tr>
</tbody>
</table>

Additional guidelines:
- When the facilitator thinks that a question/issue has not been discussed thoroughly, s/he always invites other participants to share their ideas. Encourage the participants to talk to each other. If necessary, encourage participants to ask questions.
- Make sure that a question/topic is thoroughly discussed before moving to another topic. Facilitators should avoid moving to and from different topics too much, unless participants initiate it. If the facilitator thinks that a particular issue has already been discussed, s/he may gently shift to another topic. Do not be too abrupt in introducing new topics; you may connect them to other previously mentioned points.
Facilitators should look out for participants who are quite vocal and might dominate the discussion. When there are such participants, it is all the more necessary to invite other participants to speak out, because others will tend to remain silent.

Facilitators should note disagreements/divergences in thinking and explore them further. When opposing ideas are presented, facilitators should encourage other participants to weigh in the discussion (i.e., to state their agreement/disagreement with a point and explain their reasons).

In the event that the discussion becomes “too personal” and there is likelihood of conflict, the facilitator brings the discussion back to the issues at hand.

III. Summary of Important Points and Conclusion

1. The facilitator (or secretary/documenter) summarizes key points made in the discussion.
2. The facilitator asks the participants if they have any questions.
3. The facilitator thanks all the participants and concludes the FGD.

Key Informant Interview Guide
Health Portfolio Evaluation
Local executives (governor, mayor, or former executives)

Objectives
1. To gauge the relative importance of health issues to the leadership
2. To gauge the relative grasp of the leadership of development in general and health concerns in particular
3. To obtain a sense of the value of DOH and USAID assistance to the leadership (and inferentially, their degree of commitment to and desire for continuance of the assistance)
4. To obtain a sense of the actual role the leader takes in achieving development/health objectives and degree with which he/she champions the causes
5. To assess the budgeting process and financing capability of the LGU in relation to its development/health programs
6. To obtain a sense of the attitude of the LGU regarding health sectors such as youth and tools such as health insurance

Guide for the Interviewer

I. Preliminary instructions
1. Introduce yourself.
2. Thank the respondent in advance for agreeing to participate in the interview.
3. Explain the purpose of interview.
4. Explain confidentiality: Remind the respondent that the responses he/she gives are confidential, and will not be attributed to them personally in any briefing or report. Note that they can opt out of questions that they feel they are not comfortable with at any time.
5. Ask permission to proceed with the interview.

A. Introductory questions
1. What are the top objectives or goals that your administration hopes to achieve during your term(s) as local chief executive? (Short-, medium-, long-term goals)
2. As the chief executive of your city/municipality/province, what do you believe are the major/important (development) challenges or concerns for the LGU? Why?

3. What activities, programs or projects has the municipality/province taken to address these concerns and achieve your objectives?

4. How would you rank the health concerns of your constituents (for example FP/MCH, TB, health insurance) among the concerns or programs of your LGU?

5. What do you consider as major health-related problems in your city/municipality/province?

6. How often do you get briefed by your health officer regarding the primary health care in your city/municipality/province?

B. FP/MCH

7. Please tell us about the FP/MCH program in your province/city/municipality. Do you allot budget and resources for FP/MCH? How much do you allot every year?

8. Do you procure contraceptive supplies for your locality? What methods?

9. Do you have concerns about/ plans for the youth in the LGU? Are there specific (in health in general, in FP, MCH in particular) programs of the LGU for the youth?

10. What about pregnant and lactating mothers? What are your government’s programs on breastfeeding and infant and child’s health?

C. TB

11. What are the major infectious diseases in your province/city/municipality? Is TB still a major health issue?

12. Is the DOTS program being implemented in the provincial health/city health/municipal health facilities?

13. Do you engage the private sector in DOTS? How?

D. Others

14. Do you have an active SDN for FP/MCH and TB? What are their current activities and involvement?

15. What percent of your public health facilities (hospitals, RHUs, birthing facilities) are PhilHealth-accredited? Do you think this is an effective strategy to sustain programs in the facilities? How was your experience regarding PhilHealth reimbursement?

16. What percent of the indigents in your province/city/municipality are covered by PhilHealth? Do you have a program to increase PhilHealth coverage?

17. Aside from the DOH and the national government, what are your other sources of support for health-related programs?

18. How would you distinguish the support of USAID compared to other funding agencies?

19. What are other issues regarding health that you intend to address in the future?

Open-ended Discussions with Health Service Providers and BHWs

1. Nurses/midwives trained in IPC/C, Usapan, 1 in Luzon, 1 Visayas, 1 Min

2. Nurses + Municipal Health Offices (Supervisors) 1 in Luzon, 1 Visayas, 1 Min

3. BHWs trained in IPC/C, Usapan 1 in Luzon, 1 Visayas, 1 Min
**Rationale.** In order to generate demand, strengthening and scaling up of IPC/C and social mobilization activities is a key output indicator of the FP/MCH and TB projects. The team will hold open-ended discussions with health service providers and BHWs (4-5 per group) trained in IPC/C, social mobilization (Usapan), and supportive supervision (focusing on IPC/C) for FP/MCH, TB to explore issues and gain insights on the:

- quality and relevance of the training
- post-training follow-up and support
- opportunities and challenges faced in the health facility and community in cascading relevant trainings, conducting IPC/C, social mobilization, and supportive supervision as part of the health service providers/BHWs’ regular functions

Separate discussions with BHWs are needed to understand how they perform and balance their roles as FP/MCH, TB and other health program community volunteers, probe issues regarding functionality of CHTs, and elicit areas of support to strengthen generation of effective demand for health services.

**Before the discussions,** we will inform the groups that the purpose of the discussion is to gather their views about the training and information on how they go about their work in IPC/C, community mobilization and supportive supervision. We will emphasize that this is not an evaluation of their individual performance and that what they say will be kept strictly confidential, with no names mentioned. We will explain that we need their opinions on how to improve future trainings and the institutional support for IPC/C, social mobilization and supportive supervision, so that they can become more effective in helping increase correct practices on FP/MCH, TB.

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**Request for Input from USAID Project Partners**

March 15, 2016

**TO:** USAID project partners  
**FROM:** Performance evaluation of health portfolio evaluation team

The evaluation team would appreciate a written response to some key questions for this evaluation of the health portfolio. Your answers need not relate to your specific project, and, in fact, should not relate solely to your project for the third question. Please keep your responses brief (less than a page per question) and do not share reports or other materials in answer to these questions.

We are interested in your project teams’ own experiences and opinions.

The questions are as follows:

1. What do you see as the most successful interventions supported by the USAID health portfolio in the last three to five years? Please define what you mean by successful in the context of your answer and explain the reach of the intervention (e.g., province-wide, pilot project).
2. What types of interventions do not work well within the objectives of the USAID portfolio? Why? Who else should support them?
3. What do you see as USAID’s comparative advantage in supporting MCH, FP and TB programs in the Philippines vis-à-vis the government, other donors or civil society?

Answers can be sent to the team leader, Connie Carrino at cacarrino@gmail.com. Your responses will be kept confidential by the team and will not be attributed to you directly in any briefings or reporting out of findings. Please provide responses by April 1, 2016.

Thank you for your cooperation. Your input is very important to us.
**ANNEX VI. REVIEW OF INDICATORS, POLICIES, FINANCE AND GOVERNANCE**

Following is an expanded version of points made in the Background section of this report. It covers recent changes in FP, MCH, TB and HIV indicators, the health policy and finance environment in the Philippines and a description of the decentralized governance structure in which the public health sector operates.

**RECENT CHANGES IN FP, MCH, TB AND HIV INDICATORS**

**Family planning**

The 2010 Philippine Census of Housing and Population\(^{102}\) reported a total population count of 92.34 million and an annual growth rate of 1.9 percent. Fertility remains one of the main contributors of population growth. Based on the 2013 NDHS,\(^{103}\) TFR, or the average number of children that a woman can have in her reproductive life course, is 3. This is still high, especially compared to other Southeast Asian countries that achieved replacement fertility (TFR=2) decades ago.

Several factors have been identified for the slow decline in fertility in the Philippines. Women’s education is negatively associated with fertility: Those who have low educational attainment exhibit higher fertility than women of high educational attainment (4.6 vs. 2.1). Similarly, regional disparity exists: Women in the National Capital Region have a TFR of 2.3, while women in ARMM and Bicol regions have TFR of 4.2 and 4.1, respectively. Regions adjacent to the National Capital Region also have low fertility, suggesting some spillover effect of level of urbanization on fertility behavior. Economic status also has an impact on fertility. Poor women consistently have higher fertility level than those who belong to high economic status (5.2 vs. 1.7).

Timing of first birth is also an important indicator because it signals the start of a woman’s reproductive life course. There was very slight increase in median age of first birth between 2008 and 2013. Based on the NDHS, median age at first birth in 2008 was 23.2 years while in 2013, it rose to 23.5 years.

However, what is noteworthy is the increase in teenage pregnancy. The Young Adult Fertility and Sexuality Study conducted in 2013 found that 14.4 percent of young women 15-19 have ever been pregnant. This is a dramatic increase from the 6.9 percent found in 2002. As a consequence of early childbirth, 2.7 percent of women age 15-24 have had three or more pregnancies. ARMM and Eastern Visayas, both high fertility regions, also showed a high proportion of young women who already have three or more than pregnancies. In the absence of contraceptive use, fertility among women in this age group is expected to increase.

Results of the 2013 NDHS show an almost universal knowledge of at least one FP method. Across regions, however, the ARMM registered the lowest percentage of women of reproductive age that heard of any FP method (92 percent).

Among currently married women aged 15-49, 55 percent are currently using a contraceptive method. This is slightly higher than the level found in 2008 NDHS. As shown in VI-1 below, contraceptive prevalence rate has increased slowly in the past 30 years.

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\(^{103}\) Philippine Statistics Authority (PSA) [Philippines], and ICF International. 2014. *Philippine National Demographic and Health Survey 2013*. Manila, Philippines and Rockville, Maryland, USA. PSA and ICF International.
Figure VI-1: Contraceptive prevalence 1973-2013 for all methods and modern methods
Source: 2013 NDHS

DOH 2015 program data place the use of modern FP methods (measured as mCPR) among women of reproductive age at 44 percent, slightly higher than in 2013 at 38 percent. The DOH-ROs reported wide regional disparities in mCPR, from more than 60 percent in Regions II (61 percent) and XII (62 percent) to below 30 percent in Region IV-A (29 percent). ARRM was reported to have an mCPR of 36 percent (Table VI-1).

Table VI-1: Number of Current Users and mCPR by FP/MNCHN Project Regions, 2015

<table>
<thead>
<tr>
<th>Region</th>
<th>Target population</th>
<th>Total current users (women of reproductive age)</th>
<th>mCPR (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHILIPPINES</td>
<td>12,543,816</td>
<td>5,493,037</td>
<td>44</td>
</tr>
<tr>
<td>I</td>
<td>622,782</td>
<td>354,731</td>
<td>57</td>
</tr>
<tr>
<td>II</td>
<td>426,898</td>
<td>261,271</td>
<td>61</td>
</tr>
<tr>
<td>III</td>
<td>1,392,200</td>
<td>505,339</td>
<td>36</td>
</tr>
<tr>
<td>IVA</td>
<td>1,814,801</td>
<td>533,605</td>
<td>29</td>
</tr>
<tr>
<td>IVB</td>
<td>370,269</td>
<td>185,727</td>
<td>50</td>
</tr>
<tr>
<td>V</td>
<td>719,368</td>
<td>285,247</td>
<td>40</td>
</tr>
<tr>
<td>VI</td>
<td>937,088</td>
<td>436,418</td>
<td>47</td>
</tr>
<tr>
<td>VII</td>
<td>916,518</td>
<td>299,793</td>
<td>33</td>
</tr>
<tr>
<td>VIII</td>
<td>539,277</td>
<td>234,963</td>
<td>44</td>
</tr>
<tr>
<td>IX</td>
<td>461,596</td>
<td>231,648</td>
<td>50</td>
</tr>
<tr>
<td>X</td>
<td>587,734</td>
<td>311,438</td>
<td>53</td>
</tr>
<tr>
<td>XI</td>
<td>608,509</td>
<td>330,598</td>
<td>54</td>
</tr>
<tr>
<td>XII</td>
<td>573,725</td>
<td>354,568</td>
<td>62</td>
</tr>
<tr>
<td>CARAGA</td>
<td>322,804</td>
<td>193,267</td>
<td>60</td>
</tr>
<tr>
<td>ARMM</td>
<td>433,595</td>
<td>153,841</td>
<td>36</td>
</tr>
<tr>
<td>NCR</td>
<td>1,599,424</td>
<td>710,858</td>
<td>44</td>
</tr>
<tr>
<td>CAR</td>
<td>217,228</td>
<td>109,725</td>
<td>51</td>
</tr>
</tbody>
</table>

Source: DOH WMCHDD Administrative Data, 2015
The most frequently used modern contraceptive method remains the oral contraceptive. Data show that the use of pills has gone from 38.3 percent in 2013 to 36.9 percent in 2014 and 38.7 percent in 2015. However, it was also observed that CPR for IUD, which was 9.2 in 2013 and 10.9 in 2014, had dropped to 8.0 in 2015. This is a reflection of certain factors affecting the provision of FP services, such as the greater availability and lower unit cost of pills (combined oral contraceptives) and the lack of IUD commodities and instruments and trained service providers. Implants were gaining headway until the Supreme Court restrained its use by the DOH and its agents in mid-2015. Barriers to FP services can often be traced to poverty, religious and cultural practices, lack of education and information, and poor and fragmented delivery of FP services by duty bearers.

The estimated eligible population of women of reproductive age grew annually by 1.90 percent during this period, while national mCPR grew at an annual rate of 1.78 percent only. NDHS results in 2013 showed an mCPR of 37.6 percent. An estimated 5.3 million women had unmet need for modern FP at that time. Given the population growth, an estimated 5.5 million women of reproductive age now have unmet need for modern FP.

Between 2000 and 2010, the number of women of reproductive age grew annually by 1.90 percent, while national mCPR grew at an annual rate of 1.78 percent only. The 2013 NDHS showed that an estimated 18 percent of women of reproductive age had unmet need for FP. Women belonging to the lowest economic quintile have the highest proportion with unmet need at 21.3 percent. This translates to approximately 5.5 million women of reproductive age who have indicated through their desired family size or desire to space births an unmet need for FP.

**Maternal health**

The reduction in MMR from 209 in 1990 to 52 in 2015 is one of the MDGs. However, the 2011 Family Health Survey reported that MMR increased to 221 per 100,000 births, making the MDG 5 target not achievable by the end of 2015.\(^{104}\)

Unofficial data from the 2015 Updating National Nutrition Survey revealed an MMR of 204 per 100,000 live births. A similar stagnation in MMR was observed with administrative data (i.e., Field Health Surveillance and Information System or FHSIS) from the DOH, which covers only public facilities. The 2015 DOH report reveals an MMR of 78 per 100,000 live births. There is still a wide variation in MMR levels among regions, with ARMM having the highest rate at 153 per 100,000 followed by Regions V and XI, at 128 and 122 per 100,000 live births, respectively. The lowest 2015 estimate of MMR is observed in Cordillera Autonomous Region at 42 per 100,000 live births.

The NDHS 2013, which did not include maternal mortality tracking, does report on childbearing and noted that 2 percent of women age 15-24 had sexual intercourse before age 15, and 19 percent of women age 18-24 had sexual intercourse before age 18. By age 15, 2 percent of women age 18-24 have begun childbearing. This increases to 5 percent by age 16, 9 percent by age 17, 17 percent by age 18, and 22 percent by age 19.

While the DOH 2015 program reports show lower MMR at 78 per 100,000, this information is limited to partial reports coming from public facilities. It is to be noted that FHSIS covers only patients consulting public health facilities. Thus, the poor who have no access to health care facilities are not captured in the data, and neither are those who access health services in private health facilities and from private health care providers.

DOH FHSIS data on health program coverage showed that the number of pregnant women provided at least four prenatal check-ups (ANC in the table below) decreased from 78 percent in 2014 to 75 percent.

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percent in 2015. Pregnant women attended by professional health workers during delivery (SBA) decreased from 81 to 80 percent, while women giving birth in health facilities (FBD) increased from 75 percent in 2014 to 80 percent in 2015 (Table VI-2).

Table VI-2: Selected service coverage indicators per region

<table>
<thead>
<tr>
<th>Regions</th>
<th>Number of total deliveries</th>
<th>4 ANC (%)</th>
<th>FBD (%)</th>
<th>SBA (%)</th>
<th>2 PNC (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAR</td>
<td>35,770</td>
<td>71</td>
<td>93</td>
<td>96</td>
<td>54</td>
</tr>
<tr>
<td>NCR</td>
<td>243,058</td>
<td>60</td>
<td>85</td>
<td>87</td>
<td>73</td>
</tr>
<tr>
<td>I</td>
<td>90,564</td>
<td>97</td>
<td>98</td>
<td>96</td>
<td>94</td>
</tr>
<tr>
<td>II</td>
<td>61,357</td>
<td>86</td>
<td>90</td>
<td>96</td>
<td>94</td>
</tr>
<tr>
<td>III</td>
<td>148,698</td>
<td>95</td>
<td>89</td>
<td>92</td>
<td>98</td>
</tr>
<tr>
<td>IV-A</td>
<td>168,654</td>
<td>63</td>
<td>72</td>
<td>74</td>
<td>75</td>
</tr>
<tr>
<td>IV-B</td>
<td>45,061</td>
<td>83</td>
<td>75</td>
<td>75</td>
<td>72</td>
</tr>
<tr>
<td>V</td>
<td>115,137</td>
<td>74</td>
<td>80</td>
<td>81</td>
<td>83</td>
</tr>
<tr>
<td>VI</td>
<td>82,516</td>
<td>86</td>
<td>86</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>VII</td>
<td>77,246</td>
<td>82</td>
<td>62</td>
<td>65</td>
<td>71</td>
</tr>
<tr>
<td>VIII</td>
<td>85,152</td>
<td>75</td>
<td>88</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>IX</td>
<td>74,229</td>
<td>94</td>
<td>85</td>
<td>89</td>
<td>96</td>
</tr>
<tr>
<td>X</td>
<td>61,826</td>
<td>84</td>
<td>84</td>
<td>87</td>
<td>92</td>
</tr>
<tr>
<td>XI</td>
<td>94,620</td>
<td>27</td>
<td>42</td>
<td>43</td>
<td>44</td>
</tr>
<tr>
<td>XII</td>
<td>88,580</td>
<td>78</td>
<td>80</td>
<td>84</td>
<td>81</td>
</tr>
<tr>
<td>XIII</td>
<td>57,508</td>
<td>73</td>
<td>90</td>
<td>91</td>
<td>78</td>
</tr>
<tr>
<td>ARMM</td>
<td>19,870</td>
<td>91</td>
<td>37</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>National average</td>
<td>1,549,846</td>
<td>75</td>
<td>80</td>
<td>82</td>
<td>80</td>
</tr>
</tbody>
</table>

Source: DOH National Safe Motherhood Program, 2015

TB

Tuberculosis is the sixth highest cause of morbidity and mortality in the Philippines, one of the world’s high-burden TB and MDR-TB countries. The TB prevalence found in population surveys diminished from 1997 to 2007 (28 percent for smear-positive and 38 percent for culture-positive pulmonary TB).105 TB incidence is probably underestimated at 290 per 100,000, as new and relapse cases reported by the NTP already reach that level,106 in spite of limited reporting of patients by the private sector.

The country achieved national coverage of the DOTS strategy in 2003. The NTP is under the DOH, and public service delivery is integrated into the general health care system. Cases reported are mainly pulmonary (98 percent in 2014), with 40 percent of new cases confirmed by bacteriology. Reporting includes cases diagnosed by the public system plus a limited but growing number reported by private providers. Very few are children, and few of the reported cases are extrapulmonary (4 percent), probably a result of limited reporting by hospitals and pediatricians (Figure VI-2).

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The detection of adults with respiratory symptoms suggestive of TB is quite low, under 1 percent of the population per year, with a very high proportion of them highly infectious. Smear positivity in this group reaches up to 15-20 percent (one of every four suspects with smear-positive TB) in some outpatient public health facilities, and was 13 percent on average for the country in 2014. Patients with active pulmonary TB attend outpatient facilities for other reasons and leave without being identified, with a risk to other persons attending (including children and staff) and the community. Table VI-3 provides a view of case detection by region.

Table VI-3: Respiratory symptomatic examined with sputum microscopy and positivity, Philippines, 2014 (Source: DOH NTP, April 2016)

<table>
<thead>
<tr>
<th>2014</th>
<th>Population (1,000s)</th>
<th>Sputum smear microscopy</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Presumptive TB cases examined</td>
<td>Cases with (+) smear microscopy</td>
<td>Positivity rate</td>
</tr>
<tr>
<td>I_Ilocos</td>
<td>4,993</td>
<td>35,146</td>
<td>7</td>
<td>4,845</td>
</tr>
<tr>
<td>II_Cagayan_Valley</td>
<td>3,417</td>
<td>18,555</td>
<td>5</td>
<td>2,327</td>
</tr>
<tr>
<td>III_Central_Luzon</td>
<td>11,063</td>
<td>59,294</td>
<td>2</td>
<td>10,827</td>
</tr>
<tr>
<td>IVA_CaLaBaRZon</td>
<td>14,290</td>
<td>59,542</td>
<td>4</td>
<td>7,625</td>
</tr>
<tr>
<td>IVB_MiMaRoPa</td>
<td>2,952</td>
<td>23,916</td>
<td>8</td>
<td>2,790</td>
</tr>
<tr>
<td>V_Bicol</td>
<td>5,754</td>
<td>47,182</td>
<td>8</td>
<td>6,666</td>
</tr>
<tr>
<td>VI_Western_Visayas</td>
<td>7,504</td>
<td>61,876</td>
<td>8</td>
<td>9,297</td>
</tr>
<tr>
<td>VII_Central_Visayas</td>
<td>7,309</td>
<td>71,053</td>
<td>9</td>
<td>9,099</td>
</tr>
<tr>
<td>VIII_Eastern_Visayas</td>
<td>4,321</td>
<td>31,297</td>
<td>7</td>
<td>4,263</td>
</tr>
<tr>
<td>IX_Zamboanga_Pen.</td>
<td>3,678</td>
<td>36,148</td>
<td>7</td>
<td>4,359</td>
</tr>
<tr>
<td>X_Northern_Mindanao</td>
<td>4,674</td>
<td>34,318</td>
<td>7</td>
<td>5,531</td>
</tr>
<tr>
<td>XI_Davao</td>
<td>4,843</td>
<td>46,729</td>
<td>9</td>
<td>6,234</td>
</tr>
<tr>
<td>XII_SoCCSksarGen</td>
<td>4,544</td>
<td>32,093</td>
<td>7</td>
<td>4,513</td>
</tr>
<tr>
<td>XIII_Caraga</td>
<td>2,581</td>
<td>36,408</td>
<td>14</td>
<td>3,428</td>
</tr>
<tr>
<td>CAR</td>
<td>1,733</td>
<td>13,630</td>
<td>8</td>
<td>1,023</td>
</tr>
<tr>
<td>NCR</td>
<td>12,753</td>
<td>130,632</td>
<td>10</td>
<td>15,150</td>
</tr>
<tr>
<td>ARMM</td>
<td>3,463</td>
<td>21,891</td>
<td>6</td>
<td>3,390</td>
</tr>
<tr>
<td>Total</td>
<td>99,874</td>
<td>759,710</td>
<td>8</td>
<td>101,367</td>
</tr>
</tbody>
</table>

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MDR-TB

Identification of MDR cases is low: 27,000 cases were tested for MDR in 2014 (out of nearly 100,000 bacteriologically confirmed), 3,000 were confirmed with MDR and 2,680 (90 percent) started on treatment. The capacity for rapid diagnosis (GeneXpert) has increased rapidly but is still underutilized. However, the proportion of detected MDR cases put on treatment is high (90 percent). The treatment outcomes are poor (40 percent success), mainly due to the long duration of treatment and default. The number of GeneXpert machines has increased in the last few years, to 84 in 2014, but they are underused and not always accessible. There is sufficient stock of reagents.

HIV co-infection is low (under 1 percent in new TB patients with known HIV status), although HIV infection and co-infection are increasing. Co-trimoxazole preventive therapy and antiretrovirals are used for those patients. Future priority areas are malnutrition in children and obesity/diabetes in adults; both reduce immunity and increase TB incidence.

HIV

The Philippines is one of only nine countries to have a rate of increase in HIV of over 25 percent.\(^{108}\) The levels of HIV infection have remained low (less than 0.04 percent), but the rate of increase has not. Between 2011 and 2014, the number of HIV surpassed that of the first 25 years of the epidemic (1984-2010).\(^{109}\) Data from the HIV/AIDS and Antiretroviral Therapy Registry of the Philippines show 7,829 newly diagnosed HIV cases reported from January to December 2015 (more than 24 cases a day on average). This was 30 percent higher compared to the same period last year. This brings the cumulative number of HIV cases reported in the Philippines to 30,356 since January 1984.\(^{110}\)

Most people living with HIV are in urban areas, e.g., Greater Metro Manila, Metro Cebu, and Davao City. Unprotected male-to-male sex continues to account of the majority of new infections, followed by injecting drug users. Other groups especially affected include males who have sex with transgenders, female sex workers (especially informal ones), and newborns with HIV-positive mothers who do not receive prevention of mother-to-child transmission care.

POLICY AND FINANCE CONTEXT

On December 16, 2010, in Administrative Order (AO) No. 2010-0036, President Benigno Aquino III declared achieving universal health care for all Filipinos as his health agenda. He stated that his policy was “to ensure that all Filipinos, particularly the poor, are a) Able to use quality health services at affordable cost b) Cared for in modern health care facilities and c) Prevented from falling ill through promotive [sic] and preventive health care.” His strategy included protection through expanded National Health Insurance Program enrollment and benefit delivery, and improved access to quality hospitals and health facilities. He used the attainment of the health-related MDGs as the measure of the success of his health agenda, and the law became the foundation for the USAID and DOH partnership. A more inclusive list of policy actions of relevance to reproductive health, infectious disease, poverty alleviation, and the rights of women appear in Table VI-4 below.

Table: VI-4: Policy actions in RP, ID, poverty, and women’s rights–circa 2015

Department of Health Administrative Orders

- DOH AO No. 2015-0002, creating the NIT and Regional Implementation Teams. It provided mandate to the implementation teams at the national and regional levels in managing the policy process relevant to


\(^{109}\) Philippine HIV Situation 2014 Update (presentation), UNAIDS Philippines.

\(^{110}\) DOH, HIV data for 2015, p. 1.
the RPRH law and its implementing rules and regulations, and coordinating actions of partner agencies and organization supporting its implementation.

- DOH AO No. 2015-0020 (Administration of Life-saving Drugs during Maternal Care Emergencies by Nurses and Midwives in Birthing Centers)
- DOH AO No. 2015-0021 (Deployment of MDs Graduating from Residency Training Programs in DOH Hospitals)
- DOH AO No. 2015–0028 (Guidelines on the Implementation of the Universal Health Care High Impact Five (Hi-5) Strategy) as the DOH flagship program to intensify implementation of the RPRH law
- DOH AO No. 2015-0006. Inclusion of Progestin Subdermal Implant as One of the Modern Methods Recognized by the National Family Planning Program. This AO provides guidelines in introducing progestin subdermal implant as a new FP program method to both the public and private sector providers as well as program managers and key stakeholders. It specifically described the key elements on how it will be integrated in existing FP services in the field. Note however that implementation is temporarily on hold due to the temporary restraining order issued by the Supreme Court.
- DOH AO 2015-0037. Guidelines on the Registration and Mapping of Conscientious Objectors and Exempt Health Facilities Pursuant to the Responsible Parenthood and Reproductive Health Act. The DOH issued these guidelines for the registration and mapping of conscientious objectors and exempt health facilities to ensure delivery of the full range of reproductive health services and minimize encumbrance to clients seeking such services.
- DOH AO No. 2015-0005: Guidelines on the Performance Evaluation of In-Vitro Diagnostic Reagents (HIV, Hepatitis B Virus, Hepatitis C Virus) and Syphilis Screening Confirmatory and Disease Monitoring Test Kits

Department of Health Memoranda

- DOH Department Memorandum (DM) No. 2015-0186. Access to the FP Commodities by DOH Regional Hospitals and Medical Centers and Provincial Hospitals. In support of setting up FP services in hospitals, this DM provides guidance in the allocation and distribution of FP commodities to DOH-retained hospitals and medical centers and provincial hospitals. It also includes the allocation of FP commodities to CSOs.
- DOH DM No. 2015-0174. Reiteration of Compliance to the Policy on Informed Choice and Voluntarism in Delivery of Family Planning Services. The DM directs all DOH bureaus, offices, medical centers and attached agencies and regional offices to comply with the Policy on Informed Choice and Voluntarism in the Delivery of Family Planning Services nationwide.
- DOH DM No. 2015-0341. Reiteration of Access to FP Commodities by DOH Regional Hospitals and Medical Centers, Provincial Hospitals and CSOs. This DM further defined instrumentalities that will be used by regional offices in engaging CSOs as partners in the delivery of FP services to include the use of appropriate forms, such as the revised FP Form 1 and the reporting forms for service utilization.
- DOH DM No. 2015-0366. Hiring of Consultants for the Fast Tracking of Service Delivery of FP Services. The DM supports Section 6 of the RPRH Implementing Rules and Regulations specifying the hiring and engagement of skilled health professionals for maternal health care and skilled birth attendance at the local levels with assistance from the DOH.
- DOH DM No. 2015-0357. Re: Use of the Revised FP Form 1. This DM provides instructions to all health providers on using the revised FP Form 1 as the standard client record of FP acceptors at service delivery points.
- DOH DM No. 2015-0384. Re: Establishment of the FP Logistics Hotline. This DM supports Section 8.10 on tracking and monitoring of health products purchased or received and distributed to local health systems. The FP Logistics Hotline monitors distribution and status of commodity stocks at the distribution points (local health service delivery points).
- DOH DM No. 2015-0095: Adjustment of TB-HIV Cohort Reporting and Regional Coordination on HIV Testing Kits for NTP
• DOH DM No. 2015-0260: Revised Diagnostic Algorithm Using Xpert MTB/RIF
• DOH DM No. 2015-0364: Pilot Implementation of the Rapid HIV Diagnostic Algorithm (RHVDA) Testing Strategy to 5 Cities in 6 Selected Clinics and 2 DOH-Retained Hospitals
• DOH DM No. 2015-0101: Initiation of Philippine Antiretroviral Drug Resistance Surveillance

**PhilHealth**

- PhilHealth Circular 19 s. 2010. Revision to the Outpatient HIV/AIDS Treatment Package, which clarifies covered items under the benefit, namely drugs and medicines, laboratory examination, including CD4 level determination test, viral load and tests for monitoring antiretroviral drugs’ toxicity and providers’ professional fees.
- PhilHealth Circular 24 s. 2015 on the “Social Health Insurance Coverage and Benefits for Women About to Give Birth Revision 1.” Provides additional guidelines to the policy on “women about to give birth” issued in 2014. It expanded access to FP benefit packages such as IUD insertion and non-scalpel vasectomy benefits. Hence, aside from accredited hospitals, infirmaries, and ambulatory surgical clinic; non-scalpel vasectomy can be reimbursed in primary care facilities. Also through this policy, postpartum IUD was made reimbursable as second case rate.
- PhilHealth Circular 38 s. 2015 on the “Philhealth Subdermal Contraceptive Implant Package.” Provides for the coverage of subdermal implant use. The benefit package amounts to P3,000 per case.
- PhilHealth Circular 8 s. 2015 on the “Annex 2–List of Procedure Case Rates (Revision 1.0) and Supplementary Guidelines for All Case Rates.” Includes guidelines on usage of RVS Code 59409 for complicated vaginal delivery and vaginal delivery of mothers with medical conditions or other indications that exclude them from the normal spontaneous delivery package.
- PhilHealth Circular 33 s. 2015 on the “Implementation of Point of Care Program Revision 1.” This revised policy on point of care enrollment expands the participating providers in the program. In addition to hospitals, government primary care facilities such as infirmaries/dispensaries, maternity clinics/birthing homes, TB-DOTS clinics and animal bite treatment centers may participate in the program.
- PhilHealth Circular 32 s. 2015. Enrolment and Coverage of Emancipated Individuals and/or Single Parents below 21 years old from the NHTS PR Identified Poor Families as Indigent Member. Likewise, an adolescent who is already a mother could already be enrolled as principal member.
- PhilHealth Circular 36 s. 2015 on the Implementing Guidelines of PRevEnTS (Primary Care Revitalized and Enhanced Through Skills and Services) A Primary Care Booster Package—Revision 1. Provides additional implementing guidelines on PRevEnTS (PhilHealth Circulars 29 s. 2013 and 16 s. 2014) for the availment of PRevEnts Package. Fund from PRevEnTS may be used to train the staff on basic emergency obstetric and neonatal care, use of visual acetic acid for cervical cancer screening and even FP procedures.

**Other departments’ orders and memorandum**

- The Department of Interior and Local Government issued Memorandum Circular No. 2015-145: Reiteration of Local Government Unit’s Role and Function in the Implementation of RA No. 10354 or The RPRH Act of 2012 and its Implementing Rules and Regulations. The circular addressed to all Department of Interior and Local Government field units and LGUs reiterated the observance of the RPRH law’s provisions to the LGUs. It also specifies that each LGU designate a reproductive health officer and to submit all data related to RPRH implementation to the DOH.
- Department of Education AO No. 10, s. 2016. Policy and Guidelines for Comprehensive Water, Sanitation and Hygiene in Schools Program. It aims to improve health outcomes among students through a scalable school-based water, hygiene, sanitation and deworming program. It directs all concerned schools to have clean water as well as support mechanisms for handwashing and effective menstrual hygiene management, among others.
Concurrently with this policy commitment for universal coverage came an increase in resources for health. After a stagnant budget of approximately PhP 9-10 billion annually for almost two decades, due in part to the financial crises, in 2008 the DOH increased to PhP 18 billion and then increased steadily to PhP 24.65 billion in 2010, PhP 42.15 billion in 2012, PhP 83.7 billion in 2014 to the present budget of PhP 122 billion, five times the 2010 total. Since 2014, the budget benefited from an annual increment of approximately PhP 40 billion, funded by sin taxes on tobacco and alcohol that the national government allots mostly to PhilHealth to pay for insurance premiums of the poor and elderly.  

Yet learning to spend has been a challenge. The DOH is able to obligate only about 90 percent of its budget every year. Unobligated funds are then passed on as continuing appropriations to the following budget year. These unobligated budgets further add to the increasing amounts that the DOH has to utilize the next year. Continuing appropriations that lapse are eventually returned to the National Treasury. The DOH has had to return to the National Treasury an average of PhP 1 billion per year from 2011 to 2013. In 2014, the DOH returned PhP 400 million in unspent funds.

Despite the marked increase in money spent by government for health services, out-of-pocket expenses, especially for medicines, remain a financial burden for the poor. A 2015 World Bank analysis found that “Between 2008 and 2013, self-reported health insurance coverage increased across all quintiles and its distribution became more pro-poor.” Yet the percentage of people impoverished by health spending has also increased so that “By 2012, out-of-pocket spending on health added 1.5

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111 Department of Budget and Management, April 2016, Department of Health website.
percentage points to the poverty rate . . . The main driver of health spending is medicines, accounting for almost two-thirds of total health spending, and as much as three-quarters among the poor."

In terms of sources of funding for the health system, Table VI-5 shows National Statistical Coordination Board estimates for 2013 that 18.9 percent of health funding comes from the national and local government combined, and an additional 11.5 percent from social insurance, for a total of 30.4 percent for all three spigots. Out-of-pocket funding was 56.3 percent for the same period, and grants to the health system were approximately 1.5 percent. As of 2014, the national government, except for PhilHealth, accounted for 14 percent, PhilHealth accounted for 14 percent, LGUs 13 percent, and the remaining 59 percent is estimated as out-of-pocket, with some from private health insurance, HMOs and other enterprises.113 Total health spending includes money spent on conventional treatment as well as spending on over-the-counter drugs, food supplements and even non-evidence-based types of health care that are becoming increasingly fashionable. Most are counted as out-of-pocket expenses and are not paid for by government, the NHIP, private insurance and HMOs.

Currently, total health spending as a percentage of GDP is more than 4 percent, of which 14 percent comes from government. According to the Local Government Code, LGUs must spend a fixed percentage of the internal revenue allotment that they receive as their share of the taxes collected by national government on social services, including health. Obtaining accurate data on how much local governments actually spend on health services is a challenge. Best estimates show that from 1993, when devolution occurred, internal revenue allotment increased significantly, as did local government spending on health. By 1998, however, despite the continued increase in internal revenue allotment, local government spending on health had stagnated. At present it is estimated that local governments provide 13 percent of total health spending.114


113 Philippine Statistics Authority and DOH. In 2013 the National Statistical Coordination Board estimated that 18.9 percent of health funding comes from the national and local government combined, and an additional 11.5 percent from social insurance, for a total of 30.4 percent for all three spigots. Out-of-pocket funding was 56.3 percent for the same period and grants to the health system were approximately 1.5%. [http://www.nscb.gov.ph/stats/pnha/](http://www.nscb.gov.ph/stats/pnha/)

Table VI-4: Health expenditure by source of funds, 2012 and 2013 (PhP millions)\(^{115}\)

<table>
<thead>
<tr>
<th>Source of funds</th>
<th>Amount (in million pesos, at current prices)</th>
<th>Growth rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td><strong>Government</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Government</td>
<td>89,934 (18.9%)</td>
<td>99,684</td>
</tr>
<tr>
<td>Local Government</td>
<td>55,694 (11.9%)</td>
<td>62,827</td>
</tr>
<tr>
<td><strong>Social insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Health Insurance Program</td>
<td>34,240 (7.0%)</td>
<td>36,857</td>
</tr>
<tr>
<td>Employees’ Compensation</td>
<td>52,570</td>
<td>60,440</td>
</tr>
<tr>
<td><strong>Private sources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Out-of-Pocket</td>
<td>269,419 (56.3%)</td>
<td>296,539</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>7,086</td>
<td>9,247</td>
</tr>
<tr>
<td>Health Maintenance Organizations</td>
<td>32,273</td>
<td>36,535</td>
</tr>
<tr>
<td>Private Establishments</td>
<td>11,603</td>
<td>11,752</td>
</tr>
<tr>
<td>Private Schools</td>
<td>4,236</td>
<td>4,911</td>
</tr>
<tr>
<td><strong>Rest of the world</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants</td>
<td>3,987</td>
<td>7,235</td>
</tr>
<tr>
<td>All sources</td>
<td>471,108</td>
<td>526,342</td>
</tr>
</tbody>
</table>

\(^{115}\) Revised

**The National Health Insurance Program (PhilHealth)**

PhilHealth estimates it has reached 92 percent coverage of the projected population in 2015, including all of the 15.3 million indigent members from the NHTS PR households. The total benefit payment for RPRH-related benefits in 2015 is 13 percent higher compared to 2014. Among the top 10 procedures paid by PhilHealth in 2015, five were for RH issues,\(^{116}\) and these packages comprised 13 percent of the total claims paid.

As of 2015, indigent PhilHealth members and their families are the largest single category of the population covered, with the 45 million NHTS members and their dependents representing close to 49 percent of all beneficiaries.

Premium collection for PhilHealth amounted to PhP 96.69 billion in 2015 and reimbursement totaled PhP 97.03 billion. Of that premium collection, PhP 36.26 billion came from the national government as appropriated in the General Appropriation Act for NHTS poor members. Government-sponsored members received 26 percent (PhP 25 billion) of the reimbursements. Of the total benefit payment, at least PhP 12.8 billion was paid for RPRH-related claims.

Among LGUs eligible (i.e., they have the needed facilities and personnel) to provide primary care benefits, maternity care package and TB DOTS clinics, 83 percent were accredited in 2015. The number of accredited outpatient clinics in 2015 for public health included 2,553 providing the primary care benefit package, 2,981 providing the maternity care package and 1,739 providing the DOTS package.\(^{117}\)

\(^{115}\) http://www.nscb.gov.ph/stats/pnha/


\(^{117}\) PhilHealth 2015 reporting.
Reproductive health
The RPRH law\(^{118}\) (Republic Act 10354), signed by the President in December 2012 and eventually declared constitutional (with some exceptions) in March 2013, provides the umbrella legislation for a series of new and revised policies by the DOH and other government agencies. Policies focus on a host of issues from technical guidelines for the use of drugs and reagents to ensuring access to services and commodities, informed choice and voluntarism, adolescent education, provisions for gender-based violence, financing through national health insurance and special integrated programs for the poor.

Of recent concern is a temporary restraining order issued on June 17, 2015 by the Supreme Court that prohibits registration of new contraceptives or the promotion, purchase, distribution or use of Implanon and Implanon NXT (brand names for subdermal implants) by the DOH and its agents. Presently, the order remains in effect.

Significant amounts of the DOH budget go to the implementation of programs for various elements of the RPRH. In 2015, a total of PhP 21.74 billion was budgeted for the following four categories:
- Family Health and Responsible Parenting (PhP 3,267 million)
- Expanded Program on Immunization (6,892 million)
- Health Facilities Enhancement Program (11,254 million)
- National STI and HIV Program (324 million)

Multilateral and bilateral donors provide approximately PhP 5.93 billion, and CSOs provide approximately PhP 238 million.\(^{119}\)

Tuberculosis
The Plan of Action to Control TB (PhilPACT) 2010-2016 was updated in 2014.\(^{120}\) It ends in 2016 and will be followed by a new plan, according to the TB law approved in April 2016. The major strategic priorities were to expand access to diagnostic facilities, mainly in private practice, to use rapid tests and to improve human resource capacity, logistics and capacity for program management.

The TB program is funded by domestic sources, Global Fund grants, and other grants. Both domestic and Global Fund resources increased during the PhilPACT period (see Figure VI-6).

![Figure VI-6: TB funding for the Philippines by source, 2006–2015](image)

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\(^{118}\) Also referred to at the RPRH Act.

\(^{119}\) Department of Health, 2015.

\(^{120}\) DOH/NTP. Updated 2010-2016 Philippine Plan of Action to control Tuberculosis (PhilPACT). DOH, 2014.
Diagnosis by private practice has increased through involvement of private practitioners and accreditation of facilities by PhilHealth. Rapid tests (GeneXpert) are formally to be used only to detect MDR-TB, but field observation and a very high (two-thirds) proportion of tests negative for TB suggest that the use for diagnosis is expanding. It is worrisome that there is no information regarding the decision of treating (incorrectly) or not treating those negative individuals. There is unused GeneXpert capacity in the NTP. Better access for confirmation of diagnosis will require changes in the operational guidelines and increase in the number of sites, plus availability of GeneXpert to private practice at affordable prices or covered by PhilHealth.

The TB law main resolutions are for the Secretary of Health to develop demonstration projects to generate evidence for policy and develop regional capacity, to conduct nationwide public information and education campaigns, to improve training and technical skills among health providers and to collaborate with local and foreign organizations for technical and funding partnerships. In collaboration with the Philippine Information Agency, the Secretary shall encourage local media to launch a campaign on TB control. The Food and Drug Administration shall regulate the sale and use of TB drugs in the market and ensure their quality.

All public and private health centers, hospitals and facilities shall notify all TB cases—this will increase reporting of children and extrapulmonary TB, and allow follow-up of treatment and outcomes. PhilHealth shall expand its benefit package for TB patients and make the DOTS package more responsive to patient needs.

Human resource capacity has been addressed through intensive training, but there are still weaknesses in logistics and capacity to interpret data for management at all levels. WHO advises that “Short (9 months) regimens would reduce costs, human suffering and the high default rates of the current regimen.”

The private sector shows a high expenditure on TB drugs in private pharmacies, estimated at over US$20 million in 2011.

Health facilities

Quality of health facilities in the private sector is generally better than that in the public sector. Until several years ago, most government health facilities were in a state of disrepair, inadequately equipped, scantily supplied and poorly manned. As more resources became available, the government embarked on a program of health facility enhancement, including health facilities under the responsibility of local governments, such as rural health clinics, barangay health stations and district and provincial hospitals. By 2015, more than PhP 75 billion were allocated to health facility enhancement for building, upgrading, equipping and supplying barangay health stations, rural health units, birthing clinics, district hospitals, provincial hospitals, regional medical centers, special hospitals, etc. With these funds, 2,862 barangay health stations, 2,626 rural health units, 262 LGU hospitals and 70 DOH hospitals were upgraded. This year, another 26 billion pesos have been budgeted for the program. With this money, 3,200 barangay health stations in schools will be built, six blood service facilities will be established and 13 drug rehabilitation centers will be upgraded, among others. It is really time to expand and upgrade public health facilities to levels appropriate for the provision of necessary quality health services nationwide.

GOVERNANCE CONTEXT

The Local Government Code (RA 7160) was enacted in 1991, providing for its declared policy that LGU “shall enjoy genuine and meaningful autonomy to enable them to attain their fullest development as self-reliant”

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communities and make them more effective partners in the attainment of national goals. Towards this end, the State shall provide for a more responsive and accountable local government structure instituted through a system of decentralization whereby local governments shall be given more powers, authority, responsibilities and resources.”

The country has 81 provinces administered by elected governors. Within the territorial boundaries of provinces are municipalities and cities administered by elected mayors. The smallest province has five municipalities. The largest has 44 municipalities and nine cities. The country has 1,489 municipalities and 145 cities.

While municipalities and cities may fall under the territorial jurisdiction of a province, the municipal or city chief executive and his legislature have relative autonomy in determining their development plans and priorities and corresponding budgets.

Proximate provinces with similar ethnicity are clustered into regions. The country has 18 regions. National programs of the various departments are administered through their regional offices.

Among the 18 regions of the country is the ARMM, which was created by law (RA 6734) in 1989 and ratified in a plebiscite in 1992 establishing the membership of four provinces (Lanao del Sur, Maguindanao, Sulu and Tawi-Tawi). A fifth province, Basilan, was added after the passage of RA 9054. RA 6734 provides the ARMM with a regional government headed by an elected regional governor with a Cabinet consisting of nine members. Legislative power is vested in the Regional Assembly. The powers, functions and responsibilities of the regional government include those “now being exercised by the departments of the National Government,” except in matters affecting national sovereignty and territorial integrity, such as foreign affairs, national defense and security, the administration of justice, citizenship, etc. The President of the Philippines exercises “general supervision over the Regional Government.”

To a significant degree, the performance of an LGU in the delivery of its development plans and objectives depends on the competencies and priorities of the local chief executive. By and large, the local chief executive determines policies, budget, directions, priorities and development plans in general, and consequently the strength and level of priority of health programs in the LGU. Under RA 7160, local elective officials have three-year terms and a three-term limit. Thus a local chief executive may either have a limited influence or an enduring presence if his or her proxies are elected after the term expires.

In the public health sector, LGUs assumed the responsibility for the delivery of health services and the maintenance and supervision of local health facilities and personnel. While the DOH maintains its national programs on FP, MCH and TB, the effectiveness of the interface between the DOH and the local government in achieving health plans and objectives in provinces, municipalities and cities will, to a significant extent, be affected by the priorities of the local chief executive.
ANNEX VII. CONSOLIDATED FOCUS GROUP DISCUSSION REPORTS

Findings of the FGDs added to the other data, analysis and responses received for this evaluation. Below, the evaluation team shares the consolidated FGD reports to inform the work of existing programs and future designs. The FGD reports presented cover the following groups of respondents:

- Young women, new acceptors of temporary FP methods (pills, IUD, injectables, implant, condom). They should have at least one child, or in an adolescent and youth reproductive health program. Age range: 18-21
- Women of reproductive age who are non-FP users (not currently using, but will also include those who have used any method before, discontinued/dropped out). They should have at least one child. Age: 18-35
- Husbands who received RH counseling (spouse is a new acceptor). Age range: 18-35
- Community health workers involved in TB (BHW, CHT members)
- TB patients (N=6)

VII-1: Young FP acceptors

I. Profile of FGD Participants:

<table>
<thead>
<tr>
<th>Municipality/city</th>
<th>Date of focus group</th>
<th>Number of respondents</th>
<th>Age range</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luzon Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trece Martinez, Cavite</td>
<td>March 28, 2016</td>
<td>4</td>
<td>18-21</td>
<td>1-3</td>
</tr>
<tr>
<td>Batangas City</td>
<td>April 20, 2016</td>
<td>8</td>
<td>18-23</td>
<td>1-4</td>
</tr>
<tr>
<td>Quezon City</td>
<td>April 21, 2016</td>
<td>7</td>
<td>18-25</td>
<td>1-4</td>
</tr>
<tr>
<td>Visayas Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Danao City, Cebu</td>
<td>April 5, 2016</td>
<td>8</td>
<td>19-21</td>
<td>1-3</td>
</tr>
<tr>
<td>Tacloban City</td>
<td>April 6, 2016</td>
<td>8</td>
<td>18-21</td>
<td>1-3</td>
</tr>
<tr>
<td>Mindanao Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digos City, Davao del Sur</td>
<td>April 1, 2016</td>
<td>6</td>
<td>18-24</td>
<td>1-3</td>
</tr>
<tr>
<td>Cagayan de Oro City</td>
<td>April 4, 2016</td>
<td>5</td>
<td>25-28</td>
<td>1-3</td>
</tr>
</tbody>
</table>

Total participants: 46

II. FGD Findings:

a. Notes on variations and similarities in the data

1. Teen pregnancy: Except for Cagayan de Oro, all focus groups had participants who are mostly young family planning acceptors who likely had their first pregnancy in their teens. Cagayan de Oro FGD participants were over the age limit set by the research design because the FGD organizers could not find participants that met the age requirement. There were cases in Digos and Batangas City where participants over the age limit were accepted to manage the size of the group. Nevertheless, these “over-age” participants had their first pregnancy in their teen years as well.

2. “Accidental” pregnancy: In most cases, first pregnancy was unintentional. Teens were pressured to live with their boyfriend or get married as a consequence. The more mature participants and those with strong religious beliefs such as Islam got married (cohabiting is not allowed) or decided
to go into a live-in arrangement before getting pregnant. Most respondents got pregnant soon after their first experience of sexual intercourse, and this happened with their current partner. Some were only 14 years old, the rest were mostly younger than 18 years old.

3. Islamic practice: Teen pregnancy among followers of Islam is an acceptable practice. Arranged marriage is practiced in Islam, where parents are allowed to send their girls to marry as early as 14 years old or the age when they start menstruating. Once married, there is another pressure on the young wife to produce an offspring; this pressure is usually coming from the husband’s parents, which is another contributing factor to teen pregnancy.

“Pag nakasal kasi sa Islam, yung parents gusto kaagad na magka-apo.” (Soon as you get married in Islam, the (couple’s) parents would like to have grandchildren immediately)—Digos young acceptor

The Islamic point of view was only captured in Digos City, from both female young acceptor and non-acceptor focus groups.

4. FP service delivery: There are also variations in FP service delivery. Notably, the variations observed are in the level of commitment of BHWs that may affect reach. There were also variations observed in quality and timing of counseling intervention across the different areas.

b. Context—unexpected pregnancy as a life-changing event

Across the groups, unexpected pregnancy or early initiation into sexual intercourse created pressure into a cohabitation (live-in arrangement) or marriage. Very few among the young acceptors interviewed actually chose to be pregnant or had decided to cohabitate or get married before getting pregnant.

For most, getting pregnant was a life-changing event. They moved from a carefree life as a student whose main concern was to study and to help in the house, to physically experiencing birthing pains and being transformed into a mother who now worries about taking care of another human being.

If they could only turn back the hands of time, they would choose to continue and pursue their own dreams of completing a college degree, getting a job and financially supporting their parents and siblings.

“Hetong bago, masaya, pero pag minsan, walang makain nagsisisi po ako.” (I was happy at the start, but sometimes, when there’s nothing to eat, I regret it.)”—Cavite young acceptor

“Ako po sana, maging maganda yung kinabukasan ko kasi ayaw ko po sanang mag anak, mga bata pa po kami. Gusto ko din pong makapag aral ng college dahil ako ang nag-iisang babae sa aming magkakapatid.” (I had hoped for a good future, I didn’t want to have children yet, we were still too young. I wanted to study, to finish my college education because I’m the only girl in the family.)—Quezon City young acceptor

c. Fertility intention and FP motivations

Early birthing experience and the hard reality of parenting are factors that strongly influenced the young mothers’ fertility intention and the desire to practice FP. Determining the number of children is a shared responsibility for some; for others it is not discussed at all between the couple. But in many instances, it is likely that the woman will follow the husband’s/partner’s wishes.

“Nung mag boyfriend palang kami ang sabi niya sa akin hanggang 4 lang po, sabi ko 2 lang, e naging 4 na po sabi ko tama na!” (When he was just my boyfriend he said he wanted to have 4 children and I said, I want only 2. We now have 4 children so I said that’s enough!)—Batangas young acceptor

Most would want to limit their number of children. If given the choice, they are fine with just having a maximum of two children. Those who were seemingly traumatized by their first experience of giving birth (non-verbal signals), are content with just having one child.
“Gusto ko po dalawa para mastustain ko ang pag-aaral nila. At gusto ko maka-graduate ang anak ko hindi gaya sa akin high school graduate lang.” (I want to have 2, so I could support their education. I want my children to graduate, and not to be like me, I just completed high school.)—Digos young acceptor

“Isa lang ayaw ko na!” (Only one, that's it! I don't want anymore!)—Tacloban young acceptor

“Isa lang ang gusto kong anak, 45 na ang kilo ng bigas.” (I want one only, a kilo of rice now costs 45 pesos.)—Tacloban young acceptor

“Dalawa, doon sa financial mahirap mag-alaga, maaaring di mo maalagaan yung iba imbes na maaalagaan mo ng mayos.” (Two, it is hard on the finances, it’s also difficult to take care of children, if you have too many, the others might end up being neglected.)—Quezon City young acceptor

“Hindi modaling manganak…masakit.” (It's not easy to give birth… it's painful.)—Digos young acceptor

There are other interesting motivations to have multiple children besides the desire to have a mixed-gender pair (boy and girl).

“I have 3 boys now, I am hoping to have a baby girl. I will stop when I get a girl.”—Cagayan de Oro young acceptor

“Dalawa, isang babae at isang lalake. Isa na lang kasi lalake na yung anak ko ngayon kasi caesarian ako hindi pwedeng magdam. Kung lalake ang susunod na bibigay ni Lord hindi na lang po hangang dalawang anak na lang.” (I want two, a girl and a boy. I have a boy now and since I require caesarian birth, I cannot have many. So if the Lord will give me another boy, I will stop with just having 2 children.)—Tacloban young acceptor

“Nakita ko sa nanay ko kung gaano kahirap ang nag-iisang anak, wala kang katulong pagsabay magkasakit ang magulang mo.” (I saw in my mom the difficulty of being an only child, no one could support her when both her parents got sick.)—Cebu young acceptor

“Tatlo, Pag dumating yung pagtanda nila magtutulungan sila.” (I want 3, so when they grow old they would find support in each other.)—Digos young acceptor

“I have 2 kids now, and I desire to have 2 more. It's hard to have all boys.”—Cagayan de Oro young acceptor

Coming from a large family may also encourage limiting the family size.

“Hindi naman po sa ayaw magka-anak, pag madami katulad namin, apat kami, hindi po namin kayang magbuha ng apat na anak.” (It's not that we don't want to have many children, we were 4 siblings in all, we could not afford to support 4 children.)—Digos young acceptor

### d. Awareness of FP methods

FP was virtually unknown to most respondents prior to pregnancy. Only a select few would have at least heard about FP modalities from relatives who work in the health centers. Some have seen their own mothers using contraceptive pills. FP is not openly discussed in school or at home. For those who got married before getting pregnant, they were introduced to FP concepts during pre-marital counseling.

Among those who got pregnant at a young age, some needed to be told to use contraceptive methods in order to prevent another pregnancy. A few did not need any convincing and had sought information from the health center on their own because they were serious about not getting pregnant again.

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123 Cebu is used as reference to be consistent with the project brief list of areas, but actual FGD was conducted in Danao City, which is a city within the Cebu province.
“Kapitbahay naming BHW kaya pinapunta kami sa health center.” (Our neighbor is a BHW who instructed us to go to the health center.)—Cagayan de Oro young acceptor

“Pumunta kaming center sinabihan kami ng midwife, siya yung pinupuntahan ko sa prenatal.” (We went to the center and we were briefed by the midwife, the same midwife who attended to my prenatal visits.)—Cebu young acceptor

There are those who first learned about FP during their prenatal visits or upon giving birth.

“Sa ospital kasi hindi kayo palalabasin kung hindi kayo briefing.” (You will not be released from the hospital without being briefed on FP methods.)—Digos young acceptor

“Noong nabuntis ako nagpa check-up ako sa regional, pinaliwanag nila sa akin doon.” (When I went for my prenatal check up at the regional hospital, they explained FP to me then.)—Batangas young acceptor

“Sinabihan ako pagka-panganak na mag control para maasikaso yung mga anak at may oras ka sa sarili.” (After giving birth, I was advised to control so I can take care of my children properly and also have time for myself.)—Cebu young acceptor

Young acceptors are aware of a wide range of FP methods. The pill, IUD, injectables (Depo), condom and natural withdrawal method are the more popularly known methods across all areas. Implant, vasectomy, ligation, calendar and rosary methods are not as widely known.

**e. Sources of awareness and influencers**

The main sources of awareness and considered most credible are the health center/institution and the health workers/midwives and doctors. Catching them during prenatal visits and when they go for their baby’s regular immunization seem to be the ideal opportunities to discuss FP with them.

Young acceptors also value the opinion of mothers, friends and close relatives and neighbors who have more experience in using FP methods.

Across the different areas, there is hardly any relevant recall of IEC materials for FP methods or recall of mass media advertising (TV or radio advertising). There were those who would recall receiving IEC materials from the health center, but they hardly recall specific contents.

There are some areas that take an extra effort in reaching the pregnant girls and women. House-to-house calls are done. This is especially observed to be effective in Digos City, where Islam prohibits the practice of FP.

**f. Understanding of FP methods and selection criteria**

The table below (next page) summarizes respondents’ understanding of the different FP methods and their experience with these methods. It is interesting to note that misconceptions are able to cross geographic boundaries. IUD is the method that received the most negative feedback and the most disturbing narratives.

While respondents relied mainly on recommendation by the health care professional, be it the health center midwife or doctor, they nonetheless prefer a method that would be most convenient to take and reliable in terms of being “safe” (in terms of preventing pregnancies). Some are on the pill because it is available not only in the health centers but also in drugstores. Some claim to be forgetful, and hence IUD or injectables are more convenient for them, and these are perceived to provide longer protection and therefore perceived to be more reliable or “fail-safe” than other methods.

Those with special health concerns (e.g., goiter, size of uterus, breastfeeding moms) are advised to use the most appropriate methods given their current health conditions.
g. Evaluating FP service delivery
Evaluation of the FP service delivery in the areas of interest is based mainly on respondent narratives of how they were introduced to the service, a narration of their experience and their satisfaction with the service they received.

1. Recruitment
This is one area where there are significant variations in the data. The mode of reaching or contacting target clients varies by type of facility: community-based vis-à-vis hospital-based service delivery. Perhaps not by design, the FP acceptor focus groups organized by MindanaoHealth and LuzonHealth were mainly community-based while VisayasHealth participants were mostly initiated into FP from the hospitals. This however, may not be reflective of their respective program recruitment strategies.
Community-based RHUs employ multiple touchpoints to contact target FP clients. From respondents’ accounts, one such touchpoint is the BHW, who makes house-to-house calls to look for pregnant women. Once identified, the BHW then either invites them to an activity/event such as Usapan, or she can opt to simply instruct them to go to the RHU to ask about FP.

Another touchpoint would be the community health center (RHU), where these pregnant women go for prenatal and postnatal check-up or regular immunization of their newborn. A third touchpoint is the birthing center, where the midwife or doctor discusses FP with the woman after giving birth.

In Digos, for instance, the RHU employs all three touchpoints: a BHW who makes house calls, and midwives based in the RHU who explain FP during prenatal or postnatal consultations.

“Binabahay-bahay talaga kami.” (They really go house-to-house.)—Digos young acceptor

“Noong buntis pa ako, nagpo-plano na kami mag family planning, kaya noong inoffer sa akin ng mid wife mag family planning di na ako nagdalawang isip na mag IUD.” (I was pregnant when I decided to take on FP, that’s why when the midwife suggested it, I didn’t have to think twice, I readily selected IUD.)—Digos young acceptor

“Sa ospital kasi hindi kayo palalabasin kung hindi kayo – briefing.” (You will not be released from the hospital without being briefed (on FP methods.))—Digos young acceptor

In the hospital setting, the only opportunities to engage pregnant women to take interest in family planning is during the prenatal consultation or postnatal check-up of the newborn baby. In Cebu, Tacloban, Batangas and Cagayan de Oro, there are indications of higher FP client identification during the prenatal or postnatal consultations, and relatively weaker BHW support.

“Hindi naman laging nabibisita ng BHW, ngayon lang (for the FGD).” (BHW rarely visits, it’s only now that they visited (for the FGD.))—Tacloban young acceptor

In Quezon City, public hospitals are very busy with high volume of patients, and hence they are unable to serve or recruit effectively. However, at the community level, there are reports of BHWs’ doing house-to-house visits to invite pregnant women to attend family planning activities/events.

“Sa Fabella, walang oras sa dami ng pasyente” (At Fabella, they don’t have time to explain), there are just too many patients.” –Quezon City young acceptor

“invited by health worker…umiikot po talaga (bahay-bahay).” (Was invited by health worker, they really go house-to-house.)—Quezon City young acceptor

2. **Activities/events (Buntis Congress/Usapan)**

Consistently across all areas, there are indications of weak interest to participate in FP-related activities like Usapan or Buntis Congress. One reason for this is inadequate information dissemination, and hence they could not make time for these activities. Another reason is that the respondents are not 4P clients (or conditional cash transfer clients); attendance of FP activities is a must for 4P clients. Lastly, new moms are tied to their babies after giving birth. They need adequate lead time (advance notice or a regular schedule of activities) to schedule a reliever for them to take care of their babies/children. The best timing to invite women to FP activities is during pregnancy, not after giving birth.

3. **Counseling/orientation**

Another area of inconsistency was observed in the area of RH counseling. The general observation, however, is that only a few areas had been effective in explaining FP methods to respondents that will help them to choose the suitable method for them.

In most cases, a single method is pushed. The general pattern observed is that for young clients (teens), the IUD is top of the list and sometimes the only one that is being recommended. To illustrate an extreme case, in Batangas, a young mother who delivered through caesarian section and was still dazed
when asked by the doctor if she wanted an IUD insertion and she simply nodded without knowing what was being asked of her. When she fully recovered, she could not do anything anymore and she was bleeding heavily for a month after the IUD insertion. It is only when the IUD is not suitable or when there are health concerns that need to be taken into account that other methods would be explored.

It is no surprise, therefore, that respondents would simply trust the recommendation of the health worker, midwife or doctor.

For young mothers, it seems, ligation is not an option that is offered to them. Another extreme case was in Batangas, where a young mother has four children at age 23. She asked for ligation but was discouraged by the health professional who attended to her because she was still young. It might be worth reviewing policy guidelines if there are indeed restrictions imposed against recommending ligation for young mothers or if there are informal directives from LGU executives with strong anti-RH stand.

> “Gusto ko yung pang matagalan. Bukod po sa IUD, ang sabi daw po sa akin ipaligate kaya lang bata pa po ako di pa pwede.” (I want long-term protection. Besides IUD, I was told about ligation but it was not recommended because I was still too young.)–Batangas young acceptor

There was another young mother in the same group who opted for ligation, but she only had one child. This might be a weaker case for ligation than the previous one above.

> “Ang paliwanag po, kelangan yung age daw na nung bata e pasok na sa grade 1 bago daw po pwede ipaligate…kasi pag nagpaligate di mo na masusundan pag isa.” (This was how it was explained to me, your youngest child should be of school age already, like grade 1, then you can qualify for ligation…the reason for this is that ligation is irreversible and you won’t have another child, especially in your case you have only one now.)–Batangas young acceptor

4. **Product availability and cost**

   Pills, injectables and IUDs are readily available and are given for free at the health center. In most cases, the RHUs are adequately stocked. There are instances when the RHU runs out of stock and the staff suggests for the women to simply purchase in the commercial drugstores. In the case of injectables, the drug is always available but the RHU simply runs out of syringes/needles. Again, women are asked to buy the needle first before they are due for their next injection.

5. **Staff credibility**

   Among young acceptors, they have no complaints about staff credibility in both the RHUs and hospitals where they avail of FP services.

   The best example of an effective BHW/midwife is in Digos City. Azizah is a Muslim BHW. It is known that Islam prohibits contraception. Azizah, however, practices FP, and she herself has used several FP methods. Her ability to effectively establish rapport with target clients and her experience and knowledge of FP methods are appreciated by the target clients. She is deemed to be a role model apart from being an expert in FP. Hence, she is able to convince young Muslim girls to go to the center and to know more about FP methods.

   In contrast, young FP acceptors who do not have any relationship with the RHU would not be open to receive instructions from BHWs. Instead they will rely on the hospital-based midwives and doctors to advise them on FP.

6. **Overall satisfaction with service**

   Across all areas, young FP acceptors are satisfied with the FP service delivery system in place. When asked, they agree that the person they interact with on FP is attentive, respectful and knowledgeable.

   The service is quick, with acceptable waiting/queuing time. Stocks are always available, and they consider it a minor inconvenience if they need to go and buy their FP products themselves when the stocks run
out. For young acceptors, the cost and inconvenience is insignificant compared to running the risk of another unexpected pregnancy. Pills, for instance, are affordable (below PhP 30.00 at the nearest drugstore).

h. Other observations and implications (acceptors vs. non-acceptors)

1. Non-acceptors tend to be more passive in terms of personality than the young acceptors. For example, young acceptors, when they hear a scary account about certain FP methods, immediately validate the story from the health care professionals that they interact with. Non-acceptors, on the other hand, will not because they are not comfortable asking professionals about it.

2. For some reason, even in areas where BHWs do the house-to-house rounds, the non-acceptors are not being reached. This may indicate insufficient number of BHWs in the area or a narrow scope of BHWs that limits their reach.

3. Non-acceptors are sometimes blindsided by misconceptions they hear about artificial methods of FP. Thus, they are, more comfortable with natural methods.

4. Counseling is the more important approach to take to convince non-acceptors to adopt FP methods other than natural methods. It has to be assumed that non-acceptors have heard of the serious misconceptions about FP methods. Hence, care must be taken when giving them advice. It is recommended for the RH counselor to first allow the misconceptions to surface, so they could properly address them before recommending a method to them. What we noticed in the FGDs is that these non-acceptors will not challenge/question the advice of professionals. Also, they may not necessarily follow the advice because of the myths and misconceptions they have heard, like an unpleasant side effect, which may have influenced them to think that the method recommended by the RH counselor is actually risky or dangerous.

5. For both acceptor and non-acceptor groups, the moment of high concern about the future happens when they get pregnant. This is the best opportunity to also influence them about FP because they are most afraid of getting pregnant again. It is unfortunate that non-acceptors were not reached during the prenatal phase.

6. Although this may not be within scope, there are indications that there is a need to strengthen sex education and counseling in schools to prevent teen pregnancies and teen marriages. In the FGDs, many of the teen moms were in relationships with male teens their age.

7. Still maybe out of scope and not prevalent, there are cases when poverty pushes children to get married to be able to help provide for their families. Here we find a girl in Cavite claim to have a “sugar daddy” at age 13, a 14-year-old who claimed to have married someone who was already working (in his 20s), and a 15-year-old in Tacloban who married someone twice her age.

VII-2: Women who are non-users Of FP methods

I. Profile of the FGD participants
Women of reproductive age 18 to 35 years old, with at least one child, and who are currently not using or who discontinued using an FP method, participated in FGDs conducted in seven selected project sites. The summary of these women's profiles appears in the table below:
<table>
<thead>
<tr>
<th>City/municipality /province</th>
<th>Date of FGD</th>
<th>Number of participants</th>
<th>Age range</th>
<th>Civil status</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trece Martirez, Cavite</td>
<td>March 28, 2016</td>
<td>7</td>
<td>18-35 years old</td>
<td>2 married; 5 in consensual union</td>
<td>1 to 7 children (Mean: 2.6)</td>
</tr>
<tr>
<td>Digos City, Davao Del Sur</td>
<td>April 1, 2016</td>
<td>7</td>
<td>19-29 years old</td>
<td>6 married; 1 in consensual union</td>
<td>1 to 2 children (Mean: 1.1)</td>
</tr>
<tr>
<td>Cagayan de Oro City, Misamis Oriental</td>
<td>April 4, 2016</td>
<td>7</td>
<td>18-25 years old</td>
<td>1 married; 6 in consensual union</td>
<td>1 to 4 children (Mean: 1.7)</td>
</tr>
<tr>
<td>Cebu City, Cebu</td>
<td>April 4, 2016</td>
<td>10</td>
<td>19-32 years old</td>
<td>3 married; 6 in consensual union</td>
<td>1 to 5 children (Mean: 1.7)</td>
</tr>
<tr>
<td>Tacloban City, Leyte</td>
<td>April 6, 2016</td>
<td>8</td>
<td>18-28 years old</td>
<td>1 married; 7 in consensual union</td>
<td>1 to 3 children (Mean: 1.7)</td>
</tr>
<tr>
<td>Batangas City, Batangas</td>
<td>April 19, 2016</td>
<td>4</td>
<td>18-31 years old</td>
<td>3 married; 1 in consensual union</td>
<td>1 to 3 children (Mean: 2.0)</td>
</tr>
<tr>
<td>Quezon City, Metro Manila</td>
<td>April 21, 2016</td>
<td>6</td>
<td>19-31 years old</td>
<td>1 married; 5 in consensual union</td>
<td>0 to 3 children (Mean: 1.5)</td>
</tr>
</tbody>
</table>

Total participants: 49

II. Findings

A. Sexuality and fertility

1. The age when respondents had their first sexual initiation ranged from 15 to 20 years old.

2. When participants were asked for the number of children they wanted to have, most indicated a preference for one to three children. The reasons cited for desiring this number of children were:
   - economic constraints that will make it difficult for them to feed and to send their children to school
   - desire to have their children finish school
   - desire to provide well for children’s needs
   - desire for a better life for the family
   - difficulties in childbirth and child-rearing
   - prevent children from experiencing the hardship they went through growing up in a large family

   While two children is already an ideal number for some respondents, the reason for wanting another child was to ensure that the couple will have a male or female child they did not yet have.

3. Two participants from Digos City expressed their desire to have four to five children. They reasoned that it was fun to have a big family even if they had to sacrifice, just as they had experienced in their own families. One participant from Cebu City had no preference on the number of children (any number will do). She believed that having many children is fun. It may be difficult raising them at first but they can manage later on. Quarrels among the children will be there but later on these children will end up like peers.

B. Awareness of FP methods

1. When asked whether they were aware of methods to stop or delay pregnancy, participants were able to name the different modern and traditional FP methods. A number of participants referred to certain methods using terminology like “turok” for injectable, “tali” for vasectomy, “binibilang” for
calendar method and “pagpapadede” for LAM. In Batangas City, none of the participants were aware of implants. One participant knew of withdrawal only.

2. While participants were able to name different FP methods, knowledge about the methods was very limited and spotty. This pattern was observed across all areas. This knowledge was usually based on stories passed on by neighbors, family members (mother, sister, grandmother, etc.), in-laws, close relatives and friends. Some of the information were mostly misconceptions on the effects of certain FP methods, which became a cause for concern or created fear among the participants. Some cited what their friends/relatives experienced as side effects. Among those mentioned were as follows:
   a. Pill: Causes weight gain or weight loss, body weakness, sleepiness, sunken eyes, eyebags, loss of appetite, menstrual irregularities (such as frequent menstruation, little or heavy discharge), headaches, dizziness, palpitation, stomach aches, mood swings; can aggravate high blood pressure; causes dry skin, pimples, irritability
   b. Injectable: Causes weight gain or weight loss; prevents menstruation, which can cause tumor or problems in the uterus; causes menstrual irregularities (such as frequent menstruation, little, heavy discharge or none at all); causes abdomen to become big because menstruation comes only every 3 months
   c. IUD: Can be dislocated if one carries heavy objects; can cause maternal death if uterus gets affected; can be painful if inserted because there is no anesthesia; can cause tumor; causes dysmenorrhea, headache, weight loss; affects mood; increases appetite; can get entangled in the penis
   d. Implant: Can cause cancer; cannot carry heavy objects; causes weight loss; prevents menstruation; causes dizziness, weakens appetite; causes irritability because blood is not discharged
   e. Condom: Not safe, can be left inside the uterus; can have holes; can be painful during sexual intercourse
   f. Withdrawal: Man needs to sacrifice
   g. Vasectomy: For rich people not for the poor; husband needs to carry heavy objects (Tacloban participant)
   h. Ligation: Decreases sexual satisfaction (Cagayan de Oro participant)

4. In some cases, participants' knowledge about a particular FP method was drawn from personal experiences shared by a close family member or relative on the method.

In Quezon City, one participant shared that her mother who took pills had sunken eyes, eyebags then lost her appetite (“parang lumubog yung mata niya (Mama) yung eyebags tapos wala ganang kumain). She also recounted about her aunt who had an IUD inserted and had to go to the health center every month because the IUD got dislocated since she was fond of carrying heavy objects.

In Digos City, one participant shared that her sister stopped using injectable because she developed rashes.

In Batangas City, a participant shared that her sister-in-law who had IUD got dislocated often so she had to go on frequent visits to the OB within three or six months to prevent pregnancy (“kailangan patingin palagi sa OB- 3 months or 6 months para ipaayos sabi ng hipag ko.. nawawala sa pwesto (ang IUD)… pwede mabuntis pag ganun”). Another participant related that a friend who had IUD told her that it is painful for the woman during sexual intercourse. (“May kaibigan ako pag ginagamit siya masakit talaga sa babae”)

In Cagayan de Oro City, a participant shared that her neighbor who had an implant for a year got sick and lost weight.
5. Apart from neighbors, family members, in-laws, close relatives and friends, the health center and seminars conducted by NGOs and the church were mentioned as sources of information on FP methods. A few mentioned television as a source of information on condom and pills. In Cebu City and Tacloban City, the health center was cited as a source of awareness on FP methods by participants. Also in Tacloban City, some participants mentioned that they learned about FP methods from a seminar organized by Plan International, an NGO. In Batangas City, practically all participants mentioned that they heard about FP methods from attending a church seminar on FP as a prerequisite before getting married. They shared that in the church seminar, they were told that contraceptives had side effects like the formation of cysts in the uterus and that the church prohibits tubal ligation and vasectomy.

C. Usage of FP methods

1. Participants commonly engaged in a discussion with their spouse (“pag-usapan”) as their way of preventing or delaying pregnancy. One Cagayan de Oro participant expressed confidence in the effectiveness of abstinence in delaying or preventing pregnancy (“abstinence talaga kasi 100% effective”).

2. When asked why they had not used any FP method, fear of side effects surfaced strongly as a reason. Another reason often mentioned was the ineffectiveness of the method based on experiences shared to the participants by FP method users. The inconvenience of using the method (such as pills needed to be taken every day, one can forget and miss the dose; IUD required regular visits to the health facility to ensure it is properly in place), the desire to have another child and opposition from the husband were mentioned by a number of participants.

The kind of service received at the health center came out as a contributing factor in non-use of the FP method. One participant from Batangas City who considered getting an IUD recounted the lack of attention and long wait she received when she visited the health center.

3. At least half of the participants in all the FGDs have tried a particular FP method, whether modern or traditional. Pill was the method most commonly tried. Some also attempted using injectable. A few tried condom and the calendar method. Their reasons for discontinuing pills were traced to the following:
   - Side-effects experienced from the use of pill: headaches; little amount of menstrual discharge believed to cause tumor because dirty blood is not discharged; mood swings, which resulted in quarrels with the spouse, prompting the latter to request participant to discontinue taking pills; increase in appetite; stomach ache
   - Potential side effects with prolonged use like big stomach, palpitations
   - Cost; pills are expensive, need to buy pills for breastfeeding as these are not given for free at the health center (Cagayan de Oro participant)

4. Those who tried using injectable discontinued it due to side effects, which they experienced such as headache, chest pains, irregular menstrual discharge—heavy or none at all. One participant from Batangas City discontinued with the use of injectable because there was no one at the health center to give her an injection during her follow-up visit.

Those who tried condom experienced pain and discomfort with its use and were concerned about the possibility of condom having holes.

One participant from Quezon City who tried the calendar method found the method ineffective since she became pregnant after one year.
In Tacloban City, the effect on menstruation discharge was mentioned frequently as a reason for discontinuing the method, regardless of whether the FP method tried was pills, IUD, injectable or implant. The belief that tumor can result when there is little or no menstrual discharge came out as dominant among participants.

5. Many FGD participants intend to use a FP method in the future either to space or limit their pregnancies.

Those who had no plans to use a FP method wanted to have additional children. Others would like to discuss with their spouse first and seek to arrive an agreement on the matter of spacing or limiting birth.

In Quezon City, most participants would like to try pills since this was the method recommended to them by a family member or close relative. Another reason given was the convenience in using pills; one can just take it every day. One participant who wanted to space birth every 10 years planned on using implant since it is easy to administer and did not require regular check-up unlike with the use of the IUD.

In Batangas City, all participants plan to first consult people they know who are using an FP method before making a choice. The church restrictions will not affect their choice.

In Cebu City, majority of the participants intend to consult first a health professional or people who have experienced using a method to guide them in their choice. They also had the attitude that while they were willing to try a method, if it doesn’t work, they can readily stop using it.

6. One participant from Cebu City, however, remained undecided in trying an FP method because of the experience of their teenage neighbor who used an IUD but became pregnant. The IUD entered the head of the 6-month-old baby she was carrying in her womb, which the doctor had to remove. (“Yung IUD yung kapit bahay namin 19 anyos nabuntis pero may nangyari … sa ulo nung bata pumasok yung IUD. Ang ginawa ng doctor tinanggal yung bata … anim na buwan na daw po.” Our neighbor who is 19 years old and had IUD became pregnant…the IUD went inside the head of the child…the doctor removed the fetus. It was 6 months old.)

In Tacloban City, most of the participants who were open to try a method will consider a method that the midwife or BHW recommends to them.

In Digos City and Cagayan de Oro, participants intend to use natural methods like withdrawal or abstinence since this frees them from worries on proper use of contraceptives like pills or injectables. Also, natural methods are those endorsed by their religion (Islam, Mormon).

In Cavite City, non-user participants expressed their intention to use a modern FP method in the future, mainly because of the influence of their mother. Their choice of a particular method depended on what their mother would recommend to them as an effective method to avoid getting pregnant.

D. Information dissemination on FP

Provision of information on FP methods from the health facility to most FGD participants was inadequate, or at times, none at all.

In Quezon City and Batangas City, participants reported that they do not get information on FP when they visit the health facility; neither have they been invited to attend an FP seminar nor received a visit from the health worker. One participant from Batangas City also shared that the midwife was often not available for consultation at the health center.

In Cebu City, a good number of participants mentioned that they were invited to attend a FP seminar. The other participants would like to get more information about the different FP methods and side effects since they reported that information they received from the health center is very
general. They were simply told what the FP methods were and that these had side effects but no further information was given.

In Tacloban City, participants shared that when they visited the health center, they were usually encouraged to use pills but they received no further information. Seminars on FP usually happened once a year and organized by the barangay health center or NGOs like Plan International. There were also no regular schedules in the health center related to FP discussion. One participant related a positive experience with a midwife who convinced her to use a method.

In Digos City, most participants have not received information on FP. They say that they heard about meetings on FP in the barangay but have not yet attended any. They also shared that no one came to visit them to talk about FP.

In Cagayan de Oro, participants reported that there were posters on FP at the health center and provision of free FP counselling. Barangay health workers also gave FP brochures during their house to house visits. There were also a Buntis Congress organized.

VII-3: Husbands who receive RH counseling

I. Profile of FGD Participants

<table>
<thead>
<tr>
<th>Municipality/city</th>
<th>Date of FGD</th>
<th>Number of male respondents</th>
<th>Age range</th>
<th>Civil status</th>
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<tbody>
<tr>
<td>Barangay Bunawan, Davao City</td>
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<td>6</td>
<td>21-42 years</td>
<td>3 married</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 singles</td>
</tr>
<tr>
<td>Municipality of Consolacion, Cebu Province</td>
<td>April 4, 2016</td>
<td>8</td>
<td>19-28 years</td>
<td>2 married</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 singles</td>
</tr>
<tr>
<td>Maramag, Bukidnon</td>
<td>April 5, 2016</td>
<td>6</td>
<td>24-36 years</td>
<td>2 married</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 singles</td>
</tr>
<tr>
<td>Tacloban City</td>
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<td>8</td>
<td>23-30 years</td>
<td>1 married</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7 singles</td>
</tr>
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<td>Batangas City</td>
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<td>5</td>
<td>22-36 years</td>
<td>3 married</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 singles</td>
</tr>
<tr>
<td>Quezon City</td>
<td>April 21, 2016</td>
<td>6</td>
<td>22-29 years</td>
<td>All single</td>
</tr>
</tbody>
</table>

Total FGD participants: 39

II. FGD highlights

Part 1: Reproductive health counseling

I. Have you heard about FP? Where?

All participants have heard about FP. They heard about FP from:

- Advertisements:
  - heard on TV and radio
  - read on billboards and posters in health centers and other places in the barangays
  - information shared by BHWs during their house to house visit

- Their spouses
- Their parents
  - as advice not to have big family
▪ who happened to be a health worker

- The health centers:
  - barangay
  - municipal/city

- The hospital after the delivery of their children
- The seminar on FP as requirement prior to getting married
- The school
- The church
- The Department of Social Welfare and Development (4Ps)

2. Have you attended any discussion on FP? When? Where did you attend it? Who organized this session?

In the Quezon City FGD, all of the participants have not attended any FP discussion or session except their spouses. They heard about FP from their spouses and friends. They also learned about FP through radio and TV advertisements and through the internet.

FGDs in other areas also reveal that there are also males who have attended discussions on FP, particularly the following:

- Participants who attended the seminar on FP prior to getting married:
  - 3 participants from Barangay Bunawan, Davao City
  - 2 participants ages 19 and 26 years from the Municipality of Consolacion, Cebu; one for a half day and another for a whole day FP seminar.
  - 2 participants from Batangas City; 3 days of FP seminar

- Participant who has college education:
  - 1 participant age 30 years from Tacloban City remembered having a semester of family planning subject in college.

3. What key information do you remember from this session?

- Plan for the size of the family
- Population control
- Spacing between birth of children
- Methods used in FP
- Not to have many children
- To concentrate/focus on the future of children
- More expenses for a big family with many children
- Vasectomy

4. What did you think of this information?

- Most participants find the information they got helpful
  - for not having a big family
  - to avoid pregnancy
  - for the future of their children
  - by having a vasectomy, the wife no longer need to take pills, injectables or any other temporary method

5. What did you like/dislike about the discussions?
• Most of the information heard and received by the participants is simple and easy to understand.
• The discussion on what the participants dislike about the information they received are more on the different FP methods especially on vasectomy. In most of the FGDs conducted, participants started mentioning they don’t like vasectomy particularly as it involves surgery. Particularly for those who attended pre-marriage FP counselling, some even mentioned that they will lose their “pagkalalaki” with the loss of capacity to have a child after the surgery.
• Most of the participants said that having FP discussions and seminars are very beneficial to them because they learn a lot about the welfare of their family.
• In Batangas City, a 36-year-old participant mentioned that during his younger years, he did not hear or attended any FP session until he had four kids. Had he been informed earlier about FP, he would have used the methods.

6. Did you apply whatever advice was given during this discussion? Why or why not?
• Participants applied some of the advice they heard, like the following:
  a. All have tried using condoms:
     - However, most participants decided not to use condoms because of less sexual satisfaction with the rubber on.
     - One participant from Tacloban City experienced allergy, and he believed that “may gamot ang condom (condom has some medicine on it)” and feared that his wife will have the same allergy.
     - But one participant from Tacloban City will try using condom again because for him, the experience is just the same as having none and to avoid pregnancy.
  b. Three participants from Barangay Bunawan, Davao City had vasectomy:
     - One participant (42 years old) was forced by his spouse to have vasectomy after their 6th child, otherwise his wife wouldn’t have sexual intercourse with him for fear of having another child.
     - One participant after having two children decided to have vasectomy after a barangay official had convinced him to undergo this FP method.
     - One participant age 28 from Bunawan, Davao City, after the birth of their 2nd child had vasectomy. They, as a couple, decided to have this method to avoid additional children.
  c. Other participants tried the withdrawal method:
     - Some participants in Tacloban City tried but later on avoided practicing the method, for it is not safe and may result to another pregnancy due to premature ejaculation.
     - There is less satisfaction, “bitin” for both in the couple.
     - One participant from the Municipality of Consolacion, Cebu at 23 years of age has tried withdrawal, but stopped, for he experienced forgetfulness. He mentioned he easily forgets names and has a hard time remembering things and events.

7. Were you able to share this information to any male friends or relatives?
• Participants were able to share some of this information to their male friends during informal talks and conversations.

8. Do you know any male friends who do you think can benefit from this kind of activity? Would you recommend this activity to them? What will you say to them?
• Participants are willing to share the bit of information on FP to their male friends, relatives and workmates. Most of the participants said that they would endorse the use of pills as a method to control the number of children.
• The participants believe that sharing this information will further help a lot of families:
  
  • A participant from Batangas City said that it will decrease the number of street children.
  
  • Participants from Batangas City all agreed that FP discussions are very helpful for the families to realize their own capacity.

Part II: Awareness and use of FP

1. Do you know of any FP method? If so, please enumerate those that you know.

   Almost all of the participants know the different FP methods. They were able to mention the following:
   
   - Condom
   - Calendar method
   - Injectable
   - Withdrawal
   - Vasectomy
   - IUD
   - Ligation
   - Beads

2. Are you/or your partner using any of these FP methods?

   • Some of the participants are using some FP methods:
     
     - Three participants from Bunawan had undergone vasectomy.
     - A 30-year-old participant from Tacloban City is practicing the calendar method and explained that safe sexual intercourse is done five days before the regular menstruation of his spouse (“ma men’s na ang babae di makakasiguro, 5 days na before mag men’s saka nangangalabit”).
     - In Batangas City, participants have tried using condoms, pills and injectables, but at present they prefer not to use any kind of method except withdrawal, which is effective for them. They have a strong dissent on vasectomy. According to them, it would decrease their manliness (pagkalalaki). Another participant said that he may not be of use if he undergoes vasectomy. There is a consensus that they do not like the idea of losing the capacity to impregnate a woman. This matters a lot to them. They would prefer their wives to undergo ligation. Phrases like “hindi dadami ang lahi,” “hindi ako baog,” “baka madagdagan pa ang asawa.”
     - Some of the spouses of the participants are using some FP methods:
       - Some spouses are using pills.
       - Some are using injectables:
         - One participant from Consolacion, Cebu at 27 years old has his spouse on injectable for three months.
         - Two participants from Payatas A, Quezon City have their spouses use injectables that are effective for three months.

3. If not male method, do you think you can take responsibility for using standard days method, condom or undergoing vasectomy?

   • Some participants fear that using standard days method is not safe, for it may result in another pregnancy.
• For some participants, undergoing vasectomy is not an option, for they are not sure of the effect of undergoing such surgery.
• In Batangas City, all the participants do not consider vasectomy because for them, there are other methods, and they do not want to lose the capacity to have children.
• In Maramag, Bukidnon, a participant said that he is considering vasectomy but not at his current age because as a couple they still plan to have another child.
• Most of the younger participants in all FGDs did not consider having a vasectomy because they still want to have another child.

4. What method is your wife using?
• Spouses of participants use pills, injectables, calendar method and some had IUD insertions.

5. What do you think of this method that your wife is using?
• For spouses using pills:
  ● Some participants observed no noticeable change in their spouses.
  ● Some participants observed some noticeable changes like the following:
    - One participant from Payatas A noticed that his spouse easily fell asleep and increased in weight (takaw sa tulog at tumataba).
    - One participant from Payatas A Quezon City said that his wife is having headaches so they decided to stop taking the pill.
    - Irritable and easily flares up even in small disagreement or sometimes for no reason at all
    - One participant from Tacloban City mentioned that his spouse easily gets angry without reason and the following day they are “friends again.”
    - One participant in Tacloban City, age 30 years, noticed that his spouse has lost appetite for sex (di na nangangalabit).
• For spouses who use injectable:
  - One participant in Consolacion, Cebu, 27 years old, has not noticed any changes in his spouse.
  - One participant in Payatas A noticed that his spouse became irritable, especially that her menstruation came only on the fourth month after having a 3-month injectable.
• For spouses who use IUD
  - In Bunawan, Davao City, a participant shared that his wife became more beautiful after having an IUD.

6. Did your partner seek your permission in order for her to use the pill, injectable, implants or IUD? Would you require your wife to seek your approval before using a method? Did she initiate the discussion on the method? What did you talk about?
• Participants mentioned that it is usually their spouses who initiate discussions on the FP methods for it is their spouses that usually go to the health centers.
• An exception is in Bunawan, Davao City, where one participant, after having been encouraged by his barangay official, decided to undergo vasectomy.
• In Bunawan, Davao City, a participant said that his wife can use any FP method without his permission.
• Participants believe that they should be consulted on whatever FP methods their spouses will use. They, as a couple, should agree on what FP method to use for as long as this method does
not pose a danger to the spouse’s health and should consult a doctor before using such a method.

- In Maramag, Bukidnon, two participants shared that it was their spouses who initiated the discussion on FP during bedtime moments. Furthermore, they shared that their spouses are thinking about their economic conditions.
- Also in Maramag, Bukidnon, a participant shared that his wife initiated talks about FP when he (husband) tried to have sex with her (wife) and she refused, saying that she is afraid to get pregnant.

7. Probe for fear of side effect/misconceptions?

- On withdrawal method:
  - One participant from the Municipality of Consolacion, Cebu at 23 years of age has tried withdrawal, but stopped for he experienced forgetfulness.
  - Two participants from Consolacion Cebu, ages 19 and 26, who were able to attend FP seminar prior to getting married, were helpful for sharing the information they got that “In experiencing forgetfulness as the effect of using withdrawal method is not true and more of psychological.”
- On vasectomy:
  - One participant from Consolacion, Cebu mentioned that vasectomy and the surgery involves “the removal of the testicles.” Again, the two participants from Consolacion, Cebu, ages 19 and 26, who were able to attend FP seminar prior to getting married were helpful for sharing the information they got. The two explained that it cuts only the veins where the semen passes and not the removal of the male testicles.
  - One participant, age 23 years, from Tacloban City mentioned that vasectomy necessitates surgery on the testicles (operasyon sa may itlog para di mabuntis ang babaeng). A 30-year-old participant from the same focus group clarified that it’s not operation on the testicle but rather the cutting of veins where semen passes (“inuutod”–pinuputol ang daanan ng semen).
  - Another participant, age 30, from Tacloban mentioned that the male penis also has erection and has orgasm though the semen is diluted (tumatayo pa rin at nilalabasan pero “labsaw”–malabnaw na ang semen para di makabuo).
  - A participant from Maramag, Bukidnon said that he knew someone who became gay after having a vasectomy.
  - A participant in Bunawan, Davao City said that people think and say that once you undergo vasectomy, it will lessen your strength at work.
- On pills:
  - In most FGDs, participants shared that they observe that their spouses gained weight, lost weight, became more hot-headed, easily irritated for unknown or simple reasons and aggressive.
  - In Maramag, Bukidnon, a participant shared that his wife experienced pain and hardening of the breast.
- On IUD:
  - One participant shared he knew someone who had IUD for 18 years but never had a check-up since the insertion and developed a tumor.
VII-4: TB Health Workers

I. Profile of FGD participants

<table>
<thead>
<tr>
<th>Municipality/city</th>
<th>Date of focus group</th>
<th>Number of respondents</th>
<th>Age range</th>
<th>Number of years in service</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
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<tr>
<td>Tanza, Cavite</td>
<td>March 28, 2016</td>
<td>1</td>
<td>6</td>
<td>28 to 56</td>
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<tr>
<td>Davao City</td>
<td>March 31, 2016</td>
<td>---</td>
<td>6</td>
<td>22 to 49</td>
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<tr>
<td>Opol, Misamis Oriental</td>
<td>April 4</td>
<td>1</td>
<td>7</td>
<td>30 to 51</td>
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<td>Consolacion, Cebu</td>
<td>April 5, 2016</td>
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<td>9</td>
<td>35 to 39</td>
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<tr>
<td>Javier, Leyte</td>
<td>April 7</td>
<td>---</td>
<td>9</td>
<td>23 to 59</td>
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<td>36 to 60</td>
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<tr>
<td>Quezon City</td>
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<td>10</td>
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<td><strong>Total participants:</strong></td>
<td></td>
<td>54</td>
<td></td>
<td></td>
</tr>
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</table>

II. FGD highlights:

Part 1: Diagnosing TB patients

1. What are the main reasons for general patients to consult?
   - The main reasons cited for patients to consult are the following:
     - Cough for two weeks or more
     - Fever
     - Loss of weight
     - Hemoptysis (coughing blood)
     - Body pains
     - Loss of appetite
     - Night sweats
   - Some patients go to the health facilities, private or public, for a medical certificate, which they need for work. If the x-ray results would show positive for TB, these patients were eventually referred to a DOTS center for sputum examination or treatment.
   - In some schools in Quezon City, x-ray is a requirement for students. So, the students whose x-ray finding showed positive for TB are referred to the DOTS center.

2. How do you identify TB cases?
   - In certain areas, such as Misamis Oriental and Quezon City, there is an existing TB Task Force, a volunteer group composed of 4Ps members, cured TB patients and ordinary citizens. They conduct regular visits to the community as part of their social mobilization program, to inform community members about TB and encourage presumptive TB patients to seek consultation. In Quezon City, aside from the TB Task Force, there is a Barangay Health Management Council that conducts house to house visits to look for those who are TB-symptomatic.
   - In other areas, the BHWs conduct house-to-house visits in their assigned communities to distribute posters, provide lectures and ask if there are community members experiencing TB symptoms.
In all sites, active case-finding is being done through the TB Task Force and the BHWs. In fact, the increase in case detection in all areas has been attributed to the active case-finding efforts of the TB Task Force and the BHWs. Quezon City, Misamis Oriental and Leyte have TB Task Force.

In Cavite, BHWs were trained to conduct sputum induction, and they bring these to the RHU.

In Javier, Leyte, an incentive scheme for the BHWs to do active case-finding was established two years ago. For every patient diagnosed and cured of TB, the BHW gets P 1,000 at the end of patient treatment. The patients also get P 1,000 if they finish treatment. The incentive scheme comes from the P 4,000 TB Outpatient Benefit Package from PhilHealth. Because of this incentive scheme, the case detection rate improved from 85 percent in 2014 to 100 percent in 2015. Meanwhile, in Batangas City, the BHWs are motivated to do active case-finding because of the merits/certificates being awarded by the City Health Office.

In Batangas City, an incentive amounting to P 1,000 to P 3,000 is given to each BHW for every 10 TB patients referred monthly, while in Opol, Misamis Oriental, P 75 is given to BHWs for every five patients referred to the DOTS center.

In Consolacion, Cebu, BHWs have a monthly quota of TB patients that need to be referred to the RHUs.

Contact tracing is also being done in all areas, wherein the household members of TB patients are advised to go to the health centers to have their sputum tested to make sure that they are not infected, and those who tested positive for TB undergo treatment.

One observation, particularly in areas that are industrial (Batangas City, Cavite), is the presence of migrants. They can increase detection rate, but because they are likely to move from one place to another, it is not easy to track them.

Where do you refer patients for diagnosis? Is referral a problem? Does it involve cost? What about access?

In all areas, there is an existing referral mechanism:

- From community to the DOTS center: At the community level, the BHWs refer those who are TB-symptomatic to the nearest DOTS center. The BHWs have referral forms.
- From private physicians to DOTS center: The TB-symptomatic who sought consultation from private physicians and whose x-ray results showed positive for TB were referred to the DOTS center.
- From DOTS center to Programmatic Management of Drug-Resistant TB: For patients who tested positive in x-ray but negative on sputum smear microscopy or relapsed or sputum positive after two months of treatment are referred by the DOTS center to facilities that have GeneXpert.

In Batangas City, the BHWs and midwives have sputum cups that they give to suspected TB patients. Then, those TB-symptomatic are given referral forms and are advised to go to the DOTS center. The TB-symptomatic are taught how and when to collect their own sputum.

Access to DOTS centers is not considered a challenge in most areas, except in Davao City and Opol, Misamis Oriental, where there are some villages and mining sites that are considered geographically isolated and disadvantaged areas.

The main issue in the referral process is the cost of transportation. There are instances where the BHWs bring the sputum of the patients to the facilities because the patients do not have money to pay for transportation. In other sites, the BHWs cover the transportation costs of the patients.
To address issues of transportation cost, Misamis Oriental gathers the TB-symptomatic to collect their sputum, and midwives conduct smears in the community and bring the slides to the laboratory for testing/reading by medical technologists.

In Cavite and Batangas City, some BHWs were trained to do smearing. In barangays where there are trained BHWs on smearing, there is an informal laboratory work station, wherein the BHWs conduct the smear and send the slides to the laboratory for testing.

**Part 2: Treatment of TB Patients**

1. **Do you care for TB in children?**
   - In all areas, TB cases in children are being treated in the DOTS center.
   - The TB cases in children are mostly referrals from pediatricians. Child walk-in TB patients come to the DOTS center, together with PPD and referral forms. There are patients who already undergo one-month treatment in the private facilities but due to the burden of the cost of anti-TB drugs, they go to the DOTS center to complete the treatment.
   - Some TB patients were referred by the school nurses and doctors for treatment.
   - There are very few NTP personnel who are treatment partners for TB in children, and these children are treated in the DOTS centers. It is only in Davao City that a BHW reported being a treatment partner for one child TB patient, which she regularly visits in the community. In Batangas City, the TB Coordinator herself serves as the treatment partner of children with TB. The DOTS centers usually give instructions to the mothers of these children on the dosage of the medicines. The BHWs are tasked to follow up the mothers if the medicines are consumed.
   - In Cavite City, most of the children are diagnosed by private facilities and referred to the RHU for treatment.

2. **Do you care for extrapulmonary disease?**
   - The respondents cited very few cases of extrapulmonary cases in their provinces or cities, and these cases are mostly referred to the regional or provincial hospitals.

3. **How do you obtain the drugs for treatment? How frequently? Have you experienced stock-outs?**
   - TB drugs are provided by the DOH. However, stock-outs, especially of category II drugs (streptomycin) and drugs for TB in children, have been reported in all sites, except Javier, Leyte. The stock-outs started in 2015.
   - In Javier Leyte, the LGU also purchases TB drugs. There is a TB capitation fund from the PhilHealth benefit claims. The LGU has a PhilHealth Trust fund, where the Municipal Health Officer approves the release of the funds. For any purchase less than P 50,000, no bidding is needed, so the funds can be easily released to purchase TB drugs. In 2015, there was a stock-out for TB in children due to the number of patients, but this was quickly addressed because the LGU was able to purchase the drugs.
   - In areas where there are no available drugs for Category II and TB in children, the newly enrolled patients are given three options:
     - Buy their own medicine
     - Come back when supplies are available—the BHWs or NTP staff informs the patients once the drugs are available
     - Referral to other facilities that have available drugs—usually referred to regional or provincial hospitals with DOTS facilities

4. **Do you observe each dose taken or provide drugs to the patients for several days? How do you check that the treatment is taken regularly?**
There are varying practices in providing drugs and DOTS. In some areas, the drugs are given to the BHWs or midwives and stored in the barangay health centers, who would then ask the patients to go to the barangay health centers to take their daily dose of TB medicines. In some areas, the treatment partners visit the patients to their residences to observe the patients take their medicines. There are also instances that the patients go to the residences of the treatment partners to take their medicines. There are a few cases where the patients go to the DOTS center daily for their drugs.

In Cavite City, some patients have their family members as treatment partners; they administer the taking of drugs and are monitored by the BHW on a weekly basis.

In Cebu, some patients are given a weekly supply of medicines, and the patients are required to bring the used medicine packages to ensure that these medicines are consumed properly before a new supply of medicines is given.

In Opol, Misamis Oriental, since there are remote areas where the treatment partner cannot observe the patients take their drugs daily, the eldest child or household member is assigned to monitor the patients take their drugs regularly.

The treatment partners sign the NTP cards of assigned TB patients.

In Quezon City, they are very strict that the patient should go to the health centers daily to take the medicine, in very seldom cases patients are allowed to take their medicine at home when they are very weak.

5. Do you have a system of recording and monitoring cases? Do you use a data collection system or checklist?

- In all areas, the TB health workers mentioned having NTP cards for each TB patient and treatment cards that are being filled up by the health workers.
- The progress of TB treatment and outcome are monitored by the health workers. There is a checklist on what to monitor for each patient, such as blood pressure, weight, other physical examination and sputum examination. These are done regularly and reported in the treatment cards.
- Each TB patient has a record-assigned case number, NTP cards. On the NTP cards, vital information such as weight, blood pressure, follow-up laboratory are recorded. Each patient has an envelope where documents such as referral forms, results of sputum exam and/or x-ray and other documents are stored.

6. How do you report the results? How often?

- The reports are submitted monthly to DOH or RHU/City Health Offices. In Batangas City, the BHWs or TB Task Force members are required to submit a monthly report on the number of TB patients referred to the facility in order for them to get their incentives/honorarium.
- In Leyte, Misamis Oriental and Cavite, there is a quarterly report, which is validated by the nurse and medical technologist. In Leyte, the quarterly data quality check is done with technical assistance from the IMPACT project.
- In Leyte, a TB accomplishment—case detection rate and treatment success rate—of each municipality is becoming a competition since all municipalities present their accomplishments to the PHO and DOH.

Part 3: Satisfaction

1. What are the strengths of the TB program in your facility?

- Tutok gamutan or DOT has been considered as one of the key strengths in improving treatment success rate in most sites.
LGU support has been critical in improving TB treatment in Javier, Leyte. In Javier, Leyte, the barangay officials would sometimes cover the transportation expenses of their constituents.

According to all respondents, providing free medicines in the DOTS center is critical to the success of the TB control program.

In Cavite City, the RHU has partnership with private facilities. According to them, the RHU provides medicine, while the private facilities monitor the patients.

The efforts of the BHWs, TB Task Force team and community health teams in conducting social mobilization to educate the community about the TB disease, encourage patients to seek treatment and the active case-finding has been cited in all areas as one of the strengths in improving case detection and treatment. In all areas, IEC materials have been distributed in the communities. Lectures are also being provided, and house-to-house visits are being done by the health workers. This has improved awareness on the disease and helped reduce stigma. According to the BHWs, because of the awareness campaign, patients are voluntarily seeking consultation in the health centers.

Active participation of the community also played a crucial role in detecting patients in most of the areas (e.g., people in the community report their neighbors or relatives who are symptomatic).

2. What are the main problems and how often do you address them?

The main challenge in the TB control program is the availability of drug supplies, especially in Category II and TB in children.

The cost of transportation going to the DOTS center for sputum examination and follow-up check-up is still considered a major challenge in all sites. In Javier, Leyte, this has been addressed through the support of local officials who provide transportation to TB patients. In other sites, the health workers sometimes use their personal funds to cover the transportation costs of the patients.

In some areas, the DOTS centers experienced denied claims from PhilHealth due to improper documentation.

There are still some patients who defaulted. Some defaulted because as soon as they feel better, they opted not to go for follow-up sputum or check-up. Some stopped taking their medicines. In these cases, the BHWs or treatment partners are tasked to regularly follow up and encourage the TB patients to continue their treatment.

Some patients defaulted treatment when they moved to another place and did not inform their treatment partners on their whereabouts.

In Opol, Misamis Oriental, the honorarium of BHWs has been a perennial concern. The honoraria for BHWs are low. The RHUs implemented an incentive scheme for community health workers, but the incentive is only PhP75 for every five referrals.

There is lack of personnel, especially medical technologists, in most areas.

3. Is there still stigma attached to TB in the community? What strategies do you use to mitigate this?

Most of the respondents believe that there is still stigma attached to TB, but this has been greatly reduced. The main reasons cited are as follows:

- On recall of TV commercial (Mitch Valdez)—In all areas, the respondents cited the importance of the TV commercial in improving awareness of TB. The main message recalled from the TV commercial is that TB is curable and the patients should go to the health center.
- IEC materials being distributed in the community—Posters, flyers and leaflets are being distributed to the communities.
Lectures conducted in the communities—BHWs conduct house-to-house visits and conduct lectures in the barangay.

- In Batangas City, one TB patient transferred to another barangay because the patient did not want his/her neighbors to know that he/she had TB.
- In Quezon City and Batangas City, based on experience, BHWs said that still a lot of patients are ashamed to admit that they have TB; in order to encourage them, they use different kinds of strategies (e.g., when BHWs do house-to-house visits, they ask whether there is someone who is pregnant, who gave birth, or who is using FP method, then lastly they ask if someone has cough).
- Stigma attached to TB:
  - Patient is embarrassed to be identified as TB patient for fear of being isolated by family, friends and neighbors.
  - TB patients want to avoid gossips.
  - “ayaw pandirihan sila dahil may TB”

### VI-5: TB Patients

#### I. Profile of FGD participants

<table>
<thead>
<tr>
<th>Municipality/city</th>
<th>Date of FGD</th>
<th>Number of respondents</th>
<th>Age range</th>
<th>Occupation</th>
<th>DOTS treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opol, Misamis Oriental</td>
<td>April 4, 2016</td>
<td>6 (2 females, 4 males)</td>
<td>40-72</td>
<td>(2) Carpenters Fisherfolk Laundrywoman Housewife Security guard</td>
<td>1 respondent completed treatment (cured). Other respondents are undergoing treatment ranging from 2 weeks to 6 months</td>
</tr>
</tbody>
</table>

**Total participants: 6**

#### II. FGD highlights

1. **What did you feel? What are the symptoms?**
   - Most of the respondents experienced persistent cough, loss of weight, loss of appetite and fever.
   - Some of the respondents felt tired all the time.

2. **Where did you go for diagnosis and treatment?**
   - FGD respondents consulted a physician from either a public or private hospital. The initial recommendation of the doctor was to have an x-ray. The x-ray results showed spots in the lungs and was suspected as TB.
   - The physicians referred the patients to the health center for sputum microscopy. The results of the sputum exam were negative. The patients were advised to start treatment for TB.

3. **Where did you get information on TB?**
   - Majority of the respondents received information on TB from the BHWs who conduct house visits. Posters (bond paper-sized poster) were distributed by the BHWs in the community. The posters provide information on how one can get infected by TB, to eat healthy and to not be ashamed if one has TB.
   - Only two respondents saw the TV commercial (Mitch Valdez) on TB DOTS since most of the respondents are working and do not have time to watch TV. One respondent recalled the message of the TV commercial: “wag ikahiya ang TB, pag inuubo ng 2 linggo, pumunta sa health..."
("Don’t be ashamed of TB; if you have been coughing for two weeks, go to the health center.

- One respondent did not receive any information prior to getting the disease.

4. What information was provided to you regarding diagnosis and treatment?

- All respondents said that they were informed about the duration of the treatment (six months minimum).

- All respondents were told that sputum induction should be done at 5:00 a.m. or the first cough of the day and that the sputum cups should be taken to the health center before 8:00 a.m.

- All respondents are informed that medicines should be taken daily. The supply of medicines is given on a weekly basis and the patients go to the health center for their supply.

- One respondent was given a two-week supply of medicines.

5. Do you have a treatment partner? Who is your treatment partner?

- Most of the respondents have their household members as treatment partners. Only one respondent does not have a treatment partner because she takes the medicines daily in the health center.

- There are two respondents who mentioned being monitored by the BHWs. The BHWs sign the forms that the medicines are taken daily. The other respondents preferred to be monitored by their household members (treatment partners) because they have work and do not have the time to go to the health center daily for their medicines.

6. Did you feel any side effects? Were you informed about the side effects of the medicines?

- The nurse at the health center informed the patients about the side effects. The side effects mentioned are as follows:
  - Change in color of urine
  - Might feel dizzy at the start of the treatment and may last for about a week
  - Need to stop drinking and smoking because of the side effects

- One respondent experienced allergies from the medicines.

7. Did the health center advise your household members to have a checkup or undergo sputum microscopy?

- Contact tracing was done by the health center, wherein the BHW advised the patients to encourage household members to go to the health center for check-up.

- Some of the respondents’ household members went to the health center for check-up. One respondent mentioned that it was her own initiative to have her family members checked to make sure they did not get infected with TB.

8. Were you satisfied with the treatment or services provided by the health center?

- The respondents are satisfied with the services provided in the DOTS center. The health staff explains the treatment process.

- The respondents are happy that the medicines are free. The cost of TB treatment for the patients is minimal. They would just have to pay for their x-ray exam and transportation. The transportation cost is minimal, amounting to PhP14 to PhP26 since most of the respondents live near the DOTS center.

9. Do you feel ashamed of having the disease? Do you feel any stigma?

- The respondents do not feel ashamed of their illness.
ANNEX VIII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

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USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID’s mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.

2. Before disclosing Sensitive Data, I must determine the recipient’s "need to know" or "need to access" Sensitive Data for USAID purposes.

3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.

4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.

5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.

6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.

7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to
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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law, or (iii) is required to be disclosed by law, court order, or other legal process.

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<td>The undersigned accepts the terms and conditions of this Agreement.</td>
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<th>Signature</th>
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<tr>
<td>C.M. Carrine</td>
<td>4 February 2016</td>
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<tr>
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<tr>
<td>Constance A. Carrine</td>
<td>Consultant</td>
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Signature ___________________________ Date 20 October 2015

Name ___________________________ Title ___________________________
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[Signature] Date January 27, 2016

VICTOR E. AGBAYANI
Name Title
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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[Signature] [Date: February 9, 2016]

[Name: Esperanza I. Cabrал] [Title: ]
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Signature __________________________ Date 2/1/2016

Name ELEONORA DE GUZMAN Title CONSULTANT
GOLDEN HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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ACCESSION
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Signature

Date 01/18/2016

Name LOVELE E. ZULMINA

Title
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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Date March 9, 2016

Name MAOCON V. PA/517

Title
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Signature Date

Mary Rose R. Amper March 3, 2016

Name Title
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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[Signature]

Date: March 18, 2016

Danilo B. Tenebro
Name

Title
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[Signature]

Date

3/9/2016

ORSON JEFF M. NAVELINO

Name

Title

Page 114 of 131
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Signature ____________________________ Date 3 March 2016

Name FLORENCE Z. LAGUNA Title

USAID/Philippines Health Portfolio Evaluation
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