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Philippines

PRIMARY HEALTH CARE FINANCING PROJECT 492-0371

OFFICE OF POPULATION, HEALTH AND NUTRITION
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

MINISTRY OF HEALTH AND PHILIPPINE COUNCIL
FOR HEALTH RESEARCH AND DEVELOPMENT

JULY 1983

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: _____

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: Philippines

3. PROJECT NUMBER: 492-0371

4. BUREAU/OFFICE: ASIA — 04

5. PROJECT TITLE (maximum 40 characters): Primary Health Care Financing

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 12 DD 31 YY 88

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 83 B. Quarter 4 C. Final FY 84

8. COSTS ($000 OR EQUIVALENT $1 = ₱10.00)

A. FUNDING SOURCE	FIRST FY 83 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	265	9,535	9,800	265	11,735	12,000
(Grant)	(150)	(1,850)	(2,000)	(150)	(1,850)	(2,000)
(Loan)	(115)	(7,685)	(7,800)	(115)	(9,885)	(10,000)
Other U.S. 1.						
Other U.S. 2.						
Host Country		100	100	-	10,900	10,900
Other Donor(s)						
TOTALS	265	9,635	9,900	265	22,635	22,900

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) PHX	532	500	500	-	-	2,000	7,800	2,000	10,000
(2)									
(3)									
(4)									
TOTALS						2,000	7,800	2,000	10,000

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 510 | 520 | 530 | 968

11. SECONDARY PURPOSE CODE: 582

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BRW	R/H	Coop	PART.			
B. Amount	8,000	5,000	500	5,000			

13. PROJECT PURPOSE (maximum 480 characters)

To increase access to and utilization of sustainable primary health care services managed and financed by communities and the GOP.

14. SCHEDULED EVALUATIONS
Interim MM 07 YY 85 | MM YY | Final MM 09 YY 88

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☐ 000 ☒ 941 ☒ Local ☐ Other (Specify) _____

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

17. APPROVED BY
Signature: Anthony M. Schwarzwalder
Anthony M. Schwarzwalder
Title: Mission Director
Date Signed: MM 07 DD 27 YY 83

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

Acronyms used in the Project Paper

BHW	Barangay Health Workers
BWP	Barangay Water Program
CDSS	Country Development Strategy Statement
EPI	Expanded Program on Immunization
FDA	Food and Drug Administration
FNP	Food and Nutrition Project
GOP	Government of the Philippines
IEC	Information, Education and Communication
MOH	Ministry of Health
NEDA	National Economic and Development Authority
NSTA	National Science and Technology Authority
OBM	Office of Budget Management
PCARRD	Philippine Council for Agricultural Resources Research and Development
PCHRD	Phil Council for Health, Research and Development
PCR	Presidential Commission on Reorganization
PHC	Primary Health Care
PRICOR	Primary Health Care Operations Research
PUSH	Panay Unified Services for Health
PVO	Private Voluntary Organization
RSC	Rural Service Center
U.P.	University of the Philippines
UNICEF	United Nations International Children's Emergency Fund
USAID	U. S. Agency for International Development
USPSA	United States Procurement Services Agency

PHC FINANCING PROJECT PAPER

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I. Request for Assistance

PROJECT AUTHORIZATION

Name of Country/Entity: Philippines

Name of Project : Primary Health Care Financing Project

Number of Project : 492-0371

1. Pursuant to Section 103 of the Foreign Assistance Act of 1961, as amended, and in accordance with my authority as delegated by Redelegation of Authority No. 133.1, as amended on April 15, 1982, I hereby authorize the Primary Health Care Financing Project for the Republic of the Philippines (Cooperating Country) involving planned obligations of not to exceed $10,000,000 in loan funds and $2,000,000 in grant funds over a five and one half (5.5) year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is five years and six months from the date of initial obligation.

2. The Project consists of support for selected primary health care services and support for research and experimentation in ways to improve the long term financial viability of the health care system by increasing community participation in financing primary health care services.

3. The Project Agreement which may be negotiated and executed by designated Mission staff and executed by myself, the Ambassador, or someone acting in my position per the authority so delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. a. Interest Rate and Terms of Repayment.

The Cooperating Country shall repay the Loan to A.I.D. in U.S. Dollars within forty (40) years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The Cooperating Country shall pay to A.I.D. in U.S. Dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three percent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Goods and Services.

Loan-financed goods and services, except for ocean shipping, under the Project shall have their source and origin in the Cooperating Country or in countries included in A.I.D. Geographic Code 941 and

grant-financed goods and services shall have their source and origin in the Cooperating Country or in countries included in A.I.D. Geographic Code 941 except as A.I.D. may otherwise agree in writing. Loan-financed ocean shipping under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of countries included in AID Geographic Code 941 or the Cooperating Country; Grant-financed ocean shipping under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States or the Cooperating Country.

5. No waivers to A.I.D. regulations are required at this time.

Clearances:

Typed Name	Office Symbol	Date	Initials
John J. Dumm	OPHN	7/13/83	JJD by DC
Douglas Clark	DRAD	7/14/83	[illegible] for
Thomas L. Rishol	DCD	7/18/83	[illegible]
Harold W. Collamer	CO	7/21/83	[illegible]
Richard Rheda	PD	7/14/83	RER
George A. Laudato	PD	7/14/83	[illegible] for
Peter Davis	OD/PE	7/22/83	PD
Mary C. Kilgour	OD	7/26/83	MK

Signature: Anthony M. Schwarzwalder
Anthony M. Schwarzwalder
Director
USAID/Philippines

Date: 27 July '83

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I. SUMMARY AND RECOMMENDATIONS:

A. Costs

Total project costs are as follows:

AID

Grant	$ 2,000,000
Loan	10,000,000
Subtotal	$12,000,000

GOP

Counterpart Support	$10,900,000
GRAND TOTAL:	$22,900,000

B. Purpose

The Government of the Philippines has requested USAID assistance in carrying out its program of expanding primary health care throughout the country. The purpose of the Primary Health Care Financing Project is to increase access to and utilization of sustainable primary health care services managed and financed by communities and the GOP. The achievement of this purpose is expected to contribute to the achievement of a CDSS goal which is to reduce fertility and infant and early childhood mortality.

C. Description

To achieve the purpose three major project activities will be undertaken:

1. A variety of public and private organizations throughout the country will field test schemes in which communities will finance the delivery of health care services. It is necessary to test systematically different kinds of financing schemes to discover more about what people are willing to pay for, what they can afford, how to combine essential preventive and curative services effectively into health care packages, how financing schemes can be managed in rural settings, whether schemes positively influence health seeking and spending behavior and ultimately what effect these all have on health status. Approximately 24 financing schemes will be field tested by a variety of public and private organizations in rural areas throughout the country. This activity will be coordinated by the Philippine Council for Health Research and Development (PCHRD) which is a branch of the National Science and Technology Authority (NSTA).

2. A series of special studies will contribute to the government's ability to ensure the financial viability and overall efficiency of the health care system. Approximately eight major studies will be conducted on a variety of subjects related to health sector financing and the effectiveness of GOP programs. Like the financing schemes, these special studies will be contracted to appropriate institutions by the Philippine Council for Health Research and Development which will function as the manager of these studies.

3. The project will strengthen four of the Ministry of Health's service delivery support activities. These four areas are training of health workers, village pharmacies, PHC commodity support system and the information, education and communication (IEC) program for PHC.

D. Summary of Project Analyses

The analyses contained in the project paper conclude that the proposed project is technically, socially, economically, and financially feasible. Given the nature of the project, a cost-benefit analysis was not appropriate but in the economic analysis it was determined that the activities proposed in the project are likely to be more cost effective than alternative activities. The implementation plan is sufficiently developed to begin project implementation.

E. Waivers

No waivers are anticipated under this project

F. Statutory Requirements

All statutory requirements have been met. See Annex A for the statutory checklist.

G. Recommendation

That the project paper be approved and that AID assistance be authorized under loan and grant funding so that implementation can begin in FY 1983.

II. PROBLEM ANALYSIS

The Primary Health Care Financing Project is based upon an extensive analysis of the health sector in the Philippines which is spelled out in the Mission's Population, Health, and Nutrition Strategy (1980) and which was approved as part of the 1983 CDSS. It is incorporated in this Project Paper as Annex B. Further sector analysis, which largely confirms and reinforces what is contained in the Mission's PHN strategy, was carried out in 1982 by the World Bank with support from USAID, the Asian Development Bank, and the World Health Organization. What follows in this section is a brief explanation of the issues and problems identified in those documents that this project will help address.

The two major interrelated issues relevant to this project are: (1) critical primary health care services of reasonable quality are still inaccessible to many rural communities in the Philippines and (2) the cost implications of the central government's attempting to provide such services by itself are formidable and unrealistic. While data on and analysis of these problems are incomplete, enough information exists to warrant designing a project which will help produce further information and begin to explore solutions to these problems.

A number of studies in recent years have suggested that providing free health care to poor rural residents may not be achieving the goal of increasing the demand or utilization of those services among the target group. A thorough analysis of the demand for primary health care services published by Dr. Barry Popkin and associates[1/] revealed that rural residents, in the Bicol region at least, are far more concerned about the quality of services than with the cost, and that in general, people are far less sensitive to the costs in deciding where to seek care than might be expected.

These findings are supported by a smaller USAID-funded study undertaken by Dr. Theresita Lariosa of the U.P. Institute of Public Health[2/]. Rural people in Isabela province frequently bypassed free consultations at government clinics in favor of seeking out more costly private practitioners and traditional healers. The fact that even poor people are willing to pay for health services they feel are important and their concern with higher quality care (whether real or perceived) is further substantiated by an investigation conducted by M. C. Alfiler

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1/ Akin, Griffin, Guilkey and Popkin, The Demand for Primary Health Care Services in Low Income Countries: A Review and Case Study, 1982

2/ Lariosa, Theresita, Household Health Seeking Behavior and Expenditure Patterns for Primary Health Care in Cabagan, Isabela, July 1982.

of the U.P. College of Public Administration[3/]. Alfiler found that simple health care financing schemes have evolved in various places throughout the country in which communities collectively finance health services otherwise not conveniently available to them or when they are dissatisfied with existing services.

The Philippine Government health care system, however, is impressive by Third World standards. Ministry of Health-supported rural health units, staffed by government physicians, are found in a majority of municipal centers throughout the country. Barangay health stations staffed by a MOH-paid midwife have been established in a ratio of about one per six barangays. The MOH has also launched a nationwide primary health care program intended to raise consciousness in the rural areas about the need to adopt good health practices.

There is still, however, a service delivery gap in the sense that basic PHC services are not always available at the barangay level as conveniently as needed to make further improvements in health status, especially among mothers and children. In response to this service gap there has been a proliferation of single purpose part-time population and nutrition workers at the barangay level but programs have not been well coordinated, they are extremely costly, rely on external support, and service delivery gaps have persisted. While there were good reasons for creating largely independent vertical service delivery structures, there is general agreement now that a consolidated primary health care system makes more sense financially and technically. The central government, however, cannot afford to maintain adequately trained and compensated barangay health workers in every barangay in the country. Nor does every barangay necessarily need or want such a worker depending on their proximity to alternate services. Barangay residents have often been the passive recipients of free government programs and this has exacerbated the inefficiency and costliness of these programs.

The PHC Financing Project begins to address some of the affordability and accessibility problems in ways which are referred to in the Five-Year Philippine Development Plan (1983-87). The Plan recognizes these problems and states that the private sector and health insurance systems will be used to expand and supplement the services offered by government. The project offers a mechanism by which beneficiaries can begin to participate in financing health services in small scale, experimental ways and simultaneously strengthens the MOH's capabilities to provide the supporting services necessary for a good PHC system.

3/ Alfiler, M.C., Local Resource Utilization Schemes for Selected Community-Based Primary Health Care Projects in the Philippines, November 1982

III. DETAILED PROJECT DESCRIPTION

A. Project Goal

The GOP is committed to the overall goal of "Health for all by the year 2000." Within that context, the goal of this project, as well as USAID's overall health sector goal in the Philippines, is to reduce high fertility and high infant and early childhood mortality. The rationale for and developmental significance of this goal have been explained in detail in the Mission's Population, Health and Nutrition Strategy (April 1981) and in the Mission's FY 84 CDSS. The country's crude birth rate of 33/1000 is one of the highest in Southeast Asia. The general development as well as health implications of such a high birth rate need not be belabored here. The average infant mortality of 63/1000 live births,[4/] while comparatively low, disguises the marked variations by region and by socio-economic group. USAID has determined that, given limited resources, projects in the health sector must address the goal which has been identified as a key determinant in the general development of the country.

B. Project Purpose

The specific purpose of the project is to improve access to and utilization of sustainable primary health care services managed and financed by communities and by the GOP. There are two important assumptions regarding the linkage between the specific purpose of the project and the more general program goal.

1. It is assumed that an increase in the use of certain basic PHC services will result in lowered fertility and a decrease in infant and early childhood mortality. For instance, children continue to die from diarrheal episodes because they are not rehydrated in time, from pneumonia because they have no antibiotics and from measles because they have never been immunized. Malnutrition continues to be a major contributing factor to death from these causes because small children are weakened by insufficient food. A large number of these deaths could be averted by having ready access to the drugs, vaccines, education and health monitoring provided by a skilled PHC worker. Fertility rates continue to be high, partly because people do not have access to a continuous supply of reliable contraceptives from a trusted source and they often have a fatalistic attitude towards their own fertility. Providing a convenient supply of a good mix of contraceptives at the household level and a PHC worker who can provide advice, follow-up and encouragement is essential so that families can plan for births and make decisions about desired family size.

4/ National Census and Statistics Office, 1980 estimate.

2. It is assumed that the use of primary health care services will increase in direct proportion to access to such services, and that access can be assured only if much of the true cost of providing services is borne by the communities and beneficiaries themselves. The costs of providing totally 'free' services to every household in the rural areas of a country are formidable if the central government must assume the entire burden. Cost-sharing in an equitable manner and generating new resources for PHC at the local level will help assure that the central government is able to concentrate on providing elements of PHC which are difficult for households to obtain independently and will reduce waste of government resources on elements which the communities can obtain on their own. The quality of services and the demand for service have been demonstrated to be interdependent. People's ability to demand higher quality services also will be facilitated by their participation in financing those services. People will begin to take greater responsibility for their own health both individually and as a community which will lessen their dependence on external institutions.

C. Project Outputs

Three major interrelated project activities will be undertaken which will collectively result in improved access to, and utilization of, PHC services which are managed and financed by communities with support from the government. A variety of health care financing schemes, designed with help from the beneficiaries, will be tested in different parts of the country through private and public organizations. These schemes will demonstrate the advantages of relying on communities and the private sector to organize and manage their own primary health care (PHC) services with technical support from the government. Schemes also will suggest to the government ways in which the recurrent costs of PHC services can be shouldered by equitable cost-sharing arrangements among communities, the private sector and local government.

Simultaneously, the government's ability to provide technical support to the field in several important areas of primary health care will be strengthened through the project. These activities will focus on the following four areas: (a) improved training protocols for barangay health workers (BHWs) and midwives and improvements in the MOH's ability to provide technical guidance on their selection, training, support and retention, (b) the provision of the most useful equipment and supplies to BHWs with a system of resupply of expendable supplies to be provided by the communities, (c) improvements in the MOH's ability to give technical guidance to small private village pharmacies (botica sa barangay) so that appropriate PHC drugs and commodities are available commercially at the community level, and (d) strengthening of the MOH's mass media and public information campaign to promote selected PHC services.

Before these improvements can be made, more information is needed on the cost-effectiveness of the current MOH programs. The project will fund the background studies and investigations necessary to further refine the specific inputs listed above for strengthening the MOH's ability to support technically field operations. Other studies and policy analyses will be undertaken which look at financing issues in the health sector which, together with the community level information generated by financing schemes, will help the GOP make important decisions about future health sector investments.

The following provides a more detailed description of each of these three project components.

1. Health Care Financing Schemes

A financing scheme in this project refers to an organized mechanism for linking a set of primary health care services to a system of community financing of these services. It is necessary to test different kinds of financing schemes systematically because more information is needed about what people are willing to pay for, what they can afford, how to combine essential preventive and curative services effectively into health care packages, how financing schemes can be managed in rural settings, whether schemes positively influence health seeking and spending behavior and ultimately what effect all these have on health status. The information acquired from testing such schemes will be useful to both government and private organizations in their attempts to find cost-effective means for making primary health care services available nationwide.

The objective of this portion of the project is to pilot test health care financing schemes in a variety of settings and with a diverse group of institutions. The project will have a small grants program whereby organizations could apply for grants to implement proposed financing schemes. In many places throughout the country, small projects already exist which attempt to establish formalized ways of increasing community participation in the financing of health services. These projects were often organized by individuals willing to invest their own resources in obtaining alternate services who resided in areas where the people had inadequate access to government health services. In other cases, the projects were organized by religious groups or private organizations whose funding was limited; therefore, the project leaders were forced to generate resources from the communities to ensure continuation of the programs.

There have been some rural commercial enterprises and agricultural co-ops that have expressed interest in organizing health services for their members and some that are already doing so. Often these organizations are in a good position to establish social amelioration funds or support health services through funds generated by profits. They also have the basic administrative structure upon which health schemes can be built and therefore have greater capacity to manage schemes. Dr. Carl Stevens, during a consultancy in February of 1982, investigated the feasibility of establishing such schemes through agricultural co-ops (see Annex C).

Government institutions may also present proposals for financing schemes to support the recurrent costs of health programs. Innovative methods for increasing beneficiary participation in financing government health services will be particularly attractive as the project itself is designed to encourage that, eventually on a much larger scale.

The PHC Financing Project will award grants to institutions which present promising proposals for strengthening the financing component of their existing health care programs or for setting up new health projects with community financing schemes. Grants will range from $25,000 to $200,000 depending on the size of the scheme and the complexity of the components. In most cases grants will probably be within the $50,000-100,000 range. While the size of these grants appears to be substantial, adequate funding is essential to permit the careful design and monitoring activities which are important in an undertaking which is so new and experimental. For instance, institutions receiving the grants will be required to establish data collection systems to monitor changes in health seeking behavior and expenditures (and in some cases, data on health status changes) which will not be necessary once the impact of such schemes is better understood and documented. The social and cultural dynamics involved in establishing and operating schemes will also be documented. Once the "technology" of establishing and operating financing schemes is well-developed, the per capita costs of implementing them elsewhere on a larger scale will be considerably less. Cost-effectiveness and replicability issues will be examined for every financing scheme in advance of awarding the grants to ensure that the real costs associated with start-up and maintenance of the schemes are reasonable.

The kinds of organizations that would apply for such grants will include the following:

- Small rural enterprises, irrigation or trade associations, farmers co-ops, private employers, medium-sized agri-business

- Private voluntary organizations (Philippine Business for Social Progress, religious missions, Save the Children, Project Compassion, etc.)

- Government ministries or organizations (Ministry of Health, National Nutrition Council, Commission on Population, Development Academy of the Philippines, Ministry of Social Services and Development, Ministry of Human Settlement, etc.)

- Universities with community health programs, private hospitals

- Others - Population Center Foundation, Nutrition Center of the Philippines, etc.

The general criteria for selecting schemes were jointly formulated between USAID and the GOP Technical Working Group during the project design phase. These criteria are as follows:

a. Schemes must principally support primary health care services supplemented when possible by secondary-level services,

b. Schemes should be designed to include their membership in the development, support, and maintenance of the schemes,

c. Schemes developed must be affordable by the target group of people and offer an improvement in the current method by which people obtain health services,

d. Schemes should be designed to suit the management and administrative skills and build the capacity of the institution or individuals responsible for operating the scheme,

e. Schemes should include a package of preventive and curative health services. They must include services aimed at reducing high fertility and infant mortality. Schemes will be evaluated on the impact they have on utilization of those services.

f. Schemes must aim at maximizing the sustainability of the health project. Schemes which rely on large externally generated contributions for significant activities will not be considered.

g. While the project will fund a large proportion of the capitalization costs of setting up the scheme, the institution receiving the grant will be required to

generate 10% of the capital costs. Exceptions to this rule will be considered in cases where schemes are proposed by extremely indigent communities.

The detailed critieria for selecting schemes and the procedures for submitting proposals will be developed during the early months of implementation.

Grant funds will be provided for initiating schemes involving items like training for personnel, organizing the communities, setting up accounting systems, and buying initial commodities. Technical consultants, monitoring and evaluation activities, meetings and seminars will also be funded from grant money. Project funds will not be used to pay for the recurrent costs of maintaining the schemes. Each scheme should begin financing recurrent costs as rapidly as possible and existing government or private resources should of course be included where they exist. Most pilot projects should be planned for between one and three years.

Project administrators will attempt to solicit proposals from a variety of communities, some economically better off than others. Schemes will not be funded, though, for communities which already have access to adequate and affordable health care services by virtue of their location or economic status. Proposals should be solicited from a variety of geographic areas to avoid having one particular region receive a disproportionate number of the grants. An effort will be made to solicit proposals from the five regions where AID assistance has been concentrated (I, II, V, VI, VIII) particularly among organizations which have been strengthened through other AID supported projects (i.e., rural services centers, barangay water associations, tree growers associations, etc.)

The idea of providing the funds for financing schemes on a loan basis rather than as grants was considered and rejected for the following reasons: (1) much of the costs involved at this stage in testing financing schemes are related to developing replicable prototypes; individual organizations would probably be unwilling to bear those costs on loan basis; (2) the testing of schemes is a somewhat risky activity and the pressure to repay loans would discourage smaller organizations; (3) administration of this already complex project would be further complicated by having to manage loan repayments. After prototype schemes have been developed, other organizations could then apply for loans through commercial sources or GOP channels for starting up their own schemes.

Organizations which undertake financing schemes will be encouraged to put together health care service packages which include, at a minimum, selected PHC services which are known to

have a significant impact on fertility and infant and early childhood mortality. These services are family planning, immunizations, oral rehydration therapy, growth monitoring and nutrition advice for infants and preschoolers, early referral and treatment of serious respiratory diseases in young children, and prenatal delivery and postnatal care for pregnant women. Pre-project studies indicate that people are much more willing to pay for personal health services rather than broader public health activities. They also tend to spend more money on curative care than preventive care when there is a cafeteria approach to services. On-going financing schemes, however, have demonstrated that people will participate on a sustained basis in schemes which are essentially a package of services including ones which are more in demand than others. Convenience of the services and the skill of the health care providers are important determinants of utilization.

In recognition of these factors, schemes will attempt to combine services in attractive as well as effective health care packages. In some cases, this may require a greater emphasis initially on curative services with a plan for increasing the variety of services once the scheme becomes established and accepted. Financial considerations may also require starting with fewer services and gradually expanding.

Each of the financing scheme proposals should describe how the organization planning to implement the scheme will coordinate with local government officials in the area. Coordination with local government is essential for several reasons. a) The newly legislated "local government code" requires that Provincial Governors take responsibility for coordinating all development projects within their jurisdiction. b) Experience has shown that unless the local political leadership has been consulted and feels responsible for the outcome of a development activity, that the chances of having a successful project are considerably reduced.

The final outcome of this component of the project will be a series of financing schemes which have been tested and some of which will continue to function after the funding period. Because the progress and outcome of these schemes will be carefully monitored and evaluated, eventually the government will have a wealth of information upon which to make resource allocation decisions for future health care expenditures and to formulate policy regarding the nature of PHC programs. The financing schemes will also provide useful feedback regarding the kinds of financial participation most communities are able to sustain. Annex C presents a description of some sample schemes which may be tested during the life of the project.

2. Special Studies and Policy Analysis

The design of this project has stimulated considerable dialogue on the financial and organizational issues, described earlier in this paper, among GOP planners and policy makers. These discussions led to the conclusion that, before any major changes are instituted, there was a need to generate additional information on a number of topics. Some of the studies described below provide the basis for policy change; others will help in planning the technical details of the service delivery support component of the project. The types of studies to be conducted are as follows:

a. Public and Private Health Sector Financing

In the Philippines there are many institutions which provide health services of some kind within and outside of government. Many government ministries and special area development projects are responsible for providing health care. Chartered cities have independent health care systems. Commercial firms offer health insurance schemes or subsidized clinics for their employees. Private modern practitioners and traditional healers and birth attendants are found throughout the country. Religious organizations and private voluntary institutions provide a large variety of health and health-related services. The Medicare program is also becoming a significant part of the overall health care system.

Although some data exist on the magnitude and patterns of health care financing these organizations and individuals provide, this information is found in dispersed reports and has not been systematically organized or analyzed for its implications for the future costs and structure of the Philippine health care system. Many industrialized countries currently have severe cost containment problems in their large health schemes because the future implications of the kind of funding employed were not well understood.

In some areas in the Philippines, private and public health service programs compete with each other or duplicate services, and in other areas neither kind of service is adequate. Government planners will be in a better position to identify underserved areas and avoid wasteful duplication if data can be developed for the total sector. Cost containment problems suffered by some countries can be avoided in the Philippines if policy makers are made aware of the negative long-term implications of encouraging certain unrestricted insurance programs or concentrating investments in tertiary care facilities.

Project funds will be utilized for a large-scale financing study to be conducted by Filipino economists and financial analysts with leading international consultants employed at critical junctures to provide insights gained from similar studies in other countries. The baseline information gathering phase of the study will begin in July of 1983 using Mission PD&S funds and will be continued during the project. The general terms of reference have been developed jointly by the MOH, NEDA, OBM, economists from U.P. and USAID in a workshop on the subject held in April 1983.

The results of this study will be useful to the National Economic and Development Authority, Medicare program administrators and Ministry of Health. Planning for the study, interim reports and the final results will involve planners and policy makers in all three of these organizations. The results should form the basis of decisions made about the expansion of the Medicare System, MOH coordination with the private sector delivery system, and the magnitude and nature of future public sector health investments.

b. Botica sa Barangay Operations

One of the important PHC services the MOH has been developing is to ensure that reasonably priced, essential drugs are available in each barangay. The MOH provides ₱1000 ($100) of start-up drugs for privately owned sari-sari store (village stores) or boticas set up by health workers with instructions that the drugs should be sold at least at a 10% markup on the original price to allow for restocking from commercial suppliers. There have been many problems associated with restocking with inappropriate drugs, not having reasonable restocking supply points, and lack of financial and bookkeeping expertise by botica managers. As a result many boticas have not remained viable drug purchasing entities for barangay residents beyond the initial few months. The MOH's reliance on the private sector for the provision of essential drugs is an appropriate policy especially when, in many other developing countries, one can see ministries of health trying unsuccessfully to make drugs available as the village level in a fully subsidized manner. It is important to ensure that this private system works properly. The small botica owners clearly need some technical and managerial guidance which can be funded through the MOH and which will result in an improvement in their ability to make essential drugs available.

The project will finance a thorough investigation to diagnose the exact problems encountered by botica sa barangay operators and recommend measures for making boticas more commercially viable. Pre-project studies have shown that there is a large demand for drugs at the barangay level and that often rural people resort to self-treatment using drugs purchased "over-the-counter" from local pharmacies. It is important that the village pharmacy owners have appropriate drugs in stock and that they are able to provide some patient education on the use of drugs and the need to seek consultation from health personnel. Consultants from marketing firms and pharmaceutical companies, working with the government health care administrators on such a study, could be an extremely useful way of utilizing private sector expertise to achieve a government development goal. The study will include recommendations for how the MOH should manage the activities provided for in the service delivery support component of the project which are required to assist boticas.

c. BHW Program Assessment and d. Midwife Performance Analysis

Because public resources for health care in general are limited, it is important that public services be as cost effective as possible. The Ministry of Health would like specific information on the cost and effectiveness of the current midwife and Barangay Health Volunteer programs (i.e., cost to the government in relation to: the retention rate of the workers, effectiveness of selection, training and supervision, and impact of the workers on rural communities).

Because the BHW program is relatively new, insufficient information exists on the strengths and problems of the program. There are a variety of other barangay health workers being trained and deployed by private organizations, local governments and foreign-assisted projects. These programs have different methods of selecting, training and compensating their workers. Most of these programs have been documented and compared in a compendium prepared by the University of the Philippines College of Public Administration. Cost and effectiveness comparisons between many of these programs, which to date have not been attempted, can help the MOH provide the best possible technical guidance to the field on matters related to training and deployment of BHWs and the guidance will be based on solid evidence from the collective experience of several organizations. Similarly the MOH midwives are very important providers of PHC services but more thorough

documentation and analysis of their performance in the field is needed.

Both the BHW and Midwife program studies can be performed simultaneously. The outcome of the BHW investigation should be recommendations for how to strengthen the selection, training, supervision and retention of these workers as well as the kind of equipment and supplies they should be provided with to function effectively. The outcome of the Midwife Performance Analysis study will be information on what kinds of in-service training is needed and how to improve their ability to supervise BHWs, handle referrals from BHWs and serve as the link between BHWs and the next higher level of care (Rural Health Units).

The results of these two studies will help guide the way in which the BHW and Midwife Programs are strengthened and improved. The detailed scope-of-work for these studies will include recommendations for how to ensure smooth management of the specific activities to be undertaken in strengthening those programs. The section describing the service delivery support component provides further detail on what the activities are likely to be.

e. Herbal Drug factories

In the last several years, there has been a growing interest in making better utilization of efficacious herbal remedies some of which have been used for centuries by traditional practitioners. Fairly extensive clinical trials and bio-chemical studies have been undertaken to determine which herbs are useful and what dosages are effective. Two small tablet and ointment processing centers have been set up and are producing, in small quantities, Philippine FDA-approved herbal preparations.

There is a general recognition that, in order to interest private firms in becoming more involved in processing herbal preparations and promoting these products as a lower cost substitute for certain modern drugs, economic and marketing analysis would need to be undertaken to determine the desirability of moving into larger scale production and distribution. The recommendations emerging from this study should help the GOP encourage appropriate private sector investments in this area as well as promote the backyard cultivation of herbs which can be used without dosage requirements (mostly topical applications).

f. Alabang Vaccine Laboratory

Vaccines for the Philippine Expanded Program on Immunization (EPI) have been procured largely from overseas at considerable expense. Several years ago the GOP felt that these vaccines could be produced locally at much lower cost and plans were made to construct a vaccine production laboratory. UNICEF provided all of the necessary equipment and the building construction was started. Today the construction is only partially complete. The MOH and NEDA would like to undertake several studies to determine whether the laboratory should be completed and what role the private and public sectors should play in vaccine production and distribution. Studies would include a determination of exactly which vaccines should actually be produced locally and which will still need to be purchased abroad. Engineering designs and plans need to be completed on the building and recurrent cost analyses need to be done to enable the MOH to budget for the laboratory operations if studies show that the government should produce certain vaccines. These studies would then enable the GOP to seek donor assistance to complete the laboratory. Since vaccines are such an important part of primary health care and since the potential cost-savings could be substantial in local production, the project will provide the funding to undertake these studies.

g. Assessment of Referral Facilities

The maintenance of adequate referral systems and logistical services to support primary health care programs are given high priority by the MOH. The MOH is currently undergoing an administrative reorganization which will give regional and provincial health offices much greater responsibility and which will administratively consolidate hospital and public health services. District hospitals (small primary level hospitals) are now responsible for supervising and supporting Rural Health Units. The support includes not only logistical support but also provides the referral linkage and laboratory support. Many of the hospitals and Rural Health Units lack basic equipment and many of the staff lack adequate management training to perform these functions effectively. The project will therefore provide for technical assistance to determine exactly how the referral and laboratory support functions could be improved, the training that is required, the kind of basic equipment that is lacking and whether facilities need to be upgraded. This kind of information will allow the MOH to plan ways to improve their PHC support function in the future, redirect resources into regions which are currently most in need of such improvements and secure donor assistance in funding the upgrading of facilities.

h. Cost-effectiveness Studies

Funds will also be set aside for a series of smaller studies dealing with the cost-effectiveness of various service delivery programs and PHC service support mechanisms. It is very important for planners to know whether the investments made are having the intended outcome. In most cases, this would involve looking at programmatic outputs rather than specific changes in health status. For instance, the effectiveness of a sanitation program would be measured in terms of numbers of functional toilets existing in a village rather than by reduction in diarrheal disease morbidity. In some cases alternative approaches need to be considered where the effectiveness of a program in meeting expected targets is demonstrated to be very poor for the amount of money expended. Programs such as the MOH's current oral rehydration packet production could be examined to determine whether some private sector entity may be better suited to produce and market that product. In many instances, cost-effectiveness analyses can help planners decide on which alternative program method to choose.

Management of Financing Scheme Grants and Special Studies

The administration of the grants program for financing schemes and the research/studies portfolio of this project will be a very time-consuming process and will require intensive management by an experienced institution. Therefore, the management of these two components of the project will be the responsibility of the Philippine Council on Health Research and Development (PCHRD) which will perform this function on behalf of the MOH. PCHRD is the branch of the Philippine Government's National Science and Technology Authority (NSTA) responsible for establishing health research priorities for the national government, channeling research funds into the appropriate fields and coordinating all research undertaken in the country. (See Administrative Analysis)

The functions of the PCHRD staff who managed this activity will be to: (1) stimulate the development of good proposals for financing schemes, arrange for technical assistance to help organizations design or evaluate schemes, arrange for timely review and approval of scheme proposals and monitor implementation of schemes; (2) prepare, in coordination with the MOH and NEDA, detailed terms of reference for the research and special studies, contract with the appropriate people or institutions to undertake the research, present research findings back to the GOP and follow up on how research results are used.

The PCHRD management staff will report research findings to a Project Advisory Group which will replace the Policy Committee and

Technical Working Group both of which were established by NEDA to manage the design of this project. The Policy Committee for the project design was made up of the Minister of Health, Minister of Budget, the Director General of NEDA and the Chief of the Presidential Commission on Reorganization (PCR). The Technical Working Group was composed of staff from each of those GOP units. The Project Advisory Group, with similar membership, will continue to provide policy direction during project implementation.

3. Service Delivery

The Ministry of Health has launched a nationwide primary health care program starting first with barangays which have a resident MOH midwife and gradually extending to other barangays within the midwife's catchment area. The emphasis of the PHC program at this stage has been on what is termed "social preparation" which is in fact a form of community organizing. Barangays stimulated by the midwife, assess their total development needs and form a plan of action for achieving their development goals.

The MOH anticipates a great increase in the demand for basic health services at the barangay level as the national PHC program gradually spreads. So far, the accessibility of essential health services for rural barangay residents is not uniform. Barangays having resident MOH midwives are better off than others. The catchment area for each midwife is still too large to make her services truly accessible to the more remote or distant 5-6 barangays that she is supposed to serve. Distances and lack of adequate transportation into the poblacion (municipal center) where the rural health unit and private practitioners are located present formidable obstacles to utilization of those services.

The MOH is also launching a massive training program for Barangay Health Workers who are volunteer mothers charged with monitoring the health conditions in their neighborhoods. They are felt to be important in creating awareness of health problems and promoting good health practices. There is, however, a general recognition that, while these workers are volunteers and therefore receive no salaries from the government, there are considerable costs associated with training, supervision, commodity support, etc. Keeping the costs of such programs in line with the expected benefits to the rural people is very much the motivating factor for the MOH's undertaking the assessments and improvements planned in this project. The service support activities included in the project are planned in a way that allows the MOH to use the research findings to guide the nature of the resources invested in these activities.

The project will help strengthen the MOH's ability to support health service delivery at the barangay level in four major areas:

a. The botica sa barangay program, will receive managerial and technical assistance to ensure that boticas become commercially viable outlets for essential drugs, contraceptives and PHC commodities. It is hoped that the boticas can become reliable supply points for contraceptives and oral rehydration packets, as well as essential drugs. The kind of assistance necessary is anticipated to be: the development of a formulary for essential generic drugs which can be distributed to botica owners or managers at the time the start-up drugs are given to them, training sessions to improve their bookkeeping and financial management skills, assistance in finding better ways than they are currently using for restocking drug supplies from commercial outlets, and training to enable them to provide better patient education on the use of basic drugs.

   The MOH estimates that approximately 10,000 boticas and their managers can be helped through this project. The study which precedes the detailed design of this component will identify the regions in greatest need of assistance in their botica programs. Activities will be coordinated through the regional and provincial health offices. Specific kinds of activities undoubtedly will be contracted to organizations with expertise in bookkeeping, finance and marketing. The budget item set aside for this activity roughly estimates the cost of the technical assistance, training and MOH management assistance necessary to cover the targeted 10,000 boticas.

b. The MOH barangay health worker and midwifery programs, will be provided assistance to strengthen them in the areas in which weaknesses are identified. It is anticipated that major changes in the training curriculum and methodology will be required for both kinds of workers including the development of training protocols which could be distributed to each of the 12 regional health offices. For the BHWs, the training protocols will be for preservice and in-service training while, for the midwives, it would involve the in-service training of existing personnel. (See the technical analysis, section VII.A.).

   Since the supervision and support systems and motivation and retention factors will also be scrutinized in the study of these two cadres of workers, funds are made available to initiate improvements. Training in supervision techniques for nurses (who supervise midwives) will be required.

Procedural manuals to improve the support services to midwives from the RHUs and district hospitals will be developed. Recommendations on technical guidance from the central MOH office on matters related to the selection and performance of both BHWs and midwives will emerge from the studies. The project will fund the specific technical assistance or workshop needed to provide this guidance to the 12 regional offices.

The outputs of this project activity will be new training and supervision protocols for BHWs and midwives, and other technical guidance in the form of procedural manuals, workshops and training sessions. Through these improvements, the effectiveness of BHWs and midwives in relation to the costs of the programs should be dramatically improved.

c. It is well recognized that primary health care workers need access to certain basic PHC commodities and equipment to function effectively and maintain professional credibility. In various health care programs in the country, barangay health workers are provided with kits containing emergency supplies such as simple drugs, oral rehydration salts, alcohol, dressings, thermometers and so on. The items contained in the kits usually correspond with the skill level and training of the worker and the health problems they are expected to address.

Given the MOH's desire to examine the cost-effectiveness of their BHW program and given the probable changes in the training program to be introduced through this project, the exact contents of the kits will be determined after the study of the BHW program is undertaken. The MOH currently estimates that it costs roughly ₱200 ($20) to provide one worker with the most fundamental supplies (including the cost of a durable kit). The communities are responsible for restocking the kits with the expendible items. Project money and GOP counterpart funds have been budgeted for PHC commodities for these kits to be purchased locally once the research is complete. The system for the distribution of these kits will be recommended in the BHW program assessment.

d. The final service support activity involves strengthening the public education and mass media aspects of the national primary health care program, which the MOH calls its information, education, and communication (IEC) program. Many of the IEC materials currently available are outdated or produced overseas and therefore not very relevant. The project will fund the production of new materials aimed at rural audiences in the Philippines to promote selected PHC

services which are known to have a greater impact on fertility and early childhood mortality. Radio programs and films strips will be developed to encourage child spacing and use of effective family planning techniques, the proper utilization of locally produced oral rehydration packets, promotional campaigns for the immunization program, breastfeeding and nutrition, the proper use of herbal remedies and promotion of various generic drugs. Most of the design and film production work will be contracted to private firms by the MOH's IEC unit, although a small amount of film equipment will be purchased for the IEC unit itself.

The Bureau of Quarantine in the MOH has recently been given greater responsibility for health education because the MOH has realized that the captive audiences on inter-island ships could be reached with health education messages fairly inexpensively. A large proportion of the Philippine population of all ages travel on inter-island ships throughout the year. Most of these vessels are equipped with movie or video machines to entertain passengers. The Bureau of Quarantine will be funded to develop and pilot test short videotaped messages on primary health care to be used on the ships.

In addition to supporting these central IEC production activities, the project will provide funds to each of the 12 MOH regional training centers for the production of IEC material in the languages found in each of those regions. These materials will include radio messages, films for local theaters, and written materials (comic books, leaflets). Distribution of the materials will be done through the health personnel who come in for in-service training sessions and various meetings.

Detailed implementation planning for the IEC activities will begin immediately. Actual implementation will begin as soon as FY 84 funds become available.

4. <u>Relationship among project components</u>

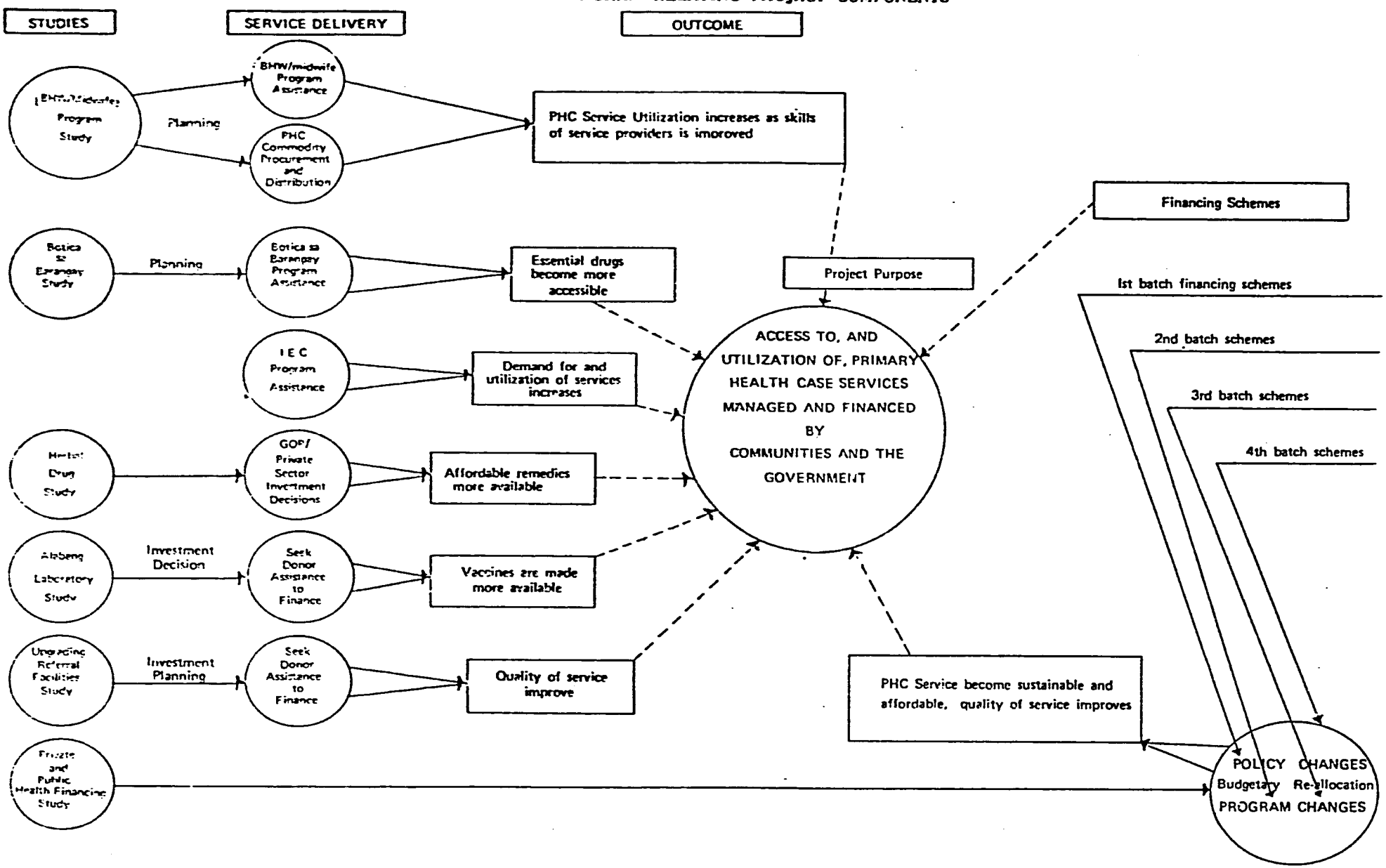
The relationship between the research and the service delivery components is obvious. The relationship between the financing schemes and the other two components is perhaps less directly obvious and deserves some discussion.

The research undertaken on the selection, training, support, and retention of primary health care workers will be useful for those who are designing health care financing schemes. Improvements in the botica sa barangay program including items such as the development of basic formularies, systems for

restocking drugs from commercial outlets and training of pharmacy aides will be useful technology for schemes which include boticas. The mass media campaigns will also help promote utilization of the services offered through the financing schemes. MOH field workers undoubtedly will be important elements in some of the financing schemes in some areas, so improvements in their performance will be advantageous. Just as important, or more so, will be the impact of the lessons learned about service delivery and the financing of PHC which will be acquired by testing financing schemes and which will influence the government system. Financing schemes may demonstrate the value of having private entities or local government units actually administer health care systems. Schemes will demonstrate how the people can be involved in supporting the recurrent costs of health care, especially primary health care, and may lead to a better cost-recovery system for publicly financed services. Knowing what people are willing and able to pay for, and what they are not, will also lead the government to concentrate its support for elements of care which will be difficult for the individual community to finance by itself.

The learning experience among the entities undertaking the implementation of various elements of the project will depend on proper recording and dissemination of the knowledge acquired in each component. Because the project addresses the critical issue of how to deal the recurrent costs of primary health care, the results of the research and experimentation in the project will be of interest to neighboring countries. The project sets aside considerable resources to fund workshops, seminars, and travel to observe different elements of the project. GOP officials and government officials from other ASEAN countries will be invited to observe financing schemes and participate in workshops and other fora where health care financing issues are being discussed. The research findings will be widely distributed and discussed at the workshops and conferences. Many of the institutions and experts involved in conducting the research will also be used as consultants to design financing schemes or evaluate them. Opportunities to achieve cross-fertilization of ideas and lessons will be maximized through implementation of the project. Specific plans for doing so will be planned in detail during the early implementation stages of the project.

SCHEMATIC DIAGRAM RELATING PROJECT COMPONENTS



D. Inputs: (AID-Funded)

1. Financing Schemes Grants Program (Illustrative List)

Scheme Type	Organization	Funding	Number	Total
Rural enterprise based scheme	Small rural industries	$75,000	4	$ 300,000
Service association based scheme	Irrigation service associations Barangay water associations	$75,000	2	150,000
Hospital associated PHC schemes	Small private or public hospitals	$150,000	3	450,000
Agricultural Co-op based health insurance	Area Marketing Cooperatives	$200,000	3	600,000
Medikong Bayan type scheme	Private Insurance group	$200,000	1	200,000
Cost recovery schemes on GOP PHC services	MOH, MSSD NNC, POPCOM	$ 75,000	4	300,000
Hacienda health schemes	Coconut or Sugar Planters Associations Local unions	$150,000	1	150,000
Community cooperatives/ associations	Consumer co-op, Mothers clubs, Day Care Centers	$ 50,000	4	200,000
Municipal government health schemes	Mayor's Office, Municipal Development staffs	$100,000	2	200,000
			24	$2,550,000
Administrative Costs				450,000
				$3,000,000

2. Special Studies

a. Private and Public Health Sector Study	200,000	
b. Botica sa Barangay Study	50,000	
c. BHW Program Assessment	200,000	
d. Midwife Performance Analysis	50,000	
e. Feasibility for Herbal Drug Factory	100,000	
f. Feasibility: Alabang Vaccine Laboratory	100,000	
g. Assessment of referral facilities	200,000	
h. Cost-effectiveness studies	100,000	
i. Administrative Costs	150,000	$1,150,000

3. Service Delivery

A. Botica sa Barangay Program	2,000,000	
B. BHW/Midwife Programs	1,600,000	
C. PHC Commodities	2,600,000	
D. IEC	1,300,000	7,500.000

4. Other Support Costs

(Participant training, Policy and Technical Group meetings, short courses, workshops)	300,000

5. Project Evaluations 50,000

Project Total: $12,000,000

Summary Financial Table (5.5 years)
Primary Health Care Financing Project
($000)

Component	USAID Grant	USAID Loan	USAID Total	GOP MOH	GOP PCHRD	GOP Total	TOTAL (GOP&AID)
1. Financing Schemes	950	2,050	3,000	-	532	532	3,532
a. Grants to Institutions	900	1,650	2,550	-	-		2,550
b. Administrative Costs	50	400	450	-	532	532	982
2. Special Studies	1,000	150	1,150	-	168	168	1,318
3. Service Delivery		7,500	7,500	10,200	-	10,200	17,700
a. Botica sa Barangay Program		2,000	2,000	1,000		1,000	3,000
b. BHW/Midwifery Programs		1,600	1,600	3,000		3,000	4,600
c. PHC Commodities		2,600	2,600	1,200		1,200	3,800
d. IEC		1,300	1,300	5,000		5,000	6,300
4. Other Support Costs	-	300	300	-	-	-	300
5. Project Evaluations	50		50				50
TOTALS	2,000	10,000	12,000	10,200	700	10,900	22,900

IV. RELATIONSHIP TO OTHER PROJECTS AND OTHER ACTIVITIES IN THE SECTOR

The Project is the logical successor to a significant amount of A.I.D. activity in the health sector* going back many years. It represents the Mission's effort to consolidate much that has been learned and established in a single project that will be the principal operational manifestation of A.I.D.'s support in the sector for the next several years.

Five recent and contemporary A.I.D.-assisted projects form the background for the Primary Health Care Financing Project: Population Planning II and III; Panay Unified Services for Health (PUSH); Bicol Integrated Health, Nutrition, and Population; and Food and Nutrition. Some of these have dealt explicitly with the local financing issue, and all five have been concerned with establishing selective PHC services at the barangay level.

Population Planning III represents the Mission's current assistance to the Government for financing of the vertical population and family planning program which AID has supported for more than a decade. PP III provides a broad spectrum of support for the program's service delivery system. Incorporated in the project design is a gradual phase-out of AID support for recurrent local costs, mostly field salaries and transportation. By the year following completion of the project -- that is, from 1986 -- the Government is to bear 100 percent of the recurrent local cost burden. The Mission believes that as the Government struggles to find ways of bearing this burden with partly locally generated funds, it will inevitably look at integration of services as one alternative that could make the burden easier to bear. The PHC Financing project is intended, in part, to help the Government examine and gain experience in alternative financing mechanisms that could be employed in support of on-going health, nutrition and family planning programs.

PUSH and the Bicol project were designed to demonstrate that full-time paid village-level workers will prove sufficiently valuable, and therefore attractive, to local governments that they will be prepared to absorb the full cost of supporting these workers. The PUSH project, which is further along in implementation, covers the first three years of salary support for the Barangay Health Workers, after which the provincial governments become responsible for these costs. The evidence from both projects thus far is encouraging. The retention rate of BHWs is exceptionally high. A mid-project evaluation of PUSH revealed strong community and local government support for the workers and a high level of satisfaction with the service they are providing. Most of the first 50 workers are now being paid by the local governments and the prospects are good that local government support

* We define the sector to include population and nutrition.

will continue. However, it is equally clear that full salary support for the BHWs will become an ever more onerous burden as the number of BHWs increases. For that reason, PUSH is now planning to experiment with cost sharing of salaries between local governments and the beneficiaries themselves. Likewise, a process evaluation of the Bicol Project, completed in May 1983, found that the Barangay Health Aides were performing their duties well and were well-accepted by their communities. There is evidence that the local governments will pay for the stipends on schedule. Given the enormous recurrent cost implications of salaried BHWs, however, the current MOH policy encourages the use of volunteer BHWs.

As a precursor to the PHC Financing Project, an operational research study, funded by ST/Health's PRICOR project, was initiated on Panay island to test financing schemes in as scientific a manner as possible. Extensive health seeking and spending behavior data were collected in both experimental and control areas before a small number of financing schemes were actually tested. The impact of the schemes on people's utilization of and satisfaction with the services is being measured carefully. The PRICOR project will provide very useful guidance to PHCF project administrators.

Finally, the Food and Nutrition Project (FNP), which concluded in 1981, produced considerable basic information on the extent, causes, and treatment of malnutrition and undernutrition in the Philippines that can be incorporated in the PHC Financing project. The PHC Financing Project looks at maternal, infant, and young child nutrition as being of critical importance in the general effort to overcome high fertility and infant mortality in the Philippines. Many of the techniques that were discovered and tested under the FNP will be applied in the service packages included in financing schemes. Among these are breastfeeding, regular weighing, nutrition education, administration of oral rehydration, home vegetable production, and instruction in food preparation and hygiene.

In summary, the predecessor activities to the Primary Health Care Financing project in the Philippines, many of which were A.I.D.-supported, established technically sound, administratively feasible approaches to various aspects of primary health care. Their greatest deficiency was in their failure to make adequate provision for long-term financing and their inability to really alter the vertical service delivery structures which are in place today, in part because of AID and other donors. The strength of this project is that it reflects the GOP desire to look at these issues analytically and to test solutions on a limited scale to gain the knowledge and experience needed for wider application. The Project seeks to capture what is best, technically and administratively, about past and current activities, and to help the Government and local communities explore ways of sustaining them on a self-financing basis, free from long-term dependence on external resources.

V. PROJECT RELATIONSHIP TO AGENCY'S POLICY INITIATIVES

A. Institutional Development

The institutional development focus of this project is building the capacity of existing rural institutions to enable them to manage health service programs for their members through financing schemes. The project will also improve the Ministry of Health's ability to provide technical guidance and support to the field and the Philippine Council on Health Research and Devlopment (PCHRD)'s ability to function as the policy analysis and health services research center for the country.

In each of the financing schemes, existing community organizations will be given assistance to enable them to become managers of health services for their members. In most cases, the organizations will be well-established and have some other principal mandate, as would be the case with irrigation associations, farmers cooperatives, rural enterprises, and so on. These organizations would be provided whatever initial assistance it takes to make them capable of managing a simple health care package for their members. In reviewing grants to these institutions, great care will be taken to ensure that the capacity to manage the financing schemes becomes a permanent function of the organization and not just an ad hoc task undertaken for the duration of the funding.

The MOH as an institution will be strengthened in the four areas of service delivery support described earlier in this paper. Its ability to provide sound technical guidance to the regional offices on matters related to the training, supervision and support of PHC workers and public education on selected primary health care services will be greatly enhanced by the research and service support activities.

And finally, the PCHRD will be strengthened by the experience it will gain in managing the grants program for the financing schemes and managing the research portfolio of the project on behalf of the MOH. PCHRD now has the mandate to plan health services research and policy analysis but has been handicapped by insufficient funds to operationalize much of that mandate. The project will help them move toward becoming the national focal point for health research in the area of service delivery and policy analysis. It will also strengthen the institutional linkages between the Ministry of Health, PCHRD and academic institutions throughout the country which are involved in health sector research and development activities.

B. Policy Dialogue

Policy changes usually happen gradually and are stimulated by an accumulation of evidence that indicates a need for change. The PHC Financing Project will begin to provide this kind of evidence with regard to primary health care financing issues. One of the important features of the project is that the Policy Committee which guided the project design will be reorganized into an Advisory Group, made up of senior officials from MOH, NEDA, PCHRD, OBM and Finance to oversee implementation. Project issues which affect national policy can be debated by this Advisory Group. In fact, in the process of project design significant policy debate at the Ministerial level has already occurred.

Much of the research planned in the project was requested by the MOH precisely to examine the basis of existing policy and programs in the area of primary health care. Analyzing the cost-effectiveness of certain approaches to service delivery may result in fairly major changes in the way the GOP views its role vis-a-vis service provision. The current policy of providing free public health services through rural health units and barangay health stations may be modified as more is learned about what rural people can afford to pay and for what services they are willing to pay. GOP officials are aware that their record on cost-recovery for health services is gradually deteriorating and that the budget allocations for the MOH are not likely to increase dramatically in the near future. A demonstration of how private resources and community financing can help pay for the recurrent costs of health care will free up GOP resources for endemic disease control programs and other efforts which cannot be community financed.

C. Private Sector

The GOP recognizes that a great deal more can be accomplished if private and public resources for health care are properly coordinated and therefore has included strengthening private sector participation in health as a strategy in the 5-year Philippine Development Plan for 1983-1987. One of the objectives of the PHC Financing project is to increase private sector participation in the health sector because doing so is viewed as an important means for helping assure the long-term financial viability of the health care system and for moving toward providing better access to primary health care services for the people.

One of the major constraints to increasing private sector participation has been the lack of information on the flow of private health care resources in the country. The introduction of the MEDICARE program in the early 1970s stimulated the rapid expansion of the private sector since some 75% of its benefits are disbursed for privately provided services. Approximately

two-thirds of the physicians in the Philippines work in the private sector.

The project includes a major health care financing study which will begin to provide GOP planners with information about the distribution and fee structure of private practitioners, the coverage of private facilities, the health care expenditures of all government entities and other information which should facilitate decisions on how to exploit the strengths of the private sector. The project will also demonstrate through the financing schemes how private, profit and non-profit, organizations in the rural areas can be used to provide important primary health care services to barangay residents in an affordable way. Eventually this should result in a decrease in MOH resources devoted to actual service delivery.

Other aspects of the project may also lead to an increase in private sector participation. The feasibility studies for the herbal drug factory and the Alabang vaccine laboratory will investigate, among other things, the financial viability of such factories and desirability of utilizing commercial firms for these activities. Improving the botica sa barangay program will not only be focused on boticas which are generally privately owned village stores, but will also use technical assistance from private commercial firms to make those boticas more commercially viable.

D. Recurrent Costs

This project responds directly to the issues raised in the AID Policy Paper on Recurrent Costs (May 1982). The Policy Paper points out that in the past foreign assisted projects in many countries were not successful in the long run because although the projects provided the capital, the host country was eventually left to shoulder the heavy burden of recurrent costs necessary to maintain the activity. In the past in the Philippines, AID has paid for certain recurrent costs in AID-assisted health projects with a phased plan for the GOP assuming those costs over the life of the project. It is increasingly evident, however, that government, on its own, will never have adequate resources to finance the recurrent costs of a primary health care system which provides high-quality services to all communities in the country.

The PHC Financing Project represents the GOP's and AID's recognition of the need to find alternate financing mechanisms for primary health care. The concept of shifting responsibility for the managing and financing of health services from central government to the communities is consistent with the GOP's (and WHO's) definition of primary health care. The project provides for studies which will help policy makers make informed decisions about what kinds of investments the GOP needs to make and what kinds of

expenditures should be the responsibility of the private sector or individual citizens. Testing financing schemes will demonstrate how rural communities can generate the resources necessary to handle the recurrent costs of primary health care and reduce their dependence on government. The results of this Philippine experimentation in community financing of primary health care should be valuable not only to planners in this country but also to those in neighboring countries who are facing similar financing problems.

E. Health Assistance Policy

Every element of the PHC Financing Project is consistent with the emphasis in AID's new health policy as described in the Health Assistance Policy Paper (Dec. 82). The basic objective of AID's health programs is to assist developing countries in becoming self-sufficient in providing broad access to cost-effective preventive and curative services. Improving the effectiveness of health programs and promoting self-financing of those programs are stated to be important strategies for achieving the overall objective. The PHC Financing Project employs both strategies. Health services research and special studies have been designed to find out how to make current government health programs more cost-effective and how to make public and private sector resources complement each other to achieve improvements in health status. Based on the results of these studies, current GOP programs will be strengthened and improved to make them more cost-effective than they currently are. These improvements will be made in the four major areas of primary health care described earlier in the paper. In addition a major theme of the project is to explore self-financing for health programs as is obvious from the title.

F. Women in Development

In the health field Filipino women traditionally have been active participants. Not only are they career professionals, para-professionals, and traditional practitioners but they are also policymakers. This is due in part to the high literacy rate of women. The literacy rate in the Philippines is 90% and it is significant that the sex difference is minimal.

Both females and males of all ages and social status within the rural communities will have the opportunity to benefit from financing schemes developed under this project. A basic assumption is that women, infants, and young children will be primary beneficiaries of all the service delivery schemes developed and tested under the project and that eventually evolve from it. Infants and pre-schoolers, in particular will benefit from immunizations, oral rehydration therapy, and nutritional advice given to their mothers. Women will receive specific benefit from

services such as pre-natal care, post-natal care and family planning.

Women in the rural communities will be actively involved in the development and design of financing schemes. Since women will be the major beneficiaries of the service, they have a stake in the outcome of the schemes, how they will be designed, and the cost. It is generally accepted that women in Philippine society either have control or at a minimum, have equal responsibility with their husbands on how income and resources are spent.

In this project several research studies will be undertaken that will provide GOP planners and policy makers with the information they need for refining the service delivery component of this project and the current MOH service delivery program. These studies and the implementation of the findings will impact directly on women as service providers. Specifically these women are the BHWs, midwives and most of the Botica sa Barangay owners. They will receive managerial and technical assistance, and training; and therefore it is expected that their roles as service providers will be enhanced.

VI. IMPLEMENTATION PLAN

A. Administrative Arrangements and Analysis

A Project Advisory Group, to be chaired by the Minister of Health and composed of senior representatives from OBM, NEDA, PCHRD, Finance and other agencies, will provide major policy direction in the implementation of the project. Both the Policy Committee and the Technical Working Group which functioned as the key design units for this project will be transformed into the Advisory Group which will be active throughout the project implementation.

The Ministry of Health will have overall responsibility for project implementation, with the Minister of Health acting as ex-officio Project Director. The Primary Health Care (PHC) Unit within the Office of the Minister will serve as the project management office and will perform the required management functions for project implementation. The Chief of the PHC Unit will act as the Project Manager who will oversee project operations on a day to day basis.

Although the MOH is the lead implementing agency, its direct implementation responsibilities will be concentrated on the service delivery support component of the project, which includes the following activities: Botica sa Barangay, BHW and Midwife training programs, IEC and PHC commodity support. Field implementation of the service delivery support component will be undertaken by the field units of MOH, i.e., the Regional Health Offices, Provincial Health Offices and Rural Health Units. MOH central support units such as the Bureau of Quarantine, the Office of Health Education and Personnel Training and the PHC Unit will also have direct implementation activities, within the context of their major role of providing the necessary support to the field units. All of the MOH offices mentioned, both field and central, are existing and functional.

The implementation of the special studies and testing of financing schemes components of this project will be managed by the Philippine Council for Health Research and Development (PCHRD) on behalf of MOH. PCHRD is a government body created by Executive Order which operates under the auspices of the National Science and Technology Authority (NSTA). Its mandate is to formulate and coordinate the implementation of a national health research and development program, with the purpose of establishing firm linkages between R&D activities and service programs. (Annex D provides a more complete description of the PCHRD organization).

MOH and PCHRD will enter into a special memorandum of agreement, which will stipulate the latter's responsibilities and

organizational relationship with MOH. The Research Management and Development Department (RMDD) of PCHRD has been identified to serve as the project management unit for the components that will be managed by PCHRD, with the RMDD Technical Director serving as the project manager. The RMDD is already existing and functional.

Following is a listing of the basic implementation responsibilities of the participating organizations:

1. Project Advisory Group

   a. Provides guidance on implementation policy matters.

   b. Reviews and recommends approval of the terms of reference for the special studies.

   c. Reviews and recommends approval of the criteria and procedures to be followed in the solicitation, review and approval of proposals for testing financing schemes.

   d. Reviews and recommends approval of the implementation plans for the service delivery support activities.

   e. Undertakes periodic review and assessment of the pace and quality of project implementation.

2. Ministry of Health

   Project Director/Primary Health Care Unit

   a. Provides overall direction of project implementation activities and insures that targets are accomplished within set timetables.

   b. Effects the procurement of supplies, equipment, services and other commodities needed for project implementation.

   c. Participates in the formulation of the terms of reference for the special studies.

   d. Participates in the preparation of the criteria for procedures to be followed in the solicitation, review and approval of proposals for testing of financing schemes.

   e. Assumes responsibility for the preparation of the detailed implementation plans for the service delivery support activities.

   f. Prepares and submits the necessary technical, financial and progress reports as called for in the implementation plan and Project Agreement.

g. Prepares and submits to OBM requests for budgetary appropriations needed for project implementation.

OHEPT (Office of Health Education and Personnel Training)

a. Provides technical support in the planning and implementation of the IEC sub-component of the project.

b. Provides technical support in the formulation of the terms of reference for the BHW and midwife performance study and in the planning and implementation of activities to improve BHW and midwife preformance.

Bureau of Quarantine - designs and implements the special IEC program for interisland ships.

Regional Health Offices - participate in the planning and undertake the implementation of service delivery support activities in targeted regions, provinces, municipalities and barangays and the preparation and submission of required project monitoring reports.

3. PCHRD

a. Assumes responsibility for the preparation of the terms of reference for the special studies and the criteria and detailed procedures for soliciting, review and approval of proposals to test financing schemes.

b. Solicits and reviews technical and cost proposals and awards contracts for the special studies.

c. Solicits, reviews and awards proposals for the testing of financing schemes.

d. Provides technical assistance in the preparation of proposals of financing schemes and during the actual testing such as the conduct of feasibility studies, designing management systems for financing schemes, evaluation of schemes, etc.

e. Designs and implements a monitoring system to keep track of ongoing studies and financing schemes.

f. Effects the procurement of equipment, supplies, services and other commodities that may be required to implement the special studies and testing of financing schemes components of the project.

g. Prepares and submits to OBM requests for budgetary appropriations for funds needed to implement the components of the project for which it is responsible.

h. Prepares and submits technical, financial and progress reports as called for in the implementation plan and Project Agreement.

4. NEDA

a. Is the official GOP agency responsible for all project documentation involving USAID and the GOP.

b. Participates in the Project Advisory Group.

5. OBM

a. Participates in the Project Advisory Group.

b. Insures that budget allocations are requested on time and that project-related funding problems and financing policy issues receive priority attention.

6. USAID

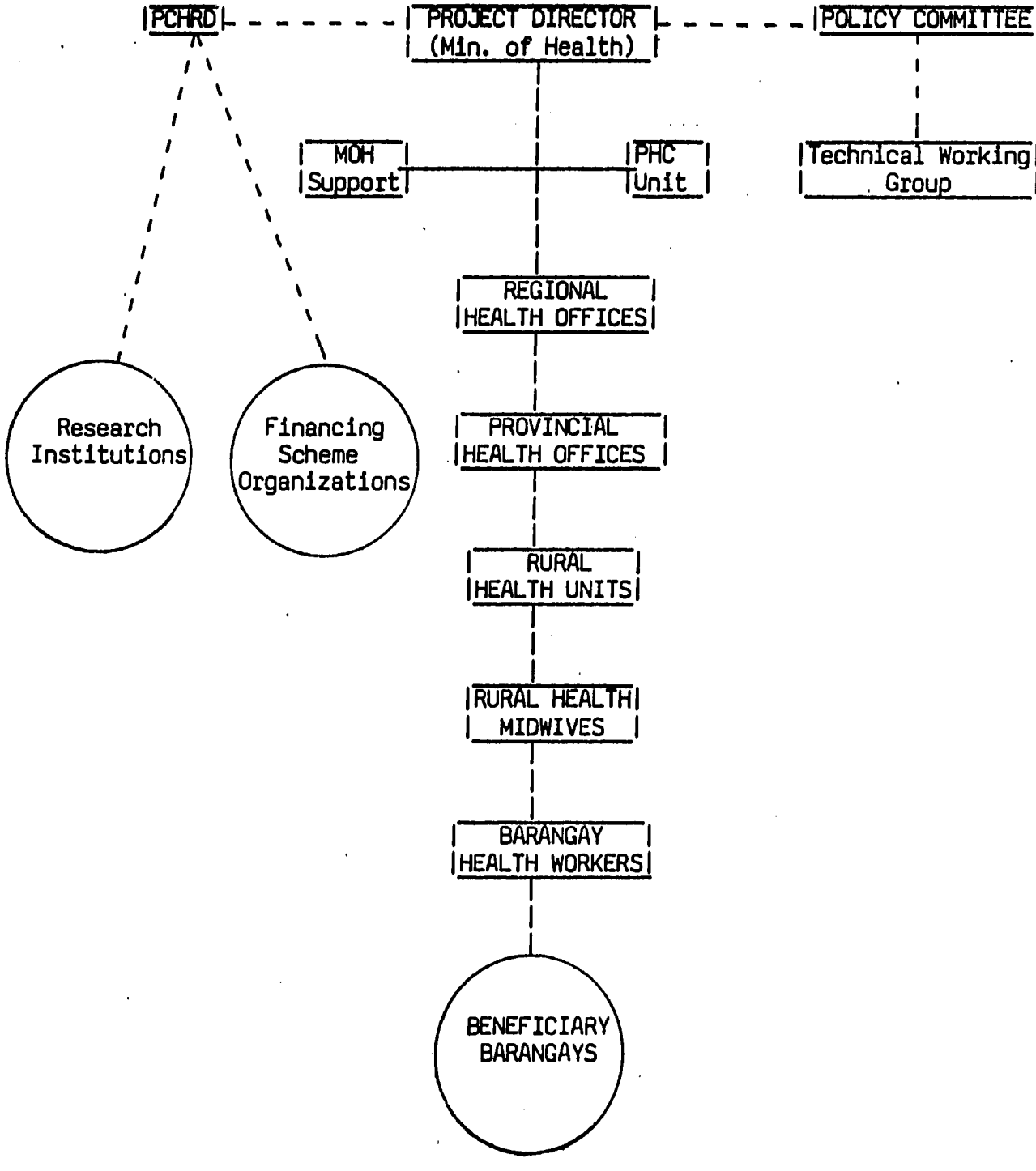
a. Provides funding as specified in Project Agreement.

b. Monitors project operations to insure that project implementation is in accordance with the terms and conditions of the Project Agreement.

c. Provides assistance in the procurement of goods and services as needed and requested by the implementing units.

d. Performs the necessary evaluation and audit as called for in the Project Agreement.

PHCF PROJECT ORGANIZATION



Although PHCF is a complex project conceptually, its management systems are simple and feasible largely because of the division of responsibility between the two major agencies involved in project implementation. The MOH, as the lead implementing agency, will concentrate on managing the larger component of the project which is the service delivery component. The project does not require any restructuring of the existing management units within the MOH but simply provides them with means for strengthening and refining functions they are already performing. Furthermore, the special studies will look into managerial weaknesses of the service delivery system. The strengthening of the specific management areas identified as weak will form part of the implementation plan and have been included in the funding for each of the service delivery support activities.

The implementation of the special studies and testing of financing schemes, which constitute the smaller but more complex portion of this project, will be managed by PCHRD. Because of its mandate, PCHRD is the natural institution to carry out the special studies and testing of financing schemes components of PHCF. These are R&D activities designed to strengthen and find more cost-effective ways of implementing the national PHC program and to explore viable mechanisms to increase the availability and utilization of PHC services on a sustained basis. PCHRD has a proven track record of administering health research grants and is staffed by leading luminaries in the area of health research. A major rationale for the creation of PCHRD was the establishment of a mechanism by which R&D findings in the area of health could be applied to policy and program changes. It has a collaborative rather than a competitive relationship with MOH.

There is adequate assurance that the collaborative relationship will function as envisioned. Since 1978, the World Health Organization has been encouraging ministries of health to collaborate with allied institutions to service their R&D requirements. Most ministries of health are organized around their main function of service delivery and find it more efficient to use external institutions to manage their research needs. The research agenda in this project was developed by the MOH staff and therefore the outcome of the research will be most useful to them. PCHRD serves as MOH's implementing arm, providing technical quality control and management of the research process.

As stated earlier, PCHRD will not actually perform the research itself. The research will all be contracted to qualified individuals and institutions. There is no shortage of qualified institutions in the Manila area which have the capability to undertake the research planned for this project. Whenever possible, PCHRD will make an effort to involve institutions in other regions of the country because it is part of its mandate to strengthen research capabilities outside of the Manila area.

In performing its functions of establishing research priorities and reviewing and approving research proposals, PCHRD works through a three-level multisectoral committee system. The first level is the Technical Committee on which the MOH is represented by the National PHC Coordinator. The intermediate level committee is the Program Planning Review Board whereon sits the Chief of the MOH Planning Service. Finally, at the Governing Council of PCHRD, the MOH is represented by its Deputy Minister. The system is an excellent example of academicians, government personnel and private agencies working collaboratively to find answers to questions which are needed by health planners and project administrators.

The presence of an AID Mission in the Philippines provides additional assurance that project management problems will be minimized. An AID project officer, assigned specifically to this project, will monitor constantly the pace and quality of implementation and will provide assistance in anticipating potential implementation problems and bringing these to the attention of project implementors.

B. Detailed Implementation Schedule

Before project implementation begins, USAID will fund a workshop to develop a detailed implementation plan for the project. The workshop will be attended by personnel from MOH, PCHRD, NEDA, OBM and USAID. At the same workshop, the management plan for the IEC activities to be implemented by the MOH will be developed. This management plan will form the basis of the first reimbursement agreement to be signed by USAID and NEDA. The implementation plan will be submitted to USAID for concurrence as it is one of the conditions precedent to disbursement. When all conditions precedent have been met, project activity can officially begin.

After the project units are organized and the implementation systems and procedures agreed upon, MOH, PCHRD and USAID will formulate the detailed terms of reference for the special studies component of the project. The studies on the BHW program, Botica Sa Barangay and midwife performance will be given immediate priority because the detailed planning and implementation of the service delivery support component of this project (with the exception of IEC) will be guided by the initial findings of these studies. PCHRD has a well-established mechanism for soliciting proposals for research topics, reviewing them and awarding grants. The Program Planning Review Board, an interagency group, is responsible for reviewing projects technically (or arranging for an external peer review for proposals outside of their technical expertise) before final approval is granted by the PCHRD Governing Council. Studies in this project will undergo the same review process. (See Annex D) The first set of special studies is expected to begin in January of 1984 and be completed by August, 1984. The second set of studies will begin in September, 1984.

Workshops will be convened to discuss the findings of the first set of studies which affect the service delivery component of the project and implementation procedures for each service delivery activity will be developed. These implementation plans will then form the basis for the reimbursement agreement to be signed between USAID and NEDA.

The service delivery activities, i.e., the BHW and Midwife Programs, the Commodity Support and the Botica sa Barangay Program, will begin by October of 1984 after the 1984 Supplemental Appropriation is released. The implementation of the IEC component can also commence any time after the appropriation becomes available. The sequence of activities in implementing the service delivery component will be influenced by the findings of the studies. In general, however, the kinds of activities will be as follows:

Botica sa Barangay

- consultants hired
- drug formularies developed
- training sessions for botica owners planned
- Regional Health Directors briefed
- planning activities started in priority regions (as recommended in studies)
- training sessions in each province conducted
- start-up commodities purchased and distributed to regional offices

BHW/Midwife Program

- development work on new training protocols for BHWs and in-service training for midwives
- printing of training protocols for the 12 regions
- supervision and logistical support procedural manuals developed, reproduced and distributed
- nurse supervisor training organized
- regional workshops organized to discuss BHW selection, compensation and support topics
- supervision and assessment teams organized to monitor implementation

PHC Commodities

- standard kit contents list developed and distributed
- commodities ordered
- kits distributed to regional offices
- methods for ensuring community resupply of commodities developed and guidelines distributed

IEC

- Bureau of Quarantine contracts awarded for the production of PHC films for interisland ships
- films tested and evaluated
- IEC equipment ordered
- IEC Unit (within OHEPT) develops the content of PHC materials to be contracted out for professional development
- Regional Health Training Centers submit plans and budgets for the development of written, radio and film campaign for PHC
- messages are developed, reproduced and distributed
- effectiveness assessed

A total of approximately 24 grants will be awarded for the testing of PHC financing schemes. PCHRD will advertise the grants program through a brochure which will provide the details on how to submit proposals, the criteria for selecting the financing schemes, the financial accountability requirements and so on. An institution will be selected to evaluate the schemes. (see p. 77) The detailed procedures will be agreed upon in advance by PCHRD, MOH and USAID. PCHRD staff will then travel to sites where financing schemes could be initiated to talk about the program and encourage institutions to submit proposals. Consultants, hired by PCHRD, will provide assistance in developing financing scheme proposals and in conducting feasibility studies. When proposals are received, they will be reviewed by PCHRD's Health Service Technical Committee composed of economists, social scientists and public health specialists to ensure their economic, social and technical viability. After necessary revisions are negotiated, the first set of four schemes will be ready for funding in September, 1984. The process is then repeated.

USAID will not be involved in the review and selection of each of the studies or financing scheme proposals. USAID's participation will be limited to helping plan the terms of reference for the studies and the selection criteria and procedures for awarding financing scheme grants.

The 24 PHC financing grants will be awarded in four batches. The first batch of four grants will be awarded in September of 1984; the succeeding batches will be awarded at 6-month intervals. Each of the schemes to be tested will have its own evaluation plan, which will be undertaken towards the end of the testing period. In January of 1986, a workshop will be organized to which members of other Asean countries will be invited to discuss the results of initial experimentation with financing schemes and the findings of the health sector financing study.

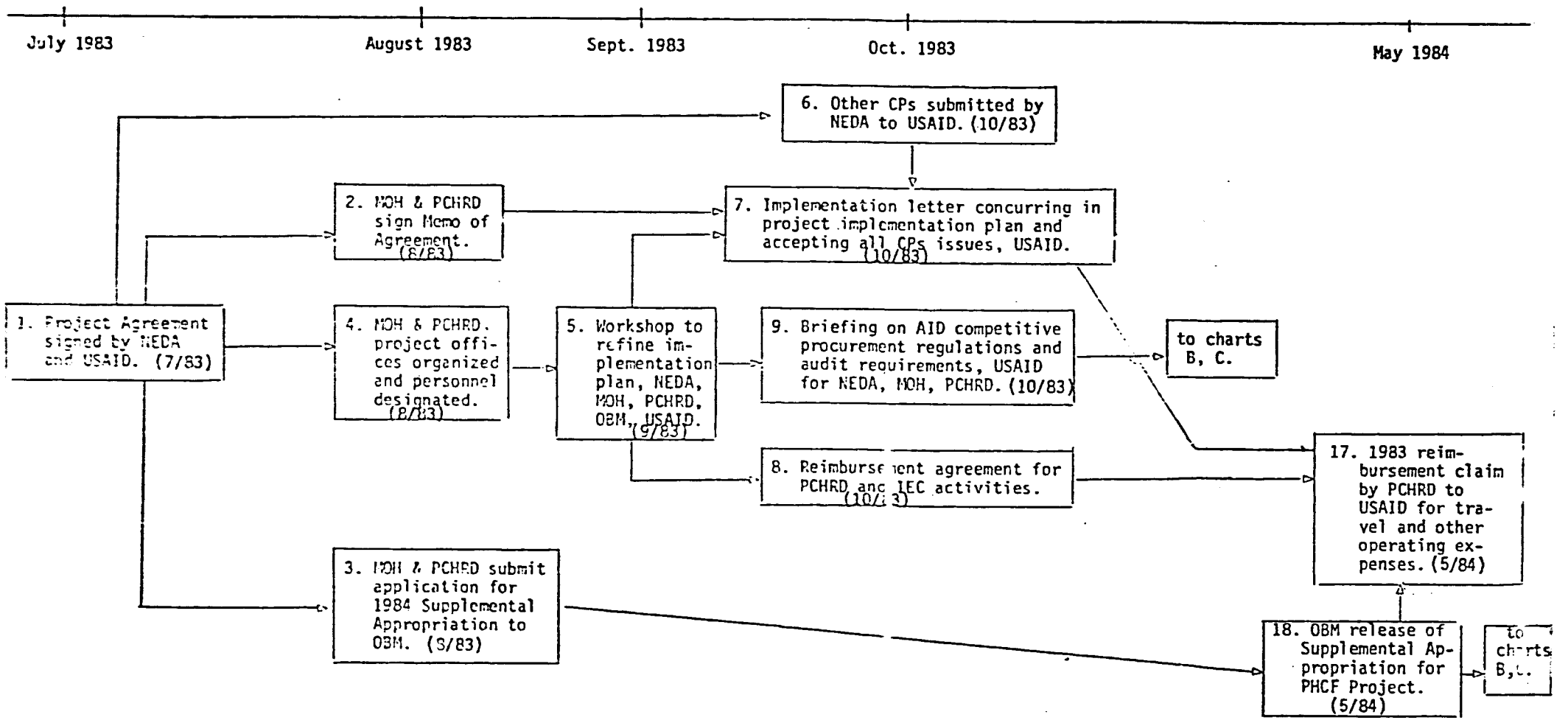
The first overall project evaluation will be conducted around July, 1985, or after an elapsed operational time of two years. Final project evaluation will be completed in November of 1988. The findings of the evaluation and the whole project experience will be

discussed at a national workshop which will be convened towards the end of the project. Based on the project's experience, the workshop will formulate policy recommendations to further strengthen the country's PHC program.

The following is a flow chart of project activities with more detail presented for the first 18 months of the project.

GENERAL FLOW CHART FOR PRIMARY HEALTH CARE PROJECT

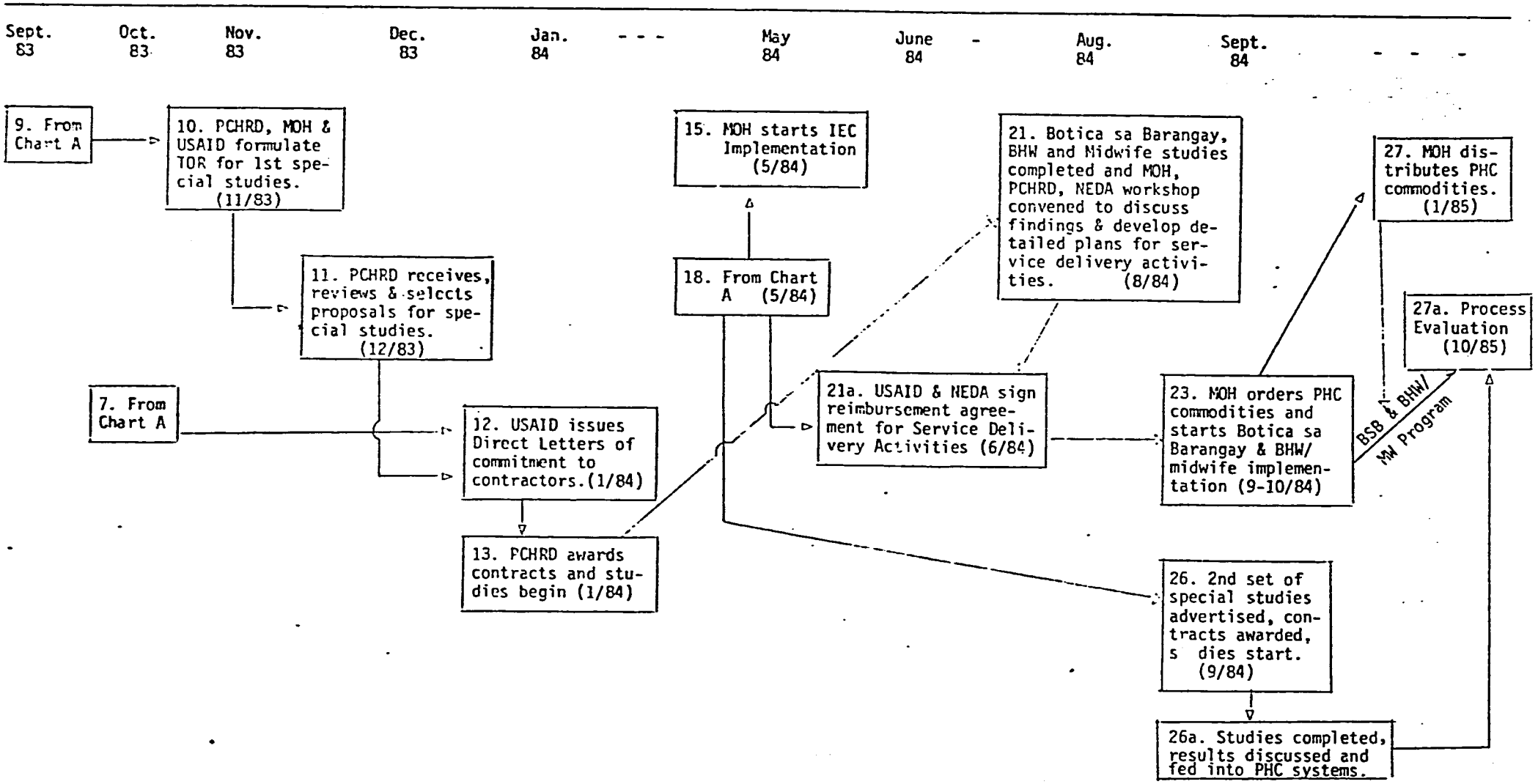
CHART A



PRIMARY HEALTH CARE FINANCING

FLOW CHART FOR SPECIAL STUDIES & SERVICE DELIVERY COMPONENTS

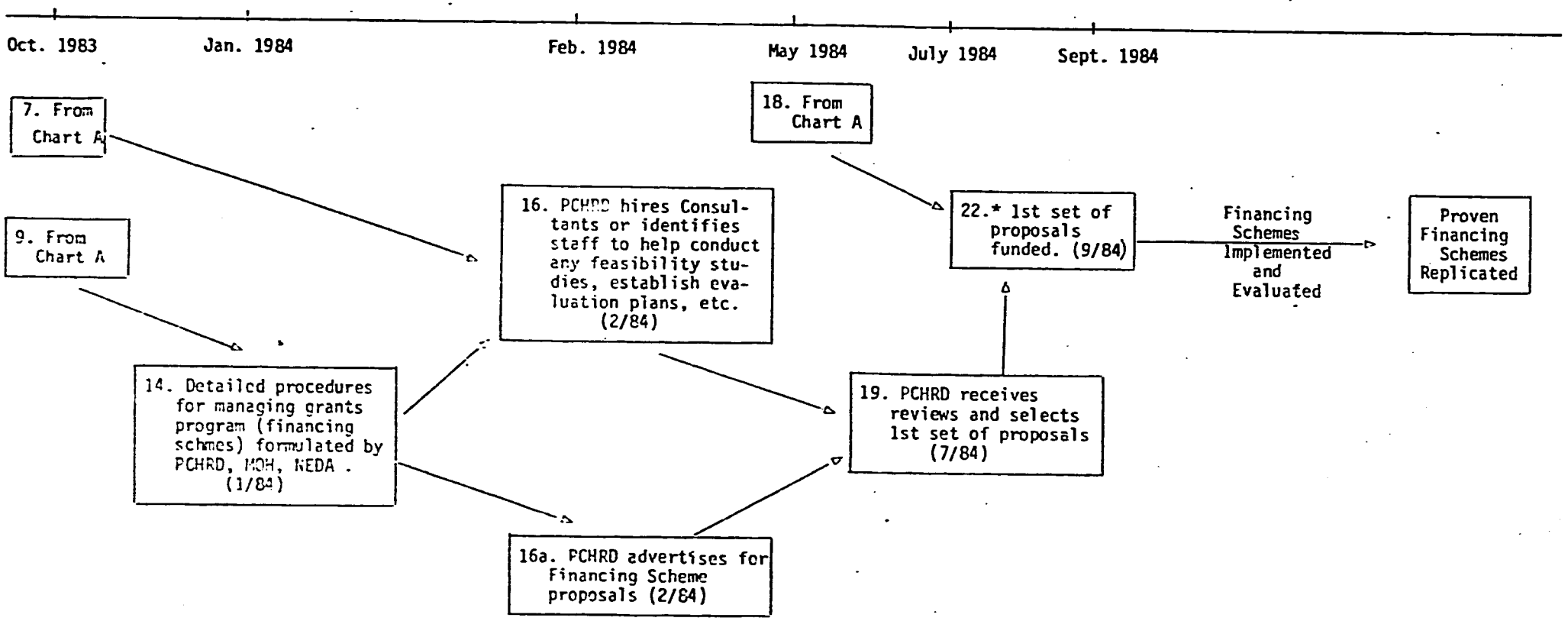
CHART B



PRIMARY HEALTH CARE FINANCING

FLOW CHART FOR TESTING OF FINANCIAL SCHEMES

CHART C



*2nd, 3rd, and 4th sets of proposals funded using same procedure.

C. Financial Plan and Analysis

1. AID Project Budget

AID will be contributing over the life of the project a total of $12.0 million, of which $2.0 will be in grant funds and $10.0 will be in loan funds. Scheduled for obligation during fiscal year 1983 is $9.800 million (all of the grant money and $7.800 of loan); the rest of the AID input, $2.200 million loan, is planned to be obligated in fiscal year 1984. A 10% inflation factor and contingency costs have been built into the costing of each project element.

The major project components and their estimated costs to AID are:

			Percent of AID Project Cost
1. Financing Schemes		$3,000,000	(25.0%)
a. Institutional grants	2,550,000		
b. Administrative Costs	450,000		
2. Special Studies		1,150,000	(9.6%)
3. Service Delivery		7,500,000	(62.5%)
a. Botica sa Barangay (Village Pharmacies)	2,000,000		
b. Barangay Health Workers/ Midwife Programs	1,600,000		
c. PHC commodities	2,600,000		
d. Information/Education/ Communication (IEC)	1,300,000		
4. Other Support Costs		300,000	(2.5%)
5. Evaluation Costs		50,000	(0 4%)
Project Total		$12,000,000	(100.0%)

2. Government of the Philippines (GOP) Contribution

The GOP is contributing a total counterpart of $10.9 million to the project from two sources: the Ministry of Health and the Philippine Council for Health Research and Development of the National Science and Technology Authority. This contribution amounts to 47.6% of the project's total budget, more than

satisfying the statutory requirements for counterpart share. The GOP funds will cover expenditures for recurrent costs (salaries, travel, operating expenses) to oversee the pilot testing of the health care financing schemes and conduct of the special studies, as well as the implementation of the service delivery activities. Financing of the latter will be from Ministry of Health funds, a combination of in-kind and direct budgetary contributions to cover personnel, facilities, training, commodity procurement and other operational costs. Direct budgetary contributions to the PHCF project from both PCHRD and MOH in the form of new GOP appropriations are estimated to be $2.550 million.

The GOP Contribution is budgeted as follows:

				Percent of GOP Project Cost
1.	Financing Schemes, Technical Assistance and Administrative Costs		$ 532,000	(4.9%)
2.	Special Studies, Administrative Costs		168,000	(1.5%)
3.	Service Delivery		10,200,000	(93.6%)
	a. Botica sa Barangay Program	1,000,000		
	b. BHW/Midwife Programs	3,000,000		
	c. PHC Commodities	1,200,000		
	d. IEC	5,000,000		
			$10,900,000	(100.0%)

The financial tables found in Annex E present in detail the scheduling of inputs to the project from AID and GOP by project component, as well as estimates of annual expenditures.

3. Financial Management of the Project

The Technical and Economic Analysis Sections of the project paper describe its innovative aspects, its emphasis on research, experimentation, and institutional capacity building. The financial management methods, however, will follow normal funding procedures employed by the GOP and the USAID. In general, all loan and grant funded foreign exchange costs will be financed through either direct or bank letters of commitment issued to suppliers or direct payment under direct

or host country contracts for technical services. Local costs, on the other hand, will be financed primarily through direct reimbursements and/or reimbursement agreements. In exceptional cases, USAID direct local currency payments to local suppliers will be used.

The timely influx of adequate funds is crucial to successful project implementation as it is imperative that project activities be synchronized and that all parties to this project understand both GOP and AID budget processes and mechanisms. The MOH and PCHRD have trained financial management staffs who have experience with foreign donor-assisted projects and are knowledgeable of the concomitant budgetary requirements and procedures. Furthermore, it is expected that the OBM representative on the Project Advisory Group will ensure the timely submission of necessary budgetary documents.

Since the Project Agreement is expected to be signed in July 1983, long after the 1984 GOP budget has been finalized, initial GOP funding for this project can only be expected in mid-1984 through a supplemental appropriation from the Foreign Assisted Projects Support Fund or Lump-Sum fund. Accordingly, the financial plan has been designed so that the initial financing scheme activities and special studies, which determine the projects service delivery component, will be grant funded with all payments to be made directly by AID. Such payment to nongovernmental institutions are classified as grants-in-aid and do not require a GOP appropriation.

PCHRD has the capacity to manage its responsibilities in the project without hiring any additional staff. However, the project will fund the use of a variety of consultants and will fund meetings and workshops and other operating expenses. Due to its role as the primary health research and development agency of the GOP, PCHRD has a unique fiduciary responsibility. It is authorized to hold all income, grants and requests-in-trust in a revolving fund to be utilized for research and development. Because this fund does not have to be returned to the general treasury every year, PCHRD will be able to provide the counterpart and seed funds required to administer the grant-funded activities in the initial year.

The financial resources for each component of the Project will be managed in the following manner.

a. Special Studies. Once MOH and PCHRD have approved the final design of each study, the Research Management and

Development Department of PCHRD will execute a contract between PCHRD and the organization chosen to conduct each study. Since PCHRD is not expected to have a GOP appropriation to cover the studies in this project at the time implementation begins, if required, USAID will make direct local currency payments to the contractors. This will include, when necessary, the provision of mobilization funds to enable the contractors to begin work immediately upon contract execution. Profit making firms or organizations will not be eligible for mobilization funds.

Each voucher submitted to USAID for reimbursement will be cleared by PCHRD and a copy provided to the Primary Health Care Unit of the Ministry of Health. Unless otherwise stipulated, vouchers for reimbursement will be submitted to USAID no more frequently than once a quarter.

When PCHRD receives a Government of the Philippines appropriation for this project, it will assume responsibility for paying contractors directly and requesting reimbursement from USAID. USAID's disbursement in this instance, of course, will be made to the Treasury of the Philippines. Copies of all financial documents will be routinely sent to the MOH.

b. Financing Schemes. The detailed description of the process that will be used for contracting the financing schemes has been covered in the implementation plan. Fifty Thousand Dollars for financing schemes in 1983 and $250,000 of the $570,000 available in 1984 for financing schemes are grant funded. Since it is unlikely that PCHRD will receive a GOP appropriation to cover this grant expenditure in 1983 and early 1984, USAID will also make direct payments to the institutions or individuals that PCHRD will contract with to design financing schemes. The manner in which disbursements will be made and the accounting and reporting procedures are the same as those described for the Special Studies component of the project. When the first batch of financing scheme grants are awarded in September of 1984, PCHRD will have the GOP appropriation and AID can then reimburse the GOP for expenditures in accordance with normal procedures used in the Philippines. Given the relative complexity of the financing schemes, PCHRD will be providing as much technical assistance in financial management to implementing agencies as will be needed to ensure proper management of these resources.

With regard to the administrative costs associated with PCHRD's management of both the Special Studies and the Financing Schemes components of the project, USAID will

reimburse the GOP for costs agreed upon in each annual implementation plan. At this stage in the project design, it does not seem necessary that PCHRD will need mobilization resources to initiate management of these components. However, as long as the resources that are needed for this purpose are grant funds, USAID stands ready to release funds directly to contractors in order to begin timely implementation of the project. PCHRD will provide quarterly expenditure and project status reports to MOH and to USAID on these two components of the project.

c. Service Delivery. Since USAID's share of the service delivery component of the project is entirely loan-financed, Philippine Government financial regulations which govern the release and reimbursement of foreign donor loan resources will be strictly followed. USAID will not be able to release any loan funds unless these funds are covered by appropriations from the National Assembly. Therefore, unlike the arrangements planned for the Special Studies and early Financing Scheme activities, USAID will be unable to make "bridge" financing available for Service Delivery.

Therefore, the sequence of actions needed to finance the four service delivery activities will be in conformity with these Government procedures. Once MOH and USAID agree on the details of the implementation plan for the four service delivery activities through a PIL, a reimbursement agreement will be drawn up in which disbursement arrangements fitting each service delivery activity will be agreed to. The MOH will initiate the financing of each service delivery activity using GOP appropriations for this purpose. USAID will reimburse MOH for expenditures based on MOH's submission of expenditure reports at agreed-upon intervals. For instance, the Botica sa Barangay program may require quarterly reimbursements since it will be an activity with a variety of different and specific actions taking place over a long period of time. On the other hand, PHC commodities should be reimbursed under one voucher since all commodities will probably be procured locally at one time. The point here is that the MOH and USAID will work out the most efficient disbursement and reimbursement plan for each of the service delivery activities.

Most of USAID's resources for this project will involve local costs financing. O/PHN has a wealth of experience in administering and controlling resources for local cost. financing of population, health and nutrition services of the type that will be financed under this project. There

is a well-defined mechanism for reviewing and certifying vouchers in O/PHN and in the Mission's Controller's Office. In addition, the Mission has begun the process of using our computer facilities in broader ways to manage project-related financial data. It is expected that an appropriate computer program will be designed to track the financial management of this project.

D. Commodity Procurement Plan

1. Responsible Agency

The MOH will be ultimately responsible for all procurement actions for the project. However, because of their limited amount and value, it is envisioned that a U. S. Procurement Services Agency (PSA) will be utilized to purchase off-shore commodity inputs on behalf of MOH under a PIO/C issued by USAID. Payment for off-shore commodities will be made in accordance with AID regulations and practices. The agent will be selected by MOH in accordance with AID regulations and good commercial practices.

The bulk of the commodities to be purchased under AID financing are shelf-item purchases of small value. The MOH and the PCHRD will be responsible for the purchase of such items as they are needed for their respective project components.

2. Method of Procurement

All procurements will be accomplished in accordance with AID regulations and good commercial practices. Procurement will take place according to the schedule presented in Section H for off-shore procurement. Local shelf-item purchases of small value items may be made by MOH and PCHRD in accordance with local cost financing regulations contained in HB 1B, Chapter 18.

3. Waivers

No commodity procurement waivers are anticipated for project purchases at this time.

4. Source/Origin of Procurements

The authorized source/origin of commodities for this project is AID Geographic Code 941 except that indigenous goods and free world shelf-items may be purchased per HB 1B, Chapter 18.

5. Delivery

Delivery for commodities procured off-shore will be arranged by

the PSA. MOH will be responsible for port clearances. Receiving reports on all equipment will be furnished by MOH to USAID.

6. Markings

Commodities procured off-shore by the PSA will be marked with AID hand-clasp emblems by the suppliers/manufacturers. Locally procured items will be marked with like emblems which USAID Logistics Division will supply.

7. Pharmaceuticals

Any pharmaceuticals to be purchased under the project will be in keeping with AID Handbooks 1B and 15. They will be limited to those pharmaceuticals which are approved by the U.S. and GOP FDAs and determined safe, efficacious and not in violation of U.S. patents.

8. Procurement Schedule

a. Shelf-items

During the first year of implementation, MOH and PCHRD will develop a life-of-project list of small-value shelf items to be procured. This list will be subject to change if and when necessary. PHC commodities will all be purchased in the Philippines and will be ordered in October of 1984 so they will be available for distribution in the country by January, 1985. Commodities will include items such as: scissors, forceps, thermometers, Oresol (locally produced oral rehydration packets), vitamin tablets, bandages, alcohol, cotton, band aids, plaster.

b. Off-shore procurement

IEC equipment to be purchased overseas will be ordered as soon as the 1984 supplemental appropriation is received. These items will include projectors, film, and other audio-visual equipment.

VII. PROJECT-SPECIFIC ANALYSES

A. Technical Analysis

The focus of this analysis will be on the technical rationale for choosing each of the three project components, the reasons the inputs are phased as they are and the methods by which the knowledge acquired in the project will be documented. An important general point should be made, though, in advance of a more detailed discussion of the project components. Because of the innovative aspects of this project and because of its potential for policy reform in the health field, the project calls for a continuous 'design' process during implementation rather than a rigid, predetermined cookbook approach to implementation. Much of the work on the financing schemes will be experimental and therefore fairly risky. Certain problems have been anticipated and preproject investigations have been undertaken to minimize the risk. However, the design has allowed for flexibility in responding to problems which may be difficult to anticipate. The other reason for the design flexibility relates to the need to match the specific service delivery inputs to the outcome of the research. These aspects of the design are described in more detail below.

1. Financing Schemes

The rationale for testing various health care financing schemes has been discussed both in the Mission's population, health and nutrition strategy (Annex B) and earlier in this paper. High-quality, essential PHC services can only be sustained at the community level if the beneficiaries themselves assume a much greater role in managing the programs and in paying for the recurrent costs of the services.

While many private and government health projects in the Philippines have relied on community contributions of one kind or another, there have been relatively few attempts to institutionalize community financing mechanisms. Studies conducted in the Philippines within the last few years suggest that people are both willing and able to participate financially in health care activities. Several of those studies provide some background on such questions as: What kinds of practitioners do people seek out for various kinds of care? What influence do factors such as the cash costs of the service and the time and transportation costs have on the choice of practitioners? What kinds of services are people apparently willing to pay for? How much does economic status affect people's choice of practitioner?

Dr. Barry Popkin and associates[5/] reached the following conclusions based on analysis of data collected in the Bicol region. (a) The costs associated with medical care consumption are not important predictors of where treatment is sought. Consumers show little sensitivity to either cash or time costs for adult outpatient, child outpatient, prenatal, delivery, well-baby and infant immunization care. (b) The seriousness of the illness for outpatient care was the most important predictor of where care is sought. Seriously ill patients preferred private modern doctors. (c) For maternal and child care, the most important explanatory variables were the mother's education, urban residence, and a measure of the mother's time constraints. The authors conclude that policies which attempt to reach the rural poor through the provision of free rural clinics were not achieving their goal. For MCH services, the wealthier 40% of their sample used the free services much more than the very poor did.

Similarly, Dr. Lariosa[6/] of the U.P. Institute of Public Health, in a study conducted in northern Luzon, found that people often bypassed free government services in favor of self-treatment or to obtain services from private practitioners. Their preoccupation with the quality of care over the costs can clearly be seen in this study. Lariosa also found that people were much more likely to seek out curative care than preventive and preferred traditional practitioners for prenatal, delivery, and postnatal care, primarily for accessibility reasons.

Both the Popkin and Lariosa studies found that people sought health care from a variety of traditional, private and public practitioners depending on the nature of the illness and the convenience of the service. Expenditures for over-the-counter drugs and for nutritional items (breast milk substitutes, dietary supplements and vitamin and mineral preparations) were substantial.

The findings of these studies suggest several important points that should be taken into consideration in designing financing schemes. (1) Services offered within schemes should include both curative and preventive ones to be both acceptable and effective. It seems unlikely that people would be willing to pay for preventive services unless they are included in a prepaid package along with services which are in greater demand. (2) People's attention to the quality of services and their preference for physicians in the case of serious illness suggests that financing schemes should include a good referral system to a higher level of care for appropriate cases. For

5/ Akin, Griffin, Guilkey, Popkin, 1982.

6/ Lariosa, 1982

many schemes, keeping a private physician on a retainer to provide supervision to the paramedical personnel and to act as a referral point for more complicated cases would be desirable. (3) Village pharmacies and public education in areas such as the proper use of essential drugs, oral rehydration therapy, contraceptive use and nutritional supplements should be a key feature in financing schemes as self-treatment is so widely attempted and, according to Lariosa, often ineffectively. (4) The fairly widespread notion that rural people place low priority on health is probably not well-founded. People have been observed to spend considerable amounts of money and travel long distances to obtain health services and commodities that they feel are important or necessary (ranging from life-threatening illness in adults to infant formula purchases for babies). Even very poor people will pay, and do pay, for health services despite a public primary health care delivery system which is "free".

Some questions associated with community financing will remain unanswered until financing schemes are systematically tested in the field. The project provides the opportunity to do just that and provides for a maximum amount of the decision-making process about the exact nature of the financial participation to remain with rural residents and their chosen representatives.

Annex C illustrates samples of the kind of schemes that will be tested during the course of this project. Proposals to implement schemes of this nature will be solicited from a variety of organizations and technical assistance will be provided to help the organizations arrive at feasible schemes. There appears to be considerable interest in the field already in developing schemes of this kind. Several organizations have, in fact, already submitted preliminary proposals to private organizations and donor agencies. The Medikong Bayan scheme, summarized in Annex C, involves establishing a simple health maintenance organization through a private corporation. The proposal, if it clears the PCHRD review process, could be funded through this project. Dr. Carl Stevens, a health economist from Reed College, during a consultation in February of 1982, investigated the feasibility of developing financing schemes with Agricultural Marketing Cooperatives (AMCs). His findings are described in Annex C. Dr. Stevens will be returning in July of 1983 to help develop further financing scheme proposals as part of the pre-implementation activities for the project.

Some of the organizations have complete primary and sometimes secondary health systems already in place and are looking for innovative mechanisms for meeting the recurring costs of maintaning the systems. In many cases the organizations are

seeking to create the services precisely because existing services are either inadequate or too expensive for the members of the organization. Commercial establishments have long recognized the relationship between productivity and a healthy labor force (in rural enterprises and farming, the labor force includes women with young children and the children themselves). Funding for schemes will include the start-up costs for establishing the services and the administrative systems necessary to ensure the schemes function well. Because the schemes are pilots, they will be closely monitored and evaluated throughout the project period by the PCHRD management group.

It should be pointed out that experimenting with financing schemes in this project fits into a continuum of research and experimentation on this subject. Some of the research has been referred to earlier. Operations research to actually test a small set of financing schemes is now underway on Panay island, funded by the PRICOR Project (S&T/Health). The PRICOR research project will provide the empirical basis for determining what kinds of schemes work and why and what impact they have on the beneficiaries. In the end it should be clear to policy makers that schemes can be established anywhere in the country as long as they are modified to conform to the institutional capabilities found in the locale and the health seeking and spending preferences of the people in that area, and are financed in a way that is affordable and sustainable over time. In extremely poor portions of the country, the cost sharing may have to include greater participation from private commercial establishments or local government and in most areas, services may have to be developed incrementally to respond to what people can afford, i.e., starting first with the most essential or the most popular services and gradually including others.

2. Policy Analysis and Research

At first glance, the areas of research and special studies planned for this project look fairly diverse and seemingly unrelated. The topics, however, were carefully chosen by the Project Design Committee (composed of representatives from the Ministry of Health, the National Economic and Development Authority (NEDA), the Office of Budget and Management and the Presidential Committee on Reorganization.) The areas of research correspond to programs in primary health care where the Ministry of Health is making major investments (or is about to) and to areas where so little reliable data exist that proper planning and policy formulation are difficult. All of the studies relate to the cost-effectiveness and long-term financial viability of the health care system in the country.

The end result of the research will be information and analysis which should minimize (1) unproductive competition of government services with private providers and duplication of services; and (2) wasteful GOP investments and unproductive program choices.

The need to undertake these analyses is illustrated by the choice to include a feasibility study of establishing one or more herbal drug factories in the country. The cost of essential drugs is often prohibitive in the rural areas and often the kinds of drugs stocked by the small private pharmacies are not relevant to the major illnesses found in those areas. Considerable basic research has been conducted on herbal plants and some of these are already processed and packaged on a small scale in two areas of the country. It is hoped that more use of locally available herbal drugs will reduce the cost of producing drugs. To date, however, no one has undertaken the kinds of benefit-cost and marketing analyses that will permit sensible decisions to be made about who should undertake this kind of production; which remedies should be manufactured on a decentralized basis; which drugs (essential drugs) will have to be imported for the foreseeable future; whether it would make more sense simply to improve the procurement and distribution system for generic drugs or just to improve public education and information on the use of generic drugs; whether to encourage the use of herbal remedies (not requiring exact dosage) grown on a backyard basis; and so on. Undertaking a broad analysis of this subject from the economic viewpoint may avoid costly future mistakes and provide the general directions for more detailed studies in the future.

Similarly, there are a set of Ministry of Health programs which may be improved dramatically if subjected to cost-effectiveness analyses. The functions of and support systems for primary health care workers at the barangay level (principally midwives and barangay health workers) could be improved by scrutinizing the costs associated with the current system and comparing them to the actual outcome as they relate to the program objectives. Various systems exist around the country, but few, if any, cost-effectiveness analyses have been performed to determine which of the systems yields better results for the amount of investment. Because health economists are a rare commodity in government and small private health care institutions, the real costs are often underestimated and the impact of the programs is often assumed to be as planned. In many instances, the analyses can be performed using currently available information and therefore undertaken for reasonable costs. It is to the credit of the Ministry of Health that it recognizes the value of such studies and now is planning them, even though the means for accomplishing such studies have been

limited in the past. Concomitant with the planning for this project, the MOH has commissioned a WHO consultant to develop a curriculum for the U.P. Institute of Public Health in Manila in health economics at the master's level. Several of the faculty members will soon be undertaking graduate work at the University of Michigan in this area so that these skills will become institutionalized over the long run. The cost-effectiveness research funded by this project will not only provide important information to MOH health planners but will build on the capabilities of institutions like the U.P. IPH to carry out the needed economic research in the future.

3. Service Delivery Component

The project design committee felt strongly that a project of this kind would be incomplete and certainly less attractive to policy makers if it did not include some funding for responding to the findings of the research and experimentation planned in the project. The four areas chosen were carefully selected because they will contribute to the purpose of the project; i.e., they are related directly to improved access to and utilization of selected PHC services and improved financial viability of the health care system. Assistance to the Botica sa Barangay program will help small village stores become commercially viable outlets for essential PHC commodities and basic drugs. Assistance in this area is attractive because it demonstrates the value of government's encouraging and supporting a private sector health service and because village pharmacies have such immediate potential for being a totally "user-financed" service.

Along with the studies conducted of the barangay health worker and midwifery programs, the project will provide assistance in improving the elements in these projects found to need strengthening. These areas are expected to be in the training, methods of supervision and support, methods of worker selection and motivational factors which affect worker retention and satisfactory performance levels. From the national level, only technical guidance and training protocols are provided. The actual training and management of these programs is the responsibility of the regional MOH.

It is anticipated that the studies will reveal the importance of adhering to a competency-based training curriculum which emphasizes skills development and to restricting the number of services offered by primary health workers to certain high-impact, selected interventions. The reasons are:

a. International experience has demonstrated that primary health care workers often are overloaded and expected to

perform a set of functions beyond their capabilities, given their limited educational backgrounds. The result is that the quality of their work suffers and the impact of their interventions is minimal. Communities are quick to notice these deficiencies and the workers lose credibility.

b. Most developing countries cannot afford to maintain a PHC support system which allows for comprehensive health services at the village level. Limited resources dictate placing priority on certain interventions which will have an impact on the most serious health problems first. A more comprehensive set of services can gradually be built onto a strong basic PHC delivery mechanism.

c. The tendency of many village health worker training programs has been to emphasize acquiring knowledge about disease causation, human physiology, principles of community development and intersectoral coordination and much theoretical information on a variety of topics. While this may be interesting for the worker, it does not provide her or him with the specific skills necessary to prevent poor health, deal with illness or avert death. Training therefore must be skill-oriented and must assure that enough time and practice is allowed to ensure real proficiency on each topic.

Project funds will be used to improve the training protocols and distribute them in sufficient numbers to the regional and provincial offices. The exact nature and magnitude of the assistance will be determined by the assessments that will be conducted during the research phase. Commodity support for these primary health care workers will also be determined by the studies to be undertaken. Another area of service delivery support included in the project will be assistance to the IEC program of the Ministry of Health. This mass media effort will be directed at educating the public about specific primary health care topics directly related to the selected PHC services being strengthened through the project. Topics will include the proper use of oral rehydration packets, the need to have children immunized on schedule, the use of effective contraceptives and the need to plan family size, personal hygiene and community sanitation messages, the importance of breastfeeding and growth monitoring, and the proper utilization of essential drugs. The project will fund the equipment and production costs of films, radio messages and written materials such as comic books which can be used throughout the country once the basic messages have been designed.

4. Documenting the Lessons Learned

The ultimate value of the financing schemes beyond the communities which actually participate in them will depend on how well the lessons learned from the experimentation are documented and disseminated. Important lessons are expected to emerge from the process of establishing the schemes, the internal mechanics of operation, the impact of the schemes on health service utilization and, eventually, health status improvements.

The baseline data necessary to measure the impact of the schemes on health seeking behavior, health expenditures and service utilization will be collected during the design phase of each scheme. Data necessary to assess the cost-effectiveness of the schemes will also be gathered. In a limited number of larger schemes in the first batch, a few health status indicators will be carefully selected and changes recorded over time (e.g., infant mortality, birth rates, prevalence of 3° malnutrition, diarrheal and respiratory disease-specific mortality). Changes in health status will continue to be monitored beyond the actual 24-46 month funding period for the individual schemes and will be assessed at the end of the 5 1/2 year total project funding period. Health status data will be collected only in schemes with a sufficient population base to draw meaningful conclusions.

Consultants will be used to set up the data collection procedures within each scheme to assess impact on service utilization in all schemes, and health impact in some. The periodic reports required from the organizations implementing the schemes will contain the collected data. The final evaluation of the schemes will present and analyze this information. Evaluations also will analyze the operational problems and replicability potential of each scheme.

All of the above information will be synthesized by PCHRD and presented to policy makers at the final project workshop described in the implementation plan (see p. 43). While this project does not fund the wider application of the schemes, the lessons learned and techniques developed will provide the GOP and other private entities the knowledge and experience base to do so.

B. Social Soundness Analysis

1. Beneficiaries

The beneficiaries of this PHC Financing project are the more than 72,000 rural households that will ultimately receive more

accessible, higher quality health care as a result of the experimentation, studies, and testing supported under the project. Women, infants, and young children will benefit the most, since improvements in quality of and access to PHC services are assumed to have major impact in lowering both fertility and infant/child mortality. All members of the household, as well as the community itself, however, will benefit, particularly in regard to the project's emphasis on environmental and preventive health measures. Secondary beneficiaries include the MOH midwives and barangay health workers who will receive improved training and the 10,000 botica owners who will be assisted through the project.

2. Social Feasibility

Two types of activities are supported in this project. Type I examines ways to improve the delivery of basic health services. Type II tests ways in which local communities, and other nongovernmental entities can shoulder some of the financial burden of operating and maintaining these health services. Type I studies relate primarily to existing programs and activities (e.g., the MOH midwife, BHW, and Botica sa Barangay programs) that are already known to be socially feasible. These studies are aimed mainly at identifying ways to improve the effectiveness of delivery of and access to health services. Most feasibility issues, thus, relate to Type II studies, namely, community and private-sector financing of basic health services. Feasibility issues related to the latter are the subject of the following discussion.

An underlying assumption of this project, and one supported by evidence from several existing programs, is that people will share in the cost of providing health services if those services are perceived by the community as efficacious. A major problem with earlier financing schemes was that the quality and accessibility of health care services were perceived by the beneficiaries to have declined after the inception of the scheme; consequently, the people stopped supporting the programs. It is planned that early studies (Type I) of the effectiveness of health services will allow the Ministry of Health (MOH) to raise the quality level of public health services which will benefit these financing schemes.

One other major project assumption is that for a public health care (PHC) financing scheme to be self-sustaining there must be maximum beneficiary participation. That is, beneficiaries themselves must have a say in the type and quality of PHC services that will be provided. They must be involved in determining the distribution of and access to services and the cost-sharing arrangements which will support these services.

Finally, they must have some means of evaluating and reporting on the effectiveness of the services to the people administering the schemes. In (Type II) designing, testing, and evaluating of experimental financial schemes supported by this project, beneficiary participation will receive major emphasis.

The project designers expect that if there is genuine commitment to the notion of maximum beneficiary participation, then most feasibility issues (such as access to services, distribution of costs, assignment of responsibilities, and supervision) will be greatly reduced. It is not so much that these problems are totally eliminated but that the people themselves provide solutions to the problems facing them in regard to their PHC financing system.

Having stated the above, however, we must quickly add that it is not the project's intention merely to allow each community participating in the PHC financing schemes to discover for itself its own solutions to rather common problems. Rather, it is expected that the early financing schemes will identify a limited range of possible solutions to PHC financing problems and issues from which communities can choose in the later implementation phases. Ideally, the project hopes to construct generative models which should be appropriate for most if not all rural Philippine communities. In most cases, the community's decision on a solution will generally be the correct one for them, though it will always be possible to modify or change their plans later. Regardless, the community can be expected to benefit greatly from the experience of other communities in regard to implementing and managing a PHC financing scheme.

Participation itself is not a major issue. There is abundant Mission experience in other projects to show that communities are willing to organize themselves and pay for a service which they deem important. The USAID-assisted Barangay Water Program (BWP), in which a community association supervises the operation and maintenance of community water supplies, is probably the most analogous to the PHC financing project. Under the BWP, communities elect a management board which not only supervises the operation and maintenance of the water system but assesses and collects household fees to support the system. The Rural Service Center (RSC) Project, though it generally focusses on poorer segments of the community rather than the community as a whole, also provides some good experience regarding the feasibility of community organization and beneficiary participation.

The exact nature of this participation, however, is something

that we plan to define more clearly through experimentation, study, and testing. For example, it seems clear that some type of management board similar to those in BWP and RSC will need to be established to manage the financial scheme; but the exact structure of the board, its size, representation, composition, duties, and responsibilities all need to be carefully examined. Similarly, we need to look closely at the nature and extent of involvement of the local government (e.g., barangay captain, barangay council, and municipal officials). While their involvement and support is critical, care must be exercised to prevent them from controlling the project. Too often in the past, so-called participatory projects eventually became operated and controlled by the local elite, the intended beneficiaries lost interest, and the projects ultimately failed.

Finally, participation of the private and quasi-government sectors needs also to be explored. For example, large plantations might be encouraged to undertake indigenous health care programs using self-financing schemes. Irrigation societies, cooperatives, and voluntary organizations might also be willing to undertake such schemes. Indeed, a number of the above have previously attempted such programs, some of which are still in operation, others of which have failed. The project will support with small grants the further efforts of these and other organizations to manage PHC financial schemes with the objective of designing a model which can be replicated in other areas of the country.

3. Spread Effects

The PHC Financing project design embodies several features to facilitate the spread of project benefits beyond the initial project areas and to promote the sustainability of PHC financing activities after the project has terminated. First, improved PHC services supported by the project will have repercussions and consequences far beyond the simple establishment of community means to finance these services. Improved curative and preventive health services will result in a healthier populace with increased productivity and a generally improved well-being. This will in turn generate the enthusiasm and commitment (if not also indirectly some of the financial support) to continue the financial schemes which provide and support these services.

A second type of spread effect that is anticipated is the interest and desire of neighboring communities to undertake PHC financing schemes on their own once they have observed its success and benefits in more progressive barangays. This has been the experience with the USAID supported RSC and BWP projects wherein, once an income generating project was seen to

be profitable or a water system proved effective, then nearby villagers, who had taken a "wait and see" attitude, were willing to consider a similar undertaking in their community. In this PHC financing project, the first barangays will undoubtedly be the more progressive ones with strong, forward-looking leadership. If these are successful in their PHC activities, then other barangays can be expected to follow their example.

A third spread effect that is anticipated is an increase in self-reliance among the target beneficiaries. In the RSC project, where communities are organized to operate and manage small income-generating projects, a recent evaluation found that there was a feeling of independence and control over the local situation that was engendered in the beneficiaries as a result of the project's strong emphasis on community organization and beneficiary participation. Under this PHC financing project, it is anticipated that these beneficiaries will also exhibit greater self-confidence and self-reliance as a result of their participation in the organization which will supervise and finance their local health care system. It is probable also that organizational and managerial skills developed under this PHC financing project can serve the community in other programs and activities. For example, some of the associations formed under the RSC and BWP were later able to avail themselves of loan money under the government's KKK program to undertake additional development activities. A similar spread effect could result under this PHC financing project.

In regard to sustainability, there are several design features of the project that should assure subproject continuation after the project's termination. First, the project places much emphasis on beneficiary participation and has structured the project to achieve maximum involvement of the people in the assessment of their health needs, the planning of services to address their needs, the management of financing schemes to support these PHC services, and the monitoring, assessment, and reporting of the effectiveness of their PHC system. It is now generally recognized by those working in development that people's participation throughout project planning and implementation is a critical factor in the long-term success and sustainability of development projects. This PHC Financing Project is not expected to be an exception to that premise.

Second, through testing, experimentation and studies, the project will explore the possibility of linking PHC financing activities to on-going associations and organizations which are generating revenue that might effectively be channelled to finance PHC activities. For example, there are more than 150

income-generating projects under the USAID-assisted RSC project. A number of these are viable enough to finance PHC activities from their revenues. BWP communities are also often generating revenues in excess of their amortization and replacement costs. This surplus revenue could also fund all or part of a community's PHC program. An advantage in linking PHC activities with BWP, RSC, or similar associations is that these local-level organizations are already mobilized and have managerial experience. The organizational and managerial skills that exist in such communities will contribute greatly to the long-term sustainability of PHC financing programs in those communities.

Although it would be ideal to join the local PHC system with on-going income-generating activities, this will not always be possible. Where income-generating activities are not already in existence, the project will explore the possibility of linking PHC activities to cooperatives, irrigation societies, church groups, local PVOs, social groups and similar associations. While none of these groups has profit generation as its main objective, they do have organizational and managerial experience that will be useful in developing and operating a PHC system within their community. The possibility will also be explored of harnessing this organizational and managerial skill and directing it toward income-generating activities which could finance partially or fully the PHC program in the community.

In barangays where there is no BWP, RSC or similar program, and where there is no strong communitywide organization, such as a cooperative or a women's club, project implementors themselves will have to do some of the community organizing to get the PHC program started. Initially, funding may have to come from household fees, which would generally be adequate enough to start the program. However, once the PHC system is underway, communities will be encouraged to supplement their household fees with revenues from other activities, ranging from income-generating projects specifically planned for financing the PHC program to community bake sales, fairs, and raffles, all of which can help support the program. By encouraging the community to explore these additional revenue sources, the project expects that the quality and coverage of the community PHC services can be increased and that the individual burden of supporting the system can be reduced or kept at modest levels. By casting its net wide in the exploration and testing of various revenue sources to finance the local PHC system, the project increases its chances of discovering a sustainable funding mechanism for PHC services.

4. Impact

The PHC services that this project is attempting to improve are oriented toward the rural areas (barangays, small municipalities) and are those most frequently used by households from the lower socio-economic segments of the community. The latter are generally those at the highest health risk. Wealthier households usually avail themselves of health services from private practitioners, clinics, and hospitals. The latter households will obviously use the project's services from time to time, particularly for minor ailments and sicknesses, but they can be expected to be the first to move to higher levels within the health care system when their maladies are severe or are not responding rapidly to treatment. In general, then, we do not anticipate that the wealthier elements of the community and the poorer people will be in competition for the project's health services such that the latter would ever be deprived of access to the services.

Despite an expected absence of competition for the project's health services, the major question still to be addressed is how provision of and access to PHC services can be equitable when needs and ability to pay for these services vary so greatly in a community? Fortunately, the analogous BWP project offers some insight into the ways communities might answer this question if they have no alternative source of revenue (i.e., an income-generating project) and must collect fees individually from households. Under the BWP, communities enter into an agreement with the Ministry of Local Government (MLG) whereby the MLG extends loan funds to construct a community water system. The community organizes itself for the management and maintenance of the system as well as for collection of fees for the amortization of the BWP loan. The entire community is encouraged by MLG/BWP field staff and community leaders to join the BWP association, though of course there are always some families who do not join.7/ Fees are relatively modest (usually about ₱15/month/household). The BWP association's management board assesses and collects fees, levies fines for delinquencies, and enforces rules regarding use of the system. Those who do not join the association or are unable to pay, however, are not denied access to the water. With the exception of household connections (where owners pay a higher fee), most BWP sources of water are public standposts from which it would be very difficult to exclude ineligible users. Community and peer pressure is brought to bear on delinquents, nonjoiners and other ineligibles, but ultimately all are permitted access to the water. What appears

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7/ Reasons for not joining include possession or access to a private well or a nearby natural source; general reluctance to join associations; lack of time, etc.

to occur is that the community views itself as a patron and part of its social responsibility (noblesse oblige) is to care for the more indigent members of the barangay. Helping others in the community is well-supported by Philippine religious and cultural values.

Under barangay PHC financing schemes, it is anticipated that a similar situation will evolve if there is no other source of revenue to finance the PHC system. It will be the responsibility of the PHC association's management board to ensure that access to the available PHC services is equitable or, at least, that no segment of the community is excluded. Both the poor and the wealthy, if they desire, should be able to use the services when needed. It will also be the responsibility of the community's management board to establish and enforce regulations and procedures that ensure equitable access to the community's PHC services.

In barangays where income-generating activities can be undertaken (either independently or in conjunction with an on-going program such as KKK or RSC) and revenue can be used to finance part or all of the PHC system, potential problems regarding the equitable assessment of financial responsibility on individual households and access to the services are greatly reduced. The need will continue for a PHC committee or management board to oversee the operation of the PHC system and guarantee that all community members have access to the services.

C. Economic Analysis

The PHC Financing Project's emphasis on research, experimentation, and institutional capacity-building does not permit a traditional cost-benefit analysis to be performed. For most project activities (health care financing schemes and special studies), final designs will be produced only during implementation; for others (the service delivery), the underlying concept itself will be further developed and enhanced during implementation.

Moreover, aside from the normal difficulty of quantifying economic benefits of health-related projects with any degree of accuracy, the paucity of good data on the costs of delivering PHC services does not provide reliable measures to allow comparisons among alternative programs and activities. Until the research component of the project produces more reliable information on the costs and quantifiable outputs of PHC-related programs, a reasonable cost-benefit analysis will not be possible.

Further, the benefits from the PHC Financing Project also include such immeasurables as greater GOP recognition of the need for, and

the ability to stimulate, greater private-sector participation in PHC programs and consideration of new health care delivery systems suitable to conditions in rural communities. It includes increasing the GOP's capacity to obtain policy-relevant information useful in identifying and improving various approaches to the problem of reallocating resources and establishing schemes that would provide additional local financial support to the PHC program. These nonquantifiable benefits will be as essential as the potentially quantifiable economic benefits obtained through subproject activities.

Given the above, the economic analysis of the Project has mainly focused on three aspects of project economic feasibility.

- Cost-effectiveness of the overall approach. How does the planned approach of Project activities compare with the alternative modes that would impact on improving the delivery of primary health care in the country?

- Alternative economic rate of return analysis. What would the Project have to achieve to yield an economic rate of return equivalent to the stated social value of capital?

- Economic analyses of subprojects. To what extent will the approval process for project activities give adequate importance to the economic soundness of individual subprojects prior to their funding?

1. Cost-effectiveness of the Overall Approach

The selected approach for project implementation is a cost-effective method of enhancing the delivery of and increasing access to PHC programs in the rural areas while encouraging active participation and self-reliance in health care services among local communities. It will enable the GOP to test a variety of innovative yet simple health financing schemes and choose those which are viable, acceptable and replicable in other areas in the country without engaging in a comprehensive but costly national effort. Sufficient information will then be available to the GOP to implement these workable schemes on a wider basis as appropriate.

In addition, there are other features in the project design which make the approach more attractive and cost-effective.

a. It provides the flexibility to experiment with various types of health insurance schemes that will differ in size, location, organization, and coverage. While some of the tested schemes may fail, or at least be less successful than others, the approach increases the chances of arriving

at several viable schemes which show potential for long-term financial sustainability and replicability nationwide. It spreads the risks across a number of alternative pilot activities and creates opportunities to learn from earlier attempts in developing community-supported PHC financing schemes.

b. The emphasis on the use of local community resources as well as those from other private groups to augment the GOP's available resources for health services is designed to encourage greater participation of the private sector in the delivery of the PHC program.

c. Project activities related to strengthening the GOP's PHC delivery support systems and to policy research include elements directed towards improving the GOP's ability to provide better access for a broader segment of the population to obtain adequate health care services.

An alternative approach to the experimental nature and process type strategy of the Project is the "standard" mode of designing all components and subactivities during a "preproject design phase". This would require that the GOP and the USAID predesign selected types of health insurance schemes that would be implemented on a wide basis with a specific implementation schedule. This approach has several advantages that justify its use in many instances: it encourages project designers to think rigorously about project costs and outputs; it enables important project interactions to be identified during design; and it provides a clear standard for project implementation and subsequent evaluation.

On the other hand, these advantages are outweighed by several disadvantages. Community-financed PHC delivery programs are a relatively new area for both the GOP and USAID. The current local experience with health insurance schemes is extremely limited so that it may not be advisable to design a comprehensive program with the information presently available. It is then highly desirable for the design of activities to proceed incrementally, enabling the design of other subsequent activities to benefit from the experience gained from earlier ones.

Furthermore, it is important that the proposed approach emphasize greater participation by the local communities and other private sector groups in the PHC program. The participation by a number of diverse groups requires a decentralized approach to both design and implementation. Without preselecting which communities and private sector groups will be involved in project implementation, it is not

possible to involve them in a design prior to project initiation. Even if they could be identified, the active involvement of an expected large number of local-level groups in a unified design activity would be cumbersome.

Finally, the pilot nature of the subactivities makes it impossible to predict at this point which of the schemes will succeed, which will need modification during implementation, and which should be discontinued after the initial trial period. A standard fixed design approach does not provide sufficient flexibility either to change or modify an activity during implementation or to scale it up or down in accordance with its performance. As it is, the proposed approach allows greater flexibility for the project to increase the economic returns of limited project resources. It permits these resources to be redirected to activities with a higher return as more information becomes available on the return of competing alternatives.

Another possible alternative approach is for the Project to commit its resources to support the expansion of the existing GOP PHC program rather than invest in experimenting with locally financed community-based PHC activities. This has some advantages: risks normally associated with pilot tests and experiments are minimized; and the organizational and management structures capable of implementing it already exist.

However, there are stronger and more valid reasons to pursue experimentations with health financing schemes. As discussed earlier, the cost implications of the GOP's attempting to be sole provider of PHC services to all areas in the country are formidable and unrealistic. Cost of training alone of the 320,000 volunteer BHWs (one per 20 households) that the MOH estimates are necessary are substantial, and training costs are just a small fraction of the real costs of supervising and supporting these workers and replacing them when they quit. The actual costs of such programs are often underestimated and frequently the calculation is not even attempted. Further, while the coverage under the on-going health system has significantly increased over the past years, it has been heavily dependent on foreign-donor support, including the financing of recurrent costs. Continued external assistance under such a situation is not cost-effective as it is tantamount to a direct resource transfer and will not stimulate the exploration of a more cost-effective, community-based and financially self-sustaining PHC delivery system. In fact, if the GOP were to pay only one BHW in every rural barangay in the country a salary of 50% of the amount received by an MOH midwife (₱700/month), the total recurrent cost will reach more than ₱175 million annually -- a level too high in relation to the current financial capabilities of the GOP.

It is indeed in the issue of financing where the Project can provide support to the GOP's health program by helping identify various approaches to the problem of reallocating resources as well as in establishing schemes that would provide additional local financing support for the PHC that will be politically and economically feasible and efficient. As Dr. Paqueo pointed out in his report, 8/ the Project's support for experimentation and for studies on public costs, subsidies, private sector health financing and the efficiency of some of GOP's PHC-related programs will also contribute to enhancing not only the implementation of the PHC program but also the expansion of the current insurance coverage of the population -- both of which are among the major GOP objectives in the health sector as stated in the Five-Year (1983-1987) Development Plan. The current compulsory insurance systems are limited only to employees in the formal sector of the economy, and it is one area where social intervention might be useful as far as the equity implications of the present system are concerned.

Meanwhile, the economic rationale for the Project's support for upgrading and strengthening the capacity of the existing health service systems to backup adequately the delivery of PHC in rural communities is directly related to the economic benefits to be gained from a nationwide reductions in fertility and infant and child mortality. The economic benefits accruing from lower birth rates and mortality rates are well-documented and need not be specified here. To achieve these reductions in fertility and mortality, substantial investments will be required in several areas of primary health care. This project addresses several important avenues for assisting the MOH to provide the support to service delivery activities in the field. These are improvement of the mass media campaign (IEC) for selected primary health care services, reorientation of the basic training of BHWs and in-service training for midwives, strengthening the botica sa barangay program to make essential drugs more available and funds for purchasing PHC commodities to support activities of BHWs.

Activities such as improving the IEC program will help generate awareness of and demand for services such as immunizations for children and family planning services for married couples. Improving the skills and effectiveness of BHWs and midwives will allow them to provide services of high enough quality to avert deaths and limit morbidity from infections and nutritional diseases. Improvements in the selection, training, supervision and incentive systems should greatly reduce attrition rates and save the GOP the resources necessary to

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8/ Paqueo, Vicente B., Economic Perspectives for the PHC Health Financing Project, January, 1983.

train replacements. Effectively trained BHWs can perform certain tasks which presently require the valuable time of medical professionals. MOH medical professionals' time could then be freed and used instead to increase the supply of medical care requiring greater skills for complicated procedures. As a result, this could allow the MOH to allocate a greater proportion of its additional budget in the future to finance its PHC program while slowing the rate of increase of resources needed for medical services.

Commodity support for the primary health care workers will further enhance their effectiveness in providing preventive and curative health services to reduce mortality amd morbidity rates arising from respiratory, diarrheal and other diseases. Moreover, the project includes provisions for local communities and/or users to pay for the costs of resupplying expendable PHC items (e.g., drugs, ointments, dressings, etc.) to reduce the costs burden on the GOP. Furthermore, an improved botica sa barangay program will assure rural barangay households' access to affordable essential drugs including contraceptives, oral rehydration salts, analgesics, etc. The Project's support for enhancing the boticas' financial viability and increasing their supply and resupply efficiency will lead to substantial savings on the part of both the barangay residents and the GOP. The program is expected to include 10,000 barangays with an estimated total population of 9 million.

2. Alternative Economic Rate of Return Analysis

The special studies on PHC-related programs and the pilot tests on financing schemes are expected to significantly improve the present PHC delivery systems and, therefore, increase the access to and utilization of PHC services in the rural areas nationwide. A major and direct economic gain by rural households from the Project is the anticipated savings on medical treatment arising from lower morbidity and mortality incidence within the communities. Although the savings, as used in the discussion here, mainly refers to the reduction in the average medical expenditures of families, it can also be interpreted to refer to the reduction in public sector costs of providing hospital and/or curative services resulting from the preventive components of the PHC program.

While it is not possible to calculate the project's economic rate of return without fully knowing the final economic output, as an alternative, the social discount rate in the Philippines can be used to determine what economic impact the Project should achieve to justify the investments for the service delivery support component. (The economic rationale and cost-effectiveness analysis of the special studies and health

financing schemes have been provided earlier.) The reasonableness of achieving that impact can then be examined in the light of existing and prospective scenarios. However, several simplifying assumptions are necessary in order to do this: (1) the project funds for the service delivery support component are disbursed annually in real 1983 dollar values in the following manner ($3.04 million of the estimated $17.70 million budget for the component are accounted by a 7% annual inflation):

1983	1984	1985	1986	1987	1988
0	2.57	4.24	4.04	2.10	1.71

(2) economic returns over a 20-year period will flow evenly for each dollar invested; (3) no new returns are attributed to the project after its completion; and (4) average medical and health care expenditures of a rural family represent their outlays for the common illnesses that are to be mainly affected by an improved PHC delivery program providing both preventive and curative services.

Using the NEDA-supplied social value of capital of 15 percent, the Project must then be achieving an annual economic return valued at $2.35 million at 1983 prices by 1989. This means that the beneficiaries, given the assumptions, will have to gain economic benefits equivalent to a value of at least $2.35 million or ₱23.50 million (based at an expected average exchange rate of ₱10=$1 in 1983) annually as a result of the Project. Otherwise, the Project should have invested the resources allocated for service delivery support in some alternative activities.

How likely is the Project to be able to achieve this level of economic return? Put another way, how much savings in medical care outlays of a rural family will have to be generated as a result of the Project? This will require an estimate of the average level of current health care expenditures of rural families. The NCSO Family Income and Expenditures in 1975 has shown that Filipino families spend an average 1.9 percent of their annual total expenditures for medical and health care expenses.[9/] If the average total family expenditures in the rural areas then had been ₱4,100 ($410), this means that some ₱78 had been allotted for health care and treatment. Adjusted for inflation, a rural family is estimated to be spending around ₱186 ($18.60), on the average, for medical care in 1983.

9/ See the 1981 Philippine Statistical Yearbook, NEDA, Table 2.12, p. 81.

If it is assumed that all the 8.6 million rural families in the country will benefit from the Project uniformly, then just a 1.5 percent savings in the average medical and health care expenses per family (or ₱2.80 from the average annual expense of ₱186 for health and medical services in 1983) will be necessary to attain an acceptable economic rate of return for the Project's investments for service delivery support. The expected reductions in the most prevalent illnesses among barangay residents, (principally, communicable diseases and diarrheal problems) attributed to the increased access to PHC services should easily result in more than a 1.5 percent decrease in real terms in the total health care expenditures of rural families.

On the other hand, while the GOP has a "Health for All by the Year 2000" goal, it may not be reasonable to assume that all rural households will have access to PHC services as a direct result of this Project. The current PHC program is available to only about one-third of the rural population. If it is assumed that the Project will enable two-thirds of the rural population to have access to and utilize PHC services, then each beneficiary-household will have to generate savings equivalent to 2.2 percent (or ₱4.10 in 1983 prices) of the estimated average family outlay for health care services. This still appears to be easily attainable.

Alternatively, if it is assumed that the Project activities for PHC service delivery will result in an average 10 percent savings in the health care expenditures of the family-beneficiaries, then approximately 1.26 million rural families will have to be reached to yield the necessary economic return (or savings) to justify the Project. This number represents some 15 percent of the country's total rural population in 1983. Evidently, the Project's impact is foreseen to affect a much larger proportion of the rural population than this figure. A more conservative assumption of a 5 percent savings will require 2.52 million rural families, or roughly 30 percent of the total number of rural families -- still well within the reasonable range of the number of potential beneficiaries of the Project.

Given these various scenarios, this analysis has tried to show that there are good reasons to expect that the Project could achieve a result that would justify its investment in service delivery support and potentially yield a reasonable rate of return on the investment.

3. Economic Analyses of Subprojects

Since specific subproject activities (i.e., financing schemes for PHC delivery) have not been fully designed and detailed

terms of reference for the research have not been developed, it is not possible to generalize in a meaningful way about the economic rationale of these activities. However, economic feasibility will be one of the criteria in selecting among proposed research and subproject activities. An economic analysis or impact statement will be required in each subactivity or research proposal with adequate discussion of its cost-effectiveness and, in the case of financing schemes, its replicability in other settings in the country. The level of details required for these analyses will be proportionate to the size of the specific activity. Proposals for major activities (i.e., those with a life-of- activity cost of more than $100,000) will be required to present more detailed analyses than smaller proposals.

The distinction is important because it preserves the integrity of economic analysis in the project. Placing an unreasonable requirement for sophisticated economic analysis on smaller proposals will inevitably lead to a proliferation of pseudo-analyses that cloud the decision process. Likewise, it increases the number of bureaucratic hurdles that must be met by the activity proponents. Rigid analytic requirements will make it difficult if not impossible for small private sector groups to submit acceptable proposals, while contributing little information of real value in evaluating proposed activities.

The type of economic analysis required will also vary depending on the nature of the activity. Those involving largely policy implications or technical research, for example, will be expected to provide limited economic analysis consisting primarily of a justification of the resources to be utilized relative to importance of the specific issues and problems addressed and the likelihood of generating additional useful information. For their part, subprojects involving health financing schemes will warrant a discussion on the economic viability of the proposed activity to include, when possible, an indication of its economic rate of return.

D. Administrative Analysis

The administrative analysis is incorporated into Part VI. Implementation Plan, Section A. Administrative Arrangements and Analysis. That section discusses the administrative feasibility of the project and the administrative capability of agencies involved. It also describes mechanisms that will be used to enhance cooperation among participating organizations.

VIII. EVALUATION PLAN

Because of its innovative and experimental nature, evaluation is central to the Primary Health Care Financing Project. Much of what will be supported by way of financing schemes and studies/research will help the Government to evaluate the efficacy of alternative approaches to the health care financing problem. Two related, but separate, types of evaluation activities are contemplated:

1) overall evaluation of project implementation to identify problem/issues and recommend solutions; and

2) discrete evaluation of separate components to gain empirical lessons for improving future programs.

A. Overall Evaluation

While keeping an eye on project goal and purpose, these evaluations will focus on collecting and analyzing information which is needed to improve internal project management. The focus will be on project implementation and linkages between inputs and outputs. While these process evaluations will be based on a clear understanding of desired goals and purposes, they will not concentrate on measuring or analyzing project impact on beneficiaries.

During the course of the project, overall evaluations will be conducted every 20 to 30 months depending on implementation progress, information needs for project management decision-making, and implementation problems encountered. An effort will be made to use the same evaluation team to facilitate temporal comparisons over time and to limit the time that is spent having the evaluation team learn basic project concepts and background. Depending on the scope of information needs, each process evaluation will involve about a six week effort by a 3 to 5 person evaluation team.

Decisions concerning team composition will be made during the second year of implementation when details of the first overall evaluation are being planned. At present, it tentatively appears that the team might be composed of:10/ (1) An international consultant who will act as team leader (perhaps from a university or some other institution enabling absences of up to 8 weeks every two years or so), (2) An AID/W health specialist (perhaps a GS employee who will remain in AID/W throughout the project and, therefore, will be available on TDY for each process evaluation), (3) and (4) suitably trained and experienced Filipino health experts who can meet time requirements of the evaluation.

10/ Perhaps hiring of a single Filipino firm/institution to manage those evaluations might be the best approach.

The estimated project cost for each process evaluation (excludes AID direct hire participant) appears to be about $20,000 at 1983 prices.

B. Evaluation of Individual Components

1. Health Care Financing Schemes

a. Impact Evaluation

The main purpose of testing these schemes is to gain information on the effectiveness, efficiency, practicality and sustainability of the scheme being tested.[11] Thus, these tests must be evaluated very carefully to insure that the lessons gained are described, analyzed, and documented properly. Consequently, this component requires a comprehensive evaluation program.

To test properly the 24 financing schemes, baseline information should be collected on: (1) current methods of obtaining and financing health care in the communities, and (2) current cost characteristics and level of health care delivery. Collection of this information will require field work and some household surveys. This kind of baseline will be collected during the design phase of each scheme and provide guidance on how to structure the scheme. PCHRD will arrange for consultants to help accomplish these studies.

Upon completion of each two-to-three year pilot test, a follow-up survey will be conducted. This will enable before-after comparisons and quantitative measurement of impact on the level of health care service delivery, the costs, and the financing sources. Changes in utilization of services which affect fertility and infant mortality will be analyzed (e.g., contraceptive prevalence rate, immunization coverage for infants and pre-school children, etc.). In addition, health status impact data will be collected in a few schemes as described in the technical analysis section.

Given the special survey and data collection skills required, implementing agencies will not be expected to undertake these impact evaluations; rather, a separate institution will be engaged. A single institution will conduct the baseline and impact surveys in each of the 24

11/ While the communities where the pilots schemes are being tested may benefit, this is really a by-product and not the reason for conducting the test.

pilot communities. This will facilitate comparison across pilot tests, reduce contract negotiating and monitoring costs, reduce contractor overhead costs, and contribute to better overall results. This approach is not expected to overburden the selected institution because the start and completion dates of pilot tests will have been staggered.

The institution will be involved with the project from the beginning until completion and reporting of the last impact survey and analysis of comparisons across pilot tests. The estimated budget for this involvement, which is expected to last for five or six years, is $100,000 which is just under 4% of the total component budget. These funds are incorporated in the cost estimates for each scheme.

b. Process Evaluation

Each proponent will be required to collect and report on information related to the process by which schemes were developed and the social and organizational problems encountered in operating schemes. These systems will be designed to provide the feedback information needed to manage properly the pilot test and to make required changes and adjustments. Each proponent will submit periodic progress reports to PCHRD.

In addition, the PCHRD management group will monitor each pilot test, make field visits, and recommend changes as needed. As information is collected and analyzed by PCHRD on the 1st batch of schemes, the results will be used to perfect subsequent designs. Furthermore, the overall project evaluation team will visit pilot test communities during their periodic evaluations, collect and analyze information, and make recommendations for improving implementation of the pilot test.

2. Special Studies

This component is in many ways an evaluation in and of itself. It will evaluate the following: midwife performance, volunteer BHW program, Botica Sa Barangay, herbal drug production, the cost-effectiveness of existing PHC delivery systems, vaccine production and the referral systems. Furthermore, the Special Studies will provide baseline information for evaluating activities under the Service Delivery Component. The special studies will be monitored closely and the resulting final reports carefully reviewed and assessed. This component also will be assessed in the periodic overall evaluations. There is no need to establish a formal system to evaluate the studies undertaken in this component.

3. Service Delivery

Many of the activities supported under this component will be based on recommendations from the Special Studies component; i.e. BHW and midwife programs (including training and commodity kits), and Botica Sa Barangay. The Special Studies will serve as baseline information against which to measure progress under the Service Delivery component. Consequently, the contracts for the special studies will indicate explicitly the baseline function of the study and also ask the contractor to outline an evaluation plan for assessing the impact of activities recommended by the studies. A small amount of the Special Studies money will be reserved for evaluating the impact of the recommendations that are implemented by the MOH. It is hoped that the same institutions conducting the special studies will be available to undertake these impact assessments, which will use baseline information collected under the original special study.

The periodic process evaluations will assess progress of service delivery activities and make recommendations concerning continuation, expansion, curtailment or redirection of individual subcomponents.

C. Flexibility

The main goal of evaluation is to collect information needed to make better decisions and improve current and future programs. Because information needs change, especially for innovative projects such as PHCF, evaluation plans must remain flexible. Thus, the evaluation schemes described herein should remain flexible and be adjusted to meet the information needs of the project, MOH, PCHRD, and USAID. The national workshop to summarize and share the knowledge acquired during the project will provide the opportunity to discuss policy matters related to the long-term financial viability of the Philippines health care system.

IX. CONDITIONS, COVENANTS AND NEGOTIATING STATUS

A. Conditions Precedent to First Disbursement

Prior to the first disbursement under the loan portion of the Assistance, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Cooperating Country, except as A.I.D. may otherwise agree in writing, will furnish to A.I.D. in form and substance satisfactory to A.I.D.:

1. An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Cooperating Country and that it constitutes a valid and legally binding obligation of the Cooperating Country in accordance with all its terms;

2. A statement of the name of the person principally representing the Cooperating Country for purposes of this Project and of any additional representatives, together with a specimen signature of each person specified in such statement.

3. A copy of a detailed implementation plan which specifies the sequence of activities, the responsibilities and inter-relationships of the various institutions involved in project implementation, and the mechanics of disbursing project funds.

4. Copy of a memorandum of agreement between MOH and PCHRD designating the latter as the organization to manage the special studies and financing schemes portion of the project.

B. Special Covenants

1. Utilization of Research Findings. The Cooperating Country covenants that the findings of the research component of this project shall be utilized, if found applicable and acceptable, to guide the implementation of the service delivery activities to be funded by AID assistance. A yearly implementation plan will be developed which will specify the project activities to be undertaken in each of the four service delivery support areas described in this project paper.

3. Project Evaluation. The Cooperating Country covenants to establish an evaluation program as an integral part of the Project. Except as the Parties agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:

   a) Evaluation of progress toward attainment of the objectives of the Project;

b) Identification and evaluation of problem areas or constraints which may inhibit such attainment;

c) Evaluation, to the extent feasible, of the overall development impact of the project.

C. Negotiating Status

Except for the writing of this Project Paper to conform with the prescribed AID documentation system, the design of this project has been undertaken by the Philippine Government. A Technical Committee, organized and chaired by NEDA and composed of representatives from MOH, OBM and USAID was specifically tasked to define the essential elements of this project.

A cabinet-level Policy Committee co-chaired by the NEDA Director General and the Minister of Health, and composed of the Minister of the Budget and the Chairman of the Presidential Reorganization Commission reviewed and approved the project components recommended by the Technical Committee. The final project design is a reflection of the kind of assistance that the Philippine Government feels it needs to improve the country's PHC delivery system.

Given the manner by which this project was designed, we anticipate no difficulties in concluding an agreement as soon as this project is authorized.

ANNEXES

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable generally to FAA funds, and criteria applicable to individual fund sources: Development Assistance and Economic Support Fund.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 481. Has it been determined that the government of the recipient country has failed to take adequate steps to prevent narcotic drugs and other controlled substances (as defined by Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or process, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully? **1. No**

2. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? **2. No.**

3. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. **3. No.**

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citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

4. FAA Sec. 532(c), 620(a), 620(f), 620D; FY 1982 Appropriation Act Secs. 512 and 513. Is recipient country a Communist country? Will assistance be provided to Angola, Cambodia, Cuba, Laos, Vietnam, Syria, Libya, Iraq, or South Yemen? Will assistance be provided to Afghanistan or Mozambique without a waiver?

4. No, No, No.

5. ISDCA of 1981 Secs. 724, 727 and 730. For specific restrictions on assistance to Nicaragua, see Sec. 724 of the ISDCA of 1981. For specific restrictions on assistance to El Salvador, see Secs. 727 and 730 of the ISDCA of 1981.

5. N/A.

6. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U.S. property?

6. No.

7. FAA Sec. 620(l). Has the country failed to enter into an agreement with OPIC?

7. No.

8. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters?

8. a) No.

(b) If so, has any deduction required by the Fishermen's Protective Act been made?

b) N/A.

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9. FAA Sec. 620(q); FY 1982 Appropriation Act Sec. 517. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any AID loan to the country? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the appropriation bill appropriates funds?	9. a) No. b) No.
10. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the amount of foreign exchange or other resources which the country has spent on military equipment? (Reference may be made to the annual "Taking into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)	10. Yes.
11. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	11. No.
12. FAA Sec. 620(u). What is the payment status of the country's U.S. obligations?	12. Satisfactory.

If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget? (Reference may be made to the Taking into Consideration memo.)

13. FAA Sec. 620A; FY 1982 Appropriation Act Sec. 520. Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed an act of international terrorism? Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed a war crime?

13. No.

14. FAA Sec. 666. Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

14. No.

15. FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements of safeguards? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such state, either received or detonated a nuclear explosive device, after August 3, 1977? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

15. No.

16. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and heads of Delegations of the Non-Aligned Countries to the 36th General session of the General Assembly of the U.N. of Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.)

16. No.

17. ISDCA of 1981 Sec. 721. See special requirements for assistance to Haiti.

17. N/A.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

1. a) No.

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the country made such signficant improvements in its

2. a) No.

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human rights record that furnishing such assistance is in the national interest?

b. ISDCA of 1981, Sec. 725(b). If ESF is to be furnished to Argentina, has the President certified that (1) the Govt. of Argentina has made significant progress in human rights; and (2) that the provision of such assistance is in the national interests of the U.S.?

2. b) N/A

c. ISDCA of 1981, Sec. 726(b) If ESF assistance is to be furnished to Chile, has the President certified that (1) the Govt. of Chile has made significant progress in human rights; (2) it is in the national interest of the U.S.; and (3) the Govt. of Chile is not aiding international terrorism and has taken steps to bring to justice those indicted in connection with the murder of Orlando Leterlier?

2. c) N/A

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance Funds, B.2. applies to projects funded with Development Assistance loans, and B.3. applies to projects funded from ESF.

CROSS REFERENCES:	IS COUNTRY CHECKLIST UP TO DATE?	Yes
	HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?	Yes

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act Sec. 523; FAA Sec. 634A; Sec. 653(b).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;	a) Congressional Presentation FY 83, Annex II, Asia, Page 135.
(b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that amount)?	b) Yes

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and

(b) a reasonably firm estimate of the cost to the U.S. of the assistance?

2. a) Yes.

b) Yes.

3. FAA Sec. 611(a) (2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

3. No further legislation is required.

4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973? (See AID Handbook 3 for new guidelines.)

4. N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

5. N/A

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs

6. No.

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the

country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

7. a) N/A

b) and c) Project will encourage and provide funds for local communities, cooperatives and private organizations to test the financing of local health care services.

d), e) and f) N/A

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

8. N/A

9. FAA Sec. 612(b), 636(h); FY 1982 Appropriation Act Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

9. The project will utilize funds from the GOP 1984 appropriation earmarked for foreign assisted projects. Therefore, it will have a separate line item in the appropriation.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have made for its release?

10. N/A

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

11. N/A

12. FY 1982 Appropriation Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?	12. N/A
13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16? Does the project or program take into consideration the problem of the destruction of tropical forests?	13. Yes and N/A
14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?	14. N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to	a. Communities, private and public organizations and cooperatives will test schemes that will provide accessible and affordable primary health care to poor rural residents especially mothers and children. The schemes will be developed and designed at the community level.

small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 203, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

b. Yes

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

c. N/A

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

d. The Project Agreement will commit the GOP to contributing more than 25% of total project costs.

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? (M.O. 1232.1 defined a capital project as "the construction, expansion, equipping or alteration of a physical facility or facilities financed by AID dollar assistance of not less than $100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character."

e. N/A

f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

f. **Yes.**

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government

g. **The primary health care financing schemes of the project will be designed and developed at the community level by the people.**

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2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest.

2. a. Available

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

b. N/A

c. ISDCA of 1981, Sec. 724 (c) and (d). If for Nicaragua, does the loan agreement require that the funds be used to the maximum extent possible for the private sector? Does the project provide for monitoring under FAA Sec. 624(g)?

c. N/A

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Section 102?

3. a. N/A

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?

b. N/A

c. FAA Sec. 534. Will ESF funds be used to finance the construction or the operation

c. N/A

or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such use of funds is indispensable to nonproliferation objectives?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

d. N/A

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5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	1. Yes.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?	2. Procurement will be from the U.S., Philippines and 941 countries.
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	3. Yes.

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	4. N/A
5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one or these areas?	5. N/A
6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent that such vessels are available at fair and reasonable rates?	6. No.
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnised by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal	7. Yes.

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agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? — 8. Yes.

9. FY 1982 Appropriation Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? — 9. Yes.

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? — 1. N/A

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? — 2. N/A

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP)? — 3. N/A

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C. Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?	1. Yes.
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?	2. N/A
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?	3. Yes.
4. Will arrangements preclude use of financing:	
a. FAA Sec. 104(f); FY 1982 Appropriation Act Sec. 525: (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion?	4. a.1) Yes a.2) Yes a.3) Yes a.4) Yes

b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property?	b. Yes
c. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	c. Yes
d. FAA Sec. 662. For CIA activities?	d. Yes
e. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	e. Yes
f. FY 1982 Appropriation Act, Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel?	f. Yes
g. FY 1982 Appropriation Act, Sec. 505. To pay U.S. assessments, arrearages or dues?	g. Yes
h. FY 1982 Appropriation Act, Sec. 506. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)?	h. Yes
i. FY 1982 Appropriation Act, Sec. 510. To finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields?	i. Yes
j. FY 1982 Appropriation Act, Sec. 511. Will assistance be provided for the purpose of aiding the efforts of the government of such country to	j. No

repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	
k. FY 1982 Appropriation Act, Sec. 515. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?	k. No

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OUTLINE OF A HEALTH, POPULATION, AND NUTRITION STRATEGY FOR USAID IN THE PHILIPPINES

Introduction

The following pages represent a first attempt to summarize USAID's emerging analysis of national needs in the population, health, and nutrition (PHN) "sector" in the Philippines and to present the outline of a program to most effectively apply AID's limited resources to these needs. The paper has two main sections: an assessment of the current situation with respect to population, health, and nutrition; and a prescription for the application of AID resources to deal with the major needs which have been identified.

Assessment of Population, Health, and Nutrition in the Philippines

The Asia Bureau's Health, Population, and Nutrition Strategy, which was issued in early 1980, identifies fertility and infant/child mortality as the two variables to which the Bureau will give most of its attention in its PHN programming over the next several years. Accordingly, this strategy outline begins with a preliminary assessment of the principal causes of high fertility and high infant and child mortality.*

When one looks initially at the demographic situation in the Philippines, it is self-evident that rapid population growth remains a critical development issue. Fertility, while it has fallen in recent years, is still too high; it continues to hamper efforts to improve per capita well being. The crude birth rate (CBR) has declined from near 40 per thousand in 1970 to the low 30's in 1980. The Mission's 1979 Multi-Year Population Strategy argues that, while a substantial proportion of the decline was unquestionably caused by factors other than the availability of family planning services per se, the basic socio-economic conditions that predispose toward smaller families are such in the Philippines that a program that attempts to make family planning services nearly universally available represents the most cost-effective approach to further lowering the fertility level. Because this issue is discussed in detail in the aforementioned documents, and because the fundamental strategy has been accepted by the Government and AID/Washington as being sound, it is not discussed further here. However, the prescriptive section of this strategy returns to the question of how, in the medium term, the delivery of family planning services might be made more consistent with other elements of this strategy.

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* The Mission is in the process of carrying out a more thoroughgoing assessment of the determinants of infant/child mortality which will be used as the basis for subsequent project planning.

While the fertility situation and AID's approach to it have been thoroughly considered in the recent past, the same cannot be said for mortality. Therefore, this section will give primary attention to the main causes of infant and young child mortality.

Compared with fertility, mortality in the Philippines is quite low.* General mortality (i.e., the crude birth rate, or CDR) is nearly as low as that typical of the industrialized countries and wealthier LDCs. Recent estimates put it at below 10 per thousand. Of course, the decline in mortality since before World War II is the primary cause of the rapid population growth of the past 30-40 years. Similarly, there have been marked declines in infant mortality over the same period. In 1960 the infant mortality rate (IMR) was estimated to be over 100 per thousand, while in the 1970's most estimates had it below 70 per thousand.

The low general mortality rate masks, however, the fact that most of the deaths that do occur in the Philippines are among the young, whereas in the industrialized countries most deaths occur among the elderly. For this reason, life expectancy is considerably lower in the Philippines than, say, in France. Both countries have CDRs of 10, but life expectancy in France is 73 years, while in the Philippines it is around 60. This reflects both major differences in the age structures of more and less developed countries and differences in the patterns of disease. In fact, the low crude death rate in the Philippines is itself a reflection of the very young population that results from an excessively high birthrate. Thus, the low death rate should not be taken as an indication that there are few public health problems. The infant mortality level, while not among the highest in the Third World, clearly reveals continuing problems of malnutrition, low resistance to disease, and consequent high prevalence of respiratory and diarrheal diseases among pre-school children.

A second factor to be considered in any assessment of infant mortality is its variability across geographic regions and socio-economic groups. For while national averages may be comparatively low, they can also obscure important differentials within the population. In fact, in the Philippines, there are marked variations in the levels of infant mortality, both by region and by socio-economic group. In terms of regional variations, infant mortality ranges from a high of around 90/1000 in the Eastern Visayas, Northern Mindanao, and the Cagayan Valley, to a low of around 50/1000 in Central Luzon. This fairly wide range reveals that several areas of the Philippines suffer from conditions that are quite depressed by any standard.

Apart from the issue of geographical distribution of infant mortality, it is important to note several distinctive socio-economic correlates of mortality

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* Please recall that infant mortality statistics are usually quite inaccurate in LDCs. The Philippines is no exception.

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differentials. A number of socio-economic variables are strongly associated with infant mortality, according to Concepcion's recent analysis of survey data.* Foremost among these are access to clear water, women's education, women's employment (especially off-farm), family income, and place of residence (urban vs. rural). One must take care in looking beneath these simple correlations when attempting to ascribe causality. (Is the presence or absence of piped water a direct (biological) or indirect (income-related) "determinant" of mortality?) However, combining what is known about regional income and overall development differentials with the socio-economic factors just discussed reveals what appears to be a fairly close fit between poverty and mortality. The places where the poorest (often landless) live are also those in which mortality is highest.

Undernutrition is a serious problem for a significant segment of the Philippine population, most notably infants, pre-school children, and pregnant and lactating women. At present, the main reason for inadequate and food intake is low incomes and a consequent low purchasing power. In 1978, the nationwide nutrition survey conducted by FNRI revealed that households with incomes of less than 500 pesos per capita per year had an average daily per capita intake of 1,650 calories which represents roughly 80 percent of the recommended dietary allowance. On the other hand, households with incomes greater than 500 pesos per capita per year had an average daily per capita intake of 1,940 calories, which represents 95.5 percent of adequacy. Finally, there is also evidence that specific nutrient deficiencies related to goiter, anemia and Vitamin A deficiency exist.

Additional survey information suggests that there is poor distribution of food within families. Adult males in the household show a higher caloric intake indicating that less food is available for the women and children. This situation contributes to the poor nutritional status of a large percentage of pregnant women, often leading to the delivery of low birth weight (below 2.5 kilograms) babies. Low birth weight in turn influences neonatal mortality, contributes to high rates of mortality and morbidity in the first five years of life, and may adversely affect the individual's potential for development.

In sum, inadequate child spacing and the consequent drain on maternal nutritient stores lead to a relatively high incidence of low birth weight babies. A significant number of babies become undernourished. Undernourished infants and children are highly susceptible to certain diseases, including respiratory and diarrheal diseases -- the two principal causes of the high infant and child mortality rates. If a child survives the first five years of life in the Philippines, he or she is likely to live just as long as a North American, European or Japanese child. However, expectation of life at birth, because of the syndrome of undernutrition and infant and childhood diseases just portrayed, is nearly a decade less.

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* Mercedes Concepcion, "Factors in the Decline of Mortality in the Philippines, 1950-75," unpublished memo, 1980.

The Philippines has developed PHN priorities that implicitly recognize the importance of undertaking the key interventions to deal with this syndrome: nutrition surveillance and child feeding, family planning, and selected primary health care services. The Multi-Year Population Strategy and the various health and nutrition project papers of the past three years fully describe the network of service delivery systems. It needs only be said here that, more than most developing countries, the Philippines has chosen to mount largely independent categorical, or vertical, programs, each of which addresses one of the program areas just mentioned.* AID has been a willing, sometimes even eager partner in this program development process. The Commission on Population runs the Population Outreach program; the National Nutrition Council coordinates the Philippines Nutrition Program; and the Ministry of Health is engaged in the nationwide implementation of a primary health care system under the auspices of the World Bank's Population II project. The Ministry of Health program is not yet fully operational. The argument in favor of the vertical approach is that, in various other health-related fields, it has proven to be more effective in achieving the desired goal than have integrated, multi-purpose programs. The malaria and smallpox eradication campaigns are often used as examples. The principal argument against the categorical approach is that it is comparatively expensive and that it fails to capitalize on the natural complementarities that exist between maternal-child health, nutrition, and family planning. USAID's approach to this issue is considered in detail in the section which follows.

Strategy for the Application of A. I. D. Resources to Population, Health, and Nutrition Issues

It seems clear that, between fertility and mortality reduction, the former has higher priority in the Philippines situation. The country is past the mid-point of the "demographic transition" -- a time when fertility is still reasonably high while mortality is quite low. This is not to say that mortality, especially infant and child mortality, is not a problem. As the last section demonstrated, infant/child mortality remains an important development problem in the Philippines. However, in a situation of scarce resources and intensely competing demands for those resources it must be acknowledged that fertility continues to demand higher priority.

Because the Mission has written extensively about population in its detailed Multi-Year Population Strategy, it is not necessary to review the Mission's approach in detail here. Suffice it to say that the strategy emphasizes the delivery nationwide of family planning services to a population in which there

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* The Restructured Rural Health Care Delivery System of the Ministry of Health is a comparatively recent effort to provide complementary HPN services, but it exists side by side with independent national population and nutrition programs.

is considerable evidence of a latent demand for these services, while at the same time addressing itself to the less direct determinants of fertility that are likely to affect family size norms and child-bearing behavior for some years to come -- Section 104 (d).

In turning, then, to the question of mortality control, two issues become important. First, are there fertility-related aspects of a mortality control undertaking that would produce greater declines in fertility than could be gained from a fertility-control program alone? Second, is the mortality problem of sufficiently high priority to represent a legitimate claim on AID's very scarce resources?

The answer to the first question depends on whether or not the probability of survival of children already born affects subsequent child bearing behavior. The "child survival hypothesis" argues that if parents can be reasonably assured that their currently living children will survive, they will have fewer children overall. Thus, in the aggregate, the hypothesis says, declining infant mortality will lead to declining fertility. In fact, the child survival hypothesis remains the subject of considerable controversy. Evidence can be generated both to support and to refute the hypothesis. The literature is far from unanimous on the subject. However, notwithstanding the difficulty of finding conclusive confirmation of the hypothesis, and recognizing that fertility apparently can decline even in the absence of significant declines in infant mortality, it is striking that there is no country in which a significant and sustained decline in fertility was not preceded by an important decline in both general and infant/child mortality.* Certainly this has been the case in the Philippines. The fertility decline that has occurred has tended to follow a prior decline in infant and young child mortality. Consequently, we accept as an important assumption of this strategy that further declines in infant/child mortality will be required before fertility will fall to satisfactory levels -- i.e., below 20/1000 by the year 2000. Indeed, there is considerable evidence that the decline in fertility that has occurred has been heavily influenced by rising age at marriage. Since the average age at marriage is now approaching the high 20's for men and the mid 20's for women, it is expected that age at marriage will have less and less effect on future fertility and that the declines that must occur if the 20/1000 goal is to be reached will have to occur as the result of declining <u>marital</u> fertility.

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* We do not mean to imply single factor causality. Clearly fertility is a function of many different variables. It may be, however, that mortality decline is a necessary if not sufficient condition of subsequent fertility decline. Furthermore, it is arguable that fertility control programs, through increased birth spacing, help to lower mortality, thus creating a mutually reinforcing cycle of fertility and mortality decline.

It is thus the Mission's conclusion that interventions that are designed to bring about lower rates of infant and child mortality are required as part of a comprehensive fertility control strategy. There is a strong fertility rationale for health programs which emphasize reductions in infant and young child mortality.

Beyond the child survival hypothesis, there is another important reason for A.I.D. to remain concerned with infant and child health care and mortality prevention in the Philippines. As the descriptive section of this paper noted, the Philippines currently has underway a series of categorical, or vertical, social services delivery systems. The immediate and longer term cost implications of these separate and often overlapping systems are considerable. Furthermore, there is substantial evidence that if these services were offered in a single "package," there would be mutual reinforcements among the different components that would make each more effective than it is when delivered alone. Thus, maternal and child health care, nutrition, and family planning, when delivered as a package of primary health care, can achieve greater impact than can be achieved when they are delivered separately. Extensive field research in various parts of the world demonstrates that an effectively delivered package of primary care can have real impact on both fertility and infant/child mortality. Although the debate continues between advocates of vertical vs. integrated health programs, even the advocates of vertical programs agree that where the possibility of genuine combination of services exists (because the essential delivery system is already in place), it is preferred in terms of cost-effectiveness.

The Philippines is much further along than most developing countries in the establishment of a health or health-related service delivery capability at the barangay level. Furthermore, communication, logistics and transportation networks are well enough established that such primary care delivery systems can be established without undue difficulty and then maintained in most of the places where they do not currently exist. On a national scale, the Population Planning II Project and the Barangay Nutrition Scholars demonstrate the feasibility of training, deploying, and supporting barangay level social service workers. AID's PUSH and Bicol Integrated HNP projects and the W.H.O.-supported Tacloban (Region VIII) rural health project, among others, demonstrate on a regional level the operational feasibility of providing primary health care services in the Philippines. What is required at this point is a political decision to gradually combine the delivery of the most essential primary health care services at the barangay level. That decision has yet to be taken despite the acknowledged high cost of maintaining separate vertical programs. On the other hand, the Ministry of Health is publicly committed to the Health for All by the Year 2000 goal of the World Health Organization and is in the midst of planning and initiating the implementation of a national primary care program. The Mission assumes that the Government will gradually effect a transformation to a more fully rationalized <u>system</u> of primary care.

The foregoing may seem a bit glib to those who have criticized AID for its support of vertical programs up to the present. While acknowledging the legitimacy of this criticism, the Mission notes that there are still few barangays in which one can find more than one type of outreach worker. In other words, there is still time to retrain existing workers to become primary health care workers as the planned primary care system expands. The workers in population and nutrition who are currently supported under AID projects can become multi-purpose workers in a primary care system.* The changes in policy that must accompany this shift are high on the Mission's agenda.

Assuming these policy changes will occur and that the Government will pursue its commitment to HFA/2000, the Mission proposes a health sector strategy that centers around the notion of selective primary care as the major vehicle for the delivery of fertility and mortality control services. All of the elements that are required to bring about significant further declines in infant and child mortality are incorporated in a selective primary care approach except one, the increased availability of nutritious foods to families with malnourished children or children at risk of becoming malnourished. Other elements of the nutrition requirement can be handled under the primary care concept, i.e., nutrition education (including encouragement of breastfeeding) and nutrition surveillance through the regular weighing of infants and young children. The Government's policy (and hence AID's position) on the question of food consumption is the subject of intense internal debate as of this writing and will be the subject of a separate treatment.

With a primary care package, the critical elements of a fertility and mortality-centered approach, besides nutrition, are: 1) early case detection and referral/treatment, as appropriate, of upper respiratory and diarrheal diseases; 2) family planning;** 3) encouragement of breastfeeding (mortality, nutrition); 4) immunization for DPT and tuberculosis; 5) immunization for neonatal tetanus; and 6) health/hygiene education (including sanitation). Barangay level workers can be taught to deal with each of these areas effectively and in a way that creates mutual reinforcements among the individual intervention.

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* Thus, the following general strategy should not be seen as an abandonment of AID's current commitment to the population, health, and nutrition projects it supports. We seek to support the Government's own commitment to primary care while preserving the best in the categorical activities that are currently underway.

** Family planning services represent more than just a fertility control measure. Family planning is also a very important (some think the most important) maternal health measure.

Since AID is but one actor on the scene, it is important to note that several other donor agencies play key roles in the population, health, and nutrition field. While AID is the major donor in population, especially Outreach, the World Bank, through its Population I and II loans, is providing large-scale support to the Ministry of Health for both family planning and primary care training and infrastructure. UNFPA provides important supplementary assistance in the population sector. UNICEF provides assistance in health (especially oral rehydration therapy) and nutrition. W.H.O. provides technical assistance in all three areas, but especially in preventive health and disease control. Because other donor assistance is available for a variety of PHN activities and especially for capital and recurrent costs, and because AID's health sector resources will be quite limited for the next few years at least, it seems reasonable to attempt to capitalize on AID's strong comparative advantage as innovator and risk-taker -- a role that is particularly suitable given our comparatively large resident technical staff and longer exposure to development programs in the Philippines.

This consideration leads directly to the central element of the Mission's PHN strategy: the financing of primary care. Just as the Agency's resources are too limited to permit large-scale water and sanitation investments in the rural areas, so also will it be impossible for AID to underwrite the costs of developing and sustaining a comprehensive primary care program. Indeed, even with their considerably greater resources, the international development banks lack what is required to build and maintain an effective primary care system. Only the Government can generate the financial resources that will be required. But the central Government also cannot afford the full costs of an effective primary care system. In the final analysis, in order for a primary care system to be established in the Philippines that provides high quality services that meet real health needs, most of the costs will have to be absorbed by the communities in which the services are delivered. That is the major challenge that faces the Philippines: how to finance primary care. The basic shape of the service delivery system is known. The key services to be provided have been identified. The major unanswered question is how to pay for the services and, more specifically, how to pay the primary care workers enough so that they will provide the quality of service that people truly value. The Mission believes that AID can make a unique contribution in assisting the Philippines to systematically explore alternative mechanisms for the financing of an integrated primary health care delivery system that emphasizes the reduction of fertility and infant and young child mortality.

USAID/Philippines has considerable experience with the financing issue because of its prior and current support of projects which employ paid Outreach workers. Population Planning II and Population Planning III; Panay Unified Services for Health, and Bicol Integrated Health, Nutrition, and Population; and Food and Nutrition all have involved full or partial salary payments or stipends to field workers at the Barangay level or just above that level. Two main conclusions emerge from this sustained support for such workers.

First, it seems clear that some form of financial remuneration is required to sustain worker motivation over an extended period. While the spirit of voluntarism and the camaraderie of a good training experience can produce high levels of worker performance initially, this enthusiasm wanes quickly unless there is some form of incentive to continue to provide the services for which the worker was trained.

Second, recent experience has shown that the structure of revenue collection and control in the Philippines makes it all but impossible for local governments to assume 100% of the recurrent costs of barangay-level service delivery programs. While the final verdict on this issue is not in, the Mission has been disappointed that the planned local government assumption of Full-Time Outreach Worker (FTOW) salaries did not occur in Population Planning II. Population Planning III, PUSH, and Bicol IHNP are all designed with the expectation that the Government will assume recurrent costs by the end of the project. Past performance and what we know about current revenue-raising and disbursing capabilities gives the Mission continuing concern about the financing issue. It seems probable that efforts to transfer the costs of primary care to the local level will require the identification of mechanisms additional to or other than local governments for the generation and management of funds.

Finally, a note on the relationship of this health sector approach to the overall regional strategy of the CDSS: The Mission is not proposing necessarily to restrict population, health, and nutrition activities to the CDSS regions despite the fact that two current health projects, PUSH and Bicol IHNP, are limited to portions of Regions VI and V, respectively. However, to the extent possible, the effort to test out alternative financing approaches will be carried in one or more of the CDSS regions.

As regards population, the population problem is national and AID has been associated with the national program for several years. The costs of a population program are small in comparison with other development programs and AID's resources in this area are sufficient to support a national program. A decision by AID to restrict resources to the CDSS regions would result in very uneven coverage by the national population program.

Second, while the strategy that has just been outlined does not lend itself particularly well to regional implementation once major policy decisions have been reached, it is the Mission's intention to support the research and development phase in regions identified in the CDSS for AID concentration.

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ANNEX C

SAMPLE FINANCING SCHEMES

Agricultural Marketing Cooperative (AMC) Health Insurance Scheme

The following scheme was described in general terms by Dr. Carl Stevens as the result of a consultancy in February, 1982 during which he investigated the feasibility of establishing health care financing schemes in Regions V and VI. Dr. Stevens consulted with officers of Samahang Nayon Cooperatives (SNs) and AMCs, who expressed definite interest in the establishment of health schemes for their membership.

Agrarian reform legislation required all beneficiaries to become members of SNs. The SNs themselves, now sponsored by the Bureau of Cooperatives of the Ministry of Agriculture (recently transferred from the Ministry of Local Government), are now regarded as permanent, mainstay cooperatives to receive major emphasis in the coming years. SNs are local organizations, at the barangay level, a typical such cooperative having a membership of about 60 households. There are about 10,000 SNs that can be really identified as organizations although at present, of these, perhaps 4 to 5 thousand are robust, effectively functioning organizations. Presumably, under the aegis of the Bureau of Cooperatives, this number may be expected to increase.

The general outline of a likely organizational format for an alternative financing/delivery system, might be as follows:

A crop-based social amelioration fund (referred to as the Fund) would be established. A group of SNs would contract with the Fund to implement a basic health service program for their members. Under the terms of this contract, the Fund would make a contribution on health-insurance account to the Coops and they in turn would agree to provide matching funds from their own savings. Members of SNs would contribute a percentage of harvest to the Guarantee Loan Fund Act at one percent of the gross value of the output of all of the members.

It would be agreed that the insurance fund built up in this way would be used exclusively for health services for the membership of the Coops. The Coops would then contract with health-service providers on behalf of the membership, compensating the providers on a capitation (so much per member per month) or a salary basis. Providers might be full-time, part-time or some mix of the two depending upon the number of beneficiaries to be served and hence, the demand for various types of service. Each beneficiary would be entitled to a drug allowance. And there might be a provision for some consumer cost sharing for drugs and perhaps services (i.e., out-of-pocket payments by the beneficiaries set at some percent of the cost of the drugs or services). The Coops would negotiate with providers for favorable rates of compensation and with suppliers of drugs, medications and other supplies for favorable prices for these inputs. Since the Coops membership would represent a substantial market, the Coops should have some bargaining power, at least where alternatives exist on the supply side of the market.

Prior to commenting upon the advantages and disadvantages of schemes constructed along the foregoing lines, it will be well to address a few remarks to the supply side of the market.

The Question of Resources on the Supply Side

Will the real resources (mainly, health manpower, drugs and medications) be available such that the Coops can in fact contract for the provision of services for their members? To answer this question would require some detailed study of each market area proposed for the implementation of such schemes. However, some preliminary comments may be in order.

It is of course true in the health-services sector that demand will not always evoke an effective supply response without planned interventions on the supply side. Nevertheless, frequently this is a realistic possibility and one which is often overlooked by health planners who tend to be preoccupied with planned interventions on the supply side. In this context, it was pointed out to me by one respondent in Region V that the advent of MEDICARE in the Philippines did evoke a supply response in the market for hospital services, i.e., hospitals started appearing all over where there had been none before.

This probably and accurately depicts the course of events to be expected for supplies such as medications, drugs, ORT salts, etc. MOH systems around the world exhibit a chronic incapacity to cope with what has come to be known as the "logistics" of drug supply. Private marketeers, on the other hand, exhibit no such incapacity. In most situations, if there is a demand for supplies of this kind, the private market will get them there, with no need for a health-plan manager to fret about "logistics". As evidence of this, it appears that in the Philippines, the sari-sari stores operating in the rural areas routinely stock a fair selection of medication and drugs, including antibiotics, for over-the-counter purchase. The capacity of this distribution channel will presumably be enhanced by the MOH's Botika Sa Barangay Project (drug outlets to be operated by existing sari-sari store owners). According to the Annual Report for 1981 of the MOH, Regional Health Office No. 5, there were as of December 31, 1981, 2,242 operational Botikas Sa Barangay.

Health manpower is a different kind of problem, e.g., for high-level manpower, lags exist in training times as well as bottlenecks in the training sector. However, pending a longer-run supply response, it will be possible in some situations to rely upon existing health manpower. There are private practice physicians found in many of the municipal center (poblacions) on Panay Island. The Coops might contract with these physicians to provide services on a "per session" basis. In Region VI, there are considerable numbers of already trained midwives and nurses who now work as clerks, etc. rather than in the professions for which they were trained. This is due to a lack of effective demand for their professional services. Some of these professional providers might respond to the opportunity afforded by the alternative financing schemes to come back into the medical-care market. Where BHWs of the type fielded by the PUSH and health projects are in place, ways might be

found in which some of the services they can provide could be contracted for on a part-time, per session basis.

Some Advantages and Disadvantages of the Fund/Coops-Type Scheme

The advantages of this (or any other) scheme are to be considered relative to the next best alternative actually available (or likely to be available) to the beneficiaries. For most residents in rural areas in the Philippines, the next best actually available alternative would be the present situation of out-of-pocket payments in the private sector for services provided on a fee-for-service basis by western-medicine or traditional practitioners.

It appears that individuals who feel in need of medical treatment usually initially resort to self-medication, obtaining drugs from pharmacies, sari-sari stores or perhaps traditional practitioners. If beyond this a consultation is required, they will seek a private practitioner (which may include MOH personnel acting in a private capacity). (Even if they seek care from the MOH system, as such, they may be required to make a "donation" on the order of what would have been the private sector fee.) This information from Dr. Theresita R. Lariosa, U.P. School of Public Health is consistent with information from other sources.

As compared with "going bare" as the lexicon would have it, i.e., sole reliance upon out-of-pocket payment to finance our demand for medical care, the advantages of health-insurance seem obvious. Generally speaking, farmers (and others) organize themselves into coops of various kinds (producers coops, consumer coops) in order to gain the advantage of collective action (bargaining power) of this kind in transacting with others. One way to look at the Fund/Coops type of schemes is that it is another instance of this general institutional strategy, this time on the demand side of the market for medical services. The individual consumer of health care has very little bargaining power vis-a-vis the fee-for-service provider in the medical market place. On the other hand, if Fund/Coops could, because of their collective bargaining power, contract with providers for the provision of services to be compensated on a capitation or salary basis (or, failing this, on a discounted-fee basis), considerable savings might be realized.

Another frequently adduced advantage of capitation or salary remuneration schemes for providers is that, unlike fee-for-service, they do not afford an incentive for "unnecessary" treatment. Thus, according to Dr. Lariosa, the standard fee in the rural areas of Region I for an injection is ₱8.0, where the cost of the medications used may be in the ₱0.5 to ₱0.8 range. There would appear to be some room for bargaining in this situation. Similarly, there may be room for bargaining with respect to prices for medications and drugs, per se.

One might inquire at this point why bother about Samahang Nayons and the like, why not just organize outright consumers coops for the purchase of medical care. One answer is that Fund-Coops schemes and the agriculture coops, as an

official part of organized agriculture, are more natural contractors with the Fund component. But there is another point to be made in this context which goes to a very important advantage of the Fund/Coops type scheme. There is a necessity for a sturdy organization framework to provide an aegis for health insurance in rural areas. To afford maximum benefit to consumers, participation in health-insurance schemes should be in some way a collective-consumption decision. Owing to adverse risk selection factors, insurance schemes in which beneficiaries are enrolled as individuals always entail much higher premiums than schemes under which beneficiaries are enrolled as members of groups (usually, groups of employees, as one advantage of employment-related health-insurance schemes is that these afford a natural mechanism for group enrolment). Fund/Coops schemes afford a natural mechanism for group enrollment of those who live and work in the rural, agriculture economy.

In terms of possible disadvantages, since not everyone in the agriculture work force is a member of effectively organized agriculture (coops or other organizations), such schemes cannot cover the entire agriculture work force and that such schemes are in a sense unfair to those who cannot participate. This objection is not be to dismissed lightly. Equity is a prime consideration. Implicitly or explicitly, proponents of this view hold to the position that we should work for and hold out for one, grand monolithic scheme which in the not too distant future would effectively cover everybody. Their position would be stronger if this were a realistic probability, which it may not be. It is more likely that the health-services sector will evolve in a heterogeneous way with different consumers obtaining services in different institutional contexts. And, without the development of alternative social-financing schemes, too many of these contexts will leave many consumers who can ill afford it making out-of-pocket payments for services provided in the private sector on a fee-for-service basis. Moreover, the equity argument cuts several ways. Thus one might inquire whether it is fair to deny those, who are organized such that they can take advantage of collective action, this opportunity just because everyone is not so organized? It seems to me likely that in the longer-run configuration of the health services sector, consumers who do not have access to alternative social-financing schemes will obtain services from the MOH system or something like it.

What might be regarded as another disadvantage of Fund/Coops type schemes relates to various aspects of their income-distribution implications. Generally speaking, those who live and work in the urban, modern economy have higher incomes than do those who live and work in the rural, agriculture economy. Contributions to health insurance funds built up on crop levies and the surplus of coops are taxed such that the incidence may fall mainly on the factors of production in agriculture. To the extent to which this is true, the poorest sector of the economy is being asked to bear the burden of its own health-care consumption. This, it may be argued, is inequitable, i.e. the richer sector (individuals) in the economy should be required by the financing schemes to subsidize the consumption of health-care services by the poorer sector (individuals). Whether or not one shares this particular

income-distribution preference, there are also practical questions to consider. It is true that, to the extent that MOH-type systems are financed from revenues yielded by progressive taxes and deliver services to those in the lower end of the income distribution, some desirable income redistribution is in this way achieved. However, the search for alternative financing schemes has become a lively concern in many LDCs in part precisely because of the apparent incapacity of Ministry of Health-type systems to obtain the financing necessary to deliver an acceptable level and quality of services, particularly to those who live and work in the rural, agriculture economy. Again, the point is that we need to compare our alternative financing schemes not to some ideal state representing the best of all possible worlds, but rather to the next best alternatives which are apt to be available to the beneficiaries of these schemes.

Rural Enterprise Related Financing Scheme

The enterprise-based health care financing scheme is a prototype scheme which has been utilized in several projects in the country. Samples of such schemes are the Davao People's Foundation Katiwala Project in Davao City and the Sudtonggan Project in Cebu.[1/] In both cases, members of small organizations involved in income generating projects agreed to utilize a percentage of the profits from the productive activities to finance health care services. While there could be a great deal of variety in the complexity of the schemes and sophistication of the services offered, the viability of the scheme depend on the financing generated by the rural enterprise and on the organizational structure normally associated with the enterprise.

In both of the schemes of this kind documented by Alfiler, the enterprises were established primarily to provide additional income to very poor groups of people. The financing of health services was added on because of the perceived inadequacy of the services the members were already utilizing. In both cases, members of the enterprise were consulted and they voluntarily agreed to the conditions of the scheme. The managers of the enterprise then assumed responsibility for organizing the health delivery mechanism.

The exact structure of such schemes would depend a great deal on the financial stability of the enterprise, the accessibility, acceptability and affordability of alternate health services, the administrative capability of the enterprise's manager(s) and the willingness of the members to participate in the scheme. In most cases, it would make sense for a scheme to evolve gradually, beginning with a fairly simple mechanism for obtaining a limited number of primary health care services to a more comprehensive health care plan involving larger funding arrangements and more complicated administrative structures.

1/ Local Resource Utilization Schemes for Selected Community-Based Primary Health Care Projects in the Philippines, Alfiler, M.C. Nov. 1982.

A very simple scheme might include the following:

(1) A full-time barangay health worker would be selected and trained in one of the on-going BHW training programs. The MOH Rural Health Unit located in the nearest poblacion would be requested to provide technical supervision and support to the BHW. The BHW will receive administrative and financial support from the enterprise management group including a small operating budget for travel and expendable supplies.

(2) A small health station could be constructed (or the barangay hall utilized) as a center for health activities. The BHW would be responsible for family health records, including a list of children needing immunization every quarter. The BHW would arrange for RHU personnel to administer the immunizations on a quarterly schedule. The BHW would also keep an RHU-provided supply of Oresol (oral rehydration packets) and contraceptives (from POPCOM) and make sure that adequate stocks are maintained and distributed free of charge.

(3) Fund raising campaigns will be used to purchase weighing scales and other one-time expenditures. Bandages and other expendable first aid supplies and folders for family records will be taken from the enterprise funds set aside for health. The enterprise treasurer would provide the BHW with travel money as needed and funds to buy the items mentioned above. Expenditures would be reported to members on a quarterly basis.

(4) A botica sa barangay would be established using free drug samples and purchasing drugs initially with the enterprise funds. Drugs will be sold at cost or a small mark-up to provide for resupply of stocks. The treasurer and BHW would purchase drugs during trips to the poblacion.

(5) Non-association users of BHW services would be charged a service charge per visit in addition to the cost of any drugs needed.

(6) An emergency medical fund could be maintained by the enterprise. In the event of death or hospitalization of any immediate family member of the workers, the family would be eligible for a pre-determined amount during a one year period.

(7) The BHW would actively promote family planning among the families and keep records on pregnancies and contraceptive use. She would teach the value of and demonstrate the use of Oresol, monitor growth of under-five children, provide nutritional guidance for pregnant women and children, teach mothers how to manage fevers and treat simple childhood problems. She will arrange for referrals to the RHU or nearest emergency hospital as necessary.

(8) A health campaign fund could be maintainted to undertake community projects like sanitation, community gardens, and so on. The BHW would get the membership's concurrence to utilize those funds.

The simple set of services described above can be financed and managed fairly easily by even a small and relatively inexperienced rural enterprise association. Problems can occur with accountability of funds and fluctuations in the profits generated by the enterprise. However, enough experience exists now to help structure such schemes in ways which help avoid these problems.

More sophisticated services can be added on to the basic package as finances and organizational capability increases. It is important to maintain a balance of services, i.e., those which are known to have a greater health impact with services which are in demand. Mortuary funds and emergency medical funds are not often viewed by health planners as essential basic PHC services, however, they are very much in demand in the rural Philippines and may form an important selling point for the whole package.

Advantages and Disadvantages of Enterprised-Based Schemes

The major disadvantage of the enterprise-based scheme is that the scheme is dependent on the financial health of the enterprise itself. In the case of the Sud-tonggan Project in Cebu, a decline in the profitability of the rock industry seriously disrupted their ability to finance the social services from the profits. They have now diversified their sources of income but there will clearly be a delay period before the community recovers from the decline in their previous mainstay industry. Clearly, a feasibility study for the initiation of such a scheme should try to anticipate similar problems and build in alternate funding sources whenever possible. It should also be pointed out that this particular disadvantage also affects people who are not participants in health care financing schemes, i.e. general decline in family income adversely affects health expenditures.

The advantages of enterprise-based schemes are fairly evident. In a typical rural environment where excess liquidity for families is uneven over time and small in any case, it is less of a burden to tax a profit making enterprise collectively than the family directly. The size of the health fund tends to remain more constant and predictable and therefore financial planning is easier. And perhaps most importantly, the problems of individual collections are eliminated i.e., the problems associated with collecting late payments, or interrupting service to those who do not maintain payments.

As in many other kinds of schemes, careful procedures will have to be built into the structure of the scheme to minimize risk of an individual absconding funds or taking on an unacceptable amount of decision making authority on behalf of the membership. Written expenditure reports distributed to the memberships, periodic audits of records, correct banking procedures, election of managers and consulting the membership on expenditure plans all serve as safeguards against such abuses.

Hospital-Based Primary Health Care Scheme

There are numerous private or government hospitals who could pilot test insurance schemes similar to the Medicare Phase II pilot project in Dumarao, Capiz described by Alfiler.[1/] The structure of this kind of scheme might be as follows:

Clients would be required to pay a fixed monthly premium in exchange for a basic service package for themselves and immediate family members. The services would include a full-time Barangay Health Worker or Midwife trained and supported by the hospital for each participating barangay, free outpatient consultations with one of the hospital based physicians if referred by the BHW, subsidized in-patient care up to certain limits, and a yearly drug allowance. In this manner, the hospital could operate a three-tiered service and referral system.

At the barangay level, the trained "hilot", midwife or skilled BHW would serve as the primary contact point. Their duties would include providing a set of preventive and basic curative services and referring cases needing professional attention to the hospital physician located in the poblacion. The services provided would be immunizations, family planning motivation and contraceptive supplies, growth monitoring and nutrition education for young children, pre-natal and post-natal care for pregnant women (plus deliveries for low-risk mothers), first aid, botica sa barangay operations and promotion of oral rehydration therapy. Hospital staff would provide technical supervision and commodity support for the barangay workers. Secondary level care would be provided by the hospital physicians to patients referred through the Barangay worker. For those who are members of the health scheme, consultation would be free. Drugs purchased either at the Botica sa Barangay or hospital pharmacy (or other commercial outlets) will be reimbursed up to a pre-determined limit per family.

In-patient care would be available to members at highly subsidized rates for confinement not exceeding a certain number of days at the subsidized rate. For cases needing more specialized attention, the hospital will refer patients to the nearest facility but reimbursements will not exceed the established rates for the base hospital.

Premiums would be payable in monthly or quarterly intervals at the hospital accounts office. Benefits will not begin until a certain minimum number of months had been collected (say three months which could be paid for in a lump sum). This would be to discourage people from paying sporadically, only when they are ill. Special discounts and other incentives will be offered those who maintain regular payments.

1/ Local Resource Utilization Schemes for Selected Community-Based/PHC projects in the Philippines, M.C. Alfiler, November 1982.

Advantages and disadvantages

The principal advantage of this type of financing scheme is the good technical and administrative support capabilities provided by having the scheme managed by the hospital. Because of the structure of the scheme, the financial incentives exist for the hospital to keeping in-patient stays minimized to reduce their own costs. There are disincentives for patients to seek care elsewhere and to conserve on their hospital stays. The screening function performed by the barangay worker will help conserve on out-patient visits requiring the doctors time for simple complaints and preventive care. The screening function also insures that more chronic illnesses or serious cases needing medical attention are referred early enough to avoid or minimize prolonged hospital stays.

The disadvantages are also several. This kind of scheme requires that the participating barangays be located within a reasonable geographic distance or be fairly accessible by affordable transportation. Benefits of membership would decline with accessibility problems to the referral facility and basic support structure. The most needy communities are often ones who are fairly isolated.

Another disadvantage lies in the individual family membership where the costs of the premiums are not shared collectively as they would be in an enterprise/profit based system. The premiums will represent a direct burden on the individual family. This may affect people's ability to maintain regular membership and discriminate against the poorest families. The Alfiler report on the Medicare Phase II pilot test in Capiz, however, offers encouraging evidence that given a reasonable membership fee and acceptable standard of care, few drop-outs may actually occur even among low income families who have seasonal work.

SAMPLE FINANCING SCHEME USING PRE-PAID HEALTH CARE PLAN

1. An alternative mode for delivering primary health care services in the rural areas is through a pre-paid health maintenance or insurance scheme to be managed and maintained by local private organizations. Like the proposed Project Medikong Bayan of POPCOM,[1/] this scheme essentially requires a private organization or association supervising and maintaining non-professional community-based health workers (or BHWs) who would be financed for the most part through a pre-paid plan subscribed to by residents in the barangay. While not appropriate for all barangays, this kind of plan might appeal to those who are dissatisfied with existing services or who want a more comprehensive set of services.

1/ Commission on Population, "Project Medikong Bayan-Project Request for U.N. Fund for Population Activities," October 1978 (Draft).

2. The organization or association will market an inexpensive pre-paid health maintenance plan that is acceptable and subscribed to by families in the barangay(s). The cost of the plan should take into account the socio-economic conditions of the households in the community and their health spending behavior. The barangay residents would be encouraged to participate in the scheme because it will allow them to spread their medical expenditures over time, possibly cushioning them from the disastrous effects of unexpected large medical care expenses. This is because the Plan will enable the subscriber and members of his family to avail of the services of a full-time BHW who will be equipped to provide them with basic curative, preventive and educative health and family plannning assistance. In addition, the health plan would include use of the services of medical personnel hired or retained by the organization to handle cases beyond the competence of BHWs, and annual medicine benefits up to a certain amount per family. The annual fees or premiums for the health plan could be paid in monthly or quarterly intervals depending on the financial capability of the households. The organization would hire collectors and offer incentives to subscribers to compel them to pay the dues on time.

3. To be able to provide PHC services to its clients in barangay, the local organization would recruit, support the training, supervise and compensate selected full-time community-based health workers and, at the same time, retain professional physicians within the municipality to assist these BHWs and provide medical services to subscribers when necessary. The BHW will undergo the regular training program for non-professional community health workers. Aside from providing PHC services and maintaining family health records, the BHW is expected to link her barangay through a referral system, to the higher levels of health services available from the government and the private sector. She would also utilize the other services provided by various public social service agencies to meet the needs of her clients in the community. The BHW would receive technical supervision from medical personnel retained by the organization, as well as informal guidance from municipal health personnel, particularly the Rural Health Unit (RHU) staff. In turn, the organization would pay the BHW a monthly stipend commensurate with the economically productive time she spends performing her duties.

4. The structure and composition of the local organization would vary depending on the existing socio-economic and political characteristics of the community. It could be run by a private group, a private voluntary agency or a civic organization. It could even be a joint government-private sector endeavor. But ideally, the organization should be comprised of local community leaders, medical practitioners and other individuals interested in uplifting the quality of health services in the area, and should be managed just like any business enterprise. For its initial capitalization, the organization could solicit donations from civic organizations, prominent families, local officials, etc.;

undertake fund-raising activities such as dances, lotteries, basketball games, etc.; and/or issue stocks of ownership to a selected group of individuals, and later on, redistribute the organization's profits from its operations to the stockholders as dividends. The funds to be generated from these activities would then enable the organization to acquire fixed assets and finance other capital expenses (i.e., office space, supplies, BHW training support, medicine kits, weighing scales, etc.).

5. Further, the organization would also establish in each of the participating communities a Botica sa Barangay using free drug samples and purchased medicines. The latter will be sold at a certain mark-up to replenish stocks and to partially support the medicine benefits of subscribers. Non-subscribers to the health plan can also avail of the services of the BHW but will be charged a fixed fee per visit in addition to the costs of any drugs needed.

Advantages and Disadvantages of a Pre-paid Health Plan Scheme

A major advantage of a pre-paid health plan scheme is that it provides a clear mechanism for generating adequate resources to improve and sustain the delivery of PHC services to participating communities. Being profit-oriented, the organization is likely to remain viable as long as it is able to serve its clients satisfactorily and run the operations efficiently. In turn, the barangay families are able to express disinterest or dissatisfaction with the scheme by either not participating on the health plan or refusing to pay the fees.

On the other hand, this type of financing scheme has several drawbacks. For one, ability to pay is an overriding factor to qualify in the health plan, so this implies that households unable to afford the fees, which usually have the greatest need for health and medical assistance, would be deprived of the organization's services and a possible source for improving their health status. Similarly, in order to finance the BHWs and the organization's operations, the market for the Plan should be large enough to make it a viable undertaking. This means that a significant portion of the barangay population should be motivated and willing to participate in it, which is very difficult to achieve in many needy local communities. It appears then that this scheme is likely to be most applicable only in relatively better-off barangays. For another, the pre-paid health plan scheme often involves a rigid and formal organizational set-up requiring some business and technical (planning, actuarial science, accounting) skills that may not be readily available in the community. Therefore, it requires more sophistication, longer design preparation and larger project staff compared to other types of health financing schemes.

Annex D

The PCHRD Structure Vis-a-Vis The R & D Component of the Primary Health Care Financing Project

The Philippine Council for Health Research and Development (PCHRD) has been mandated through Executive Order No. 784 to enhance the systematic coordination of health research and developmental activities in the country. In the pursuit of this mandate, the PCHRD promulgates policies related to health research, develops a comprehensive health research and development plan and ensures the dissemination and utilization of research results.

In view of these mandated functions, the Council has the organizational structure required to plan, develop, evaluate and monitor research projects. Moreover, it already has a well-developed mechanism to undertake these functions. Therefore, the management of the R & D component of the USAID-supported Primary Health Care Financing Project (PHCF) will very well fit into these existing organizational and functional structures.

More importantly, the PCHRD has identified Health Services Research as one of its priority research programs and has already identified primary health care as one of the priority research areas under the program.

In the management of the PHCF, the following structures in the PCHRD will be involved:

1. Secretariat

The PCHRD secretariat, particularly its Research Management and Development Department, using as a framework the research program developed by the Health Services Technical Committee, will identify capable project proponents and assist them in project development. The Secretariat will also be responsible for monitoring on-going projects.

In terms of fiscal management, the Secretariat has the following mechanism:

A. Government GIA Funds

A.1 GIA funds received as part of the Council's appropriation are allocated among approved research proposals based on previously defined priorities.

A.2 GIA released to the different proponents are deposited in a special current account with the PNB or any authorized bank in the locality in the name of the project. Unexpended balances at the end of calendar year are not reverted to the general fund (P.D. 1502).

A.3 Memoranda of Agreements stipulate specific obligations of each party.

B. Loan Proceeds

Proceeds from loans form part of the appropriation for the Council and are administered in the same manner as A.

C. GIA Funds From External Sources

C.1 Grants received by PCHRD from all sources without any stipulation/qualification as to the manner by which such grants shall be spent shall be subject to the provisions of the PD 1177. The grant shall be deposited in a Trust Fund and shall be spent in accordance with a Special Budget duly approved by the Ministry of the Budget.

C.2 Grants intended to support specific projects in health with qualifications and/or stipulations as to the manner by which such grants shall be spent per signed memoranda of agreement shall be deposited in a designated bank as a Special Trust Liability. Expenditures shall be in accordance with the terms and conditions of the agreement and approved line item budgets.

In all cases, the pertinent and relevant provisions of PD 1502 relative to research shall apply.

2. Technical Committee on Health Services Research

The Committee is an intersectoral and interdisciplinary body composed of the following:

Dr. Amanda Valenzuela	- Dean, UP Institute of Public Health
Dr. Flora A. Bayan	- Head, Primary Health Care Program, Ministry of Health
Dr. Ledevinia Carino	- Dean, UP Institute of Public Administration
Dr. Loreto Cabanos	- National Economic and Development Authority
Dr. Sergio Gasmen	- Comprehensive Community Health Program, Bay, Laguna
Dr. Vicente Paqueo	- UP School of Economics
Dr. Dolores Recio	- Dean, UP School of Nursing

The Committee will primarily be responsible for project evaluation, identification of research gaps, prioritization of research proposals, and the overall assessment of the progress of the health services research program.

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3. Program Planning Review Board (PPRB)

The PPRB, likewise an inter-agency group, will review projects before final approval by the Governing Council to ensure that these projects are not only technically feasible, but in accordance with national development goals.

The membership of the PPRB include:

Dr. Andres Galvez	- Chief, Planning Service Ministry of Health
Ms. Fleur de lys Torres	- Director, Social Services Staff National Economic and Development Authority
Dr. Ramon Abarquez	- Chairman, Medical Division National Research Council of the Philippines
Mr. Maximo Domingo	- Director, Budget Operations Ministry of the Budget
Dr. Y. S. Kim	- Program Coordinator to the Philippines World Health Organization
Mr. Fortunato dela Pena	- Chief, Planning Service National Science and Technology Authority

4. Governing Council

In the Governing Council is vested the authority to approve research projects. In addition, it will provide policy guidelines and will ensure that projects are translated into policies and programs which can be utilized by concerned service agencies.

The Governing Council consists of the following:

Dr. Emil Q. Javier	- Director General National Science and Technology Authority
Dr. Antonio Acosta	- Deputy Minister, Ministry of Health
Dr. Florentino Herrera	- Chancellor, Health Sciences Center University of the Philippines
Dr. Alberto G. Romualdez, Jr.	- Executive Director Philippine Council for Health Research and Development
Ms. Delfina Aguillon	- Deputy Director National Nutrition Council

Dr. Perla Santos-Ocampo	)	
Dr. Juan Torres	)	representing the private sector
Fr. Emeterio Barcelon	)	
Dr. Paulo Campos	)	

To summarize, the PCHRD has existing organizational and functional structures capable of managing research programs and projects, such that no additional structure will be necessary to see to the efficient management of the R & D component of PHCF.

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Estimated Budgetary Requirements
By Year ($000)

	COMPONENT	1983 AID	1983 GOP	1984 AID	1984 GOP	1985 AID	1985 GOP	1986 AID	1986 GOP	1987 AID	1987 GOP	1988 AID	1988 GOP	TOTAL (AID&GOP)
1.	Financing Schemes	50	34	570	100	796	100	696	106	654	96	234	96	3532
	a. Grants to Institutions	-	-	470	-	700	-	600	-	600	-	180	-	2550
	b. Administrative Costs	50	34	100	100	96	100	96	106	54	96	54	96	982
2.	Special Studies	600	16	275	25	159	25	59	34	41	34	16	34	1318
3.	Service Delivery	-	-	1000	1750	2300	2550	2400	2550	1000	1750	800	1600	17700
	a. Botica sa Barangay Pr.	-	-	100	50	500	250	500	250	500	250	400	200	3000
	b. BHW/Midwifery Prog.	-	-	100	500	500	800	500	800	300	500	200	400	4600
	c. PHC Commodities	-	-	600	200	1000	500	1000	500	-	-	-	-	3800
	d. IEC	-	-	200	1000	300	1000	400	1000	200	1000	200	1000	6300
4.	Other Support Costs	-	-	60	-	60	-	60	-	60	-	60	-	300
5.	Project Evaluations	-	-	-	-	25	-	-	-	-	-	25	-	50
	TOTALS	650	50	1905	1875	3340	2675	3215	2690	1755	1880	1135	1730	22900

*GOP figures include imputed costs.

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AID-Funded
Budgetary Requirements
By Year ($000)

COMPONENT	1983 Grant	1983 Loan	1984 Grant	1984 Loan	1985 Grant	1985 Loan	1986 Grant	1986 Loan	1987 Grant	1987 Loan	1988 Grant	1988 Loan	TOTAL
1. Financing Schemes	50	-	310	260	260	536	160	536	110	544	60	174	3000
a. Grants to Institutions	-	-	310	190	260	442	160	420	110	464	60	134	2550
b. Administrative Costs	50	-	-	70	-	94	-	116	-	80	-	40	450
2. Special Studies	600	-	225	50	125	34	25	34	25	16	-	16	1150
3. Service Delivery	-	-	-	1000	-	2300	-	2400	-	1000	-	800	7500
a. Botica sa Barangay Pr.	-	-	-	100	-	500	-	500	-	500	-	400	2000
b. BHW/Midwifery Prog.	-	-	-	100	-	500	-	500	-	300	-	200	1600
c. PHC Commodities	-	-	-	600	-	1000	-	1000	-	-	-	-	2600
d. IEC	-	-	-	200	-	300	-	400	-	200	-	200	1300
4. Other Support Costs	-	-	-	60	-	60	-	60	-	60	-	60	300
5. Project Evaluations	-	-	-	-	25	-	-	-	-	-	25	-	50
TOTALS	650	-	535	1370	410	2930	185	3030	135	1620	85	1050	12000

Projection of AID Estimated Expenditures by Calendar Year and Component
Primary Health Care Financing Project
($000)

	Component	1983	1984	1985	1986	1987	1988	TOTAL
1.	Financing Schemes	50	480	826	746	564	334	3,000
	a. Grants to Institutions	-	380	730	650	510	280	2,550
	b. Administrative Costs	50	100	96	96	54	54	450
2.	Special Studies	175	600	259	59	41	16	1,150
3.	Service Delivery	-	1000	1550	1975	2025	950	7,500
	a. Botica sa Barangay Program	-	100	450	525	525	400	2,000
	b. BHW/Midwifery Programs	-	100	400	400	450	250	1,600
	c. PHC Commodities	-	600	500	750	750	-	2,600
	d. IEC	-	200	200	300	300	300	1,300
4.	Other Support Costs	-	60	60	60	60	60	300
5.	Project Evaluations	-	-	25	-	-	25	50
	TOTALS	225	2,140	2,720	2,840	2,690	1,385	12,000

Summary Cost Estimate and Financial Plan
($000)
RHC Financing Project

SOURCE	AID Grant FX	AID Grant LC	AID Loan FX	AID Loan LC	GOP FX	GOP LC	(GOP & AID) TOTAL FX	(GOP & AID) TOTAL LC	Total FX & LC
1. Financing Schemes	50	600	34	2,316	-	532	84	3,448	3,532
a. Grants to Institutions	-	600	-	1,950	-	-	-	2,550	2,550
b. Administrative Costs	50	-	34	366	-	532	84	898	982
2. Special Studies	-	1,000	16	134	-	168	16	1,302	1,318
3. Service Delivery	-	-	65	7,435	-	10,200	65	17,635	17,700
a. Botica sa Barangay Prog.	-	-	-	2,000	-	1,000	-	3,000	3,000
b. BHW/Midwifery Programs	-	-	-	1,600	-	3,000	-	4,600	4,600
c. RHC Commodities	-	-	15	2,585	-	1,200	15	3,785	3,800
d. IEC	-	-	50	1,250	-	5,000	50	6,250	6,300
4. Other Support Costs	100	200	-	-	-	-	100	200	300
5. Project Evaluations	-	50	-	-	-	-	-	50	50
TOTALS	150	1,850	115	9,885	-	10,900	265	22,635	22,900

Note: All line items have inflation and contingency factors built in.

ANNEX F

AID 1020-20 (5-73)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: PRIMARY HEALTH CARE FINANCING PROJECT 492-0371

Life of Project:
From FY 83 to FY 86
Total U. S. Funding $12,000,000
Date Prepared: April 18, 1983

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1) To reduce fertility and infant and early childhood mortality in the Philippines.	**Measures of Goal Achievement: (A-2)** - A reduction in fertility rates - A reduction in infant mortality rates - A reduction in 0 – 5 mortality rates	**(A-3)** - Census data - Demographic studies	**Assumptions for achieving goal targets: (A-4)** - Utilization of selected primary health care services offered through financing schemes and government programs will decrease fertility and mortality. - A more financially stable and reliable health care system will contribute toward reduced fertility and mortality.
Project Purpose: (B-1) To increase access to and utilization of sustainable primary health care services managed and financed by communities and by the GOP.	**Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)** 1. Beneficiaries participating in financing PHC services in the demonstration areas. 2. Programmatic changes in the GOP health system which reflect the research findings. 3. Evidence that the four NGO programs receiving project assistance are functioning more effectively.	**(B-3)** - Project records - Evaluations of financing schemes - Evaluation of NGO programs which received project assistance (baseline info provided in project research)	**Assumptions for achieving purpose: (B-4)** - Utilization of modern PHC services will increase if the services are of high enough quality, readily available and affordable. - People will pay for health services that they believe are efficacious, particularly when the illness is perceived to be serious. - People's participation in financing PHC services will improve their ability to make demands on the quality and nature of the services provided. - The chances that people will have improved access to PHC services over the long term will be increased if the costs of the services are shared by the beneficiaries, the private sector and government.
Project Outputs: (C-1) 1. Tested health care financing schemes which involve beneficiary financing. 2. Series of completed research and special studies 3. Improved NGO service support mechanisms in place in the areas of village pharmacies, IEC for primary health care, training/facilitation of PHC workers, provision of PHC commodities.	**Magnitude of outputs: (C-2)** 1. 24 tested financing schemes 2. 8 major studies completed in the areas of health sector financing, herbal drug factories, NGO program, midwifery program, bottom up barangay, cost-effectiveness analyses, health referral facilities and vaccine production. 3. Policy guidance, training programs, improved procedures for village pharmacies - Improved training protocol for midwives and NGOs - Improved community support system for NGOs - New set of mass media messages supporting selected PHC services	**(C-3)** - Project monitoring and evaluations - Papers and workshops presenting outcomes of special studies - Field visits	**Assumptions for achieving outputs: (C-4)** - Testing financing schemes can help demonstrate the viability of combining private, public and community resources to improve PHC service delivery. - The special studies to be undertaken will stimulate government to make the recommended health sector program changes and adjustments. - Assistance in the four areas of the NGO service support system will result in substantial improvements in these programs.
Project Inputs: (D-1) 1. Developing, testing, and evaluating financing schemes. 2. Planning and implementing special studies. 3. Developing improved training protocols for NGOs and Midwives, technical guidance on their deployment and community support to NGOs. 4. Providing technical assistance, training and support to Bottom. 5. Providing funding for development of new IEC materials. 6. Conducting workshops and conferences to discuss funding of studies and financing schemes.	**Implementation Target (Type and Quantity) (D-2)** AID Inputs 1. Financing Schemes a. Grants $ 2,330,000 b. Administrative costs 430,000 2. Special Studies 1,130,000 3. Service Delivery Support a. Bottom 2,000,000 b. NGO/Midwifery 1,600,000 c. PHC Commodities 2,000,000 d. IEC 1,300,000 4. Other Support Costs 300,000 5. Evaluations 30,000 AID TOTAL $ 12,000,000 GOP TOTAL $ 10,000,000 GRAND TOTAL $ 22,000,000	**(D-3)** - Project implementation documents	**Assumptions for providing inputs: (D-4)** - Sufficient technical expertise will be available in the form of Filipino and foreign consultants to guide the development of financing schemes and special studies. - The disbursement system planned for in releasing the loan and grant funds for the project will function as expected and in a timely manner. - Sufficient numbers of organizations will be interested in developing proposals for financing schemes to be submitted for project funding. - GOP Budget allocations are available on a timely basis.

Best Available Document

Annex G

INITIAL ENVIRONMENTAL EXAMINATION

Project Location	:	Republic of the Philippines
Project Title	:	Primary Health Care Financing
Funding	:	FY 83 $ 9,800,000
Life of Project	:	FY 83 - FY 88 $12,000,000
IEE Prepared By	:	Joy Riggs-Perla, Public Health Advisor
Date	:	July, 1983

Environmental Action Recommended: Negative Determination

Concur: Anthony M. Schwarzwalder Date: 27 July '83

Do Not Concur: _____ Date: _____

Anthony M. Schwarzwalder
Mission Director
USAID/Philippines

Examination of Nature, Scope, and Magnitude of Environmental Impacts

I. Description of Project

The Project Proposes to increase access to and utilization of sustainable primary health care services managed and financed by communities and the GOP. To achieve this, the project will provide support for three sets of activities: (1) the testing of financing systems, (2) special studies and policy analyses to improve the GOP health policy and programs and (3) assistance to the MOH to improve their ability to provide service delivery support to the field. The end result should be a more cost-effective and rational health care system which combines community, private sector and public sector resources.

II. Identification and Evaluation of Environmental Impact

There will be no major project impact on the physical environment However, the human environmental should benefit from the improved availability of PHC services.

III. Recommendation for Environmental Action

A negative determination is recommended.

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Annex H

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AIDAC

E.O. 12065: N/A
AGS:

SUBJECT APAC APPROVAL OF PID FOR FINANCING PRIMARY HEALTH CARE PROJECT (492-0372)

1. SUMMARY. THE ASIA PROJECT ADVISORY COMMITTEE (APAC) APPROVED THE PROJECT IDENTIFICATION DOCUMENT (PID) FOR SUBJECT PROJECT FEBRUARY 8. THE APAC AND USAID REPRESENTATIVE AGREED TO A CONTINUED EXCHANGE OF VIEWS AS TO (A) INSTITUTIONAL RELATIONSHIPS IN THE PROPOSED PROJECT, (B) HEALTH CARE FINANCING SCHEME(S) TO BE ADVANCED, (C) PROJECT COSTS, (D) WHAT AID WOULD FINANCE, AND OTHER DESIGN CONCERNS, DURING PROJECT PREPARATION. END SUMMARY.

2. WHILE APPLAUDING THE PID'S ANALYTICAL APPROACH AND PROBLEM DEFINITION, THE APAC WAS CONCERNED THAT THE DESIGN OF NEW INTERVENTIONS IS STILL NOT DEFINITE. WE RECOGNIZE, IN THIS REGARD, THAT USAID/GOP DESIGN DISCUSSIONS ARE A CONTINUING PROCESS. IT IS THUS LEFT TO THE USAID TO ADVISE AID/W OF KEY DESIGN DEVELOPMENTS FOR WHICH WASHINGTON REACTION SHOULD BE SOUGHT BEFORE FINAL PROJECT DESIGN IS DECIDED.

3. BASICALLY, FOUR ELEMENTS OF PROJECT DESIGN WERE REVIEWED WITH THE USAID REPRESENTATIVE IN LIGHT OF THE PID AND SUBSEQUENT USAID EXCHANGES WITH THE GOP:

(A) ADMINISTRATIVE ARRANGEMENTS. WE UNDERSTAND THESE WILL BE SIMILAR TO THE PANAY (PUSH) PROJECT, INVOLVING FUNDING RELATIONS BETWEEN THE REGIONAL DEVELOPMENT COUNCILS AND THE PROVINCES; AND

(B) TYPE OF HEALTH SERVICES TO BE OFFERED. THESE HAVE BEEN REFINED THROUGH PREVIOUS PROJECT EXPERIENCES, AND CORRECTIONS HAVE BEEN MADE TO ORIGINAL PROJECT DESIGNS. THESE TWO ELEMENTS APPEAR RELATIVELY FIRM AND THE USAID SHOULD CONFIRM THEM WHEN APPROPRIATE. THIS LEAVES:

(C) FINANCING SCHEMES TO BE ADVANCED UNDER THE PROJECT; AND

(D) HOW TO COMBINE THE THREE SUPPORT STRUCTURES (HEALTH, POPULATION, AND NUTRITION). THESE TWO ELEMENTS (C

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AND D) ARE YET TO BE DEFINED, AND THE USAID SHOULD ADVISE AID/W WHEN THEY ARE MORE CLEARLY DETERMINED.

4. THE BASIS FOR THE SPLIT BETWEEN POPULATION AND HEALTH FUNDING WAS SEEN DIFFERENTLY FROM AID/W AND USAID PERSPECTIVES: AID/W OFFICES SEEK A RATIONALE FOR CLAIMS ON SCARCE FUNDS; AND THE USAID IS CONCERNED THAT AN INTEGRATED PHC APPROACH WITH HIGHEST PRIORITY ON FERTILITY REDUCTION BE THE RESULT. IT IS SUGGESTED THAT THE USAID OBTAIN ASIA BUREAU GUIDANCE ON THE KIND OF FUND SPLIT JUSTIFICATION REQUIRED BEFORE FINAL PP PREPARATION.

5. ADMINISTRATIVE ARRANGEMENTS (THROUGH REGIONAL DEVELOPMENT COUNCILS) APPEAR SIMILAR TO THOSE PROPOSED FOR THE LOCAL RESOURCES MANAGEMENT (LRM) PROJECT. THE PP FOR LRM SHOULD TAKE INTO ACCOUNT WHETHER THE SAME MACHINERY AND RESOURCES CAN SERVE BOTH PROJECTS AND PROJECT APPROACHES IN TARGET REGIONS. THE PP FOR THIS PROJECT SHOULD ALSO ADDRESS THIS ISSUE.

6. THE APAC FELT MORE INFORMATION WILL BE NEEDED TO DEFINE THE MINIMUM LEVEL OF APPROPRIATE PHC SERVICES THAT CAN BE AFFORDED FOR THE POOR. THE USAID REPRESENTATIVE ACCEPTED THAT THERE IS A CONTINUING NEED FOR MORE INFORMATION FOR THE PROJECT AND INDICATED PLANS TO USE EXISTING BILATERAL, PD AND S AND CENTRALLY FUNDED

ACTIVITIES FOR THE RESEARCH NEEDED TO SPELL OUT: THE PRESENT PATTERN OF HEALTH EXPENDITURES; MOST EFFECTIVE TRAINING AND INCENTIVES FOR PHC PROVIDERS; AND OTHER DESIGN QUESTIONS. THE RESULTS OF THIS PROCESS SHOULD BE INCORPORATED IN THE PP.

7. THE APAC STRONGLY STRESSED THE NEED FOR ECONOMIC/FINANCIAL ANALYSIS OF THE SUSTAINABILITY, REPLICABILITY AND COST EFFECTIVENESS OF FINAL PROJECT DESIGN. THE USAID REPRESENTATIVE AGREED THAT THE PP TEAM WOULD INCLUDE A FINANCIAL ANALYST FOR THIS PURPOSE TO DEAL WITH FINANCIAL FLOWS AND RESPONSIBILITIES FOR THE PROJECT AT ALL LEVELS IN THE SYSTEM, AND RELATED FEASIBILITY CONCERNS.

8. THE APAC ALSO RAISED THE ISSUE OF STAFF INTENSIVITY OF THE PROJECT. THE USAID REPRESENTATIVE NOTED THAT THE PROJECT WOULD CONSOLIDATE PROGRAM ACTIVITIES IN THE SECTOR INTO A SINGLE PROJECT WHICH, IN TIME, WOULD REQUIRE LESS STAFF THAN AT PRESENT. THE PP SHOULD ADDRESS THIS ISSUE ON THE BASIS OF FULL PROJECT DESIGN.

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ACT: AID-6 INFO: DCM CPU/8

ANNEX H

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ACTION COPY

Action taken:
No action necessary:
Date:

AIDAC

E.O 12356: N/A
TAGS:
SUBJECT: PRIMARY HEALTH CARE FINANCING PROJECT (492-0371)

REFS: A. MANILA 14469, B. MANILA 13497

1. AA/ASIA HAS DECIDED NOT TO REQUIRE USAID TO SUBMIT PRIMARY HEALTH CARE FINANCING PROJECT TO AA/ASIA FOR REVIEW AND AUTHORIZATION. MISSION DIRECTOR MAY REVIEW PHCF PROJECT FOR AUTHORIZATION UNDER REDELEGATION OF AUTHORITY 133.1.

2. PROJECT PAPER SHOULD PROVIDE FOR A MAJOR, JOINT AID/GOP EVALUATION OF THE PROJECT BETWEEN TWO AND THREE YEARS AFTER SUB-ACTIVITIES START AND PRIOR TO NEW STARTS FOR THE THIRD YEAR OF THE PROJECT. THIS EVALUATION SHOULD BOTH EXAMINE THE RESULTS OF EXPERIMENTAL APPROACHES TO PHCF AND PROVIDE EXPERIENCE ON WHICH TO BASE SIMILAR ASSISTANCE IN OTHER COUNTRIES. IT SHOULD ALLOW FOR AID/W AS WELL AS USAID PARTICIPATION IN THE SCOPE OF THE EVALUATION AND IN THE EVALUATION ITSELF. WE ASSUME PP AND IMPLEMENTATION LETTERS WILL ALSO PROVIDE FOR BASELINE AND OTHER RELEVANT DATA COLLECTION. AID/W REVIEW AS WELL AS USAID REVIEW OF THE EVALUATION REPORT SHOULD PRECEDE NEW STARTS FOR THE THIRD YEAR OF THE PROJECT. THE FORMULATION FOR THIS EVALUATION REQUIREMENT MAY BE SIMILAR TO THAT PROPOSED REF B FOR THE SMED PROJECT. DAM

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ANNEX I

6-248

Republic of the Philippines
NATIONAL ECONOMIC AND DEVELOPMENT AUTHORITY
P.O. Box 1116, Manila

JUN 16 4 08 PM '83

Tels. 50-39-71 to 95
Cable Address: NEDAPHIL

10 June 1983

Mr. Anthony M. Schwarzwalder
Director, USAID Mission
Metro Manila

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Dear Mr. Schwarzwalder:

I have the honor to request AID assistance in funding the Primary Health Care Financing Project to be implemented by the Ministry of Health.

The project seeks to contribute to the general promotion of health and the reduction of infant and child mortality through the provision of support to health services delivery, the development of resources to support PHC recurrent costs, and the conduct of needed research that will generate information critical to policy formulation, resource allocation and program evaluation.

Specifically, the assistance requested would consist of $16.0 M in loan and $3.0 in grant to finance the three (3) major components of the project as follows:

a)	Support to health service delivery	$15.0 M
b)	Pilot PHC and resources generation scheme	3.2 M
c)	Research and other studies	0.8 M
	Total	$19.0 M

ACTION TAKEN
NAN
Type
No.
Other
Dated
Initials

In carrying out the project, the Government will contribute the equivalent of $10.6 M. The project is designed for 5-year implementation and it is expected to provide the needed support to the current Primary Health Care Program being implemented by the Ministry of Health as part of its effort to achieve health for all by the year 2000.

Your favorable action on this proposal will be highly appreciated.

Thank you and warm regards.

Very truly yours,

CESAR VIRATA
Director General

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