

THE DELIVERY OF PRIMARY HEALTH CARE SERVICES
IN THE RURAL PHILIPPINES
Towards a Comparative Analysis of the
PANAY and BICOL Regional Projects

Prepared by

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FOREWORD

This report has been prepared to assist in the conceptualization of a comparative analysis of two projects in the Philippines which were intended to deliver primary health care services and infrastructure support to rural barangay residents. The projects, located in the Bicol and Panay regions, were designed and implemented almost concurrently, over a period of several years, and are now in their final stages of operation.

A new project, Primary Health Care Financing, is about to succeed these (and a myriad of other Health, Nutrition and Family Planning) projects. Thus any lessons that can be learned from the experiences in the Panay and Bicol efforts should be highlighted for review and applicability by all concerned, to enhance the prospects for the successor project's success.

For projects which were as geographically dispersed as these, touching many lives in so many different ways over such a long period of time, a succinct, definitive picture of accomplishment and/or failure, right or wrong, cause and effect is all but impossible to discern. The dimensions of development extend beyond the bounds of objectively recorded indicators and reside in the subjective views of the many participants and observers. Thus, the statistical data available must be weighed with the anecdotal accounts and perceptions that can be gleaned from reports and interviews. Nevertheless, even when considered from different perspectives, the views should be of the same general phenomena, and some synthesis should be helpful in guiding policy makers and the next cycle of project implementers.

Project Evaluations can take many forms and can examine many issues. Some of these examinations can produce interesting, nice-to-know information of the "who struck John" variety - interesting in the specific sense, but of little general utility since the incident is unlikely to recur. Of more use are the general patterns of behavior by project donors, deliverers and recipients - activity and response, since these are likely to persist in the longer run, unless rectified, regardless of the specific project. It is on these latter issues that I recommend framing the comparative analysis of the Panay and Bicol Health projects. Studies such as this take time and cost money. We are not interested in chronicling the detailed history of both projects, nor conducting an investigative post-mortem audit to discern or dredge up evidence of wrong-doing. On the contrary, we are looking for patterns of relative success, wherever they may occur, that may be beneficially passed on to others. Of course, in this process, any problems previously encountered which are likely to persist are also worth noting so that remedial steps may be initiated to avoid them in the future, if at all possible.

My report outlines a two stage approach in four parts:

- Stage 1 - Secondary Source Synthesis & Conceptual Framework Design, with an Annotated Bibliography
- Stage 2 - Field Followup, Findings and Recommendations.

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PART I

THE BICOL AND PANAY PRIMARY HEALTH CARE SERVICES PROJECTS

Project Designs, Implementation and Other Evaluations

A Synthesis of Secondary Sources

THE BICOL AND PANAY PRIMARY HEALTH CARE SERVICES PROJECTS

Project Designs, Implementation and Other Evaluations: A Synthesis of Secondary Sources

This section will summarize the stated objectives of each of the two projects, the means for attaining those objectives - in both organizational and technical terms - and the experiences during implementation which are contained in the documentation reviewed, which may be pertinent to any subsequent analysis.

THE BICOL INTEGRATED HEALTH, NUTRITION & POPULATION PROJECT

The BICOL Integrated Health, Nutrition & Population Project (herein after referred to as the BICOL project - as distinct from the BICOL PROGRAM which is composed of a variety of projects and sub-projects) was conceived in 1976 as a \$4.5 million U.S. contribution to a larger Philippine government project intended to improve the health and nutrition status of the residents of the rural barangays in Camarines Sur and Albay Provinces, and reduce the birthrate. This was to be accomplished by providing health, nutrition, family planning, and preventive health education and services to the barangay population, and also by improving the access to potable water, and sanitary waste disposal through construction or improvement of wells, springs, pumps and household toilet facilities.

Background Situation The project designers identified three major problem areas in the rural Bicol, related to Health, Nutrition and Population:-

1. Communicable Disease - especially Water-borne diseases and intestinal parasites.
2. Malnutrition
3. Rapid Population Growth

With respect to communicable diseases, the Project Identification Document (PID) and Project Review Paper (PRP) stated that surveys indicated a parasitic infestation rate for the Bicol region's population above 90%, with 70% carrying more than one type of worm. Over 30% of reported illness is attributable to enteric, water-borne diseases resulting from poor sanitation and contaminated water supply. These afflictions include the intestinal parasites, bacterial and viral dysenteries/diarrheas, and specific diseases such as typhoid, cholera, hepatitis and polio.

Only 28 percent of the region's population in 1976 was served by water-works, and very few of these were considered satisfactory by prevailing national health standards. Poor waste disposal and drainage systems in the area exacerbated these problems. Morbidity and mortality rates from preventable disease was considered "very high".

The following Tables (1 - 7) from the PID & PRP identify the population distribution by household and barangay throughout the region (Table 1); the ten leading causes of morbidity by province and city (Table 2); the ten leading causes of mortality (Table 3); the crude death and birth rates (Table 4); the registered infant mortality rate (Table 5); the existing water facilities by type, number and population (Table 6); and the status of waste disposal facilities, by locality (Table 7), as of 1975.

PROJECT AREA

REPUBLIC OF THE PHILIPPINES

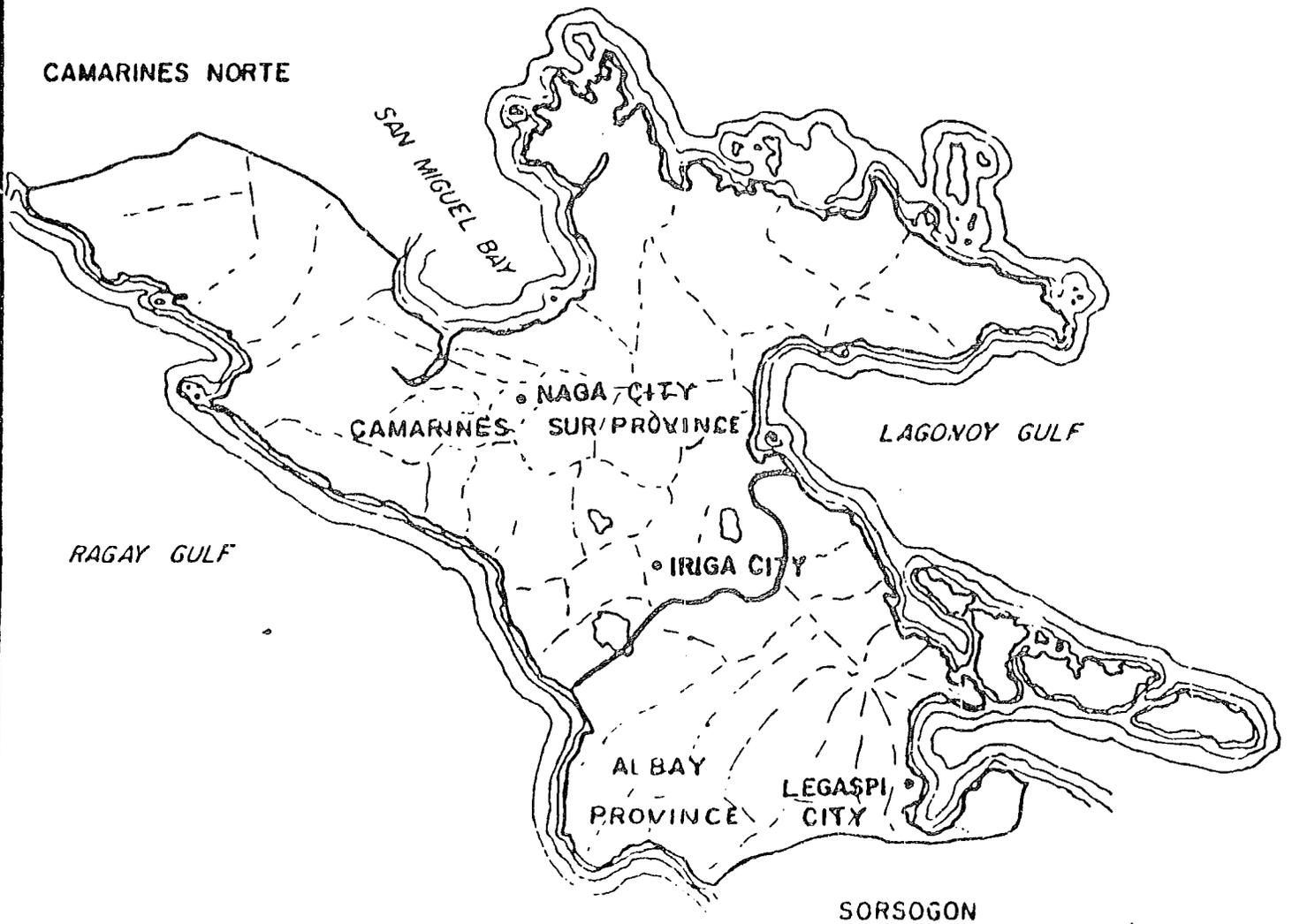
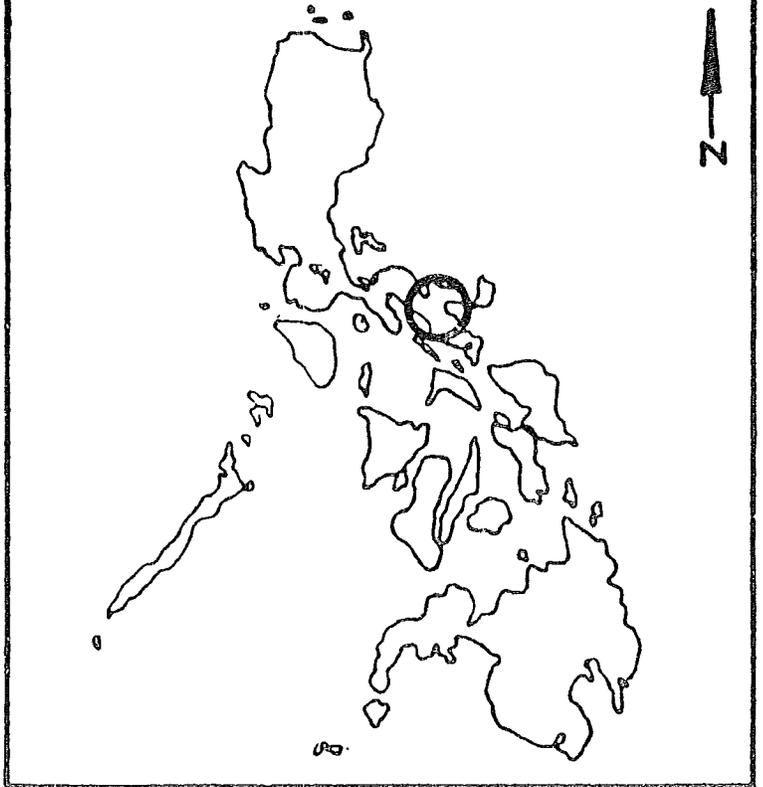


Table 1. Number of barangays and households, and population figures ^a in the proposed health program area as of May 1, 1975, by localities

Program area localities	No. of Barangays	No. of Households	Population (Both sexes)
<u>Camarines Sur</u>			
1. Baao	30	4,822	30,050
2. Balatan	17	2,079	13,113
3. Bato	33	4,332	28,247
4. Bombon	8	1,248	7,472
5. Buhi	38	7,350	44,256
6. Bula	33	5,914	36,803
7. Cabusao	9	1,628	10,392
8. Calabanga	48	6,671	40,161
9. Camaligan	13	1,539	9,823
10. Canaman	24	2,345	14,367
11. Caramoan	49	5,266	31,316
12. Del Gallego	32	2,294	13,717
13. Gainza	8	888	5,624
14. Garchitorena	23	2,569	16,442
15. Goa	34	5,588	33,814
16. IRIGA CITY	36	10,861	75,621
17. Lagonoy	38	5,557	33,392
18. Libmanan	75	10,856	66,164
19. Lupi	38	3,305	19,535
20. Magarao	15	1,983	11,837
21. Milaor	20	2,062	13,174
22. Minalabac	25	4,359	27,012
23. Nabua	40	7,836	48,280
24. NAGA CITY	27	13,130	82,774
25. Ocampo	25	3,194	19,212
26. Pamplona	17	2,976	18,310
27. Pasacao	19	3,426	21,860
28. Pili	26	5,983	36,440
29. Presentacion	18	2,139	13,505
30. Ragay	38	5,453	32,508
31. Sangay	18	2,385	17,849
32. San Fernando	22	2,485	15,468
33. San Jose	29	3,591	21,715
34. Sipocot	46	6,291	39,178
35. Siruma	22	1,802	10,433
36. Tigaon	23	4,066	25,044
37. Tinambac	44	5,805	34,290
	<u>1,060</u>	<u>164,592</u>	<u>1,019,285</u>

^a

Source: National Census and Statistics Office (NCSO)

Table 1. Number of barangays and households (cont'd)

Program area localities	No. of Barangays	No. of Households	Population (Both sexes)
<u>Albay</u>			
1. Bacacay	56	5,568	40,710
2. Camalig	48	7,188	41,723
3. Daraga	54	10,521	62,587
4. Guinobatan	45	8,359	49,710
5. Jovellar	16	2,356	14,102
6. Libon	41	7,661	47,231
7. Ligao	55	10,023	61,802
8. Malilipot	18	3,415	21,807
9. Malinao	29	4,324	24,008
10. Manito	16	2,269	13,628
11. Oas	53	3,072	51,040
12. Pio Duran	29	5,022	30,308
13. Polangui	44	8,447	52,345
14. Rapu-rapu	35	3,564	21,957
15. Sto. Domingo	17	3,053	17,464
16. Tabaco	47	10,665	65,122
17. Tiwi	26	4,027	24,257
18. LEGASPI CITY	69	14,666	88,004
	698	119,200	729,335
 TOTAL	 <u>1,758</u>	 <u>283,792</u>	 <u>1,748,623</u>

Table 2. Ten leading causes of morbidity in the proposed program area, by province and city, in 1975 ^a ^b

Causes and Locality	Rate (per 100,000 population)
<u>Camarines Sur</u>	
1. Influenza	529.91
2. Bronchitis	391.92
3. Gastro-enteritis & Colitis	372.28
4. Pneumonia (all forms)	291.67
5. Tuberculosis (all forms)	218.84
6. Whooping cough	33.22
7. Measles	24.39
8. Nephritis (acute)	21.60
9. Tetanus	17.53
10. Typhoid fever	15.33
<u>Iriga City</u>	
1. Gastro-enteritis and colitis	292.4
2. Pulmonary tuberculosis	193.5
3. Influenza	179.0
4. Broncho pneumonia and pneumonia	162.5
5. Upper respiratory infections	134.2
6. Bronchitis	84.7
7. Neoplasm	15.3
8. Measles	7.0
9. Whooping cough	5.8
10. Mumps	4.7
<u>Iapa City</u>	
1. Pulmonary tuberculosis	775.90
2. Influenza	407.01
3. Gastro-enteritis	431.73
4. Pneumonia (all forms)	398.22
5. Typhoid	236.19
6. Meningococcal infection	33.08
7. Infectious hepatitis	33.08
8. Measles	27.38
9. Tetanus	20.53
10. Diphtheria	14.83

a

Excluding the municipality of Basud, for which no data were available
Source: DOW, Region V

b

This excludes the much higher incidence of under and malnutrition.
For example, the incidence of third degree malnutrition is 5,900
per 100,000 population.

Table 2. Ten leading causes of morbidity (cont'd)

Causes and Locality	Rate (per 100,000 population)
<u>Albay</u>	
1. Pulmonary tuberculosis	274.82
2. Gastro-enteritis	265.22
3. Influenza	224.75
4. Pneumonia	218.57
5. Cardio-vascular accident	86.94
6. Bronchitis	56.80
7. Hypertension	30.90
8. Whooping cough	24.08
9. Avitaminosis	22.27
10. Congenital debility	21.81
<u>Legaspi City</u>	
1. Influenza	2,687.78
2. Gastro-enteritis	2,546.12
3. Bronchitis	1,445.55
4. Broncho-pneumonia	1,306.77
5. Pulmonary tuberculosis	182.75
6. Pertussis	23.61
7. Cardio-vascular accident	21.55
3. Tetanus	19.50
9. Beri-beri	6.15
10. Measles	6.15

Table 3. Ten leading causes of mortality in the proposed program area, by province and city, in 1975.

Causes and Localities	Rate (per 100,000 population)
<u>Camarines Sur</u>	
1. Pneumonia (all forms)	195.95
2. Tuberculosis (all forms)	111.62
3. Disease of the heart	97.92
4. Gastro-enteritis and colitis	25.90
5. Tetanus (all forms)	18.12
6. Ill-defined causes	14.98
7. Asphyxia neonatorum	12.70
8. Bronchitis (acute)	12.54
9. Nephritis	9.40
10. Malnutrition	9.17
<u>Iriga City</u>	
1. Pulmonary tuberculosis	100.0
2. Broncho pneumonia and pneumonias	91.1
3. Arteriosclerotic heart diseases	65.9
4. Senility	62.4
5. Gastro-enteritis and colitis	28.2
6. Beri-beri	25.5
7. Acute bronchitis	17.8
8. Neoplasm	15.3
9. Meningitis	14.1
10. Avitaminosis	11.7
<u>Naga City</u>	
1. Pneumonia	156.32
2. Pulmonary tuberculosis	146.05
3. Gastro-enteritis	28.52
4. Meningococcal infection	21.67
5. Measles (due to complications)	15.99
6. Tetanus	12.55
7. Diphtheria	11.49
8. Typhoid	10.26
9. Dysentery	4.56
10. Acute Encephalitis	2.28

Source: DOH, Region V

Table 3. Ten leading causes of mortality (cont'd)

Causes and Localities	Rate (per 100,000 population)
<u>Albay</u>	
1. Pneumonia	124.05
2. Pulmonary tuberculosis	107.99
3. Cardio-vascular accident	86.94
4. Bronchitis	56.80
5. Hypertension	30.90
6. Gastro-enteritis	22.57
7. Avitaminosis	22.27
8. Congenital debility	21.81
9. Malignancy	17.87
10. Meningitis	13.63
<u>Legaspi City</u>	
1. Broncho pneumonia	104.64
2. Cardio-vascular accident	86.04
3. Pulmonary tuberculosis	79.05
4. Bronchitis	71.80
5. Coronary occlusion	39.01
6. Congestive heart failure	57.98
7. Gastro-enteritis	35.93
8. Malnutrition	25.64
9. Myocardial infection	24.62
10. Accidents	24.62

Table 4. Crude death and birth rates, by locality, in the program area in 1975.

Locality	Death rate ^a	Birth rate
Camarines Sur	7.00	29.68
Iriga City		27.36,
Naga City	7.75	42.97
Albay	7.26	36.14
Legaspi City	10.10	36.63

a
Death rate is per 1,000 population

Source: DOH, Region V

Table 5. Registered infant mortality rate, by locality, in the program area in 1952^{a/}

Locality	Live Births	Deaths under 1 year	Rate ^{b/} (per 1,000 live births)
Camarines Sur	34,461	1,285	36.36
Iriga City	2,323	105	45.20
Naga City	3,966	151	40.09
Albay	23,861	919	38.51
Legaspi City	<u>3,224</u>	<u>138</u>	<u>42.80</u>
T O T A L	<u>67,635</u>	<u>2,548</u>	<u>37.67</u>

a/ Source: Regional and City Health Offices

b/ The under registration of infant deaths is approximately 50%.

Table 6. Existing Water Facilities by Type, Number and Population Served in the Program Area (1975)

<u>Type of Facility</u>	<u>Number</u>	<u>%</u>	<u>Population Served</u>	<u>%</u>
Municipal Waterworks	33	0.09	428,017	24.20
Barrio Waterworks	88	0.23	61,900	3.50
Public Drilled Artesian wells	524	1.35	334,393	18.90
Shallow wells	28,072	72.50	310,354	17.50
Improved springs	569	1.47	193,569	10.90
Unimproved springs	1,406	3.63	216,692	12.20
Improved dug wells	3,785	9.78	112,132	6.30
Unimproved dug wells	3,961	10.23	100,952	5.70
Rainwater Storage Tanks	<u>279</u>	<u>0.72</u>	<u>11,712</u>	<u>0.70</u>
TOTAL	38,717	100.00%	1,769,721	99.9%

Source: DOH, Region V

Table 7. Waste Disposal Status, by locality, in the program area, 1975^a

<u>Province/City</u>	<u>Total Households</u>	<u>Households with toilets</u>				<u>Households Without toilets</u>	
		<u>Satisfactory</u> ^{1/}		<u>Unsatisfactory</u> ^{1/}		<u>No.</u>	<u>%</u>
		<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>		
1. Albay	119,200	20,408	17.1	38,812	32.6	59,980	50.3
2. Camarines Sur	127,235	52,446	41.2	32,284	25.4	42,505	33.4
3. Legaspi City	15,001	2,637	17.6	5,053	33.7	7,311	48.7
4. Iriga City	10,861	4,628	42.6	2,811	25.9	3,422	31.5
5. Naga City	14,680	9,725	66.2	2,455	16.7	2,500	17.0
TOTAL	286,977	89,844	31.3	81,414	28.4	115,718	40.3

^a Excludes the municipality of Basud, for which no data was available at the time of the review.

^{1/} Satisfactory includes water sealed toilets with or without septic bowls
Unsatisfactory refers to Pit Privies

TABLE 11

Republic of the Philippines
Department of Health
NATIONAL NUTRITION SERVICE
Manila

SUMMARY OF WEIGHT SURVEYS

(As of September 1976)

BY MUNICIPALITY, CAGAIKINES SUR PROVINCE
APPROX. POPULATION 868,376

No. of Children Weighed 104,467
No. of Municipalities 34
No. of Barangays surveyed 853
No. of Families Surveyed 91,307

Total No. of Municipalities 35
Total No. of Barangays 978
Total No. of Families Surveyed 91,307

MUNICIPALITY	Total no. of Bar- rangs/Pook	No. of Puroks/Pooks Surveyed	No. of Pro- school chil- dren eight (0-7 mon)	NUMBER OF CHILDREN WEIGHED UNDER EACH CATEGORY OF MALNUTRITION								% of MALNU- TRITION	REMARKS		
				3rd Degree		2nd Degree		1st Degree		U.N.				Normal	
				No.	%	No.	%	No.	%	No.	%			No.	%
1. Baco	29	2,300	2,757	191	6.93	583	21.17	1,363	49.50	-	-	616	22.40	77.60	
2. Bato	32	7,205	4,900	363	7.39	955	19.49	2,086	42.41	-	-	1,505	30.67	69.33	
3. Bula	33	5,215	6,477	242	3.73	1,206	18.61	3,244	50.08	-	-	1,785	27.58	72.42	
4. Buhí	34	6,330	7,188	603	8.38	1,947	27.08	3,275	45.49	-	-	1,363	19.05	80.95	
5. Bumbon	8	888	1,273	30	2.35	315	24.74	699	54.60	-	-	229	18.01	81.99	
6. Cabusac	9	1,220	1,565	164	10.47	434	27.73	719	45.94	-	-	248	15.80	84.14	
7. Canaman	22	1,157	2,217	71	3.20	587	26.47	1,137	51.01	-	-	422	19.31	60.69	
8. Camaligan	13	1,073	1,381	26	1.88	298	21.57	834	60.89	-	-	223	16.16	83.84	
9. Gainza	8	782	682	22	3.24	169	24.78	359	52.43	-	-	132	19.37	80.63	
10. Garchitorena	23	1,365	2,611	12	4.67	571	21.86	1,232	47.22	-	-	685	26.25	73.75	
11. Goa	32	3,596	4,561	467	10.23	1,601	35.10	1,936	40.40	-	-	560	14.27	95.73	
12. Lupi	35	2,292	3,167	164	5.38	660	21.03	1,629	51.62	-	-	679	21.67	78.33	
13. Milao	19	2,293	1,476	55	3.72	327	22.15	751	50.88	-	-	343	23.25	76.75	
14. Linalabac	25	2,861	2,689	122	4.62	625	23.68	1,290	48.28	-	-	602	22.62	77.18	
15. Negarao	14	1,763	1,988	50	2.50	481	24.19	997	50.15	-	-	460	23.16	76.84	
16. Nabua	41	6,243	7,002	351	5.01	1,225	17.69	3,558	50.81	-	-	1,968	26.61	73.31	
GRAND TOTAL															

APPROVED BY:

PREPARED BY:

s/c HELEN S. FRANCO
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Republic of the Philippines
Department of Health
NATIONAL NUTRITION SERVICE
Manila

SUMMARY OF WEIGHT SURVEYS
(As of September 1976)

BY MUNICIPALITY, CAMARINES SUR PROVINCE

Total No. of Municipalities
Total No. of Barangays
Total No. of Families Surveyed

No. of Municipalities
No. of Barangays Surveyed
No. of Families Surveyed
No. of Children Weighed

MUNICIPALITY	Total No. of Puroks/Puroks	No. of Puroks/Puroks Surveyed	No. of Pre-school children weighed (0-7 mos)	NUMBER OF CHILDREN WEIGHED UNDER EACH CATEGORY OF MALNUTRITION								% of MALNUTRITION	REMARKS		
				3rd Degree		2nd Degree		1st Degree		O.K.				Normal	
				No.	%	No.	%	No.	%	No.	%			No.	%
17. Uson	18	1,171	1,735	88	7.12	770	29.95	590	47.76	-	-	197	15.17	84.83	
18. Daolona	17	2,597	3,008	357	11.86	919	30.53	1,276	42.42	-	-	456	15.17	84.83	
19. Pasacao	18	2,977	2,857	255	8.94	676	23.70	1,176	41.18	-	-	747	26.20	73.80	
20. Pili	26	2,724	3,120	101	3.23	448	14.36	1,648	52.82	-	-	703	22.51	77.46	
21. Nagay	34	4,167	4,478	235	5.24	1,176	26.40	2,185	49.00	-	-	842	18.99	81.01	
22. Sengay	16	1,640	1,771	261	15.13	581	33.70	671	38.00	-	-	211	13.00	86.92	
23. San Jose	29	3,077	3,580	164	4.58	991	27.69	1,714	47.87	-	-	711	19.87	80.13	
24. Sipocot	46	5,454	6,078	370	6.21	1,246	20.49	2,797	46.07	-	-	1,659	27.32	72.68	
25. Siruan	22	1,012	1,806	105	5.56	494	26.00	907	47.70	-	-	427	22.87	77.33	
26. Tigaon	23	2,494	3,366	291	7.75	864	25.09	1,520	45.15	-	-	741	22.00	77.97	
27. Lalatan	10/17	850	1,743	58	4.59	229	18.00	510	40.39	-	-	467	37.03	63.02	
28. Calabanga	24/42	4,097	3,777	187	5.11	811	21.80	1,845	48.91	-	-	908	24.09	75.91	
29. Dal Gallego	9/32	509	674	11	1.67	163	24.00	375	55.22	-	-	130	19.12	80.84	
30. Lagonoy	22/38	2,104	2,658	161	6.05	771	28.77	1,298	68.80	-	-	467	16.37	83.63	
31. Libmanan	61/75	5,694	7,094	494	6.96	1,694	23.87	3,279	46.19	-	-	1,633	23.04	76.96	
32. San Fernando	13/22	1,470	1,864	76	4.07	402	21.59	964	51.60	-	-	424	22.72	77.28	
33. Tinambac	14/44	1,337	2,193	110	5.15	428	20.00	1,101	51.01	-	-	494	23.17	76.81	
34. Presentacio	10/18	1,057	1,256	239	17.97	575	30.00	748	40.37	-	-	294	15.50	84.10	
GRAND TOTAL	803	91,301	104,467	6,595	6.30	24,955	23.54	49,691	47.56	-	-	23,226	22.60	77.40	

PREPARED BY:

s/t HELEN S. FRANCO

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To alleviate this odious situation, the project proposed initiating a study to review, classify, quantify and prioritize the existing levels of sanitation throughout the region, in terms of desired (and reasonably attainable) standards, as the first step in a systematic program of follow-up action. Two sanitation levels were selected as benchmarks. Level I - to be achieved by all barangays in the Bicol during the five year program included the provision of paved accessways located to serve the bulk of the homes in the barangay - located above normal flood levels; drainage ditches (usually alongside the access ways) for the removal of all liquid wastes from the community, as well as surface runoff. Periodic maintenance of these ditches is also required to keep them free-flowing. To improve community water supply to the Level I standard, a few public taps should be located at strategic points throughout the barangay to provide 50 liters per capita per day (lpcpd) for the population within a 100 meter radius. This system could be complemented with a rainwater collection system together with piping to the taps, or a treated surface supply with piping. For waste (excreta) disposal, Level I standards, the objective is that all homes in the barangay (or group of homes) construct a pit privy with a water-sealed toilet. The existing method of solid waste disposal - burying, burning or consumption by domestic animals - was considered appropriate to the rural situation and no additional solid waste collection or disposal facilities were deemed necessary. Level II sanitation was considered applicable to "a significant portion of the barangays where current or improved socio-economic conditions permit". Level II standards would include construction of small side drains from all side streets and some individual house drains connected to the main drain, chlorination of all public water supplies to insure potability, and septic tanks (with pumping service available) for excreta disposal.

A rating system for classifying and assessing village sanitation facilities on a 1,600 point scale was outlined in the PRP annex, and is outlined below and on the following pages.

Seven Measures for Improving Village Sanitation and their Relative Importance in Village Communicable Disease Control

<u>Basic Village Sanitation Measure</u>	<u>Points</u>
1. Water Supply - adequate and safe (Surface and/or ground water)	250
2. Facilities for hygienic use of water - toilets, washing, bathing	250
3. Removal of excreta from premises and village environment	300
4. Waste treatment prior to discharge to the waterway	100
5. Solid waste collection and disposal	200
6. Provision of adequate surface drainage	200
7. Paved access ways	<u>100</u>

Sub-total = 1,400

These factors are then assessed as to their impact on Communicable Disease (80% of total score); Water Pollution Control (items 4 & 5 - with a different scale contributing to 15% of the overall rating), and Community Aesthetics (with still another scale contributing to 5% of the overall rating). For detail see the following Table:-

Table 2-1:
RATING SYSTEM FOR EVALUATING EFFECTIVENESS OF VILLAGE SANITATION FACILITIES

	Impact on Village Communicable Disease Hazard	Impact on Water Pollution Control	Impact on Community Aesthetics	Total Impact
(a) Water Supply	250 max		200 max	
(1) Quantity	(150)			
(2) Quality	(100)			
(b) Hygienic Use of Water	250 max	(Only significant as relating to treatment or collection for purpose of treatment)	100 max	
(c) Excreta Removal	300 max	(See Item d)	200 max	
(1) Sanitary Sewer	(300)		(200)	
(2) Septic Tank (without leaching system)	(150)		(100)	
(3) Septic Tank/Leaching System	(300)		(200)	
(4) Pit Privy (before becoming filled)	(150)		(150)	
(5) Open Drainage Ditch (Paved)	(150)		(100)	
(6) Defecation in Field	(100)		(50)	
(d) Waste Treatment	100 max	750 max	100 max	
(1) Treatment Plant	(100)	(750)	(100)	
(2) Pit Privy (before becoming filled)	(50)	(375)	(50)	
(3) Septic Tanks (no leaching)	(50)	(375)	(50)	
(4) Septic Tank/Leaching Systems	(100)	(750)	(100)	
(e) Solid Waste Collection and Disposal	200 max	250 max	200 max	
(f) Surface Drainage (paved)	200 max		100 max	
(g) Paved Access Ways	100 max		100 max	
(h) Total	1,300 max	1,000 max	1,000 max	
Relative Importance to BBTHIP	80%	15%	5%	100%

Notes: (1) Item (a): Of total of 250, allow 150 for quantity and 100 for quality.
(2) Item (b): Of total of 250, allow 125 for a toilet and 125 for washing and bathing.
(3) Item (e): Allow 100 points for collection and 100 points for disposal (removal).

The malnutrition situation in the Bicol in 1976 was viewed as another critical area in need of intervention. Baseline data from the Philippine government's national nutrition program "Operation Timbang" of weighing pre-school children revealed that 24% of pre-schoolers in the region were in Second Degree Malnutrition, and another 6% in Third Degree Malnutrition. This meant approximately 106,000 children (85,000 @ 2°, and 21,000 @ 3°). About one fourth of these children were being reached with food assistance through various programs - CARE, Catholic Relief Service, Diocesan programs, Department of Education and Culture, Department of Social Services & Development day care centers, Provincial Hospital Nutriward, Department of Health mothercraft nutrition centers - extensions of rural health units, and similar centers operated by the Bureau of Agriculture Extension. Furthermore, the Bureau of Agricultural Extension, Bureau of Plant Industry and Bureau of Animal Industry extension agents - home management technicians, youth officers and other personnel - provide nutrition education to rural families and promote food production through gardens and animal production, as well as the distributing seeds and animals. Project Compassion operates another nutrition awareness program through a Family Development Committee at the barangay level in Albay Province. The Philippine Business for Social Progress (PBSP) also operates through the Diocese in Camarines Sur to support a swine dispersal project to augment the incomes of low-income families.

Despite the plethora of outreach services, the malnutrition problem was sufficient to warrant further initiatives. Severe malnutrition in children can cause mental and physical retardation, as well as lower productivity in the labor force. The project proposes to help distribute commodities to the children with second and third degree malnutrition. Additional feeding centers will also be opened, and U.S. P.L. 480 food commodities (not funded by this project) distributed.

The following Table (Table 11 from the PRP) summarizes the results of sample survey weighings of pre-school children in Camarines Sur Province as of Sep 1976. [NOTE: The headings of several columns appear to be in error. Specifically, columns 2 & 3 appear to have wrong headings in that the number of Puroks/Pooks Surveyed exceeds the Total No. of Puroks/Pooks by a large magnitude. Also, column 4 "No. of Pro-school [sic.] children weight/weighed (0-7 mon)" is probably intended to be 'Number of Pre-school children weighed (0-7 years)'. These are minor errors however which are easily overcome. The significance of the tables lies in the high incidence of malnutrition, particularly if one also considers 1st Degree Malnutrition as an appropriate 'target'.]

Although the classifications 1st, 2nd and 3rd degree malnutrition are used, there are no definitions of these terms in any of the documentation provided on the project. The following guidance was obtained from AID's Bureau of Science & Technology, Office of Nutrition:-

Gomez Classification System

Weight-for-Age Method

<u>Classification</u>	<u>Percentage of Median</u>
NORMAL	90% <
1st Degree Malnutrition	75% - 90%
2nd Degree Malnutrition	61% - 75%
3rd Degree Malnutrition	< 60%

The problems of health and nutrition are intertwined. The three leading causes of infant mortality are pneumonia, gastro-enteritis, and bronchitis. These are complicated by a high incidence of malnutrition among pre-school children. With parasitic infestation and water-borne enteric diseases endemic the resultant nutrient loss further depletes an already inadequate diet. Poverty is thus deepened as the nutritive value is not fully received from the food eaten. The three leading causes of adult mortality in the project area are pneumonia, pulmonary tuberculosis and heart disease. Corresponding causes of morbidity are gastro-enteritis, pneumonia and influenza. Thus, a similar pattern prevails. Nine of the ten leading causes of death in the area are considered "preventable" by improving sanitation, nutrition, water supply, and an appropriate vaccination and health education program.

The gross population growth rate for the area is estimated as 3.3% which is higher than the 3.1% national average. This gross rate is masked by the extremely high out-migration from the area, leaving a residual 2.2 per-cent rate. Thus, while regionally there appears to be no problem as a result of high birth rates, in effect the problem is being passed to other regions, and is thus of major importance in the national context. Few Bicol households practice effective methods of birth control, and there appears to be little awareness that family planning is a feasible choice. While 82 percent of mothers surveyed did not want more children, it was felt by only 50 percent that they would not have more. There is resistance to family planning due to misinformation and the fear of embarrassment. Surveys reveal that only 25 percent of Bicolano married women have ever visited hospitals, health or family planning centers. The rural mother and housewife simply does not usually perceive that there are available services which will enhance the health and happiness of their families, which they can afford to utilize. With a 1.75 million population, of which approximately 80 percent is composed of rural households, and an average 6.2 persons per household, there are about 225,000 rural households which need to be 'reached' with information and advice concerning available modern contraceptive methods, and assistance in gaining access to them.

Project Objectives and Strategies To address this three fold problem of communicable disease, malnutrition and rapid population growth, the Bicol Integrated Health, Nutrition & Population Project decided to focus its efforts on 400 of the most depressed rural barangays. Originally, in the PID and the PRP, the designers had their sights on 'at least 1,200 barangays' - an 88 percent coverage of the 1370 rural barangays in Camarines Sur and Albay Provinces and the rural areas of the three autonomous cities of Naga, Iriga and Legaspi. By the time the project was approved, however (for reasons which are unstated) this had been modified to the '400 most depressed' barangays. In any event, 400 barangays was still a formidable undertaking.

The 'integrated' thrust anticipated reaching 400,000 direct beneficiaries based on an average 1,000 individuals per barangay; - about 23 percent of the total population in the two provinces of the region, and 29 percent of the rural population.

The overall goal of the project was to raise the quality of life and the real per capita incomes of the residents of these 400 barangays through improved health and nutrition status - from reduced death rate, reduced occurrence and controlled spread of communicable and preventable diseases, maintenance of population growth at a desirable level, and the achievement of local government units' self-reliance in health, and health-related services.

Indicators and targets which were considered appropriate in attaining this goal were as follows:-

<u>Indicator</u>	<u>Baseline</u>	<u>Desired Goal</u>
Incidence of Parasitic Infection	90 %	30 %
Life Expectancy	59 yrs	62 yrs
Infant Mortality (per 1,000 live births)	73	54.4
Incidence of Third Degree Malnutrition	5.8 %	1.5 %
Incidence of Second Degree Malnutrition (among pre-school children)	24.8 %	15.8 %
Incidence of Tuberculosis and other Pulmonary Diseases (per 100,000)	1,500	1,000
Birth Rate (per 1,000)	37.86	30.32
Local Government Units Completely Funding <u>all</u> Required Expenses in Support of the Project in the 400 Target Barangays	None	All

The project designers further anticipated that in order to achieve these objectives, activity and involvement would have to be raised to the following levels:-

<u>Indicator</u>	<u>Level</u>
Targetted Households Using Recommended Health Practices	90 %
Immunization Indices for BCG, CTPa, DPT, Tetanus Toxoid and TOPV	'recommendations would be achieved' (?)
Infant Participation in Nutrition Programs	80 %
Expectant and Nursing Mother Participation in Nutrition Programs	50 %
Married Women of Reproductive Age Using Family Planning Methods	40 %
Population Using Satisfactory Toilets	50 %
Barangay Health Aide Stipends Funded from Local Government Revenues	100 %
Barangay Development Centers Established from Local Funds	400
Community-type Water Facilities and Communal School Toilets Maintained by Barangay	100 %

<u>Indicator</u> (Continued)	<u>Level</u>
Repayment Rate on Loans for Barangay and Individual Household Facilities	75 %
Blind Drainage Systems Developed by Families in the Barangays	100 %

In order to attain this level of activity and community involvement, the project's designers planned to provide up to \$7.787 million dollars (with AID's contribution being a \$2.5 million loan, plus \$750 thousand in PL 480 currency; as well as another \$1.170 million in PL 480 commodities which were non-additive). These inputs would be used for the following outputs:-

<u>Outputs</u>	<u>Quantity</u>
1. <u>Barangay Health Aides</u> - Recruited, Trained, Equipped and Deployed	400
Criteria:- local male or female, 18 - 45 yrs old, minimum 6 yrs education/equivalent.	
Training:- Formal Training & Orientation	6 weeks
Supervised Field Experience	2 weeks
Refresher Training, every Six Months	1 week
Content:- Health promotion, disease prevention, clinical and referral functions	

The Barangay Health Aide (BHA) was envisaged as being the principal barangay contact and facilitator for sanitary inspectors, social workers, population specialists, nutrition workers, and other health-related personnel as they carry out their agency functions.

The BHA should be a permanent resident of the barangay, nominated by the barangay council, endorsed by the Rural Health Unit, the municipal mayor and the Regional Director of Health, with appointment by the Provincial Governor. Technical and administrative supervision of the BHA will be the responsibility of the Rural Health Unit. The BHA will be a full time worker of the local government, paid a monthly stipend through the municipal treasurer.

The BHA's duties and responsibilities were many and diverse, as listed in the Project Paper:-

a) Community Organization Consult with barangay residents and coordinate and facilitate assistance in finding solutions to their health-related problems.

b) Environmental Sanitation Promote cleanliness, safe water and proper waste disposal. Identify areas needing improved sanitary facilities and coordinate with Rural Health Unit to obtain assistance and commodities.

c) Nutrition Encourage all households to strive for a balanced, adequate diet. Instruct on infant and child nutrition, and the importance of breast feeding. Weigh and keep records of children under 6 years of age, assist in distributing food assistance commodities, and conduct barangay feeding programs for malnourished children. Refer Third Degree malnutrition cases to Rural Health Unit for treatment. Assist in barangay food production campaign and help formulate and implement an effective nutritional program.

d) Family Planning Participate in population education and family planning programs. Provide information on contraceptives, and refer acceptors to appropriate agencies. Supply on-going users with commodities. Organize a family planning program if non has been established.

e) Communicable Disease Control Promote disease control campaigns of the Rural Health Unit. Identify and prioritize immunization targets, and obtain services and supplies. Maintain records of immunization, and instruct families on the role of immunization in health maintenance. Refer notifiable diseases to the Rural Health Unit, and maintain follow-up.

f) Vital Statistics Record births and deaths in the barangay, and report them periodically to the Rural Health Unit. Develop and maintain spot-maps of important health and sanitary information on the barangay, and prepare and maintain individual family health folders containing disease records, treatment and outcomes, for Rural Health Unit reference.

g) Curative Functions Provide emergency treatments for sickness and accident, referring cases to the nearest medical facility when necessary. Monitor regimens prescribed by the Rural Health Unit for chronic disease patients. Maintain health and nutrition kits and see that approved supplies of medicine are replenished from the Rural Health Unit.

2. BHA Training Program - Develop and conduct training programs for BHAs, including training materials in various media - audio-visual, video, programmed learning, etc.

Regional Health Training Center, Legazpi City will be the locus of the six week BHA training program.

3. Information, Education, Communication and Motivation Campaign (IECM)
A barangay-oriented IECM campaign, utilizing the tri-media approach on health, nutrition, sanitation and population education. The Project Management Office (PMO) will explain the project to barangay and municipal councils to enlist their support and gain official commitments for eventual financing of the project.
4. Botica sa Barangay (Village Drugstore) Establishment of a supply point for non-prescription medicines at a low price in each of the 400 barangays. To be owned and operated by a Barangay Cooperative Association. BHA will provide leadership in development and utilization of the store.

5. Equipment & Incentives for Nutrition and Community Development
Worker Vehicles, and specialized equipment (grinders and scales for preparing weaning mix, and in weighing children) for various organizations based in the municipality to help in their outreach programs. The BHA will assist these organizations and their staffs and help organize Rural Clubs in the barangay as part of their educational and promotional efforts. All barangays will be encouraged to establish multi-purpose Barangay Development Centers (BDC) for meeting, feeding, and office space.
6. Immunization Program The Ministry of Health Expanded Immunization Program will be subsidized by the project. BHAs will assist rural health personnel in pursuing targeted immunizations in their barangay.
7. Barangay Supply Points POPCOM - the Philippine Commission on Population - has designated barangay contraceptive service points (BSPs) to support family planning functions of BHAs. These will be supplied with contraceptives and other program-related facilities.
8. Microscopy Center Assistance Each Rural Health Unit will be provided with microscopy equipment and supplies for tuberculosis and intestinal parasitism detection.

On the Health Infrastructure and Sanitation Development side, the project anticipated funding the following activities:

1. Barangay Household Water & Waste Disposal Facilities

	<u>Quantity</u>
Construction of water-sealed toilets for individual households	32,000
Construction of school toilets	400
Construction of 'appropriate' barangay domestic water supply (chlorinated)	400
Establishment of Cooperative Association to own, operate, and maintain community water facilities. Determine, and collect fees monthly, and remitted to municipal treasurer.	

2. Health Infrastructure Construction of
new Barangay Health Stations 9
- Renovation of Municipal Health Centers 7
- Construction of Municipal Health Center Extensions 52
- Construction of City Health Center Extensions 3
- Upgrade Regional Laboratory and Provincial Laboratory facilities, primarily for more adequate bacteriological and chemical analysis of water . 3

Annual output targets are shown on the following table:

Table 1 - Magnitude of Outputs

PROJECT OUTPUTS	MAGNITUDE OF OUTPUTS					TOTAL
	YEAR					
	1979	1980	1981	1982	1983	
1. Rural Institutional Development						
a. BHAs trained and fielded	80	160	160	-	-	400
b. BHNPTs organized	80	160	160	-	-	400
c. BHA Manuals Distributed	80	160	160	-	-	400
d. BHA Kits Distributed	80	160	160	-	-	400
e. Regional Training Team Organized	1	-	-	-	-	1
f. Barangays covered by IECM	80	160	160	-	-	400
g. Barangays with Functional Rural Clubs	80	160	160	-	-	400
h. Diocesan Nutritionists trained and fielded	5	-	-	-	-	5
i. Food-for-Work Coordinators trained and fielded	2	-	-	-	-	2
j. Community Organizers trained and fielded	3	-	-	-	-	3
k. Barangay Development Centers Operationalized	80	160	160	-	-	400
l. Village Drugstores Established	80	160	160	-	-	400
m. 1) School entrants immunized with BCG	-	2320	6960	11600	11600	32480
2) Infants immunized with BCG	-	2080	6240	10400	10400	29120
3) Persons immunized with CTPs	-	56000	168000	280000	280000	784000
4) Infants immunized with DPT	-	2080	6240	10400	10400	28120
5) Pre-natal cases immunized with Tetanus Toxoid	-	1600	4800	8000	8000	22400

Table 4 - Magnitude of Outputs

PROJECT OUTPUTS	MAGNITUDE OF OUTPUTS					TOTAL
	YEAR					
	1979	1980	1981	1982	1983	
6) School entrants immunized with Trivalent Oral Polio Vaccine (TOPV) -		1040	3120	5200	5200	14560
n. Microscopy Centers Established	38	-	-	-	-	38
2. Physical Health Infrastructure and Sanitation Development						
a. Laboratories Upgraded	3	-	-	-	-	3
b. Municipal Health Centers Renovated	7	-	-	-	-	7
c. Barangay Health Stations Constructed	9	-	-	-	-	9
d. City Health Center Extensions	3	-	-	-	-	3
e. Municipal Health Center Extensions Constructed	52	-	-	-	-	52
f. Barangays Surveyed for Health and Sanitation Status	1370	-	-	-	-	1370
g. Community-type Water Supply Facilities Constructed	-	253	337	338	338	1266
h. Individual Household Water Supply Facilities Constructed/Upgraded	-	400	533	533	534	2000
i. Households Chlorinating Drinking Water	-	12800	25600	25600	-	64000
j. Households with satisfactory toilets	-	6400	12800	12800	-	32000
k. Barangay schools with communal toilets	-	80	160	160	-	400

The means for carrying out an integrated program of this scope was to be through extensive coordination and cooperative arrangements of various local, provincial, regional and national organizations, with the Ministry of Health acting as the lead agency. While integration of services implies the participation of several organizations and agencies with varying degrees of input to the project, it was considered essential to success that clear lines of direction of the Barangay Health Aide's activities be established, and the authority of the Ministry of Health's Rural Health Unit to define and schedule the BHA's activities be preserved. Thus, all agencies, and barangay officers were to clear and plan programs involving the BHA, with the Ministry's Rural Health Unit prior to implementation.

At the regional level, a Project Management Coordinating Committee (PMCC) was to be created, with the Regional Director of the Ministry of Health as the chairman; and the Regional Directors of the nine major national agencies as members. Also to be members were the Provincial Governors of Camarines Sur, and Albay, as well as the City Mayors of Naga, Iriga and Legazpi, and the Program Director of the Bicol River Basin Development Program. This Committee was to provide advisory support in formulating management guidelines and organizational policies, and was to meet regularly to thresh out any coordinative problems in agency participation. The nine member agencies were:- the Bureau of Agricultural Extension (BAEx), Ministry of Public Information (MPI), Bureau of Public Works (PW), National Nutrition Council (NNC), Ministry of Local Government and Community Development (MLGCD), Ministry of Social Services and Development (MSSD), Ministry of Education and Culture (MEC), Commission on Population (POPCOM), and the National Manpower and Youth Council (NMYC).

Within each province, a Provincial Health, Nutrition and Population Committee (PHNPC) was to be created, chaired by the Provincial Governor, with the Provincial Health Officer as vice-chairman. Representatives of all agencies engaged in health, nutrition, population and related services were to be members of this committee. This committee was to provide advisory and coordinative support to the implementing agencies at the provincial level.

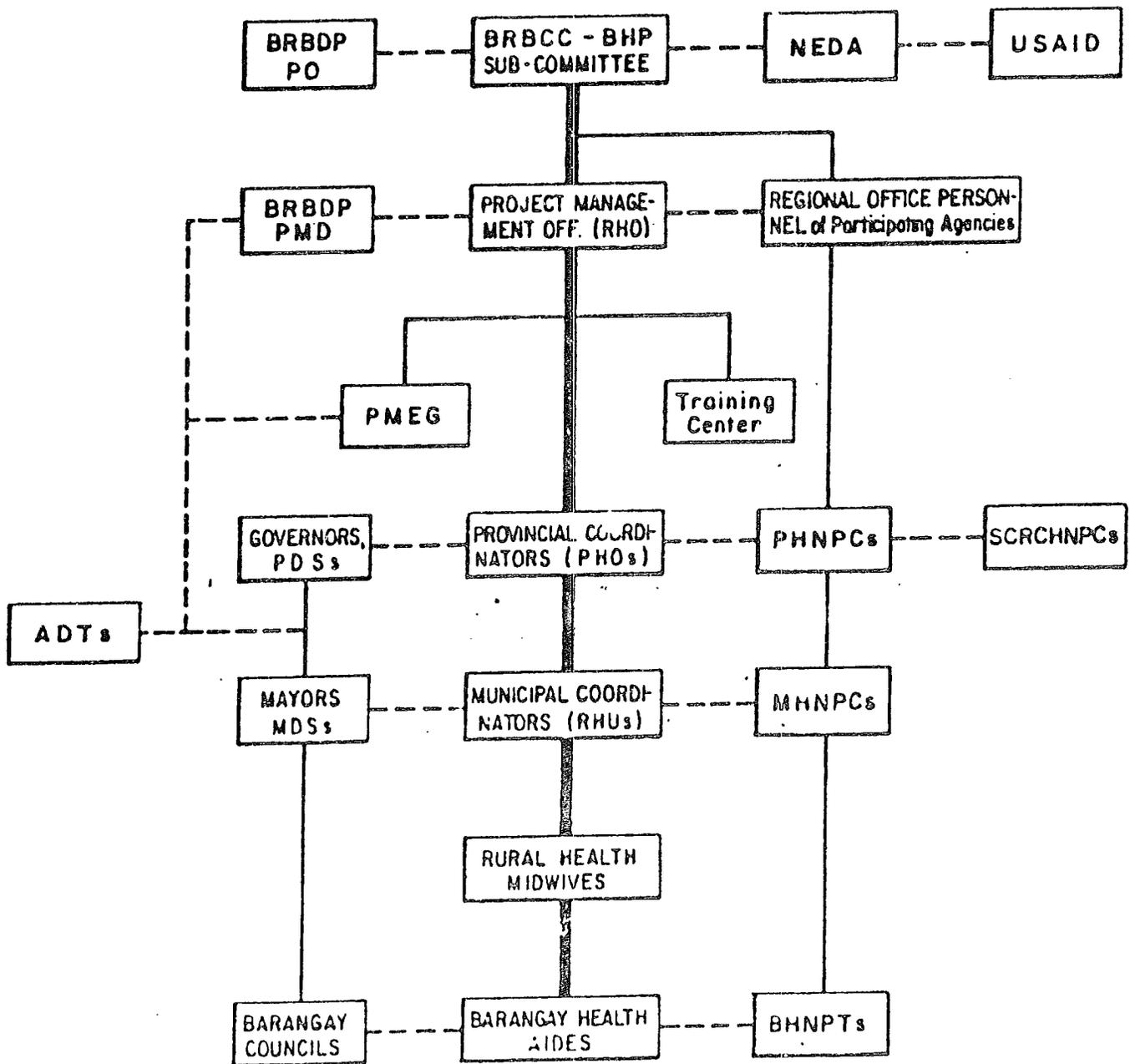
A Socio-Civic-Religious Clubs Health, Nutrition and Population Committee (SCRCHNPC) was also to be organized at the provincial level to coordinate and ensure non-duplication of social service activities in the private sector organizations, and to effect a pooling of their services. The presidents of provincial or city level organizations were to comprise the membership of this committee.

The Project Manager was also to work closely with the Bicol River Basin Development Program's Program Management Department, which would assign two staff members to monitor project activities, full-time, for the BRBDP.

Another group, under the supervision of the Project Manager, would be a contract Project Monitoring and Evaluation Group, for component-specific monitoring and performance, and impact evaluation.

The Information, Education, Communication & Motivation (IECM) group was also to be under the supervision of the Project Manager, composed of the Public Information Officers of the nine major national agencies, with the Ministry of Public Information taking the lead role.

ORGANIZATIONAL CHART



LIST OF ABBREVIATIONS :

BRBDP - PO	Bicol River Basin Development Program - Prog Office	PDS	Provincial Development Staff
BRBCC	Bicol River Basin Coordinating Committee	MDS	Municipal Development Staff
NEDA	National Economic and Development Authority	PHNPC	Provi Health, Nutrition and Population Committee
BRBDP - PMD	BRBDP - Program Management Department	SCRCHNPC	Socio-Civic-Religious Clubs Health, Nutrition & Population Coma
RHO	Regional Health Office	MHNPC	Municipal Health, Nutrition & Population Committee
PMEG	Project Monitoring & Evaluation Group	ADT	Area Development Team
PHO	Provincial Health Office	BHNPT	Barangay Health, Nutrition & Population Team
RHU	Rural Health Unit		

At the Barangay level, the Barangay Captain was designated as the Chairman of the Barangay Health, Nutrition and Population Team. The Barangay Health Aide (BHA) was to function as coordinator of the team. Since the line agency workers usually covered several barangays, they would in effect provide backstop support and technical advice to the BHA, as needed. The Barangay Team (BHNPT) would assure the establishment and maintenance of the village drugstore - Botica sa Barangay.

Funds Flow

The funds flow for the project were to be governed by the provisions of Presidential Decree No. 1177. The Ministry of Health, as the lead agency, would prepare a special supplemental 1979 budget request for sufficient funds for the first year of the project. Funds for subsequent fiscal years were to be specified in the loan agreement (PROAG) and the project implementation plan submitted to fulfill the project's Condition Precedent.

The general procedure envisaged, was for the regional office of the Ministry of Health to include the amount required for the project in its budget request. This would be included in the MOH budget proposal and submitted to the Ministry of the Budget for review and approval. After authorization, the Ministry of the Budget would release project funds to the Project Management Office - through the Ministry of Health and the MOH Regional Office - on a quarterly basis, by the allotment and cash disbursement ceiling system.

The Project Management Office would in turn release amounts to the participating agencies to cover incentive allowances, and to different municipal treasurers - through the provincial treasurers - to cover BHA stipends. Funds for construction of physical infrastructure were to be managed by the Project Management Office, directly. Construction funds would be paid to the construction contractors after they had complied with accounting and auditing requirements.

At the end of each quarter, the Ministry of Public Works would certify the percentage of completion of all construction being undertaken during the quarter.

Medicines for Botica sa Barangay were to be purchased by the Project Management office, in bulk, through their standard operating procedure. The PMO was also to formulate guidelines for sale and replenishment of supplies.

Release of funds for maintenance costs were anticipated to commence during the second year of implementation, and yearly thereafter, following the procedure for furnishing the BHA stipend.

After the end of every quarter (or on a date specified), all participating agencies were to submit disbursement reports, with supporting documents, while in addition, the municipal treasurers would also submit collection reports.

The Project Management Office would in turn submit the consolidated disbursement reports to the National Economic & Development Authority

(NEDA) - through the Regional Health Office - as the basis for a request for reimbursement from USAID.

Accountability shall also be made by the Project Management Office to the Ministry of the Budget - through the Regional Health Office and the Ministry of Health.

The project is funded, in part, from a USAID Loan, as well as PL 480 generations of local currency.

Arrangements for the PL 480 generated funds were to be made with NEDA through the Ministry of Social Services and Development. For draw-down of the loan, the Fixed Amount Reimbursement (FAR) procedure was to be utilized. Under the FAR system, the Philippine government provides the cash requirements of the project in the first instance, and when the activity/output (for which the funds were expended) is completed, AID reimburses the government in an amount, or rate, previously agreed upon.

Implementation and Accomplishments

The series of Quarterly Project Status Reports, supplemented by the May 1983 Report of a Process Evaluation, Bicol Integrated Health, Nutrition and Population Project published by USAID/Manila's Office of Population, Health & Nutrition, are the principal sources of information for this summary of implementation experience and accomplishments.

The quarterly reports are presumably based on data reported by the field activities of the total project. The Process Evaluation data was based on a simple random sample of 14 barangays, and interviews of two residents per barangay, in addition to other operational staff interviews and reviews of records.

The quarterly reports provide information on only a few of the Output level indicators, and almost none of the Purpose or Goal level indicators. The latest figures available (as of 31 Mar 1984) indicate that an excess of 400 Barangay Health Aides had been trained, equipped, deployed and received refresher training. This was necessary to cover program losses due to reemployment to other health-related positions in the area, and resignations. On the environmental sanitation front, some 98% of the 32,000 household water-sealed toilets had been procured, and approximately 25,000 (78%) constructed and in-use. Only 13 of the 400 school toilets had been constructed. For the barangay water supply component, 241 of the 400 barangays had had handpumps installed, and 13 spring improvements had been undertaken. (It was not clear whether the 13 springs were in other barangays as alternatives to handpumps, or additive). The reports are silent regarding the activities of the BHAs, or other aspects of the project.

The Process Evaluation report (now more than a year old) concluded that the overall performance of the BHAs generally met the objectives for which they were trained. There appeared to be adequate evidence that they were performing most, if not all, of their assigned duties. The positive impact which their performance has had was evidenced by the following findings:-

- Indications by the Rural Health Unit staff that barangays with BHAs had fewer patients coming to the RHU for medical services.
- Requests for replacements of BHAs, by barangays, whenever one departed. Further noted that departures were usually due to upward mobility in the Ministry of Health.
- Requests from local officials to expand the BHA program to other barangays.

One area of concern noted was that there were conflicting perceptions about the major functions of the BHA. Some saw the BHA as only a health facilitator; others as a health provider. Training was geared to the perception that the BHA is a provider of health services. This preference was reflected in recruitment of non-resident midwives as BHAs, rather than resident (non-midwife) high school graduates, despite the original project emphasis to select barangay residents as BHAs. However, the evaluation did not establish any correlation between full-time residency and BHA effectiveness. Furthermore, despite the orientation towards health provider training, rather than preventive health coordinative activities, there appeared to be general satisfaction with the BHAs presence and the work they were doing to improve conditions in their respective barangays.

The Environmental Sanitation Infrastructure program fell seriously behind the schedule planned, with the exception of the household toilet construction. Two major reasons were cited for this delay:- a lack of personnel at the Project Management Office to manage ESI, and, to a lesser degree, the slow release of funds from the Office of Budget Management. There is a long listing of problems - most stemming from inadequate: management attention, technical assistance, and followup. Because these issues may not have been resolved since the 1983 report, they are repeated here for reference by the next evaluation team.

- The Project Management Office (PMO) has no overall plan of action for implementing ESI.
- Directors and technical personnel from line agencies which should be involved are minimally aware (at best) of their responsibilities.
- Cooperatives which were to be formed to own, operate, maintain and repay the project for the cost of materials, have not been established, and no efforts have been taken to form them. There has been no followup by the PMO.
- There is confusion at all levels on ESI. Communication has been only verbal and informal.
- Information requested from the barangay regarding water facilities has been insufficient, and inefficiently handled. Extra site visits have been necessary to process requests accurately.
- No planning was done to upgrade individual household water facilities.
- No planning was done to chlorinate water, as originally conceived in the project documentation.

- Although laboratories were upgraded in both provinces so that water analysis and other bacteriological analysis could be conducted, none is being done in Camarines Sur, and only a limited amount in Albay; for reasons unknown.
- Although installation of household toilets was about 33% completed progress was slow because residents lacked money to purchase the construction materials - such as cement. Consequently most toilets were constructed with indigenous materials as a temporary measure. Some were not properly sealed and were thus unsanitary.

For awhile, there appeared to be a problem in the local government assuming the cost of BHA stipends. The later quarterly progress reports indicate that this is no longer a problem, however, and 'all municipal governments have made budgeting provisions and most of them have started paying their share of the stipend'.

The project was conceived as a integrated one, necessitating inter-agency coordination from the regional to the barangay level. Sixteen national and regional government agencies and entities were committed to active involvement in the project, coordinated through various local level committees. The Process Evaluation findings revealed this as a weak area.

- The only coordinating committee is at the regional level - the Project Management Coordinating Committee (PMCC) and it did not meet regularly.
- Regional Directors of some of the agencies were only vaguely aware of the project, and most of the provincial level officers were even less knowledgeable. This was attributed to three principal circumstances:
 - Several of the agencies had major reorganizations after the Bicol Integrated Project began, with apparently no transitional follow-through.
 - Many agencies appeared to have internal communications problems; details unspecified.
 - Weak communication between the Project Management Office and the agencies, and little follow-up by PMO to insure that any work was being carried out.
- Few agencies send regular permanent representatives to the PMCC. Thus an inordinate amount of time was spent at each meeting in updating the new representatives.
- The interagency Task Force at the Regional level which was to serve as the technical arm of the Project Manager had not met between 1981 and May 1983.
- Aside from interagency coordination, there was not much evidence of individual agency participation in the project either - with the partial exception of POPCOM and MSSD.
- At the municipal and barangay levels, there was little evidence to suggest that there was any planned interagency coordination or integration - only resourceful barangay level workers who were making conscious efforts to coordinate their activities.

In summary, there seemed to be a question as to whether the project was really an integrated project in any sense of the word.

The project was being implemented through the organizational structure of the Ministry of Health (MOH). The Project Management Office (PMO) was not a separate entity, since most of the project's technical and administrative staff were designated from the Ministry of Health's Region V office, to perform project functions in addition to their other on-going responsibilities. Thus, despite the efforts of most staff to double-up and tackle two jobs at once, there were insufficient staff to implement the project effectively. Furthermore, since the interagency task force was inactive, the support from other agencies at the provincial and municipal levels was not forthcoming.

The financial management aspects of the project also experienced major difficulties during implementation. Disbursement from both foreign exchange and local currency costs were slow compared to the level of expenditures planned. This sluggishness apparently continued, for the Quarterly Project Status Report as of 31 Mar 1984 indicated that with 86 % of the time elapsed, only 36 % of the funds had been expended, and 43 % committed, and 44 % earmarked. Of course, much of this is the effect of the initial delay in the ESI component.

The reimbursement rate was also slow (in 1983) because of the slowness of the Philippine government to file claims for reimbursement for expenses they had already incurred. This was partly due to what the evaluation team adjudged inadequate or inappropriate mechanisms for the flow of funds, and partly to the lack of full-time personnel in the Project Management Office to attend to the financial management aspects of the project.

Requirements for financial management of the project were stringent and compliance with the requirements of the various agencies exacting. The financial manager of the project was also the full-time finance officer for the Regional Health Office of Region V, and did not have time to give the project sufficient attention.

The budget under which the project was operating in 1983 was four years old. Since then, there had been several changes in project expenses and inflation had invalidated estimated project costs.

There was also confusion over how long Barangay Health Aides were to be paid from the Project's loan funds. The Project Management Office had a different interpretation to the local government units. However, from subsequent quarterly reports, it appears that this situation has been rectified.

Community participation in identifying health related problems and solutions, and in planning activities was considered weak in the 1983 evaluation. However, the team noted that community support and participation during implementation itself was considered adequate. In most instances, it appeared that the BHA conducted barangay meetings to inform residents of upcoming activities rather than involving them in planning and defining community needs and activities.

Community acceptance of the BHA was generally quite strong. This was particularly noted where the BHA had established rapport with the community through living in the barangay. Even those who did not reside in the barangay when originally hired, usually moved in at least part time - during the work week.

A factor which hindered community participation was the dire poverty of some residents, resulting in no time for community activities. This is often overlooked by external 'providers' of assistance programs. Also the requirement for even token payments to encourage initiative and self-reliance on the part of the recipient may be good philosophy but difficult development reality for the poorest of the poor. They cannot, in many instances afford the cost of the water-sealed household toilets - thus, the realization of improved sanitary facilities and conditions in the barangay had to be deferred.

A final conclusion of the 1983 evaluation was that the monitoring and evaluation system of the project was not functional. Because this system was not operational, no one had a good grasp of the actual detailed progress of the project and impediments to success.

THE PANAY UNIFIED SERVICES FOR HEALTH (PUSH) PROJECT

The PUSH Project was conceived early in 1976 to extend basic health services to barangays in the provinces of Aklan, Antique, Capiz and Iloilo on the island of Panay in the Western Visayas region, which had not been reached by conventional health service delivery systems. AID's contribution to the project was to be \$5.716 million, consisting of a \$5.4 million loan, and \$316,000 grant, in support of a \$9.716 total estimated project cost.

The project's objective was to improve the health status of the residents of 600* depressed barangays by reducing the incidence of a) malnutrition among children aged six years and below, b) tuberculosis, diphtheria, tetanus and gastro-intestinal infections, c) infant mortality, and d) reducing the crude birth rate. This was expected to be accomplished by recruiting, training, equipping and deploying a Barangay Health Worker (BHW) in each of the 600 target barangays, who would provide simple preventive, curative and health promotive services, as well as a linkage to higher levels of the region's health service system. The project was also to provide community support for the repair and construction of waste disposal, water supply and drainage facilities in the barangay.

Background Situation It was estimated in the Project Paper that the Panay population was about 2.4 million, of whom 70% live in rural areas, with little or no access to organized medical care. Thus, despite the extensive health facilities located in the larger communities, in the depressed rural areas, limited facilities and health manpower resources exist. Even when these services are available, they are often delivered on an intermittent basis which is insufficient to produce any significant impact on the morbidity picture.

The four major health-related problems in the area were identified as:-

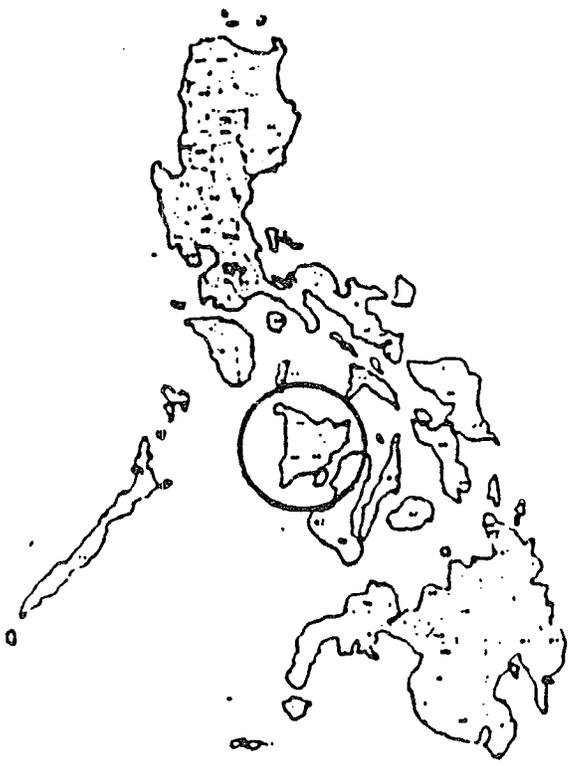
1. Malnutrition
2. Tuberculosis and Pneumonia
3. Gastro-enteritis and Parasitism, due to Poor Water Supplies and Sanitation Facilities
4. High Birth Rates

Malnutrition constitutes the most serious single public health problem, affecting an estimated 85% of children aged six years and below. The incidence of third degree malnutrition alone is 7,000/100,000.

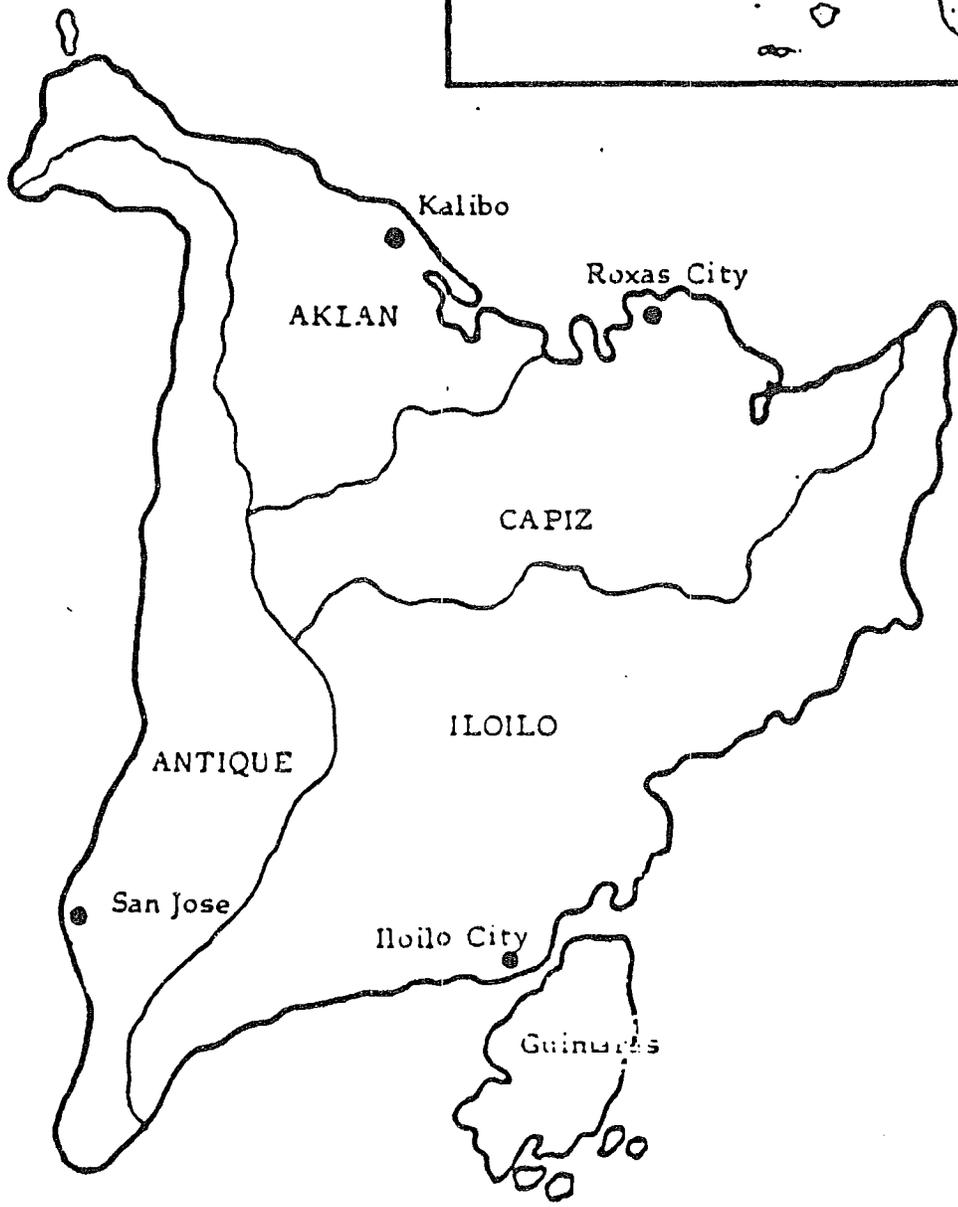
With a TB rate of 284/100,000, and a pneumonia rate of 225/100,000 the Project Paper indicated that these were the number one and two causes, respectively, of morbidity and mortality. Although preventable and curable, because of the inaccessibility to health providers, most TB and pneumonia goes untreated in the rural areas of Panay.

* Originally 1,800 barangays were considered, but this was later reduced to 600.

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Over fifty percent of the rural households use water from unimproved shallow-dug wells, according to data cited in the Project Paper (PP). Thirty-five percent of the households on Panay had no toilets, and of the 65% having toilets, only 30% were deemed to be in satisfactory condition from a public health standpoint. Thus, nearly 70% of the households on Panay had unsanitary waste disposal, and over 40% had unsatisfactory water supplies. Consequently, the average parasitic infestation rate for Panay was estimated at 72.4% of the population. The situation was believed to be much worse in the depressed barangays targetted for PUSH. In these areas, an estimated 65% of the population had no access to water supplies in adequate quantities and desirable quality, and as many as 85% of the population were estimated to lack excreta disposal facilities which met minimum sanitation standards. No estimate of parasitic infestation was provided, however.

The prevailing crude birth rate at the beginning of the project was estimated at 31.5 per thousand, with a contraceptive prevalence rate of 23 percent. While the crude birth rate is unquestionably high, no further details on the situation were provided in the project documentation, nor was there much discussion of the status of the family planning program which had been designed to address this problem.

This summary constitutes the essence of the background situation provided for the PUSH Project in the project documentation. There is a dearth of supporting descriptive and statistical data such as was available for the Bicol region. It is to be hoped that this lack of base-line information is only temporary - i.e. available in Manila and Iloilo project offices - rather than absolutely unobtainable as it provides the foundation upon which subsequent impact studies are built.

Project Objectives and Strategies As indicated earlier, the project's proponents decided to target 600 depressed barangays on Panay. Although there have been numerous single action health programs in the past - such as Project Compassion, Family Planning, and Operation Timbang - none of these has attacked the problem in an integrated way. They have all been developed and controlled by the national government as components of a nationwide campaign to deal with a specific issue.

Thus, a significant difference in the PUSH Project was that it was to be developed and implemented regionally in an integrated manner to address a variety of problems simultaneously. The focus of the project was to be the Barangay Health Worker (BHW) who would function as an extender of the various preventive, educative, promotive and curative services provided by the Rural Health Units.

Panay Island has vital statistical indices and age/sex composition as other areas of the Philippines. However, the four provinces are also a geographically self-contained unit separated from other islands sufficiently to allow controlled evaluation of project significance.

The project's designers hoped that experience gained from the implementation here with local integrated development would be useful for adaptation in other areas.

The project anticipated reaching 336,360 direct beneficiaries in 61,200 households of the 31 most depressed municipalities in Panay. Eighteen of these municipalities are situated along the coast, while 13 are located in mountainous areas. Many of the barangays of the inland municipalities are inaccessible by land transportation. The population is therefore relatively isolated, and contact with urban centers is minimal. Houses in both coastal and inland barangays are typically built along roads, usually near the school house; or along the coastline or river where there is also a road leading to the water. In the interior, houses are built on the farm itself, and are therefore far apart. The wide dispersal of houses and the distance of these barangays from the poblacion (the center of the municipality) make them relatively inaccessible to any organized social service delivery system.

The overall goal of the PUSH project was to improve the health status of the residents in the targetted barangays. Indicators and targets which were considered appropriate in attaining this goal were as follows:-

<u>Indicator</u>	<u>Baseline</u>	<u>Desired Goal</u>
Incidence of Tuberculosis (per 100,000)	284	213
Incidence of Tetanus	(not given)	- 25%
Incidence of Gastro-intestinal infections (- " -)		- 25%
Infant Mortality (per 1,000 live births) (- " -)		- 25%
Crude Birth Rate (per 1,000 population)	31.5	24.0
Incidence of Third Degree Malnutrition* (per 100,000 children 0 - 6 yrs old)	7,000 (?)	4,200 (?)
Incidence of Second Degree Malnutrition* (not given)		- 70%

* The combined malnutrition status of children ages 0 - 6 yrs old is shown in the Project Paper as 83% (85% in another place). Presumably this combines 1st, 2nd and 3rd degree malnutrition. The data is not disaggregated however. In the Implementation Plan, the issue is addressed in a different manner as "approximately 10,000 children with 2nd and 3rd degree malnutrition rehabilitated" stated as an Output objective. the 7,000 was inferred from another 'random' statistic, and the 4,200 derived from it, @ 40% reduction. However, these are questionable since they do not appear to be consistent with the 10,000 total, and presumably higher 2nd degree levels of malnutrition. Hopefully there is better data available to USAID and the project, for impact evaluation, and other comparative purposes.

In order to achieve these objectives, health services delivery activity and community involvement would have to be increased to the following levels:-

<u>Indicator</u>	<u>Level</u>
Households using Sanitary Waste Disposal Facilities	60 %
Households with an Adequate Supply of Improved Quality Water *	80 %
* Neither 'adequate' nor 'improved' are further quantified	
Target Population Immunized with BCG & DPT	70 %
Contraceptive Prevalence Rate	38 %
Rehabilitation of Malnourished Cases	10,000

In order to attain this level of activity and community involvement, the project's designers planned to provide up to \$9.716 million dollars (with AID's contribution being a \$5.4 million loan and a \$316,000 grant). These inputs would be used for the following outputs:-

<u>Outputs</u>	<u>Quantity</u>
1. <u>Barangay Health Workers</u> - Recruited, Trained, Equipped and Deployed	600
Criteria:- Male or female resident of the barangay, 18 - 45 years old, minimum 6 yrs education/equivalent.	
Training:- Formal Training & Orientation	6 weeks
Refresher Training, every Six Months	2 weeks
Content:- <u>Seven</u> general areas - environmental sanitation, medical care, control of communicable disease, family planning, nutrition, vital statistics and community mobilization. (Emphasis was given to environmental sanitation and medical care.)	

The Barangay Health Worker (BHW) was conceived as the key figure in the proposed barangay health care delivery system. He/She would reside in the barangay and respond to simple medical problems and undertake preventive and health promotive activities, under the technical and administrative supervision of the Rural Health Unit. The BHWs will be barangay contact points and facilitators for existing technical personnel such as sanitary inspectors, social workers, municipal population officers, nutrition workers and general health workers carrying out their line agency functions. To avoid confusion with other line agency technicians in utilizing BHWs, coordination of all health related activities will be maintained at the municipal level through the Rural Health Unit. The BHWs will be paid full-time employees of the provincial government.

As an extender of the services provided by the Rural Health Unit, at the barangay level, BHWs will work on seven general areas of concern:-

- a) Environmental Sanitation Identify areas in the barangay where sanitation facilities need to be constructed or improved. Organize the community and expedite efforts to obtain commodities and expertise to construct or improve water facilities, and promote proper water handling and utilization. Monitor water quality and apply simple water treatment procedures. BHWs also campaign for sanitary waste disposal and organize the community to obtain basic commodities and expertise for construction of water-sealed toilets for every household in the barangay. Provide practical advice on the proper handling of household refuse, fly and mosquito control, and other disease-causing environmental nuisances in the barangay.
- b) Family Planning Provide information on different forms of contraceptives available, motivate potential contraceptive users, refer acceptors to appropriate agencies, and resupply on-going users with required commodities. Support any existing family planning program. If none exists, organize one.
- c) Nutrition Weigh and keep records of weights of children in the barangay, 6 years old and below, to prioritize the nutrition targets in the barangay. Provide barangay residents with basic information on nutrient requirements, common food sources of essential nutrients and proper infant feeding techniques. Assist in the food production campaign of other agencies, and in distribution of food assistance commodities. Initiate and conduct barangay feeding programs for 1st and 2nd degree malnourished children and refer 3rd degree malnutrition cases for rehabilitation. If a nutrition program exists, the BHW will support the nutrition worker of the line agency. If none exists, the BHW will organize one.
- d) Communicable Disease Control Identify and prioritize the targets of the barangay immunization program. Obtain technicians and supplies necessary for the immunization campaign. Identify signs and symptoms of notifiable diseases, and report and refer them for treatment, and follow-up regularly. Provide barangay level assistance to the disease control campaigns of the Rural Health Unit.
- e) Curative Functions Screen patients, administer first aid, and refer individuals to nearest medical facility if necessary. Follow-up patients undergoing prolonged treatment regimen to insure that medicines are being taken regularly and that proper patient care is provided.
- f) Vital Statistics Keep records on deaths and births and submit periodic reports to the Rural Health Unit. Maintain spot-maps of household status in the barangay. Maintain individual family health folders with records of illnesses, treatment received and outcome of illness of the household members.
- g) Community Organization Organize barangay residents and mobilize them into collective action to combat existing barangay health problems. Assist in identifying health projects, formulating project plans and in securing external assistance needed for project implementation. Hold group meetings with barangay residents to disseminate nutrition and family planning information and promote proper health habits and practices.

Training for Barangay Health Workers was not classified as a separate activity, but was subsumed under the Barangay Health Worker category.

2. Barangay Household Water and Waste Disposal Facilities (Also listed as Environmental Sanitation)

The emphasis on environmental sanitation was outlined in the Project Paper, both in the training of the Barangay Health Workers, and in the priority listing of activities. It was asserted that eight out of ten of the identified major causes of morbidity in Panay Island were directly or indirectly related to inadequate and/or unsafe water supply sources and unsanitary means of human waste disposal. In order to achieve the project purpose of providing an adequate water supply of improved quality to the project beneficiaries, the following targets were established:-

	<u>Quantity</u>
Construction of Drilled Deep Wells	560 *
(* Originally this was set at 280 satisfactory for household use)	
Construction of Driven Shallow Wells	1,200
Improvement of Open Dug Wells	5,400
Construction of Water-sealed Toilets	40,000 *
(* based on previous Philippine experience, it is anticipated that only 75% will be used regularly)	

3. Botica sa Barangay

A village drug-store will be established for each of the barangays, owned and operated by the community. The BHW will help the barangay develop its own accounting, pricing and resupply system and make arrangements for custody of the drug supply. Rural Health Units will provide continuing technical supervision in the process, especially on the nature of the drugs that the barangay needs to stock. The project will provide each barangay with \$100 worth of drugs as starting capital.

4. Rural Health Units

One hundred Rural Health Units in the four provinces to be supplied with vaccines in support of the DPT and BCG immunization drive. Anti-TB drugs also supplied for treatment and control of tuberculosis in the project areas.

5. Provincial Health Laboratories

Four Provincial Health Laboratories - one in each province - to be equipped to perform water analysis, bacteriological examination and sputum examination for early detection of tuberculosis.

6. Barangay Nutrition Outreach Services

A total of 600 barangay nutrition outreach services points - one in each target barangay - to provide nutrition services and commodities to malnourished children.

7. Barangay-level Family Planning Supply Points & Services

A total of 600 barangay family planning supply points and services - one in each target barangay - including dissemination of information on family planning, motivation of potential contraceptive users, resupply of commodities for current users, and referral services.

The following table outlines the annual targets for each of these Output components:-

TABLE 1 Project Outputs
PUSH Project

<u>OUTPUTS</u>	<u>M a g n i t u d e o f O u t p u t s</u>					<u>TOTAL</u>
	<u>Year 1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	
1. Environmental Sanitation						
Drilled Deep Wells	112	112	112	112	112	560
Driven Shallow Wells	52	154	254	300	440	1200
Improved Dug Wells	104	412	866	1208	2810	5400
Water-sealed Toilets	966	3732	8298	12732	14272	40000
2. Barangay Health Workers Trained, equipped and deployed	50	100	150	150	150	600
3. Barangay Drugstores stocked	50	100	150	150	150	600
4. Rural Health Units supplied vaccines and TB drugs	100					
5. Provincial Labs upgraded	4					
6. Malnourished Children pro- vided Nutrition Services and commodities	400	800	2000	2800	4000	10000
7. Barangays provided family planning supplies points and services	50	100	150	150	150	600

The means for carrying out this integrated program was through a PUSH Project Management Team (PMT) under the direction of the Panay Regional Development Council (RDC) - Region VI of the National Economic & Development Authority. The RDC is composed of the provincial governors city mayors and regional directors of the national agencies operating in the region. The RDC was to manage the project, while administrative direction and support was channeled through the regional office of the Ministry of Health, and the province and municipal governments.

Panay Regional Development Council was asserted to be one of the strongest in the country, having participated in the AID-assisted Provincial Development Assistance Program (PDAP). Furthermore, the Regional Director was a graduate of the Career Executive Service Development Program, Development Academy of the Philippines.

The Regional Development Council in Panay has a membership of 40 people. The PUSH Project Management Team (PMT) was formed as a 14 member committee, and charged with directly overseeing the project's implementation. The Regional Executive Director of the National Economic & Development Authority (NEDA) was designated as the Team's Chief, and responsible to the RDC chairman. The other team members represented the line agencies which had functions related to areas of concern by PUSH. The Ministry (then 'Department') of Health was to assume the administrative direction and support for the project. Team members were the Regional Health Director; Regional Director, Public Works; Regional Nutrition Office; POPCOM Regional Representative; Regional Representative Department of Local Government & Community Development; Regional Representative, Department of Social Services and Development; Regional Office Representative, Department of Agriculture, a representative from the private medical sector, a representative of the Minister of Health, and a representative from each of the four provincial governments; plus the Chief, of the Project Support Staff.

The Project Support Staff was a full-time five person staff, concerned with day-to-day management:- planning, programming, monitoring and follow-up.

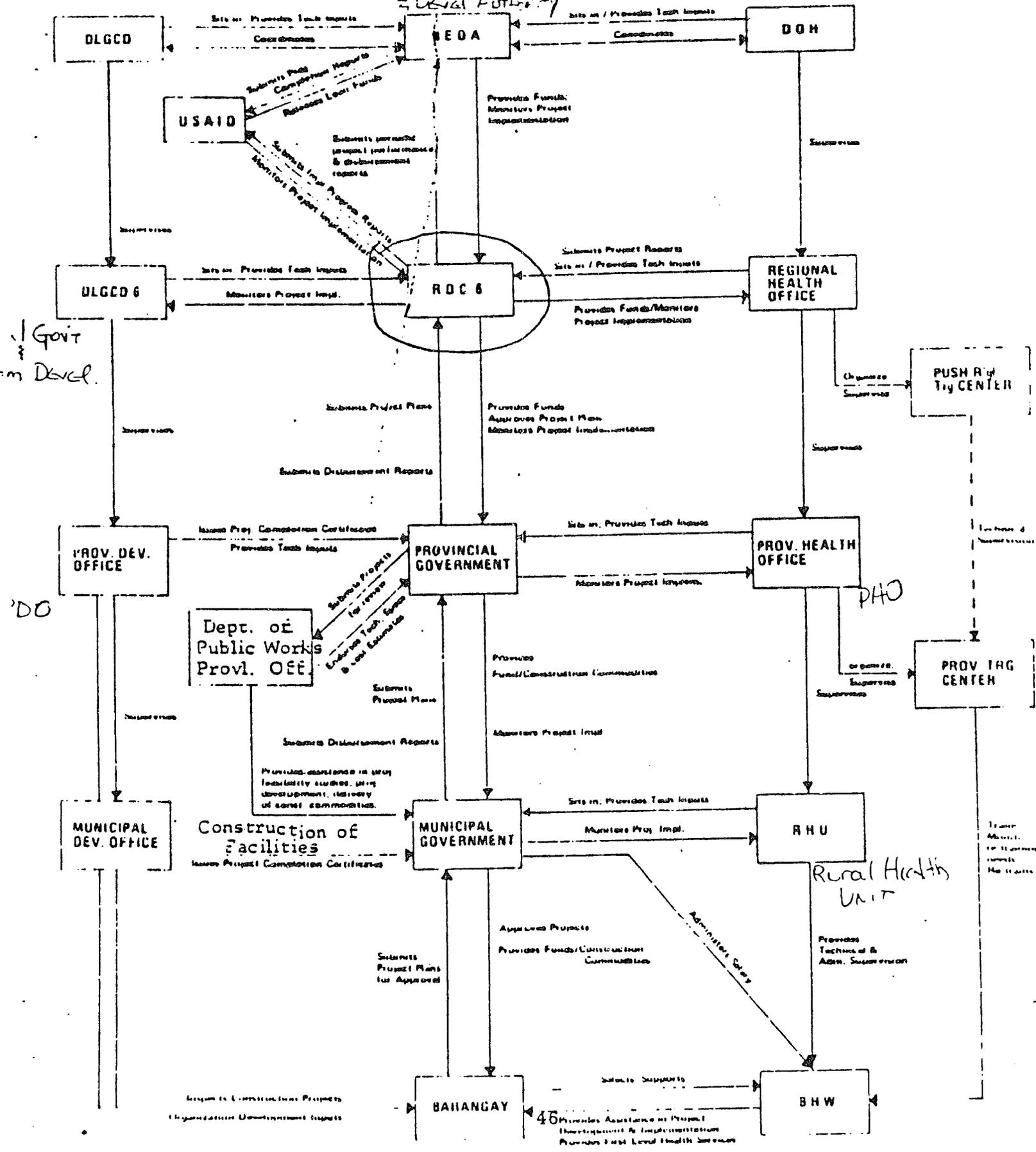
The responsibilities for each participating team member organization are spelled out in great detail in the Project Paper (PP). The chart on the following page attempts to clarify this network of interacting relationships.

Funds Flow

Arrangements for administering funds under the project were equally described in the PP as illustrated in the subsequent charts- PUSH Project Fiscal Management: System of Operation, and Funding & Reporting Flow: Push Project. In essence, several Trust Funds were established to draw upon for procuring project commodities, BHW salaries, and other support activities, and Special Revolving Funds for small barangay projects. Standard GOP accounting, auditing and cost-standardization procedures were to be followed.

PUSH PROJECT: SYSTEM OF OPERATION

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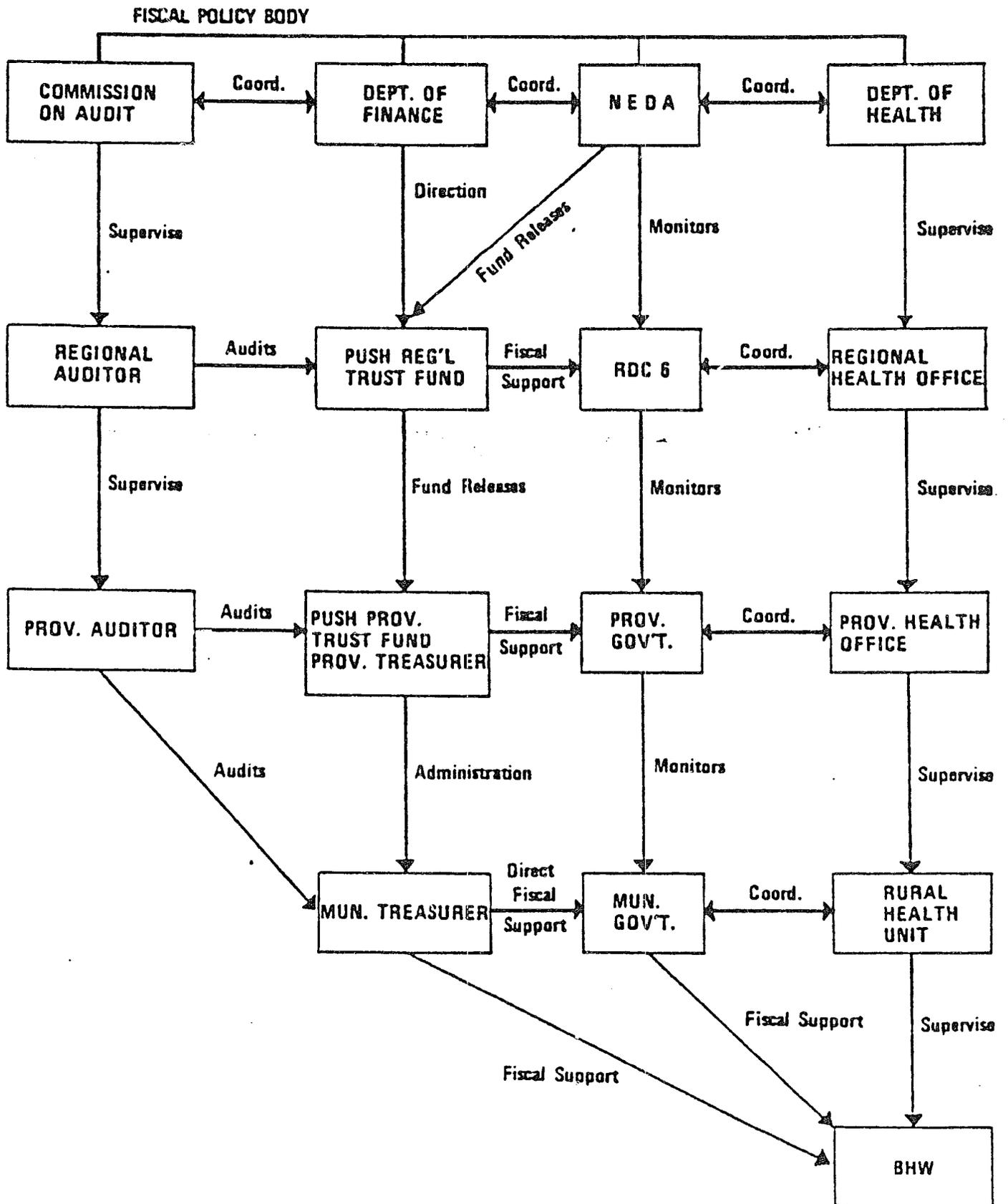


The PUSH Project was supported in part by a \$5.4 million AID loan. USAID indicated in the Project Paper that it would request a Direct Reimbursement Authorization (DRA) for the local currency costs under this loan, estimated at \$4.944 million. The balance of \$.456 million was to be used for financing foreign exchange requirements of the project. The following are the general operating procedures:

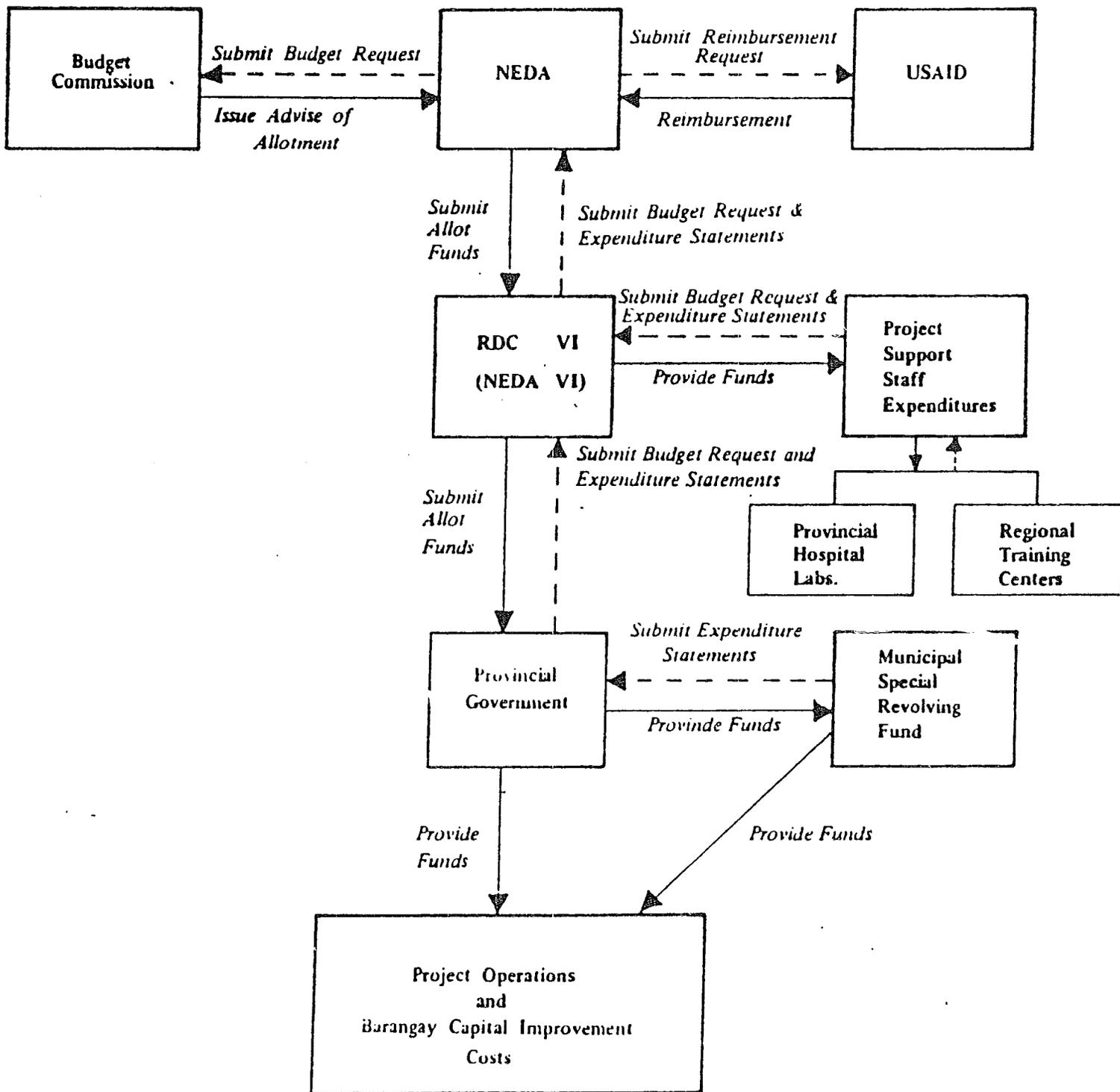
1. The Regional Development Council (RDC) VI submits a work program to the National Economic & Development Authority (NEDA) with budget requirements for the following year. This should be submitted to NEDA two months prior to the start of the next operating year.
2. NEDA reviews and approves the work plan and budget, and releases one-half of the annual budget to the Regional Trust Fund (RTF), which is administered by the Regional Treasurer.
3. The Regional Trust Fund, in turn, releases one-half of the estimated PUSH provincial budget for the year to each Provincial Trust Fund (PTF), administered by the Provincial Treasurer.
4. Upon expenditure of funds, the province requests the second half of the annual budget. This request should be accompanied by expenditure statements of the funds previously released, supported by pertinent documents, signed and certified.
5. The RDC VI submits the expenditure statements and required supporting documents to NEDA, to obtain the second half of the PUSH regional budget.
6. NEDA processes a reimbursement request to AID, together with the supporting documentation.
7. AID reviews the request for reimbursement, and approves payment of those items which comply with the Fixed Amount Reimbursement Agreement previously negotiated. AID requests a reimbursement check from the US Regional Disbursing Office (USRDO). On receipt, USAID transmits the check to NEDA.

NOTE: Under the general provisions of a Fixed Amount Reimbursement (FAR) Agreement, AID and the Host Country jointly estimate costs for construction of facilities, and/or operations for a forthcoming period, and the quality standards to be achieved. The Host Country then uses its own funds to carry out the task, and upon completion, seeks to be reimbursed by AID at the previously-agreed-to amounts. AID inspects, and if the facilities/operations are up to standard, AID authorizes payment. The quality of the work is the determining criterion, not its actual cost. The FAR was developed in this manner to provide an incentive for producing quality work while carefully managing costs. If cost estimates were too unrealistic (either over or under-estimated) on the first phase, periodic renegotiation of subsequent batches of work should rectify the situation.

PUSH PROJECT FISCAL MANAGEMENT: SYSTEM OF OPERATION



FUNDING & REPORTING FLOW: PUSH PROJECT



Implementation and Accomplishments

The series of Quarterly Project Status Reports, supplemented by the three reports - Report on the First Evaluation of PUSH Project, (Internal Evaluation by Joint Philippine-USAID Team), 1981; Evaluation of the Impact of the Panay Unified Services for Health Project, Trinidad S. Osteria, 15 Dec 1982 - 30 Apr 1983; and The Impact of the Panay Unified Services for Health (PUSH Project; A Final Report, Sylvia H. Guerrero and Elsa P. Jurado, Philippine Center for Economic Development, University of the Philippines, Undated - are the principal sources of information for this summary of implementation experience and accomplishments.

The quarterly reports are presumably based on data reported by the field activities of the total project. The first evaluation covered the initial two year period from 1 Jul 1978 to 30 Jun 1980 and reviewed performance against planned targets, and attempted to identify the causes or factors responsible for any failures to attain pre-established targets and also to assess the effectiveness of Barangay Health Workers in performing their assigned functions. The Osteria report prepared a simplified evaluation scheme to measure project impact, and identified major weaknesses in the initial record keeping system. The Guerrero report is a classic systematically structured "after-only" statistical and field study of the project and its effects. A series of hypotheses are established, variables and indicators developed, and stratified samples of barangays and households selected for structured interviews.

The quarterly reports provide information on only a few of the Output level indicators, and almost none of the Purpose or Goal level indicators. The latest figures available (as of 31 Mar 84) indicate because of severe budgetary problems the Philippine government had requested to reduce project coverage from the planned 600 barangays to only 450. No further statistics were cited in this latest report although the narrative stated that "some ESI targets, like construction of household toilet facilities have already been exceeded." It was not clear however whether this was with respect to the original target of 40,000, or some newer, pro-rated target. The previous report which was available (30 Sep 1983) indicated 30,734 water-sealed toilets had been constructed to that date, as well as 1,738 'household water facilities' (an aggregate, presumably of the deep wells, shallow wells, open dug wells and spring improvements) not otherwise identified. Four Hundred and Fifty Barangay Health Workers had been deployed earlier (QPSR 31 Mar 1983). The difficulties with the record-keeping and reporting system were noted as well as the contract with the University of the Philippines in the Visayas to do something about it. The project was extended for one year, to 30 Aug 1984, but there was some concern expressed that the Philippine government did not have the funds to maintain the Project Support Staff after AID assistance was terminated.

The series of Project Implementation Letters (PILs) from USAID to the Philippine government, and the Reimbursement Agreements - both FARAs and RAs depict an egregious financial administration situation. Both USAID and the Philippine government were continuously delinquent in preparing and submitting paperwork to each other, and constituted a series of ex post facto administrative "bail outs", the reason for which were never apparently rectified in over three years of project operations.

The joint evaluation team made a number of findings from their review, with recommendations for subsequent improvement. Since the team was composed of members responsible for the PUSH project's implementation, the findings themselves were important, and the likelihood of the recommendations being implemented was considerably enhanced.

In general, the evaluation team found the barangay health workers (BHWs) performing satisfactorily, although there seemed to be an over-emphasis on environmental sanitation to the detriment of providing health care. This was a function of their prior training however, and could not be faulted as a failure to perform. The team recommended that the procedures for selecting BHWs be reviewed and adhered to, as in some instances, municipalities and barangays had deviated from it. Nevertheless, the BHWs selected were apparently all qualified. (No mention was made of the degree of compliance with barangay residency requirements so this was either not violated, or was not considered an important issue in Panay.) It was also noted that after the first batch of BHW trainees, the criteria for selection had been raised: Age - from 18 to 21, and Education - from 6th grade to high school graduate. It was noted that although the initial BHW training was being conducted in a satisfactory manner, no follow-up evaluation had been conducted of its effectiveness, and no follow-up retraining had been given, although it was supposed to occur every six months, for a two week period.

The Barangay Fund which was provided for the BHWs to spend on small local project activities appeared to be well utilized. However, the 300 peso limitation seemed to be too small in view of commodity price escalation. Furthermore, there was some administrative difficulty in processing requests through the Rural Health Unit, and the Municipal Treasurer's office.

BHWs salaries were considered too low, considering their wide-spread responsibilities and activities. Inflation had also taken its toll. Payment of salaries was also apparently a frequent problem because they were made at the Provincial Capital instead of more conveniently at the Municipality.

Documentation for liquidation of funds met with delay at both the provincial and municipal levels. Apparently PUSH project activities are considered an 'extra' workload without commensurate compensation by the offices involved, and the project receives but low priority attention in processing.

Coordination and integration seemed to occur more in paperwork planning than in operational reality. The Ministry of Health was particularly noted as giving the project much less attention than had originally been anticipated. Some duplication of effort, and lack of consistent follow-through was also indicated with respect to the family planning efforts of POPCOM and the nutritional activities of the National Nutrition Council, and more conferences were recommended to thresh out coordination problems.

Community participation by barangay residents was also less than anticipated in some instances. Difficulties arose on the degree and

frequency of participation, particularly during the planting and harvest seasons when residents were busy in livelihood activities. Also, some residents - who had already contributed labor - were reluctant to do so again, especially when the benefits were limited, and when the project sites were located far from residential areas.

The Botica sa Barangay component appeared to have been delayed considerably by the reluctance of Rural Health Physicians and Provincial Health Officers to permit the Barangay Health Workers (as essentially lay people) to hold, account for, and dispense drugs. Some question still existed on the kind of drugs to be procured and sold at the barangay level.

The off-shore procurement of equipment to upgrade the provincial laboratories to conduct bacteriological water analysis and sputum examinations had not yet resulted in deliveries. Thus, this portion of the project was delayed. It was also noted however, that even if the provincial laboratories were upgraded, this would not solve the situation for some barangays since they were too remote for samples to be transmitted and remain viable.

In many instances, the original targets established for the environmental sanitation component were found to be unrealistic because of varying local conditions. These numbers had been adjusted according to local need, and were not a hindrance to the project, but should be noted in evaluation of accomplishments. For example, Antique has no shallow driven wells, deep drilled wells or open dug wells, because of its topography. Instead they reallocated the funds for spring development projects, as permitted under the Fixed Amount Reimbursement Agreement.

On the family planning front, the BHWs are generally perceived as motivators and referral agents, or sometimes as suppliers of condoms and pills, rather than providers of new acceptors. Most seem reluctant to go beyond the more limited role, due to a lack of confidence as a result of limited training.

There appears to be overlap in the nutrition area, where both the BHW and Day Care Workers were weighing the same population. It has also been difficult to maintain participation in the program because of the inconsistent availability of food commodities for the feeding program.

In the communicable disease control component, BHWs have been active in assisting with the screening and targetting the population, and in providing information on vaccinations and countering mis-information about side effects. Difficulties have been encountered in motivating people because of deeply held fears of vaccination. Also, in many instances, follow-up doses for series immunizations have not arrived on schedule. Further, some BHWs do not know when to administer what type of immunization for particular age groups.

Although BHWs are given some basic training in first aid, their competence in medical care needed to be upgraded in the opinion of the first evaluation team. The BHWs were referring patients to the Rural Health Units for treatment, but the administrative system for referral and follow-up appeared to have many deficiencies.

Reporting by the BHWs was generally not considered very effective by the evaluation team. Forms were unavailable, and in many instances, BHWs had devised their own unique formats and data items. Others appear to have reported the same data from month to month. Apart from Antique Province, however, no attempt seemed to have been made to consolidate the information submitted by the BHWs at the provincial level. The information in the reports appeared to be informationally oriented rather than for analysis and prioritizing action. Little or no feedback was provided to the BHWs from the Rural Health Units however. Timeliness in submission of reports was also lacking.

Guerrero and Jurado's study focussed on the 'impact' or outcomes intended by the project, rather than the input or 'process'. They also approached the study in a rigorous, statistically analytical manner to test the various hypotheses implicit in the project. As such, their study probed a lot of areas which could not be observed or monitored on a day-to-day (or even month-to-month) basis by the Project Support Staff, and subjected them to a causal analysis. The report is hard on the bureaucratic digestion because it is laid out in the classical academic research design style, where the findings are buried in the body of the document, surrounded by its most significant artifacts - the data tables and discussion of methodology. A summary of their findings is presented below.

Impact on the Environment Significant changes occurred as a result of the project, and the Barangay Health Worker's influence. Not only were many household toilets installed, but - only one year after the BHWs were fielded in the barangays - two-thirds of the households had changed their practices of waste disposal, using covered trash cans and compost pits for solid wastes and blind drainage for liquid waste.

Also significant was the change in water source for many households from contaminated open dug wells, shallow driven wells and unimproved springs to improved variations.

Impact on Communicable Disease Control The deployment of BHWs in 1979 and 1980 appeared to have significantly increased the number of immunizations. Reported cases of tuberculosis increased with the deployment of BHWs; probably indicating the improvement in reporting rather than an increase in the incidence of the disease. The percentage of reported parasitism among children was considered "incredibly low" and was attributed in part to a low level of awareness/concern for this type of infection. It was speculated that it is not even considered an illness by most mothers, nor reported by the children themselves.

Utilization of BHW for Curative Medical Treatment At the time of the study, the BHW was not being utilized by most of the population for treatment. A high proportion of the population did not consult anyone for health, family planning or nutrition assistance, but of those that did, private doctors, midwives, Rural Health Units and hilots were the

predominant sources of assistance, rather than the BHW.

Impact on Nutrition The malnutrition levels in the project barangays were found to be comparatively better than those found in the Western Visayas, and there were significant overall improvements in the pre-schoolers nutrition levels after one year of sustained PUSH activities.

Impact on Fertility One year after the BHWs were deployed, there was a significant increase in the proportion of family planning users. This is all the more remarkable in that about 40% of the BHWs had not yet undertaken any Family Planning activity.

Impact on Barangay Residents Perceptions The study revealed that the PUSH project in general, and the Barangay Health Worker in particular were regarded in a very favorable light by the majority of residents in the target areas because of the improved conditions that they have brought about, and the services they have provided.

The authors noted that the timing of their study was premature for long term, second-order impact assessment, though in general, the trends seemed to be in the desired direction.

Some additional base-line data was provided in their report, which is included here for possible future comparative purposes.

TABLE 52
 TEN LEADING CAUSES OF MORTALITY IN REGION 6
 RATES/100,000 POPULATION
 5-YEAR AVERAGE (1975-1979) AND 1980

Causes	1980		5-Year Average (1975-1979)	
	No.	Rate	No.	Rate
1. Pneumonia	5013	110.62	4660	113.85
2. TB, all forms	2921	64.57	3680	89.88
3. Gastroenteritis	1379	30.42	1266	30.87
4. CVA (Cerebro-vascular accidents)	890	19.84	776	18.92
5. Malignant neoplasm	578	12.75	423	10.31
6. Bronchitis	469	10.14	648	15.80
7. Heart diseases	295	6.51	820	19.99
8. Tetanus, all forms	273	6.02	206	5.02
9. Measles	248	5.47	98	2.39
10. Malnutrition	205	4.52	1073	26.16

Source: Ministry of Health, Region 6 Annual Report, 1980.

TEN LEADING CAUSES OF MORBIDITY IN REGION 6

TEN LEADING CAUSES OF MORBIDITY IN REGION 6
 1979 AND 5-YEAR AVERAGE (1975-79) AND 1980

Causes	1979		5-year Average (1975-79)	
	No.	Rate	No.	Rate
1. Bronchitis	24507	540.76	21967	484.72
2. Influenza	15152	334.34	16379	361.41
3. Pneumonias	14562	321.32	7591	167.50
4. Gastroenteritis	10070	215.29	13590	299.87
5. TB, all forms	11022	243.11	13595	299.98
6. Measles	2507	54.53	1012	31.16
7. Dysentery, all forms	1617	35.68	1071	32.46
8. Whooping cough	1013	22.35	1663	36.81
9. Infectious hepatitis	843	18.60	516	11.39
10. Malignant Neoplasm	149	3.29	162	3.95

Source: Ministry of Health, Region 6 Annual Report, 1980.

TABLE 34

COVERAGE OF DTP AND BCG IMMUNIZATION AMONG PRE-SCHOOLERS
AND NEW ENTRANTS TO SCHOOL BY REGION, PHILIPPINES: 1978

	DTP (% Fully Immunized)	BCG (% Coverage)
PHILIPPINES		<u>81.9</u>
NATIONAL CAPITAL REGION	66.0	
I Ilocos	54.1	93.9
II Cagayan	73.7	96.0
III Central Luzon	52.7	91.8
IV Southern Tagalog	52.4	64.4
V Bicol	39.7	92.3
VI Western Visayas	44.7	67.3
VII Central Visayas	33.6	59.2
VIII Eastern Visayas	36.9	73.0
IX Western Mindanao	75.0	76.0
X Northern Mindanao	68.5	91.7
XI Southern Mindanao	42.0	83.0
XII Central Mindanao	38.9	67.5

Source: Ministry of Health

TABLE 24
TEN LEADING CAUSES OF INFANT MORTALITY IN REGION 6
RATE/100,000 LIVE BIRTHS
5-YEAR AVERAGE (1975-1979) AND 1980

Causes	1980		5-year Average (1975-1979)	
	No.	Rates	No.	Rates
1. Bronchopneumonia	1828	20.28	1584	17.25
2. Gastroenteritis	577	6.40	639	6.96
3. Prematurity	457	5.07	494	5.38
4. Tetanus neonatorum	261	2.89	326	3.55
5. Bronchitis	249	2.75	410	4.47
6. Congenital debility	241	2.67	257	2.79
7. Asphyxia neonatorum	143	1.59	134	1.46
8. Sepsis neonatorum	72	0.79	56	0.61
9. Measles	54	0.59	28	0.31
10. Malnutrition	51	0.56	91	0.99

Source: Ministry of Health, Region 6 Annual Report, 1980.

PART II

A CONCEPTUAL FRAMEWORK FOR COMPARATIVE ANALYSIS

A CONCEPTUAL FRAMEWORK FOR COMPARATIVE ANALYSIS

Both the Bicol and the Panay projects attempted to accomplish similar objectives - namely, to improve the health status of relatively poor, and predominantly rural communities - by similar means. The Barangay Health Aide (BHA) in the Bicol and the Barangay Health Worker (BHW) in Panay were essentially locally-selected, regionally trained para-medical personnel, hired to administer to the needs of their community's health in a wide variety of activities. Although, obviously, the individuals involved and the geographic location of their activities differed, the two projects were essentially addressing similar target groups with similar treatments in an attempt to alleviate similar afflictions.

While not sufficiently comparable to meet rigid, classical experimental design standards (i.e. randomized selection of participants, identical treatments in both amount and manner, and free from contamination by other outside variables, and with a control group for comparative purposes), nevertheless, the conditions are much more favorable for making such comparisons than can usually be found in development projects of this general nature. While there is no way to objectively prove that either project intervention was more effective than the other, or that they were superior to no intervention at all, there was some baseline data, and some targets established, which can be used to cast some light on the situation.

A principal difference between the two projects was the administrative structure for managing, monitoring and funding them. While both were 'integrated', necessitating coordination and cooperation with a plethora of organizational entities at all levels, from national to barangay levels, the arrangements were different in each case. The Bicol project relied upon the national Ministry of Health to serve as the 'lead agency' to implement; coordinating with other organizations as necessary. On the other hand, while it used the Ministry of Health, the Panay project was a creature of regional responsibility to make things happen.

Before embarking upon an extensive project review, it is important to determine the purpose of the study. With projects of this nature, there are so many things that could be examined, but there is usually insufficient time, personnel, money or interest to support them all. For example, the health outcomes of each project could be studied - i.e. did the health status in each area reach the levels anticipated, or were there considerable shortfalls? If these were not attained, was it the result of poor project design (i.e. unrealistic), or poor implementation? Can the critical factors in each project be isolated sufficiently that cause-effect impact can be predicted? Is one (or more) component(s) more critical than another in improving health status (i.e. environmental sanitation) or is an 'all or nothing' approach preferable? Do the economic aspects make a significant case for providing health services, or is it primarily a humanitarian program?

Similarly, one could focus on the organizational and administrative aspects of the two projects - i.e. is a national lead agency concept more, or less effective than a decentralized regional approach; or is there any discernible difference between the two? Is an 'integrated' approach more, or less effective than a single action program? Was the 'integrated'

project concept actually implemented, or only attempted? Did the funding process in either case enhance, or inhibit project accomplishment? What are the prospects for continuation of the project elements after AID funding is terminated?

In short, from an impact standpoint, did either of the projects make a difference? From a process standpoint, was one approach preferable to another; and from a development standpoint, what next? Are there features which can or should be replicated, or things to be avoided? What are the lessons learned from these two applications which may be useful in other situations in the future? What still needs to be done?

Impact or Process? General or Specific?

In discussing these issues with various personnel, it is apparent that there is no consensus at this time as to the purpose of the study. PPC's Office of Evaluation seems to be particularly interested in evaluating these two projects from an impact standpoint which will serve as a model for evaluating similar health delivery projects in other countries. This means focussing on the attainment of health outcomes. On the other hand, the USAID mission, while endorsing a comparative study of the two projects from a process standpoint, and avowing a strong interest in 'lessons to be learned', does not see the need for this to be an impact evaluation (as this is already being done internally), and certainly not to be billed as an evaluation. Still others in AID/Washington suggest that a health impact study per se would be generally inconclusive because of the projects complexities, and therefore not worth the effort that would be required to undertake it. The comparative study is strongly endorsed however - as a Philippine-specific case study for possible further application there, - rather than attempting to seek highly generalizable principles of cause and effect which might be applicable to projects in other countries.

Yet another suggestion was to examine the economic cost/benefit implications of both projects, as well as the social cost/effectiveness in terms of improved health status of the targetted communities, and the implications for replication.

Since I am in no position to make such a policy determination, I am presenting herein a conceptual framework for doing each of the above, with the data requirements and approach for undertaking them, and the limitations which can be anticipated. Hopefully, this will clarify the situation for all concerned, and assist in formulating what is to be done.

Health Impact

Every development project is unique in its implementation, despite the similarities which may exist in overall sector goals. Moreover, since actual baseline conditions vary from one country-specific situation to another, the targets at the purpose and output levels differ. Thus, in the strictest sense, there can be no 'model' evaluation framework to apply to different development projects. Each has to be approached and evaluated on its own terms. This is the basis of the logical framework - as the key reference point for planning and evaluation.

For the health sector, an attempt has been made to identify some

generic questions and indicators for health project/progress evaluation, as outlined in Dunlop's Toward a Health Project Evaluation Framework. While these items provide useful guidance in approaching any health situation to be evaluated, they are not a ready-made questionnaire and sampling frame for application. The requirements to satisfactorily answer such questions, or provide levels of measurement for many of the indicators, are all but impossible to attain in a time- and resource-limited evaluation. Some of the questions are highly subjective (i.e. 'consumer satisfaction'), and some only half formulated (i.e. 'employment status changes'); while other, quantitative items (i.e. 'cost per unit of change in other indicators') have no readily available data base upon which to draw for answers, and cannot be generated from ex post facto surveys. The few items which survive this 'test' are utilization rates and changes in vital events such as 'infant mortality' and 'morbidity'. Even these are so far removed from the experimental intervening project variables that causal linkages can only be inferred provided no alternate hypothesis appears dominant.

Regrettably, therefore, the standardized evaluative model is still not a reality, and is unlikely to become so in the near future. What could be done, however, is to formulate some specific health status questions for the Philippine situation which might be adapted for other country program and project studies, and outline the data requirements to satisfy them.

Trinidad Osteria's report Impact Evaluation of the Panay Unified Services for Health Project provides a useful analytic framework, and it can also be utilized for the Bicol project. This essentially depicts cause and effect as a linear process - from 'Program Inputs' through 'Intermediate Changes' to 'Outcome' - rather than reflecting the more complex interactive dynamics of the "real world" (with the exception of 'nutritional status' and 'morbidity'). The health outcomes to be measured are:-

1. Mortality Rates
2. Fertility Rates
3. Morbidity Rates, and
4. Nutritional Status.

These can, and should, be disaggregated to the extent possible because of the differential rates between age groups - particularly infants, mothers and women of reproductive age, and the older generation.

Furthermore, a closer look should be taken at the incidence of water-borne communicable diseases and the prevalence of intestinal parasites. While both projects indicated their determination to tackle these public health problems, in neither geographic area was intestinal parasitism listed as one of the top ten morbidity indicators, and indeed the Guerrero report noted that "it is probably not even considered an illness by most mothers, nor reported by the children themselves". However, in attempting to measure project impact in terms of health outcomes, it would be foolish not to review outcome objectives the projects established for themselves, while scrutinizing secondary effects such as mortality rates, with which the projects have only a tenuous cause-effect connection.

Figure I presents the analytic framework for the PUSH program operations.

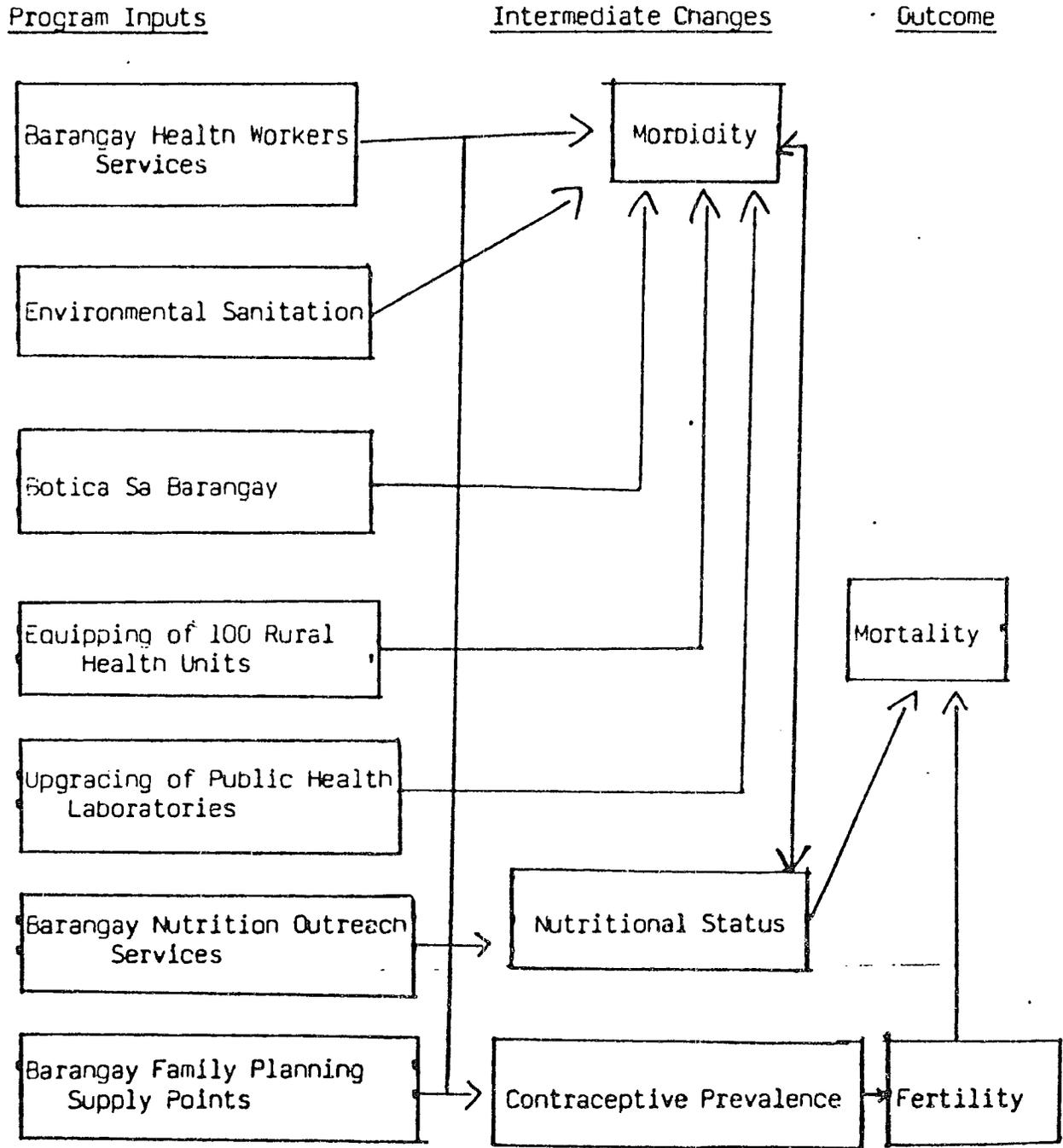


Fig. 1 Operational Framework for the PUSH Project

Some objectively verifiable data should exist on these indicators for both the Bicol and Panay projects, either from the Ministry of Health and Operation Timbang data, or regional on-going program reports. Certainly some baseline information is available on some of the indicators, as was outlined and included in the previous section of this report (i.e. 'Ten leading causes of morbidity in the proposed program area [Bicol] by province and city, in 1975). It would be highly desirable to therefore if current status reports could be obtained from the same source, gathered and compiled in the same manner.

Failing this, a special, short-term random sample (stratified by each category - i.e. area and age-group) of residents in the target area would have to be conducted. In addition, since no control was (or is) possible, a time-series comparison with overall national trends would be a useful guide in attempting to correlate and attribute change (if any) to each project's intervention activities. For obvious reasons, however, this could in no way be considered conclusive 'evidence' even if a strong positive correlation were detected. On the other hand, little or no correlation might raise questions of project efficacy, while negative correlation might point towards improved reporting of vital statistics.

To recapitulate, for a comparative health impact study in the two project areas, an evaluation team would be looking for secondary evidence of:-

1. Mortality Rates (by age and sex)
2. Fertility Rates (by age)
3. Morbidity Rates and Rankings of the Top Ten Diseases (by age and sex)
4. Incidence Rates of Intestinal Parasites (by age)
5. Nutritional Status of Pre-School Children (0-7 yrs) in terms of Normal; 1st, 2nd and 3rd degree Malnutrition

Where such data was unavailable, a sample survey would need to be undertaken.

While not the complete picture, these appear to be appropriate proxy measures of 'health status' and indeed most of them were specifically targetted by both projects for improvement.

To these quantifiable indicators, I would include Dunlop's concern for some measure of consumer satisfaction with their health status quo. Even though highly subjective, and unstable, nevertheless such an indicator provides feedback on the target population's perceptions and felt needs which should be useful for future health programming efforts. A scheme for conducting such an assessment is outlined in my paper Improving the Delivery of Health Services in Korea: An Analytical Framework, 17 Sep 1976, and is essentially to classify the population under study into one of six major categories:

- a. Healthy
- b. Sick, but receiving adequate service
- c. Sick, and receiving inadequate service
- d. Sick, and not receiving any service
- e. Deceased, infants
- f. Deceased, all other

In these terms, 'adequate' means any level of service which the recipient considers adequate for his/her needs - regardless of the actual quantity, quality, source, appropriateness or effectiveness of the service rendered.

Since there are no recurring reported statistics on the healthy, and the sick who are not receiving any treatment at all, and self-treatment data is not available, and patient perceptions of treatment are not usually the subject of periodic reports, such data will only be obtained by surveys. And of course, no baseline data is available for comparative purposes. Nevertheless, such data, even obtained at this stage would provide baseline guidance for the future, recognizing that as some needs are met to their level of expectation, it will stimulate increasing demands for more and even better service!

Such a survey could be undertaken by team (or teams) of Filipinos familiar with each of the local areas and dialects, under the direction of a survey research specialist. To develop the interview questionnaires and protocols, train the interviewers, gather and process the data would take about two to three months, depending upon the sample size and dispersal of the population, and size and competence of the survey team.

Project Accomplishment

Each project established specific indicators, and targets to accomplish for each indicator, in its Log-Frame. While several of these are reflected in the Project Impact data outlined above, many of the indicators reflect 'throughput' rather than 'outcome' objectives, particularly those in the Barangay Health Aide (Worker) deployment, and environmental sanitation infrastructure aspects. The hiring, training and deployment of a health worker to a barangay was unquestionably a project objective, but it was a means to an end rather than an end in itself. It is an act of faith, a working hypothesis, albeit a widely accepted one, that a barangay health worker will improve the community's health status through her/his efforts but it is not demonstrable without evidence of the type outlined in the foregoing Project Impact section. Similarly, the provision of several hundred wells of various types, or construction of several thousand water-sealed toilets is a task the projects set themselves to do. The project record keeping system should have maintained data on these accomplishments, and examination of such information should be a relatively simple task in order to ascertain which project most closely adhered to its plan. Again however, the linkage between better water supply and improved health status, and sanitary toilet facilities and improved health status is only a good working hypothesis - not an indisputable 'given'.

If project accomplishment (in the limited sense of delivery of items as planned) is to be evaluated, a study team should be able to verify this from a review of the existing project documentation, supplemented by a

brief field visit to each area to verify that the items/services were actually delivered as indicated, are in use as intended; and to establish the reason or reasons for any major deviations from the plan. (For instance, apparently the local soil situation in some provinces of Panay precluded construction of wells and extensive reprogramming was authorized. Also, budgetary problems of the Government of the Philippines necessitated a scaling down of the program coverage from 600 to 450 barangays.)

At the risk of being redundant, these indicators and targets have been summarized again below for both projects. Note however that in many instances there are not corresponding targets in both project areas, which again should emphasize their uniqueness, and the difficulty of direct comparative analysis.

<u>Indicator</u>	<u>Bicol Target</u>	<u>Panay Target</u>	<u>Source of Data & Means of Verification</u>
# targetted barangays - classified as 'most depressed'	400	600	Project records Site visits - sample survey
# barangay health aides/workers recruited, trained, equipped and deployed	400	600	Project records Site visits - sample survey
# barangay development centers established from local funds	400	N/A	Project records Site visits - sample survey
# regional training teams organized and institutionalized	1	1	Project records Site visits
# new barangay health stations constructed	9	N/A	Project records Site visits - sample survey
# municipal health centers renovated	7	N/A	Project records Site visits - sample survey
# municipal health center extensions constructed	52	N/A	Project records Site visits - sample survey
# city health center extensions constructed	3	N/A	Project records Site visits - sample survey
# regional and provincial laboratories upgraded and equipped for bacteriological and chemical analysis of water	3	4	Project records Site visits - sample survey
# barangay drugstores established and stocked with basic medicines and supplies	400	600	Project records Site visits - sample survey

<u>Indicator</u>	<u>Bicol Target</u>	<u>Panay Target</u>	<u>Source of Data & Means of Verification</u>
# community-type water supply facilities constructed	1,266	N/A	Project records Site visits - sample survey
# 'appropriate' barangay domestic water supply facilities constructed (chlorinated)	400	N/A	Project records Site visits - sample survey
# cooperative associations to own, operate and maintain community water facilities. Determine and collect fees monthly, and remit to municipal treasurer	400	N/A	Project records Site visits - sample survey
# households with chlorinated drinking water	64,000	N/A	Project records Site visits - sample survey
# drilled deep wells constructed	N/A	560	Project records Site visits - sample survey
# driven shallow wells constructed	N/A	1,200	Project records Site visits - sample survey
# open dug wells improved	N/A	5,400	Project records Site visits - sample survey
% households with an 'adequate' supply of 'improved quality' water	N/A	80	Project records Site visits - sample survey
# water-sealed toilets constructed	32,000	40,000	Project records Site visits - sample survey
% water-sealed toilets used regularly	N/A	75	Site visits - sample survey
% population using satisfactory toilets	50	N/A	Site visits - sample survey
% families in barangays with blind drainage systems	100	N/A	Site visits - sample survey
% households using 'sanitary waste disposal facilities' unclear what is encompassed by this definition	N/A	60	Site visits - sample survey
% targetted households using 'recommended health practices'	90	N/A	Site visits - sample survey

<u>Indicator</u>	<u>Bicol Target</u>	<u>Panay Target</u>	<u>Source of Data & Means of Verification</u>
# school toilets constructed	400	N/A	Project records Site visits - sample survey
% communal school toilets maintained by the barangay	100	N/A	Site visits - sample survey
# rural health units supplied with vaccines and TB drugs	N/A	100	Project records RHU records Site visits - sample survey
% target population immunized with BCG and DPT	N/A	70	Project records RHU records Site visits - sample survey
# school entrants immunized with BCG	32,480	N/A	
# school entrants immunized with TOPV - trivalent oral polio vaccine	14,560	N/A	
# infants immunized with BCG	29,120	N/A	
# infants immunized with DPT	28,120	N/A	
# persons immunized with CTPs	784,000	N/A	
# pre-natal cases immunized with tetanus toxoid	22,400	N/A	
% infants participating in nutrition programs	80	N/A	Project records Operation TIMBANG MOH & NNC records Site visits - sample survey
# infants participating in nutrition programs	N/A	10,000	
# family planning supply points, providing services and supplies	N/A	600	Project records Site visits - sample survey
% married women of reproductive age using family planning methods	40	38	Project records POPCOM records Site visits - sample survey
% local government entities completely funding all required expenses to maintain the existing health delivery system network established, on the termination of AID assistance	100	100	Project records Site visits to regional project offices and sample local government budget & fiscal offices - municipal treasurers, etc.

These limited objectives could be attained by an evaluation team in approximately three months - two weeks to review the available data in Manila and discuss with appropriate personnel and develop a survey questionnaire and protocol; a month in each project area, and a final two weeks to summarize the findings. If a more in-depth, cause-effect analysis is required, then the 'impact' data surveys would also be necessary in addition to this project 'accomplishment' data.

Again, much of the above data could be obtained and compiled in advance - either gleaned from existing records, obtained by field surveys conducted by project personnel (or a contractor on their behalf) or through the medium of a special one-time status report from the Barangay Health Aides and Barangay Health Workers. This would considerably reduce the time and expense of an outside evaluation team, while still permitting them the flexibility to spot check case examples of each project's activities to independently verify health outcomes and/or issues of appropriateness, effectiveness and efficiency. Depending upon the extent of the data that could be obtained in advance, a follow-up team could probably do a sufficient job in a month - one week to review available data in Manila and meet appropriate personnel, a week in each project area, and a final week in Manila to summarize their findings and make recommendations for further assistance.

Project Process Evaluation

An additional thrust of an evaluation team could be to examine the accomplishment of each project in terms of 'Effectiveness' and 'Efficiency'.

Effectiveness means how well the provision of 'inputs' - money, facilities, commodities, people and service - satisfied the target population's demand for service, and/or reduced the need for such service.

Efficiency means at what level of cost the 'inputs' were provided.

For example, health services could be delivered very effectively to a barangay but at an extremely high cost, and therefore not be very practical. In other words, it would be rated as an effective, but inefficient system. On the other hand, some health services could be provided very efficiently (i.e. at a low cost), but if the service did not meet the felt needs of the target population at some predetermined 'level' or objective 'standard', the delivery system would be rated ineffective.

The attempt to balance effectiveness and efficiency, or 'optimization' is a worthwhile objective. However, without knowing what range of possibilities exist, optimization is too vague and meaningless a concept. What can be done though is sub-optimization -- identifying the existing situation and attempting to improve upon it -- or satisficing. This appears to be the most practical way of incrementally upgrading a complex administrative management situation.

Given the similarities between the Bicol and Panay projects, even though they are not strictly comparable in an experimental or quasi-experimental sense, some rudimentary attempt could be made to determine which aspects of each were preferable - i.e. more cost-effective. That is, which provided the same amount of service for less cost, or more service for the same cost.

If the project cost, impact and accomplishment data is readily available, this would be an interesting study to undertake. If the data is not available however, it would be extremely difficult (if not impossible) to reconstruct. In any event, it would still only be tenuous, rather than conclusive, since so many variables are involved in each situation which are not quantifiable or replicable. Thus, while an interesting 'research' study, it may not be conclusive enough for AID to use for making generalizable recommendations. We have discussed the impact and accomplishment data earlier. The cost data would need to be categorized in terms of 'unit costs' for each outcome, or accomplishment. If the projects management information systems captured this type of data, or it could be derived therefrom, it might be feasible to undertake this type of analysis. If not, and the data is not readily available elsewhere, then the opportunity for such analysis has probably already passed.

If there is a lack of data for a cost/effectiveness analysis, there may still be sufficient documentary evidence, which when supplemented with project participants anecdotal experiences might provide a sense of comparable utility. Highlighting particular strengths and weaknesses encountered in each project could be a useful learning experience worth recording and sharing with others - either on these, or similar projects in the Philippines, or elsewhere. It should be emphasized however that few, if any, 'revelations' are likely to emerge from such an exercise, which are not already generally known or recognized by participating project personnel. The major function of the evaluation team under such circumstances is to observe, interview, record, and comment as relatively objective and unbiased observers. If this is desired, attention should be focused on the project accomplishment data and the administrative means for carrying it out. In this regard, the evaluation team should concentrate on the two project staffs perceptions concerning the difficulties and breakthroughs encountered during implementation, and attempting to relate them to factors such as:

- Centralization/Decentralization of Authority and Responsibility
- Multi-sectoral/Lead Agency Approach for Implementation
- Coordination - Matrix Management for Decision Making, and Action
- System Flow, and Bureaucratic Bottlenecks for Planning, Budgeting, Approval, Transmittal of Funds, Obtaining Commodities and Technical Assistance and Administrative Support
- Flexibility, Responsiveness, Turn-around Time
- Recruiting, Training, Deployment, Utilization, and Attrition of Health Workers
- Political Power and Intra-Bureaucratic Relationships
- Local Initiative at the Barangay Level

Target beneficiaries perceptions of needs, and project activity in attempting to meet these needs would also provide a useful cross-reference perspective.

Such a study could be conducted by an interdisciplinary team, in a relatively short period of time - about one month. The emphasis would be to interview representatives of the project implementation staff at each

phase and administrative level of the project to gain an understanding of how each project functioned, and to make some visits to several barangays to see the end results, and perceptions of the delivery system at the recipient level. For this type of evaluation, the team should be composed of a public administration/management systems specialist, a public health specialist, a sociologist, and an individual familiar with the projects who can provide access to Philippine government project administrators and staff, as well as guidance and clarification to the 'outside' team.

Timing for such a study would be relatively open-ended - 'it takes as long as it takes' since it is less rigorous than a quantitative analysis. It could probably be conducted in a minimum time frame of one month - if key people were accessible at each level - on the following schedule:

- one week to review project background data and develop itinerary for interviews and field visits (in Manila)
- one week interview/visit in each region - Bicol and Panay (two weeks total)
- one week summary discussion and report writing (in Manila)

The longer the available time, the more visits, interviews and information that could be gathered. While there is no definite outside limit to how long this process should take, it is probable that diminishing returns would be realized after doubling the above schedule - with the possible exception of the report writing period. The more data one gathers, the harder it is to compile! Accessibility to knowledgeable individuals would be the critical determinant in this interview process, and this can best be determined by knowledgeable USAID and Philippine government personnel.

Development Evaluation

Another useful activity of an evaluation team could be to examine the accomplishment of each project in terms of viability, and the implications for further development activity. When the AID assistance terminates, several critical issues come to the fore. Will the target areas continue to receive the services of health workers, delivery of health supplies, and appropriate guidance in sanitary health practices, and maintenance of health facilities? Or will such assistance cease and the network of personnel, services and supplies disintegrate - either abruptly or gradually through lack of support? How much of a continuing need exists in the targetted areas? Will the health aspirations of the targetted population continue to be met, or will they - in effect - be worse off than before; having been placed on the road to greater awareness and better health care, then be denied access for lack of funds, supplies and technical assistance? Wherein lies the local capacity motivation and wherewithal to provide the service and assistance needed by these rural, impoverished barangays? What are the prospects for this type of health delivery system (or some modification thereto) being extended beyond the current projects confines, to other communities in the two regions, or other regions of the Philippines? What lessons are to be learned from these experiences in primary health delivery that might be beneficial for other developing countries?

These, and similar questions could be addressed by a team composed of individuals conducting the project 'process' evaluation. The 'development' focus would be on viability and sustainability - to examine the Philippine

government's capacity, and arrangements for continued administration and financing of each project - whether from the national budget, or from locally developed and administered resources. The outline prepared by Dr. James Brady in April 1984 highlights the concerns in this area. For convenience, some of these questions are listed below, together with others, for review and consideration:-

- What were the original goals of the project?
- How realistic were/are the goals perceived to be (by various concerned parties)?
- How were the goals communicated to people at various levels of the project organization?
- How were the project sites selected?
- How have the goals changed during the life of the project?
- Which goals are likely to be stressed in the future?
- How were existing funding allocations in the project or related organizations changed and/or increased to reflect project goals?
- What are the priorities for funding among the different project objectives?
- What percentages of the total cost of services is paid by various government units, users, and others?
- How have the relative percentages of funds changed over time?
- Do fund-sharing trends indicate decreasing central government funding and increased support by local governments, private groups and users?
- What are legal constraints on increasing revenues to support the system (i.e. limitations on charging clients for services, or sales of drugs by government-sponsored barangay boticas)?
- Which services are most valued by users/community? Are they more willing to pay for these than other services?
- Were allocated funds released to local units and disbursed on time? (Was the payroll of people at all levels met on schedule?)
- Were project inputs procured and obtained as requested and needed?
- How will operations and services (especially new paramedical personnel and required support at barangay and municipal level) be funded in the future, after project termination by AID?
- How much has staffing been increased or modified by national and local organizations to implement project activities?
- Who has taken what steps to improve the quality of staff (via training, recruitment, etc.)?
- What factors are associated with outstanding staff quality at the community level (i.e. use of local people, local leadership, interagency cooperation, community income level)?
- To what extent did health workers utilize their specialized training?

- What changes were made in recruitment practices over time, and were there any discernible effects (i.e. shifting from midwives to non-midwives in the Bicol, and hiring non-residents to work in barangays)?
- How effective was/is the project in retaining, and attracting good staff (are salaries a significant factor)?
- What are the constraints on using various types of health workers (i.e. rules against non-physicians providing medical services and dispensing medicines; Ministry restrictions on paying workers, or efficacy of utilizing volunteers)?
- How useful were the project monitoring and information systems in providing project managers with progress/problem feedback and in stimulating corrective action?
- How time consuming and burdensome was the information reporting required of barangay and other health workers? How reliable and accurate was the data reported? how timely?
- What are alternative sources of health services? What factors make these more or less attractive than the project services?
- What are the interrelationships between project and other health workers (pharmacies, traditional healers, private doctors, and other public-supported outlets - family planning, nutrition, rural health unit personnel, sanitarians, etc.)?
- Which outputs and services are most valued by the community, local governments and national agencies involved in the project?
- What potential exists for continued external donor support, from USAID, or other organizations?
- What are the political, socio-cultural, economic and geographical/physical constraints to health service delivery?

Answers to the above questions, from knowledgeable USAID and Philippine government personnel, would be extremely helpful to an evaluation team in preparing guidance for follow-on project activities. Hopefully, much of this information is already readily available in the collective minds of project managers and staff, or is obtainable for the asking. If formally collected and collated by USAID and provided to the evaluation team during initial orientation for a 'process' evaluation, the 'development' evaluation could be assimilated into the team's interview protocol with little additional time and effort expended in gathering data. If however, such information is not readily available, and the team has to seek out and gather it for itself, the minimum time could well be two months rather than one, to permit more extensive interviewing. Certainly these questions are not answered and cannot be, from the documentation reviewed in AID/Washington.

One additional, critical element of this thrust is the financial and economic focus. Ideally, a health planner/economist and/or financial analyst would be a useful addition to the evaluation team in addressing the issue of viability and sustainability, and examining the Philippine structure for raising, budgeting, obligating, expending and accounting for project funds.

PART III

ANNOTATED BIBLIOGRAPHY

ANNOTATED BIBLIOGRAPHY

The following documents were received from the USAID/Philippines Mission by AID/Washington's Office of Evaluation (PPC/E), and provided for preliminary review and analysis:

The Bicol Integrated Health, Nutrition & Population Project

Lynch, Frank, S.J., Illo, Jeanne F.I., & Barrameda, Jose V. Jr. Let My People Lead: Rationale and Outline of a People-Centered Assistance Program for the Bicol River Basin. Quezon City, Philippines: Social Survey Research Unit, Institute of Philippine Culture, Ateneo de Manila University, Aug 1976.

A social soundness analysis which recommends that the strategy for assistance in the Bicol should be to let the people concerned (i.e. the Bicol residents) decide for themselves what improvements need to be undertaken, given appropriate technical advice from officials and experts from elsewhere.

Van der Vlugt, Gerold, Doody, William & Marinelli, Lawrence A. Project Identification Document (PID) - Bicol Health, Nutrition & Population Project. Manila, Philippines: USAID, undated.

Proposal for a \$4.5 million loan to a \$6.4 million project that is intended to improve the health and nutrition status of the rural population, and reduce the birthrate in Camarines Sur and Albay Provinces by improving the health, nutrition, population, sanitation and water services to rural barangays, and improving the sanitary environment and household water supply in those areas.

Van der Vlugt, Gerold, Doody, William & Marinelli, Lawrence A. Project Review Paper (PRP) - Bicol Integrated Health, Nutrition & Population Project. Manila, Philippines: USAID, 2 Nov 1976.

Further discussion on, and justification for a \$4.5 million loan on a \$6.433 million project to improve the health and nutrition status of the rural population in Camarines Sur and Albay Provinces. Outlines the scope of the project, and the strategy for accomplishing the project's objectives.

Project Performance Network for Bicol Health, Nutrition and Population Project
Philippines, 4 Nov 1976.

Summary schedule of principal project activities and milestones, (Critical Performance Indicators - CPIs).

Van de Vlugt, Gerold. Project Paper (PP) - Bicol Integrated Health, Nutrition & Population Project - 492-0319. Manila, Philippines: USAID, May 1979.

Detailed description - background, analysis and strategy for a \$2.5 million loan, plus \$1.92 million in PL 480 currency and commodities towards a \$7.787 million total project to improve the health and nutrition status of 400 rural barangays in the provinces of Camarines Sur and Albay.

Bicol Integrated Health, Nutrition & Population Project - Implementation Plan. Pili, Philippines: Bicol River Basin Development Program, San Jose, Camarines Sur, undated.

Detailed restatement of project objectives, components and targets, activity network and bar-chart schedule, with financial plan. Agreement by participating local government officials indicated by signature.

Popkin, Barry M., Roco, Sulpicio S. Jr., Bragais, Perfecto Jr., & Callison, Stuart, 1978 Bicol Multipurpose Survey - Volume 1: Survey Design and Implementation, with cover memo: Background to a University of North Carolina, Carolina Population Center-School of Public Health Proposal, Chapel Hill, North Carolina, undated.

Outline of a survey design and methodology for data analysis with the proposal for doing something similar to the Bicol Multipurpose Survey which was conducted in 1978-79, at a cost of \$71 per household for data collection, and \$130 per household with some additional in-country analyses. Estimated cost for a 1900 household survey, with additional in-depth analysis is projected at \$250,000 - \$450,000, depending on survey and research goals. Additional background provided on capabilities of NC staff. No substantive data on the Bicol situation contained in this Volume 1, or conclusions which might be appropriate to the subsequent evaluation of the project.

Project Loan Agreement (PROAG) for the Bicol Integrated Health, Nutrition & Population Project - in Draft. Philippines: USAID & GOP, 7 Aug 1979 (pencilled annotation).

Summary description of the project (Annex 1), financing arrangements, loan terms, conditions precedent, covenants, and means of disbursement and communication between USAID and the GOP. Annex II outlines the standard provisions re: procurement and administration of the project. Annex I - the project description is particularly useful as it outlines plans, targets, and funding estimates for the project.

Bicol Biennial Evaluation. Manila, Philippines: Bicol River Basin Development Program, GOP/BRBDP-USAID, Aug 1979.

Discusses the overall Bicol Program's organization, administration, staffing concepts and experience in dealing with an integrated area development concept. Does not deal with the health project, per se.

Roco, Sulpicio S. Jr., Imperial, Sonia S. & Illo, Jeanne Frances I. Final Report - Bicol Integrated Health, Nutrition and Population Project: A Problem of Medium. Quezon City, Philippines: Social Survey Research Unit, Institute of Philippine Culture, Ateneo de Manila University, Feb 1979.

A discussion of the beliefs and practices of the Bicol people with respect to health, nutrition and family planning, and an assessment of the social soundness of the Bicol integrated project. No definitive conclusion reached, but several social impediments are highlighted, the resolution of which are considered essential to project success.

Survey Form: Interview Schedule, Bicol Health Project Community Baseline Survey Form (CBS-010), 12-4-81 (12 Apr or 4 Dec 81)

A six page questionnaire - with matrix worksheet, multiple choice and open ended responses (Blank form)

Interview Schedule, Bicol Health Project Community Baseline Survey Form (CBS-010), undated

A seven page questionnaire - with matrix worksheet, multiple choice and open ended responses (Blank form)

Almost identical to the six page questionnaire above. Differences are removal of "tubal ligation" as a method practiced in family planning [Section II.F - Health Status], and addition of "Liquid Waste Disposal" category as well as modification of the "Solid Waste Disposal" category [Section III.C & D - Environmental Sanitation]

Interview Schedule, Bicol Health Project Community Baseline Survey Form (CBS-010), Mid-Survey Study, 31 May 83

A five page questionnaire - Matrix worksheet, multiple choice and open ended responses (Blank form)

1st page cover sheet, 2nd page, coded for computerized analysis of Population data in the Baseline Survey Form (CBS-010) above and Health Status - Births, Deaths and Morbidity. However, the morbidity data is collapsed from the original survey data which segregated "Acute" and "Chronic" diseases/illnesses.

The rest of the Schedule is not coded for computerized analysis but is worksheet matrixed to obtain "Nutritional Status", "Vaccination History" (with some further collapsing of information from the original baseline survey - "BCG" omitted) and "Family Planning Practices". The Environmental Sanitation portion is not coded for computer analysis either, but is a summary schedule in multiple-choice format to record totals against each category, based on the seven page questionnaire, above. However some variation has again been introduced for "Liquid Waste Disposal" in that all categories are open ended, rather than pre-structured. Finally, the 10 open ended questions on "health Beliefs and Practices" are included in the form, but no attempt at coding, structuring or other indication as to how these will be analyzed.

BHA Monthly Accomplishment Report, (BHA Form 01), Legazpi City, (Bicol) Regional Health Office No.5, undated.

A five page report - Matrix worksheets on "Curative Services Consultation" "MCH-Nutrition-FP Services" "Communicable Diseases Control" "Health Education" "Environmental Sanitation" "Community Organization & Participation" "Barangay Health Related Actions, Programs/Projects Implemented" - and three open ended questions on problems, accomplishments and needs.

Bicol Integrated Health Nutrition & Population Project - EVALUATION PLAN, Bicol River Basin Development Program, undated.

Brief description of the project, objectives, and scope of evaluation, proposed indicators and organizational arrangements for evaluation.

Sommer, John G., Aquino, Rosemary, et al. Special Evaluation Report Summary of Bicol Integrated Area Development - PN-AAJ-179 AID Project Impact Evaluation Report No. 28, AID/Washington: Office of Evaluation, Bureau for Program and Policy Coordination, Jan 1982.

Evaluation of project implementation - half the trainees started field practice without adequate preparation, and field supervision was limited. Nevertheless, all trainees were judged to be doing satisfactory work. Guidelines for a revised training program were provided. Noted that CHAs (Nurse Aides) had high turnover rates. Recommendations were that final training evaluation estimate the quality of preventive and curative services; the management and supply system, and standardized training and evaluation for nationwide deployment of CHps.

Health News, Vol 1, No. 1 Introductory Newsletter. Legazpi City, Bicol: Regional Director, MECS Region V, undated

General health information training tips, and materials for improving health education programs in the barangays.

Health News, Vol 1, No. 2 Foods & Nutrition. Legazpi City, Bicol: MECS Region V, undated.

Health information training tips and materials focussing on Food and Nutrition practices for rural population.

Health News, Vol 1, No. 3 Eye Health Care. Legazpi City, Bicol: MECS Region V, undated.

Health information training tips and materials focussing on Eye afflictions, and appropriate treatment, and preventive care.

Robinson, David M. Productivity, Integration and Participation: A Brief Look at the Bicol River Basin Development Program. Evaluation Working Paper No. 47. AID/Washington: Office of Evaluation, Bureau for Program and Policy Coordination, Nov 82.

A background review of the Bicol area, and steps leading to the development of an integrated Bicol Program. Some considerations of the theoretical foundations for integrated area development and their applicability to the Bicol situation - typified as "an ideology in search of a methodology". The BRBDP is a mixed approach to the problem of integrated area development. The program-level focus is embodied in a planning and monitoring unit . . . that overlaps sub-national administrative boundaries. . . . other the other hand, the Bicol's smaller area-based project efforts use a discrete project management unit within a lead-line agency, but with cooperating personnel assigned from other functional ministries. Robinson concludes that decentralized decision-making involving participation of all concerned, is appropriate.

Report of a Process Evaluation, Bicol Integrated Health, Nutrition and Population Project. USAID, Philippines, May 1983.

Twelve principal findings are highlighted, to the effect that while training and performance of Barangay Health Aides is generally satisfactory, there is a perceptual difference - whether their role is that of a health provider, or health facilitator/educator; funding problems were being encountered at various levels, and there are insufficient personnel to implement the project.

Revised Implementation Plan, Bicol Integrated Health, Nutrition and Population Project (492-0319). Sept 1983

Modification to the original project plan, flowing from the February 1983 Process Evaluation (sic)[presumably written up in the May 1983 report] and the interagency task force reassessment of the implications thereof.

BICOL QUARTERLY PROJECT STATUS REPORTS and BICOL PROJECT IMPLEMENTATION REPORT - SEMI-ANNUAL SUMMARIES for the BICOL INTEGRATED HEALTH, NUTRITION & POPULATION PROJECT. Manila, Philippines: USAID/Philippines, Gary W. Cook, Project Officer, dates as indicated:

Quarterly Project Status Report (QPSR), 30 Sep 81 Gary W. Cook

35% of time elapsed, 4% of funds expended.

Delays encountered in most activities - hiring of Project Management Office (PMO) staff, construction of PMO facility, hiring of implementation consultant, procurement of commodities. Program Management Coordinating Committee (PMCC) has not met in months. Information, Education & Communication (IEC) campaign not developed by Ministry of Public Information.

94 Barangay Health Aides (BHAs) trained and deployed,
51 more BHAs in training.

EES (?) completed, and target barangays selected.
Project Management Office Operations Manual, and Environmental Sanitation Systems and Procedures Manual completed.

2 Laboratories extended, 4 MHCs (Maternal Health Centers) improved,
4 Barangay Health Stations constructed.

QPSR, 31 Dec 81 Gary W. Cook

40% of time elapsed, 5% of funds expended.

Training of BHAs on schedule - 200 trained and fielded,
Retraining of 1st batch BHAs on schedule

PMO has not revised financial plan based on current prices needed for GOP budget consultation meeting. Sanitary water supply component delayed.

QPSR, 31 Mar 82 Gary W. Cook

45% of time elapsed, 7% of funds expended

No project monitoring and evaluation activity.

No progress in environmental sanitation component - other than distribution of 6,500 water-sealed toilets; about $\frac{1}{2}$ installed.

Commitments and disbursements of funds, slow.

5 year work plan presented for IECM campaign.

BHA manuals published and distributed

BHA kits for project have been procured

BHAs now have uniforms and government life insurance.

FF (?) construction completed - 2 labs renovated (100% of target), 7 BH stations (78%), 6 main health centers renovated (86%), and 1 hospital malward (50%).

Semi-Annual Summary PIR Sheet, 31 Mar 82 Gary W. Cook

BHA training and fielding on schedule and high quality
GOP construction and renovation of various health facilities
on schedule.

Water supply not yet started and water-sealed toilet installation
slow.

QPSR, 30 Jun 82 Gary W. Cook

50% elapsed time, 7% of funds expended

Environmental Sanitation component stagnant!

Comprehensive work plan prepared by BRBDP, and implementation started.

QPSR, 30 Sep 82 Gary W. Cook

60% elapsed time, 16% of funds expended

7th group of BHAs trained. One group remains to meet project goal
of 400. Budget Ministry issued cash disbursement ceiling for the
Environmental Sanitation Component, so that aspect can proceed.

Environmental Sanitation has not yet begun.

Semi-Annual Summary, 30 Sep 82 Gary W. Cook

Training almost complete. GOP funds available for ES component.

Commodities arrived. Consultant hired. Principal issues - delays,
need for more funding, need to extend PACD.

QPSR, 31 Dec 82 Gary W. Cook

62.5% elapsed time, 17% of funds expended

400 BHAs trained and fielded. Periodic retraining will continue
1st village water project begun.

Environmental sanitation component a "small beginning"

Anticipate shortfall of GOP counterpart and loan proceeds in FY 83.

QPSR, 31 Mar 83 Gary W. Cook

67% elapsed time, 18% of funds expended

98% of barangays provided with household water-sealed toilets.
32,000 toilets delivered. 70% constructed.

First village water project inaugurated. Construction underway
at 66 other barangays.

Problem in obtaining reimbursement from local governments for BHAs.

Semi-Annual Summary, 31 Mar 83 Gary W. Cook

all 400 BHAs trained and fielded.

98% of barangays provided with household water-sealed toilets.
70% constructed and in use.

66 barangays provided with water supply system construction mat-
erials.

Findings: Staffing arrangement at PMO inadequate for project
implementation. Need full-time staff.

Premature reduction of BHA stipend has occurred, without adequately
assuring that local governments can, or are willing to pay the other
50%.

QPSR, 30 Jun 83 Gary W. Cook

72% elapsed time, 18% of funds expended

Dr. S. Casin (AID project implementation consultant) appointed
as full-time project manager.

248 handpumps constructed

3 improved springs constructed

1 school toilet constructed

QPSR, 30 Sep 83 Gary W. Cook

77% elapsed time, 33% of funds expended

583 handpumps constructed

8 spring improvement projects completed

1 school community toilet completed

62% of water-sealed household toilets installed

Semi-Annual Summary, 30 Sep 83 Gary W. Cook

All 400 BHAs trained and fielded

98% of targetted barangays provided with household water-sealed
toilets.

62% constructed and in use [Note: decrease since last Semi-Annual]

583 handpumps constructed

8 village spring improvement projects.

Revised Implementation Plan prepared.

QPSR, 31 Dec 83 Gary W. Cook

81% of time elapsed, 32% of funds expended

26 new BHAs recruited, trained and fielded. 389 BHAs now cover 400 barangays. Most vacancies created by BHAs moving up to midwife jobs.
838 pumps constructed for 166 barangays
12 spring improvement projects completed
8 community school toilets constructed
Local government support appears to be positive for program.

QPSR, 31 Mar 84 Gary W. Cook

86% of time elapsed, 36% of funds expended

All 400 BHAs trained and fielded.
Both provinces, and most municipal governments have begun paying their share of the BHA stipend.
Progress in construction of toilet facilities and handpump installation.
Minor problems noted in submission of final budget for 1984.

Semi-Annual Summary, 31 Mar 84 Gary W. Cook

Project is progressing in all areas, and will accomplish most of its targets at substantially less cost than originally budgetted.

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The Panay Unified Services for Health (PUSH) Project

Project Paper (PP) - Panay Unified Services for Health (PUSH). Manila, Philippines: HRD/Health, USAID, 31 Jan 1978.

Rationale, description and proposal for a \$5.4 million loan and \$0.3 million grant towards a total \$9.7 million Philippine Project to improve the health status of residents of 600 depressed villages in the Island of Panay, Philippines, by reducing the incidence of tuberculosis, diphtheria, tetanus, gastro-intestinal infections, infant mortality, crude birthrate, and malnutrition among children 6 years old, and under.

Project Loan and Grant Agreement (PROAG) between the Republic of the Philippines and the United States of America for Panay Unified Services for Health. Manila, Philippines: USAID, 2 Jun 1978.

Summary description of the project (AID Loan No. 492-U-053, AID Project No. 492-0312) (Annex I), Financing and Loan Terms, Conditions Precedent, and Special Covenants, means of disbursement and communication between USAID and the GOP. Annex II outlines the standard provisions re: procurement and administration of the project. Annex I - the project description is particularly useful as it outlines plans, targets, and funding estimates for the project.

Implementation Plan - Panay Unified Services for Health (PUSH) Project.
(Otherwise unidentified). Presumably USAID/Philippines, undated.
circa. Jan 1979; together with copy of transmittal cable TOAID-A
31, Subj: PUSH Status Report - Project No. 492-0312, 21 Feb 1979.

An outline of the PUSH project organization, responsibilities,
administrative, funding, scheduling and evaluation arrangements.

Report on the First Evaluation of Panay Unified Services for Health (PUSH)
Project. Philippines: Joint USAID & Philippine Government Eval-
uation Team, 1981.

Barangay Health Workers (BHWs) considered most critical indicator
of effectiveness of project implementation - rated satisfactory.
Significant findings: Participation of Ministry of Health was
not as strong as envisioned; overemphasis given to Environmental
Sanitation Infrastructure (ESI) in training and barangay activities;
municipal and provincial level support to BHW were weak; coordina-
tion of inter-agency activities at regional, provincial and municip-
al levels needed to be strengthened; participation of barangay
residents in implementing projects was inadequate.

Recommendations:- retraining course addressing knowledge and skills
deficiencies needed, as well as restructuring balance between ESI
and health, nutrition and family planning services; education of
provincial and municipal level implementors re: project concept and
goals; develop means of more effective financial management to pay
BHW salaries and procurement and delivery of ESI construction mat-
erials; community mobilization and autonomy/flexibility; and a
deeper involvement in project by Ministry of Health.

Sinding, Steven W., & Capul, Rosendo R. Executive Summary of First PUSH
Project Evaluation Report. Manila, Philippines: O/PHN, USAID,
24 Aug 81.

Late release of funds, delayed project start-up 6 months from
Jun 78 to Jan 79. Evaluation findings were Ministry of Health
participation weaker than expected; overemphasis on Environmental
Sanitation Infrastructure in BHW basic training and barangay act-
ivities, municipal and provincial support to BHW weak; stronger
coordination between regional, provincial and municipal levels
needed, as well as greater participation of barangay residents.

Guerrero, Sylvia H. and Jurado, Elsa P. The Impact of the Panay Unified
Services for Health (PUSH) Project: A Final Report. Quezon City,
Philippines: Philippine Center for Economic Development, Univer-
sity of the Philippines, Diliman, undated.

A systematically structured "after-only" statistical and field
study of the project and its effects. Conclusions are that house-
hold and community facilities have been visibly and dramatically
improved, and the perception is that the project BHW has been
largely responsible for these changes and increased access to the
health services, and of raising the peoples health consciousness.
However, an inordinate amount of time appears to be spent by the
BHWs in paperwork, and elaborate bureaucratic reporting and
expediting activity rather than health service delivery, per se.
A centralized, standardized "package" delivery approach is apparent
with little room for local innovation or diversity in approaches
and methods of problem identification and solution.

Testing Alternative Strategies for Primary Health Care Financing in Six Barangays in Iloilo. Iloilo City, Philippines: University of the Philippines in the Visayas, undated.

The study focuses on the basic issues involved in financing health care, the nature of health care expenditures, the perceived means by which health care financing could be implemented, and the implications of the findings on the primary health care financing scheme. While a range of narrative differences are discussed in the various barrios, no conclusions appear to have been reached in terms of advantages/disadvantages of various strategies, or generalized recommendations made. The final two pages of the study outline several problems encountered by BHWs in providing services to the barangays, and some recommended solutions. General community apathy towards health education, nutrition, family planning, and even a negative attitude towards the ESI aspect of PUSH because of failures or delays in delivering items.

Osteria, Trinidad S. Impact Evaluation of the Panay Unified Services for Health Project - Final Report. Contract AID-492-0312-C-00-i202-00 Period Covered: 15 Dec 1982 - 30 Apr 1983.

Identified major constraints in the initial record keeping system for program evaluation purposes (i.e. service statistics do not reflect target population, hence utilization rates and other vital statistics could not be generated; population "at-risk" not clearly defined, so targets for specific intervention could not be identified; linkages between nutrition and infection could not be traced; causality of impact of program inputs could not be established; health problems were not viewed from household perspective, but from the health provider's viewpoint; records do not guide BHW in identifying problem areas in the community, health needs or priorities, and comparison between recipients and non-recipients of services is not possible since there is no control group.

A new record keeping system was established in late 1982. The report describes the protocol for gathering and processing the data, listing of variables, and proposal for an Annual Report with a final overall monograph to be prepared by Feb 1985. (Blank sample format for recording data is inclosed. However, this is incomplete - it does not include the form for all the questions outlined in the narrative protocol. [Many of these questions and formats are very similar to those in the Bicol Community Baseline Survey])

PANAY UNIFIED SERVICES FOR HEALTH (PUSH) PROJECT - QUARTERLY PROJECT STATUS REPORTS and PUSH - SEMI-ANNUAL SUMMARIES. Manila, Philippines: USAID/Philippines, Rosendo R. Capul, Project Officer, dates as indicated:

Project Implementation Report - Panay Unified Services for Health Philippines: USAID/Philippines, as of 30 Sep 80.

Computerized, coded check-list report, indicating 44% of project time elapsed and 97% of obligated funds expended (but only 5% of \$5.716m to be obligated under project). Minor, or No Problems, and Improving Trend. Difficulties in obtaining seed money for 1981 operational year anticipated to affect training, retraining and construction. Problems of reimbursement of 1979 construction activities still being resolved. Alternative procurement method for vehicles and equipment identified. Revised reimbursement procedures for sanitation component.

PIR - PUSH, As of 31 Mar 81.

54% of project time elapsed, 14% of obligated funds expended. (\$5.716m obligated). Minor, or No Problems, and Improving trend. Problems: Difficulty in obtaining seed money for year anticipated to affect training and retraining schedules and construction activities. Problems of reimbursing for 1979 construction activities still being resolved.

Quarterly Project Status Report, PUSH. 30 Sep 81 Rosendo R. Capul

64% of project time elapsed, 27% of obligated funds expended. Training and deployment of 50 BHWs, retraining of 50 BHWs, revision of BHW curriculum, procurement of offshore commodities, implementation of evaluation recommendations.

QPSR, PUSH 31 Dec 81 Rosendo R. Capul

69% of project time elapsed, 27% of obligated funds expended.
200 BHWs trained and deployed
50 BHWs retrained
50 BHWs in retraining
Agreement reached on guidelines for implementing Botica sa Barangay (Barangay Drug Store)
Late budget release for training

QSPR, PUSH 31 Mar 82 Rosendo R. Capul

73% of project time elapsed, 23% of obligated funds expended. (Note: decrease in amount, although obligation base unchanged) Completion of ESI sub-projects in Iloilo accelerated. Funding received for doubling training targets to compensate for 1981 shortfall. More involvement of Ministry of Health noted, but lukewarm attitude. Intensified implementation of Botica sa Barangay.

QSPR, PUSH 30 Jun 82 Rosendo R. Capul

78% of project time elapsed, 27% of obligated funds expended.

QSPR, PUSH 30 Sep 82 Rosendo R. Capul

83% of project time elapsed, 27% of obligated funds expended.
350 BHWs trained and deployed
700 water facilities and 13,000 household toilet facilities constructed.
Capiz Province unable to pick-up salaries of BHWs deployed since 1979.

Semi-Annual Summary PIR Sheet, 30 Sep 82 Rosendo R. Capul

Identical comments to Quarterly Report, above.

QPSR, PUSH 31 Dec 82 Rosendo R. Capul

74% of project time elapsed, 28% of obligated funds expended.
(Note: decrease in elapsed project time due to extension of
Project Assistance Completion Date)
50 Additional BHWs trained and deployed.
Existing record-keeping and reporting system deficient. Simplified
system developed and being implemented. Data management consultant
contracted to assist in implementation.
Budget cut one-third because of overall Philippine Government
retrenchment policy.
Project Assistance Completion Date (PACD) extended one year, from
30 Aug 83 to 30 Aug 84.

QPSR, PUSH 31 Mar 83 Rosendo R. Capul

78% of project time elapsed, 33% of obligated funds expended
Budget cut.
450 BHWs deployed
Simplified approach for measuring project impact, and new record-
keeping and reporting system developed. Contract with University
of the Philippines in the Visayas - to manage implementation of
the system and produce reports, is imminent.

QPSR, PUSH 30 Jun 83 Rosendo R. Capul

82% of project time elapsed, 33% of obligated funds expended
All Panay Provinces are paying salaries of BHWs deployed in 1979
and 1980 (early).
In conjunction with PRICOR (?) project, 6 Iloilo barangays have
formulated community based financing schemes to support BHW salaries.
Contract with UP, Visayas to manage implementation of impact eval-
uation, - completed, and implementation begun.

QPSR, PUSH 30 Sep 83 Rosendo R. Capul

86% of project time elapsed, 38% of obligated funds expended
1,738 household water facilities and 30,734 water-sealed toilets
constructed. In addition, more than 4,000 small sub-projects have
been completed.
All BHWs have been trained in new record keeping and reporting
system.
Because of Philippine government policy to limit government expen-
ditures in Calendar Years 83 and 84, project coverage targets have
been reduced from 600 to 450 barangays.

Semi-Annual Summary PIR Sheet, 30 Sep 83

Same information as Quarterly Report above, plus earlier information
in Jun 83 report on 6 Iloilo barangay community based financing
scheme to support BHW salaries in conjunction with PRICOR.

QPSR, PUSH 31 Mar 84 Rosendo R. Capul

94% of project time elapsed, 41% of obligated funds expended
Some ESI targets - i.e. construction of household toilet facilities -
exceeded. GOP does not have funds to maintain Project Support Staff
after PACD.

Panay Unified Services for Health (PUSH) - PROJECT IMPLEMENTATION LETTERS (PILs), FIXED AMOUNT REIMBURSEMENT AGREEMENTS (FARAs), and REIMBURSEMENT AGREEMENTS (RAs); dates as indicated:-

PIL 1 31 Jul 1978

Establishes procedures for utilizing loan funds and additional information to guide in implementing the PUSH project in accordance with the Project Agreement.

PIL 2 12 Oct 1978

Acknowledges receipt of documents from Philippine government designed to satisfy Conditions Precedent in the Agreement, and request for extension of the Terminal Date for meeting Conditions Precedent.

Advises that the documents are under review, and grants extension of Terminal Date from 30 Sep 1978 to 30 Nov 1978.

PIL 3 5 Feb 1979

Advises that Conditions Precedent review is complete and that all the conditions have been satisfied.

PIL 4 17 Jul 1979

Transmits Fixed Amount Reimbursement Agreement (FARA) # 1, for 902,000 pesos.

FARA 053-01 (Program Operations and Training) 9 Jul 1979

902,000 pesos is estimated as 75% of the cost for Operational Year # 1 (1 Jan 1979 - 31 Dec 1979) of Barangay Health Workers operations and training, project support staff operations and local procurement of equipment and materials. Terminal Date for Reimbursement Requests (TDRR) is established as 31 Mar 1980.

PIL 5 2 Oct 1979

Transmits FARA # 2 for 1,750,000 pesos.

FARA 053-02 (Environmental Sanitation Infrastructure) 28 Sep 1979

1,750,000 pesos is estimated as 71.6% of costs for construction of up to 50 drilled deep wells, 50 shallow driven wells, and improvement of up to 100 open dug wells, construction/installation of up to 1,000 household toilet facilities, and other environmental sanitation facilities such as spring development, filter systems and drainage; plus a fund of 2,500 pesos for each of 50 Barangay Health Workers deployed, for financing small (300 peso) environmental sanitation projects in their barangays. Terminal Date for Reimbursement Requests (TDRR) is established as 31 Mar 1980.

PIL 6 22 Apr 1980

Acknowledges receipt of request for reimbursement under FARA 053-01, and advising that a check for 720,916.46 pesos will be issued.

PIL 7 22 May 1980

Acknowledges that Governor Conrado J. Norada and Mr. Alex G. Umadhay are additional authorized representatives of the Philippines Government for the PUSH project.

PIL 8 9 Jul 1980

Transmits proposed Amendment # 1 to FARA 053-02, extending the completion date from 31 Dec 1979 to 31 Jul 1980, and the Terminal Date for Reimbursement Request from 31 Mar 1980 to 31 Oct 1980. Some modifications in the distribution of funding in various elements was also included.

FARA 053-02 (Environmental Sanitation Infrastructure) - Amendment # 1
11 Jun 1980

Cost 1,735,075 pesos - estimated 71% of total cost for construction of up to 38 drilled deep wells, 93 shallow driven wells, 115 open dug wells and 1,138 household toilet facilities.

(NOTE: Reduction in number of drilled deep wells (from 50 to 38), an increase in shallow wells (from 50 to 93), open dug wells (from 100 to 115) and toilet facilities (from 1,000 to 1,138).

PIL 9 5 Aug 1980

Transmits Amendment # 1 of FARA 053-02.

PIL 10 15 Sep 80

Draft of proposed FARA 053-03 (Program Operations, Training and Barangay Fund) and FARA 053-04 (unidentified), for up to 2,802,757 - estimated 75% of costs for Operating Year 2 (1 Jan 1980 - 31 Dec 1980). The PIL also notes that prior to issuing a FARA for Operating Year 2 - Environmental Sanitation Infrastructure, a detailed reconciliation of actual costs and reimbursements for Year 1 be provided. (This indicates AID's awareness that the Philippine Government was experiencing some difficulty in either obtaining and/or supporting detailed costs data on the work accomplished to date.)

NOTE: FARA 053-04 was apparently to have been for the Environmental Sanitation Infrastructure activities for Year 2. However, the copy of FARA 053-04 in the files I reviewed was actually for Program Operations Training and Barangay Fund for Operational Year 3 (1 Jan 1981 - 31 Dec 1981). Presumably, then, the proposed FARA 053-04 transmitted by PIL 10 for Operational Year 2 was never issued, because subsequently, under Amendment # 2, the Terminal Date for Reimbursement Request for FARA 053-02 (Environmental Sanitation Infrastructure) was extended again - from 31 Oct 1980 to 31 Mar 1982.

PIL 11 15 Oct 1980

Acknowledges request to reallocate some 94,211 pesos for Environmental Sanitation activities from the Philippine Government, and approves 92,411 pesos. (Not a typo. - one item was disapproved.)

PIL 12 29 Oct 1980

Commits AID Grant Funds up to 70,000 pesos for conducting the first evaluation of the project, and outlining the evaluation plan.

PIL 13 6 Nov 1980

Transmits names and specimen signatures of current USAID Representatives for the PUSH project.

PIL 14 4 Nov 1980

Transmits copies of FARA 053-03 for Project Operations, Training and Barangay Fund for Operating Year 2 (1 Jan 1980 - 31 Dec 1980).

FARA 053-03 20 Oct 1980

2,802,757 pesos - estimated 75% of total cost for training operations, support, equipment and materials, and up to 6,757 pesos for each of 100 Barangay Health Workers (BHWs) deployed in Operating Year 2, and up to 6,081 pesos for each of 50 BHWs deployed in Operating Year 1 - for barangay projects not to exceed 300 pesos per unit.

NOTE: considerable increase in Barangay Health Worker funding, from 2,500 pesos to over 6,000 pesos, while the unit cost per project remained constant at 300 pesos. This indicates a major change in decentralization by giving greater financial support and leverage to the BHW to initiate local development.

PIL 15 2 Mar 1981

Grants source waiver to procure two utility vehicles locally - and notes that this aspect of the project (vehicle procurement) has been considerably delayed.

PIL 16 3 Mar 1981

Notes that the Project Assistance Completion Date (PACD) was incorrectly established as 30 Aug 1982, in the Project Agreement (i.e. four years after the Project Agreement signing, instead of five years as intended). Corrects the error by formally establishing 30 Aug 1983 as the official PACD.

PIL 17 25 Mar 1981

Authorizes local procurement of some office and training equipment commodities.

PIL 18 22 Apr 1981

Acknowledges receipt of request for partial reimbursement under FARA 053-03, and approves extending the completion date of FARA 053-03 to 31 Jul 1981. Transmits Amendment # 1 to FARA 053-03 to this effect.

FARA 053-03 (Program Operations, Training and PUSH Barangay Fund) - Amendment # 1 22 Apr 1981

FARA Completion Date extended from 31 Dec 1980 to 31 Jul 1981, and the Terminal Date of Request for Reimbursement from 31 Mar 1981 to 30 Sep 1981.

PIL 19 17 Jul 1981

Off-shore procurement agreement modified to permit transportation on Philippine flag carriers on the Loan-financed portion, and Philippine marine insurance on the Grant-financed portion.

PIL 20 9 Oct 1981

Acknowledges Philippine government request to extend the Terminal Date for Reimbursement Request under FARA 053-02 (Environmental Sanitation Infrastructure), and provides immediate reimbursement for 80% of the maximum amount reimbursable (presumably from the documentation provided). AID notes that it is aware of Philippine government difficulties in documenting and substantiating its requests, and agrees to extend the Terminal Date to 31 Mar 1982, by Amendment # 2.

FARA 053-02 (Environmental Sanitation Infrastructure) - Amendment # 2,
9 Oct 1981

Extends Terminal Date for Reimbursement Request from 31 Oct 1980 to 31 Mar 1982.

NOTE: Apparently lapsed for a year through inaction on the Philippine government's part and/or administrative oversight on USAID's part. In any event, this Amendment legalized the situation again.

PIL 21 13 Jan 1982

Transmits FARA 053-05 for Environmental Sanitation Infrastructure for Operational Year # 3 - Calendar Year 1981 - which had just ended.

NOTE: Apparently by extending the TDRR and accepting some documentation for reimbursement under FARA 053-02, the way was administratively cleared to authorize funding for subsequent ESI activity.

FARA 053-05 (Environmental Sanitation Infrastructure) 13 Jan 1982

4,190,480 pesos - estimated 56% of total cost for up to 5 drilled deep wells, 458 shallow driven wells, 176 open dug wells, 14 spring improvements and 12,384 household toilet facilities.

Completion Date for activities: 31 Mar 1982, and TDRR 30 Jun 1982.

NOTE: Although this FARA was issued for Operational Year # 3 - by the time it was actually issued, (Jan 1982) the normal operational year had lapsed. Thus, apparently, the additional three months beyond the normal operating year were added so that the documentation was not completely retroactive.

PIL 22 14 Jan 1982

Transmits Amendment # 2 of FARA 053-03 (Program Operations, etc.) which authorizes extension of the TDRR from 30 Sep 1981 to 30 Jun 1982.

NOTE: Apparently lapsed more than three months earlier, and reactivated.

FARA 053-03 (Program Operations, Training, etc.) - Amendment 2, 14 Jan 1982

Completion Date extended from 31 Jul 1981 to 31 Dec 1981, and TDRR from 30 Sep 1981 to 30 Jun 1982.

NOTE: This legalized, after the fact (for the second time) any project activity between 1 Aug 1981 and 31 Dec 1981.

PIL 23 21 May 1982

Transmits Amendment # 1 to FARA 053-04, extending the Completion Date from 31 Dec 1981 to 30 Aug 1982, and the TDRR from 31 Mar 82 to 30 Oct 1982.

NOTE: Yet another ex post facto administrative "bail out". Whatever difficulties the Philippine government's project office had encountered in monitoring activities and accounting for them, had not been rectified in over three years of operations. This warrants reclassification from a temporary, or acute, problem to a chronic administrative affliction.

NOTE FURTHER: On the USAID side, there is no record of FARA 053-04 (Program Operations, Training, etc.) for Operational Year # 3 (1 Jan 1981 - 31 Dec 1981) ever being formally transmitted by PIL, unless (contrary to other practice) this was the same FARA 053-04 transmitted with PIL 10 on 15 Sep 1980 for the succeeding year. Apparently the original 053-04 number assigned to Environmental Sanitation Infrastructure was reused for Program Operations and Training when the Philippine government failed to request reimbursement in a timely manner for ESI activities.

The FARA 053-04 authorized up to 2,690,000 pesos - estimated 74% of the total cost of BHW operations, training, support staff operations and local procurement of equipment and materials. Original Completion Date would have been 31 Dec 1981, with TDRR 31 Mar 1982.

FARA 053-04 (Program Operations and Training, etc.) - Amendment # 1
21 May 1982

Completion Date extended from 31 Dec 1981 to 30 Aug 1982, and TDRR from 31 Mar 1982 to 30 Oct 1982.

PIL 24 31 Aug 1982

Transmits Reimbursement Agreement (RA) 053-06 for Program Operations and Training, etc.

NOTE: Modification of terminology from the earlier fixed amount reimbursement agreement, to simply reimbursement agreement. However, from the timing of the documents, it is apparent that the programs are operating for most of the year without any agreement (or guarantee) of repayment, and the amounts to be reimbursed have already been incurred. Hence the 'estimates' are (or should be) actuals. Thus, there is little or no incentive for effective cost management on the part of the Philippine government, or opportunity for cost efficiency by USAID. Furthermore, since without an Agreement for most of the year, the Philippine government has no assurance of reimbursement, any activity it undertook or expense incurred, was 'at risk'. Under such circumstances, the fact that anything was accomplished is a tribute to the initiative of project personnel who were willing to proceed despite the bureaucracy!

REIMBURSEMENT AGREEMENT (RA) 053-06 14 Sep 82

3,609,679 pesos - estimated 73.8% of total cost of training and operations support staff, equipment and materials, through 31 Dec 1982; with a TDRR of 31 Mar 1983.

NOTE: The Reimbursement Agreement no longer specifies funding for an Operational Year (i.e. 1982 would have been OY # 4), but only the Completion date. Although not necessarily the intent, this would permit prior year expenditures which may have exceeded reimbursement limitations to qualify for reimbursement under this RA.

PIL 25 16 Sep 1982.

Authorized extension of TDRR under FARA 053-03, from 30 Jun 1982 to 31 Dec 1982 because of the Philippine government's difficulty in assembling the required documentation to support reimbursement requests.

NOTE: Another extension - after the TDRR had lapsed.

FARA 053-03 (Program Operations, Training, etc.) - Amendment # 3,
23 Sep 1982

Terminal Date for Reimbursement Request extended to 31 Dec 1982.

PIL 26 22 Nov 1982

Transmits RA 053-07 for Environmental Sanitation Infrastructure through 31 Mar 1983.

RA 053-07 14 Dec 1982

1,935,000 pesos - estimated 55% of total costs for up to 3 drilled deep wells, 226 shallow driven wells, 100 open dug wells improvement, 2 springs improvement, and 3,410 household toilet facilities. 5,000 pesos to each of 96 barangays, and 9,500 pesos each to two barangays in Iloilo which had not previously received their barangay fund allocations, for small 300 peso projects. Completion date 31 Mar 1983. TDRR 30 Jun 1983.

NOTE: Money made available to the Barangay, rather than the Barangay Health Worker for use in the Barangay, as previously.

PIL 27 20 Dec 1982

Noting a request for 83% reimbursement under FARA 053-05, this PIL advises the finding of an AID inspection team that some of the items requested for reimbursement had not been completed, or were sufficiently defective as to render them non-functional and 74,320 pesos claimed as not eligible for reimbursement. The PIL authorized a lesser amount of only 3,422,353 pesos, but provided additional time to correct the deficiencies and receive reimbursement by extending both the Completion Date from 31 Mar 1982 to 31 Jan 1983, and the TDRR from 30 Jun 1982 to 31 Mar 1983.

NOTE: Again, the PIL is papering over both administrative and technical deficiencies which should have been resolved six months earlier.

FARA 053-05 (Environmental Sanitation Infrastructure) - Amendment # 1
20 Jan 1983

Completion Date extended to 31 Jan 1983, and TDRR to 31 Mar 1983.

NOTE: The date of the Amendment in this, and several other instances, is later than the PIL which transmits it, because that is the date on which the Agreement was signed by the recipients.

PIL 28 23 Dec 1982

Extends the Project Assistance Completion Date (PACD) from 30 Aug 1983 to 30 Aug 1984 - one year extension - and revises the financial plan.

PIL 29 8 Feb 1983

Advises the Philippine government that USAID's controller has tracked compliance and documentation with implementation actions required under the Project Agreement. Notes that submission of reimbursement requests has occurred long after expiration of the agreed to terminal dates, and that as of the end of 1982, while 20.7 million pesos had been expended for local costs, only 8.6 million pesos had been reimbursed. USAID requests the Philippine government to review its administrative management procedures to improve tracking documentation and filing of claims.

PIL 30 10 Mar 1983

Agreement by USAID to fund impact evaluation and to utilize the University of the Visayas Foundation Inc. as the contractor to oversee evaluation activities.

PIL 31 7 Jun 1983

Approves extension of TDRR for FARAs 053-03, 053-04, 053-05 and RA 053-06.

FARA 053-03 (Program Operations, Training, etc.) - Amendment # 4 13 Jun 1983

TDRR extended from 31 Dec 1982 to 30 Jun 1983.

NOTE: Another belated attempt to permit the Philippine government to get their documentation in order and obtain reimbursement.

FARA 053-04 (Program Operations, Training, etc.) - Amendment # 2 13 Jun 1983

TDRR extended from 30 Oct 1982 to 30 Jun 1983.

NOTE: Another instance of administrative deficiency on the part of USAID as well as the Philippine government - 9 months late.

FARA 053-05 (Environmental Sanitation Infrastructure) - Amendment # 2,
13 Jun 1983

TDRR extended from 31 Mar 1983 to 30 Sep 1983.

NOTE: Another lapsed TDRR administratively recovered.

RA 053-06 (Program Operations, Training, etc.) - Amendment # 1, 13 Jun 1983

TDRR extended from 31 Mar 1983 to 30 Sep 1983.

NOTE: Yet another delinquent document redeemed.

PIL 32 30 Jun 1983

Advises the Philippine government that USAID has reviewed the draft contract for Project Impact Evaluation, and is earmarking \$67,914.21 to finance it.

PIL 33 1 Jul 1983

Transmits RA 053-08 (Program Operations and Training, etc.) for Calendar Years 1983 and 1984.

NOTE: No longer any mention of Operational Years (i.e. 1983 would be OY # 5, and 1984 OY # 6).

RA 053-08 (Program Operations, Training, etc.) 1 Jul 1983

5,894,620 pesos - estimated 65% of total cost of operations for Calendar Years 1983 & 1984. Completion Date 30 Aug 1984. TDRR 31 May 1985.

NOTE: No barangay funds for small activities.

PIL 34 28 Jul 1983

Transmits Amendment # 1 to RA 053-07 (Environmental Sanitation Infrastructure).

RA 053-07 (Environmental Sanitation Infrastructure) - Amendment # 1, 28 Jul 1983

Authorizes extension of Completion Date from 31 Mar 1983 to 30 Nov 1983 and TDRR from 30 Jun 1983 to 31 Dec 1983.

NOTE: Allows more time to complete tasks, some three months after the due date had expired, with apparently the same problems of documenting what has been accomplished.

PIL 35 24 Oct 1983

Authorizes project to procure computer services for data analysis of impact evaluation.

PIL 36 16 Jan 1984

Transmits RA 053-09 (Environmental Sanitation Infrastructure) for Calendar Year 1983.

NOTE: Another ex post facto agreement.

RA 053-09 (Environmental Sanitation Infrastructure) 24 Jan 1984

5,416,299 pesos - estimated 62% of total cost for 3 drilled deep wells, 1 drilled deep well with jetmatic pump, 323 shallow driven wells, 206 open dug wells, improvement of 9 springs, construction of 14,430 household toilet facilities, provision of 5,000 pesos each to 149 barangays for small health sanitation projects at no more than 300 pesos per unit; 4,000 for 149 barangays at the same rate, construction of 6 free-flowing wells, and construction of one rainwater collection tank.

Completion Date: 30 Aug 1984; TDRR 30 Dec 1984.

PIL 37 10 Feb 1984

Authorizes reduction of PUSH project coverage from 600 to 499 barangays, and revises the project's financial plan accordingly - with life of project funding total not to exceed \$3.53 million.

PIL 38 3 Apr 1984

Amends RA 053-08 (Program Operations & Training, etc.), to reduce the amount of funding available, based on the reduction in scope of the project to support 450 Barangay Health Workers, retraining of 200 BHWs, supervisory training of 200 Ministry of Health supervisors, as well as salaries and operations of the PUSH Training Center. Funding reduced from 5,894,588 pesos for Calendar Years 1983 & 1984 to 3,820,275 pesos, and the dollar equivalent from \$620,486 to \$272,877. This also reflects a change in the exchange rates from 9.5 pesos per dollar to 14 pesos per dollar.

PIL 38 submitted as proposal to the Philippine government.

RA 053-08 (Program Operations & Training, etc.) - Amendment # 1 15 May 1984

Agreement as outlined in PIL 38, above, signed 15 May 1984.

PIL 39 24 Apr 1984

Transmits RA 053-10 (Environmental Sanitation Infrastructure) for Calendar Year 1984.

RA 053-10 (Environmental Sanitation Infrastructure) 11 May 1984

9,150,370 pesos - estimated 75% of total cost for 2 drilled deep wells, 1,166 shallow driven wells, 656 open dug wells, 24 springs improvement, 8,909 household toilets, and 12,000 pesos to 100 barangays, 7,000 pesos to 150 other barangays, 3,000 pesos to 150 other barangays, 2,500 pesos to 5 "Tapaz" (?) barangays, and 2,000 pesos to 5 "Jamindan" (?) barangays. In addition, construction of 3 free flowing wells, and 1 rainwater collection tank.

Completion Date: 30 Aug 1984; TDRR 30 Dec 1984.

NOTE: This is the final Reimbursement Agreement under the PUSH project for environmental sanitation infrastructure development. In six years of operation, the cost per unit of small barangay project activities was limited to 300 pesos.

OTHER PERTINENT DOCUMENTS REVIEWED

Project Paper (PP) - Primary Health Care Financing. Manila, Philippines:
USAID, 1 Jul 1983.

Rationale, description and proposal for a \$10 million Loan and \$2 million Grant towards a total \$22.9 million Philippine project to increase access to, and utilization of sustainable primary health care services managed and financed by communities and the Government of the Philippines.

A follow-on project to consolidate the experience from prior projects in Health, Family Planning, and Nutrition, and to provide decentralized funding assistance to locally designed project activities.

Cable: Request for TA: Comparative Evaluation of PUSH and BICOL Health Projects, Manila: Manila 31001, 28 Nov 1983.

Request for AID/Washington assistance in reviewing two projects the findings from which should be helpful to PHC Planners in the Philippines and elsewhere. Suggests comparison of different administrative structure, lead agency, and different criteria for becoming a village health worker. Need to develop a scope of work for the evaluation - objectives, methodology and requirements for comparative evaluation.

Draft Paper: Sketch for Institutional Issues Scope of Work: Philippine Health Impact Evaluation - Comparative Study of PUSH and BICOL Primary Health Care Projects. Source and author anonymous, undated

Outlines several topics and questions about the institutional aspects of the two projects which might be incorporated into a more detailed scope of work. National, regional, local level government entities, AID Mission management, barangay social structures, inter-donor relationships, and linkages among these levels. With major institutional differences noted - i.e. the implementation lead executing agency of NEDA and the Regional Development Council, v's the Ministry of Health. [Note: it is unclear which is which, since there are a plethora of organizations involved in both - both national and regional/local in character.] Other issues to study were coordination, bottlenecks, political power, intra-bureaucratic coalitions, centralization/decentralization, budgetary considerations, replicability and diffusion of innovation, sustainability, institutionalization, project time frame, implementation, monitoring and the feedback system.

Draft Cable: Preliminary Scope of Work for PUSH/BICOL PHC Comparative Evaluation. AID/Washington, undated.

Suggests identifying differences in effectiveness of each approach, assessing financial viability and institutional continuity of services provided, which will be useful in planning and implementing future AID health assistance efforts in the Philippines and other missions. Four basic questions highlighted are 1) Financial viability, 2) institutional viability, 3) effectiveness and sustainability of village health workers, and 4) critical factors for success or failure.

Cable: Comparative Study of AID-Assisted Health Delivery Systems: PUSH
PUSH and BICOL Health Projects. Manila: Manila 06753, 14 Mar
1984

Discussion on approach, composition and timing of evaluation
(recommended prior to Aug 1984).

Brady, Jim An Outline for Studying the Organizational Systems of the PUSH
and BICOL Primary Health Projects in the Philippines. AID/
Washington: M/PM/TD, 6 Apr 1984

Highlights definitional requirements, and major questions to
be considered at each level of the project logical framework
in terms of Funding, Staffing, Technology and Information (i.e.
INPUTS, THRUPTS and OUTPUTS, as well as EXTERNAL CONSTRAINTS
such as legal, political, socio-cultural, economic and geographic/
physical.)

Cable: Comparative Study of PUSH and BICOL Health Projects. Manila: Manila
11154, 27 Apr 1984

Second thoughts by the Philippine USAID Mission - earlier proposal
for evaluation too complex. Current thinking is the need to
synthesize data on hand with a few additional interviews and
write up a "readable twenty page report". Timing - last quarter
of the year (i.e. Oct - Dec 1984) rather than August. Data in
BHA reports are "of very little use" - not necessary to collate
as had been anticipated earlier.

Dumm, John J. Preliminary Results of the 1983 National Demographic Survey
(NDS). Manila: USAID/OPHN, 2 Mar 1984

Results of the survey call into question the present program
strategy and implementation performance.

No change in Crude Birth Rate in Philippines for past eight
years.

Overall contraceptive effectiveness has not changed from 1978
level.

Attitudes toward desired family size have changed little since
1978, and no change in attitudes towards family planning methods.

Only bright spot: mean age of marriage for females rose 1.2
years since 1978.

Evaluating the Health and Economic Impacts of the Philippines Provincial
Water Project. Local Water Utilities Administration, U.S. Bureau
of the Census, International Statistical Programs Center, Oct 1983

Executive summary and comparative data on two cities.

Conclusions: No clear indications of significant positive health
impacts resulting from the project. Water system improvements
alone do not result in immediate health impacts. Provision of
'safe' water to lower status households is not sufficient to
bring about health improvements. Safe water may not remain safe
after it is handled and stored by untrained household members.

Barth, Gerald A. STREET FOODS: Informal Sector Food Preparation and Marketing. Iloilo City, Philippines: Equity Policy Center, 1983

Some 30 percent of household food expenditures in Iloilo City are for food prepared outside of the household (i.e. sidewalk vendors). Even though expenditures for food are a high percentage of the household budget, nutrient intake among lower-income groups is below recommended levels. Problems of the vendors are numerous - high risk of business failure, lack of access to capital or credit, administrative difficulties in obtaining licenses to conduct business. Problem for the consumer: Sanitary improvements are required in these sidewalk vendor establishments in both the preparation and handling of food in order to reduce incidence and risk of contaminated food.

POPULATION, HEALTH AND NUTRITION IN THE PHILIPPINES: A Sector Review. Report No. 4670-PH Volume I: Summary of Findings, Issues and Recommendations. Washington: Population, Health and Nutrition Department, the World Bank, FOR OFFICIAL USE ONLY, 13 Jan 1984

Rapid population growth has exacerbated problems of poverty and underemployment. Regions that are the least developed and least urbanized show little or no decline in fertility and have higher current fertility and lower contraceptive practice, and strong socio-economic incentives for large families. Improvements in health status have been considerable, but decline in infant and maternal mortality rate improvement since the mid-1970's warrants reconsideration of health programs directed toward child and maternal health. Communicable diseases are still the main cause of death, and the problem of malnutrition for pre-schoolers for 1980 is at 28 percent.

Overall achievements are substantial, and compare very favorably with other countries at the same level of income. Nevertheless, internally and absolutely, HNP is a dismal picture and linkages to field implementation strategies are not very effective. Recommends a decentralized approach with strengthened Ministry of Health institutional support and extension services.

Other References

- Carlson, Craig W. Panay Unified Services for Health (PUSH): An Introduction for U.S. Peace Corps Health Volunteers Assigned to PUSH-Targetted Municipalities. Mimeo. 7 Aug 1980.
- Smith, Kenneth F. IMPROVING THE DELIVERY OF HEALTH SERVICES IN KOREA: An Analytical Framework. Seoul, Korea: Korea Health Development Institute, 17 Sep 1976.
- Song, Kun Yong & Smith, Kenneth F. EVALUATION PLAN FOR THE HEALTH DEMONSTRATION PROJECT OF THE KOREA HEALTH DEVELOPMENT INSTITUTE (KHDI). Seoul, Korea: Korea Health Development Institute, Jan 1977.
- Dunlop, David W. TOWARD A HEALTH PROJECT EVALUATION FRAMEWORK, USAID, Washinton AD Evaluation Special Study # 8, PN-AAJ-619, June 1982.

Personnel Interviewed

Dr. Lois Godiksen, PPC/E, AID/Washington; Officer-in-Charge of Health Evaluation
Dr. James Brady, M/PM/TD; formerly ASIA/TR AID/Washington
Ms. Joy Riggs-Perla, USAID/Philippines; Project Officer, Primary Health Care
Ms. Maura Mack, S&T/Nutrition, AID/Washington, formerly with USAID/Philippines
Dr. Steven Sinding, S&T/Population, AID/Washington, formerly with USAID/Philippines
Mr. Craig Carlson, Former Peace Corps Volunteer, Visayas, Philippines

PART IV

FIELD FOLLOWUP, FINDINGS & RECOMMENDATIONS

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(TO BE COMPLETED)

I recommend that this phase of the study be conducted by a team of interdisciplinary professionals as follows:-

1. Initial reading and review of this report.
2. Orientation in Manila, with USAID, NEDA, MOH, and other appropriate organizations and individuals.
3. Agreement on what aspects are to be studied in each project and what evidence is required (and should reasonably be expected to be available) to be obtained to substantiate or refute, or otherwise cast light on tentative hypotheses.
4. Field visit to the Bicol region, to meet with BRBDP personnel and selected sample barangays, health personnel and residents.
5. Field visit to the Panay region, to meet with regional personnel and selected sample barangays, health personnel and residents.
6. Return to Manila to summarize trip findings, draft final report with recommendations, and discuss with both USAID, NEDA and MOH, as well as other appropriate organizations and individuals.
7. Publication of final report.

The team should be composed of a minimum of two external, previously uninvolved professionals - one with a public administration/management background, to study the process and one with a public health administration/planning background, to study the substance of both projects. If possible, they should be supplemented by an individual (or individuals) who will have longer term follow-through administrative responsibilities for applying the findings to the new project, and/or disseminating the results to other projects.

It is extremely important that this team also includes representatives of the Philippine government in either an administrative, or professional/technical analytical capacity.

Finally, it would seem desirable that a representative of USAID accompany the team on each field visit and in consultations with various government officials in Manila - both for protocol and facilitating discussions/work and understanding of all concerned.

	<u>Weeks</u>
I estimate that items 1,2 & 3 could be completed in one week,*	1
4 & 5 would take about a week each	2
another week would be required for item 6	1
while item 7 would be completed by PPC/E without further involvement by the consultants.	
TOTAL =	4 weeks

* Minimum - See Part II for component estimates

Assuming that the team is composed of direct hire personnel, with the exception of the two external consultants; and that the Philippine government and USAID personnel would be budgetted for separately, the approximate cost of this study would be: \$9,500 per person (consultant) plus International and In-Country Air Fare and travel costs.

i.e. Salary \$252 per day x 4 weeks @ 6 days per week	=	\$6,048
Per Diem and Misc. Expenses \$100 per day x 4 weeks		
@ 7 days per week	=	\$2,800
		<hr/>
plus Salary for two days of International Travel		\$8,848
(1 day each way allowed) @ \$252 per day	=	504
		<hr/>
		\$9,352
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<u>plus Airfare, taxis, airport fees, and per diem</u>		
while travelling, overnight rest-stop en route, etc.		

NOTE: If, instead of obtaining the services of two individuals to conduct this study, you elect to contract with an Indefinite Quantity Contractor (IQC), the costs will be approximately doubled (except of course for travel costs) because of the necessity for paying corporate overhead charges and fees.

I would be most interested in participating in the field followup aspect of this study, serving as the public administration/management specialist consultant. In addition to the knowledge gained from reviewing the material to prepare this report, I have had over five years of AID experience in the Philippines, and am familiar with both the Bicol and Panay areas; and have also served in other countries in Asia in the Health, Population and Nutrition sector as a project officer, management advisor and chief of the division - with primary health care extension, health worker training and environmental sanitation project portfolio. Thus, although not primarily a public health specialist, I have a working acquaintance with the sector and its technical issues. Academically, I am nearing completion of a doctorate in public administration, with emphasis on analysis and evaluation in development administration; and my Master's Thesis (MIT, 1970) was on POPULATION DYNAMICS: A computerized simulation for Systematic Policy Analysis. I have participated in a number of project designs, implementations and evaluations in a variety of countries and sectors, with and for AID as both a direct-hire officer, and, subsequently as a consultant.