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A REPORT ON THE ORGANIZATION
OF THE MINISTRY OF HEALTH
OF THE REPUBLIC OF THE PHILIPPINES
AND THE STATUS OF
THE PRIMARY HEALTH CARE PROGRAM

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ABBREVIATIONS

ADB	Asian Development Bank
BHS	Barangay Health Station
BHW	Barangay Health Worker
BNS	Barangay Nutrition Scholar
BSPO	Barangay Service Point Officer
CS	Consultant's Suggestions or Consultant's Scheme*
DAP	Development Academy of the Philippines
FP	Family Planning
FTOW	Full-Time Outreach Worker
GOP	Government of the Philippines
IBRD	International Bank for Reconstruction and Development
IEC	Information, Education, and Communication
MCH	Maternal and Child Health
MHO	Municipal Health Officer
MOH	Ministry of Health
NEDA	National Economic Development Authority
NSDB	National Science Development Board
O/PHN	Office of Population, Health, and Nutrition
PHC	Primary Health Care
PCM	Protein Calorie Malnutrition
PHN	Public Health Nurse
PHO	Provincial Health Officer
PNP	Philippine Nutrition Program
POPCOM	Population Commission

* The abbreviation "CS" is used in Appendix D to denote charts reflecting the suggested organizational schemes of the consultant.

RHP	Rural Health Physician
RHU	Rural Health Unit
ROP	Republic of the Philippines
RRHCDS	Restructured Rural Health Care Delivery System
UPPI	University of the Philippines Population Program
USAID	United States Agency for International Development
WHO	World Health Organization

I. EXECUTIVE SUMMARY

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Introduction and Background

Purpose and Scope of Work

As defined in the scope of work for the consultancy, two principal tasks were to be undertaken. These were:

1. To review, with the Minister of Health of the Philippines, the planned reorganization of the Ministry of Health (MOH), the major thrust of which is decentralization of responsibilities, operations, and funds to the provincial health office and the subsidiaries, the rural health unit (RHU) and the barangay. The reorganization will involve the integration of both curative and preventive services.
2. To assess the current status of the implementation and operation of the primary health care (PHC) program in the Philippines.

Methodology

In conducting this assignment, the consultant held discussions with the Minister of Health and members of his staff; interviewed individuals both within and outside the government, private practitioners, and international officials involved in health programs; made field trips and on-site visits; reviewed documentation and organization charts; and met for informal conversations with retired health officials, evaluation team members of the World Bank, and other persons.

Most important was the invitation from the Minister of Health to attend four meetings of the regional directors. The Minister himself and staff from the central office were present at these sessions, which were held in Davao, Tacloban, and Manila. The meetings were devoted primarily to discussions of progress in implementing the primary health care program, the integration of health services, and facilities, funding, and inservice problems in each area.

Current Conditions

In preparing for the assignment, the consultant reviewed information on current conditions in the Philippines and assessed the government's efforts to provide primary health care. A summary of the most pertinent findings follows.

1. The current structure of the Ministry of Health allows for no acceptable degree of flexibility in management and operations.
2. The results of rapid growth of the Filipino population are now visible in housing, education, sanitation, sewerage, waste and trash disposal, malnutrition, potable water supplies, adequate food of the right type, transportation, and health--all of which affect the quality of life.
3. The lack of proper nutrition is endemic in certain segments of the population. (See Appendix C.)
4. The provision of primary health care and integrated health services has become an established, stated policy of the Minister of Health. The recently-appointed Minister of Health is a highly qualified, well-trained person interested in all aspects of the study of health, including research. He has represented the Philippines at several international meetings in different countries. He has an unusual ability to discern and understand problems and the changes that may have to be made to provide acceptable health services to the people.
5. All 12 area or regional directors are exceptionally well-trained. All are graduates in medicine, have a master's degree in public health, and have trained at the Development Academy of the Philippines (DAP).
6. In all 12 areas or regions, there are well-developed and well-coordinated training programs for people in provinces and barangays.
7. The barangay is an ideal area in which to implement the program of primary health care and integrated health services.
8. There is a plethora of international, national, bilateral, governmental, and non-governmental organizations, foundations, religious groups, institutions, individuals, etc., involved in or supporting health and health-related activities in the Philippines. Some of these groups may be involved in specific activities that are not necessarily related to the work of others.

9. Unusual emphasis is given to surveys, studies, and research as health problems become more complex. The country's economic, health, education, agricultural, and natural resources and the necessities for improving the quality of life are not adequate to keep pace with the increases in population.
10. Approaches to health and associated problems, especially staffing, funding, organization, and regionalization, are parallel and often duplicative, and they are best demonstrated in the population, nutrition, and medicare activities.

Identification of Problems

Ten principal problems were identified during the consultancy. They are summarized below.

1. The structure of the Ministry of Health needs to be adjusted to achieve the complete decentralization of all operations, responsibilities, authority, and funds to the provincial health office and its subsidiaries, the rural health unit and the barangay. (See Appendix D.)
2. There is an urgent need to integrate the resources of the large number of individuals, governmental and non-governmental agencies, international groups, and others who are interested in, or are already providing, assistance to the primary health care program of the Ministry of Health. (See Appendix A.)
3. An adequate, acceptable logistics system is lacking in the Ministry of Health.
4. It is necessary to recognize that current programs to relieve the pressures of population growth may stagnate if the resistance of the National Economic Development Authority (NEDA) is not overcome.
5. Given current knowledge, current efforts to prevent, control, and eradicate tuberculosis are seriously deficient.
6. An acceptable legal definition of a hospital and of what is required of a hospital (e.g., adequate staffing, supplies, materials, and funds) to ensure that the public receives quality care is needed.
7. Nutrition, generally, is inadequate in the Philippines.

8. The media do not use to full advantage the innovative, educative, and promotive capabilities at their command to develop a strong thrust to assist the Ministry of Health in implementing primary health care and integrated health services programs. An effort to take full advantage of these capabilities would constitute a public service of the first order.
9. The people of the Philippines have been conditioned over the years to equate hospitalization and clinical care with optimal health. Consequently, they regard these services, and not educative, preventive, and eradivative measures, as essential to optimal health.
10. Health personnel are distributed unevenly throughout the Philippines.

Summary of Assumptions and Recommendations

To solve the various problems now constraining the delivery of primary health care services, certain assumptions will have to be made, and a series of broad recommendations will have to be implemented. These assumptions and recommendations are summarized below.

1. The World Health Organization's (WHO's) definition of "health" is valid.
2. Much needs to be done in the Republic of the Philippines (ROP) to achieve the goal of optimal health.
3. Achievement of this goal will take years unless aggressive, continuous efforts are made to obtain from all citizens of the Republic help in identifying priorities.
4. The barangay is an appropriate place to begin the effort to identify priorities and to seek the full support of the community to resolve local health problems.
5. All approaches to health problems should be fully integrated and based on conditions in the barangays that have been identified locally.
6. All health-related technical assistance should be channeled through the rural health unit and the barangay for study and approval, because these organizational units are most familiar with the health priorities determined by residents of the barangays. If further assistance is needed, it can be requested from the provincial and municipal health offices and the regional or area office.

7. All categorical health activities should be restudied immediately to determine the relationship between input and output, given personnel, funds, and the objectives of the specific categorical program.
8. The current organization of the Ministry of Health is outmoded. A streamlined, efficient, and effective substitute should be found that is feasible, given current conditions, and acceptable to the people. The effort to reorganize the MOH will require the participation of citizens at all levels, and especially those in the higher echelons at regional and central levels.
9. A first priority might be modification, adjustment, and change to integrate the categorical programs, bureaus, offices, divisions, etc., and decentralize pertinent activities to the regional, provincial, and municipal levels. To the extent possible, all administrative, management, and logistics functions should be grouped together, and research activities that can be conducted elsewhere under better conditions and at no cost to the MOH or the ROP should be identified. Activities that can be done better in the ROP will be more efficient and effective if funds, personnel, materials, etc., are redistributed.
10. It would be worthwhile to approach the University of the Philippines, the University of the East, and other medical schools to determine whether they would be willing to assume, under contract, the operation and support of the major centrally-located hospitals as teaching and service institutions.
11. The suggestion to decentralize purchase and supply may have merit. For example, supplies could be obtained by "drawdown" method as they are needed, thus eliminating the need for large quantities of drugs, antibiotics, etc., which are subject to deterioration and pilferage.
12. The new research building can be used in a variety of ways to reduce operating costs, and it could become a vehicle for training in research.
13. All hospitals need an institutionalized system of preventive maintenance in all areas.
14. The term "hospital" needs to be redefined.
15. Buildings that accommodate 25 or fewer beds need to be considered as health stations or collecting points where a diagnosis, followed by appropriate treatment and release of the patient, can be made.

16. A definition of "hospital" should be based on considerations of the quality and training of the staff, among other things, and the numbers of staff available to provide quality services, given current knowledge of techniques and methods.
17. Adequate funds, supplies, and materials should be made available to ensure the optimal treatment of Filipinos' health needs.
18. Maximum use should be made of relatives and friends to provide attention to hospitalized patients.
19. No new hospitals or clinics should be constructed unless the following criteria are met:
 - a. A continuous, adequate supply of water is available at all times.
 - b. The structure is built to minimize the possibility of hazards.
 - c. A competent group of specialists is assembled to study the plans for new hospitals (if any new hospitals are being built) and the revisions of existing plans to ensure that the facilities will be able to meet the needs of the country and accommodate patients, employees, and visitors comfortably. This group should include the public so that special-interest groups and lobbyists cannot gain control. Either a majority or a plurality of the members should be public citizens or non-medical people.
 - d. Requirements for energy are considered in the plans for construction.

II. SUGGESTED DESIGN FOR RESTRUCTURING
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Objectives and Description of Design

All people have the right to and responsibility for good health. The principal function of any ministry of health is to assist the people in establishing this right and in identifying their responsibilities.

People also have the right and responsibility not to be hospitalized. A primary function of a ministry of health is to help them to avoid hospitalization.

A major task of the Ministry of Health of the Republic of the Philippines is to design a government operation that will be efficient and effective in helping the people to obtain a satisfactory state of health and to improve the quality of their lives.

In view of current knowledge and existing conditions, it might be helpful to replace the Ministry's current system with one that is more flexible and streamlined. One possible design is discussed in this paper.

The Ministry of Health has a large cadre of well-trained health personnel with which to begin an innovative, productive health activity that could gain the population's support, if it functions properly and at full capacity. The MOH must adjust to a framework of government that allows for complete flexibility and productiveness that exceeds the input of human and physical resources. The rationale for all actions must be the improvement of health services, a goal that can be accomplished by giving the people an opportunity to make maximum use of their own resources, with the assistance of the technical staff of the MOH. The desires and expectations of the people should be considered first, and their responsibilities should be understood. Technical experts should provide all the data and information that are needed to design a methodology to conduct any project to which the people assign first priority. A system of operation must be costed out in great detail; all available local resources have to be identified and the means to use resources effectively must be determined. With this information, the people can decide whether they themselves or other sources will be able to provide the resources the project will need.

In restructuring the MOH, the principal objective is to reduce the total workload of the Office of the Minister and identify those functions that rightly should rest with that office. The Office of the Minister of Health is now responsible for the health of 50 million Filipinos. The total amount of work required to attend to the health needs of so many

persons is of such magnitude that much of it must be delegated to high-level assistant ministers with specialized education and training. Only by delegating work to others can the Ministry function efficiently and effectively.

A major goal is to move all operating responsibilities and funds to the government unit closest to the people to be served. All aspects of the proposed new design reflect the recognition that the function of the MOH is to protect the health of the people and to provide acceptable health services.

The new design calls for the establishment of three new posts:

- Assistant Minister for Management, Budget, Financial, and Legal Services;
- Assistant Minister for Primary Health Care and Barangay Health Attention; and
- Assistant Minister for Health Education and Special Health Support Services.

Each assistant minister will have under his immediate supervision and direction a director of staff and support personnel. The type of person who should be recruited for the position of Director of Staff is described elsewhere in this report. (See Appendix D.) The Director of Staff will be recognized for his or her expertise in identifying competent persons and in organizing ad hoc groups to study all the activities under the direct jurisdiction of the Assistant Minister. Ad hoc groups will be organized to study specific problems. They will receive the details about those problems, in addition to the necessary guidelines, be informed of constraints, and be given a reasonable period of time to complete their tasks. As soon as the task is completed and a report has been submitted to the Minister of Health, the group will be disbanded.

Authority, Responsibilities, and Functions of Positions

A. Assistant Minister for Management, Budget, Financial, and Legal Services

The Assistant Minister will study and review in detail the studies of the Director of Staff and all the components of the design proposed in this report. (The items have not been ranked in order of importance because it is the prerogative of the Assistant Minister to determine priorities.)

The objective of the studies will be to obtain data and other information, in addition to funds; identify the functions of each person participating in the studies; and determine how the information and financial support can be made available to the regional area directors and their staff to facilitate their work.

In the proposed new design, the Assistant Minister for Management, Budget, Financial, and Legal Services and the Assistant Minister for Health Education and Special Health Support Services have direct lines to the Ministry of Health via the Assistant Minister for Primary Health Care and Barangay Health Attention. (See Appendix D.) In this arrangement, then, all studies from these offices will be directed toward achieving the Ministry's goal to develop efficient and effective primary health care and to conduct successful health programs in the barangays. A number of health activities--the Family Health Services--have been brought together under the Assistant Minister for Primary Health Care and Barangay Health Attention. All these activities will be directed primarily to primary health care and barangay health attention. Services will be available immediately to those in the barangays as they establish their priorities.

The Assistant Minister for Health Education and Health Support Services will oversee the Director of Staff and a working staff whose responsibility will be to bring together in an integrated system all the activities supervised by the Assistant Minister.

In addition to integration, all studies should have as their objective the decentralization of all health activities, funds, and responsibilities to the responsible government unit closest to the people. In the Philippines, that unit appears to be the provincial health office. The results of the studies should become available to the regional health office upon completion of a study in the Office of the Minister. It is hoped that they will facilitate the work of the regional director and his staff.

B. Directors of Staff

The directors of staff who report to the three assistant ministers have similar responsibilities and qualifications. They all must be articulate, experienced, and trained in management, group organization, and operations. They must be leaders, expert at coordinating efforts and stimulating action. Each must be masterful in selecting individuals with special abilities and expertise in the areas where services are needed and in getting a job done.

Each staff director will report directly to an assistant minister and will be responsible for bringing together special persons from within and without the government to study and resolve specific health problems. These problems may be identified by the Minister, the ministers of other

government agencies, officials in the barangays, regional offices and provincial office staff, the municipal health facility, the rural health unit, business leaders, the public, and international groups.

It may or may not be possible to find solutions to every health problem. Upon completion of a study of a particular problem, a report with appropriate recommendations is to be submitted, and the ad hoc group is to be disbanded. The directors will be responsible for following up on the recommendations.

The services of all staff are to be contracted for four years, subject only to abrogation for cause. If a member of the staff is evaluated and his or her services are determined to be of the quality required, that person's contract can be renewed.

The directors of staff will have a variety of other responsibilities. They will be required to:

1. Identify any problems that require attention.*
2. Select qualified individuals or groups to work on the problems.
3. In cooperation with the members of the special study group, establish guidelines for conducting the efforts.
4. Consult frequently with the individual groups.
5. Establish deadlines for the completion of the studies.
6. Review with the groups their findings and conclusions.
7. Meet with the assistant ministers to discuss the completed studies.
8. Upon approval from the Minister, disband each study group.
9. Implement each group's recommendations and follow up to determine whether the problem has been resolved.

* The problems may be identified in the field, by sources outside the government, by international agencies, by executive, legislative, and judicial sources, by the Minister of Health or assistant ministers, and by other sources involved in health-related activities.

The directors of staff will be responsible for counseling field staff on health matters, reviewing health programs, suggesting adjustments, if necessary, and following up the programs periodically to ensure that problems are being resolved.

The directors of staff will be able to convene an ad hoc committee to study existing hospitals and health facilities and plans for future facilities. It is assumed that any doctor, operating room nurse, supervisory nurse, dietician, architect, plant engineer, preventive maintenance engineer, anesthetist, X-ray technician, laboratory expert, etc., will have sufficient education and experience to be a member of an ad hoc committee.

The ad hoc committee will have to consider the need for an additional hospital; determine whether land, with a title, is available and in the proper location; identify the services the hospital will provide; determine and identify sources of funds for equipment and materials; determine whether materials for construction are available; determine availability and source of energy; and provide models that show how different facilities are interrelated and integrated into the country's entire health structure. This kind of information is needed to ensure that optimal services are provided to patients and that working conditions facilitate the hospital's operations.

C. Assistant Minister for Primary Health Care and
Barangay Health Attention

Under the direction of the Minister of Health, the Assistant Minister for Primary Health Care will be responsible for the development of all programs in primary health care and barangay health attention.

The Assistant Minister will make full use of the Director of Staff, who, as his immediate collaborator, will help to develop a means to integrate all available resources, both human and physical, for the coordinated effort to provide primary health care and barangay health attention. The Director of Staff will assemble representatives from all the agencies and organizations in the Philippines that conduct work related to primary health care and barangay health attention. (See Appendix B.) A general meeting should be arranged so that guidelines can be developed and constraints to integration can be identified.

The Assistant Minister will give general direction to the Director of Staff and oversee the appointment of the ad hoc committees that will work on various problems as they arise. Care must be taken not to disrupt life in the barangays while assisting the people to attain a standard of living which they perceive is satisfactory.

The Assistant Minister will be responsible for seeking and establishing communication with all individuals, groups, governmental and non-governmental organizations, and national and international agencies with

an avowed interest in primary health care and barangay health attention. He also will be responsible for implementing and following up activities to ensure that all human and physical resources are being used efficiently and effectively.

D. Assistant Minister for Health Education and
Special Health Support Services

The Assistant Minister for Health Education will have numerous responsibilities in many areas. Some of these tasks are summarized below.

- Prevention, Control, and Eradication of Disease
 - Quarantine and Health Protection of Traveling Public
 - Vaccination and Immunization
 - Vermin Control
 - Health Education
 - Alabang Laboratories
 - Other

- Health Services
 - Special Hospitals
 - All Other Categories of Hospitals
 - Rural Health Services
 - Provincial Health Services
 - Municipal Health Services
 - Sanitation, Potable Water, Sewerage, Trash and Waste Disposal
 - Other

- Maternal and Child Health
 - Nutrition
 - Health Education
 - Population
 - Other

- Health Media Support
 - Television
 - Radio
 - Newspapers, Magazines, and Health Journals
 - Schools
 - Other

- Health Support Groups

- Governmental
- Non-Governmental
- Other

- Safety of Citizens

- Food Sanitation
- Drugs and Chemicals
- Tobacco
- Accidents
- General Guidelines for School Health, Recreation, and Sports
- Recreation
- Development of Rapport with Citizens of the Republic and Conjoined Action to Provide Optimal Health (clubs, churches, schools, unions, Boy Scouts, etc.)

- Disaster Relief

- Disaster Teams
- Supplies and Materials
- Funding
- Coordination and Cooperation with All Government and Private Agencies

- Health Education and Training

- Health and Health-Related Research of All Kinds

E. The Regional or Area Office

The regional office will serve as a consultant, counselor, and adviser on all technical, legal, managerial, fiscal, operational, educational, and training activities. It will also have responsibility for population and nutrition activities in the area.

F. Area Director

The most important responsibility of the Area Director will be to plan, formulate, and develop an integrated health education and training program. The program will be for all employees under the control of the Area Director. It will include exercises in the following subjects:

- Preventive Maintenance
- Specification Writing
- Security
- Transportation
- Medical Care
- First Aid
- Health Education
- Population and Nutrition Activities
- Control and Expenditure of Funds
- Budget Preparation, Formulation, and Apportionment
- Administration and Management
- Understanding and Resolution of Legal Problems
- ICU Activities
- Sanitation
- Cleanliness of Premises
- Proper Disposal of Waste and Trash
- Potable Water Supplies
- Ambulatory Services and Operations
- Personnel Activities and Service Provision.

Another major responsibility of the Area Director will be the regional integrated health and training unit. This unit is to provide training for all persons employed in health-related positions, including health chiefs, ambulance drivers, nurses, laboratory technicians, nutritionists, family health personnel, health educators, barangay health aides, medical graduates, nursing graduates, plant operators, preventive maintenance personnel, anesthetists, cooks, ward attendants, janitors, general maintenance staff, sanitation workers, and potable water providers.

It is well known that a health program will break down if staff are untrained or careless and that the result is often a dramatic increase in

morbidity and mortality. To avoid such problems, all health personnel in the Republic will be trained. Through integrated health training all health personnel can take pride in their work.

The Area Director will be responsible for advising the Minister of Health on the health status of people in the area. The provision of primary health care and activities in the barangay will be of particular interest. In addition, the Area Director will seek ways to develop health support groups and study the possibilities of contracting for services to provide health care.

Approximately 70 percent of the director's time will be devoted to meetings and liaison. Whether in the provinces or the municipalities, the Area Director will meet with church groups, attend union meetings, and speak with his or her cohorts, citizens' groups, clubs, and individuals. In this way, health problems can be identified and the public can learn what the Ministry of Health is doing to resolve them. An effort will be made to visit all private health facilities and health personnel and to discuss these facilities' methods of operation. Staff will be asked to comment on how they think both government and non-governmental agencies can coordinate their health activities and, in some instances, integrate their services to benefit all Filipinos. During these visits, the Area Director will be able to observe how the programs are working and to offer comments and suggestions to make the programs more effective. In addition, the staff will have an opportunity to present their own ideas and problems and to hear what others are doing elsewhere in the Philippines. Discussions of new plans and programs contemplated by the Ministry of Health also will generate interest among the employees.

The Area Director will have other duties. For example, he or she will provide counseling and advice on expediting and evaluating programs approved in each area. And, during the summer vacation, after consultation with educators, the Area Director may offer education and training to high school students or adults who are interested in integrated health training activities.

G. Provincial Health Office

In the proposed new design, all authority, responsibility, funds, and operations have been delegated to the Provincial Health Officer. (See Appendix D.) Additional positions will have to be established, however. The following positions will be needed:

- Assistant Provincial Health Officer for Barangay Health Attention and Primary Health Care;
- Disbursing Officer;

- Cashier; and
- Payroll Clerk.

An Office of Provincial Health Services will be created to oversee the complete integration of all educational, promotive, preventive, curative, and rehabilitative components of the health care and service delivery program.

The Office of Provincial Health Services, the district hospitals, the rural health units, and other field units will coordinate field activities with other government offices and local non-government agencies.

The Provincial Health Officer will be expected to visit all health facilities, both government and non-government, to determine how they can integrate their services to benefit the people.

The Management, Budget, Financial, and Legal Services Division will be responsible for contractual services.

Health education, nutrition, population, primary health care, barangay health attention, dental services, communicable disease control, schistosomiasis, dermatology, trash and litter control, potable water, sanitation, and waste disposal have been placed under the Division of Integrated Family Health Services. The responsibility for control of funds can be given to the Provincial Health Officer. The Disbursing Officer will report to the Management, Budget, Financial, and Legal Services Division and will be responsible for controlling and disbursing all funds in accordance with directives from the Office of Provincial Health Services.

The Cashier will have authority to issue checks to all health personnel and expenses incurred in the operation of the Provincial Health Service.

The Payroll Clerk will be responsible for all time sheets and attendance reports of employees of the Office.

The Office of the Assistant Provincial Health Officer for Barangay Attention and Primary Health Care has been established and will perform the following functions:

- Administer, manage, and coordinate all health activities related to the educational, promotive, preventive, curative, and rehabilitative aspects of medicine in the province.

- Exercise administrative direction, supervision, and control over the rural health units, hospitals, sanitariums, and other field units in the province.
- Exercise through the Assistant Provincial Health Officer responsibility for primary health care and barangay health attention.
- Perform such other functions as may be provided by law.

The city or municipal health office may follow the pattern in the provinces and also integrate health and medical services.

The Office of Provincial Health Services will be composed of the Division of Management, Budget, Financial, and Legal Services, the Division of Integrated Family Health Services, and provincial and other hospitals.

The Division of Management, Budget, Financial, and Legal Services will include three new positions: Disbursing Officer, Cashier, and Payroll Clerk. The first two positions will be bonded.

Field health units in any particular area may be temporarily supervised by a district hospital. This would be a first step in the process to integrate health and medical services in a province. Each rural health unit and other field units will become an outpatient department of a nearby district hospital.

All MOH programs and projects in population, nutrition, malaria, and other areas will be integrated into the Division of Integrated Family Health Services.

The new design must be accepted by the Minister of Health before reorganization can begin.

H. Provincial Integrated Health Activity

As an operational unit of the Ministry of Health, the Office of Provincial Health Services will have complete authority and responsibility for all health management, control of funds, personnel, property, logistics, purchase and supply within the laws, and orders and constraints of the Ministry of Health. Reports will go directly to the Minister of Health.

The rural health unit will report to the Provincial Health Officer and will be responsible for providing immediate health assistance to designated health personnel in the barangay.

III. THE PRIMARY HEALTH CARE PROGRAM

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The Minister of Health is responsible for working with an estimated 49 million people to develop an efficient and effective scheme that will provide acceptable health services. The Minister recognizes that the government's resources are not sufficient to provide all the health services that are needed. To help resolve this situation, the Minister has decided to use two schemes. In one, the primary health care system will be used to provide health attention to the barangays. In the second scheme, all health authority, responsibility, and operations will be decentralized to the provincial health office. Through this office, the necessary technical assistance will be provided to the barangays to help the people there to mount an acceptable health program of their own, using their resources.

As envisioned by the Ministry of Health, the program for primary health care is a prodigious undertaking. The current system of operation, which is entirely different--generations-old, highly centralized, with a canopy of health services implemented in the community by residents of the barangays, with technical assistance from the Ministry--must be uprooted and replaced. The change from a centralized operation to a barangay-oriented system will be difficult to accomplish. It was fortunate that during a static period, when there was little change in attitudes and practices that favor a curative, and not a preventative, approach to health care, the MOH was able to develop a cadre of well-trained health personnel with a different orientation. This group can be expected to administer the policies of the Ministry of Health and effect the necessary changes, provided it receives support to develop a good logistics system and integrate health services with the agricultural, educational, and population and nutrition programs of the government. Assistance from government, private, and international agencies also will be needed.

It appears that the program will move rapidly, because it has the support of the president and members of the Cabinet, who believe it to be desirable. The stated policy of the Minister of Health is that primary health care will be delivered as rapidly as possible and that all the facilities of the MOH will be made available for this purpose.

Meetings of Regional Directors

The Minister of Health invited this consultant to attend four meetings of the 12 regional directors. The Minister himself and his staff in the central office also were present. The sessions were held in Davao, Tacloban, Leyte, and Manila. The regional directors presented reports on

their activities to conduct the primary health care program in their respective areas. Discussions followed these presentations. The problems inherent in developing and implementing the PHC program became readily apparent. They are problems inherent to all attempts to move rapidly into rural areas to provide services that are not sufficiently understood by the people. Rural people are naturally suspicious of sudden interest in their culture, habits, and welfare, and they regard uneasily strangers who come to their communities espousing ideas foreign to their usual mode of life. In the Philippines, the people misunderstood what the PHC program would and would not do, and how much it would benefit those who resided in the barangays. Some common problems were a lack of resources and unwillingness to use local resources. Some areas were reluctant to use their own resources and demanded help from outside. Some barangays became politicized. In addition, the presence of too many agencies and other groups, all of which were attempting to introduce their own programs without integrating them with other activities, created problems.

The area directors identified three problems in particular:

- The need to strengthen relationships with persons and groups involved in similar health activities;
- The need to strengthen the planning capacity of barangay workers to enable them to "mobilize their strategies"; and
- The need to institute fiscal reforms to attain adequate and appropriate logistics support at the periphery.

Some problems were due to inflexibility and lack of collaboration with others employed in the same division or department.

The major problems were quickly identified. They were prevention and control of communicable diseases, maintenance and improvement of environmental sanitation, improvement of nutrition status, reduction of the rate of population growth, socioeconomic inequity, poverty, low income, lack of mobility and accessibility to basic health services, and lack of cooperation between and among groups interested in providing health services.

Visits to Barangays

Several barangays were visited. It was found that each barangay has its own unique set of health needs, conditions, and resources. For example, in one barangay with excellent resources, the residents provided the barangay health worker (BHW) with a very fine structure. Supplies and materials were readily available. The local residents were enthusiastic

about the setup and felt that they were in a good position to continue to support it. In another barangay with moderate resources, the residents themselves constructed and equipped a clinic. In still another barangay that was obviously lacking in physical resources, jobs, and adequate housing, the people constructed a small structure, equipped with a minimum of supplies and equipment, in which they took great pride.

The Barangay Health Worker

The presence of the barangay health worker is one of the most important factors in the implementation of the PHC program. The BHW is trained and apprised of his functions before he is drafted to the field. He has a significant number of responsibilities that cover broad categories of health care. The following is a list of some of those functions excerpted from an article in ASAHAN (Special Issue, Vol. 1, No. 4, Davao City, Philippines, January 1982).

A. Maternal and Child Health

1. Case-Finding of Pregnant Women.
2. Case-Finding of High-Risk Mothers:
 - a. Very Young Mothers, Aged 17 and Below;
 - b. Older Women, 35 Years and Over;
 - c. Those with Poor Obstetric History; and
 - d. Those with Abnormal Medical History.

B. Medical Care

1. Case-Finding and Treatment.
2. Giving First Aid to Emergency Cases.

C. Family Planning

1. Motivation and Dispensing of Condoms and Resupply of Pills to Continuing Users.
2. Follow-up of Defaulters.

D. Nutrition

1. Assist RHU Personnel In:
 - a. Operation Timbang;
 - b. Feeding Program of Malnourished Children of Tubercular Patients;
 - c. Deworming; and
 - d. Food Production.

E. Environmental Sanitation

1. Campaign for Proper Sewage and Garbage Disposal.
2. Campaign for Construction of Sanitary Toilet.
3. Assist the Rural Sanitary Inspector in the Collection of Samples.
4. Perform Health Survey in the Community.

F. Health Education

1. Assist in the Organization of Community Assemblies and Mothers' Classes.

G. Control of Communicable Diseases

1. Assist in Immunization Campaign.
2. Case-Finding.
3. Referral of Cases to the Midwife of RHU Personnel.

H. Recording and Reporting

1. Daily Service Record to the RHU.
2. Monthly Report to the RHU.
3. Monthly BTH Meeting.

I. Referrals

1. High-Risk Mothers.
2. Severely Malnourished Children.
3. Emergency and Sick Cases Beyond Their Capabilities.
4. All New Family Planning Acceptors, Except Users of Condoms.

J. Other Duties

1. Assist in Clinical and Field Activities of the Midwife.
2. As Need Arises.
3. Inter-Agency Linkage.

This list is evidence of the extensive responsibilities assigned to the barangay health worker. It is likely that these responsibilities will have to be reduced considerably to enable BHWs to do adequate jobs.

There was considerable discussion at the time this report was written about compensation for BHWs, and it was asked whether BHWs would be salaried or work as volunteers. The Ministry of Health has decided that volunteers will work at the barangay level.

Basin-wide PHC programs do exist in some areas and the barangay health workers are paid. Undoubtedly, given the differences among the 50,000 barangays, careful study will be necessary. Recommended solutions to problems in the barangays will have to have the approval of residents of each barangay.

Current Policies and Programs of the Ministry of Health

The consultant received a report on the Ministry's policies and programs on primary health care, and problems in implementation. Some of this information has been summarized in Exhibit III-A.

Exhibit III-A

SUMMARY OF PHC POLICIES AND PROGRAMS OF THE MOH

A. Policies Supportive of PHC

1. Nationwide expansion of PHC to cover 42,000 barangays by 1984.
2. Reorientation of Five-Year Health Development Plan (1982-1987) to PHC.
3. Integration of preventive and curative services at the implementing level.
4. Delivery of complete health programs, using the PHC approach.
5. Decentralization of vertical programs by 1983.
6. Reprogramming of P50 million from the budget of the regional health offices to support PHC expansion in 1982.
7. Provision of funds for PHC in the national health budget by 1983.
8. Training and IEC support directed toward barangay health development programs in PHC, effective 1982.

B. PHC Programs Currently Under Way

1. Social preparation for various levels of community participation:
 - a. Organization of PHC committees at national, regional, provincial, municipal, and barangay levels;
 - b. Conduct of regular PHC meetings at these levels; and
 - c. Conduct of intra- and intersectorial workshops at these levels.
2. Establishment of intersectorial linkages with:
 - a. KKK* (to develop community-based, income-generating projects);

* The KKK is a national livelihood program of the government.

Exhibit III-A, cont.

- b. Ministry of Education and Culture (to use formal and non-formal education programs to disseminate information on PHC activities);
 - c. Private sector, community-based programs;
 - d. Medical, nursing, and midwifery schools (to develop curricula incorporating PHC; to be achieved in the former in 1981, and in the latter by 1982);
 - e. Different professional organizations (to evaluate their contributions to efforts to deliver primary health care); and
 - f. Media (to update dissemination of information on PHC).
3. Development of support systems for PHC:
- a. Provision of essential drugs;
 - b. Barangay health information system;
 - c. PHC indicators;
 - d. Human resource development program;
 - e. Community research and development of collaborating mechanism for health development; and
 - f. Monitoring and evaluation of PHC activities.
4. Barangay health workers program in the 12 regions.
5. Workshops and use of medicinal herbs in six regions as of March 1982.

C. Problems

1. Intrasectorial:
- a. Maintenance and sustenance of intrasectorial collaboration; and
 - b. Commitment of private health sector to PHC.

Exhibit III-A, cont.

2. Intersectorial:

- a. Redirection of intersectorial plans toward PHC;
- b. Maintenance and sustenance of intersectorial collaboration;
and
- c. Magnitude of coverage of all sectors, including the community,
through information, education, and communication.

3. Administrative:

- a. Constraints on mobility of health personnel, lack of vehicles,
limited travel expenses, and high cost of gasoline;
- b. Support for PHC from GOP funds, limited especially for
provision of essential drugs; and
- c. Need to improve managerial skills in PHC at implementing
level.

4. Other health-related problems:

- a. Issues to resolve the poor socioeconomic condition of masses;
and
- b. Effective way to generate data from the households.

D. Other Needs

1. Strengthen the clinical skills of rural health physicians, because
public health nurses and midwives are trained to provide primary
health care;
2. Improve the epidemiological skills of the staff of the rural
health units (physician, nurse, midwife, and sanitary inspector)
to ensure the effective delivery of primary health care; and
3. Orient hospital staff to PHC and make RHU staff aware of hospital
activities to facilitate the integration of health and medical
services.

Observations and Comments

This consultant cannot emphasize too strongly that it will take much time and effort to introduce and implement the primary health care program. The Ministry of Health has set up a good framework to attain its objectives, and it is moving rapidly with a fine, dedicated, and well-trained staff of health workers. Moreover, residents of the barangays have responded enthusiastically to the concept of primary health care.

From observations and conversations with various individuals during the 40-day assignment, the consultant would conclude that considerable problems must be overcome before an efficient and effective PHC program, satisfactory to the residents of the barangays, can be established. If solutions to current problems are not found, such a system will not function.

As a first step, the Minister of Health must bring together all the resources of the individuals, agencies, and categorical programs and conduct continuous sessions until a decision is made about how to integrate all activities. Different groups' activities must be integrated to avoid overwhelming the residents of the barangays with a multitude of projects, the components of which may be both foreign to the residents' way of life and confusing. The improper use of resources can become a major obstacle to the implementation of the PHC program. It would be to the Ministry's benefit to avoid such an obstacle.

Implementation Teams

It has been recommended that groups of workers be formed to assist in the implementation of the PHC program. Six teams of personnel with special training, skills, and motivation in the implementation of PHC and integrated health services programs should be organized. Each so-called Primary Health Care and Integrated Health Services Team should include one each of the following:

- Provincial Health Officer;
- Chief of Hospital;
- Chief Nurse;
- Public Health Nurse;
- Budget and Fiscal Expert;

- Population and Nutrition Adviser; and
- Sanitary Inspector.

Each group should be assigned for at least two weeks to a provincial health activity, providing motivation and assisting in any and all aspects of the implementation of the PHC and integrated health services programs. The term "in-shop," rather than "workshop," should be used when referring to the teams. The teams will have three specific responsibilities:

1. They will meet with the staffs of the provincial hospitals and other health facilities, and with local people who may have an interest in the PHC program, to explain what they plan to do.
2. They will discuss the policies which the Minister of Health has formulated to guide the implementation of the program.
3. They will inform the people of the progress of the program at the time of their visit; discuss successes, problems that have developed, or which may appear in the future, logistics, and manpower needs; describe the supportive health care infrastructure that will be required to provide and maintain primary, secondary, and tertiary health care; and discuss plans for reorganizing the MOH.

After these meetings, an open forum will be held, at which time anyone may express his or her opinions. This will be followed by a series of scheduled meetings with all persons with special problems. For the remainder of the visits, the teams will help to solve problems, reduce and eliminate operating problems, suggest ways to improve personal relationships, and provide motivation and assistance in developing more efficient and effective operations. They will listen to others' suggestions about ways to improve the program locally, regionally, and nationally. These suggestions may help them to determine how they might best approach the local citizenry and improve relationships with other agencies, both governmental and non-governmental, and individuals interested in the PHC program.

The last two days of each visit will be given over to open forums. The teams' findings will be presented; the suggestions and ideas of the local staff will be discussed; and the visiting staff will discuss their own general suggestions and present their recommendations to improve the PHC and integrated health services programs.

The USAID Proposal

The USAID mission has proposed a project to increase the use of selected primary health care services while simultaneously establishing the long-term viability of the delivery system. The proposal was presented and discussed by the director of the Office of Population, Health, and Nutrition, USAID mission, at one of the four meetings of the 12 regional health directors.

The Minister of Health recommended that the project be reevaluated by a joint group composed of staff from the USAID mission and the Ministry of Health. He believes that the Bicol and PUSH projects provided sufficient information and background, and thus does not feel that further study of the type proposed is warranted. He recommended reviewing the PHC program now under way in the barangays which makes maximum use of volunteers, as opposed to paid barangay health workers. It was pointed out during discussions that the BHWs will be eligible for certain government benefits. This means, theoretically, that all the workers could become government employees when the project is terminated.

IV. GENERAL RECOMMENDATIONS

IV. GENERAL RECOMMENDATIONS

A summary of recommendations based on the principal findings contained in this report is given below.

1. One of the two designs for restructuring the Ministry of Health should replace the one in existence at this time.
2. The three positions for assistant ministers should be established.
3. Immediately upon appointment, the Assistant Minister for Primary Health Care and Barangay Health Attention should begin to implement, to the greatest extent possible, the primary health care and barangay health attention programs.
4. As the first step, the assistant ministers should assign to the directors of staff the responsibility of bringing together as many as possible of the resources identified in "Resources for Primary Health Care Delivery," part of a draft report on an assessment of the Philippine health sector prepared by the International Bank for Reconstruction and Development (IBRD), the Asian Development Bank (ADB), and the USAID.
5. As a corollary to the establishment of the positions of Assistant Minister and Director of Staff, the staff of the regional health offices should be reduced. Only the positions of the Director and the Deputy Director for Primary Health Care and Barangay Health Attention, two secretaries, a clerk-stenographer, a clerk, and a driver should be retained.
6. All technical staff should be assigned to the most active and well-run provincial health departments, where their services can be constantly used, pending completion of temporary duty (TDY) in other provinces, and at the discretion of the regional director.
7. All personnel in management, administration, and similar areas also should be transferred to the provincial health office, and the budget should be adjusted accordingly. This change will free the area directors to function in a purely staff capacity (i.e., their responsibilities will include, at the least, consultative, advisory, counseling, and similar functions) and to direct all their efforts and energy to the implementation of all primary health care programs and the integration of health services in the provinces, municipalities, rural health units, and barangays.

The functions and responsibilities of the other two assistant ministers are delineated in the first design. These persons' efficiency and operating effectiveness will depend on their full use of the directors of staff and their assistants.

In the alternative design, as well as in the regional design, the Assistant Minister for Health Education and Special Health Support Services should make full use of those persons who have special education, skills, and training.

8. Categorical programs in population and nutrition should be integrated into the primary health care program. This step should be taken in the interest of the Philippine people and to realize a considerable savings in funds.
9. An administrative device should be established in the MOH so that international, bilateral, and individual organizations and government and non-government agencies can be invited to form a consortium, the objective of which would be to solve, by orderly, effective means, the problems given priority by the ROP. In this way, a piecemeal and fragmented approach to health problems could be avoided. Such a consortium would have the potential to contribute significant assistance, both in-kind support and dollars, and provide to the MOH an unparalleled opportunity to assess the effectiveness and productivity of the "all-for-one-and-one-for-all" approach to better health services for the people.
10. Current efforts to attain complete integration of health services should be continued.
11. The structure of the MOH, including all the legislation, orders, administrative directives, and other devices to keep the entire organization flexible and pointed toward the goal of optimal health for the people should be kept under continuing review. The continuing efforts to provide integrated health services to the barangays should be expanded and intensified.
12. The current logistics system should be studied by an expert committee or the Director of Staff, and a time sequence should be followed.
13. Some change should be made in the curricula of the medical schools, the schools of nursing, and other training institutions. For example, courses in preventive and promotive medicine that are basic to the attainment of good health might be added, and it could be stressed that curative and rehabilitative care is the result of inadequate attention to preventive and promotive services.

V. PROPOSED TOPICS FOR CONSIDERATION BY MOH

V. PROPOSED TOPICS FOR CONSIDERATION BY MOH

Selection of Assistant Ministers

To aid the Minister of Health in selecting the assistant ministers, a process must be developed so that qualified personnel will rise through the ranks and thus become eligible for higher positions.

One approach would be to place promising personnel in the office of each Director of Staff, allowing them to work with the directors for a specified period of time as assistant ministers of health. Their work during each assignment would be carefully observed, and their qualities, abilities, and experience would be measured against the requirements of the job. When a vacancy occurs, those persons who have been judged to be qualified for the position of Assistant Minister of Health can be examined, and an appropriate selection can be made.

In reviewing the graphic structure of the Ministry of Health and the positions of the three assistant ministers, it is obvious that it will be difficult to find candidates with the full complement of necessary skills. Therefore, other techniques and devices must be developed and used to make the MOH as efficient and effective an operation as possible.

Consortium of Research Activities

A considerable number of individual and group efforts in research are under way, but many of them are not being coordinated with the activities of others who are doing research in the same field.

The Minister of Health should take the lead to bring together the NSDB, the Nutrition and Population Council, the international agencies, the private agencies, individuals, foundations, and other organizations working in the Philippines to discuss the entire field of basic and applied research.

The Minister of Health, with the aid of the directors of staff, could identify all the areas of health-related research now under way, noting those areas in which the Ministry of Health has a specific interest. Priorities could be assigned to the most important research efforts, and the entire study could be brought to the attention of the Consortium of Research Activities.

Consortium Research Groups

It has been suggested that a consortium of all persons engaged in basic and applied health research be formed, at the request of the Minister of Health.

The objective of this group would be to conduct research that would directly benefit the Philippine people. If research is controlled or supervised, duplication, replication, disorganization, and the unnecessary expenditure of funds can be avoided. Also, by establishing a consortium, the government might be better able to secure the cooperation of unilateral, multilateral, and private groups conducting research in similar health-related fields.

Ad Hoc Health Management Groups

The ad hoc health management groups should report directly to the Minister of Health. They should be formed to:

- Streamline the Ministry of Health.
- Develop long- and short-term strategies for health management to provide primary health care services to the people as effectively and efficiently as possible.
- Develop an effective logistics system with built-in safeguards to protect against aberrations.
- Develop an effective system for the purchase, distribution, and use of equipment, supplies, and materials.
- Develop a well-considered plan for the acquisition of resources, both human and material, and the proper allocation and use of those resources.
- Review continuously all issues, legislation, orders, annual programs, budgets, and major management processes, establishing the methods, means, and deadlines for making changes, adjustments, modifications, and abrogations and for fine-tuning management practices and policies.
- Form ad hoc subgroups, with deadlines, to resolve existing management problems and to adopt new management methods as need arises.
- Provide for the exchange of information and communication at all levels, including the barangays.

- Examine all resources, both human and material, to determine whether input bears any significant relation to output.
- Develop methods and techniques to examine resource use and to resolve problems.
- Establish approaches to make the MOH an efficient and effective health service where manpower is essential to provide immediate services to the people. (In other words, funds normally targeted for supplies, materials, drugs, food, equipment, etc., will not be used to pay the salaries of certain health service providers.)
- Develop a strategy to assist the barangay members in solving problems they have identified and in achieving goals they have set.
- Develop zero-based budgets based on continuous review of resources.
- Design approaches to prevent rigidity and unresponsiveness in the MOH structure by continuing to review, adjust, and modify when necessary.
- Develop a system for contracting health services to ensure a holistic approach to health.
- Develop a system for contracting health services to improve the entire complement of health services delivered through the MOH.

Ad hoc groups of specialists and experts should be tightly-knit implementing teams, each with its own specific purpose(s), guidelines, and reasonable deadlines. Maximum effort should be made to accomplish the assigned objectives and to complete the work on time.

Individual groups and institutions also could be contracted to design plans and programs with specific objectives and deadlines. Work would be completed according to the terms of each contract.

Whichever method is chosen, continuous control and supervision will be necessary to ensure that time and funds are not wasted and to prevent "over-runs" in any area.

Continuous review of all activities in both basic and applied research will be necessary to avoid duplication, replication, and waste of skills and funds. All operations, functions, personnel matters, etc., should be scrutinized constantly.

The barangay is the functional unit toward which all efforts of the MOH should be directed. To ensure that the best knowledge is available, the positions of Minister and Assistant Minister must be filled with highly qualified and capable people.

The three assistant ministers occupy what are generally classed as staff positions and are responsible for keeping the MOH operating at an optimal level in the interests of Filipinos throughout the Republic. They must continuously review and study the entire system to keep all the various units, divisions, and departments operational and to identify those which no longer offer a valuable service or which produce little or no output, compared to the input of personnel, funds, supplies, materials, and energy. To aid them in their work, the assistant ministers each need a director of staff with sufficient support staff to carry out the duties and responsibilities assigned by the Minister of Health.

Under the proposed new plan, the Director of Staff will be responsible for bringing together experts from the government and the private sector to work in teams to solve designated problems. These teams of experts will be governed by specific guidelines, deadlines, etc., established by the Director of Staff. All the teams will be ad hoc, and after a study has been completed, each team will be disbanded.

With this approach to government operations, rigidity, static operations, heavy-handed bureaucracy, and the waste of funds, personnel, and energy can be avoided and output can be balanced properly with input. Current innovations in health that will benefit the people can be applied. Furthermore, operations can be streamlined so that objectives can be achieved with a minimum of personnel, funds, and energy.

Computer System

The government should weigh the benefits of installing a computer. Information and data of all kinds is needed for the management and budgetary, financial, legal, and other operations of the Ministry of Health. Without such information, it is difficult to provide optimal health services. A computer which could store all information on health personnel, including their positions, entitlements, salaries, allowable vacation and sick leave, length of service, educational training, episodes, and other biodata, could facilitate the Ministry's operations.

It would be possible, with proper legislation, to arrange for salaries to be paid locally, based on printouts from the computer; or, as an alternative, checks could be delivered or sent directly to the banks of each person's choice. This method would minimize the likelihood of pilferage or loss by other means.

A computer has many uses. But what is input must be accurate, so that output is correct.

If a computer is used, all requirements of a contract must be met on time. The contract might require that a standby computer be available in the event the main computer breaks down.

Placement of Area Supervisory and Technical Personnel
in the Staff of the Provincial Integrated
Primary Health Services Program

The Minister of Health could assign area supervisory and technical health personnel, including the staff's positions and operating funds, to the Provincial Integrated Primary Health Services Program, where the need is greatest. The Area Director would be authorized to request tentative details about such personnel elsewhere, when necessary, and when demonstrated to be to the advantage of the Ministry of Health.

Such action would have, at the least, the following advantages:

1. The supervisory and technical personnel would be immediately involved, on a continuing basis, in the operation of a provincial integrated primary health services program.
2. The staff's personal expertise would be available to the program daily, thus facilitating the operation of the integrated primary health process.
3. The personnel will have daily knowledge of the expectations and desires of the people in the barangays with respect to the health services they receive.
4. The experience and knowledge obtained in this way would be useful to other areas and to the other barangays.
5. The strength and weaknesses of the operation of health activities will be better understood and can be evaluated for study and use by the Area Director and health personnel elsewhere.
6. Funds allotted for travel can be used more effectively.
7. The Provincial Integrated Primary Health Services Program will be a continuing field laboratory for study and examination leading to more efficient and effective operations to meet the desires and expectations of residents of the barangays.

Public Awareness of MOH Activities

The successful integration of all MOH activities depends on public awareness of Ministry programs, plans for future projects, costs, and strategies for execution. The government should fully inform the citizens of the Philippines of its efforts to deliver primary health care services;

it should be aware of the population's expectations, and explain how it intends to meet those expectations; it should know what priorities the people have established, on their own or with others' help, and attempt to help the people to set attainable goals. Public participation in public programs is crucial. The Ministry of Health should seek to involve all people, agencies, health societies, medical organizations, and educational institutions in its efforts to make the public aware of the meaning and value of optimal health and how such a state may be attained, and at what cost.

Budget Planning, Formulation, Processing, Apportionment, and Execution

The budgeting process will begin in the barangay, progress through the rural health unit, the MHO, the CHO, and the PHO, advance to the offices of the Area Director and the assistant ministers, and then reach the office of the Assistant Minister for Management, Budget, Finance, and Legal Services. The latter will study the data and prepare a tentative budget for review by the Minister of Health.

The necessary consultation will take place and any required adjustments will be made.

Each governmental unit will send its requests directly to the control budget formulator, who will use the computer to process and audit the budget requests.

Each governmental unit should be requested to submit three budget requests: a request for minimal resources that would enable the unit to maintain nothing more than a subsistence level; a median-level budget which would improve the unit's ability (by approximately 20 percent) to provide services to its constituents; and an optimal budget which would enable the unit to operate under ideal conditions and thus provide excellent health services to the people.

Once the budget has passed through the various levels and has become law, MOH funds should be apportioned first to the lowest level, then to the next highest level, and so on, step by step, until the highest level--the Minister of Health--is reached. In this way, the necessary economies are made at the higher levels, thus ensuring that sufficient funds are available for services for the people at the lowest levels.

Recommended Reporting Service

In the new system, reports will be made only twice each year, and the data will be formatted for computer processing. Appropriate printouts will be provided to each reporting agent and to the MOH.

Suggested Timing for Reports

The reports will be both timed and related to the budget and fiscal and management year. One report at six months and one report at eleven months, projected to 12 months and correctable in the next budget year, should be prepared.

Operating reports will be sent directly to the Assistant Minister for Management, Budget, Financial, and Legal Services.

Schistosomiasis Programs

A new hospital, the Schistosomiasis Hospital, has been built in Ormoc, Leyte. Better use might be made of this hospital if the schistosomiasis control program were moved from Manila to Ormoc. Headquarters could be set up in the midst of this area where schistosomiasis is endemic.

International figures interested in schistosomiasis research could be invited to come to Ormoc and work with their Filipino counterparts. The Philippine consortium could establish the conditions for the research, and approximately \$2 million a year could be allocated for studies. It is likely that under these conditions the research would yield especially valuable data.

The staff in Ormoc also could participate more readily in the activities of the Health Education and Training Center. They would be able to help retrain all the health personnel in the integrated program, as well as people from the barangays who have expressed an interest in the government's efforts.

Hospitals

The term "hospital" needs to be redefined. All existing information and data need to be reviewed to determine what constituted a "hospital" as of February 1982. Criteria need to be developed before any building can be constructed and designated a "hospital." Four steps should be taken in undertaking this process. They are:

1. Determine need.
2. Determine the willingness of the community to support a hospital.
3. Hold open meetings with members of the community to explain the purpose, the function and the benefits of the hospital, constraints, and how the community can use and help to operate the facility.

4. Explain staffing needs, requirements for supplies, materials, and equipment, preventive maintenance and replacement costs of equipment, warehousing and transportation costs, and the responsibility for security.

An expert committee on hospital equipment should be formed to determine what the hospital will need to operate effectively and efficiently. The committee should ask the following questions:

1. What equipment is needed?
2. What are the types and specifications of the equipment?
3. How many pieces of each kind of equipment are needed?
4. What should the quality be?
5. How can the equipment be purchased?
6. Is equipment in place and working well at this time?
7. How much preventive maintenance will be necessary? Is preventive maintenance being done?
8. What special equipment is needed? Consider, for example, a body scanner.
 - a. What type of hospital needs this kind of equipment?
 - b. How is the equipment distributed?
 - c. If owned by a private hospital or clinic with ultra-expensive equipment, can the equipment be used under contract or for a service fee?

When is a hospital a hospital? The Webster and College dictionaries define "hospital" as an institution for the care of the sick and the injured. However, no mention is made of the acceptability or quality of the care. For the general public, a building with a sign on the exterior that denotes "hospital" is generally sufficient. But is an institution with one bed and a doctor a hospital? And does it belong in the same category as a 100-bed facility with 50 doctors?

Given current knowledge and data, the availability of sophisticated equipment, and the presence of adequately trained and experienced health personnel, it is possible to provide good care to the sick and the injured. Few might object if one were to define a "hospital" as an institution with at least two internists, a surgeon, a surgical nurse, an anesthesiologist, obstetrical and gynecological specialists, a pediatrician,

several highly trained nurses, and a good laboratory technician. The presence of other trained health personnel would be considered a plus.

In what way does size define a hospital? Is it appropriate to say that a "hospital" must have 50 beds, operate at near capacity regularly, and have at least five well-trained doctors? How should one define a facility with fewer than 50 beds? As an "emergency health station"? And should such a facility limit its treatment to emergency cases until they can be transferred to an adequately staffed and equipped hospital?

Of particular interest to the non-medical public is the criterion that a facility must be capable of providing acceptable, quality service before it can be licensed and called a "hospital." The Ministry of Health must include in its legal definition of the term "hospital" this proviso: that the facility be able to provide acceptable and quality service and offer full protection to the public. Those health facilities that do not fall within the constrictions of the licensure process must be identified.

It may be time for the MOH to make a series of contractual arrangements with medical centers in the Philippines (e.g., Makati Medical Center) and with small public and private hospitals--the so-called "satellite" hospitals--that can provide full medical, surgical, and other health services under a reciprocal agreement for staff.

In the interest of public safety, a hospital with limited staff and inadequate equipment and laboratory facilities should not be considered acceptable.

Hospitals and Optimal Health

Optimal health is a goal beyond the reach of some people in populated areas because the emphasis is on the construction of buildings that are hospitals in name only. Many so-called "hospitals" lack adequately trained and sufficient staff, supplies, materials, and operating funds. More often than not, little or no water is available; frequently, energy is not available to operate sophisticated equipment or plants. Basic health problems are ignored or neglected because the facility is operating with a minimum of funds, energy, time, and personal services. Programs in nutrition, disease control, disease prevention, genetic counseling--all suffer. The problems of population, tobacco smoking, use of drugs and chemicals of all types, and inadequate sanitation and waste disposal are neglected. The value of human wastes as a fertilizer is not recognized. The need for a national continuing health education program that gives consideration to people's culture and priorities is seldom met.

The emphasis on the construction of hospitals and highly sophisticated institutions must be shifted so that attention can be given to the elimination of basic health problems. Preventive health care must be

emphasized over curative care. Because of neglect of basic health problems, hospitals continue to fill to capacity--to the tremendous detriment of the goal to achieve optimal health for all. Numerous health problems have been solved outside hospitals, including poliomyelitis, smallpox, diphtheria, tetanus, pertussis, many tropical diseases, malaria, and tuberculosis of the bones and joints.

Hospitals serve limited numbers of the total population at tremendous cost, and they are a hazard to the good life of most of the people using them.

Medical education should be rethought. It should emphasize the value of helping people to achieve good health, without which they cannot lead productive lives. Exotic care, health education, and prevention of health aberrations should not be stressed over preventive care.

Basic research in genetics, genetic counseling, and an understanding of the fundamental functions of the body are needed and should be made a part of all medical training programs.

Public health need not be separate from holistic medical education; rather, it should be fully integrated into medical training.

No more than 30 percent of the general population should need hospital attention during their lifetimes. Of that 30 percent, perhaps 10 percent could be screened at clinics or by medical practitioners. Health care at a hospital is costly by any standard. As much as or more than 100 percent of a person's income and assets may go for hospital care, depending on the person's place of residence and the severity of the illness. This economic burden has serious consequences for the quality of life.

A logical question might be: Why do hospitals maintain so important a place in health care, both in economically developed countries and countries with few resources? Have we all been conditioned to equate hospitals with optimal health, as necessary to the prevention of disease or holistic good health? Some may regard hospitals as blocking devices, preventing the elimination of disease and the attainment of good health. Major gains in health and disease prevention have occurred not in hospitals, but by accident, as the result of basic and applied research, or through the application of ancient medical folklore. The following assumptions may be valid and need to be considered:

1. That hospitals block the achievement of optimal health, beginning with individuals and groups, ultimately affecting the health status of entire nations.
2. That the cost to operate hospitals and hospital systems is prohibitive, making it impossible for the individual, the group, or the nation to conduct life-sustaining activities that result in improved quality of life.

3. That this situation need not be maintained. By focusing on health education, nutrition, disease prevention, genetic counseling, potable water, sanitation, recreation, exercise, population pressures, etc., and by providing funds to support these activities, the current system can be changed.
4. That, fundamentally, full employment and adequate sharing and proper use of natural resources are essential to effecting change.

The current system cannot be uprooted overnight, but a start can be made in organized health departments, in medical schools and health-related schools, health organizations, organized medicine, etc.

Hospitals will not become redundant,* but they should not be an object of adulation or thought to represent a means to achieving optimal health. It is better to think of hospitals as institutions where pain and suffering can be relieved and life prolonged.

It is important to recognize, as a first step, the need to study objectively health departments and hospitals and to be prepared to institute wide-ranging reforms to bring these facilities up-to-date, to make them aware of the most recent knowledge of what constitutes optimal health.

Diagrams of the various organizational entities of a ministry of health are attached to this report. They reflect the recommendations of this consultant to reorganize the structure of the Ministry of Health of the Philippines. The correlates can be filled in without impinging on the structural design.

The weaknesses of existing structured health systems cannot be eliminated immediately without injury to the systems themselves, and continuous pressure on the structure is needed to change indoctrinated, entrenched patterns of thought and living. The "pop-the-pill" habit must be eliminated, as must the belief that hospitalization is a cure-all and the means to optimal health.

* Sanitariums, so-called "open-air resorts," set up to treat tuberculosis are a case in point. "Pest houses" have disappeared with the eradication of smallpox; leprosariums are on the way out; dermatological clinics are in. Hospitalization resulting from complications from whooping cough, diphtheria, tetanus, polio, and other communicable diseases is on the wane. In many countries, malaria has been eradicated. Typhoid, once a scourge, is rarely seen today. Hospital wards used to be filled with polio victims.

VI. EPILOGUE

VI. EPILOGUE

The Ministry of Health has a scheme for integrated primary health care that should have world-wide repercussions. It will be implemented nationwide to cover more than 49 million individuals. It will constitute a marked change in attitudes toward the provision of health services and an understanding of who must accept responsibility for implementation and continuity, and the provision of human and physical resources and funds to support the health structure.

This consultant suggests that the American Public Health Association invite the Minister of Health to present his program at its next annual meeting. By then, the scheme should be well on its way and many of its characteristics should be well-known. The APHA's invitation should be covered by funding, because the presentation will be most useful to the APHA and other organizations engaged in large-scale health schemes.

APPENDICES

Appendix A

LIST OF PERSONS CONTACTED

Appendix A
LIST OF PERSONS CONTACTED

Ministry of Health

Dr. Jesus Azurin, Minister of Health
Dr. Antonio Acosta, Deputy Minister
Members of the Central Staff
Dr. Manuela Unite, Regional Director, Region I
Dr. Manuel Najera, Regional Director, Region II
Dr. Napoleon Noveno, Regional Director, Region III
Dr. Jose Ibanez, Regional Director, Region IV
Dr. Cristituto Daguinsin, Regional Director, Region V
Dr. Luis Montero, Regional Director, Region VI
Dr. Fernando Avelino, Regional Director, Region VII
Dr. Manuel Roxas, Regional Director, Region VIII
Dr. Hilarion Ramiro, Regional Director, Region IX
Dr. Jose Salcedo Quimpo, Regional Director, Region X
Dr. Edilberto G. Fernando, Regional Director, Region XI
Dr. Serapio Montaner, Regional Director, Region XII

USAID

Mr. Anthony M. Schwarzwald, Director
Dr. Steven W. Sinding, Chief, Office of Population, Health, and
Nutrition (O/PHN)
Dr. John J. Dumm, Deputy Chief, O/PHN

Mr. Gary W. Cook, Health Development Officer, O/PHN
Mr. William R. Goldman, Public Health Adviser, O/PHN
Ms. Charlotte C. Cromer, Population Adviser, O/PHN
Dr. Rosendo R. Capul, Public Health Adviser, O/PHN
Dr. Angelica V. Infantado, Medical Consultant, O/PHN
Ms. Zynia L. Rionda, Project Officer, O/PHN

Others

Dr. Jose Caedo, Administrator, Waterous Clinic
Dr. B. Angtuaco, Member, Board of Medical Examiners;
Former Dean, Medical Schools of UST and MCU
Dr. Andres Angara, Former Administrator, WHO Western Pacific
Regional Office
Dr. Floria D. Velasquez, Former Dean, MCU Medical School

Note: Some members of the evaluation team of the World Bank and many other retired health officials who are too numerous to mention, in addition to private citizens, were interviewed during the assignment.

Appendix B

RESOURCES FOR PRIMARY HEALTH CARE DELIVERY

Appendix B

RESOURCES FOR PRIMARY HEALTH CARE DELIVERY*

The Government currently supports three national primary health care (PHC) programs. Two are categorical: Population Outreach, based on a network of outreach workers and barangay volunteers; and the outreach component of the Philippine Nutrition Program (PNP), based on Barangay Nutrition Scholars (BNS). One is integrated, the Ministry of Health's Restructured Rural Health Care Delivery System (RRHCDS). A brief description of these and other PHC-related public and private delivery systems follows.

In an effort to expand its services, the Ministry of Health in 1975 initiated the RRHCDS which provides for the delivery of a package of health services, including medicare, maternal and child health (MCH), family planning (FP), immunization, nutrition, and environmental health-promotion measures. The town-based Rural Health Unit (RHU), of which there are approximately 1,600, is the basic unit of RRHCDS. The service delivery system is extended to sub-municipal clusters of barangays through retrained midwives fielded in barangay health stations (BHS) at a rate of one for every 5,000 population. The BHS midwives are supported by clinic-based nurses and sanitary engineers who, in turn, refer cases beyond their capacity to the physicians in the RHU. Further care is provided through a system of referrals to district, provincial, regional, and central hospitals.

The Ministry of Health now feels that the expanded coverage under RRHCDS is not sufficient to meet the health needs of the people. Last year, the MOH reexamined its structures, resources, and strategies and adopted the goal of "Health for All Filipinos by the Year 2000." To accomplish this goal, plans were drawn up to improve the quality and quantity of health care, especially to the underserved, at a price affordable by the community and the government through innovation and experimentation involving communities, government, and private organizations. The strategy which will be implemented in three phases over the next 20 years will consist of three main elements: (1) the engagement of selected communities in developing and implementing community PHC activities; (2) strengthening and improvement of the MOH support structure and resources; and (3) the inclusion of the private and other government sectors in activities which support and strengthen community health services. By 1985, at the end of the first phase, the MOH plans that 19% of all barangays will have access to on-going, self-sustaining PHC services.

* This is an excerpt from a draft report, prepared by the IBRD, the ADB, and the USAID, on an assessment of the Philippine health sector.

The Commission on Population established the Population Outreach project in 1976 to provide family planning information and services to rural residents not being reached by the clinic systems. The fundamental concept of outreach is to provide single-purpose, full-time outreach workers (FTOWs) (one for approximately 1,000 eligible couples) throughout the country. Supervised by a network of regional, provincial, city, and district population officers, each FTOW is to recruit, train, and support roughly 15 volunteer barangay service point officers (BSPOs). The BSPO supplies oral contraceptives and condoms to contraceptive users, provides information, motivates, refers new acceptors to clinics, and maintains records. Over the next five years POPCOM (Population Commission), with USAID and IBRD support and under local government auspices, plans to maintain an outreach staff of 3,600 paid personnel, of whom 3,000 are FTOWs, and a minimum of 45,000 BSPO volunteers. POPCOM is now beginning to plan for the period after 1985 when AID support for recurrent costs will end and new sources will have to be tapped or a restructured program approach will be required.

The Philippine Nutrition Program (PNP) established the Barangay Nutrition Scholars (BNS) program in 1978 to deliver basic nutrition, health, and family planning services in the barangay through the use of these village-level outreach workers. The BNS has four basic tasks: (1) planning and organization; (2) identifying and locating target groups; (3) providing information and basic services (nutrition, health and family planning, environmental sanitation, food production, reading instruction, physical fitness, and culture); and (4) reporting and monitoring. The BNS, who currently number more than 10,000, are supported by an infrastructure consisting of more than 300 full-time district and city coordinators and hundreds of part-time provincial, municipal, and city-level action officers. Currently, the PNP plans to expand the BNS program to include 16,500 BNS and 500 full-time district and city coordinators over the next five years.

In addition to the national delivery systems of MOH, POPCOM, and PNP, other government ministries maintain support for national infrastructure delivery programs that provide services that include, as part of a package, some PHC components. These programs include those of the Bureau of Agricultural Extension, the Ministry of Social Services and Development, the Ministry of Local Government and Community Development, the Ministry of Human Settlements, the Ministry of Labor, the Ministry of Public Works, the Rural Waterworks Development Corporation, and Medicare.

The existing networks of private, non-profit clinics and hospitals and commercial clinics, hospitals, and pharmacies are additional resources contributing to the delivery of PHC services. There are over 1,500 private facilities providing a variety of health care services, many with village PHC service delivery components (e.g., Institute of Maternal and Child Health, Silliman University, and Capiz Emmanuel Hospital). The commercial network is even larger, consisting of 8,000 clinics and hospitals and over 7,000 pharmacies.

Appendix C
MALNUTRITION IN THE PHILIPPINES

Appendix C

MALNUTRITION IN THE PHILIPPINES*

Health

The Philippines today is beset by serious undernutrition, especially protein calorie malnutrition (PCM) and deficiencies in Vitamin A (xerophthalmia), iron (anemia), and iodine (goiter). PCM is the most widespread, and infants and young children are the most seriously affected by it. Official reports indicate that more than one-third (almost 9 million) of pre-schoolers are either moderately or severely malnourished. Three out of every four children are anemic, and about the same number [are] deficient in Vitamin A. For many of these children, the damage to their physical and mental development would already be difficult to reverse. Thus, [the] government is now targeting its nutrition program on PCM among pre-schoolers to reduce its prevalence rate from 30.6% to only 5% by the year 2000.

Adults too have not been spared from PCM, which results in general physical debility and low resistance to infection. Particularly affected are pregnant and lactating mothers and hard-working laborers. Compared to some Latin American, African, and Asian countries, the Philippines has one of the highest prevalence [rates] of third- and second-degree malnutrition.

A 1975 U.P. School of Economics socio-economic survey (GINA) showed a total of 295 cases of felt illness per thousand persons per month, or almost two cases per household. Of these cases, 67.8% were regarded as acute, 26.9% chronic, and the rest, disabilities and accidents. The average number of sick days per case per month was 11.2 days, and of work/school days lost due to illness, 2.8. This means that during the year, an average person would, apart from failing ill for 40 days, also lose 10 work/school days due to illness. ...

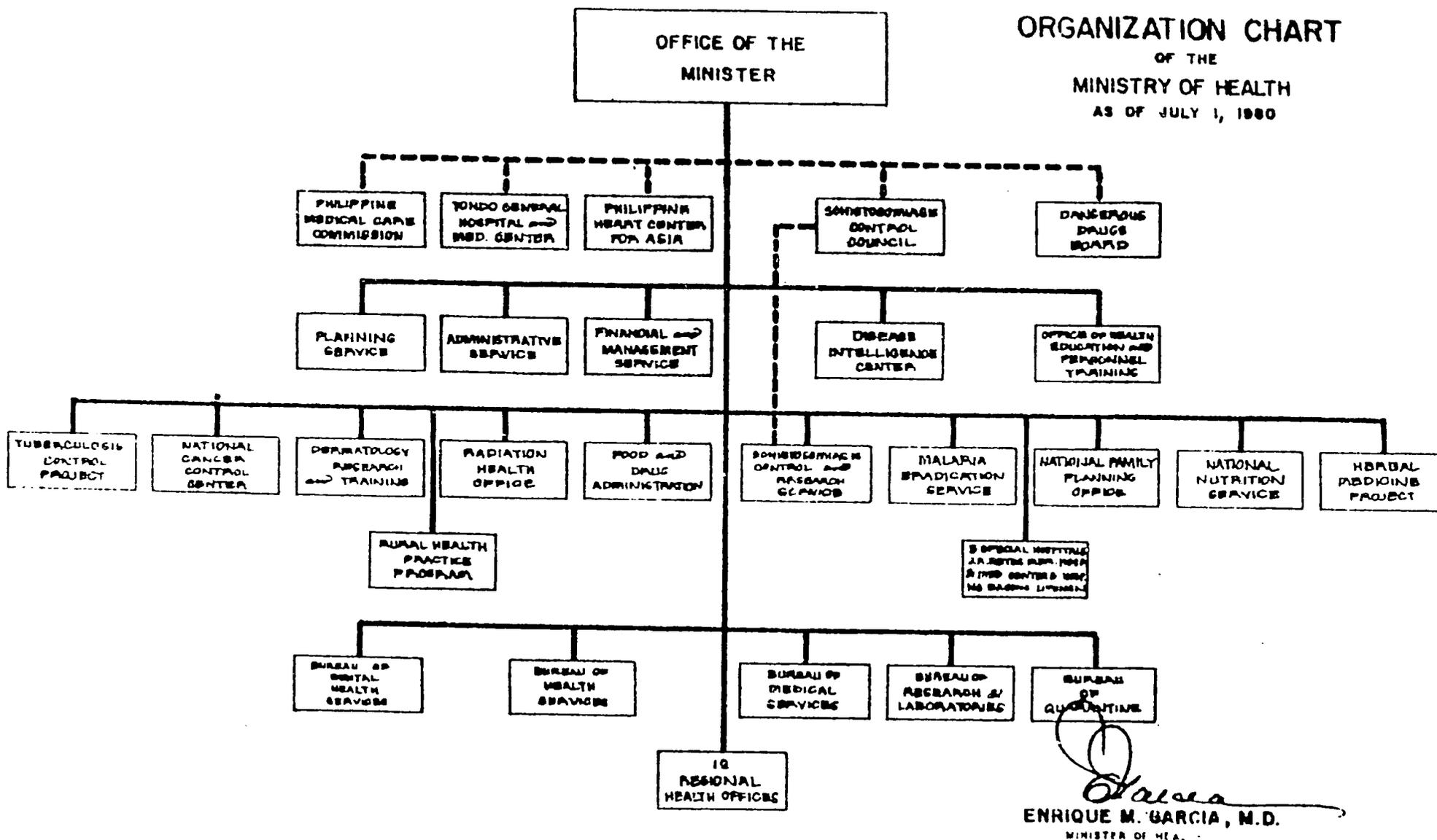
* This excerpt is taken from a report on malnutrition, published in Philippine Scenarios, 2000 A.D., prepared by the PREPF, the DAP, and the UPPI. Readers should refer to Report No. O 301.32, P516, 1979, page C-4.

Appendix D

SUGGESTED ORGANIZATIONAL STRUCTURES
FOR DIFFERENT LEVELS OF HEALTH DEPARTMENTS
(Exhibits 1-13)

Exhibit 1

ORGANIZATION CHART
OF THE
MINISTRY OF HEALTH
AS OF JULY 1, 1980

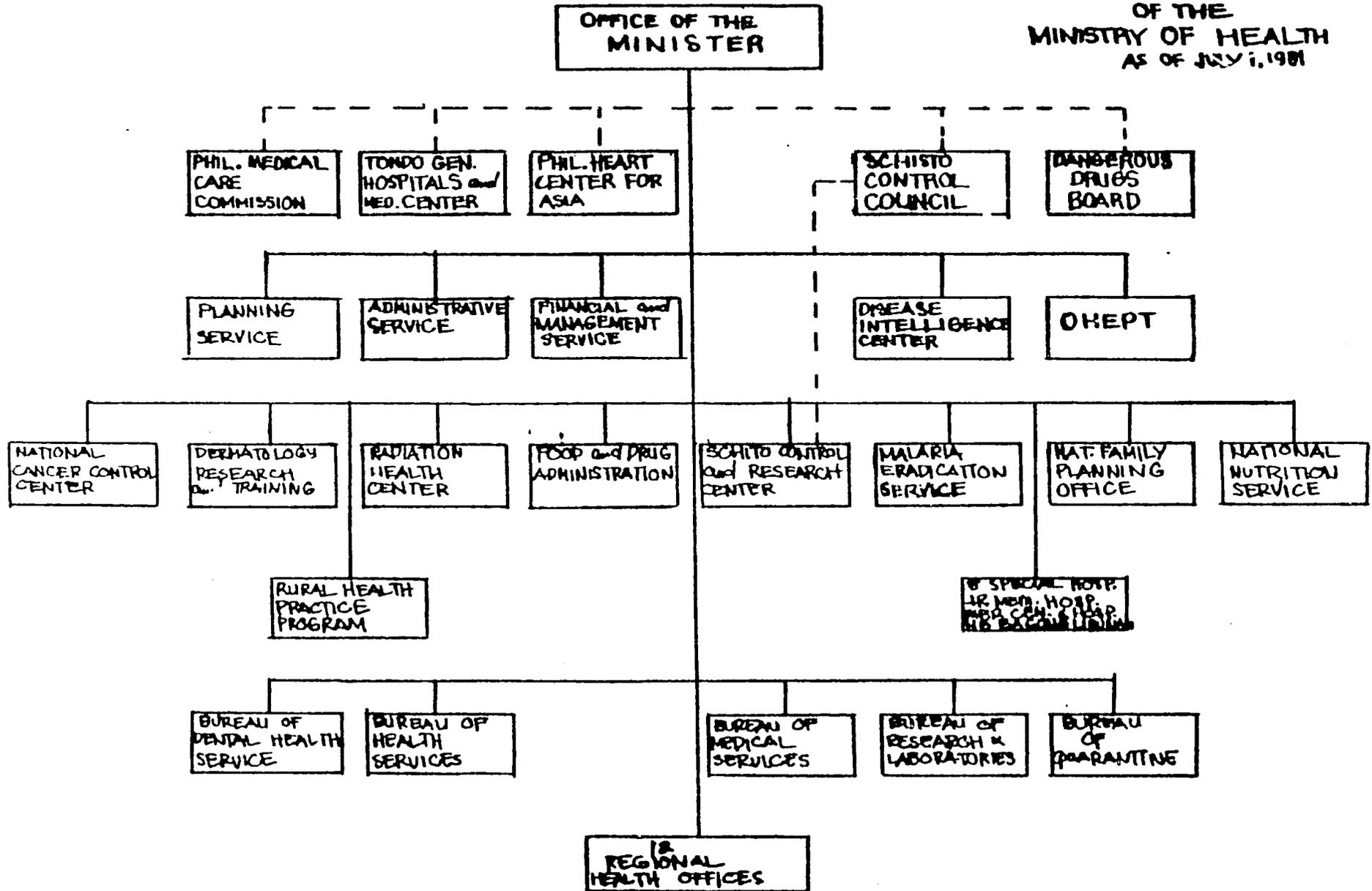


Enrique M. Garcia
ENRIQUE M. GARCIA, M.D.
MINISTER OF HEALTH

Note: This organization was approved by the Minister of Health in July 1981.

Exhibit 2

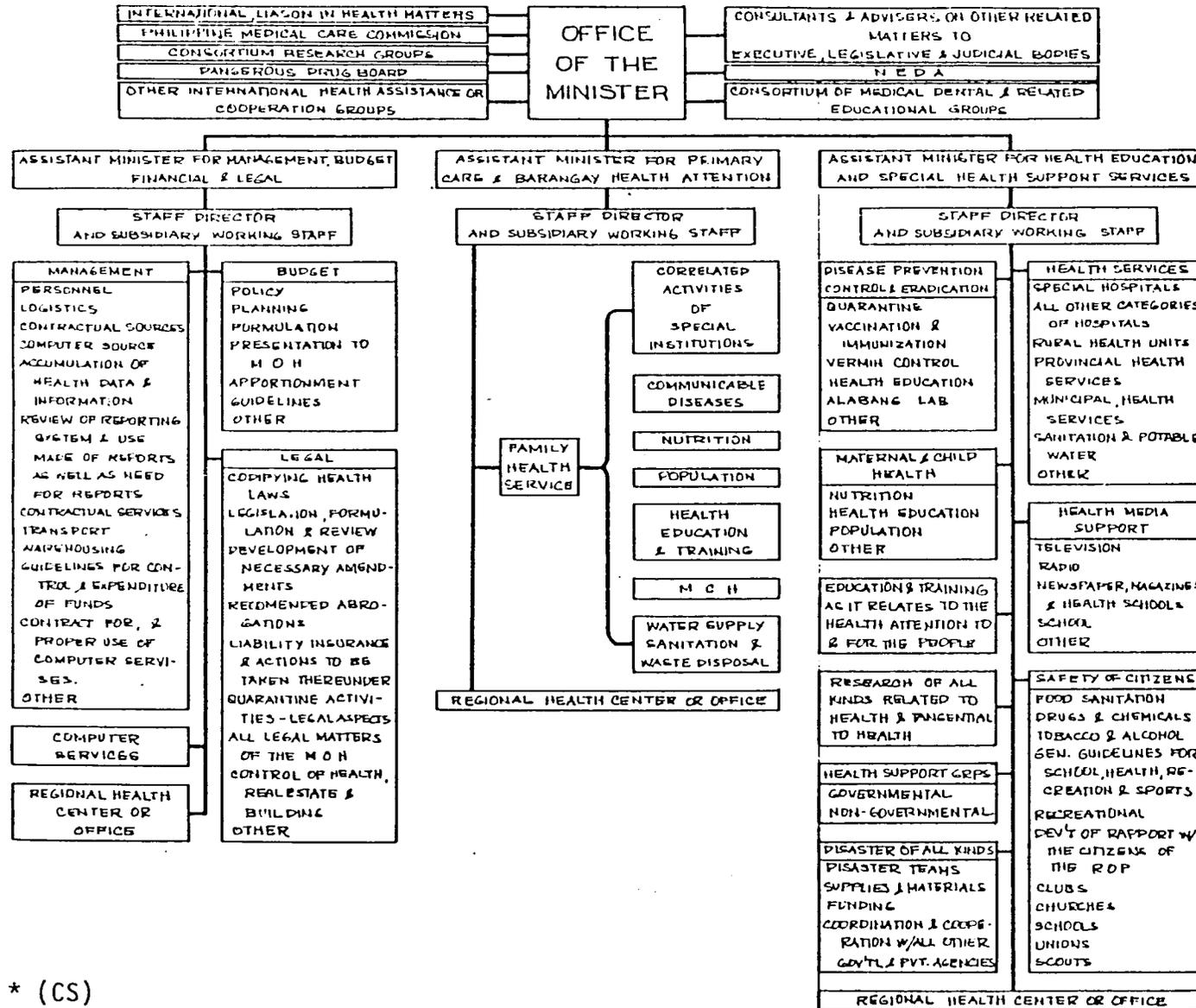
ORGANIZATION CHART
OF THE
MINISTRY OF HEALTH
AS OF JULY 1, 1981



D-2

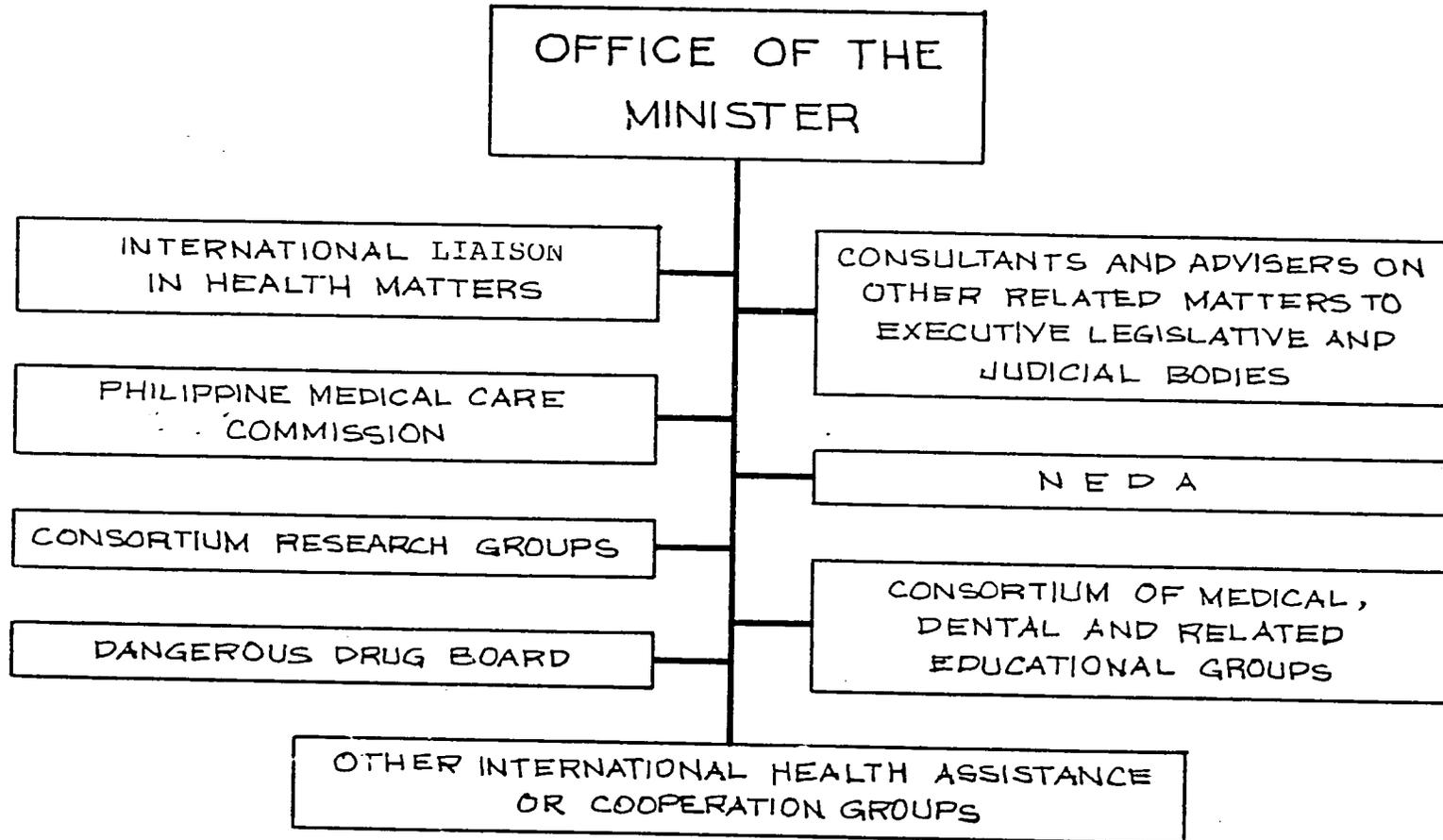
Note: This organization was approved by the

Exhibit 3*



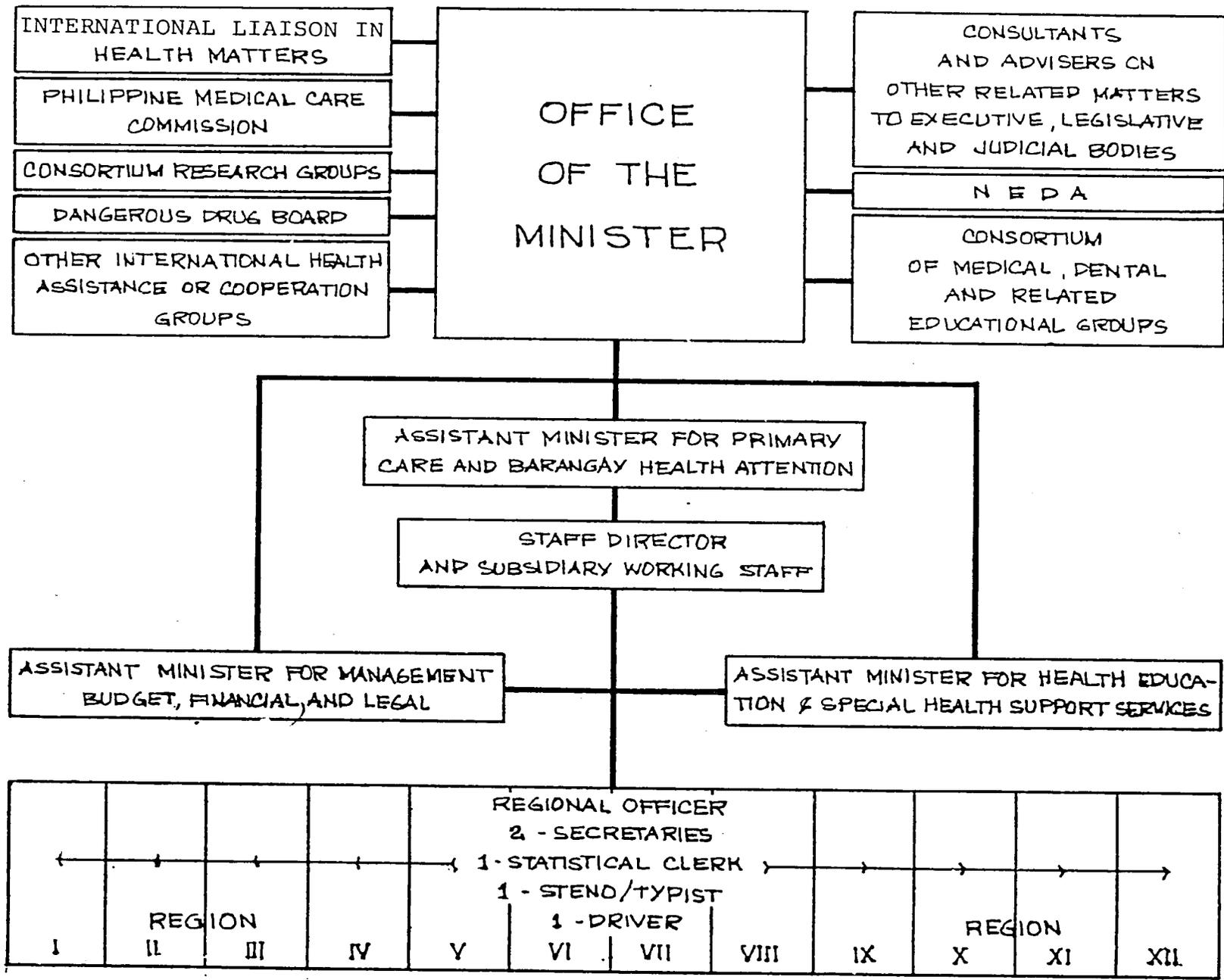
* (CS)

Exhibit 4*



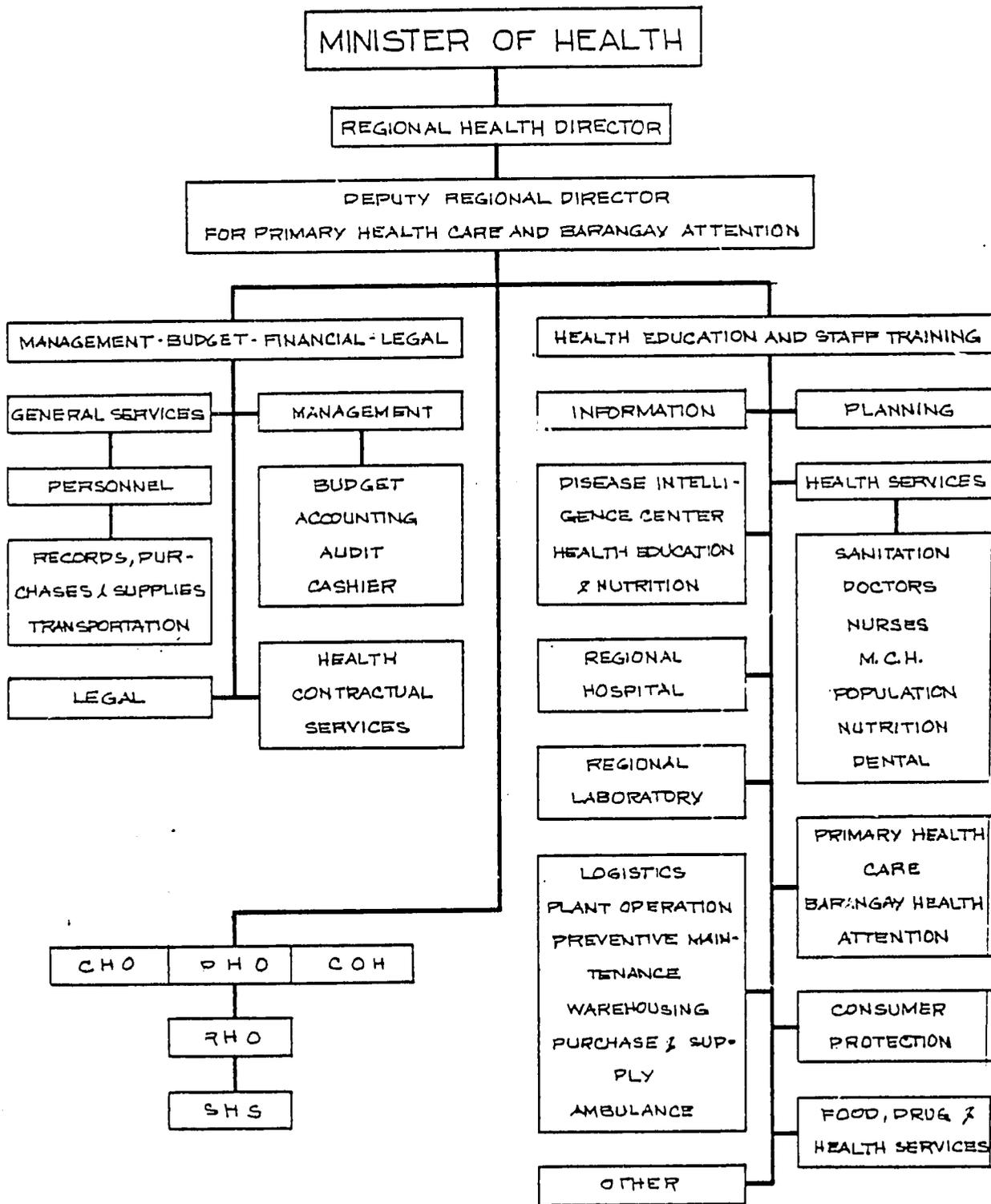
Note: All management, budget, financial, and legal functions will be in the most accessible provincial office in each region.

* (CS)



Note: All management, budget, financial, and legal functions will be in the most accessible provincial office in each region.
 * (CS)

Exhibit 6



* (CS)

ORGANIZATION CHART
REGIONAL HEALTH OFFICE NO. 4
QUEZON CITY

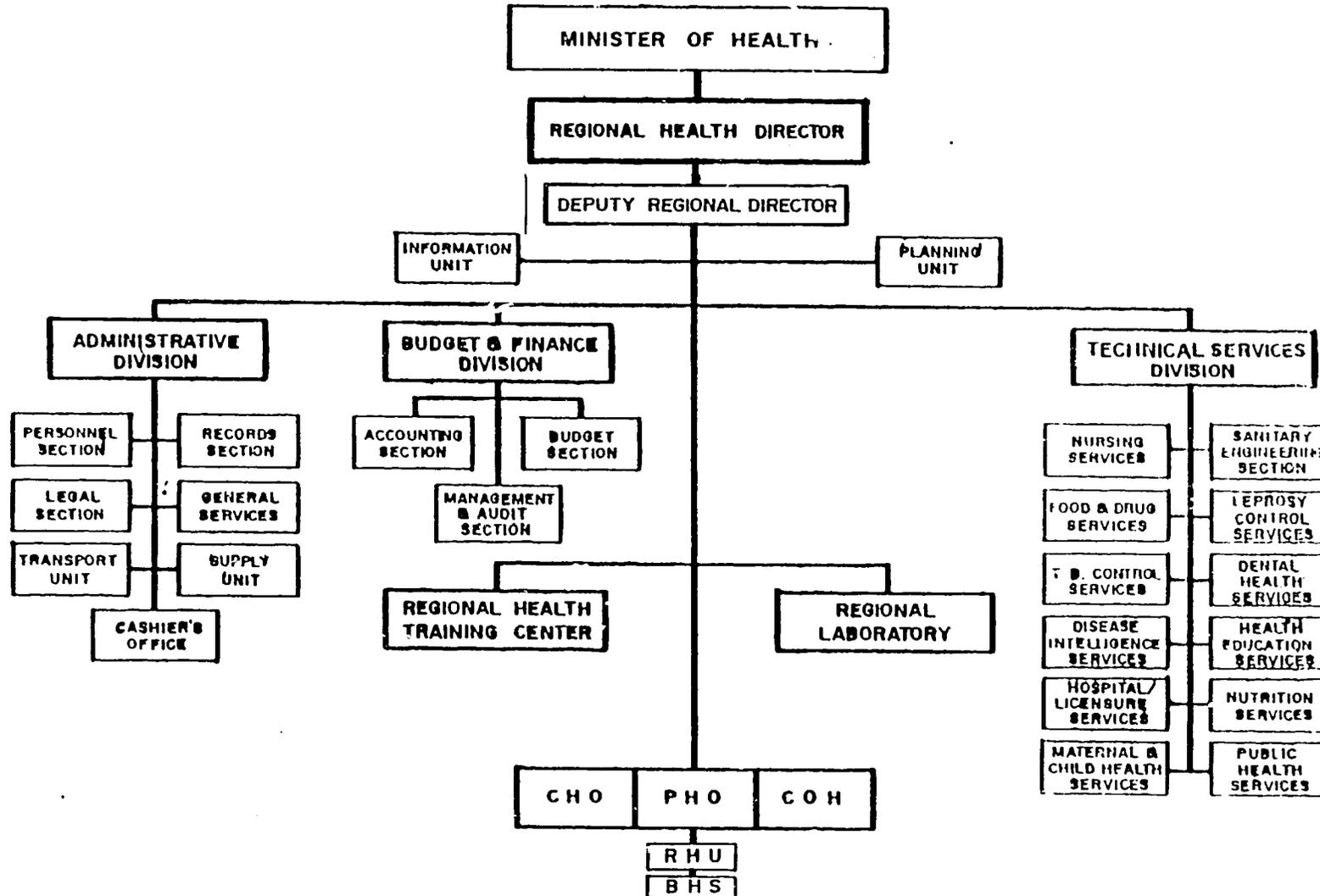


Exhibit 8

ORGANIZATION CHART
PROVINCIAL HEALTH OFFICE
DEPARTMENT OF HEALTH

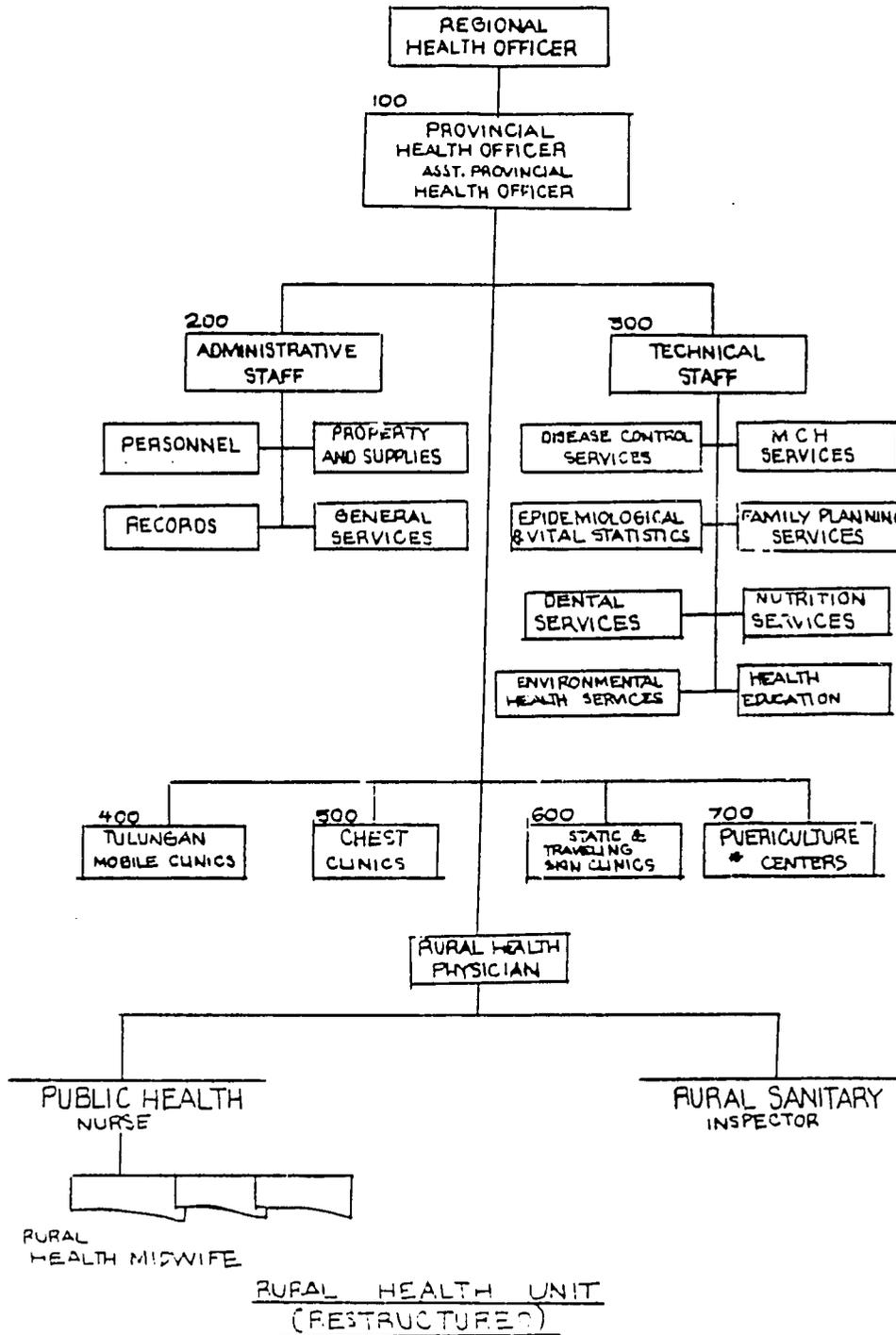
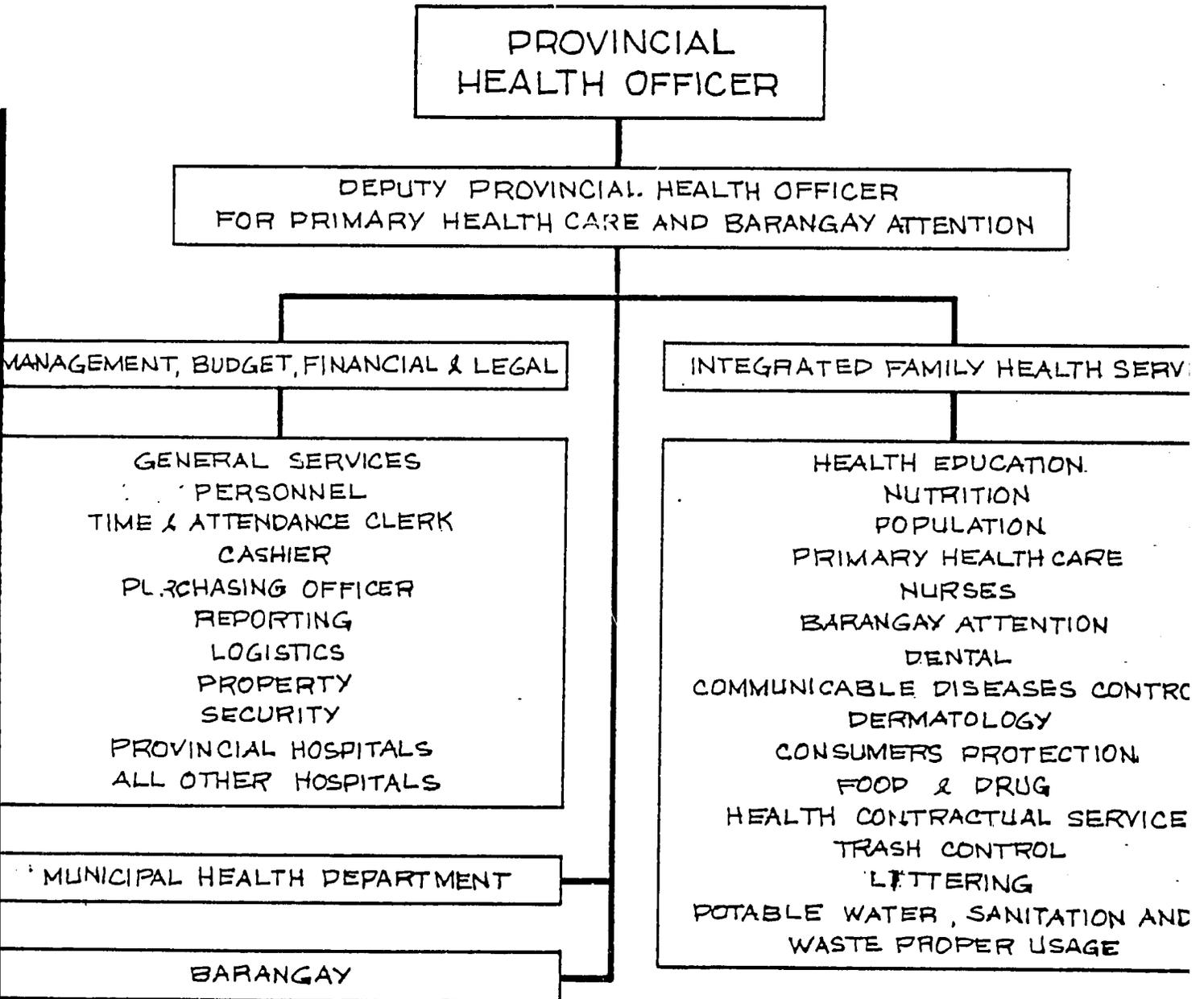
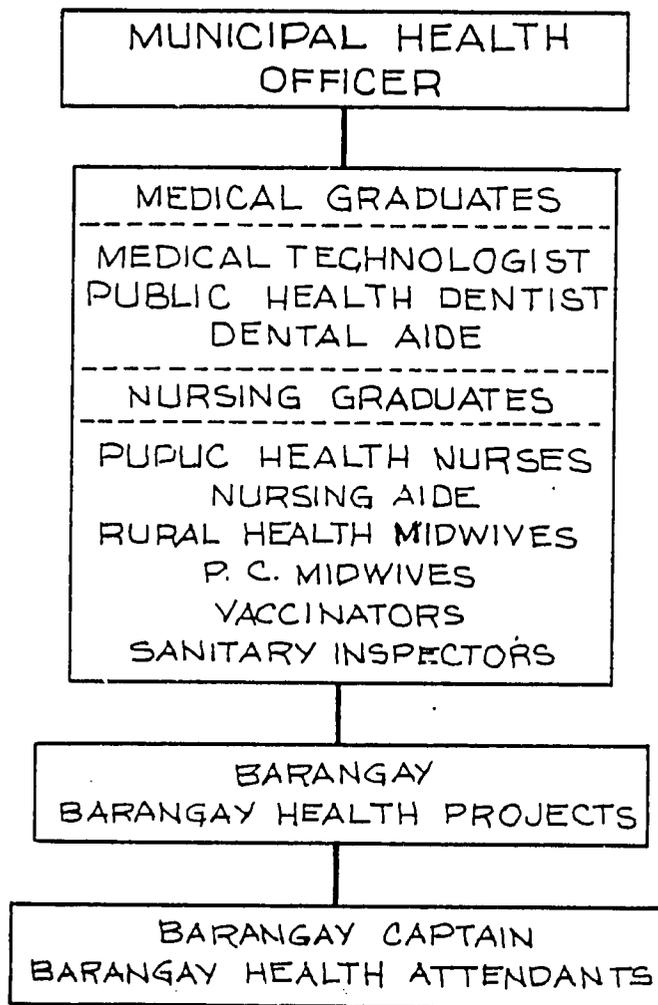


Exhibit 9*



* (CS)

Exhibit 10*



* (CS)

RHU ORGANIZATIONAL CHART

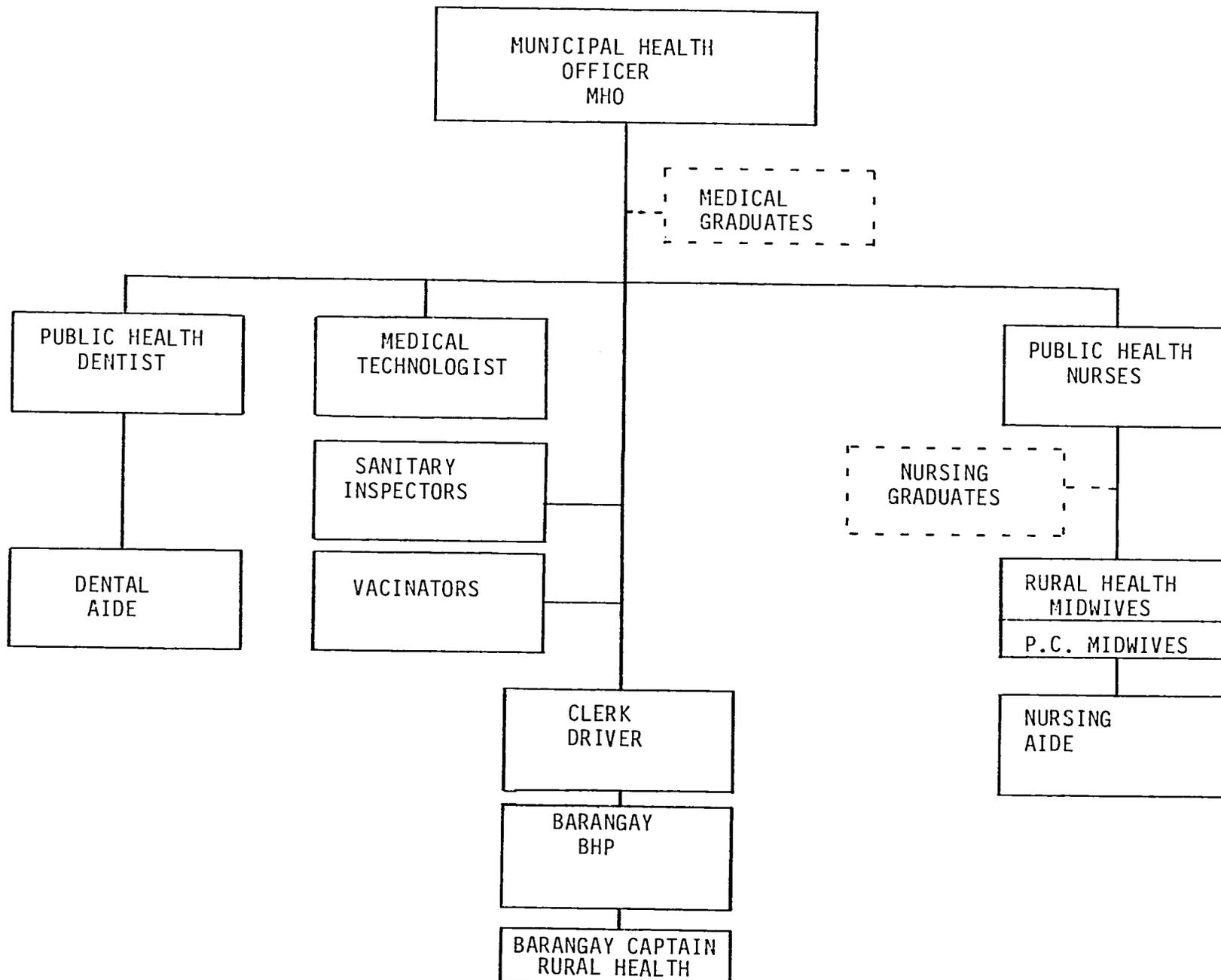
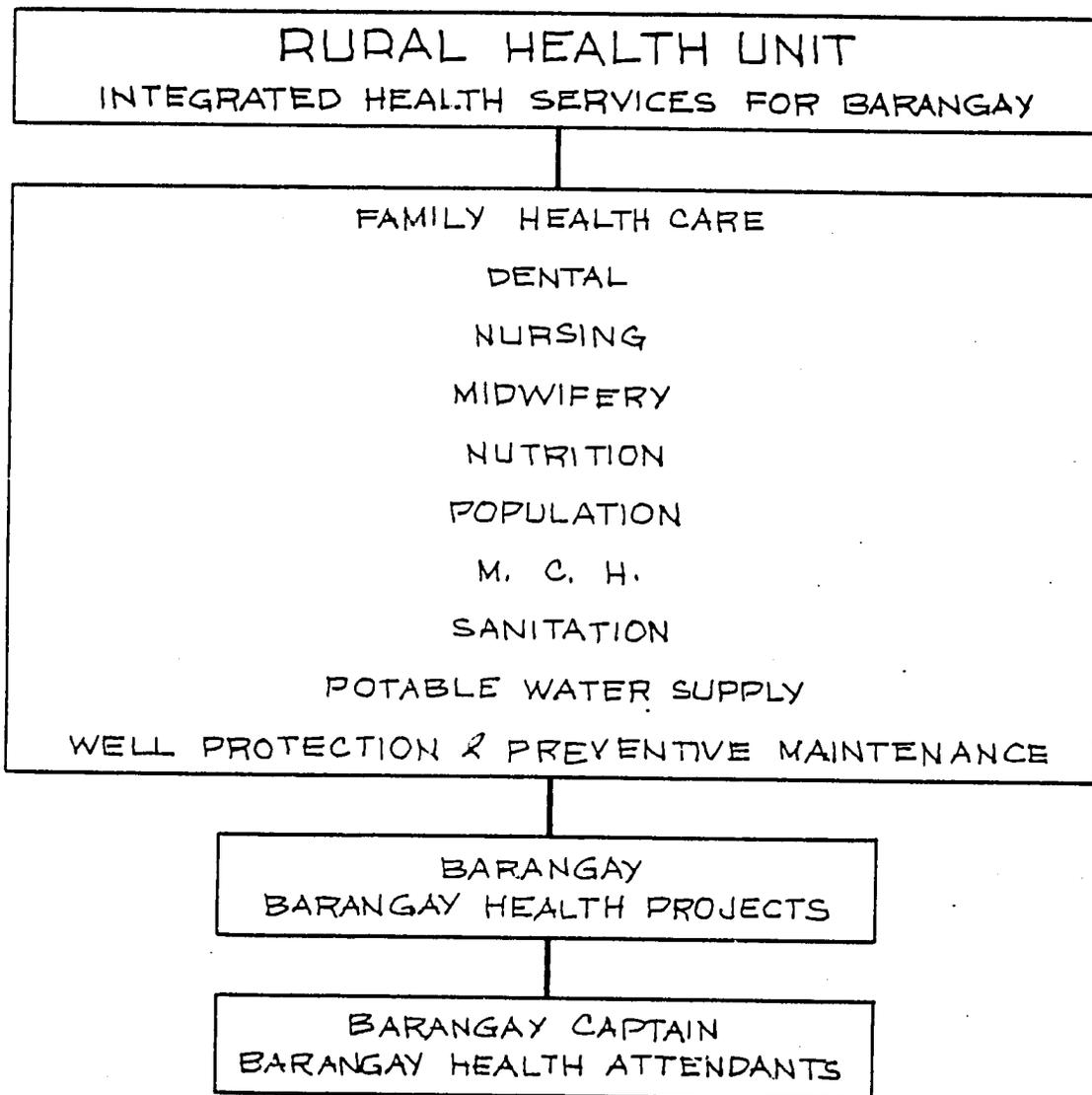


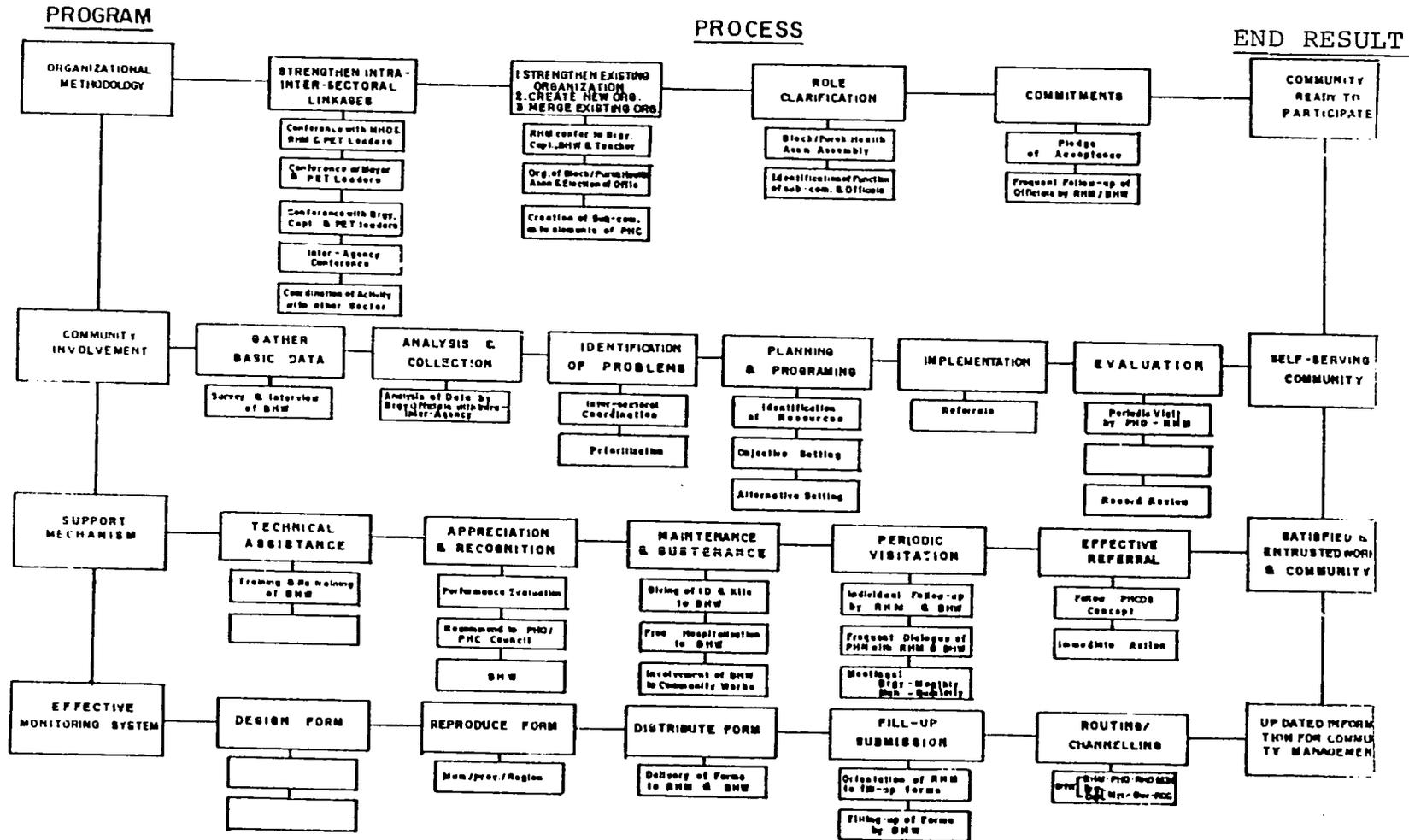
Exhibit 12*



Note: All management, budget, financial, and legal functions will be integrated with the functions of the provincial health office.

* (CS)

MODULE, COMMUNITY INVOLVEMENT
 PRIMARY HEALTH CARE
 REGION XI
 Davao City



Appendix E

SEQUENCE OF EVENTS IN PRIMARY HEALTH CARE
UNDERTAKEN BY REGION XI

Appendix E

SEQUENCE OF EVENTS IN PRIMARY HEALTH CARE UNDERTAKEN BY REGION XI

<u>Date</u>	<u>Process</u>
May 3-31, 1980	Training of chief, Technical Services Division, and at the same time designation of regional primary health care coordinator, regional nurse supervisor, chief, regional health training center, and nurse training officer, at OHEPT, MOH, and PRRM, in PHC concept.
June 5, 1980	Briefing of the regional health director and staff by health personnel named above.
June 7, 1980	Briefing of PHOs, CHOs, and COHs and heads of units, dentists, PET, SPHNs, chief nurses of hospitals and cities, by the regional health director.
June 7, 1980 - July 8, 1980	Three task forces created to undertake primary health care training activities in different provinces and cities, including training PET leaders and representatives of inter-sectorial agencies in the provinces.
July 15, 1980 - October 6, 1980	Training of RHP, PHN, dentists, MWs, RSIs, and PET, in addition to representatives of inter-sectorial agencies in the municipalities, by the Provincial Training Task Force.
October 12, 1980 - December 1980	Training of barangay health workers (30 days) simultaneously in all barangays in all provinces and cities, by respective municipal training task force.

<u>Date</u>	<u>Process</u>
July 2-17, 1981	Training of 15 volunteer post-board physicians as catalysts in primary health care.
August 2-7, 1981	Training of 40 volunteer post-board nurses in primary health care to be used as change agents.
August 25, 1981	Conference with mass media people on primary health care.
August 27, 1981 - September 11, 1981	Survey of 350,000 families conducted in different barangays; data profile of each barangay completed.
October 22-23, 1981	Evaluation of Carrascal, Surigao del Sur, in primary health care, by PHOs, CHOs, heads of units, and regional health office staff.
November 1-4, 1981	Training in strengthening of nurses' supervisory capabilities in PHC, Davao del Norte and Davao del Sur; Regional Health Conference Room.
November 4-7, 1981	Training of strengthening of nurses' supervisory capabilities in PHC, South Cotabato, and Surigao del Sur.
November 9-12, 1981	Training in strengthening of nurses' supervisory capabilities in PHC, Davao City, General Santos City, and Davao Oriental.
November 26, 1981	Evaluation of Lupon, Davao Oriental, in PHC, by PHOs, CHOs, heads of units, and regional health office staff.
December 14-15, 1981	Evaluation of Tampakan and Banga, South Cotabato, in PHC, by PHOs, CHOs, heads of units, and regional health office staff.

<u>Date</u>	<u>Process</u>
December 16, 1981	Evaluation of Padada, Davao del Sur, in PHC, by PHOs, CHOs, heads of units, and regional health office staff.
December 18, 1981	Evaluation of Maco, Davao del Norte, in PHC, by PHOs, CHOs, heads of units, and regional health office staff.
December 21, 1981	Awarding of primary health care prize to Maco RHUs as result of the consensus evaluation of PHOs, CHOs, and chiefs of hospitals.
January 19-20, 1982	Carmen, Davao del Norte, visit by regional directors and provincial health officers in 3 barangays.
March 4-5, 1982	Training of rural health physicians of Davao del Norte and Davao del Sur in organizational methodology, community involvement, support mechanisms, and effective monitoring; Regional Health Conference Room.
March 8-9, 1982	Training of rural public health nurses of Davao del Norte and Davao del Sur in organizational methodology, community involvement, support mechanisms, and effective monitoring; Regional Health Conference Room.
March 10-11, 1982	Training of rural health physicians of Davao Oriental, Surigao del Sur, and South Cotabato in organizational methodology, community involvement, support mechanisms, and effective monitoring; Regional Health Office Conference Room.

<u>Date</u>	<u>Process</u>
March 11-12, 1982	Training of rural public health nurses of South Cotabato in organizational methodology, community involvement, support mechanisms, and effective monitoring; Regional Health Office Conference Room.
March 15-16, 1982	Training of rural public health nurses of Davao Oriental and Surigao del Sur in organizational methodology, community involvement, support mechanisms, and effective monitoring; Regional Health Office Conference Room.

Appendix F

HEALTH STATISTICS FOR THE PHILIPPINES
(Tables 1-4)

Table 1

*POPULATION GROWTH, CRUDE BIRTH RATE, CRUDE DEATH RATE,
INFANT MORTALITY RATE, NEO-NATAL DEATH RATE, MATERNAL
MORTALITY RATE, FOETAL DEATH RATE AND LIFE EXPECTANCY:
PHILIPPINES, 1970 1972 & 1977*

<i>HEALTH INDICES</i>	<i>1970 RATE</i>	<i>1972 RATE</i>	<i>1977 RATE</i>
<i>POPULATION GROWTH</i>	<i>3.0</i>	<i>3.0</i>	<i>2.6</i>
<i>CRUDE BIRTH RATE (CBR) *</i>	<i>27.4</i>	<i>24.8</i>	<i>29.9</i>
<i>CRUDE DEATH RATE (CDR) *</i>	<i>6.7</i>	<i>7.3</i>	<i>6.9</i>
<i>INFANT MORTALITY RATE (IMR) **</i>	<i>59.3</i>	<i>67.9</i>	<i>56.9</i>
<i>NEO-NATAL DEATH RATE (NDR) **</i>	<i>28.7</i>	<i>31.9</i>	<i>24.0</i>
<i>MATERNAL MORTALITY RATE (MMR) **</i>	<i>1.9</i>	<i>1.4</i>	<i>1.4</i>
<i>FOETAL DEATH RATE (FDR) **</i>	<i>7.3</i>	<i>14.0</i>	<i>10.8</i>
<i>LIFE EXPECTANCY</i>	<i>57.97</i>	<i>58.0</i>	<i>60.96</i>

** PER 1,000 POPULATION*

*** PER 1,000 LIVE BIRTHS*

SOURCE: DIC-MINISTRY OF HEALTH, PHILIPPINE HEALTH STATISTICS.

Table 2

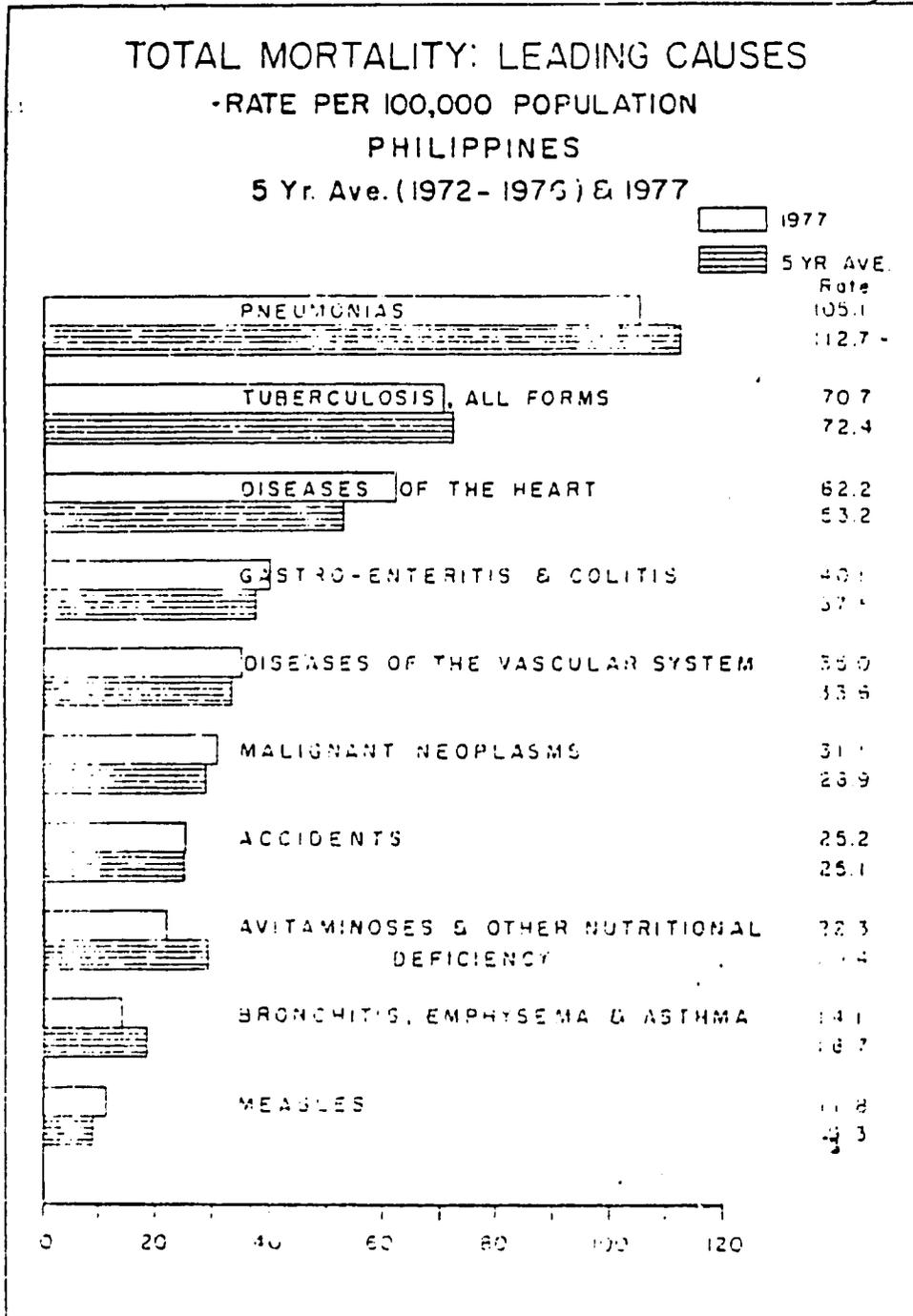


Table 3

MINISTRY OF HEALTH
 DISTRIBUTION OF APPROPRIATION,
 BY PROGRAM,
 CALENDAR YEAR 1980

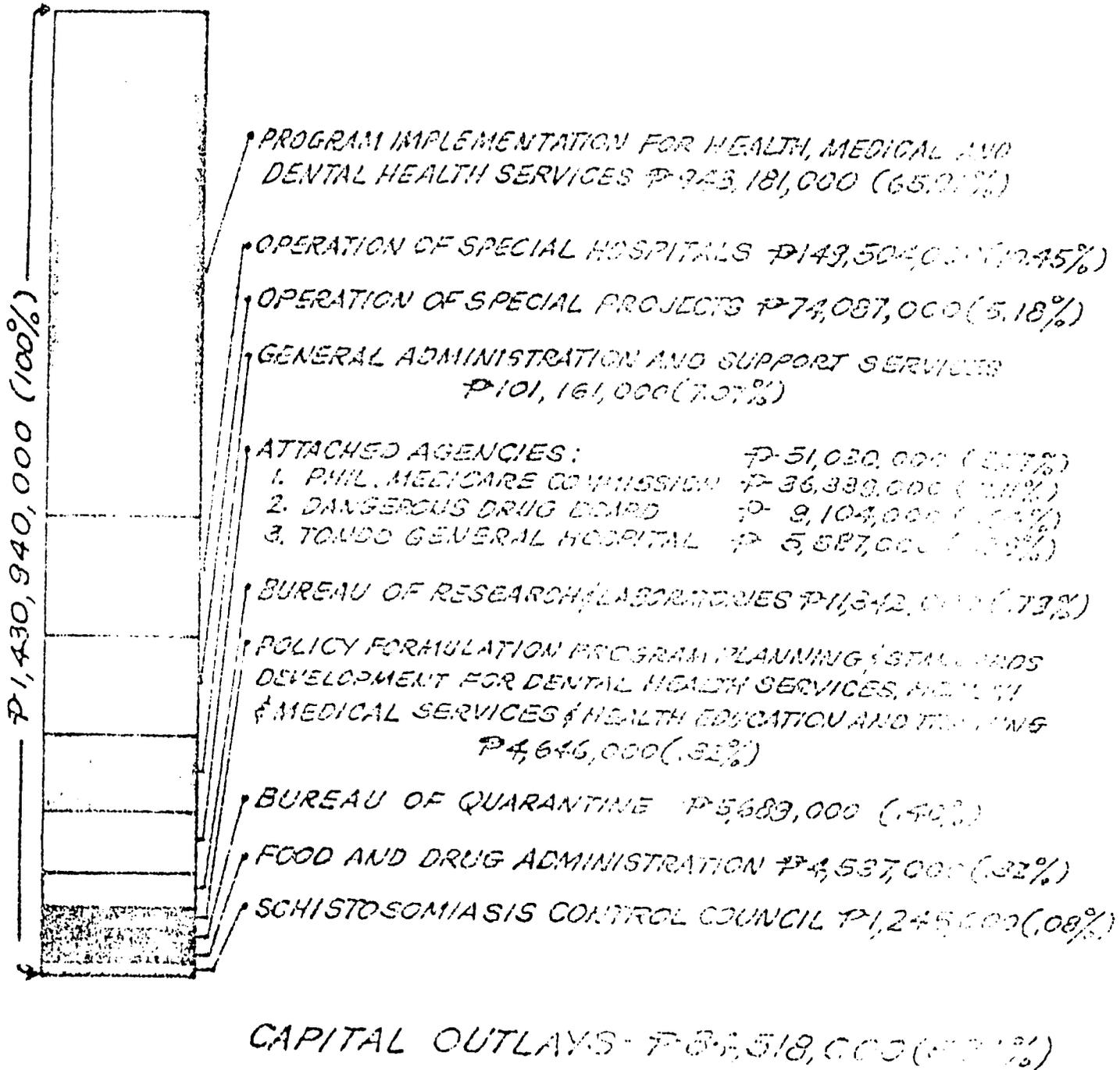


Table 4

MINISTRY OF HEALTH
FUNDING HISTORY,
CALENDAR YEARS 1975-1979

