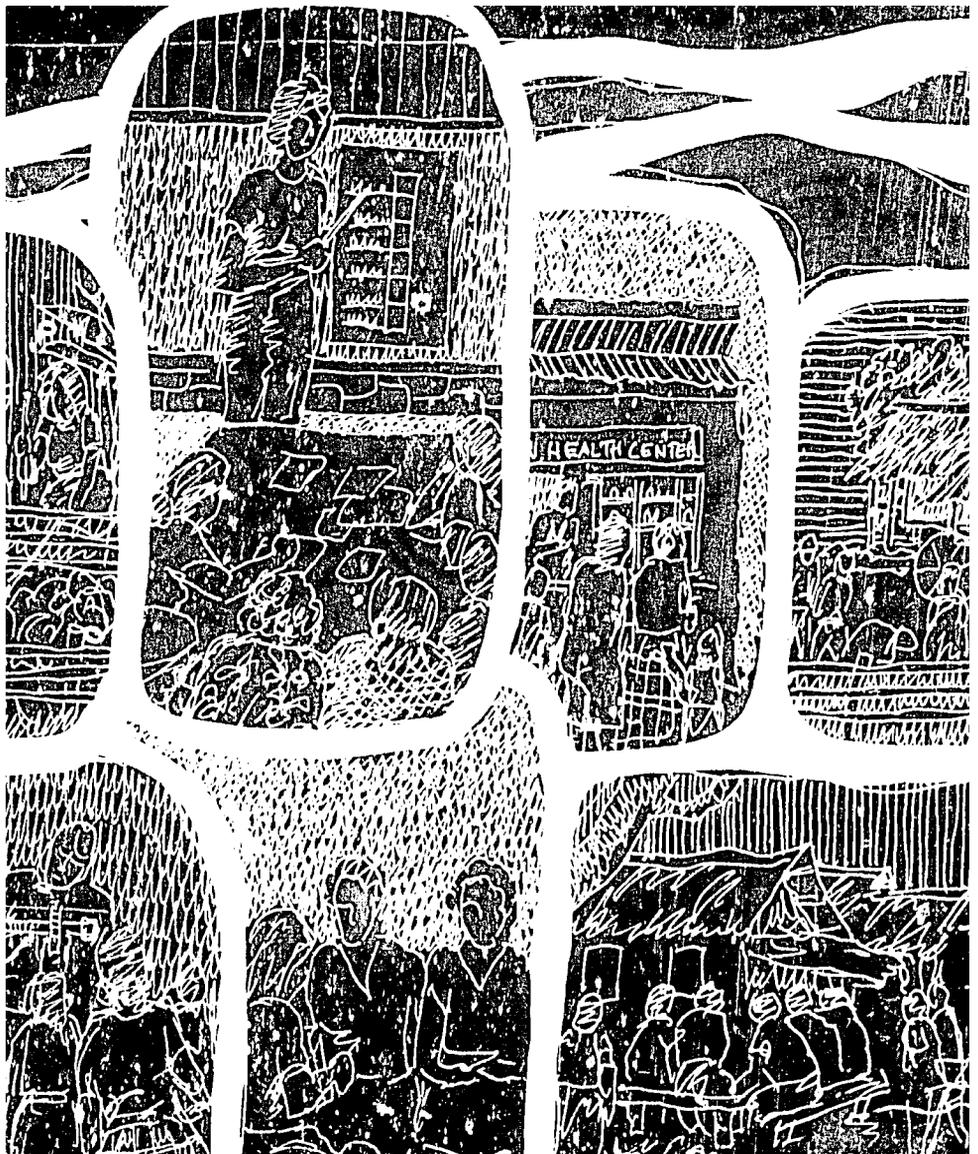


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ALTERNATIVE STRATEGIES FOR FINANCING PRIMARY HEALTH CARE:

Lessons From Six Case Studies

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A RESEARCH PROJECT OF THE UNIVERSITY OF THE PHILIPPINES IN THE VISAYAS (UPV) IN COORDINATION WITH THE NATIONAL ECONOMIC AND DEVELOPMENT AUTHORITY (NEDA), REGION VI AND THE PANAY UNIFIED SERVICES FOR HEALTH (PUSH) PROJECT WITH THE SUPPORT OF PRIMARY HEALTH CARE OPERATIONS RESEARCH (PRICOR)

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FOREWORD

The idea of undertaking research on health financing schemes was first broached to the University of the Philippines in the Visayas (UPV) by USAID Project Officer Ms. Joy Riggs-Perla, who at that time was developing a project package on Health Care Financing. Since UPV had for some time been involved in health and nutrition studies, the prospect of exploring capabilities of communities for supporting and underwriting community-based health care schemes posed a challenge and was unhesitatingly accepted.

What resulted was a two-year research effort, a great part of which was spent in the field, documenting the activities and progress of communities along their chosen financing scheme. The case studies which are considered the substance of this report provide a detailed account of the dynamics at work as barangay residents are mobilized and catalyzed into participating in health financing.

I would like to express my gratitude for the grant extended to this institution by the Primary Health Care Operations Research (PRICOR) of the Center for Human Services, which has made this study possible. It is my hope that the findings surfaced by this effort may be of use to our policy makers and to the various levels of health managers and workers. May it generate continuing interest and similar such endeavors.

CHANCELLOR DIONISIA A. ROLA
UP in the Visayas

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Undoubtedly this research would not have been possible without the cooperation of the residents of our six experimental barangays — Badiang, Bololacao, Bucaya, Maribuyong, Milleza, Tastasan — who consented to participate in exploring alternatives for primary health care financing. Their experience is what this report is about. To each one of them — core group members, lead mothers, health workers, municipal officials — whom space limits us from naming individually: our sincerest thanks and gratitude.

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Finally we would like to acknowledge the help of the members of the UPV community: the research team composed of our research associate Maricor de los

Santos, research assistants Arlene Miranda and Rosemarie Gange who all worked indefatigably and conscientiously among the barangay residents; our support staff consisting of Hazel Tidon, administrative assistant, and Cora Jimena, secretary; to our field interviewers; to Prof. Mildred Gonzales and Mrs. Rebecca Cajilig for their valuable editing assistance; and to the administrative support given by Ms. Norma Pison, Fely Mendoza, and Ester Gamez.

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(Co-Principal Investigators)

EXECUTIVE SUMMARY

The need to explore alternative health care systems becomes pressing in many developing countries as economic conditions preclude the scale of public sector financial expansion necessary to bring basic health services to the still underserved populations. As a consequence, governments are determining ways to expand health services without subjecting government budgets to impossible increases. It is then in their interests to seek and find innovative financing alternatives in primary health care that will offer new opportunities to increasingly use the communities in meeting their health care needs. This concern brought about attempts to develop community self-reliance that will focus on the two dimensions of health financing, allocating funds for health resources and devising financing mechanisms for efficient methods for service delivery.

In January 1983 UP in the Visayas embarked on an operations research aimed at testing the feasibility and effectiveness of health financing schemes that involved community participation from the planning to the evaluation stage. This project was funded by PRICOR. Focusing on the community management approach, the project was divided into three phases: (1) Needs assessment for the identification of elements which affect the viability of particular health care financing schemes; (2) Planning, formulation, and implementation of the strategies selected; and (3) Evaluation of outcomes. Initially, a conceptual paradigm was involved which linked the determinants of appropriate schemes (provider factors, community variables, extent of institutional support) to the strategies developed (flat rate, fee for service, contribution and areas where contributions will be directed) and the eventual outcomes (changes in health seeking behavior and expenditure pattern).

Six barangays in Iloilo where an established Primary Health Care Program was in operation constituted the research sites to represent the various economic sectors (rice, sugar, fishing) in the province. A set of six villages with almost similar characteristics was designated as the controls.

Phase I – Needs Assessment

To identify the determinants of appropriate financing schemes, a survey was carried out on all households constituting the study barangays to determine their socio-demographic characteristics, the common health problems, income and expenditure pattern, health resources and their utilization, perceived health needs, and potentials for participation in future health schemes in the community. Several observations emerged from the survey:

1. Annual incomes were low (P2,657 to P5,332) and they were offset by higher expenditures (P2,659 to P5,583). The allocation for medical care was below 10 percent of the total expenditures. Furthermore, the residents did not foresee any changes in their incomes in the subsequent year.
2. Respiratory illnesses were reported as most common, followed by gastrointestinal infection.

3. While most households do initial home remedies (through herbal medicines or purchase of over-the-counter drugs), there is a subsequent utilization of health service providers particularly traditional healers.
4. The principal health needs mentioned were lack of drugs and adequate water supply.
5. A large number of households signified their willingness to participate in health care financing schemes and mentioned flat rate contribution and donation of services as the mechanism for involvement.
6. The households felt that the contributions should be directed to the purchase of drugs and improvement of the environmental sanitation facilities.

Phase II – Planning, Formulation and Implementation of the Program

The second phase of financing the project involved the planning, formulation and implementation of the program. The survey results were charted in pictographs and presented in individual community assemblies composed of local political leaders, teachers, health service providers and the residents. The community's response was elicited in terms of their evaluation of the findings of the study and the development of viable solutions to the health problems through financing. Schemes were subsequently selected and a workshop was organized for each participating barangay to strengthen its capability in undertaking the schemes and operationalization of the donation of services and materials.

The common financial scheme selected was the contribution of a flat rate on a monthly basis (an average of P1) and voluntary contributions from proceeds of sales of farm produce and livestock as well as the donation of services. The major areas of activity were the operation of the "botika sa barangay" (village drugstore) and the training of lead mothers for the provision of basic services except in Mari-buyong where the residents opted for the emergency loan fund instead of the botika. For the botika operations, residents were selected to manage the botika in terms of sales, credit collection, and replenishment of supply. In certain barangays, 2 or 3 depots were established to ensure accessibility. Lead mothers were identified based on the survey results (those who were willing to donate the health services) and trained for the basic provision of preventive and simple curative care. Their major activities focused on environmental sanitation campaign, promotion of vegetable and herbal gardening, and to a certain extent acting as drug depots. Certain difficulties were delineated in the first ten months of the project operations that may have precluded the determination of changes in health seeking behavior or expenditure pattern. In the case of the botika, poor management, inability to record sales and procurement, inadequate mark-up of prices, inability to replenish the supply, variability of drugs within a narrow range capped by the low initial capitalization worked against the efficient operations of some drug depots. In certain cases where the operation have been successful, the strong support of the community leader and the midwife as well as additional funds to augment capitalization (through a raffle) were contributory determinants. The passivity of the community as a result of the initial low response due to the nuance of

the project delayed the implementation as well as caused the inability to draw the expected contribution.

The lead mothers proved to be potential providers of health services. However, their activities are limited to only a few areas — environmental sanitation, herbal gardening, and food production. The short training duration as well as the inability to impart a wide variability of preventive, promotive and curative skills might be deterrent to their effective participation. Besides, in certain barangays interest waned with the lack of appropriate structural support from the midwife and BHW, and the pressure of other house and income-generating activities that they had to undertake. In one barangay with the emergency loan fund, there was delay in the utilization of this fund. Caution was exercised in the utilization as the first debt was incurred in May which was nearing the project completion. Again, the nuance of the scheme might have precluded the immediate response.

Phase III — Evaluation of Outcomes

Changes in health-seeking behavior and expenditure pattern were determined through two data sources: a pre and post implementation survey and the time series analysis from the record keeping system comparing the experimental barangays with their controls. The following observations were made:

1. It seems that the short operation period notwithstanding delays in data collection and project implementation limited an effective assessment of changes in outcome indicators.
2. Declines in illness volume were noted but it is not known if this is secular or seasonal and cannot be entirely attributed to the program. Likewise, the declines in health expenditure could be contingent to these changes. The utilization of controls failed to elicit the required differences as in certain instances, the controls fared better than the experimental barangay which may indicate that similarity of community characteristics may not necessarily result in similarity in health seeking behavior. Rather, the barangay health worker factor may have to be taken into consideration.
3. There was a reported increase in the level of utilization of the botica sa barangay. However, the largest level was still half of the households. Therefore, there could still be room for improvement with more efficient management.
4. At the end of the project period, 82 percent to 92 percent did not perceive lack of drugs or environmental sanitation as a problem although the level of utilization was relatively lower.
5. Participation in the project was high — from 83 percent to 99 percent but it may include a mere contribution of P1 for a month.
6. A substantial number of households professed awareness of the lead mother (from 65 percent to 81 percent) although the utilization was low (rarely exceeding 10 percent).

The project was able to identify both the constraining and facilitating factors to the effective implementation of the financing schemes. A better community

organization mechanism, increased recognition of the importance of health, more time for planning of viable schemes, better structural support from the health providers and the political leaders, and a more efficient management scheme would result in a more definitive change in outcomes. Despite the problems inherent in the project operations, the results would contribute significantly to advance the efforts made along the line of building community self-reliance in primary health care delivery.

The frank effort to objectively assess the project does not diminish the importance of what was accomplished with the limited resources and time among the barangays in Iloilo. This will usefully stimulate other health planners and guide a variety of projects in the country.

CONTENTS

FOREWORD	iii
ACKNOWLEDGMENTS	v
EXECUTIVE SUMMARY	vii
CONTENTS	xi
LIST OF TABLES AND FIGURES	xii
LIST OF ACRONYMS USED IN THE REPORT	xiv
I. INTRODUCTION	1
II. REVIEW OF RELATED LITERATURE	4
III. ALTERNATIVE HEALTH CARE FINANCING IN SIX BARANGAYS IN ILOILO	9
Methodology	9
The Setting	14
IV. PROFILE OF THE HOUSEHOLDS IN THE STUDY BARANGAYS	19
Demographic and Socio-Economic Characteristics	19
Characteristics of the Respondents	21
Income and Expenditure Patterns	23
Illness Pattern and Management	24
Health Care Expenditures	26
Accessibility of Health Facilities	28
Health Needs and Means of Meeting Them	29
Attitude Towards and Willingness to Participate in Health Financing Schemes	30
Discussion	32
Synthesis	33
V. FORMULATION AND IMPLEMENTATION OF THE ALTERNATIVE FINANCING SCHEMES	33
Methodology	35
The Case Studies	
Barangay Milleza	41
Barangay Bucaya	48
Barangay Bololacao	59
Barangay Badiang	70
Barangay Maribuyong	79
Barangay Tastasan	89
VI. LESSONS FROM THE VARIOUS CASE STUDIES	96
A. Strategy Development	96
B. Structure of Financing Schemes	97

C. Psychology of Participation in Financing Schemes	97
D. Community Participation and Leadership	98
E. Lead Mothers and Health Workers	99
F. Botika sa Barangay/Emergency Loan Fund	99
G. Role of Extension Agents	100
VII. EVALUATION OF OUTCOMES	106
The Conceptual Paradigm	106
Data Sources	106
The Control Barangays	108
Data Analysis	110
Badiang vs. Batuan	118
Tastasan vs. Barosong	129
Bololacao vs. Badiangan	133
Milleza vs. Nipa	137
Bucaya vs. Bularan	141
Maribuyong vs. Poscolon	145
Summary of RKS Data Analysis	149
Awareness, Attitude and Participation in the Project	150
VIII. CONCLUSIONS AND RECOMMENDATIONS	161
APPENDICES	163
Appendix A (The Research Dissemination Workshop)	164
Appendix B (Baseline Questionnaire)	166
Appendix C (Post - Implementation Survey Questionnaire)	173
Appendix D (Monthly Household Health Record)	179

LIST OF TABLES

Table No.	Page
1 Total expenditure of the Ministry of Health, 1975-1981	3
2 Population size by sex, six barangays, 1983	19
3 Age distribution of the population, 1983	20
4 Percentages of the population 10 years old and above by highest educational attainment, 1983	20
5 Percentage of population 10 and above, by occupation, 1983	21
6 Percentages of households by family type and average family size, 1983	21
7 Distribution of respondents by average age and household, position, 1983	22
8 Percentages of respondents by educational attainment, 1983	22
9 Mean and median annual incomes and expenditures, 1983	23
10 Distribution of annual expenditures, 1983	24
11 Household members reported ill in six barangays, 1983	25
12 Percentages of households consulting specific health providers, 1983	26
12a Median expenditures for medical care, 1983	27
13 Perception of the cost of medical services, 1983	28
14 Accessibility of health facilities by distance and travel time	29
15 Principal health needs perceived by the community, 1983	30

16	Attitude towards and willingness to participate in health financing schemes	30
17	Ranking of preference for specific schemes	31
18	Ranking of health areas where contributions can be directed, 1983	31
19	Summary of financial schemes selected for the six experimental barangays, 1983	36
20	Summary of implementation plans of six barangays	37
21	Summary of volume of activities of lead mothers in environmental sanitation and vegetable/herbal gardening by barangay	40
22	Monthly sales of Botika sa Barangay in 5 barangays	101
23	Monthly net profit of Botika sa Barangay in 5 barangays	101
24	Statement of total working capital, total sales and total net profit, August 1983 to August 1984	102
25	List of herbs and their uses (Barangay Maribuyong, Duonas)	103
26	Summary of barangay performance on the resource generation activity	104
27	Flat rate contributions of five barangays	105
28	Percentages of households which resort to home remedies	112
29	Distribution of the population by sex, pre- and post-implementation surveys	113
30	Distribution of the population by age	114
31	Distribution of population 10 years and above by highest educational attainment	114
32	Distribution of population 10 years and above, by occupation	115
33	Percentage distribution of households by family type and average family size	115
34	Average income and expenditure	116
35	Distribution of annual expenditure in percentage	119
36	Illness pattern of population 0 - 6 years of age	120
37	Illness pattern of other household members	120
38	Percentage of HHS consulting specific health providers (for respiratory illness)	121
39	Percentage of HHS consulting specific health providers (for GI/diarrhoea)	121
40	Perception of the cost of medical services	122
41	Median expenditures for medical care	122
42	Principal health needs perceived by the community	123
43a	Badiang, Anilao: Household health expenditure pattern	126
43b	Batuan, Duonas: Household health expenditure pattern	127
43c	Tastasan, Buenavista: Household health expenditure pattern	130
43d	Barosong, Tigbauan: Household health expenditure pattern	131
43e	Bololacao, New Lucena: Household health expenditure pattern	135
43f	Iniligan, Badiangan: Household health expenditure pattern	136
43g	Milloza, Jordan: Household health expenditure pattern	138
43h	Nipa, Concepcion: Household health expenditure pattern	139
43i	Bucaya, San Joaquin: Household health expenditure pattern	142
43j	Bularan, Banate: Household health expenditure pattern	143
43k	Maribuyong, Duonas: Household health expenditure pattern	146
43l	Posolon, San Rafael: Household health expenditure pattern	147
44	Awareness of PRICOR Project	158
45	Participation in schemes	158
46	Average amount contributed	159
47	Utilization of Botika/Loan/Fund	159
48	Donation of services and materials	160
49	Awareness and evaluation of lead mothers	161

Figure

1	Framework in analyzing determinants of health-seeking behaviors	10
2	A conceptual framework for the PRICOR financing project	13

LIST OF ACRONYMS USED IN THE REPORT

BHC/BHS	Barangay Health Center/Barangay Health Station
BHW	Barangay Health Worker
BNS	Barangay Nutrition Scholar
BSPO	Barangay Service Point Officer
BTH	Barangay Technician for Health
BSB	Botika sa Barangay (Drugstore in the barangay)
CRS	Catholic Relief Services
ELF	Emergency Loan Fund
FTOW	Full-Time Outreach Worker
GNP	Gross National Product
HMT	Home-Management Technician
KB	Kabataang Barangay
LUKAT	Lupot, Kalamay, Asin, Tubig (Salt-Sugar Solution)
MA	Ministry of Agriculture
MECS	Ministry of Education, Culture and Sports
MOH	Ministry of Health
MSSD	Ministry of Social Services and Development
MDC	Municipal Development Coordinator
NACIDA	National Cottage Industry
NEDA	National Economic and Development Authority
ORT	Oral Rehydration Therapy
PUSH	Panay Unified Services for Health
PTA	Parent-Teachers' Association
PHC	Primary Health Care
PRICOR	Primary Health Care Operations Research
PHN	Provincial Health Nurse
RKS	Record Keeping System
RHM	Rural Health Midwife
RHP	Rural Health Physician
RHPP	Rural Health Practicing Physician
RHU	Rural Health Unit
RIC	Rural Improvement Club
RSI	Rural Sanitary Inspector
USAID	United States Agency for International Development
UPV	University of the Philippines in the Visayas
WB	World Bank

**ALTERNATIVE STRATEGIES FOR FINANCING
PRIMARY HEALTH CARE:
LESSONS FROM SIX CASE STUDIES**

I. INTRODUCTION

Background

In the Philippines, there has been a significant decline in mortality from a crude death rate of 20 per 1000 population in 1950 to about 7 per 1000 in 1982. This remarkable reduction was attributed to the public health program that involved the creation of rural health centers, provision of potable water supply, and sanitation facilities as well as campaigns against parasitic and infectious diseases. Despite the magnitude of the change, the pattern of mortality typical of developing countries persists. Infant mortality accounted for 25 percent of all deaths. Almost 30 percent of infant deaths are from prenatal causes while the remainder are attributed to pneumonia, gastroenteritis, malnutrition, other respiratory infections, measles, and meningitis (IBRD, 1984). These disease patterns indicate that despite advances in the field of medicine and public health, efforts to improve the health of the communities have not reached the masses. The major causes of mortality for all ages remain constant — infections, parasites, and respiratory diseases — which account for 54 percent of all deaths in 1980. The morbidity pattern remains basically the same as that of the decade before.

Health Policy of the Government

Since the early 1970's the Ministry of Health has been strongly committed to the extension of basic health services to poor people in the remote areas of the country. In 1973, a Restructured Health Care Delivery System was introduced as part of the first World Bank-assisted population project. This system was designed to achieve a better utilization of the medical personnel and delegate responsibilities to the auxiliary staff. An evaluation of the performance of five provinces in 1977 showed that despite full implementation of the program, only about 65 percent of the community health needs could be met. The 1978-82 Plan adopted the concept of primary health care (PHC) concentrating on the problems of communicable diseases and malnutrition, poor sanitation, and a rapidly growing population.

The Concept of Primary Health Care

The achievement of "health for all by the year 2000" through the universal and effective administration of primary health care of all nations was sought in the Alma-Ata Conference in September 1978. This conference paved the way for action in recognition of the need to make essential health services accessible to individuals and families at the community level by "means acceptable to them, through their full participation and at a cost that the community can afford" (WHO, 1978). This would allow the provision of promotive, preventive, curative, and rehabilitative services through a wide range of activities including nutrition, environmental sanitation, maternal and child care, family planning, immunization, prevention and control of locally endemic diseases, health education, and curative services. The philosophy of primary health care revolves around the development of maximum com-

munity and individual self-reliance through full community participation in the planning, organization, and management of the health services. Such premise rests on proper coordination at all levels between health and the other sectors concerned.

The Primary Health Care (PHC) is an approach to health development which is carried out through a set of activities and whose ultimate aim is the continuous improvement and maintenance of the health status of the community. This envisages that the community will define its own health problem/needs, devise, and carry out programs or activities to solve them in partnership with the government and the private sector (MOH, 1980). As an approach, it should be: (1) community-based, accessible and acceptable; (2) sustainable at a cost which the community and the government can afford; and (3) interrelated with the overall socio-economic development. These facets, however, hinge on the following assumptions: (1) that health knowledge must be available to the community, (2) that health services must be within the reach of the people where and when they need them; (3) that all segments of the population whether in the remotest barrio or in the most depressed and crowded urban slum areas are ready and willing to identify and solve their own health problems; (4) that the community and the government would implement health programs within their budgets by using appropriate technology or ways and resources that are available to the community; and (5) that self-reliance in health is the single most important approach to attaining a quality of life that will enable the individual to lead a socially and economically productive life.

The essential constituent health services include: (1) education concerning prevailing health problems and the means of preventing and controlling them; (2) promotion of adequate food supply and proper nutrition; (3) an adequate supply of safe water and basic sanitation; (4) adequate shelter; (5) maternal and child care including family planning, immunization, prevention, and control of locally endemic diseases; (6) treatment of common diseases; and (7) provision of essential drugs. It is a program initiated and undertaken by the community arising from an awareness of its health needs, planned and designed within socio-economic and political conditions of the people, and sustained by active community involvement and participation in partnership with the government and private agencies.

It has been observed that despite the fielding of midwives to serve the basic health needs of the remote rural areas, 33 percent of the rural population remain under-served and unserved — a situation that has further been aggravated by the problems of poverty, rapid population increase, inadequate shelter, unequal distribution of health resources, and high cost of medical care. Therefore, an intersectoral approach to health service delivery was deemed necessary in building the foundations of health — through the active participation of the community which determines the priorities for action. The mechanics for carrying out the PHC program involves an active community participation in planning, implementation, and redirection of health, community, and health-related programs, and linkages among the government health agencies and health workers; use of indigenous technology to meet local health needs; and the development of support mechanisms to sustain the program.

The Government Health Expenditure Trends

In 1982, the total amount appropriated for health services by the Philippine Government was P3.1 billion which was less than 1 percent of the GNP and 5.4 percent of total central government appropriations for that year. Table 1 gives the expenditures of the Ministry of Health from 1975-1981.

Table 1. Total expenditures by the Ministry of Health, 1975-1981.

Year	Total (Recurrent and Capital) (in million pesos)	% of GNP Total
1975	626.2	3.3
1976	784.1	3.5
1977	396.5	4.0
1978	890.4	3.2
1979	1135.5	3.5
1980	1550.0	3.7
1981	1867.7	3.4

Source: IBRD, 1984

It was estimated that the sum of central government, local government and private household outlays on health services and programs exceeded P10.5B in 1982 — approximately \$25 per capita and 3 percent of the GNP. It was recognized that in the immediate future, funds will be grossly insufficient to support the expected requirements, if public policies follow the lines indicated in the development plan. Reviews of projects that used community financing to compensate community health workers indicate the need for a satisfactory method of mobilizing local financial support for the provision of basic health services

The Concept of Primary Health Care Financing

The need to explore the alternative health care strategies has become more pressing as economic conditions in nearly all developing countries preclude the scale of public sector financial expansion necessary to bring basic health services to the still under-served populations of the Third World. As a consequence, governments are determining ways to expand health services without subjecting government budgets to impossible increases. As McPherson (1984) succinctly stated:

It is in all our interests to seek and find innovative financing alternatives in primary health care — alternatives that will offer new opportunities to increasingly use the private sector in meeting health care objectives.

The underlying concern of health planners and economists is to identify elements which may affect the viability of particular health care systems. Continuing problems with payment mechanisms frequently undermine primary health care

planning, projects, and programs. Unless solutions to funding problems are sought it will be difficult to maintain an effective and continuing coverage for primary health care. A health program generates recurrent costs which makes it essential to build local capacity and develop self-reliance within communities. Such self-reliance requires a new pattern of organization and building of skills. In primary health care financing, the problem becomes two dimensional — allocative, which involves raising finances and earmarking resources for health projects; and operational, which involves devising financing mechanisms and cost-effective methods of delivering health services to achieve the desired improvements in health status. Health services financing systems in use in various less developed countries feature a wide variety of packages including tax revenues generated at various levels of government, insurance premiums, out-of-pocket payments for services and commodities, other kinds of monetary contributions by patients, voluntary and semi-voluntary labor for the construction of facilities and the provision of services, and economic activities producing income for associated health services delivery systems (Stevens, 1982). In most countries, there is a broad consensus that rationality and equity in the health services sector call for the social financing of the demand for health care.

II. REVIEW OF RELATED LITERATURE

Despite an upsurge in interest in many developing countries to develop alternative financing schemes for basic health services, there are only few articles written on the issue. This could be partly explained by the historical dependence on a monolithic governmental health system the financing of which is drawn from tax revenues and designed to reach the total population. However, with the present harsh economic realities, the need to transcend the traditional method of delivering services through the expansion of alternative systems has been understood. Various experiments have been undertaken in many countries of the Third World that involve commitment of communities.

The Third World Perspective

Small-scale community financed prepayment schemes were experimented on in India, Indonesia, Bangladesh, and Sri Lanka (National Council for International Health, 1984). In India, a dairy cooperative movement had supported a maternal and infant care program with village health workers providing the basic treatment backed up by a mobile health team. In Indonesia, a national prepayment scheme is being implemented under the label "fund for health" which grew out of a community development project for improved agriculture, irrigation and cooperatives. In Bangladesh, a health insurance scheme has been introduced which moved toward community development and income generating activities. A trend costing system was devised according to the paying capacity of the population. In Sri Lanka, workers conduct health activities as part of their overall community development work. These studies show that prepayment schemes work best in those affiliated with a continuing monetary flow such as cooperatives. The increase in the

capacity of communities and individuals to solve their own problem is contingent upon the ability of people to make better use of their own efforts and resources. Cooperatives have been recognized as one of the best organizational channels for enhancing this capacity once they maintain their autonomy from excessive bureaucratic rigidity. In Mexico, where primary health care is delivered to rural areas through a social security scheme, where the consumers are peasants who are not part of the wage-based economy or modern sector, the form of payment is non-monetary-through communal work, e.g., activities providing the community with safe water supply (Fernandez, 1984).

Stinson (1982) in his review of country experiences in community financing for health services, recognized eight major funding categories: service fees, drug sales, personnel prepayment, income generating schemes, community or individual labor, donation and ad hoc assessments, festivals, raffles, and similar activities. Major expenditures were directed toward the compensation of health workers, restocking of basic drugs, general revenues, partial defrayal of training, partial defrayal of hospitalization costs and supplementation of government health services. Zschock (1979) determined the public and quasi-public sources of health financing, such as: general tax revenues, deficit financing sales tax revenues, social insurance, lotteries and betting, direct employer financing, private health insurance, charitable contributions, direct household expenditures, and communal self-help.

In China, self-reliance in health care financing was accompanied with a combination of health insurance funds operated at the brigade level and the direct payment of fees for services (Wan and Hay, 1972). Likewise, there was a heavy reliance on low-level health practitioners. In rural Java, the Village Health Insurance scheme attempted to mobilize the existing economic potentials of the community in order to meet the cost of its members' health care. Each household had to pay a monthly contribution of RP50 (US\$20) which entitled them to health services (Hendrata, 1972). In Nepal, health insurance schemes were introduced in the Laletpur District in three areas — Asrang, Batgaon, and Bungmati where labor was considered equal to the value of the premium. The benefits included all health post services, drugs without charge, Rs50 charity for each outpatient visit, and Rs100 charity for each in-patient stay at the Lhanta Bhavan Hospital (Donaldson, n.d.).

The Philippine Scenario

Basic information on health expenditure pattern and financing strategies adopted in small scale health programs remain fragmentary and limited in the Philippines. The documents included studies on expenditure allocation for different types of health services, utilization of various types of health providers, demand for health services, and a compendium of the different projects in health care financing. Pioneering efforts to assess the demand for health care services were initiated by Popkin et al (1979) in the Bicol Multipurpose Survey conducted in 1978 from a sample of 1903 households. The survey procured information from the women on health, nutrition, income, work history, residence, and demographic characteristics.

However, no adequate analysis of survey data was made due to lack of price information on specific components of health care (e.g., physician services, drugs, etc.). Hence, another study was carried out in 1981 (Akin et al, 1982) which collected specific information on prices charged, transportation costs, hours of operation, payment methods, pharmaceutical charges, and waiting time.

Some of the findings could be specified as follows:

1. While government clinics charge no fees, voluntary contributions or donations were sought at a range of from P0.25 to P5.00.
2. Some government and private health practitioners priced services and medicines according to the perceived economic status of the patient.
3. The average cost of public visits was P0.50. Traditional health workers' visits cost an average of P3.10; and private visits, P14.49.
4. There was a reduction in the probability of a public visit relative to a traditional visit. The farther the traditional facility, the more likely was a visit to a private facility relative to a public clinic. The major attraction of traditional practitioners, it seems, was their convenience.
5. The longer a traditional visit takes, the more likely it would be preferred to the alternative since they might be pleasant experiences which add to the attractiveness of traditional medicine.
6. Having insurance led not only to a preference for private practitioners over traditional ones but also to a preference for public practitioners over traditional ones.
7. There was a diversion of private resources toward the male members of the households which might indicate better quality care for males.

A survey of 146 households in three barangays in Cabagan, Isabela was conducted by Lariosa (1982) to determine the household health-seeking behavior, expenditure pattern, and their determinants. Households initially resorted to home remedies in the treatment of their children. There was also a preference for modern providers in contrast to traditional and government health personnel. The mean monthly expenditure for respiratory or gastro-intestinal illness in children under six years of age was P7.40. Pre and post natal health-seeking behavior was low. The service provider most sought was the traditional midwife. Health-seeking behavior for preventive care was almost nil. Preventive medicine occupied a low priority among the residents since immediate benefits were not visible and the threat to life of the diseases to which they were directed was not recognized.

Cruz (1976) in a study of health-seeking behavior in an urban community, observed that the utilization of indigenous and professional non-medical health workers tended to be higher among clients with lower socio-economic status. Income played a significant role in the utilization of preventive care services in that higher income groups availed of preventive services more than the lower income classes do. Poorer clients tended to use government health facilities found within or in the immediate boundaries of the community. Utilization of herbs for treatment was common among rural bred clients with limited economic resources. Edu-

cation was a powerful leverage for differentiating the type of health-seeking behavior though.

Carino et al (1982) in a compendium of the operations and impact of five health delivery programs noted that in the poor's own perspective, health was not a priority need. The more important requirements included money, means of livelihood, and education. For the community, meanwhile, the needed triumvirate were roads, water, and electricity. Health was therefore not considered a salient necessity by the poor, although objective analysis showed that good health was basic not only to a decent life, but also to survival.

However it was noted that "When illnesses occur despite diligent and active efforts towards prevention and control, the price and availability of drugs and treatment become important considerations. Keeping these within the reach of the medically indigent requires several approaches." These are:

1. The utilization of herbal medicines and indigenous system of care.
2. Research into the systematic packaging of herbal and other locally available medicine.
3. The use of generic drugs in prescription.
4. The control of prices of these drugs so that they are within the reach of the masses.
5. The use of such devices as village drugstores, so that people can obtain needed drugs without incurring high transport costs, etc. The operation of the present medicare system should be studied with the end in view of increasing its beneficiaries.

From the aforementioned studies, it could be inferred that socio-economic status may be an important differentiating factor in the type of provider and management rendered. While higher income groups tended to have the means to purchase more health care than poor people, it seemed to be a common practice too for providers of health care to charge high income patients more per unit of health care than they would charge patients with lower incomes. Besides, at higher levels, people preferred to purchase health care that was either of higher quality per unit of service or had greater convenience attached to it. Accessibility was also an important factor in the choice of the service provider.

Alfiler (1982) compiled six case studies which documented the processes involved in the initiation, planning, organization, and implementation of specific projects operating in six areas in the country, namely, the Emmanuel Hospital project in Capiz, the Makapawa in Western Samar, the Barangay Health Worker Station in Oras, Eastern Samar, the Nagcarlan Barangay Health Mediks Program, the Barangay Health Workers Project in Bukidnon, and the Barangay Technician in Rizal and Muñoz, Nueva Ecija. In her introduction, she enunciated her observation that:

Community based projects represent a significant departure from the traditional view that the quality of health care in a community is the function of the community's gaining access to expert medical professions alone. Instead, these projects adhere to

the thinking that the more critical factor in ensuring good health for the people is the community's awareness, acceptance and active participation in identifying its health needs and determining the means through which these needs can be met in the context of the political, social and economic realities obtaining in the community. The projects seek to foster community self-reliance in health by developing and strengthening the community's sense of responsibility and its capability of prioritizing needs, initiating action, organizing itself and make decisions at the same time tapping resources for its own health needs.

Common to all these six projects is their reliance on the local community health worker who offers her services to the community as a volunteer. Hastening the community organization processes and providing the community free "services" run counter to the long-term objective of self-reliance as it promotes dependency and inhibits community mobilization. Most of the communities provided cash contributions but no statement of regularity was given. Participation of the community was mainly focused on decisions as to the means of raising the funds or mobilizing resources as well as how these resources are to be managed and controlled. Alfiler's conclusions were as follows:

1. The depressed rural communities had limited cash resources but abundant supply of human resources and other resources in kind;
2. Local resource utilization schemes for community-based approach to health tended to be one-shot, initiated through irregular fund-raising activities, and implemented by community organizations;
3. Resources produced by these efforts tended to be meager and limited so far to the financing and purchase of drugs.
4. Other local resource utilization schemes tended to generate limited resources which are grossly inadequate to cover cost of comprehensive medical services encompassing all levels of health care. This situation called for the development of a mechanism by which local resources tapped and mobilized might be supplemented from public and other sectors, to constitute an adequate resource base to finance an extensive and comprehensive community health care at all levels.

III. ALTERNATIVE HEALTH CARE FINANCING IN SIX BARANGAYS IN ILOILO

In January 1983, the Primary Health Care Operations Research (PRICOR) funded an operations research project in the province of Iloilo in Western Visayas to test the feasibility and effectiveness of alternative health care financing schemes devised and formulated by the communities themselves. The project was divided into three major components: Phase I (Baseline Information Procurement; Phase II (Formulation and Implementation of the Alternative Financing Schemes); and Phase III (Assessment of Program Outcomes).

Methodology

Phase I — Baseline Information Procurement

Preliminary to the task of planning and implementing appropriate community health financing schemes, two things were considered: (1) the formulation of an adequate conceptual framework that delineated the important variables and their interaction to describe the dynamics of the relationship essential to the definition of specific strategies, and (2) the undertaking of a community survey to elicit the perceived health problems in the community, the financial resources available, health seeking behavior, perceptions of attitudes towards and utilization of current health service providers, and prospects for participation in a health financing scheme. A general analytic framework, therefore, was devised which took into account the elements essential in the formulation of a health financing scheme. Basic to this was the recognition of two salient points:

1. An explicit assessment of the factors that determine demand for specific health services; and
2. Linkage of the knowledge of these factors to the formulation of strategies or programs that will ensure the improvement of the quality of the health services provided, and coverage to deliver the services to the inaccessible poor.

Knowledge of the determinants of the demand for the health services could be the starting point for the development of an administrative mechanism for implementation which will provide a feasible machinery for an effective program.

The framework is illustrated in Figure 1.

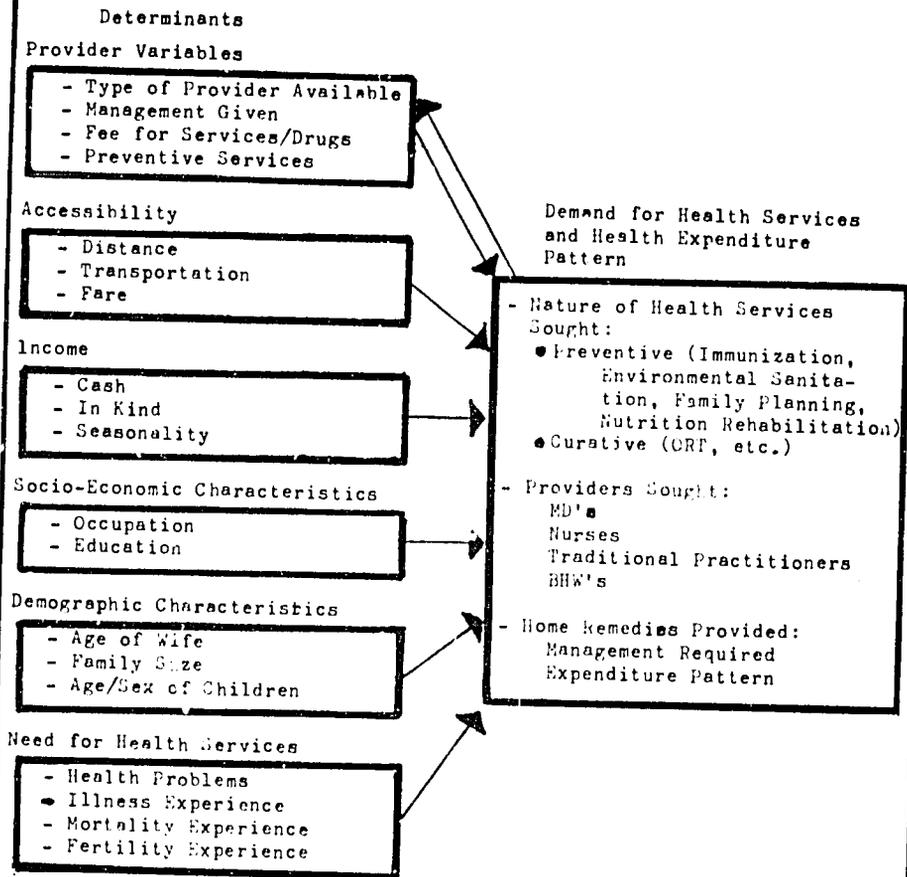


Figure 1. Framework in Analyzing the Determinants of Health-Seeking Behavior

The framework illustrated in Figure 1 delineates the interaction of the variables that can predict the demand for specific health services and their relationship with the provider variables. The core of the analysis, therefore, is the behavioral pattern in health care from the consumer and the providers' perspective. The demand variables include the basic expenditure pattern, the providers' sought for specific health problems, income, accessibility and home remedies resorted to, while the provider variables include the characteristics of providers, the management given, the fee for services, and preventive services given. This interaction is affected by socio-demographic variables such as age of wife, occupation, education, income, accessibility of health sources, and family size. Such knowledge leads to the determination of the appropriate schemes for community financing in health services.

Phase II – Formulation and Implementation of the Alternative Financing Schemes

The second stage of the project involved several processes: (1) situational analysis from the baseline information obtained; (2) community feedback and discussion; (3) selection of feasible alternatives; (4) discussion of the operational aspects of the strategies proposed; (5) assessment of the resource capability of the communities; (6) development of a blueprint for the operation plan; (7) formulation of a mechanism for implementation and monitoring; and (8) documentation of the processes involved, including problems encountered in project implementation.

Therefore, the project focused on the operational aspects of the program – the mechanism by which strategies were drawn and implemented taking into account constraints and facilitating factors within the set-up as well as externalities.

Phase III – Assessment of Program Outcomes

Program outputs were assessed through two major indicators – changes in health-seeking behavior and health expenditure pattern. In the first phase of the project, a baseline survey was conducted to elicit among others: the income and expenditure pattern of households with reference to health, the health-seeking behavior, perception, and utilization of health resources as well as potential for community participation in financing health care. A post implementation survey was carried out dealing with the same inquiries and assessing changes in the areas of concern. Besides, the PUSH Monthly Record Keeping System which was filled out on a monthly basis was utilized in the study communities and the selected control areas to assess changes on a time series basis. The conceptual framework for the entire project is given in Figure 2.

Figure 2. A CONCEPTUAL FRAMEWORK FOR THE PRICOR FINANCING PROJECT

DETERMINANTS

OPERATIONAL

- Existing health problems
- Existing health services
- Community financial and manpower resources
- Potential resources
- Availability of health manpower
- Community organization
- Level of political commitment

PARTICIPATORY

- Household resources (Financial, manpower, material)
- Utilization pattern of existing health facilities (gov't., private, indigenous)
- Perceived health problems in the community
- Perception of health promotion as a household responsibility
- Current expenditure on health
- Willingness to allocate funds for health services

HEALTH FINANCING SCHEMES

STRATEGIES

Individual Household

- Monetary fee for service based on direct care services (payment made during harvest months)
- Flat rate monetary contributions to be made by all households regardless of service utilized
- Sliding scale of fees depending on the household capability independent of service rendered
- Individual savings for future health needs (health insurance)
- Donation of materials and services in exchange for health care (e.g. assistance in feeding programs, environmental sanitation, contraceptive distribution, etc.)

Community

- Income generating activities to procure funds for health services
- Community involvement in specific health services (environmental sanitation, feeding programs, nutrition education, etc.)
- Allocation of funds (government or private) for health services (MLGCD)
Fund raising activities (benefit dance, beauty beauty contest)

HEALTH SEEKING BEHAVIOR

- (+) Increased participation in immunization programs, family planning programs, environmental sanitation campaigns, food production; increased utilization of community health service facilities for preventive and curative purposes
- (-) Shift toward traditional and indigenous medicine
- (-) Utilization of free health services in adjoining communities which will unduly impose a burden on the said areas

HEALTH EXPENDITURE PATTERN

- (-) Health expenditure allocation in the total budget
- Proportion of expenditure on preventive services in relation to the curative services
- Change in health expenditure before/ after inception of the financing scheme
- Cost effectiveness, cost efficiency
- Government expenditure relative to household expenditure

The Setting

Six rural communities or barangays in the province of Iloilo where an established Primary Health Care Program is in operation constituted the research sites. The areas served by Barangay Health Workers (BHWs) trained for the PUSH project formed the primary unit for the selection of the study areas. The six research sites were chosen purposively to represent the various economic sectors (rice, sugar, fishing) in the province. A set of six villages with almost similar demographic characteristics was designated as controls for evaluative purposes.

Geo-Physical Characteristics of the Province

Iloilo is one of the four provinces that comprise Panay Island. The province of Antique bounds it on the west, Capiz on the North, Visayas Sea and Guimaras Strait on the east, and Panay Gulf and Iloilo Strait on the south and southeast, respectively. Iloilo also includes the sub-province of Guimaras, a small island lying at the opposite and southern part of the main island. It has a total land area of 5,324 square kilometers with 46 municipalities.

Iloilo has a total population of 2,433,641 as of the 1980 Census with an annual growth rate of 2.4 percent. The province is predominantly rural in character with 27.7 percent of the population residing in the rural areas and 61 percent employed as farmers, fishermen, hunters, loggers, and related workers. The rest are craftsmen, production process workers, and laborers (9.6 percent); sales workers (7.4 percent); service, sports, and related workers (7.1 percent); professionals and technical-related workers (5.1 percent); and workers in transportation and communication (4.0 percent); and others.

The Study Barangays

Badiang, Anilao. Badiang is one of 21 barangays in Anilao, a sugar-producing municipality on the northern portion of Iloilo. It is four kilometers from the Poblacion or town proper. Much of the agricultural land is devoted to sugar cane and a smaller portion to fishponds. It has a total population of 986 in 158 households, not including the countless sugar cane laborers or the sacadas who are considered temporary migrants in Hacienda Rica.

Badiang is subdivided into three sub-communities: the Barangay Proper, Balagon, and Hacienda Rica. The barangay proper is located along the national road. The public elementary school, the talipapa, and the health center are found here. On the other hand, Hacienda Rica is a kilometer away from the barangay proper. People are employed by the Hacienda as sugar cane laborers. Sitio Balagon is on the northern part — a kilometer and a half from the barangay proper. Most of the population is concentrated in this area. Houses in Badiang are made of mixed materials, usually of cement, wood, or bamboo for walls, and nipa or G.I. sheets for roofing.

Maribuyong, Duenas. Maribuyong is remote from the Poblacion and is one of the sparsely-populated barangays of Dueñas. It has 103 households and a total population of 533. Most of the people depend on sugar cane and rice farming for livelihood. The barangay has a public elementary school, a chapel, a multipurpose hall, and a health center.

It is bounded by barangays Inadlawan on the north, Catig on south, Fondacion on the east, and Banogan on the west. Most of the houses are scattered and made of light and mixed materials like G.I. sheets or nipa for roofing, and cement, wood, or bambon for walls.

Balcon Milleza, Jordan. Balcon Milleza is located on the northern part of Jordan, a municipality in the sub-province of Guimaras. It is bounded by the Iloilo Strait on the northwestern portion, Hoskyn on the east, and Balcon Maravilla on the south. Rainy days in the barangay usually fall in the months of November to May. Dry season occurs during the months of June to October. It has a total population of 635 with 109 households.

The mountainous terrain distinctively separates the barangay into two sub-communities (sitios), namely, the barangay proper (Balcon) and Sitio Singcalang. The barangay proper is two kilometers away from the national road and the Poblacion. It is accessible to any type of vehicle. People in the barangay proper cultivate corn and other rootcrops for their source of livelihood. Others engage in charcoal-making. Sitio Singcalang can be reached by pump boat from Iloilo City, and thereafter on foot when going to the barangay proper. Here the populace relies heavily on fishing, fruit growing, and cattle-fattening for subsistence.

The barangay has a public primary school situated in the barangay proper, a health center in Sitio Singcalang, and a dilapidated chapel which they call "ermita." Houses made of light materials like bamboo and nipa are a common sight in the barangay.

Bucaya, San Joaquin. Bucaya is three kilometers from the poblacion of San Joaquin, a municipality on the southern portion of Iloilo. It is a coastal barangay, situated along the national road. Most of the people spend the wee hours of the morning by the sea; then, by midday one can find them upland doing their farm chores.

Bucaya has a total population of 935 with 174 households as of the 1980 Census. Houses in the barangay are clustered and are made of light, strong or mixed materials.

Bucaya has a public elementary school, a secondary school and a health center.

Bololacao, New Lucena. Barangay Bololacao is a kilometer away from the poblacion of New Lucena. It is bounded on the west by Barangays Guinobatan and Wari-wari on the south, and the Poblacion on the southeast. The main road leading to the barangay proper is dusty and stony and is accessible to all types of vehicle. Although the tricycle is the chief means of transportation, places can be reached by walking. Bololacao is basically a farming community where people depend on their rice and corn produce for livelihood and where most of the land is rainfed. To

augment their meager incomes, people are engaged in poultry-raising and vegetable gardening.

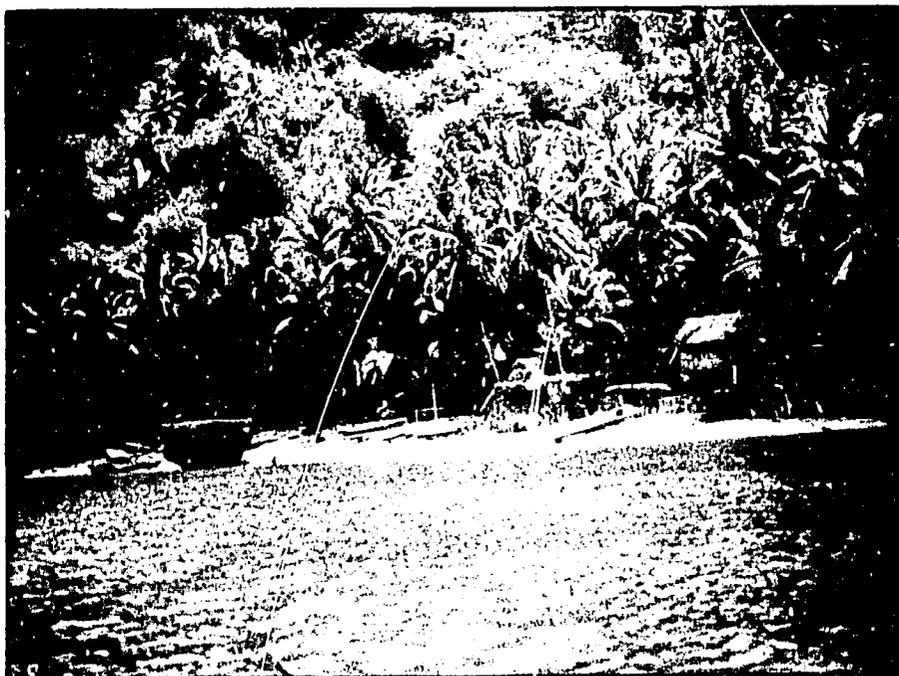
With 168 households and a total population of 902, the barangay is a solid settlement subdivided conveniently into five puroks or sub-communities, namely: Tan Abo, Juan Sikol, Tan. Roman, Tana Monang, and Tan Aqua. Houses in the barangay are built of a wide range of materials: strong, mixed and light.

Among the facilities available in the barangay are the rural health center, a chapel, a community hall, a public elementary school, and a secondary school.

Tastasan, Buenavista. Tastasan is one of the 41 barangays on the eastern part of the municipality of Buenavista in Guimaras. It is two kilometers away from the Poblacion. It has a total land area of 245.1 hectares and is suitable to rice, corn, and citrus fruits. Land is not irrigated in Tastasan but rainfed.

Tastasan has a total population of 758 with 131 households. Aside from farming, people augment their incomes by poultry raising and cattle fattening.

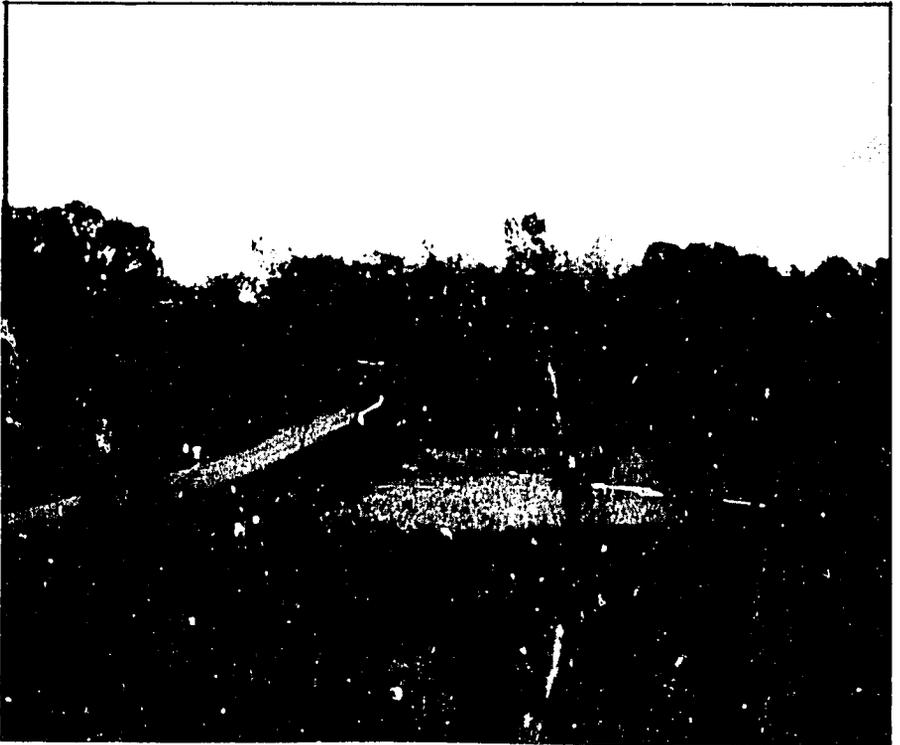
Houses usually made of mixed materials are distinctively scattered about half a kilometer apart. Facilities are insufficient. Water, for example, was a problem during the recent drought. The health center is far from the center of the barangay, and no multi-purpose hall exists within the barangay. People have to use the school rooms during assembly meetings. Although there is an existing public primary school, most of the young students prefer to walk to a school in the neighboring barangay.



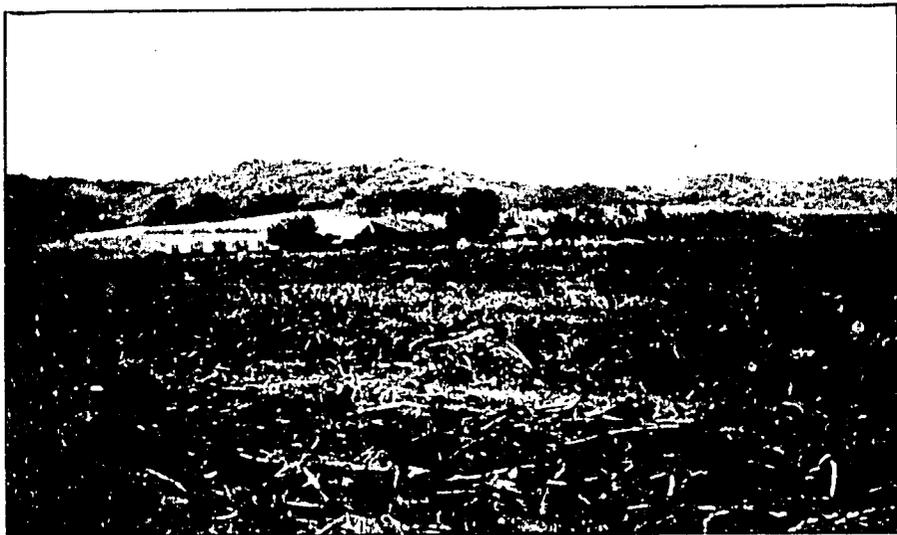
MILLEZA, JORDAN: A coastal barangay



BUCAYA, SAN JOAQUIN: A coastal barangay



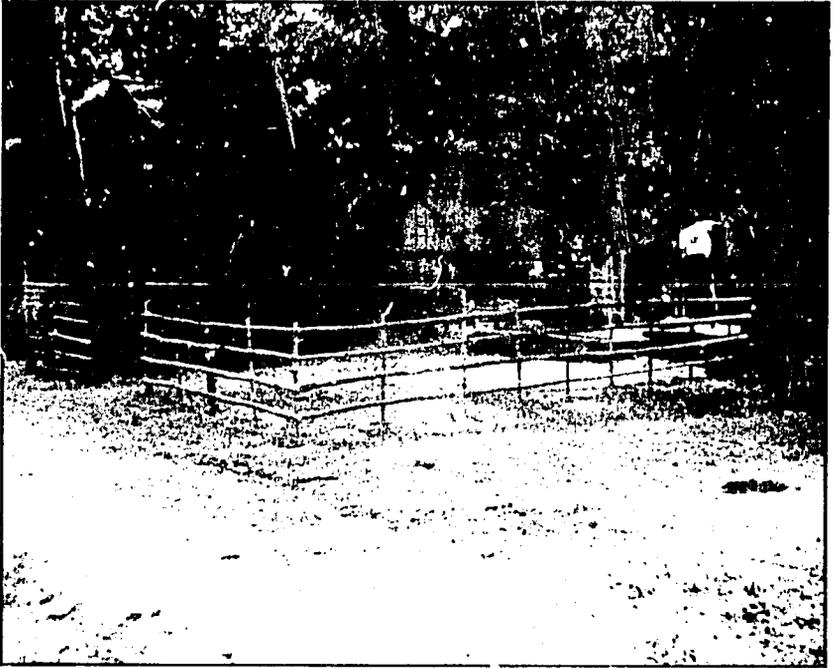
BOLOLACAO, NEW LUCENA: A rice-based barangay



BADIANG, ANILAO: The sugar-based barangay



MARIBUYONG, DUENAS: whose population depends on both sugar and rice for livelihood.



Fencing (above)
and
Weighing (left)

IV. PROFILE OF THE HOUSEHOLDS IN THE STUDY BARANGAYS

Demographic and Socio-Economic Characteristics

Population Size

The six experimental barangays have population sizes ranging from 533 to 986. In Milleza, Badiang, and Bololacao the females outnumber the males, while in the remaining three, the males predominate.

Table 2. Population size by sex, six barangays, 1983

BARANGAYS	MALE		FEMALE		TOTAL	
	N	%	N	%	N	%
Milleza	300	47.2	335	52.8	635	100.0
Bucaya	471	50.4	464	49.6	935	100.0
Maribuyong	270	50.7	263	49.3	533	100.0
Badiang	483	49.0	503	51.0	986	100.0
Tastasan	397	52.4	361	47.6	758	100.0
Bololacao	347	48.5	465	51.5	902	100.0

Age Distribution

The population in these barangays is relatively young as judged from their average ages: Tastasan – 23.2 years, Milleza – 23.6 years, Badiang – 23.9, Maribuyong – 26.4, Bololacao – 26.8, and Bucaya – 27.3. The preschoolers (0-6 years old), as a proportion of the population, are 19.6 percent for Tastasan, 19.1 percent for Bololacao, 18.4 percent for Milleza, 17.8 percent for Badiang, 15 percent for Bucaya, and 14.8 percent for Maribuyong. Over a third of the population are in the economically dependent ages, below 15 years.

Educational Attainment

More than half of the barangay population ten years old and above, have less than 6 years of education. In Milleza, only 18.7 percent of population have had more than six years of schooling. On the other hand, for Maribuyong and Bololacao, the percentages with better levels of education (high school and above) are higher at 43.0 percent and 44.8 percent respectively. For the remaining three barangays, the figure is approximately 37 percent. On the other hand, Bololacao, Bucaya, and Badiang report a considerably higher percentage (11 to 12 percent) with college education.

Table 3. Age distribution of the population, 1983

Age Range	Milleza		Bucaya		Maribuyong		Badiang		Tastasan		Bololacao	
	N	%	N	%	N	%	N	%	N	%	N	%
0 - 6	117	18.4	143	15.3	79	14.8	176	17.8	149	19.6	172	19.1
7 - 19	214	33.7	305	32.6	174	32.6	332	33.7	241	31.8	261	28.9
20 - 49	222	35.0	323	34.6	190	35.6	363	36.8	281	37.1	309	34.3
50 & Above	82	12.9	164	17.5	90	16.8	115	11.7	87	11.5	160	17.7
TOTAL	635	100.0	935	100.0	533	100.0	986	100.0	758	100.0	902	100.0
Mean (\bar{X}) Age	23.6		27.3		26.4		23.9		23.2		26.8	

Table 4. Percentages of population 10 years old & above by highest educational attainment, 1983

Educational Attainment	Milleza		Bucaya		Maribuyong		Badiang		Tastasan		Bololacao	
	N	%	N	%	N	%	N	%	N	%	N	%
None		8.1		3.6		2.7		3.7		3.7		2.5
Grade 1-4		34.2		24.8		19.3		28.2		26.9		22.4
Grade 5-6		39.0		33.0		35.0		31.8		32.8		30.3
HS 1-4		11.6		15.8		23.2		19.3		19.6		21.7
HS Grad		3.3		9.0		8.8		3.3		5.3		7.1
College 1-4		2.6		4.9		6.6		7.0		7.0		5.2
College Grad		.5		6.4		2.4		5.0		2.9		7.2
Vocational Grad		.7		2.5		2.0		1.7		1.8		3.6
TOTAL		100.0		100.0		100.0		100.0		100.0		100.0
N		448		715		410		728		592		646

Occupation

The major occupation of the population ten years and above is expected to relate to the economy of their locality. In the fishing barangays of Milleza and Bucaya, a significant proportion is engaged in farming and fishing.

In the areas of Maribuyong and Badiang which are both classified as predominantly sugar-based, the occupational profile varies. About 20 percent of the respondents in Maribuyong indicate farming as the major occupation and 6.1 percent are laborers. In contrast, in Badiang only 2.3 percent are farmers and 19.0 percent laborers. It is observed that in Maribuyong, while the laborers are sugar workers, a significant percentage farm their small lots. However, in Badiang, the household heads are mainly sugar workers who are affected by the seasonality of labor in large sugar cane haciendas. While Tastasan and Bololacao are supposed to represent the rice producing areas, only 7.7 percent and 9.4 percent of the respond-

Table 5. Percentages of population 10 & above, by occupation, 1983

Occupation	Milleza	Bucaya	Maribuyong	Badiang	Tastasan	Bololacao
Farming	15.6	8.1	20.3	2.3	7.7	9.4
Fishing	11.6	9.6	-0-	-0-	-0-	-0-
Laborer	5.7	1.3	6.1	19.0	7.4	6.3
Vendor	2.4	1.7	-0-	2.3	.2	1.1
Professionals	.4	3.4	3.4	2.3	.9	3.7
Clerical	3.7	1.0	2.0	2.1	1.5	1.4
Housekeeper	19.9	24.9	20.5	13.0	22.1	23.4
Unemployed	6.6	6.7	13.2	6.6	14.2	6.1
Student	24.3	27.0	32.0	38.3	27.6	28.9
Others	9.8	16.3	2.5	14.1	18.4	9.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
N	248	715	410	728	592	646

ents, respectively, are engaged in farming. In Tastasan, for instance, a large number are classified as laborers. Across all barangays, the housekeeper and student categories have the highest frequencies. High percentages of unemployment are found in Tastasan (14 percent) and Maribuyong (13 percent).

Characteristics of Respondents

Family Type and Size

Bucaya, Bololacao, and Badiang have large numbers of households at 174, 168, and 158, respectively. Badiang has the highest average family size with 6.2 members which may account for its having the biggest population size among the six experimental barangays. Maribuyong has the smallest average family size at 5.2.

Table 6. Percentage of households by family type and average family size, 1983

BARANGAYS	Percentage		Mean Family Size			No. of Households
	Nuclear	Extended	Nuclear	Extended	Both	
Milleza	80.7	19.3	5.8	6.2	5.8	109
Bucaya	67.2	32.8	5.2	5.6	5.4	174
Maribuyong	89.3	10.7	5.1	5.7	5.2	103
Badiang	75.3	24.7	6.1	6.6	6.2	158
Tastasan	80.2	19.8	5.5	7.0	5.8	131
Bololacao	71.4	28.6	5.2	5.6	5.3	168

More than 65 percent of households are nuclear in character (parents and unmarried children) with Maribuyong exhibiting the highest proportion (89 percent). The average nuclear household size is six for Badiang and approximately five for the rest. The average size for extended families is seven in Tastasan; six in Badiang and Milleza; and approximately five in Bololacao, Maribuyong and Bucaya.

Age of Respondents

Majority of the respondents are wives (Table 7). However, in Tastasan and Milleza a considerable percentage of the respondents are husbands (13.7 percent and 11 percent, respectively). In Bucaya, other relatives constitute 16.6 percent of the respondents. In terms of age, the husbands are on the average of 52.7 years while the wives are 43 years.

Educational Attainment of Respondents

The median educational attainment of the respondents in all barangays is Grade 6. As in the section on schooling of the general population, the educational

Table 7. Distribution of respondents by average age and household position, 1983

BARANGAY	N	Household Position (in %)				M E A N A G E		
		Husband	Wife	Others	TOTAL	Husband	Wife	Others
Milleza	109	11.0	85.3	3.7	100.0	58.3	42.2	- 0 -
Bucaya	174	.6	82.8	16.6	100.0	52.0	44.6	59.4
Maribuyong	103	5.9	92.2	1.9	100.0	55.3	45.0	- 0 -
Badiang	158	- 0 -	92.4	7.6	100.0	- 0 -	41.5	56.5
Tastasan	131	13.7	84.0	2.3	100.0	53.1	41.8	- 0 -
Bololacao	168	6.5	81.1	12.4	100.0	52.0	44.5	53.9

Table 8. Percentage of respondents by educational attainment, 1983

Educational Attainment	Milleza	Bucaya	Maribuyong	Badiang	Tastasan	Bololacao
No. Schooling	10.1	5.2	3.9	6.3	6.1	1.2
Grade 1-4	33.0	26.9	15.5	22.8	29.8	23.7
Grade 5-6	45.9	38.1	54.4	49.4	39.7	42.6
HS 1-4	7.3	12.6	11.6	12.0	10.7	11.8
HS Grad	2.8	4.6	5.8	3.2	3.8	8.9
College 1-4	0.9	3.4	2.0	3.2	6.9	2.8
College Grad	- 0 -	8.0	3.9	2.1	1.5	5.9
Vocational Grad	- 0 -	1.2	2.9	- 0 -	1.5	3.0
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
n	109	174	103	158	131	168

profile of respondents in Milleza is relatively in the lower level. Bololacao has the smallest proportion of respondents with no schooling (1.2 percent). Bucaya and Tastasan have higher percentages of respondents with some college education.

Income and Expenditure Pattern

Average Income and Expenditures

Median incomes are consistently lower than average income, indicating the presence of earnings at the extreme upper income groups. The highest median income (P6,333) is reported in Badiang which has a predominantly sugar-based economy and a significant proportion of the working population as sugar laborers. On the other hand, Maribuyong which is an extensive sugar area has the lowest median income (P2,657) among the participating barangays. It was earlier noted that despite Maribuyong's classification as a sugar-based area, most of those employed are farmers. The high median in Badiang may be attributed to the better wage structure and wage monitoring in the sugar industry despite the gross work seasonality experienced by sugar workers. The rice-based barangays of Tastasan and Bololacao have median incomes of P3,863 and P4,192 respectively. Milleza and Bucaya which are fishing villages have lower median incomes of P2,739 and P3,473, respectively.

Expenditure seems to be unrelated to income. In Milleza, Bucaya, Badiang, and Bololacao, income exceeds the expenditure; in the remaining barangays, the reverse is noted. Faulty recall of expenditures may explain the under-reporting of expenses since the survey question on expenditure pertained to the previous year.

**Table 9. Mean and median annual incomes and expenditures, 1983
(in Pesos)**

Barangays	Income		Expenditure		N
	Mean	Median	Mean	Median	
Milleza	3270.00	2739.50	2967.38	2658.59	109
Bucaya	4844.32	3473.18	4644.00	3287.96	174
Maribuyong	3897.55	2657.30	3897.55	2803.85	103
Badiang	6834.94	6332.83	6151.39	5582.83	158
Tastasan	4530.00	3863.14	5346.82	4658.59	131
Bololacao	4870.75	4191.80	4673.15	4092.09	188

Expenditure Allocation

The expenditure pattern reveals that food has the biggest allocation ranging from 61-67 percent except in Maribuyong, where the proportion of expenditure on food is 53 percent. Education is the second biggest expenditure item. The percentages range from 7 percent to 14 percent. Maribuyong and Bololacao have bigger

Table 10. Distribution of annual expenditures, 1983

Expense Allocation	Milleza %	Bucaya %	Badang %	Maribuyong %	Tastasan %	Bololacao %
Food	63	65	62	53	67	61
Housing	8	5	6	9	6	7
Clothing	7	6	6	9	6	6
Education	8	7	7	14	7	8
Medical Care	7	6	6	7	6	1
Others	7	11	13	8	8	17
TOTAL	100	100	100	100	100	100
Median	2659	3288	3582	2804	4659	4092
Mean	2957	4644	6051	3897	3911	3155
N	109	174	158	103	131	168

percentages of expenditures for education relative to the other barangays which supports the earlier observation that these two barangays have higher educational attainment. The allocation for medical care has been extremely low (below 10 percent) for all barangays.

Perception of Projected Income

When the households were queried on whether they anticipated any changes in their incomes in the subsequent year, the majority of the respondents felt that their incomes would not change at all. The exception is Maribuyong wherein only 20 percent of the respondents perceived neither improvement nor deterioration in their income while 78.6 percent expected a decrease in their income. In general, more households expected a decrease than an increase in their income for the following year.

Illness Pattern and Management

Pattern of Illness

The retrospective nature of the data collection on illness pattern in the past year precludes an adequate quantification of the prevalence of specific illnesses, their severity, and duration. Therefore, the respondents were asked about the common illnesses that occurred in the household for children and adults, the health providers sought, and the management given. In the six barangays studied, respiratory illnesses (cough, colds, influenza) stood as the most common health problems among children and adults. This was followed by gastrointestinal infection manifested mainly by diarrhea. November, December, and January were the reported peak months for the occurrence of respiratory infections while no specific months were given for gastro-intestinal illnesses.

Table 11. Household members reported ill in six barangays, Iloilo, 1983

Population (0-6 Years of Age)

Illness	Milleza No.	Bucaya No.	Maribuyong No.	Badiang No.	Tastasan No.	Bololacao No.
Respiratory	86	60	29	100	77	94
Gastrointestinal	18	14	13	39	20	19
Measles/Mumps	15	5	9	14	18	3
Others*	6	8	6	13	11	16
n	117	143	78	176	149	172

*Inflammation of the ear, convulsion, etc.

Population (7 Years & Above)

Illnesses	Milleza No.	Bucaya No.	Maribuyong No.	Badiang No.	Tastasan No.	Bololacao No.
Respiratory	169	91	87	127	69	107
Gastrointestinal	23	15	15	20	14	22
Measles/Mumps	15	2	12	3	21	4
Others*	75	45	41	118	65	78
n	518	792	609	810	354	580

*Heart Failure, Rheumatism, Eye Diseases, Paralysis, Hepatitis, etc.

Table 11 shows the pattern of illness by the respondents and their frequency of occurrence as reported. The problem of recall limits the adequate measurement of disease frequency. Therefore, the aim of this table is to present only the occurrence of specific illnesses. Percentages were not obtained since the figures in each category were not mutually exclusive and respondents tended to report more than one illness in the time frame considered. Besides, more than one member of household could be reported. Clearly, there was an understatement of the magnitude of the illness in the households.

Management

Majority of the respondents resorted to home remedies prior to outside consultation. These were manifested in the form of over-the-counter drugs, herbal medicine, massage, and sponge bath. The following is a breakdown of households that utilized home remedies upon perception of illness:

Milleza	—	92.7%
Bucaya	—	98.9%
Maribuyong	—	96.1%
Badiang	—	96.9%
Tastasan	—	93.8%
Bololacao	—	89.6%

The more common over-the-counter drugs for respiratory illnesses were **Medicol**, **Neozep**, **Biogesic**, **Afebrin**, **Tuseran**, **Paracetamol**, **Temptra**, and **Vicks**. For **gastro-intestinal** diseases including diarrhea, medications included **Diatabs**, **Guanamycin**, **Pedialyte**, **Kaopectate**, **Sulfaguanadine**, and **Oresol**.

The more common herbal medicines were **buyo**, **ginger**, **pasaw**, **alibhon**, **bitter melon**, **cotton leaves**, **oil**, **calamansi**, and **guava** for respiratory diseases, while **star-apple**, **string beans**, and **rice water** were ingested for diseases of the gastrointestinal tract

Table 12. Percentages of households consulting specific health providers, 1983

Item	Milleza	Bucaya	Maribuyong	Badiang	Tastasan	Bololacao
Respiratory						
Private Doctor	18.3	9.9	33.3	18.8	41.9	13.1
Government Doctor	1.8	20.9	3.5	12.8	20.9	15.9
Midwives	9.5	23.1	26.1	24.2	9.3	16.8
BHW	17.8	—	5.8	1.5	5.8	4.7
Trad. Healer	26.0	7.7	13.0	15.8	4.7	11.2
Gastro-Intestinal						
Private Doctor	21.7	26.7	21.4	9.5	52.4	13.6
Government Doctor	—	33.3	—	14.3	4.8	22.7
Midwives	4.4	13.3	14.3	23.8	4.8	9.1
BHW	13.1	—	7.1	—	4.8	9.1
Trad. Healer	30.4	—	35.7	38.1	—	18.2
n	109	174	105	158	131	168

*Percentages don't add up to 100 due to a tendency to report more than one provider

There was a wide variability among the six barangays in terms of the persons sought for specific problems. For respiratory illnesses, private physicians were commonly consulted in Maribuyong and Tastasan. In Bololacao, Bucaya, and Badiang, the midwives and government doctors provided the curative services. A different feature was observed in Milleza with the traditional healer (soruno) as the person consulted most frequently for respiratory problems. A notable observation in the health management in Milleza was the relatively higher utilization rate of the BHW, both for respiratory and gastro-intestinal problems. With regard to gastro-intestinal illnesses, private doctors were utilized in Tastasan. An added dimension was the increasing use of traditional healers in Maribuyong Milleza, and Badiang. Medications reported included a combination of the aforementioned over-the-counter drugs and herbal medicines. Government doctors provided major services for gastrointestinal therapy in Bololacao and Bucaya. Based on these findings, it seems that barangay residents have different perceptions of specialists for specific health problems.

Health Care Expenditure

The amount and proportion of household incomes spent on health care depend on how much people value health in comparison with other categories of

goods and services. While health care is regarded as a necessity, it is difficult to assess its relative importance in the provision of a minimally adequate standard of living when compared with other basic needs such as food, clothing, and shelter due to its crisis orientation in many households. This problem is compounded by the fact that health care is perceived as an occasional need by most individuals, while food, clothing and housing are considered daily needs. Thus, health care expenditure can be postponed until the need arises while the cost of other necessities must be borne on a continuing basis. The largest proportion of private income allocated to health care is spent for curative services which could be explained by the fact that the lower the household income, the more likely it is that only the immediate needs are provided for. Curing acute illnesses obviously represents a more pressing need than reducing latent illnesses or the risk of future illnesses. Besides, health care practitioners are trained and experienced primarily in providing curative rather than preventive care. The medical profession has in the past responded to immediate demand for curative services rather than make a concerted effort to create the demand for preventive health care. The low priority given to preventive care in many communities is due to the perception that preventive measures are not regarded as health care activities, e.g., environmental sanitation, nutrition education, and immunization.

Medical Expenditure Pattern

Consultation fees in the six barangays vary widely. However, the figures might not be precise due to the difficulty of remembering the exact amounts paid for specific consultations over the year. In principle, the barangay health centers are not supposed to charge for consultation but donations are encouraged. Based on the survey, the BHWs, BHCs, and midwives are given donations averaging P5.50 per consultation.

Table 12a shows that a big expense is incurred for hospitalization although in Maribuyong and Bololacao it is second only to the amounts spent for medicine. Expenses for drugs are relatively sizeable ranging from P46 for Tastasan to P96 for Maribuyong. Among the service providers, the households paying most for the

Table 12a. Median expenditure for medical care, 1983

Expense Items	Milleza	Bucaya	Badiang	Maribuyong	Tastasan	Bololacao
	(in Pesos)					
Doctor's Fees	47	42	33	37	56	35
Traditional Healers	28	26	28	26	38	28
Midwife/Paltera	49	37	66	31	55	30
Drugs/Medicines	48	73	87	96	46	82
Hospitalization	125	125	225	87	156	44
Others (e.g. donation)	24	27	26	25	28	26
n	103	174	158	103	131	168

doctor are in Tastasan and the average amount is P56 for each consultation. In Milleza and Badiang, payments to midwife/paltera exceed doctor's fees.

Outlets for drugs included the barangay health center, the rural health units, and the sari-sari stores (small variety stores). The cost of drugs reported by the respondents were aspirin – P0.45/tablet, Myracof – P0.35 tablet; Biogesic – P0.25/tablet; Ampicin – P18/bottle; Kaopectate – P21/bottle; and Tuseran – P10/ bottle. With repeated bouts of illnesses, it is estimated that the annual expenditure on drugs could range from P100 to P150. A tendency for physicians to provide a different type of management to higher income groups is reflected in the use of X-rays, dextrose, and more expensive drugs in a small number of cases wherein household incomes are relatively high.

Most of the respondents procured their drugs from either the botika-sa-barangay (barangay drugstore) or the rural health units. The frequency of occurrence of respiratory and gastro-intestinal problems might have accounted for the cumulative expenses incurred for drugs which represented almost half of the total medical expenses. Given the more common health problems, the cost of drugs and consultation rates, it is reasonable to assume that annually the total medical cost per household would range from P200-P300. It is rather difficult to arrive at a fixed estimate due to recall problems in terms of number of consultations, amounts paid, type and cost of medication. At best, rough calculations were made just to gain insight into the relative expenditure for medical care. It is believed, though, that this range is still on the low side.

More than a third of the respondents felt that the cost of medical services was high. However, a substantial portion expressed that it was affordable.

Table 13. Perception of the cost of medical services, 1983.

Perception of the Cost of Medical Expenses	Milleza	Bucaya	Maribuyong	Badiang	Tastasan	Bololacao
High	28.4	46.0	39.8	32.0	67.3	26.2
Low	21.2	10.9	15.5	11.0	6.9	10.1
Affordable	46.8	42.5	41.7	57.0	25.8	63.7
Don't know	3.6	0.6	3.0	— 0 —	— 0 —	— 0 —
	100.0	100.0	100.0	100.0	100.0	100.0

Accessibility of Health Facilities by Distance and Travel Time

The pattern of utilization of health services is influenced by a number of factors – the state of health of the household members, geographical locations, and socio-economic status. The provider is usually the determinant of the type and cost of medical services. Accessibility, aside from cost, can likewise limit the utilization of

health care. Majority of the barangays felt that the health services were accessible in the percentages given as follows:

Tastasan	—	84.7%
Maribuyong	—	51.4%
Bucaya	—	92.5%
Milleza	—	69.7%
Bololacao	—	75.6%
Badiang	—	71.5%

For those who claimed that the health services were accessible, 83 percent in Maribuyong, and 85 percent in Bololacao lived within the 1 kilometer radius of the health facilities. Most of the respondents who claimed that the health facility was not accessible, lived beyond 1 kilometer. For those who indicated the accessibility of the health facilities, the travel ranged from 10 to 36 minutes. For those coming from remote areas, travel time ranged from 35 minutes to 2 hours.

Table 14. Accessibility of health facilities by distance and travel time, 1983

BARANGAY	% Who mentioned that distance was ≤ 1 km among those who perceived that HF is accessible	% Who mentioned that distance was > 1 km among those who perceived that HF is inaccessible
Milleza	51.3	69.7
Bucaya	61.5	92.3
Maribuyong	82.9	92.0
Badiang	42.5	82.2
Tastasan	35.7	100.0
Bololacao	85.0	77.7
Travel Time		
Milleza	17.8 min	1.0 hour
Bucaya	11.2 min	1.5 hours
Maribuyong	36.0 min	2.0 hours
Badiang	16.4 min	57.0 minutes
Tastasan	10.0 min	2.1 hours
Bololacao	11.2 min	35.0 minutes

Health Needs and Means of Meeting Them

To guide program planners and administrators on the appropriate health services that the community would support, the survey incorporated a set of questions on the perceived health needs of the community.

The respondents mentioned lack of drugs as the major community health need in Tastasan, Badiang, Bucaya, and Milleza; in Bololacao and Maribuyong, lack of water facilities was cited. In Tastasan, nearly 40 percent of the respondents bewailed the inefficient medical services in the community while this problem was felt by 21.4 percent of the respondents in Milleza.

Table 15. Principal health needs perceived by the community, 1983
(in percentage)

Health Needs	Milleza	Bucaya	Maribuyong	Badiang	Tastasan	Bololacao
Lack of Water Facilities/Supply	18.9	10.3	51.4	24.0	10.4	52.0
Poor Environmental Sanitation	1.7	10.8	0.9	6.2		1.6
Lack of Drugs	51.2	55.0	39.4	60.0	50.0	39.5
Lack of Food	6.9	10.2	1.9	6.1		4.6
Insufficient Medical Services	21.4	13.7	6.4	3.7	39.6	2.3
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
n	109	174	103	158	131	168

Attitude Towards and Willingness to Participate in Health Financing Schemes

Majority of the respondents expressed their willingness to participate in the health financing schemes, and had generally positive attitudes (Table 16). Such participation was perceived to be best enlisted through a meeting to be convened by the Barangay Council wherein both areas of health care financing and mechanisms by which the schemes selected could operate would be discussed.

When asked to rank the scheme preferences, a wide disparity in the choices was revealed. For Badiang and Tastasan, the flat rate was the financing mode of choice. For Bololacao and Maribuyong, donation of services was selected. For Bucaya, it was fee for service. For Milleza, income-generating activities through livestock raising and vegetable gardening were meant to provide the health service funds.

As to the health areas where contribution can be directed, there was a general consensus in terms of channeling the funds toward the purchase of drugs and environmental sanitation improvement. Assistance in food production and feeding

Table 16. Attitude toward and willingness to participate in the health financing schemes, 1983

BARANGAYS	With Favorable Attitude (%)	Willing to Participate (%)	n
Milleza	100.0	89.0	109
Bucaya	97.1	93.7	174
Maribuyong	99.0	92.3	103
Badiang	99.4	97.5	158
Tastasan	97.7	97.0	131
Bololacao	95.8	95.2	168

Table 17. Ranking of preference for specific schemes, 1983

Schemes	Milloza	Bucaya	Maribuyong	Badiang	Tastasan	Bololacao
Fee for Service	3	1	3	2	2	5
Flat Rate Community	6	2	4	1	1	6
Health Insurance	5	5	5	3	3	4
Donation of Materials	4	4	2	4	4	2
Donation of Services	2	6	1	6	5	1
Income Generating Activities	1	3	6	5	6	3

Table 18. Ranking of health areas where contributions can be directed, 1983

Health Areas	Milloza	Bucaya	Maribuyong	Badiang	Tastasan	Bololacao
BHW Salary	5	6	6	6	6	6
Purchase of Drugs	1	1	1	1	1	1
Construction of Toilets/Sewage	4	2	2	2	2	2
Purchase of Contraceptives	6	5	5	5	5	5
Assistance in Food Production	3	4	3	3	4	3
Assistance in Feeding Program	2	3	4	4	3	4

program were likewise mentioned by the respondents. When queried on the mechanism by which health financing could be operative, respondents were unanimous in favoring a flat rate of five pesos per month. For those who indicated their willingness to donate services, health education, contraceptive referral/distribution, and weighing/feeding of preschoolers were mentioned. Schemes should be selected to provide guidelines for the determination of the financing plan appropriate for the community. Ways of minimizing expenditures to expand health care coverage have to be delineated. Findings from this study could be used as a means for mobilizing new sources of support including community financing. While a clear problem is the insufficiency of financial support to provide minimally adequate health care for everyone who needs it, the potential of self-reliance at the community level is not to be discounted. A clear obstacle in the achievement of this is the lack of coordination between the health service providers and funding machinery within the community which hinders the smooth implementation of the plan proposed. There is also the problem of limited absorptive capacity by the existing cadre of the health service providers. While additional funds need to be generated for the

purchase of drugs and improvement of environmental sanitation facilities, the increase in supply of health practitioners and the geographical expansion of health care delivery system to encompass the remote and outlying areas need to be emphasized. There is also the fundamental philosophy that doctors must be the principal providers of health care which is opposed to the current interest in the use of paramedics or local-level personnel. Local self-reliance is difficult to achieve if large segments of the population at the bottom of the social structure always look to the government or some peripheral organized system for such support. Results from this survey can be an important take-off point for the mobilization of community resources for health services.

Discussion

In determining the health financing scheme in many countries, little attention is given to the demand for health care by individual households since it is believed that they did not have much independent decision-making power over how much to spend on health care and what to purchase. The providers of health care are thought to influence if not actually determine the level and allocation of household incomes for health care. In the first phase of the study, a new dimension was added by eliciting the community perception of its health needs and mechanisms by which the health demand could be met. The analysis of the health-seeking behavior and expenditure pattern of households as shown by this survey revealed that there was an expression of recipients' preference for the type of health care sought. Self-administered and prescribed drugs constituted a large proportion of total health sector expenditures that had been recognized in addition to the provider's services fees. The decision on where to obtain health care remained largely with the household. If the household required medical care, it had the choice of whether or not to consult a health practitioner and decide on the type of practitioner to consult (traditional or modern, public or private). Households tended to vary the health services sought depending on the nature of the health problem. The procurement of information on health care utilization and expenditure was deemed as one of several important analytical approaches to the appraisal of the viability of health care financing at the community level. The study showed that the different communities exhibited different patterns of health service utilization.

Perceived demands on health services by the recipients, however, should be differentiated from the need of medical care as determined by the providers. A household in need of health care with limited financial capabilities would in most cases not receive the appropriate care unless a communal geographical responsibility exists. In many areas, large proportions of the population were in need of health care but financial resources were insufficient. An important issue in financing is to quantify the funding required to provide the population with at least minimally adequate health care and translate the needs as perceived by the provider and the recipients into demand. Such estimate should encompass both the curative and the preventive aspects of medical care which subsequently would form the basis for the contribution.

Synthesis

A commonality of findings emerged from the survey of the six barangays. The major health problems were respiratory and gastro-intestinal in nature. Outside management was sought from physicians, nurses, midwives, and traditional attendants. The annual medical expenditures ranged from P200 to P300, the bulk of which were spent on drugs and service fees. The unavailability of drugs and poor water supply facilities were considered the major problem areas. Majority of the households expressed their willingness to participate in health financing schemes that may be developed in the community. Their participation would be in the form of service donation, contribution of materials, and flat rate. In the six barangays, purchase of drugs and operations of a drug depot were considered important means where contributions could be channeled.

V. FORMULATION AND IMPLEMENTATION OF THE ALTERNATIVE FINANCING SCHEMES

The increasing need for government health services and the willingness of the population to participate in its provision adds impetus to the setting up of viable schemes for financing health services. The growing population size and the limited health resources available intimate that if there were no innovations, the situation could further worsen. An escalation of the consequences of the increasing demand for health services and the limited health resources available, both manpower and material, would become imminent. There would be higher infant mortality, higher prevalence of infectious and communicable diseases, malnutrition, and greater mortality across all ages.

The urgency of the situation and the favorable survey results obtained prompted the PRICOR project staff to move towards the formulation of appropriate strategies for the provision of health services. Employing the participatory or community organization approach, the project aimed to secure the participation of the residents in creating community-based financing strategies for the identification, mobilization and management of their health resources. The reason for community involvement was pragmatic. It was the community residents who were in need of services and can play a crucial role in setting up and sustaining an appropriate health program given the limited resources available.

As indicated in the earlier section, the task of soliciting community participation was not easy. A health resource inventory for a closer look at the totality of the health situation of its potential beneficiaries was called for. The beneficiaries' basic needs must first be identified and then met, structural obstacles to participation must be dealt with, and effective strategies for eliciting participation must be incorporated into the program of work. Towards the end, the gain is a profound understanding of the conditions prevailing in the study areas and the mechanism for responding appropriately. In the subsequent sections, the process by which financing strategies evolved, and the problems in implementation and immediate outcomes would be described.

The objectives of the subsequent case studies are the following:

1. To document the activities of various entities involved in the project planning and implementation, i.e., the UP Visayas PRICOR staff, Ministry of Health staff, Barangay Health Workers, personnel of other participating agencies as well as the community residents.
2. To document the problems and issues arising from the project implementation with emphasis on their evolution, their relation to the work plan, their perception by the project entities, and their subsequent resolution.
3. To identify crucial problem areas (resources, manpower, participation) in project implementation and their effect on program participation.
4. To determine the community response to the project and the outcomes of such efforts on the short term health seeking behaviors and the community.
5. To evolve lessons from the results of the case studies and explore ways of concretely utilizing these experiences in subsequent financing projects.

As such, the case studies recorded in a comprehensive and detailed manner the following information:

1. *Community Feedback.* Kind of information from the survey relayed to the community; manner of communication; nature of interaction; community response; collaborative efforts on project planning and implementation; related conflicts or crisis situation and their resolutions.
2. *Role of Project Leaders.* Interaction with residents; activities undertaken with the community; roles assumed; supervision and monitoring.
3. *Community Participation.* Expectations about the project; expected benefits and means of realization; expected inputs; organization for specific activity; emergent leaders and mode of their identification; characteristics of formal/informal leaders; followers/supporters; groupings emerging from the community, mode of formation; issues concerning or dividing residents; management and mechanism for project implementation; and nature of participation.
4. *Specific Project Activities.* Specific activities undertaken by the project; mode of implementation; project leadership in these activities; roles played; work program demands imposed upon the community residents' time and resources; types of skills, knowledge, and attitudes the activities require of the participants and how these are met.
5. *Emergent Issues and their Resolution in the Course of Implementation*
 - a. Issues emerging as a result of the implementation of specific project activities;
 - b. Issues emerging as a result of the nature of the interaction between the UPV staff/BHW and the community residents;
 - c. Issues emerging as a result of community residents' relationships with one another;
 - d. Issues emerging as a result of the peculiar ecological and sociological characteristics of the barangay as well as the socio-psychological characteristics of the residents; and
 - e. Manner of management and resolution of these issues.

Methodology

Phase II started after the results of the baseline survey on health-seeking behavior and health expenditures were obtained. The following stages took place:

1. The survey results were charted in pictographs and presented in individual community assemblies composed of local political leaders, teachers, the health service providers, local government officials, and the barangay residents. The highlights of the survey results were presented and the potentials for community involvement were explained. The community's response was elicited, and they were asked to develop workable financing strategies acceptable to them. The schemes and the mechanism for implementation were formally presented by the different barangay representatives in a meeting held at the NEDA regional office. This latter lent the entire activity some element of "being official" which may have served as a motivating force for them to actively pursue their schemes. Table 19 shows the summary of schemes which the experimental barangays selected.
2. After a month during which the barangays started their respective schemes, the research proponents organized a workshop for each of the participating barangays for the purpose of (a) strengthening capabilities to undertake their schemes, and (b) to operationalize the donation of services and materials scheme which was quite popularly articulated in some of the barangays. The workshop was participated in by each barangay health worker and the key leaders of the community.

In this workshop, the concept of primary health care, principles of community organization and communication patterns were presented. More importantly, the coordination of donation of services was discussed and plans were made for the organization of the barangay mothers into groups of ten to twenty adjacent households under the supervision of lead mothers. These lead mothers would be trained for the provision of household preventive and curative services and referrals of pertinent health services such as immunization, family planning supplies, and nutrition rehabilitation. The training, supervision, and back-up support would be undertaken by the midwife, rural health nurse, and physician. In this particular workshop, the lead mothers were identified for subsequent training. Table 20 presents a summary of the implementation plans of each barangay.

3. Monitoring forms for scheme payments, drug inventory, and service provision were drawn up and disseminated to the lead mothers who would regularly gather the information for their catchment households.
4. Aside from the data generated through the monitoring forms, the project fielded research monitors to observe and document relevant events and processes pertinent to the implementation of the schemes. A monitor stayed in a barangay one week per month and was expected to meet with either the barangay health worker or whoever was the community's project leader. The visit enabled her to see the progress in their scheme activities, check on record keeping of lead mothers, provide technical assistance for problems encountered, and gain

Table 19. Summary of financing schemes selected for the experimental barangays, 1983.

Barangay	Schemes	Monetary Input (Targets)	Area where contribution can be directed
1. Milleza, Jordan	Flat Rate Contribution	P3/Quarter for 2 Quarters	Botika sa Barangay
2. Bucaya, San Joaquin	Flat Rate Contribution and Pledges	P1/Household Pledges (P5.00-P50.00)	Botika sa Barangay
3. Maribuyong, Dueñas	Flat Rate Contribution	P5.00 During the 1st and 2nd Cropping Collection for Sale of Livestock and Farm Produce P5.00/Pig; P3.00/Goat; P10/Carabao P5.00-P10.00/Fruit Tree	Emergency Loan Fund for Hospitalization, Medi- cine, Transportation of the Sick
4. Badiang, Anilao	Flat Rate Contribution	P1/HH/Month	Botika sa Barangay
5. Tastasan, Buenavista	Flat Rate Contribution	P1/HH/Month P200.00 – Contribution of Barangay Captain	Botika sa Barangay
6. Bololacao, New Lucena	Flat Rate Contribution	P3/HH Initial Membership and P1/Monthly thereafter	Botika sa Barangay
	Dances	P1,000.00	Improvement of Health Center and Equipment for the Health Center
	Movies	P 500.00	
	Mah-jongg Parties	P1,000.00	

Table 20. Summary of implementation plans of six barangays

Target Households under Each Lead Mother	Health Areas	Service Delivery Strategy
Milleza		
LM 1 21 HHs	Environmental Sanitation	Monthly House-to-House Campaign
LM 2 12 HHs	Immunization Referral	Purok Assembly
LM 3 9 HHs	Health Education	Informal Communication
LM 4 10 HHs	Maternal/Child Care	
LM 5 15 HHs	Nutrition Education	
LM 6 20 HHs	Rehabilitation and Surveillance	
LM 7 11 HHs		
LM 8 23 HHs		
Bucaya		
LM 1 17 HHs	Environmental Sanitation	Purok Assembly
LM 2 15 HHs	Maternal/Child Care	Informal Communication
LM 3 16 HHs	Food Production	Monthly Follow-up
LM 4 16 HHs	Nutrition Rehabilitation/Surveillance	Feeding Session
LM 5 16 HHs	Health Education	House-to-House Campaign
LM 6 19 HHs	Family Planning Referral	
LM 7 17 HHs	First Aid	
LM 8 14 HHs		
LM 9 14 HHs		
LM 10 14 HHs		
LM 11 11 HHs		
LM 12 14 HHs		
LM 13 14 HHs		
Maribuyong		
LM 1 12 HHs	Health Education	Informal Education
LM 2 21 HHs	Food Production	Monthly Follow-up
LM 3 10 HHs	Nutrition Education	Purok Assembly
LM 4 15 HHs	Herbal Garden	
LM 5 11 HHs	Family Planning	
LM 6 11 HHs	Record Keeping	
LM 7 12 HHs		
LM 8 7 HHs		
LM 9 5 HHs		
Badiang		
LM 1 21 HHs	Environmental Sanitation	Monthly Follow-Up
LM 2 21 HHs	Immunization Referral	House-to-House Campaign
LM 3 25 HHs	Health Education	Purok Assembly
LM 4 20 HHs	Maternal/Child Care	Client Consultation
LM 5 15 HHs	Nutrition Education	
LM 6 17 HHs	Maternal/Child Care	
LM 7 13 HHs	Food Production	
LM 8 21 HHs	Drug Depot	
LM 9 13 HHs	Herbal Garden	
LM 10 12 HHs	Family Planning	
Tastasan		
LM 1 14 HHs	Environmental Sanitation	Monthly House-to-House Campaign
LM 2 24 HHs	Food Production	Purok Assembly
LM 3 18 HHs	Nutrition Education	Weekly Classes
LM 4 27 HHs	Maternal/Child Care	Informal Communication
LM 5 8 HHs	Preventive Control and	
LM 6 10 HHs	Endemic Disease	
LM 7 15 HHs	Immunization Referral	
LM 8 15 HHs		
LM 9 14 HHs		
Bololacao		
LM 1 16 HHs	Health Education	House-to-House Campaign
LM 2 16 HHs	Preventive Control of Endemic	Purok Assembly
LM 3 22 HHs	Diseases	Informal Communication
LM 4 18 HHs	Maternal/Child Care	Client Consultation
LM 5 26 HHs	Family Planning	
LM 6 28 HHs	Immunization Referral	
LM 7 13 HHs	Nutrition Education	
LM 8 14 HHs	Environmental Sanitation	
LM 9 20 HHs	Food Production	
	Herbal Garden	

insights on group and personal processes which transpired. As much as possible the monitor inhibited herself from making decisions for the barangay members, but rather utilized the technique of assisting them in identifying their actual problems and alternative solutions and allowing them to develop their own solutions. The monitor also avoided doing actual tasks, e.g., data gathering, soliciting services from households, etc. which lead mothers or other identified entitles were supposed to undertake. However, the monitor may be seen as an active participant in the sense that inevitably her presence alone in the barangay exerted a subtle pressure on the residents to perform, according to what they had committed themselves to do.



Catalyzing the community to make decisions on their health care.



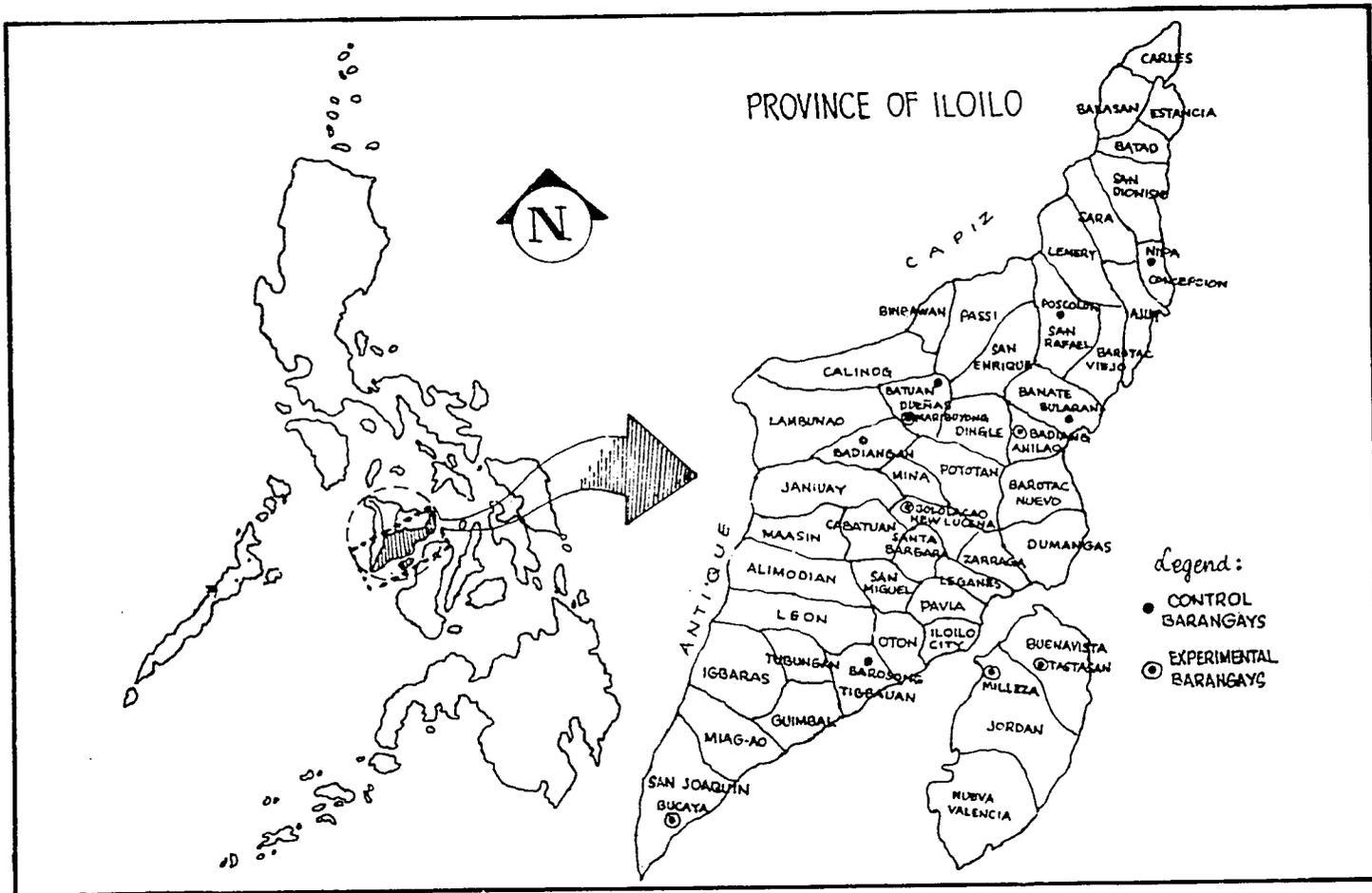


Table 21. Summary of volume of activities of lead mothers in environmental sanitation and vegetable herbal gardening, by barangay.

ITEM	Milleza	Bucaya	Badiang	Tastasan	Bololacao	Maribuyong
No. of Lead Mothers						
Active	3	12	8	4	9	8
Inactive	5	1	2	5	0	1
Resigned	2	0	0	2	0	0
No. of Households	109	174	158	131	168	103
Vegetable Gardening						
Initial*	99	92	9	97	99	--
End	103	156	40	99	147	--
Compost Pit						
Initial	19	67	23	82	28	--
End	23	148	55	89	67	--
Toilet Construction						
Initial	82	98	88	89	136	--
End	83	151	96	94	148	--
Fencing						
Initial	64	--	--	--	--	--
End	76	--	--	--	--	--
Garbage Can Installation						
Initial	26	--	--	--	--	--
End	27	--	--	--	--	--
Water Improvement (Add'l)						
Initial	56	--	--	--	--	--
End	141**	--	--	--	--	--
Herbal Garden						
Initial	--	89	12	91	43	0
End	--	156	12	91	43	7

(Communal)

*"Initial" refers to existing number of households with a particular environmental feature at the time the lead mothers were fielded. The difference between *Initial* and *End* represents the accomplishments attributable to the lead mothers' efforts.

**Nine lead mothers were beneficiaries of 9 additional water pumps which enabled 100 percent of households to have access to water supply.

CASE STUDY NO.1

BARANGAY MILLEZA

JORDAN, GUIMARAS

COMMUNITY FEEDBACK OF SURVEY DATA

The results of the survey were reported on June 14, 1983 to the core group of the community composed of the barangay captain, six councilmen, two school teachers, a traditional healer and some municipal/provincial personnel, such as the Rural Health Physician and the midwife. The major findings of the survey were:

1. Prevalent illnesses reported for the previous year were primarily respiratory and to a lesser extent gastro-intestinal.
2. The community perceived the lack of drugs and insufficient medical services as their principal health problem.
3. The more preferred schemes for health financing were income-generating activities and donation of services.
4. Preferred uses for resources generated from health financing were the purchase of drugs, assistance in feeding program, and assistance in food production.

The group responded in a positive manner and readily accepted the idea of health financing as a possibility for the community. Their only hesitation was determining what scheme and how to implement it. Ideas were shared and a core structure was organized with the following:

Over-all Chairman -- Barangay Captain
Members: Six Barangay Councilmen
Barangay Treasurer
BHW
Two School Teachers
Adviser: Rural Health Midwife

They then scheduled a community assembly for the next week to disseminate information gathered from the survey results.

COMMUNITY PARTICIPATION IN SCHEME SELECTION AND PLANNING

Selection of Strategies

At the barangay assembly, about 70 percent of households attended. Ironically, more of these came from the sitio of Singcalang which was a 2-kilometer walk over hilly terrain. The BHW presided over the session and explained the survey results. The assembly was marked by active interaction from those present. They considered several suggestions for raising funds, ranging from income-generating activi-

tios, such as livestock or poultry-raising or cattle-fattening, to simple monetary contributions. By votation, they settled for monetary contributions of P3 per household per quarter to be collected by the councilmen. They chose to direct the contributions to setting up a botika. At this time, the PUSH botika had not yet been established.

The community decision was presented at the NEDA Conference by the BHW, assisted by the midwife, barangay captain, and barangay councilman. They were advised to work out details of the botika operations and to consider the possibility of implomenting a service donation scheme. During the following two weeks, the scheme was further refined. At the end of July 1983, a second assembly was convened to announce and finally adopt procedures. This time only 30 households came.

Organizing the Community

The core group members attended a pre-implementation seminar-workshop to prime them for their role in the delivery of primary health care activities in the barangay. After the motivational exercises and lecturettes on aspects of primary health care they proceeded to draw up an implementation plan for the community. Two working groups representing Balcon and Singcalang resulted. Each group identified its respective health problems and proposed activities to alleviate these. Lead mothers to supervise clusters of 10-15 households were identified based on perceived willingness to serve and potential for primary health care delivery. The mechanics of implementation were drawn up specifying the health areas and strategies to be used, supervision and role of the core group. (Table 20)

PROJECT PERFORMANCE/IMPLEMENTATION

Lead Mothers' Program

Organization

The ten lead mothers identified during training were supervised by the BHW. The barangay captain who was the local PRICOR Chairman attended meetings but did not exercise leadership in the project activities. The members of the core group were expected to provide support to their activities although during the project period the support was not evident as it was not tapped. Since the lead mothers were also chosen and trained by the MOH as barangay technicians for health (BTH), a link with the RHU personnel was forged.

The incidence of drop-outs among the lead mothers was high. After one month, two resigned. By the fifth month, all three lead mothers in Singcalang hinted at their desire to be relieved of the designation. In general, the reason given for non-continuance was their lack of time due to pressure of farm and other income-related activities. Towards the end of the project period only three lead mothers could be considered active.

During the project period the PRICOR field researcher regularly visited the lead mothers although she noted that it was difficult to meet them as a group. In-

dividual visits resulted. During the first quarterly evaluation eight lead mothers came; however, during the second and terminal evaluation only three came. These quarterly evaluation sessions were intended to enable them to review and plan out activities.

Training

Lead mothers were given a one-day training (October 20, 1983) on their tasks and functions. One mother was unable to attend. The scope of training included environmental sanitation, maternal and child care, nutrition education, health education, family planning, oral rehydration therapy, and simple record-keeping to monitor household health-related information. The main resource persons were the rural health physician and nurse with the assistance of the midwife and BHW. After the mothers were oriented on the aforementioned areas of primary health care, their roles in assisting and coordinating in its delivery among their catchment households were explained. They reviewed the activities contained in the implementation plan drawn up by the core group and were taught how to keep records on their activities. Role playing as a learning technique was utilized for this group.

Seven of the lead mothers participated in the MOH Primary Health Care Worker Training in November 1983, since they were also designated as BTH's for their area. The three-day training also dealt on similar content areas although in a slightly greater depth. Two first aid kits were given for their use.

Activities

Since the lead mothers were also the MOH's designated BTH's they possessed information on the catchment households generated through their house-to-house survey. Consequently the lead mothers, to varying degrees, conducted a campaign for the setting up of fencus, compost pits, vegetable gardening, garbage disposal, and toilet construction. Compliance among the households was poor, especially in Singcalang where the lead mothers were less active and where the hilly terrain made their work more difficult. By April 1984 only two lead mothers were active in assisting the BHW in weighing and in immunization.

During the later campaign for donations to their botika, some lead mothers assisted in collection efforts. Likewise, two lead mothers acted as depot managers for Balcon Milleza when the original person, a councilwoman, gave up the depot.

Community Response

In general the barangay residents were passive with regards the project activities. Only a few immediately responded to the campaign of the lead mothers, while others resisted. The BHW was unable to freely visit the Balcon area since he had differences with some residents. Some of the lead mothers themselves were not enthusiastic about the project. The purok assembly was not considered an effective method for bringing residents together since attendance was usually low.

Factors Affecting Performance

The geographical configuration of the barangay practically divided it into two distinct communities (Balcon and Singcalang) with very little interaction with one another. In Balcon Milleza, the houses are scattered at wide distances between them which made cooperative efforts and influences less likely. In Singcalang, even though houses were clustered, the hilly terrain was not conducive to vegetable gardening and fencing.

Although the lead mothers would have been at an advantage since they were in a position to harness MOH local resources being BTH's themselves, they were unable to accomplish any substantial gains. Only three of them persisted to the end. Most were busy earning a living and could not lend time with some regularity to the health-related activities.

On the other hand the BHW whose role was to coordinate and supervise these lead mothers was himself very busy and could not easily be located in the barangay. He was expected by the local officials to put in time at the sub-provincial office thus decreasing his time in the field. Moreover, as previously mentioned, he had a rift with some residents in Balcon Milleza, which resulted in his even more infrequent visits to the sitio. As a result, the lack of supervision of the lead mothers discouraged any interest which may have been sparked by the project.

Aside from the BHW, there was no other resident community worker in Brgy. Milleza, who could play an active and supportive role with regards the project. There were other programs introduced into the barangay such as Sariling Sikap and Balikatan, but follow-up from outside workers may have been minimal. Similarly, no barangay official or resident emerged to assume active responsibility for the project.

Capitalizing a Botika from Community Donations

Generating Resources

Barangay Balcon Milleza chose to implement a flat rate donation of P3 per quarter for every household for a period of two quarters. With the 122 households in the barangay, the targetted amount for the six-month period was P732.00.

Collection was primarily done by the BHW and the barangay council members assigned to household clusters. By September 1983 they were able to collect P204 which then served as their botika's initial capital. Later, lead mothers were asked to hasten the collections. At the end of the second quarter, an additional amount of P215 was collected. In sum, P419 was collected for their botika capital constituting 57 percent of the target amount.

Botika Operations

1. Management Structure and Location

When the botika first operated, two depots were established. The BHW man-

aged the one in Sitio Singcalang while a councilwoman of the barangay attended to the other one in Balcon Milleza. In February, this council member was replaced due to her inability to cope with the task. In her stead two lead mothers were assigned at different sites since the wide distances between households warranted two supply points.

The lead mother depots remitted their sales to the BHW who monitored and replenished the stock. The designated auditor, as per original plan, was the midwife but in the actual implementation the PRICOR field monitor/researcher audited the transactions. The BHW audited his two depots.

In October 1983, the PUSH-BSB was established at Sitio Singcalang and managed by the BHW. It had a separate accounting and inventory scheme from PRICOR BSB, but in July 1984, because of the difficulty in maintaining separate inventory, the BHW decided to integrate both botikas.

2. Demand for Botika Services

Drugs for fever, cough, diarrhea, ailments like muscle aches, stomach pains, and wounds, and some vitamins were available at the botika. Five drugs were available for fever, four for coughs, and two for diarrhea. These three were the major health problems in the barangay.

Demand for the medicines as judged from the records showing quantity sold was quite low. The main reason for this was probably the frequent inavailability of the drugs as well as the presence of the PUSH-BSB which carried similar drugs. At least six drugs registered a zero level of supply, meaning these were not replenished.

In one sitio, there was a great demand for medicines specifically for headaches, fever, and flu and some of the barangay residents were still asking for drugs, especially for ailments like rheumatism and asthma. These, however, were not adequately supplied due to the inability of the BHW to monitor the level of supply; so, replenishment was not only delayed but unresponsive to expressed need.

3. Sales

In the one year of botika operation, average monthly sales was P47. The lowest sales were registered in December 1983 and June 1984 at P28.15 and P23.40 respectively; and the highest in October 1983 at P81.00. The extremely low levels in December 1983 and June 1984 may be attributed to the failure to replenish the stocks. When the stocks are low usually only tablets, which have lower unit prices compared to liquid preparation, are available. Thus the lower sales levels.

4. Mark-Up and Profit

The mark-up on cost of tablets ranged from five to fifteen centavos; and on syrups, from P2.05 to P2.15. However, botika prices in the two Balcon depots were not adjusted in response to the rapid change in prevailing market prices since they had no way of knowing the extent of price changes. The BHW was able to do this

to some extent in his depot as his frequent visits to the poblacion provided him with this information, which unfortunately was not relayed to the others.

From September 1983 to June 1984 the botika accumulated P120.64 in profits from total sales of P654.77. These profits were in turn added to the capital to purchase additional stocks of medicine.

5. Credit and Collection

Credit was allowed in the depots. At the end of every month the managers made a collection round and sometimes the managers advanced payments for remittances to the BHW. Ironically the BHW made no serious effort to replenish.

6. Replenishment

Replenishment was quite slow and not responsive to the demands of the depots. The BHW had no mechanism for effectively monitoring the supply level in the depot to enable him to replenish even before the supply totally ran out. He admitted that due to his multifarious activities he is unable to replenish the stocks.

This replenishment problem was more seriously felt in Balcon Milleza depots where the supply depended on the BHW's ability to replenish. The main reason for low sales in these depots was the unavailability of medicines. From February to June, the depots were replenished only twice. Because of this, the depots subsisted merely on an average of eight brands: four for fever, two for diarrhea, one for cough, and the rest for muscle pain and wounds. This resulted despite the increase in capitalization brought about by additional contributions during the second quarter and the sales remittances.

7. Record-Keeping and Auditing

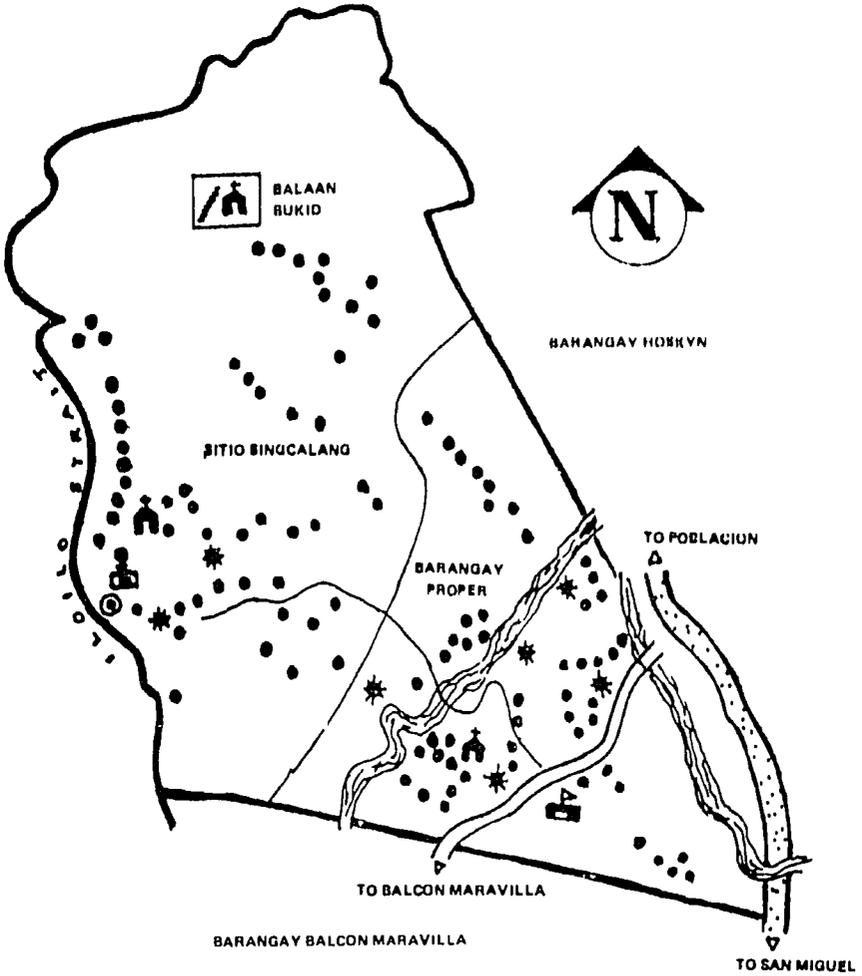
Both depot managers kept records of their daily transactions and stocks while the BHW undertook the audit of these transactions. Simple forms were prepared for keeping track of transactions.

An audit in December 1983 of the council member who originally managed the botika in Brgy. Balcon Milleza showed that her sales records were incomplete. Moreover, the money she had on hand representing sales was short of the amount she would have had, based on remaining stocks. It is likely that unrecorded purchases were made and the money inadvertently used somewhere else. At the time a substitute was assigned to run the depot, the council member was still accountable to the botika by P55.50.

8. Post Project Plans

The BHW intends to do a better job at replenishing the depots and to tap the barangay captain to perform the quarterly audit. Furthermore, he plans to increase stocks by collecting the unpaid donations of some households.

SPOT MAP OF BARANGAY BALCON MILLEZA JORDAN, GUIMARAS



- | | |
|---|---|
| ● HOUSEHOLD |  SCHOOL |
| ⊙ BHW'S HOUSE |  CHURCH |
| ★ LEAD MOTHER'S HOUSE |  HEALTH CENTER |
| — BARANGAY ROAD |  RIVER/CREEK |
|  NATIONAL ROAD | |

CASE STUDY NO. 2 BARANGAY BUCAYA SAN JOAQUIN, ILOILO

COMMUNITY FEEDBACK OF SURVEY DATA

Results of survey data in Bucaya was presented to the community on June 15, 1983. The feedback meeting was attended by the key persons in the barangay consisting of (1) the barangay captain and two councilmen, (2) the school principal and seven public school teachers, (3) the BHW, the midwife, and their ex-officio rural health physician, and (4) the municipal development officer and two of his staff members.

The highlights of the survey results which were presented at the meeting included:

1. Common illness occurrences were respiratory problems like cough, fever, and flu.
2. Some dissatisfaction existed regarding the inadequate supply of medicine in barangays.
3. The need for toilet and water facilities was expressed.
4. Scheme preferences ranked fee for service and flat rate contribution within the first two slots.
5. The preferred uses of resources generated from financing schemes were purchase of drugs and construction of toilet and water facilities. The least liked was its use for payment of the BHW's salary.

At the meeting, several questions were raised regarding the PRICOR Project. Some individuals were wondering whether this was another dole-out project. Clarification was made by the PRICOR staff present regarding the research nature of the project. The leaders were consequently asked whether they wanted to participate in the financing scheme. The group accepted the project, although grudgingly.

A PRICOR committee was formed with the following membership:

- Chairman: A Postmaster who also happens to be the husband of the Barangay Captain
- Secretary: Brgy. Secretary
- Treasurer: School Teacher
- Auditor: School Teacher
- Members: Bgy. Council Members
Religious Organizations
MECS Teachers
Rural Improvement Club
Rural Health Midwife

The leaders were not able to give a fixed date at which they would call the barangay to an assembly for purposes of presenting the project and eliciting participation. They expressed their desire for more time to think about the project. They however promised to hold an assembly by the last week of June.

COMMUNITY PARTICIPATION IN SCHEME SELECTION AND PLANNING

Selection of Strategies

The earlier reluctance of some leaders as observed during the first meeting further manifested itself in the effort at calling a barangay assembly. The PRICOR staff had to return to Bucaya three times to confirm the date for the assembly. The first date set for June 24 was postponed since many residents would be busy in the fields it being the start of the planting season. Difficulty at setting another date was experienced since the barangay captain and the barangay secretary were conveniently not available. They had earlier been very vocal about their position that the proposed project would encounter difficulty in their barangay since the residents were busy and uncooperative. The opinion of the secretary seemed to hold considerable weight with the barangay captain. In a last ditch effort, the staff sought the assistance of the PRICOR committee chairman who promised to convince the two barangay officials to call the assembly.

Their first assembly was held on July 2. Contrary to what the staff had been led to expect, a record 80 percent of the residents attended. The committee chairman and his secretary presided over the meeting. Although the BHW was present, survey results were presented by the two presiding officers. Based on the results, the assembly opted to give a one-time contribution to be used to set up a Botika sa Barangay. Inasmuch as the BHW had dissipated the money intended for the PUSH botika, the assembly proposed that the PRICOR botika would be put under the supervision of both the barangay captain and the secretary. During this first meeting actual donations were given while others gave pledges.

The scheme, as formulated, was formally presented by the committee chairman, secretary, and barangay captain in a conference at NEDA. In addition to what had earlier been agreed, details were presented, such as the pricing of medicines at a cost lower than at the poblacion, development of inventory control system, the remittance to the treasurer of their monthly profit, and the conduct of a quarterly audit. Policies for extension of credit still had to be drawn up.

Organizing the Community

The committee members and the BHW were to compose the core group of the project. In order to provide them with additional knowledge regarding the nature of primary health care and skills for mobilizing the community, a seminar-workshop was conducted.

Eighteen core group members attended the two and a half days assembly held in an open space at the back of the secretary's house. The resource persons included:

the midwife, the rural sanitary inspector, the district health nurse, and the lady RHP of San Joaquin. The core group manifested interest in the lectures and activities and were responsive during the workshop.

The output of the workshop was the identification of 13 lead mothers, and the drawing up of implementation plans for mobilizing the community towards primary health care and a training curriculum for the lead mothers

PROJECT PERFORMANCE/IMPLEMENTATION

Lead Mothers' Program

Organization

Thirteen lead mothers were chosen on the criteria of perceived capability, willingness, availability, and rapport with the residents. Seven lead mothers serviced the Bagatnan (Southern) area and six were in Aminhan (Northern), at a coverage of 11-17 households per lead mother. Later in February 1984 five assistant lead mothers for the Bagatnan area were recruited to help in the PUSH record keeping system (RKS) which task was assigned to the lead mothers.

While theirs is a loose organization, the monthly visit of the Project Researcher would suffice to bring them together. Their committee chairman coordinated and showed active interest in their activities and he was easily accessible to lead mothers. Every quarter, a feedback and planning session was supposed to take place to enable the lead mothers to review their accomplishments and to firm up their plans for the consequent period. Two such sessions were actually conducted.

Training

The lead mothers were given a one-day orientation (November 1983) training on the different aspects of primary health care and their expected role in providing it. The training content consisted of lectures on maternal and child care, immunization, health and nutrition education, and first aid. Resource persons were the district nurse, midwife, and sanitary inspector. Their assigned major role as lead mothers was to catalyze and guide their catchment household to undertake the activities earlier identified by the core group in the implementation plan. A refresher course (April 1984) was given to the mothers. The content of the one-day course included nutrition, breastfeeding, food groups, food preparation, oresol, and use of Lukat Spoon for managing diarrhea.

Activities

The first activity which the lead mothers embarked on was an environmental sanitation campaign. They went on a house-to-house visit to introduce themselves as lead mothers and to explain their purpose. They further instructed their members to clean their surroundings, make a backyard garden, and put up a house-

hold garbage disposal system. As may be seen in Table 21, the accomplishments of the lead mothers in the aforementioned areas were notable, having succeeded during the short span in catalyzing more than a third of the households into undertaking concrete health related improvements in their homes.

Backyard Gardens and Environmental Sanitation

After only a month, it was observed that the residents had started making herbal and vegetable gardens and cleaning their surroundings. At the start, the lead mothers complained of stubborn and uncooperative members. However, with their constant prodding, citing the advantages of a clean environment, the residents began to realize the beneficial effects. Some, who observed the efforts of their neighbors, felt embarrassed about their own unresponsiveness and non-cooperation, so that eventually they complied. Houses along the shore became unusually well-maintained. What used to be vacant lots were replaced by garden plots while canals were rid of piled-up driftwood and dry leaves. Each household dug its own hole for the garbage while some lead mothers set up one large dump site for the use of their respective members.

After the positive response to the campaign, the lead mothers maintained the efforts of the households by a regular monthly visit to inspect their catchment area. People living in the vicinity of the committee secretary's house tried harder to keep their yard in order. It was observed that people oftentimes scampered for their brooms and cleaned their area whenever they sighted the approach of the PRICOR researcher. It was also noted that some lead mothers motivated their members to keep their houses clean by informing them that project visitors may visit them unannounced.

After four months, practically every household had a vegetable and herbal garden. Many realized that they no longer needed to buy vegetables since alogbate and camote were easily available in their gardens. Some were even able to sell their backyard produce. At one time the group was thinking of working a communal garden for commercial purposes. However, due to lack of capital, nothing materialized.

Another positive result of the environmental sanitation campaign was the sanitary maintenance of backyard sites. Previously, pig sties built along residences were not regularly and properly cleaned resulting in the offensive odor which bothered the neighbors. Concerned persons began complaining to the lead mothers, who in turn referred the matter to the PRICOR researcher. The latter brought this to the attention of the sanitary inspector. The sanitary inspector consequently conducted an inspection in the barangay and advised those concerned on how to properly keep their pigpens clean.

Other Activities

A close coordinative relationship developed between the midwife and the lead mothers. She utilized them as a link to the individual households. At the start she

gave each lead mother 100 tablets of paracetamol (intended for fever, headache), and four packs of oresol to service the needs of their households. Some households were reported to have dropped by the lead mothers to ask for their advice in minor ailments. Simple prescriptions were also given and medication promoted.

During the immunization period (March 1984) the lead mothers helped in the identification of target children and the dissemination of information on schedules and types of vaccines (BCG, DPT, polio).

The lead mothers assisted the chairman of the Rural Improvement Club, concurrently a lead mother and chairman of their rural Catholic Relief Service, in the conduct of weighing preschoolers.

The lead mothers were tapped to assist in the PUSH Record Keeping System. In February 1984, they were given training on how to accomplish the forms. In response to the request of certain lead mothers, five assistants were recruited to help in the RKS. After two months, their performance on record keeping system showed that some had not yet started on the task while others needed to be clarified on certain instructions. Those who were unable to put in effort gave lack of time as a reason. Later observation indicated that some lead mothers found the records complicated and that it took considerable time to complete a single household's data. Consequently, the PRICOR researcher simplified this by using secondary data for nutrition (from the BNS), family planning (from the BSPO) and immunization (from the midwife). As a whole, the lead mothers, except for three, had substantially been of help in the RKS.

Distribution of PUSH Pumps and Toilet Bowls

The NEDA-PUSH monitor for environmental sanitation infrastructure had informed the barangay during the community assembly that additional pumps and toilets were being channeled to their barangay from funds made available by PUSH drop-out barangays. The PRICOR chairman had then asked the lead mothers to prepare a list prioritizing recipients based on need so as to facilitate distribution as soon as the commodities would arrive. In fact, as a result of this information some households started digging holes in anticipation of their receipt of toilet bowls. When ten water pumps actually arrived in February 1984 the list drawn up by the lead mothers became the main basis for the allocation. However, there were deviations in the case of two pumps which then resulted in disgruntlement from the group. The lead mothers affected threatened to resign since their own area members were blaming them. Only through a lot of explanation by the PRICOR chairman, who was perceived by some to be partly to blame, were they pacified and prevailed upon to remain. Nonetheless the participation of the lead mothers in the allocation and distribution of a highly valued commodity served to boost their image as resource persons in the community. It also motivated the households to cooperate with them.

In April 1984, 70 toilet bowls with cement bags and iron bars arrived. Once again the lead mothers' list of households with inadequate toilet facilities was used. Since there were more needy households than toilet bowls available, disagreements

arose. Those with repairable toilets still wanted to have new ones. Likewise, two households who were perceived as being of means to acquire toilets on their own (having family members working overseas) received the commodity. This created some amount of discontent among the lead mothers and residents in the area affected. As a consequence, one lead mother resigned her post.

Community Response

The committee chairman, as earlier noted, directly supervised the activities of the lead mothers. Of the core group members, it was mainly the KB chairman who gave the most active support to their activities by participating in meetings and accompanying them in their activities. The PRICOR researcher visited them one week per month, during which time she monitored and noted their activities and interacted with them. Almost always they met with her as a group.

Other barangay personages were involved in assisting the tasks of the lead mothers. The barangay captain gave her support on problems referred to her, such as lack of cooperation from some residents or disagreements that arose. Invariably she would approach these individuals and settle the differences. The midwife, as mentioned, was supportive by delegating certain tasks which the lead mothers could easily do, e.g., information dissemination, depot for certain medication, etc. The sanitary inspector made herself easily available when needed. The BHW was not active in the project.

Factors Affecting Performance

While the activities undertaken by the lead mothers in Bucaya may have been limited in scope due to the limited period of the project, their potential as a community resource for promoting health care has been demonstrated in the short run. Within a year wherein their services were called on, only one lead mother had actually resigned, and only towards the end of the project period. At meetings, training, and other activities which called for their presence, a high attendance rate was always noted. Their cooperation for activities agreed upon by them was evident. At the last quarterly evaluation they signified their willingness to continue serving as lead mothers as long as their services are called upon. They asked to be provided with a kit of simple apparatus (thermometer, blood pressure, first aid) to enable them to better service their households.

Facilitative Factors in Bucaya

- a. Geographical factors wherein houses were clustered resulting in ease of communication and coordination.
- b. Existence of a number of active organizations in the barangay – RIC, Foster Parents Plan, CRS, KB – which presupposes prior experience in working together.
- c. Appropriate choice of lead mothers – capable, willing, responsive, and with some time available from home chores.

- d. Active support from political leaders.
- e. Active support from the rural health midwife and sanitary inspector.
- f. Leadership exercised by the committee chairman and members of the core group.
- g. Unexpected availability of pumps and toilets for distribution which had the effect of engendering in the residents the perception that decisions of the lead mothers were crucial in determining recipients. This increased their credibility.

Constraining Factors

1. Absence of close supervision which could have been provided by a BHW who would delegate some of his functions to the lead mother and who could further give technical support and transfer his training to the lead mothers. Such a BHW could help the group set activity goals relevant to community health needs for which he is expected to be better trained to diagnose and meet.
2. Lack of simple apparatus and drugs which could help them in identifying common illness and provide immediate remedy for emergency cases.

Capitalizing a Botika from Community Donations

Generating Resources

The financing scheme chosen by the barangay was to raise funds from optional donations of residents in order to operate a barangay drug service point or botika.

After the barangay committee meeting which approved the scheme, the treasurer, district leaders, and barangay captain proceeded to campaign and collect donations from the residents. Out of 205 households, 139 or 68 percent, donated varying amounts of P1 to P.50. The following shows amounts donated:

<u>Amount</u>	<u>No. of Households</u>	<u>Total</u>
P 1.00	110	P 110.00
P 2.00	9	18.00
P 5.00	8	40.00
P 10.00	10	100.00
P 50.00	2	100.00
TOTAL	139	P 368.00

The total amount raised from households was P368 to which an amount, approximately P180, was added from their barangay fund. Initial capitalization of their botika amounted to P548.00 and which enabled operations to start in August 1983.

Botika Operations

1. Management Structure and Location

Two depots were set up at the drug (supply) outlets strategically located so that both the southern and northern areas of the barangay were serviced. One depot was managed by the wife of the barangay secretary and the other by the chairman of the PRICOR committee. Each depot operated independently of one another, such that replenishment and accounting of one had no influence on the other.

Although at the start the barangay committee identified a teacher resident to act as botika auditor, no serious effort was exerted to require her to exercise her function during the one year of operation. Auditing was performed by the PRICOR field monitor/researcher.

2. Demand for Botika Services

The barangay midwife identified the medicine which would be made available at the botika. In fact she made the first purchase. Drugs available were mainly for cough, diarrhea, and fever, although about 19 other items for varying ills, such as stomachaches and vitamins were available in the depot. In all, 38 brands were on sale. Four brands were available for coughs, another four for diarrhea, and nine for fever. In both depots, medicines ordered by residents suffering from asthma, rheumatism, and ulcer were kept on stock. A glance at their botika records indicated that certain brands were more preferred by most residents patronizing the botika. Likewise certain items were very slow moving while two or three brands on stock had no demand at all.

Some residents from the nearby barangay had also been observed to buy medicine at the depot.

3. Sales

Table 22 presents a monthly record of the level of monetary transaction at the botika. The lowest sales were recorded for September 1983 at P67.65 and the highest for August 1984 at P465.80. While the fluctuation in sales may be due to seasonality in the common illnesses, a noticeable stability in level of demand was evidenced starting after the first two months with sales not going below P240.00 starting January 1984. This may indicate that the botika depots are considered reliable drug sources and therefore are consistently patronized by barangay folks.

4. Mark-up and Profit

The price mark-up on medicines was arbitrarily determined by the depot managers who relied on their intuitive feel of what would be acceptable. Generally, for tablets, mark-up on cost ranged from five to fifteen centavos while for bottled liquid preparation it was from P1.00 to P1.50. The managers reported that their prices were always lower than prices at the botika in the poblacion.

Prices in one depot were slightly higher than in the other since the botika manager who works in the poblacion is able to monitor drug prices there, and consequently adjusted his own mark-up. While he shared the information with the other depot manager, the latter did not alter the mark-up on old stock since she felt sorry for the buyer. Although prices between the two depots differ, no complaints have arisen since buyers do not compare their prices, but rather approach only the depot located closest to them. Across the thirteen months of operation, the accumulated profit was P567.02 which amount has been transformed into additional medicine stock. On the average, the percentage of net profit to sales constituted approximately 17 percent.

5. Credit and Collection

The depot allowed purchase on credit. So far credit has been minimal and these were promptly paid. Those who buy on credit are usually either those who happen by the depot and have brought no money or those fixed wage earners who defer payment until pay day.

6. Replenishment

There was no regular schedule for stock replenishment. The depot managers, who closely monitor their stocks, replenish when they see that generally stocks are low which may be the presence of, say, five tablets of a kind.

One depot manager had no replenishment cost since he bought at the poblacion where he goes to work daily. The other manager bought in Iloilo City. In the past the latter sourced repurchases through her daughter who studies in the city and therefore the cost covered only the fare from her boarding house to the drugstore. At present, however, her daughter has graduated and repurchase costs consequently are a bit higher.

7. Record Keeping and Auditing

Both depots have diligently maintained records on the prescribed form which specifies the daily transactions, the stock on hand, replenishment, purchase price, mark-up, quantity bought, running stock balance, amount paid and profit realized. Every month the managers prepare a summary of the month's transactions and this is presented for audit.

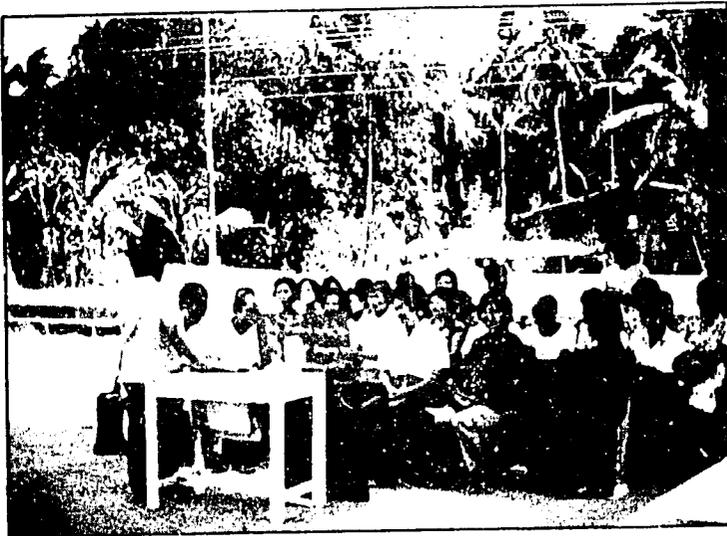
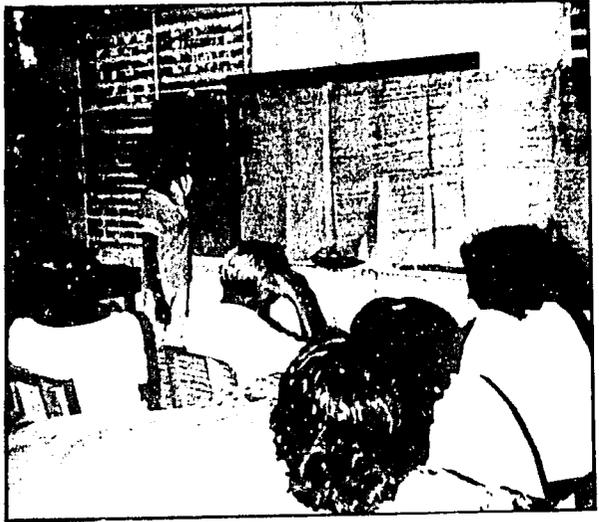
8. Post-Project Plans

At the workshop for botika managers on August 1984, the committee representatives signified their intention of continuing the operations of the botika. The following actions will be taken to improve their operations:

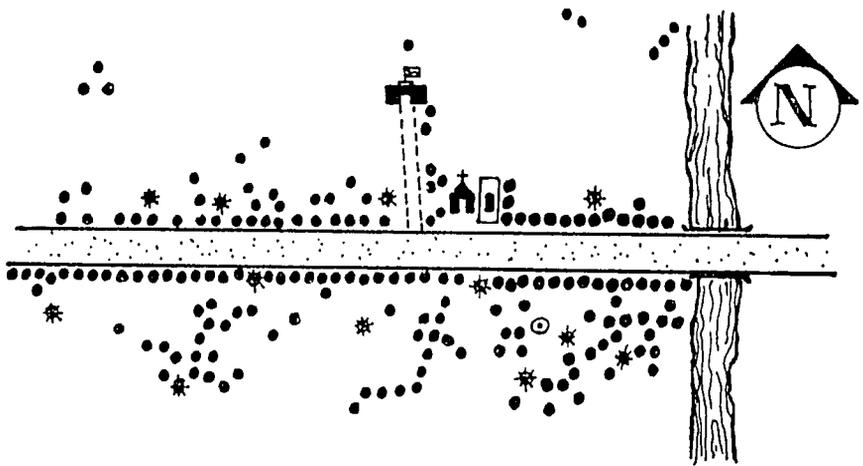
- a. Apply a 20-25 percent mark-up on medicines, so that funds may be raised for other health activities.

- b. Ensure that quarterly auditing be done by the designated auditor.
- c. The botika manager will assume responsibility for any credit extended.
- d. Utilize barangay assemblies to report on status of the botika.
- e. Retain the present botika managers since they are trusted individuals in the barangay.
- f. Another campaign to increase botika capital will be launched in January 1985.
- g. Profits from the botika will later be used for health projects, e.g., buy seeds for the gardens.

**Preparing the
Core Group and
Lead Mothers to
support and assist
the delivery of Pri-
mary Health Care.**



SPOT MAP OF BARANGAY BUCAYA SAN JOAQUIN, ILOILO



Legend:

- HOUSEHOLD
- ⊙ BHW'S HOUSE
- ✱ LEAD MOTHER'S HOUSE
- ▬ NATIONAL ROAD
- ▬ RIVER/CREEK
- 🏫 SCHOOL
- 🏰 CHURCH
- 🏞️ PLAZA

**CASE STUDY NO. 3
BARANGAY BOLOLACAO
NEW LUCENA, ILOILO**

COMMUNITY FEEDBACK ON SURVEY RESULTS

The survey results were given by the PRICOR staff on June 11, 1983 at the barangay elementary school. Gathered in the classroom were the leaders consisting of the barangay captain and his wife (also the BSPO), the rural health physician, the school principal and a private doctor.

The following are the highlights of the survey results presented to the assembly:

1. Both respiratory and gastro-intestinal illnesses were prevalent.
2. The two top-rank health needs were the lack of water facilities/supplies and lack of drugs.
3. The three ranking choices for financing scheme were donation of services, donation of materials, and income generating activities.
4. The first two most preferred health use of resources generated by the schemes were purchase of drugs, and construction of toilets and water facilities. The least preferred were BHW salaries and purchase of contraceptives.

The presentation of the survey results and the PRICOR concept elicited only a minimum of questions from the group. The rural health physician manifested an infectious interest in the project, particularly the concept of health financing. He elaborated on the benefits which the barangay could derive from such a project. Without much ado, they chose the members of their PRICOR Committee, as follows:

Chairman: PHC Chairman
Finance Group: Barangay Treasurer
Barangay Councilmen
Audit Group: Council Member, a Teacher and a KB
Chairman
Members: School Principal
Chairman of PHC Committee
Rural Health Midwife
BHW
BNS
BTH
Special Assistance Group:
Rural Health Physician

Municipal Development Coordinator
PTA President
KB Chairman

The school principal facilitated the discussion although she signified that she could not actively participate in the project due to her school responsibilities.

The core group tentatively identified the setting up of a botika as the health project towards which they would direct household contributions. Although Project PUSH already had an existing botika, they felt this could be expanded to enable them to sell antibiotics through prescriptions issued by the rural health physician.

A community assembly was then scheduled for the purpose of presenting the project idea to the residents and getting their feedback.

COMMUNITY PARTICIPATION IN SCHEME SELECTION AND PLANNING

Selection of Strategies

The barangay assembly that materialized was actually a PTA meeting at the school. Only 40 percent of those assembled were from Bololacao while the rest were parents from other barangays. The mixed group caused some confusion during the discussion of the PRICOR agenda.

The BHW presented the survey results but quite ineffectively and almost immediately talked about health financing without sufficiently giving any rationale for it.

The PRICOR committee represented by the barangay captain, BHW, RHP, midwife, PHC chairman, and another member, attended the scheme presentation at NEDA. They constituted the biggest delegation at that forum. Aside from the regular contribution from the residents, they proposed fund-raising activities in the form of games of chance, e.g., mah-jongg, which were indulged in regularly by many residents. Some individuals present at the NEDA assembly expressed misgivings about the propriety of such a scheme as it would tend to encourage gambling.

Other meetings were convened by the committee in order to refine their scheme and draw up the details of implementation. The committee seemed to perceive the RHP as crucial to their work and would postpone meetings when he was absent. On the other hand, the RHP disclosed to the PRICOR staff (who stayed in the barangay for two days to ascertain community awareness of the scheme) that he did not want to be too actively involved in the project since he wanted the barangay residents to take the active lead. The final presentation of the scheme to the residents was at an assembly which was attended by only 36 households. The scheme agreed on was the collection of a membership fee of P3.00 and a monthly P1 contribution; all proceeds were to be directed to the botika sa barangay. Moreover, a 25-centavo donation per consultation with the midwife was to be collected for miscellaneous health-related activities.

Before the August 1983 implementation, the barangay council passed a resolution embodying their formal participation in the PRICOR project.

Organizing the Community

To ensure the participation of a significant portion of the community, a 3-day seminar workshop for the committee members was held at the School Shop Building on October 4-6, 1983. Eighteen participants came, including the barangay captain, his wife who happens to be the BSPO, some council members and health workers of the barangay. Some participants did not attend all the sessions.

A resource speaker was the district nurse while the doctor was around to answer questions. The workshop proper started with the orientation of the core group on the new approach to primary health care delivery which relied on residents as providers of services. Three workshop groups were formed to plan for the eight puroks of the barangay. The appraisal of the health problems pertaining to each purok or group of puroks was the basis for the plan. A training curriculum was drawn up for the lead mothers who would head the plan implementation in the puroks.

In the mechanics of implementation, the nature of service delivery was identified for each health area, as well as a clear-cut referral system for the lead mothers, and the role of the core group in the whole implementation plan.

Lead mothers were identified to serve as health workers for groups of households. Those chosen were women with experience in dealing with the residents, such as the councilwomen and purok leaders.

During their closing ceremonies, the municipal mayor and his municipal officers attended and were consequently apprised of the implementation plan.

PROJECT PERFORMANCE/IMPLEMENTATION

Lead Mothers' Program

Organization

Nine lead mothers were chosen to cover five puroks at an average ratio of one mother per 20 households. The lead mothers respond to the calls for activity of the BHW. These calls were for activities ranging from those indicated in their PRICOR implementation plan to those which pertain to the BHW's task such as the record keeping system. The PRICOR chairman provides moral support and advises on health matters which entail barangay participation. The midwife provides technical supervision over the BHW and assists her and the lead mothers along her capacity. Of the nine, three were trained to be BTH's by the MOH, and are better prepared to service the needs of their households. Both midwife and BHW are stationed in the barangay health center where most of the lead mothers' meetings are held.

During the first eight months of the project, the rural health physician was easily available to respond to their needs; after that he resigned from his post.

Training

The lead mothers had a two-day training (October 1983) on the content areas where they were expected to be of assistance. These were on environmental sanitation, immunization, family planning, nutrition education, health education, food production, oral rehydration, and first aid. Their trainers consisted of the sanitary health inspector, and rural health midwives of the poblacion and the barangay, the full-time outreach worker, the home management technician, the provincial health nurse, and the RHP of a neighboring municipality.

After the content on health was given, the lead mothers were instructed on simple record-keeping to monitor their households' health status and activities. They were also made to role-play some typical barangay situations encountered in service delivery.

Six months later a refresher course was given to mothers by the BHW. Special emphasis was given on the use of oresol and the sugar salt solution with the LUKAT spoon.

Activities

After their training the lead mothers held purok assemblies to orient residents on their role in the delivery of primary health care. They announced that their first activity would be the campaign for environmental sanitation which would entail setting up of compost pits and waste cans in every household for proper disposal of garbage and the installation of blind drainage.

Environmental Sanitation and Backyard Gardening

The households gradually responded to the call of the lead mothers to clean and maintain their surroundings. After two months, only a few had done anything about constructing compost pits and drainage systems. Nevertheless, the lead mothers continued to prod their members. One lead mother eventually convinced one target household head to fence the area of the water pump, thus preventing the possible contamination of the water.

Non-usage of toilet was also commonplace. Some had no toilets whatsoever while a few had PUSH-provided toilets which were not being used. The lead mothers called on the BHW and the midwife to help in talking with the households concerned, usually to no avail. The lead mothers considered these households as their special challenge. They even considered invoking the municipal ordinance which punishes those with no sanitary means of waste disposal. Eventually they decided that an inspection of households by the rural health physician and the sanitary inspector might be effective. The barangay captain's wife was able to prevail upon the physician together with the RHU staff, to personally conduct the inspection. The problem households were among those visited. The latter were given a deadline for complying with this requirement and were to be monitored by the lead mothers. After a week their lead mothers reported positive response from these households.

Vegetable gardens in every household as well as a community gardens were set up.

Information Dissemination

Information about health-related activities was disseminated by the midwife through the network of the lead mothers. Specifically this was useful in informing them of immunization schedules and clarifying fund-raising activities and donations, schedules of health education classes, and presence of the botika sa barangay.

Record-Keeping

The new record-keeping system of PUSH was implemented by the BHW with the assistance of the lead mothers. The lead mothers were able to obtain accurate information on the conditions of their catchment households. Only one lead mother experienced difficulty with the reporting forms.

Role and Functions in Health Financing Schemes

The lead mothers improved the collection of the membership fees and monthly donations of households. They were moreover instrumental in the conduct of the raffles especially in the selling of raffle stubs and solicitation of prizes. The wife of the barangay captain was very active not only in campaigning for the raffle but also in the holding of benefit mah-jongg sessions. In the construction of the health station annex, the lead mothers not only spearheaded the activity but also donated food and cooking services for the hired labor.

Community Response

The lead mothers respond to the calls for activity of the BHW. These calls are for activities ranging from those indicated in their PRICOR implementation plan to those which pertain to the BHW's task such as the record keeping system. The PRICOR Chairman provides moral support and advice on health matters which entail barangay participation. The midwife provides technical supervision over the BHW and assists her and the lead mothers. Of the nine lead mothers, three were trained to be BTH's by the MOH. With their kits, they are better prepared to service the needs of their households.

Factors Affecting Performance

The performance of the lead mothers in Bololacao may be considered relatively successful especially in terms of their conduct of activities related to health financing. Since a lot of energy was directed towards the latter, their more direct primary health care functions were limited in scope. However, since their group was cohesive, they were easily available to the BHW and midwife who utilized their services for information dissemination.

To start with, the lead mothers showed interest in the project and most of them had available time to spare for their functions. While some had reservations at implementing their plans, this was dispelled by further task clarification directed to them by the BHW and the PRICOR staff as well as by the infectious enthusiasm of their co-members. The group's initial interest was sustained by the response of the local health personnel. During their lack of success with some stubborn households regarding toilet construction, the mothers appealed to the rural health unit, especially the doctor, to conduct house-to-house visits as a means of pressuring the recalcitrant ones. The RHP obliged their request although this was beyond his scope of work. Such an action served to assure the lead mothers that there was back-up support they could rely on and this bolstered the legitimacy of their role. With the RHP taking an active interest in the project, his staff in the barangay could do no less. There also existed a synergistic relationship between the midwife and BHW. Similarly, the PRICOR chairman facilitated their activities particularly in mobilizing support from council members. The town mayor was also perceived as partial to the project and thus open to any solicitation from them.

A key factor to their success might be ascribed to the leadership exercised by one of the lead mothers who happens to be the wife of the barangay captain. Accustomed to being quite influential due to her husband's position, she positively affected the participation of the lead mothers and the households and could easily approach the mayor and other officials to get assistance. She spearheaded most of their fund drives.

Capitalizing a Botika from Community Donations

Generating Resources

The 177 households were expected to pay an initial membership fee of P3 each and P1 monthly thereafter. The targetted collections for one year would have been a total of P2,655 wherein P531 would come from membership fees and P2,124 from the 12-month contributions.

Although the contributions were supposed to start in August 1983, it was only in November 1983 that an initial capital of P300 was accumulated. Towards the last week, stocks of drugs were purchased using the list of medicines provided by the RHP. The initial difficulty in collecting was overcome by having the lead mothers assume the collection responsibility from the purok leaders. Due to the initial eagerness of the lead mothers, some headway in collection resulted.

An accounting of contributions conducted in November 1983 showed that about 69 percent of households had submitted their membership fees, a number of which were still in partial payment. The rest paid their fees in trickles and only in April 1984 was a 92 percent (of HH) level of payment reached, although again many had not yet given their full payment.

The payment of the monthly contributions was dismally low. By that November only seven percent of households had started paying their monthly contributions and the amount collected was only P22 or three percent of what would

have been submitted by that time. An upsurge in collections was experienced in the months of March, April, and May 1984 due to a revitalization of collection efforts through the barangay assembly. In July 1984 the total collected for the monthly flat-rate contribution was P290 or 13.6 percent of target.

Thus the total contribution from the households for their botika amounted to P717 or 27 percent of that expected at the start.

Botika Operations

1. Management Structures and Location

At the start the BHW in the Barangay Health Center served as the depot for the barangay during daytime. After her usual working time the BHW transferred the drugs kept in a kit to a core group member, who was also a BTH and whose residence was accessible to most households. Thus the core group member served as the depot after the BHW's office hours.

In June 1984, the core group member resigned and the depot was transferred to a lead mother.

The BHW monitored the flow of stocks. At the start, close coordination was effected with the rural health physician who helped them prepare their list of stocks. Later when the RHP resigned, the midwife extended assistance.

Auditing was originally assigned to certain barangay residents, but was not implemented. Rather, the PRICOR staff's input along this line seemed sufficient. Before the termination of the PRICOR Project, the PRICOR Chairman agreed to serve as the botika auditor.

2. Demand for Botika Services

Medicine was available for fever, diarrhea, coughs, and colds as well as for a variety of common ailments such as muscle aches, and wounds. Vitamins and specific TB drugs were also available. An inventory showed that they had 28 brands. For fever they had five brands; diarrhea, four brands; coughs and colds, five brands.

During the first months of operation demand for drugs was limited. However, by the fourth month of operation and possibly with the growing community awareness of their botika, a wide range of drugs was purchased.

3. Sales

Except for the month of February 1984 when sales reached only P29.70, the sales figures generally reflect an increased use of the botika as a source of drugs for the residents. The records also showed that stocks were always available.

4. Mark-up and Profit

Generally less expensive drugs were given a higher mark-up than those that

were costly. Liquid bottled preparation which were more expensive, had a 10 to 15 percent mark-up only, while those on tablets averaged 13 to 25, percent.

After a few months' experience at running the botika and with the escalating cost of medicine, both the BHW and botika manager regularly monitored drug cost in the poblacion and consequently adjusted their prices regardless of the cost of their stocks. This was favorable for their botika and accounted for the relatively higher profit realized. The strategy also minimized losses resulting from inflationary price increases.

5. Replenishment and Inventory

Stocks replenishment had been timely performed by the midwife and botika manager. Usually replenishment was done on a monthly basis and directed towards the fast-moving drugs.

It was observed that the botika carried quite a number of brands that were expensive. For instance, the antibiotics which were listed by the RHP were no longer in demand when he resigned. They remained as non-moving stocks.

6. Credit and Collection

Credit was allowed for those who had given membership dues. Up until June 1984, no major problems had arisen with regards to the collection. When the other lead mother took over the depot, she asked the midwife for assistance in collecting the past credit. The midwife sent out collection letters and the residents promptly paid up.

7. Record Keeping

While some difficulty was experienced in record-keeping with the first botika manager, this has been eliminated with the efficiency of the lead mother currently handling the depot.

8. Post Project Plans

At the project conference of botika managers, the following actions were proposed:

- a. The PHC chairman will audit the botika monthly. Stock cards will be used to keep the inventory;
- b. New forms for the botika records will be used, wherein the name of the buyer/creditor will appear. This will give a better picture of the health status of the community and the client information on who patronizes the depot.
- c. An incentive consisting of a percentage of monthly sales is proposed to be given to the botika manager. While this is a proposal to be presented

to the appropriate barangay body, the intention is to raise botica prices to the level of the Poblacion boticas.

- d. To systematize credit management, the debtor will sign a promissory note and will be given notice two days prior to date due.
- e. Continued collection of all the uncollected membership and monthly dues.
- f. Possibility of shifting to cheaper brands with the same product quality.

Fund-Raising Activities to Construct Barangay Health Station Annex

As early as December 1983, the lead mothers started considering the idea of embarking on another financing scheme in the form of a raffle to raise funds initially for the botika in order to relieve the residents of the burden of their monthly contributions. The original target was to raise P10,000 then P5,000 and by April 1984, they decided that realistically they could raise only P360. The idea of the raffle was approved in a barangay assembly. By then, they decided to direct all proceeds to the barangay health center, for which some amount was already available.

The lead mothers spearheaded the sales of the raffle tickets and solicitation of prizes. Each raffle ticket cost P2 and the solicitor was entitled to a free ticket for every ten sold. Their enthusiasm enabled them to raise P855 or more than twice the amount targeted. One lead mother alone sold eleven stubs.

Additional money was raised through one mah-jongg party. The lead mothers provided the venue and snacks for the mahjong sessions while "tong" was given by the players. A total of P175.00 was raised.

By the end of May 1984 a substantial amount was available to start construction. The breakdown of their resources were:

Mah-jongg party Proceeds	P175.00
Raffle	855.00
Donation from Bgy. Fund	500.00
Donation from Rural Health Unit	500.00
Prize at Balikatan Contest	100.00
Donation from Abroad	200.00
	<u> </u>
TOTAL	P2,330.00
	<u> </u>

Construction materials worth P700 had likewise been won as a prize in the Kaunlaran Contest. The above-mentioned resources were realized in one way or another through the leadership of the lead mothers who participated in contests or made representations for donations.

By the time the project formally withdrew from the barangay, the lead mothers were embarking on another raffle activity to raise additional funds to complete the Annex.

The lead mothers spearheaded the construction, which took place in June 1984. In three days, the Annex, though still incomplete, was put up. They had exhausted their funds with P1,865 expended on materials and P465 for labor. Moreover, the lead mothers collected donations of rice and foodstuff (e.g., chickens) for the laborers' meals. Some volunteered to do the cooking.

Income-Generating Activities for Health

Two projects were initiated by the lead mothers to generate income for themselves as well as for the barangay's health activities.

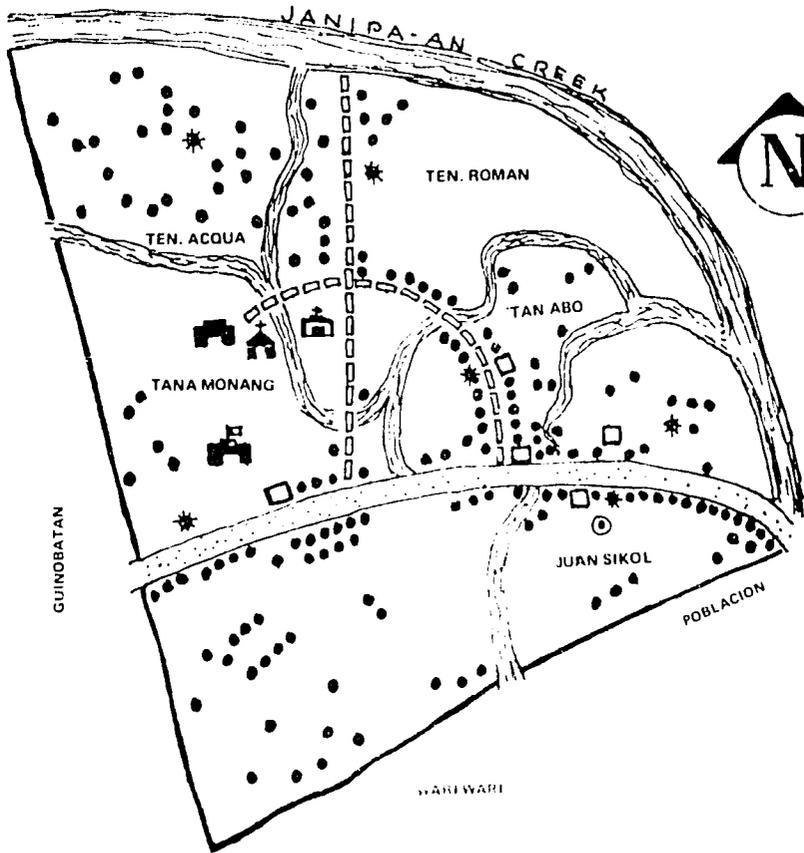
Fan-Making

One of the lead mothers has a home enterprise of making fans out of a kind of root commonly found in the barangay. The selling price per fan is P5.00. Since there is a potential market for 100 fans per month, she asked the other members to join her. The lead mothers intend to donate P0.25 per fan sold to the health fund.

Bag-Making

Two housewives in the barangay make banig bags from the buri palm. They intend to teach interested housewives this handicraft. Moreover, the lead mothers have made representations with the NACIDA to provide them training for better product technology. As of now the lead mothers help sell the bags and earn P1.00 per bag for the health fund.

SPOT MAP OF BARANGAY BOLOLACAO NEW LUCENA, ILOILO



Legend:

- HOUSEHOLD
- ⊙ BHW's HOUSE
- ★ LEAD MOTHER'S HOUSE
- ▭ PROVINCIAL ROAD

- RIVER/CREEK
- SCHOOL
- CHURCH
- HEALTH CENTER
- BARANGAY HALL
- WATER SOURCE

CASE STUDY NO. 4: BARANGAY BDIANG ANILAO, ILOILO

COMMUNITY FEEDBACK OF SURVEY DATA

Results of the survey on Badiang were first reported to a barangay core group on June 26, 1983. The group consisted of the barangay captain, rural health physician, the BHW, midwife and some barangay councilmen.

The highlights of the survey which were discussed were:

1. The most commonly perceived health needs were drugs and water facilities.
2. Respiratory and gastro-intestinal causes were responsible for most of the illness reported.
3. Preferred financing schemes were flat rate donation and fee for service.
4. Preferred uses of resources generated from health financing were for purchase of drugs and construction of toilets and water facilities.

The rural health physician, the BHW and the midwife actively participated in the discussion which ensued. They expressed their support for such a project. During this first meeting they constituted a PRICOR barangay committee with the following membership:

Chairman: Barangay Captain
Vice Chairman: 1st Councilman
Secretary: Councilwoman
Treasurer: Brgy. Treasurer
Auditor: Brgy. Resident
Business Manager: Selected Residents
PRO: Councilwoman
Advisers: Mayor, RHP, BHW, RHM

Their initial appreciation of schemes led to the proposal to collect P1.00 monthly from each household for the purpose of setting up a Botika sa Barangay.

COMMUNITY PARTICIPATION IN SCHEME SELECTION AND PLANNING

Selection of Strategies

A barangay assembly was convened in order to present the project for their consideration. Being a Sunday, better attendance resulted with 91 households or

54 percent of all households. The BHW presented the survey results with some assistance from PRICOR staff. Then the midwife introduced the idea of financing schemes, focusing on the specific proposal earlier identified by the core group. Some proposed a higher monthly contribution but eventually everyone settled on P1.00 monthly. The collection would be undertaken by their business managers who were assigned at one per sitio: Bgy. Proper, Balagon, and Hacienda Rica. The RHP was present. The barangay captain was represented by his son.

At the scheme presentation at the NEDA Office, the barangay was represented by the BHW, the midwife and the RHP. In the period that followed, a PRICOR staff member stayed in the barangay to assist them in working out the details of their scheme. In addition to their monthly contributions, the core group endeavored to include a donation of services scheme in the form of mothers' classes and environmental sanitation/ beautification campaign. Since their scheme envisaged the botika to be handled by the BHW, the latter wanted a place designated to house the botika. The PUSH Botika was kept in her house and was quite inconvenient. When the alternative of using the barangay health station was posed, the midwife objected, saying that the community might misunderstand and think that the health station was selling medicine.

Organizing the Community

In order to prepare the community for implementing their health financing scheme, the core group members were asked to participate in a seminar-workshop on September 25 to 27, 1983. Fourteen persons attended the sessions held in one of the school buildings; the participants included not only the core group but other members of the barangay council. Resource persons included the district health nurse and the RHP.

The output of the 2-1/2 days session was an implementation plan which would also serve as guidelines for the training curriculum of lead mothers.

PROJECT PERFORMANCE/IMPLEMENTATION

Lead Mothers' Program

Organization

The lead mothers were chosen for the three puroks with the following locational distribution: Barangay Proper — 2; Balagon — 6; Hda. Rica — 2. The BHW supervised their activities. The midwife usually participated in the meetings of the lead mothers although she did not concern herself with their day-to-day activities. Thus, she was not able to support them in their bid to assist in the delivery of primary health care. Although the lead mothers had signified their availability for involvement in community health care, the midwife did not really tap them for lack of activity herself.

Training

Ten lead mothers attended a one-day training which oriented them on primary health care and their tasks *via-a-vis* their households. The resource persons were the rural health physician, rural health nurse, midwife and the full-time outreach worker and the BHW. The content areas were environmental sanitation, health education, nutrition, family planning, immunization, first aid, oral rehydration, and maternal and child care.

A refresher course was conducted several months later. Focus was on oral rehydration and first aid.

Activities

Environmental Sanitation and Backyard Gardening

The first activity which the lead mothers identified was their campaign for environmental sanitation and the creation of home gardens. Fencing was deemed necessary since the numerous farm animals owned by the hacienda would not only trample on their vegetable plots but dirty their yard as well. In the hacienda, it was more difficult to maintain vegetable gardens since almost all free space was planted to sugar cane. As a whole the response to this campaign was not encouraging except in Hacienda Rica and two areas in Balagon where the lead mothers were more active.

Since not all households received toilets from the PUSH Project, the lead mothers campaigned for the construction of antipolo toilets. They also encouraged households to repair/build the structures that housed their toilets, using abundant local materials such as coconut leaves and ipil-ipil trees. Usually when admonished to do so in the past, they reasoned that they could not afford the expense.

At the start of the lead mothers' project the BHW initiated steps at acquiring for the barangay the PUSH Barangay Fund of two drop-out PUSH barangays in their municipality. Once released, this would purchase toilet bowls and water pumps, the recipients of which would be determined by the lead mothers based on the criteria of need. However, despite the active follow-up, the amount had not yet been received as of August 1984, probably delayed somewhere along the fiscal channels of government. The delay was unfortunate as it could have boosted the image of the lead mothers.

Collection of Monthly Donations

Due to the slow collection rate, the lead mothers took over this function from the business managers. The lead mothers and core group agreed to issue receipts for all monthly contributions and remitted all collections to the treasurer. The collections improved somewhat because of the persistence of the lead mothers although some residents remained recalcitrant.

Others

Aside from the aforementioned which took up the first six months, the lead mothers were unable to perform any other significant primary health care. After the first six months, they programmed their subsequent activities to include assistance in immunization, feeding, and weighing. However, except for weighing of preschoolers, immunization was not realized since the midwife was unable to obtain the vaccines. As for the malnourished who were the target of feeding, the supplies were not directed to them by the midwife. Feedback on children's weights were not provided their mothers. Somehow the BHW and the lead mothers were waiting for the midwife to initiate the activities they were willing to assist in.

Community Response

The barangay residents were not responsive to the initial campaign of the lead mothers for environmental sanitation. Thereafter, since their activities were few, even these may not have been attributed to their efforts.

About half of the core group who had attended the seminar-workshops did not actively involve themselves in the consequent implementation. Likewise, the barangay captain, who happens to be the father of the BHW, did not take an active concern in the project and was conspicuous only during the survey feedback and the seminar-workshop. The RHU staff of the poblacion gave their technical support especially as resource persons in the forums for lead mothers. However, the midwife who could have enhanced the health work capability of the lead mothers was the weak link as already noted earlier. On the other hand, the BHW while concerned about the lead mothers was not able to initiate new activities independent of the tasks given by the midwife. Thus the group was left in a position of merely waiting for the midwife to mobilize them.

Factors Affecting Performance

Basically the lead mothers were responsive to the idea of being service providers for their catchment households. The BHW was willing enough to implement and coordinate the activities spelled out but was not able to provide the leadership to surmount the odds presented by an apathetic group. The observed apathy may be disinterest in the activities which called for community participation. For one, the geographical set-up of Badiang militate against the enhancement of any existing community relationship. The houses are lined along the roadside while those located in the inner portions are quite dispersed. Any gains such as cohesiveness and "groupiness" generated by clustered houses were not present here. Hacienda Rica is the exception and it is here where the lead mothers were relatively more successful.

The support from health personnel and local officials was at the barest minimum. The midwife who was the major resident health worker in the barangay was not particularly concerned about the activities and behaved as though the project was independent of her own duties instead of integral and an area for collaboration.

Furthermore, as already mentioned in the previous section, local officials did not actively involve themselves.

Ultimately, only the lead mothers' function as drug depot managers sustained them as a group. The botika became a tangible area wherein many of the residents perceived that service was actually being provided.

Capitalizing a Botika from Community Donations

Generating Resources

The scheme chosen by Badiang was to collect a flat rate donation of P1.00 monthly from each household for the purpose of setting up a botika sa barangay. While originally they planned on a year-long period of donations, a few months' experience of the difficulty in collecting resulted in a decision to collect only for a five-month period, covering August 1983 to December 1983. In effect, each household's full donation would amount to P5.00. Projected collections for the 166 households in Badiang would amount to P830.

Collection of Flat Rate Contribution

Although the botika would have been started in September based on the initial contributions, such was not realized until December 1983. Contributions were slow in coming in, although some lead mothers made a good effort at collecting. The relatively more successful lead mothers were the two assigned to the two sugar haciendas. The lead mothers coursed the collection through salary deductions during workers' pay day. The other households who worked on odd jobs and occasionally as fishpond laborers were recalcitrant donors. Thus by December 1983 only 115 households or 69 percent of all households had made some kind of donation (i.e., of varying number of months paid up). Total collection was only P306 or roughly 37 percent of the targetted amount. The aforementioned constituted the starting capital. Collections were continued and aimed at having all households complete their contributions.

Botika Operations

1. Management Structure and Training

Four drug depots were set-up: Brgy. Proper — 1, Hda. Rica — 1, Balagon — 2. The latter is widely spread with occasionally hilly areas necessitating more depots for better access. Each depot is operated by a lead mother from the area. The BHW monitors the operations and makes recommendations for improving its management. The barangay treasurer receives all cash remitted from the depots and keeps the amount until the BHW replenishes the stock. End-of-the-month audit is performed by the PRICOR field researcher assigned in the barangay. The PRICOR ba-

rangay core group had earlier identified a barangay auditor who, because of illness, was unable to discharge her duties.

2. Demand for Botika Services

The botika carried medicines intended for the leading illnesses prevalent in the barangay namely, respiratory infection, diarrhea, and fever. Generally, drugs for respiratory illnesses were responsible for most of the monthly sales. Residents are observed to be very selective about the brand of medicine they purchase. For example, although Tylenol is an effective drug, it is not as popular as the less effective types which the botika carries. About two or three brands of the same type of drug are available at the botika, resulting in a broad spread of limited capital. The tendency to run out of stock is likely since demand for some brands will be high; but because other less popular brands are kept in stock, specific supply is low.

Among the depots, that in sitio Balagon registers the highest demand for botika services. Drugs have a fast rate of turnover, so that usually within two to three weeks, replenishment becomes necessary.

3. Sales

Table 22 shows the combined drugs sales of all depots. Marked fluctuation characterizes the month-to-month level of transaction. This is mainly due to the considerable delay in stock replenishment, such that even if customers needed to buy drugs, the depot had run out of them. The first purchase done in December 1983 was replenished only towards the end of February 1984, thus explaining the diminishing sales across the three months. The February 1984 sales of P27.75 are a reflection of the low stock available so that customers had to run elsewhere for their purchases.

4. Mark-up and Profit

No definite percentage is applied to cost price in arriving at the selling price. The latter is based on a comparison with prevailing prices at nearby sari-sari stores and in the botika at the poblacion. The depots maintain the same price as the sari-sari store while they apply a minimum mark-up of from five to twenty centavos over the poblacion botikas. In the case of the latter, the lead mothers confer on what mark-up to apply. The monthly record of profit reflects percentages over sales of from 9 to 29 percent.

5. Replenishment and Inventory

As mentioned the replenishment had not been timely, resulting in inadequate stocks. The inability to replenish in time was due to the following interrelated reasons:

- a. Replenishment is done only by the BHW, who waits for all depots to remit cash sales before she makes repurchases.

- b. Since credit level is high, depots are unable to remit regularly.
- c. Due to their peculiar botika structure, the money has to be remitted first to the treasurer who turns over the money to the BHW for repurchase. Considerable delay results.

The system did not incur transportation expenses (for replenishment) since the BHW's husband drove a passenger bus.

6. Credit and Collection

Credit purchases in the depots are rampant and have become a problem. The lead mothers feel they cannot in conscience turn away a customer who is unable to pay for medicine. The lead mother in the sugar hacienda (Hda. Rica) puts in an extra effort to collect on paydays and in her case, more often than not, the households are able to gradually pay back. One lead mother however reported lack of success in her collection efforts as the households would say they still did not have the money. In her case, the households work in different haciendas so that she is unable to apply the method of collection used by the aforementioned lead mother. Due to this situation, the lead mother at times feels compelled to advance the payment herself in order to remit cash to the BHW for stock replenishment. As a result of the tension, she has expressed a desire to take a leave from her duties as a lead mother and depot manager.

An examination of the level of credit shows that the average collection period of the botika runs to about one to two months. There was one instance wherein because of credit sales one depot in Sitio Balagon was unable to remit the collection of P163.10 for the second and third purchases. Generally, credit occupied 30 to 50 percent of the sales of the botika. In spite of the high percentage of credit sales in the botika, did not suffer any bad debts.

7. Record Keeping

The depot managers experienced difficulty in keeping track of botika transactions. The two sources of difficulty were: (a) they were not accustomed to filling up forms or even writing down anything for that matter, and (b) they would forget to record transactions. Despite attempts at training them to record transactions on simplified forms, most were still weak in this function.

8. Post Project Plans

At the end-of-project botika workshop, the depot manager proposed the following measures to improve their operations.

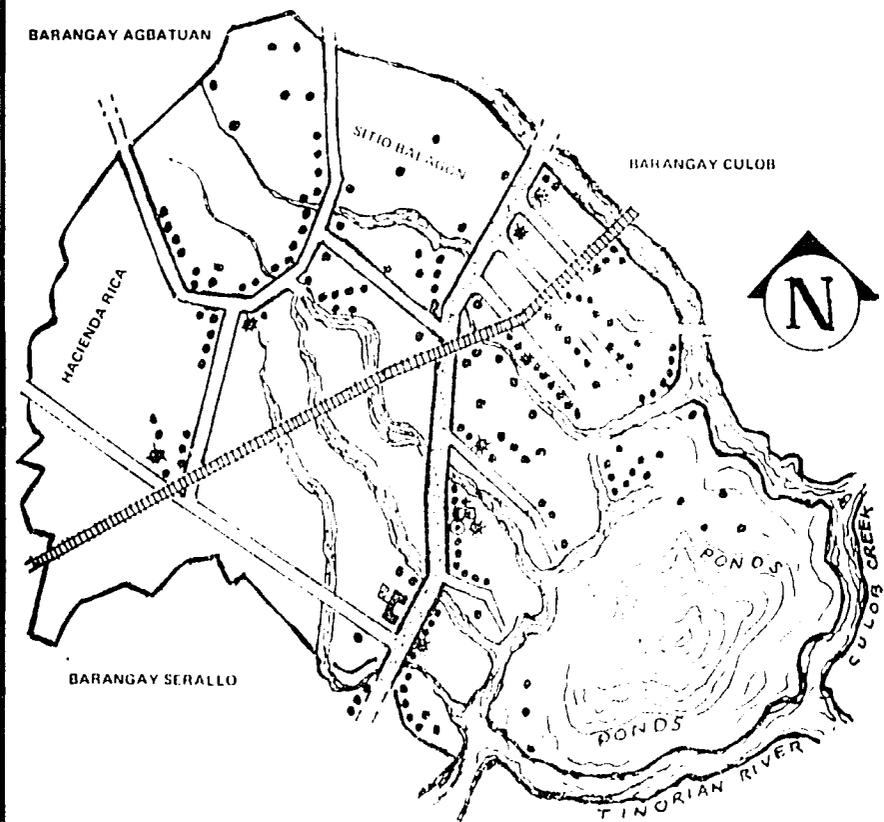
- a. Extension of credit will be selective and limited in amount. Creditors will be assessed on the criteria of ability to pay, previous credit record and need. It was noted that some households which can afford to pay for medicines go into credit simply because it is allowed.

- b. To prevent recurrence of the depots' running out of stock, the BHW shall conduct a regular (every 4th and 19th day, of the month) inventory check per depot and consequently purchase needed stocks. To ensure that money is available for this, any amount collected shall immediately be remitted to the treasurer.
- c. Recording systems will be improved for easier tracking.
- d. Quarterly feedback to the barangay regarding botika performance.
- e. Collect uncollected donations.



The community participants include women of varying ages.

SPOT MAP OF BARANGAY BADIANG ANILAO, ILOILO



Legend:

- | | | | |
|---|---------------------|---|---------------|
| ● | HOUSEHOLD |  | SCHOOL |
| ⊙ | BHW'S HOUSE |  | HEALTH CENTER |
| ✱ | LEAD MOTHER'S HOUSE |  | RIVER/CREEK |
| — | BARANGAY ROAD | | |
| — | NATIONAL ROAD | | |
| — | RAILROAD TRACK | | |

CASE STUDY NO.5 BARANGAY MARIBUYONG DUENAS, ILOILO

COMMUNITY FEEDBACK OF SURVEY DATA

The survey results feedback was given on June 10, 1983 at the barangay multipurpose center. The vice mayor and the rural health physician were the more prominent municipal officials present while the barangay leadership was represented by the council members and service workers (BHW, BTH, midwife, teachers). Their barangay captain was on leave at that time.

Among the salient features of the barangay health profile were:

1. Generally the private doctors were consulted most frequently. The traditional healer was also consulted for specific complaints;
2. Only 51 percent of households said that health services were accessible;
3. The most pressing perceived health need were the lack of water facilities/supplies, and the lack of drugs;
4. For health financing purposes, the majority preferred donation of services and donation of materials while health insurance and income generating activities were the least popular;
5. Resources generated from schemes would be preferably channeled to purchase of drugs and construction of toilets/water facilities.

These and other related health and demographic data were presented using pictographs. The only notable comment from the audience was their opposition to the information that the government health service providers have received some payment from the clients. The staff clarified this by saying that this might have been isolated responses and payment might have been a donation for use of some materials but which nevertheless was perceived by the client as service payment.

The concept of primary health care financing was explained reiterating the survey questions of the feasibility of household participation in such a scheme. The research interest in documenting community processes as well as correlates of success/failure of financing schemes was likewise mentioned.

The Vice Mayor consequently spoke to the constituents in their peculiar dialect, further clarifying the project's intent, emphasizing that Maribuyong would not be receiving any monetary aid from PRICOR. However, he appealed to the barangay residents' sense of cooperation and self-pride in that they were among the six chosen of all Iloilo barangays to participate in the PRICOR Project.

The rural health physician essentially gave the same message, motivating the core leaders to attend to the project.

Probably due to the active participation of these two municipal personages, the local residents were not too vocal but were nevertheless attentive.

At the end of the session, the BHW facilitated the group towards the selection of members to their PRICOR Committee which would coordinate the selection of an appropriate scheme by the residents. The resulting organization below had practically the same composition as their Primary Health Care Committee with a former barangay captain as their chairman.

Chairman: Ex-Barangay Captain
Vice Chairman: Brgy. Councilman
Secretary: Brgy. Secretary
Treasurer: BTH
Auditor: Samahang Nasyon Treasurer
Members: Past Brgy. Captain
Councilmen

The core group scheduled a community assembly meeting for that afternoon for the purpose of presenting survey results eliciting suggestions and consensus on appropriate health schemes.

COMMUNITY PARTICIPATION IN SCHEME SELECTION AND PLANNING

Selection of Strategies

Through a series of community assemblies the barangay core group was able to dialogue with the residents and finalize their financing scheme.

During the first assembly, about 80 percent of household heads were present. Those present were partial to making a regular flat rate contribution for the purpose of establishing a health emergency loan fund. The contribution would entail having each household pay P1.00/monthly for 10 months or equivalent to P5.00/cropping. The fund would further be augmented by a kind of tax to be collected on the sale of the livestock or farm produce. The **purok** leaders would perform the collection and remit payments to the treasurer who would then issue the corresponding receipt. The fund would be made available to any barangay resident for health expenses, e.g., hospitalization, medicine, related transportation expenses upon the recommendation of both the BHW and midwife and the signature of a loan guarantor. Interest would be charged on the loans.

At the NEDA presentation, the barangay was represented by the midwife BHW, BTH, the acting barangay captain and two council members. In addition to the selected scheme, the BHW reported that the core group had identified donation of services and materials for still unspecified health activities as an additional scheme.

The second barangay assembly was convened after the NEDA presentation. It provided residents the opportunity to clarify the mechanics of the scheme especially on the tax imposition which they had obviously accepted. The assembly also decided to remove the interest on loans made.

Thereafter, the PUSH researcher was able to monitor the extent of awareness of the residents by engaging them in informal discussion. By then the barangay captain was back. At first, he had reservations about the taxation aspect since according to him, the barangay already taxed these items resulting in double taxation. The issue was resolved by proposing that the Barangay Council approve the motion that for the year the tax collection on farm produce would go to a health fund.

Organizing the Community

A workshop was conducted on September 22 to 24, 1983 to improve the ability and enhance the attitudes of the core group in implementing their schemes. An unusually large group of participants (26) attended since the BHW involved not only the PRICOR committee members but also others whom she perceived as key persons in the barangay. The workshop started auspiciously with the mayor appealing to the residents for cooperation with the project and to demonstrate the "fame of Maribuyong". On his part, the RHP advised them to "learn the lessons" given in the seminar. As before, he attempted to arouse their sense of pride in their barangay.

Among the resource speakers was the District Health Educator who spoke on the scope of Primary Health Care. The participants exhibited a keen interest in herbal medicine as an inexpensive but effective defense against the entry and spread of common infection and ailments. They pointed to the need to explore the use of these herbs considering the rising cost of drugs. The discussion on the proper construction of toilets relative to water source was also well appreciated.

After receiving a substantial orientation on primary health care, the participants identified the health concerns of their barangay and prepared corresponding action plans for the different household clusters.

Part of the plan was to field lead mothers to handle clusters of households. Nine lead mothers were identified and selected in terms of their perceived capability, resourcefulness and enthusiasm as service providers. A training curriculum was then drawn up for the lead mothers. Special emphasis was given once again on herbal plants, its identification, and preparation for actual use.

The seminar-workshop culminated with each group presenting their respective plans before the mayor and the RHP (Table 21). The mayor announced that he would donate a prize to whoever would have the cleanest purok. The RHP committed his assistance in their activities especially on the use and availability of herbals.

PROJECT PERFORMANCE/IMPLEMENTATION

Lead Mothers' Program

Organization

The nine lead mothers were assigned at an average ratio of one lead mother for every 15 households. Later, due to the pressure of other concerns on some lead

mothers, two assistants were recruited. The BHW monitored and guided their activities. The midwife gave them technical assistance when called upon. Their committee chairman did not become actively involved in the activities of the lead mothers.

Training

A one-day training was given to the lead mothers on the areas of food production, health education, nutrition education, herbal medicines, first aid and record keeping. The extension workers from the Ministry of Agriculture, the rural health physician, the rural health nurse and the home economics teacher served as their resource speakers. Three of the lead mothers were unable to attend.

A refresher course was given six months later, focusing on immunization, family planning, weighing and oral rehydration.

Activities

Setting Up Communal Gardens

Among the first activities engaged in by the lead mothers was the establishment of herbal gardens. The common procedure was for them to catalyze their respective households into participating in setting up a communal garden. This usually resulted in members donating materials, such as bamboos for enclosures and paint for labelling and beautification purposes. Most important were the service hours of the households which were necessary to prepare the plots, establish the herbals and consequently maintain them. Unfortunately, many lead mothers ended up doing the work themselves since their neighbors were busy with housework and farming that they were delayed in putting in the necessary work hours. Some lead mothers did not mind working since their catchment houses were usually their close relatives. However, for a few, maintaining a garden which was supposed to be a communal effort became a chore. At any rate, each lead mother was able to establish a communal garden which was usually approximately 7 x 5 meters in size with herbal plants neatly grouped according to types of illness they were intended for. The BHW taught the lead mothers the proper dosages of the herbs.

As an incentive towards the maintenance and use of the herbal garden, the contest for "most outstanding herbal garden" was launched. The criteria set by the BHW was:

- a. Utility/Quality. Over-all usefulness of herbs planted in relations to common illness among barangay folk – 25 percent;
- b. Variety/Quality. Number of varieties found within each garden – 25 percent;
- c. Physical arrangement. Orderliness and systematic physical lay-out – 25 percent;

- d. Participation of Group Members. Level of cooperation and coordination among members on the actual putting up, cultivation, and maintenance of herbal garden – 25 percent.

The garden contest was judged by the RHP, sanitary inspector, MSSD Worker and midwife from New Lucena. The competition was keen, as all the gardens showed that sustained effort had been put into them. Certificates and garden tools were awarded to the first, second, and third place winners.

When summer set in, the lack of water reflected in the drying up of plants. Some mothers were able to do some replanting to renew their gardens.

In retrospect, the herbal garden turned out to be a major activity of the lead mothers. Whether or not the gardens were functional to the residents may be gleaned from the reports of the lead mothers on what were the most often "picked" herbal, which according to them averaged two to three persons per day. These are the following which are purposely for diarrhea, fever, coughs, colds, wounds, rheumatism, and bruises:

1. Alibhon
2. Herba Santa Maria
3. Sen-san-soy
4. Herba Buena
5. Lampunaya
6. Star-apple
7. Malunggay

Others

The lead mothers became an effective channel for informing the residents about not only health matters but also other barangay concerns. Notices of assembly coursed through them usually resulted in better attendance.

Their role in immunization was in informing the target children in their household clusters and sometimes bringing the children to the health station. The lead mothers also effected the information dissemination on the conduct by the staff of free sputum examination in their health station.

In July 1984 weighing was initiated by one of the lead mothers. Unfortunately, neither the midwife nor BHW was around to supervise. Those whose lead mothers were unable to conduct weighing were asked to bring their children to the health station.

Community Response

The orientation conducted for the key persons in the barangay enabled them to rouse the awareness of the residents. The lead mothers might be considered successful in eliciting the interest of the households regarding the areas of primary health in which they had some activity. The PRICOR chairman, however, did not exercise any active leadership over the activities of the project. The

midwife, BTH and the BHW cooperated in their technical capacities. As a whole, the community had a positive attitude towards the project except for a few who exhibited a "wait-and-see" attitude.

Notable was the concern shown by municipal officials particularly the mayor, vice-mayor and the rural physician. They gave prompt responses whenever their assistance was sought, such as in providing resource persons for the project, giving donations for the raffle, acting on complaints regarding the BHW's infrequent presence in the barangay, and even acting as judges for the herbal garden.

Factors Affecting Performance

The lead mothers program met with a good start. Their first activity of setting up vegetable and herbal gardens resulted in commendable efforts by most households to cooperate with the lead mothers. The lead mothers were eager to deliver primary health care service within their limited capability. At the start, the BHW who then was residing in the barangay, conscientiously and dynamically followed up and supported the work of the lead mother. However in the second quarter of the project period she encountered personal problems which prompted her to leave the barangay and reside in the poblacion. Although she retained her position as BHW of Maribuyong, she was no longer able to keep regular hours in the barangay. Consequently, her health functions were not fully carried out and the lead mothers in a sense lost their source of direction and active support. It may be to the credit of the lead mothers that in spite of the irregularity of the BHW's visit, they were still able to carry out a minimum of activities.

The choice of lead mothers was appropriate as the core group was able to identify women who had the respect of the community.

The strong support of municipal officials for the project was another positive factor which recommended the program to the residents. They felt both assured of support, and motivated to cooperate.

The fact that Maribuyong is a barangay at a relatively far distance from the poblacion makes it an insular place. This may account for the close knittedness of the residents and the ease of soliciting their participation.

Establishing a Barangay Emergency Loan Fund

Generating Resources

The barangay had chosen to finance a barangay emergency loan fund by means of the collection of taxes on sale of livestock and fruits and of P1.00 per month per household or P10.00 per household for two croppings in a year's period. The features of the taxation scheme were:

1. P5.00 per pig sold;
2. P2.00 per goat sold;
3. P10.00 per carabao sold;

4. Any donation for firewood sold; and
5. P10.00 from big capitalists and P5 from small capitalists for fruits and coffee.

As for the flat rate the target amount monthly was P107.00.

The lead mothers monitored the sale of livestock and fruits as well as the flat rate contribution per household. The barangay purok leaders lent assistance especially for difficult collection cases. Nevertheless, collection was quite slow. Four months after the scheme was supposed to be in operation only P85.00 had been collected. At the start, the households would defer their payment to "after the first cropping" when money would be more available. However, even when harvest came, the payment still was not forthcoming and they reasoned out that they would wait for the second cropping since the drought resulted in a poor harvest. The hesitancy rather than the inability to pay was obvious. In a barangay assembly, the residents discussed the problem of the prevailing non-payment. Some residents said they withheld payment because they wanted to be better clarified on how the funds would be used and how accounting would take place; In tackling the problem, three suggestions emerged: (a) to pass a barangay resolution penalizing those who failed to pay their animal taxes, (b) have the treasurer bonded, and (c) undertake a raffle as an incentive for payment of contribution. The third one was immediately chosen and the second was to be considered.

The BHW with the lead mothers prepared for the conduct of the raffle. They were instrumental in soliciting prizes. There were two first prizes, two second prizes, two third prizes, and 20 consolation prizes. Compared to the amount intended to be raised, the prizes might be considered disproportionately expensive. Since the idea of the raffle was to ensure household contribution to their loan fund, only those who completed their payments were entitled to the raffle tickets. For every cropping contribution paid, one ticket was given or two tickets for two croppings.

Most of the residents were able to complete their two cropping payments in time for the raffle. A total of P1,086 had been collected: P96 from taxation and P990 from donation. Some residents who were considered by the core group as very indigent were exempted from payment.

The residents were satisfied with the conduct of the raffle. However, after its conduct, the collection of taxes was no longer pursued.

Of the P1,086 collected, P836 was deposited in the rural bank of the Poblacion, and P250 was entrusted to the treasurer as standing cash for easy availability to residents.

Operation of the Emergency Loan Fund

Mechanics

The policies on the use of the emergency loan fund was laid down even at the project start but was formally embodied in their barangay resolution only

in February 1984. These guidelines were:

- a. Any bonafide household member of the barangay may avail of the fund for health emergencies at an amount not exceeding 25 percent of the current balance. The presence of such an emergency will be attested to by either the midwife or BHW. The actual amount to be loaned will also depend on the severity of illness. Approval of the PRICOR Chairman was likewise sought. These three constitute the Loan Fund Board.
- b. The borrower must present a guarantor or co-maker for his loan, who will be responsible for the loan in case of default by borrower.
- c. Repayments which can be given in installments must be in cash within a month's period.
- d. Previous loans must be fully paid before a new loan can be obtained.
- e. Joint signatories for bank withdrawals shall be the barangay captain, treasurer, and midwife.

On the matter of signatories, the barangay health worker was originally designated to be a signatory. The barangay assembly, however decided otherwise since they noted the growing infrequency of the BHW's visit, which fact might affect the ease with which her signature may be obtained.

An additional policy prohibiting the treasurer from lending the standing cash in her possession without the knowledge of the board was included. This resulted from the experience wherein the treasurer lent out the money at her own discretion.

Utilization of Fund

Despite the availability of money as early as November 1983, the first transaction transpired only in May 1984. By the time PRICOR withdrew from the barangay in August 1984, only four had borrowed from the fund.

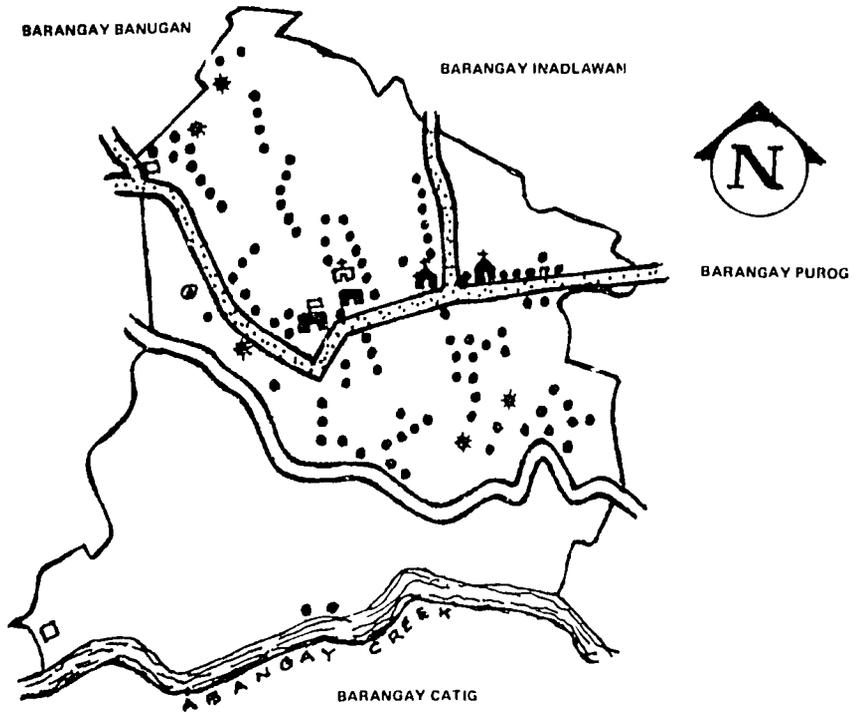
The first borrower made representations for herself and her neighbor. Their children had bronchopneumonia and needed money for medicine and the necessary transportation cost. Although she had the option to avail of the maximum amount of P250, she chose to borrow only P200 since this was what they could afford to repay. She was able to repay the loan on time.

The next two borrowers took out amounts of P100 each. One needed medicine for a urinary tract infection while the other had to consult a doctor for a wound. They paid back after 1-1/2 months, thus exceeding the stipulated repayment period.

One applicant was unable to avail of the loan. Since she borrowed at a time when the treasurer's standing fund was committed, bank withdrawal was necessary. However, the treasurer was away and could not sign. By the time the treasurer returned, the borrower no longer needed the money..

Although households experienced illness, only when they had exhausted all possible sources of funds, e.g., borrowing from relatives, did they turn to the loan fund.

SPOT MAP OF BARANGAY MARIBUYONG DUEÑAS, ILOILO

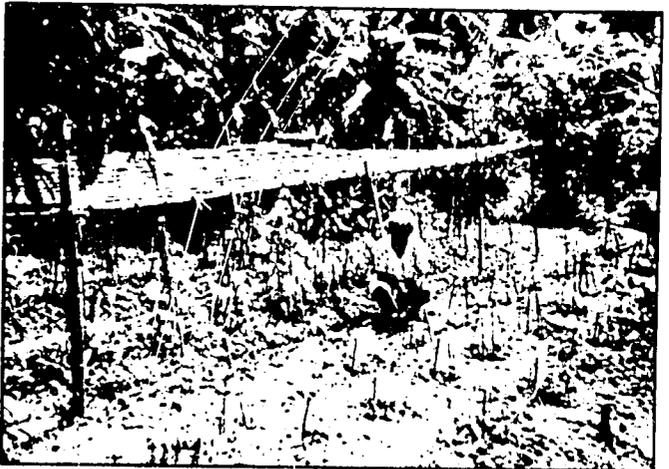


Legend:

- HDUSEHOLD
- ⊙ BHW'S HOUSE
- ★ LEAD MOTHER'S HOUSE
- || BARANGAY ROAD
- ||| PROVINCIAL ROAD
- ~ RIVER/CREEK
- 🏫 SCHOOL
- 🏰 CHURCH
- 🏥 HEALTH CENTER
- 🏛️ BARANGAY HALL



Herbal/
Vegetable
Gardening



CASE STUDY NO. 6
BARANGAY TASTASAN
BUENAVISTA, GUIMARAS

COMMUNITY FEEDBACK OF SURVEY DATA

The results of the community survey were conveyed by the PRICOR team on June 13, 1983 to a core group of the barangay consisting of the barangay captain, the councilmen, the BHW, BNS, the rural health physician, rural health midwife, municipal development coordinator and a staff member of the provincial government.

The highlights of the survey results were.

1. Respiratory illnesses were the most common cause of morbidity followed by gastro-intestinal ailments.
2. Commonly perceived health needs were for drugs and medical services.
3. This health financing scheme preference was for the flat rate contribution of P3 monthly and fee for service.
4. The resources generated were to be directed towards purchase of drugs and construction of toilets and water facilities.

A lively discussion surrounded the issue of health financing. The group was ambivalent about the idea. Some expected it to be a dole-out type of project with PRICOR infusing funding into the barangay. This misconception was promptly corrected. The barangay captain was doubtful in spite the views articulated through the survey, that the residents would be willing to contribute P3 monthly. He cited the economic difficulties prevailing. However, he anticipated that with the support of local government, financing schemes may be worth a try. The rural health physician disagreed with the latter idea which implied dependency on government, whose resources are very inadequate. He mentioned that due to low salaries, the government had not been able to attract doctors to the RHU, resulting in the current situation wherein he himself had to serve three municipalities. He appealed to the barangay leaders to espouse self-reliance among their constituents and to obtain their support in trying out the health financing scheme.

After the discussion, the group organized themselves into a committee to explore the possibilities of implementing the project.

Chairman	--	Barangay Captain
Vice Chairman	--	Barangay Councilor
Secretary	--	KB Chairman
Treasurer	--	Bgy. Treasurer
Bus. Manager	--	Bgy. Councilman
Auditor	--	Elementary School Teacher
PRO	--	Bgy. Councilman
Board of		
Directors	--	BHW and Midwife

COMMUNITY PARTICIPATION IN SCHEME SELECTION AND PLANNING

Selection of Strategies

The barangay assembly on June 16, 1983 was attended by only 30 percent of households, due to faulty information dissemination. The BHW presented the survey feedback aided by the midwife. The assembly was passive. When the schemes were discussed they chose to adopt a flat rate contribution but only for P1.00 monthly to be directed toward the capitalization of a botika. At this time, no barangay botika was existent.

The BHW, BNS, two barangay councilmen and the barangay captain represented their barangay at the NEDA Conference. The BHW presented their scheme of P1.00 monthly for a botika with the consideration that donations of rice, eggs or vegetable may be accepted in lieu of cash. These goods would be sold at the local market and the money realized would be turned over to the treasurer. During the discussion, the barangay captain confided his problem of getting people to cooperate in projects.

At the second barangay assembly called to finalize pre-implementation details, 50 percent of households attended. Again it was observed that the community was passive, as though they were content at leaving matters to the barangay captain. A PRICOR staff member who stayed in the barangay to provide technical assistance obtained feedback by talking to residents. Some expressed satisfaction at the prospect of having the botika, thus precluding the need for going to the poblacion to purchase medicine.

Organizing the Community

A seminar-workshop was held for the core group members to properly orient them on their responsibilities regarding the primary health care activities. This was held at an open area beside the barangay captain's house. After the motivational exercises and lecturettes on aspects of primary health care, the 14 participants were assigned to two groups to plan for their assigned target areas. For each target area, a lead mother was identified to supervise anywhere from seven to 27 households depending on the best clustering. Moreover, the peculiar problems per area were noted and appropriate activities specified. Items like supervision, role of core group and training of lead mothers were also discussed.

PROJECT PERFORMANCE/IMPLEMENTATION

Lead Mothers' Program

Organization

Eleven mothers were originally assigned to household clusters ranging from seven to 27 families. Four were supposed to serve in Sitio Bunlao and seven in Barangay Proper. When two mothers failed to attend their training, they were

dropped from the list and their catchment households redistributed among the nine who were trained. In the course of implementation, four additional lead mothers were recruited as assistants. After a few months, five lead mothers and two assistants resigned for varied reasons, such as for maternity purposes and demands of their jobs. Only eight mothers remained by the end of the project.

The BHW who was expected to supervise their activities was not able to regularly monitor or direct the lead mothers, as he was busy on other matters. Fortunately, the barangay captain who was also the PRICOR Chairman sustained the lead mothers' efforts even if only on administrative aspects. The midwife, although not a resident in the barangay, was willing to provide assistance to the project upon request. She was also the supervisor of the BHW.

Training

Only nine lead mothers were able to attend their training which was given on a staggered afternoon schedule for five days in consideration of the mothers' time within which to attend to household chores. The resource speakers invited to handle the different topics in the curriculum were the sanitary health inspector, the full-time outreach worker, the home management technician, a private doctor, a midwife and the BHW. The barangay captain was present in all the sessions. The content of the training covered these areas: environmental sanitation, family planning, food production, nutrition education and rehabilitation, maternal and child care, health education, record keeping, and oral rehydration therapy. Three of the lead mothers were designated as barangay technician for health of the MOH and consequently underwent a more intensive training.

Activities

Environmental Sanitation

The first activity of the lead mothers as per implementation plan was their campaign for the creation and maintenance of clean surroundings and the setting up of vegetable gardens. Their strategy was to make house-to-house visits and inform households of the campaign as well as to introduce themselves in their new roles. Some of the mothers were remiss in this. While the performance for the vegetable gardens was satisfactory, the campaign for cleanliness did not have much impact on the residents. Surroundings were still dirty and only a few dug holes for their trash. They preferred to heap these in the immediate surroundings of the citrus fruit trees.

Health Information Campaign

During the second quarter of implementation, they embarked into a health information campaign, going by puroks and having themselves as resource speakers. Eight areas of primary health care were addressed quite satisfactorily by five lead mothers. The purok residents responded by asking questions.

Their second purok information assembly was held in Bunlao. During its first scheduled date, it was postponed since only five residents came. At the next date, 17 residents attended. The residents were interested in knowing how to avail of feeding rations and were disappointed to learn that this was intended only for malnourished children. Aside from this group activity, the lead mothers also disseminated information on immunization schedules among the target households.

Others

A few lead mothers were more active than others and were able to undertake additional activities. Since one lead mother was the barangay nutrition scholar, she did the weighing with the help of another lead mother. Some mothers were likewise active in collecting for the monthly botika contributions. One lead mother in Bunlao acted as a botika depot manager.

Community Response

As noted earlier, the residents were not responsive to the attempts of lead mothers to influence some of their health practices. Although about 30 to 50 percent attended their assemblies, these forums did not seem to excite them into action. It may be surmised that they may have expected to receive more material gains from the project rather than for them to put in their services and/or resources. Thus, their passivity.

Factors Affecting Performance of Lead Mothers

The resistance of the community to the project activities which sought their cooperation discouraged the lead mothers even at the very start. They felt that they themselves had really nothing tangible to offer the households which would motivate them out of their passivity.

The BHW was not able to regularly meet with the lead mothers to supervise their activities. When the PRICOR field researcher would come for her monthly barangay stay, usually the BHW was not available so that meetings with lead mothers proceeded without him. He was, however, helpful in facilitating some of the assemblies.

The barangay captain might be considered the program's sustaining force. From the very start, he assumed a paternalistic and patronizing stance and did all he could in order to facilitate the implementation. However, in his desire for a viable operation, he may have encouraged too much dependence on himself. For one, he did not extract participation from the barangay folk and did not censure their lukewarm response. If he could do the work for them, he would do so.

The selection of the lead mothers was faulty, since a number of those identified were in no position to be effective. They were busy with their own jobs. Moreover, two of them were pregnant and could not be as mobile.

CAPITALIZING A BOTIKA FROM COMMUNITY DONATIONS

Generating Resources

Barangay Tastasan chose to implement a flat rate contribution scheme wherein each of the 144 households would give a monthly contribution of P1.00 to capitalize a botika sa barangay. At the start, the residents planned on a twelve-month contribution. However, after noting the difficulty in collecting, the lead mothers group reduced the period to ten months. Thus, the target amount was P10 per household or P1,440 for the entire barangay.

After the fifth month of the project, it was noted that the collection efforts of the lead mothers was minimal. The feedback received during the lead mothers' meeting was that many, especially in Bunlao, refused to pay the monthly dues. Their reason was that they did not anticipate using the botika since the depot was too far from their residences. Due to the negative responses experienced by some mothers, lead mothers were hesitant to approach the residents.

In another brainstorming session to improve collections, the idea of holding a raffle was proposed. This was, however, opposed by some since it was perceived as gambling and would require just as much effort to sell as the collection of the monthly dues.

By August 1983, only P73 of the P144 had been paid up. The barangay captain, in his eagerness to start, voluntarily lent the botika an amount of P200, to be repaid when the contribution would have been substantially collected. With P273, their botika started operations on August 15, 1983.

From then on, the contribution to the botika fund trickled in with no more than two to 11 percent of the households, on the average, submitting their monthly dues. The lead mothers found the monthly chore of collecting tedious. As of June 1984, the end of the ten-month period for donations, the total amount contributed was P234 or 16 percent of the target.

Botika Operations

1. Management Structures and Location

The drug supply was set up at the barangay captain's house. As he was not around all the time, a system was set up wherein either the buyer or whoever was around in the captain's household listed down the purchases and left the payment therewith. In the evening the captain reviewed the day's transactions.

In November 1983, the funds for the PUSH botika was released. The PUSH stocks were managed separately from the PRICOR stocks, in spite of suggestions to combine the two. The main reason for this was in order not to confuse the stock accounting and inventory which was required as well by the PUSH. The PUSH botika as distinguished from the PRICOR stock was managed by the BHW and was likewise in his possession. In effect, Tastasan had two drug depots located strategically in the barangay so that different areas served as catchment for the two. By

April 1984, a third depot was set up in Sitio Bunlao in order to accommodate residents living in that area. This was managed by a lead mother.

2. Demand for Botika Services

Drugs were available for three main illnesses: cough, fever and diarrhea, although eight other items were noted, such as for muscle ache, wound, stomach pains, etc. Eighteen brands were available in the PRICOR botika, the choice of which was provided by the midwife. There were four brands for fever, two of which seemed to be relatively more in demand. Records showed that there was almost equal demand for the two diarrheal drugs, while only one of the four cough medicines was in regular demand.

3. Sales

The level of sales from September 1983 to June 1984 ranged from P29 to P109 monthly or an average of P66.87. Lowest sales were reflected for the months of October 1983 to April 1984 at P29.95 and P31.55, respectively.

4. Mark-Up and Profit

The botika manager adopted a minimal percentage of mark-up averaging P0.10 on all tablets. In the same manner he also took into consideration the current price existing in Sto. Rosario's drugstore. He saw to it that by close monitoring, his manner of pricing would not exceed that of the drugstore.

Because of erratic increases in the drugs' prices for the past months, he saw to it that the price of his remaining stocks would be adjusted to the current price in order to offset losses. Profit garnered for twelve month operation reached up to P176.29 or an average of 19 percent of sales.

5. Credit and Collection

The barangay captain extended credit to those who were in immediate need and in cases where some customers did not have sufficient cash on hand. Usually, these were paid promptly but for those who could not, the barangay captain took it upon himself to advance the payment.

6. Replenishment

Replenishment was done by the barangay captain himself during his regular visits/trips to Iloilo City, thus entailing no cost to the botika. Stock levels were consistently high and no instance of "running out of stock" had ever occurred. Even when sufficient stock was still at hand, repurchases would already be made.

There were instances during replenishment when he used his own money. This practice enabled the botika to keep sufficient stocks even if the sales could no longer have bought the same quantity of medicine as before.

Post Project Plans (Tastasan, Buenavista)

1. The site of the botika sa barangay will be transferred from the house of the barangay captain to the newly-constructed health station situated at the center of the barangay.
2. The management of the botika sa barangay at the barangay proper will be handed over to a lead mother.
3. Incentives will be given to the lead mother in-charge of the depot.
4. The botika at the barangay proper will be audited by a lead mother while the other botika, situated at Sitio Bunlao will be audited by the KB Chairman.



VI. LESSONS FROM THE VARIOUS CASE STUDIES

A. Strategy Development

A most notable lesson that has emerged from the studies is that to people in rural communities, who have been accustomed to receiving free health services, the concept of their having to finance primary health care did not make much sense. At the start, when the idea was presented to them, they thought that another doleout project was in the pipeline.

The PRICOF Project adopted the participative approach to planning by allowing the communities to identify what they perceived as a viable scheme based on their assessment of their articulated health problems. While this is ideal for ensuring project involvement, the experience in this project is that participants need to have some skill in decision making to enable them to more effectively identify, explore and weigh alternatives upon which to make a decision. It may have been an oversimplification to just present or mirror to the residents their health profile and expect them to develop a scheme which would be appropriate to the solution to their health needs. Moreover, it cannot be fully assumed that the participants are motivated enough to seek workable, feasible and effective solutions. For most, they engaged in the initial exercise of developing a scheme simply, for purposes of compliance.

On the other hand strategy development may require a longer gestation period before the communities can effectively respond in more creative ways, taking stock of their problems and resources and combining these into viable strategies. While this development stage could have been better effected through community organization and preparation prior to implementation, time constraints limited the period devoted to this stage. Thus the *barangays* chose highly similar designs which were concrete and simple, though not necessarily innovative. Later in the middle of the implementation period, some developed slightly more complex projects.

Another observation drawn from the study is that the perception of health needs between providers and recipients differ. Whereas providers see community health problems as mainly springing from poor preventive health care activities, the people assumed a more curative perspective, as manifested by the services they chose to finance — drugs and hospitalization emergencies. Health becomes their concern when someone in the family is sick. While they were willing to participate in preventive services through the lead mothers, the sustainability of such activities are dependent on too many factors. (See later discussion.) The implication may well be that schemes incorporating both perception — preventive and curative — need to be developed, if they are to be attractive to the participants. Riggs-Perla (1984) contends that

“health care financing schemes which include public health activities must make sure that there are indirect ways of financing those activities or offer

preventive services as part of pre-paid packages with incentives for the providers to promote them . . . Schemes must include services which are in high demand by the people who are expected to support them. In some instances, to attract membership to schemes, scheme managers may have to begin with an emphasis on curative services and incorporate preventive care once the scheme is established and financially stable."

B. Structure of Financing Schemes

Since monetary contribution in rural economies is difficult to realize, some schemes structures had better chances for success. All the schemes in the study consisted of flat rate contributions (except in Bucaya which did not specify the amount) but with varying payment periods. What proved to be more productive was the single payment schedule as in the case of Bucaya and Maribuyong. Payments spread across an extended time period entailed too much collection efforts which the designated collectors could not cope with for lack of a workable system. In the post implementation survey a most frequently given answer to "why they failed to give their monthly payment" was that no one collected. Actually that may be more accurately interpreted as "no one kept coming back to collect." So, while spreading payments would make it easier on the pockets, it is feasible only if (a) such payments are tied up to regular income/tax periods as in Badiang, and (b) if a collection system has been established and functional.

C. Psychology of Participation in Financing Schemes

Barangays are willing to participate in schemes which require them to invest their hard-earned and scarce monetary resources as long as they can see that benefits redound to them. Thus, although during the initial survey ascertaining willingness to participate, the socially desirable answer of "yes" was given, in the implementation they were cautious in paying their dues. This was manifested not only in the difficulty encountered in collections but also in the decrease of amounts they decided to contribute for the scheme compared to higher amounts signified in the survey (from five pesos to mostly one peso).

It would seem that they wanted an assurance that their money would be properly used and that they stood to gain something from their investment. At most at the start, they gave token amounts whereas subsequent fees were more difficult to collect. Once they perceived tangible results, such as an operational botika, they were more willing to embark on other enterprises. This happened in the case of Bololacao wherein a spin-off effect resulted in additional fund-raising schemes. At the time the project terminated the lead mothers were considering other plans to generate a health fund. In Bucaya, the residents were also prepared to explore other financing possibilities, an attitude contrary to their initial reluctance.

The use of raffles was also appealing not only because of its single payment structure, but also because the probability of winning a prize was real enough. In

Maribuyong the high collection rate is attributed to the fact that the raffle served as an incentive, which consequently sped up payments. The same effect held true in **Bololacao** as shown by the ease with which the lead mothers were able to dispose of raffle tickets.

On the other hand the first survey revealed the disinclination of the residents to the idea of paying either fees or a regular salary to the barangay health worker. Salaries of workers were viewed as the responsibility of the government. In a sense while there were many advantages of working within PUSH barangays, a disadvantage, especially in relation to financing, was that people were accustomed to getting free services from the BHW, free water and sanitation systems, and a small barangay development fund to work with. Consequently the people did not feel the same degree of urgency about organizing and putting up money for health projects as might have been the case in underserved areas where services are not as easily available. This may be an important consideration for those who are selecting sites to initiate health care financing schemes.

D. Community Participation and Leadership

1. Community participation is best ensured when adequate orientation, preparation and organization are directed towards the communities. This would be a distinct phase in the development of community-based financing schemes and be carefully planned for, since its later benefits are far-reaching. In the study, the researchers assumed that being PUSH barangays, a certain level of organization already existed. However this could have been better strengthened in some of the barangays, wherein passivity of the residents was noted.

2. The organizational structure which emerged in each community for the implementation of their respective projects constituted the core group upon whom the leadership of the project was supposed to more actively fall. This committee, however, may stand as a distinct class with power and prestige that may accentuate stratification at the barangay level and inhibit participation, unless adequate measures for consciously and regularly communicating with the less visible residents are instituted.

3. A project which receives the attention and recognition of local officials, preferably of several tiers in the hierarchy, will have more chances of obtaining the support of the barangay residents and hence more likely to succeed. This is more so in the Philippine rural areas where people are still more authoritarian in orientation and respond to perceived expectation of those in positions of authority.

4. Different leadership styles were observed in the six experimental barangays. In most barangays, a local person from within the core group is identifiable as the one who assumed responsibility for the conduct of the project. The more successful leadership style was that which developed/encouraged shared leadership. This was the case in **Bololacao**, **Bucaya**, and **Maribuyong**, where individual leaders emerged: the barangay captain's wife, the barangay captain's husband, and the BHW. Yet their group of lead mothers was characterized by active participation

and dynamic involvement which interacted effectively with their leadership style. In Tastasan, the barangay captain was clearly the leader for the project, but due to his more paternalistic style he engendered the residents' dependence on himself which in the long run was adverse to the development of self-reliance in the community.

5. In two of the barangays, difficulties with the schemes developed when the leader encountered personal problems. The capability of the communities to cope with such inevitable disruptions depends on the level of organization and the degree to which leadership has been developed among the other community members.

E. Lead Mothers and Health Workers

The project demonstrated that the lead mothers themselves could be mobilized for the provision of basic health services (environmental sanitation campaign, health education, oral rehydration therapy, record keeping) with increasing competence provided that appropriate training and support are given them. The lead mothers' involvement is thus contingent on the amount of supervision, the attitudes and enthusiasm of the basic health providers such as the municipal physician, midwife, barangay health worker. In certain instances, the lead mothers enhance the task of midwives by lightening their burden and carrying out tasks within their capabilities. On the other hand certain health providers feel that the lead mothers infringe on their activities. Careful recruitment of lead mothers need to be exercised. When they are recruited from among the recipients themselves, local capabilities and skills for health are developed and immediate response to daily operations of the project are better elicited. However willingness to serve and time availability for the project should be among the more important considerations. In the project, a major deterrent to the adequate performance of the lead mothers was their involvement in outside activities. Income-generating tasks in Milleza prevented their effective performance and resulted in high attrition rates.

F. Botika sa Barangay/Emergency Loan Fund

The demand for drugs is assumed to be substantial considering that this need was articulated by a majority. However, efforts to increase awareness of the drug depots' existence should be exerted in order to maximize sales possibilities. Moreover certain aspects of management should be attended to if viable operations are to result:

1. There is a need for a more solid basis for ensuring profitability of the botika. Replenishment, for instance, should be approached on a more systematic basis. The more successful botikas had a simple basis of mark-up, by pricing drugs slightly lower than those prevailing in poblacion drugstores. Close monitoring of poblacion prices enabled them to adjust prices at the barangay vis-a-vis current levels. This crude method would later have to be better rationalized in order to consider actual costs of operations at the barangay level, as this may differ from those of poblacion botikas.

2. In two botikas (Milleza and Badiang) low demand levels may be largely attributed to the inability to replenish supply. When replenishment is not responsive to stock balances, customers are turned away leaving the impression that the botika is an unreliable drug source and eventually resulting to decreased patronage.
3. Timely repayment of credit is crucial to sustained botika operations. In Badiang where the time lag for such payments was relatively long (a month or so) replenishment was delayed. Unless capital is increased to a level which can sustain credit payment delays without affecting stock availability, credit, which is almost inevitable in poor communities, will necessarily hamper operations.
4. Recording of sales and inventories have to be kept simple but adhered to strictly. Individuals with less years of education had a more difficult time maintaining records and found the routine burdensome.
5. There is a need to re-educate the community on the effective but inexpensive drugs. Residents were observed to be selective about the brands of medicine purchased, resulting in a broad spread of limited capital.
6. The botikas may want to experiment on the granting of incentives to the depot manager, a suggestion which emerged in their botika conference, to see what effect this would have on the viability of operations.
7. In Maribuyong, the amount collected for the emergency loan fund would not be enough to cover the needs of the residents. There is a need to keep up this resource to give the community a feeling that there would be back-up when the need arises. It was noted however that the community would seek other sources prior to utilizing these funds.

G. Role of External Agents

The PRICOR staff and the support of NEDA PUSH field monitors played a crucial catalytic role not only in the laying of the groundwork for the project but in the supervision and monitoring of the implementation. The extent to which the events that transpired during implementation are attributable to the presence of these external agents rather than to real outcomes of community concern for health care is difficult to determine. Similarly the continuity of the project after the staff severs its ties from the community will be put to the test. In anticipation of possible dislocation that may be created by their withdrawal, the staff conducted a meeting with the core group to discuss measures for sustaining the project. A feedback session was likewise undertaken to appraise communities of the research findings and to share with them the lessons learned in the study.

Table 22. Monthly sales of Botika sa Barangay in 5 barangays (in P)

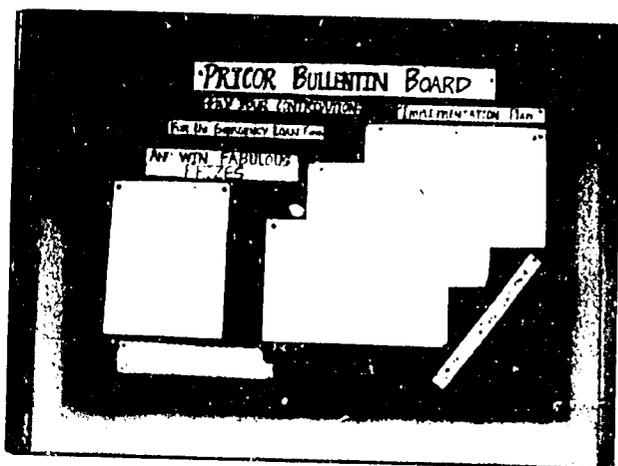
MONTH	TASTASAN (BUENAVISTA)	BALCON MILLEZA (JORDAN)	BUCAYA (SAN JOAQUIN)	BADIANG (ANILAO)	BOLOLACAO (NEW LUCENA)
1983					
August	—	—	165.75	—	—
September	68.10	34.70	67.65	—	—
October	29.95	81.05	238.65	—	—
November	44.30	56.30	240.00	—	4.50
December	65.10	28.15	168.30	131.75	80.20
1984					
January	78.60	53.60	264.55	106.70	80.45
February	69.00	56.80	323.25	27.75	29.70
March	83.65	42.40	276.55	237.25	186.20
April	31.55	56.80	430.80	154.65	183.50
May	109.16	43.47	242.60	74.30	142.35
June	89.30	23.40	381.65	181.95	268.70
July	104.30	32.50	374.00	176.10	209.50
August	163.40	45.60	465.80	41.65	136.25
TOTAL	936.40	554.77	3,639.55	1,132.10	1,321.35

Table 23. Monthly net profit of Botika sa Barangay in 5 Barangays (in P)

MONTH	TASTASAN (BUENAVISTA)	BALCON MILLEZA (JORDAN)	BUCAYA (SAN JOAQUIN)	BADIANG (ANILAO)	BOLOLACAO (NEW LUCENA)
1983					
August	—	—	37.09	—	—
September	14.10	6.51	20.12	—	—
October	5.36	14.60	40.04	—	—
November	9.07	10.04	32.70	—	1.50
December	10.92	5.31	21.62	24.88	13.85
1984					
January	13.54	10.09	28.88	23.08	8.19
February	12.34	9.17	46.43	4.55	6.66
March	13.80	7.89	41.23	21.53	12.96
April	5.64	14.09	71.67	25.19	32.89
May	20.64	13.44	34.05	21.84	27.05
June	16.01	8.95	67.83	44.98	49.32
July	20.86	9.15	48.14	36.72	40.98
August	34.61	11.30	77.22	7.77	26.50
TOTAL	176.89	120.54	567.02	210.54	219.90

Table 24. Statement of total working capital, total sales and total net profit for the period covering August 1983-August 1984 (in P)

PARTICULARS	TASTASAN (BUENAVISTA)	BALCON MILLEZA (JORDAN)	BUCAYA (SAN JOAQUIN)	BADIANG (ANILAO)	BOLOLACAO (NEW LUCENA)
Total Working Capital	434.00	419.00	548.00	306	717.00
Total Sales	936.40	554.77	3,639.55	1,132.10	1,321.35
Total Net Profit	176.89	120.54	567.02	210.54	219.90



Generating resources for the Botika sa Barangay.



**Table 25. List of herbs and their uses
(Barangay Maribuyong, Dueñas)**

Herbal Plants	Uses
1. Alusiman	Hemorrhoids, toothache, urinary infection
2. Kasla	Hemorrhoids, sprain, headache
3. Alibhon	Bad breath, insect bites, eczema, rheumatism, skin diseases, amenorrhea,
4. Loko-loko	Dysentery, wounds, stomachache
5. Adgaw	Beri-beri
6. Herbal Santa Maria or artamisa	Swelling, bruises, eczema, parasitism, stomachache, TB, cough, sore throat
7. Herba Buena	Insect bites, asthma, fever, headache
8. Dama de Noche	Asthma
9. Atiotes	Fever, swelling
10. Kalachuchi	Sprain
11. Himbis-himbis	Fever; toothache
12. Bugnay	Fever; Headache
13. Mostasa	Fever, rheumatism
14. Mansanilla	Fever, Amenorrhea
15. Ahos (garlic)	Hypertension, fever, insect bites, chilling
16. Kalawag	Skin diseases
17. Manunggal	Skin diseases
18. Malungguy	Wounds, toothache
19. Buyo	Kulibra, headache
20. Lampunaya	Bruises
21. Ginger	Bruises, swelling, sore throat
22. Kamantigue	Swelling of nails
23. Organo	Burns
24. Amargoso or Ampalaya	Wounds; cough
25. Lagundi	Rheumatism
26. Tanglad	Toothache
27. Pasay	Headache
28. Huya-huya	TB
29. Guava	Hemorrhoids, skin diseases, wounds, diarrhea
30. Starapple	Diarrhea
31. Sensansoy	Diarrhea, stomachache
32. Mada de Cacao	Skin diseases

Table 26. Performance on the various health financing schemes

Barangay	Target Amount (P)	Actual Amount Collected (P)	Collection as % of Target
Milleza	732	419	57%
Bololacao			
Membership	531	427	92%
Monthly	2,124	290	14%
Others	—	2,330	—
Badiang	830	306	37%
Tastasan	1,440	234	16%
Maribuyong			
Flats rate	1,070	990	93%
Taxation	—	96	—
Bucaya	—	368	—



A community leader explaining the mechanics of the health care program.

Table 27. Flat rate contribution of five barangays: Amount, percentage of target number and percentage of contributing households

BARANGAY	AMOUNT CONTRIBUTED		% OF TARGET		NO. OF THE HHS WHO CONTRIBUTED		% OF THE WHO CONTRIBUTED	
	Flat Rate (P)	Membership (P)	Flat Rate	Membership	Flat Rate	Membership	Flat Rate	Membership
BOLOLACAN	26,000	40,000	100	50.4	82	76	46.3	92.1
BADIAN	20,000	NA	47.1	NA	144	NA	86.7	NA
TASTASAN	254,000	NA	100	NA	58	NA	19.0	NA
J. TALLEZA	41,000	NA	57.0	NA	80	NA	66.0	NA
MARIBUON	100,000	NA	98.0	NA	99	NA	96.1	NA

1. Barangay Buhaya has had a one shot fund campaign consisting of donations.

VII. EVALUATION OF OUTCOMES

The second part of this report dealt with formulation and implementation of alternative financing strategies for the provision of basic health care in six barangays in Iloilo. The major schemes selected were the maintenance of the botica sa barangay through a fixed monetary contribution (approximately P1 per household per month), the donations of services through the identification, training, and monitoring of the lead mothers, and other fund-raising activities.

An added interest in undertaking this project stems from the evaluation of outcomes -- the immediate and intermediate effects of the program on the health seeking behavior and expenditure pattern of the community.

THE CONCEPTUAL PARADIGM

A conceptual paradigm (Fig. 1) was devised which partitioned the variable into three major components: the determinants, the scheme selected, and outcomes. Subsumed under each heading were the various indicators that could affect the subsequent stage where the community variables determine to a great extent the appropriate strategy for health financing which in turn could affect the outcomes in terms of health seeking behavior and expenditure pattern. The first two elements -- determinants of schemes and selection, planning, and implementation of selected strategies -- were analyzed adequately in the first two phases of this report. This third phase deals mainly with outcomes. Specifically, the following questions are addressed:

1. Has there been a change in the health seeking behavior in the communities studied as a result of the introduction of the financing schemes? What was the pattern of the change? -- in the selection of the health service provider, the nature of preventive services practices? attitude toward the current service providers?
2. To what extent has the health expenditure pattern been affected by the inputs? In what specific health expenditure area was the change significant?
3. What were the immediate outcomes in terms of health status changes in the study communities?

DATA SOURCES

The evaluation of project outcomes makes use of two data sources: (1) the record keeping system (RKS) which was formulated for the PUSH monitoring; and (2) the survey (pre and post-implementation) of all house-

holds in the study communities. In order to attribute whatever changes accruing to the community to the financing schemes per se, control communities were selected for time series comparisons in the Record Keeping System.

The Record Keeping System (RKS)

In late 1982, with the pressing need for the measurement of the impact of the Panay Unified Services for Health (PUSH) project which was nearing its fifth year of operations, a new record-keeping system was devised which compiles in one form the health program inputs, health-seeking indicators and outcomes. The record delineates all these variables on a monthly basis. For each household, two forms were kept by the Barangay Health Worker (BHW). The first procures baseline information on the household composition as well as environmental sanitation facilities and is updated at the beginning of each year. The second form is dichotomized into health inputs and outcomes. The first part obtains information on the environmental sanitation facilities (toilets, well, etc.) immunization status, family planning status, nutrition, food production and lactation pattern. The second part pertains to vital events (illness, deaths, births), migration and health expenditure. Such household events could be linked with program inputs to assess the extent to which intervention affects outcome.

The utilization of the form is as follows:

1. The population at risk which would serve as the denominator of rates could be determined from the household record.
2. The household coverage (utilization rates) of the BHW's for specific services can be quantified.
3. Targets for specific intervention areas could be identified.
4. Changes in preventive health activity within the household can be monitored.
5. Causal inference on the program efforts and effects can be made.
6. A holistic approach to the measurement of changes in health status can be utilized through the identification of the relative effects of the various inputs.

The Survey

In March 1984, a survey was conducted by PRICOR in the constituent households of the six study barangays. Specifically, the survey aimed at eliciting the following information:

1. Socio-economic characteristics of the households constituting the study barangays.
2. Income and expenditure pattern with particular emphasis on ex-

- penditure for health care.
3. Illness pattern, management and health resource utilization.
4. Perception and attitude towards health resources available.
5. In the pre-implementation survey, information was sought on the possibility of participation in health financing schemes, area of participation, mechanism for soliciting the barangay cooperation, and present involvement in income generating activities. After the program implementation, a post-project survey was undertaken with essentially the same questions as the pre-implementation survey. However, a block was incorporated inquiring into the awareness of the PRICOR project, the nature of participation in the health schemes, the amount of contribution, donation of services, utilization of the schemes, and suggestions for improvement of the schemes.

METHODOLOGY

In reviewing the records, a time series analysis was planned which will examine, on time trend basis, changes in health program inputs as well as in health status in the study barangays. For comparative purposes, control barangays were selected to determine if similar changes which are not attributable to the program occurred in these communities.

The survey data are compared during the pre and post implementation phase and changes documented in the attitudes, perceptions, and utilization of specific health resources as well as the health expenditure pattern.

THE CONTROL BARANGAYS

Six barangays were selected as controls corresponding to the study barangays. The following is the list of barangays:

<u>Experimental</u>	<u>Control</u>
1. <i>Fishing</i>	
Milleza, Jordan	Nipa, Concepcion
Bucaya, San Joaquin	Bularan, Banate
2. <i>Farming</i>	
Bololacao, New Lucena	Iniligan, Bardiangan
Tastasan, Buenavista	Barosong, Tigbauan
3. <i>Sugar</i>	
Badiang, Anilao	Batuan, Dueñas
Maribuyong, Dueñas	Poscolon, San Rafael

Description of the Control Barangays

Batuan, Duenas – Batuan has a total population of 1,117 and a total number of 189 households. It is two and a half kilometers away from the Poblacion and very accessible in terms of transportation. A great portion of the agricultural land is devoted to sugarcane and a smaller portion to farming. In fact, much of the sugarcane land is owned by only one family. Hence, most of the residents of Batuan are sugar laborers. To augment their income, they also engage in poultry and hog raising. Houses in Batuan are scattered and are made of both mixed and light materials. It has an elementary school, a newly-built health station, and chapel. Batuan is the control barangay for Badiang, Anilao.

Poscolon, San Rafael - Poscolon is located two kilometers from the town proper of San Rafael, a municipality in the northwestern portion of Iloilo. It has a total population of 608 within 110 households. Poscolon's terrain is hilly which makes the land suitable to upland farming although a generous portion is planted to sugarcane. Houses along the provincial road are clustered while the rest of the houses are scattered. The most distinct feature of the barangay is that most of the houses' roofs are made of cogon grass. The elementary school situated in the Barangay Proper is the center of activity where most of the barangay residents converge. The health center is also accessible to the residents since it is strategically located along a crossroad where it can service both those within the Barangay Proper and those houses that are far. Poscolon is the control barangay for Maribuyong, Dueñas.

Iniligan, Badianan - Barangay Iniligan is two kilometers away from the Poblacion of Badianan – a municipality in the central portion of Iloilo. The biggest in terms of population and land area among the twelve PRICOR barangays, it has 227 households and a total population of 1,207. Houses in the Barangay Proper are clustered though there are sub-communities or puroks situated on a hilly portion that have houses far from each other. Among the facilities available in the barangays are the barangay health center, a day care center, both located within the premises of their public elementary school, three chapels (Baptist, Catholic and Iglesia) and a multipurpose center. Iniligan is basically a farming community though portions of the land are utilized for sugarcane. Aside from rice and corn, the people resort to crop rotation and inter-cropping of root crops, ginger and gabi, coffee and cacao. Iniligan is the control barangay for Bololacao, New Lucena.

Barosong, Tigbauan - Barosong is eight kilometers southwest of Tigbauan. It is separated from the Poblacion and the rest of the neighboring barangays by a wide river which makes the barangay inaccessible during rainy season and bad weather. Land, although rainfed, is suitable to rice, corn and legumes. Aside from farming, Barosong is also noted for its budding cottage industry – bamboo craft and mat-weaving. With a population of 911 in 170 households, Barosong is a solid settlement. Houses are clustered along the provincial road and are made of light and mixed materials. It has a public ele-

mentary school, a chapel and a very functional health center. It is the control barangay for Tastasan, Buenavista.

Bularan, Banate - Bularan is a fishing community and a solid settlement where houses both along the main road and seashore are clustered. Houses are so near each other that from afar it looks like a squatter area. It has no public elementary school nor a health station since the barangay is less than a kilometer away from the Poblacion of Banate. Therefore, the 179 households with a total population of 933 have much access to the facilities offered by the Poblacion. The major source of income is fishing. People in Bularan are either fishermen, fish vendors or fish dealers. Bularan is the control barangay for Bucaya, San Joaquin.

Nipa, Concepcion - Nipa is situated in one of the northern coastal towns of Iloilo. It is six kilometers away from the town proper of Concepcion and has a rugged topography. Such terrain makes the barangay isolated from the rest of the world during rainy and stormy seasons. Hence, it can only be reached by either an hour's climb or by pumpboat from the town. Nipa is sub-divided into two sub-communities - the upland portion and the shoreline. Most of the population are concentrated along the seashore. Houses are nearer though scattered compared to those in the upland portion. Nipa has a public primary school, a health station and a chapel. The main source of income is fishing augmented by mat-weaving, copra and fruit trees. It has 172 households with a population of 635 and is the control barangay for Milleza, Jordan.

DATA ANALYSIS

Pre and Post Implementation Surveys

Population Size

Population size of the six experimental barangays suffered from declines between the baseline and post implementation surveys. There are Milleza with a difference of 24, Bucaya with 63, Badiang with 77, Tastasan with 52, and Bololacao with 18. These decreases are mainly attributed to outmigration. Maribuyong experienced a slight increase from 533 to 549 - a difference of 16 due to an excess of births over deaths. The proportional contribution of males and females to the total population remained basically similar.

Age Distribution

Except in Bololacao where the average age slightly declined (26.8 to 26.4), the average ages in the other barangays experienced slight increases (from 23.6 to 25 years in Milleza; 27.3 to 27.7 years in Bucaya; 26.4 to 27.2 years in Maribuyong; 23.9 to 24.1 years in Badiang; 23.2 to 23.8 years in Tastasan). The percentage of the preschoolers (less than 6 years of age) slightly increased from 18.4 to 19.6 in Milleza; 15.3 to 16.2 in Bucaya; 14.8 to 18.2 in Maribuyong; 17.8 to 18.9 in Badiang;

19.7 to 21.6 in Tastasan; and 19.1 to 21.2 in Bololacao. However, these changes have been slight to merit concern.

Educational Attainment of Population 10 yrs Old and Above

The improvement in the educational level of the household head is reflected in the lower percentage with less than primary education in the second survey and a corresponding increase in the proportion of those with intermediate and high school education. In certain instances such as in Maribuyong and Bololacao, an increase in the percentage of college educated heads was noted from 9.0 to 14.0 percent in Maribuyong and from 12.4 to 14.2 percent in Bololacao.

Occupation of the Population 10 Years and Over

A shift in the occupational structure of the population was noted wherein there was an increase in the proportion of housekeepers. On the other hand, a reduction in the percentages of farmers and fishermen from 27.1 to 20.1 percent in Miteza and from 12.7 to 14.1 percent in Bucaya were noted, and increases of 20.3 to 21.4 percent in Maribuyong, 2.3 to 2.85 percent in Badiang, 7.7 to 9.6 percent in Tastasan; and 9.4 to 10 percent in Bololacao.

Family Type and Average Family Size

The percentages of households that are nuclear in character range from 67.1 percent in Bololacao to 81 percent in Badiang and Tastasan. Nearly a third of the households in Bololacao and Bucaya exhibit the extended family system. The average family size remained vertically the same for the extended households in Tastasan which showed a decline from 7 to 5 and Bololacao which manifested an increase from 6 to 7. The average family size was 6. The number of households likewise decreased between the baseline and the post implementation surveys – by 8 in Miteza, 10 in Bucaya, 6 in Maribuyong, 11 in Badiang, 10 in Tastasan, and 13 in Bololacao.

Income and Expenditure Pattern

There has been an increase in the median income between the baseline and post implementation surveys. It is not known whether this is a real change or a seasonal observation resulting from the sale of farm produce. However, increases in median expenditure exceed the increment in median income. The increases in median income ranged from P710 to P2,175.53 while the increases in median expenditure ranged from P604 to P2,351.45. The highest increment in income was reported by Maribuyong (P2,175.53) followed by Tastasan (P1,886.36) while the highest increase in median expenditure was observed in Badiang (P2,351.45) followed by Maribuyong (P1,895.65).

Food takes the highest share for the household expenditure accounting for close to or more than half of the total expenses. Medical care only takes less than 10 percent of the total. The proportional allocation of expenses for medical care remained stationary during the interval. It is only in Bololacao where there was a rise from one to six percent during program implementation.

Illness Pattern

There has been a trend toward a decline in illness incidence but attribution to the program is not definitive.

Respiratory illness accounted for the greatest portion in morbidity of the preschoolers followed by unspecified causes (fever, headache, etc.). Despite the relative magnitude of morbidity by cause, there has been a decline in the number of cases in September. The baseline survey was conducted in the early part of the year which is characterized by a high prevalence of respiratory infections. The seasonal nature of these illnesses might account for the reduction in their magnitude between the two surveys. The same pattern prevailed for the older household member and the same decline in disease magnitude was observed. Again, the seasonality factor is not to be discounted.

Illness Management

Majority of the households resort to home remedies prior to outside consultation. Except for Bucaya, where the percentage declined from 98.9 to 95.7 percent, increases were noted in the households of the other barangays.

Table 28. Percentage of households who resort to home remedies

Barangay	Baseline	Post
Badiang	96.9	97.2
Bucaya	98.9	95.7
Botolacao	89.6	95.4
Maribuyong	96.1	98.9
Milleza	92.7	98.0
Tastasan	96.0	96.6

Table 29. Distribution of the population by sex, pre and post implementation surveys

	BASELINE						POST					
	MALE		FEMALE		TOTAL		MALE		FEMALE		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
MILLEZA	300	47.20	335	52.80	635	100.00	295	48.30	316	51.70	611	100.00
BUCAYA	471	50.40	464	49.60	935	100.00	438	50.20	434	49.80	872	100.00
MARIBUYONG	270	50.70	263	49.30	533	100.00	298	52.60	260	47.40	549	100.00
BADIANG	483	49.00	503	51.00	986	100.00	450	49.50	459	50.50	909	100.00
TASTASAN	397	52.40	361	47.60	758	100.00	315	51.98	291	48.02	606	100.00
BOLOLACAO	347	48.50	465	51.50	902	100.00	425	48.08	459	51.92	884	100.00

Table 32. Percentage of population 10 years & above by occupation

	MILLEZA		BUCAYA		MARIBUYONG		BADIANG		TASTASAN		BOLOLACAQ	
	Baseline %	Post %	Baseline %	Post %	Baseline %	Post %	Baseline %	Post %	Baseline %	Post %	Baseline %	Post %
Farming	15.6	10.3	8.1	6.6	20.3	21.4	2.3	2.7	7.7	9.6	9.4	10.0
Fishing	11.6	9.8	9.6	7.5	0.0	0.0	0.0	0.15	0.0	0.0	0.0	0.0
Laborer	5.7	5.9	1.3	10.6	6.1	6.6	19.0	30.8	7.4	8.0	6.3	17.4
Vendor	2.4	0.2	1.7	1.6	0.0	0.0	2.3	0.3	0.2	0.0	1.1	1.2
Professional	0.4	0.2	3.4	2.0	3.4	2.2	2.3	2.6	0.9	1.4	3.7	4.0
Clerical	3.7	0.0	1.0	1.5	2.0	0.0	2.1	0.8	1.5	0.0	1.4	1.0
Housekeeper	19.9	23.9	24.9	24.5	20.5	24.4	13.0	20.3	22.1	24.2	23.4	26.4
Unemployed	6.6	13.0	6.7	7.8	13.2	14.3	6.6	4.4	14.2	17.7	6.1	4.5
Students	24.3	24.1	27.0	26.9	32.0	26.9	38.3	27.3	27.6	26.4	28.9	27.5
Others	9.8	12.5	16.3	10.8	2.5	4.0	14.1	10.6	18.4	12.5	9.7	8.0
TOTAL	100.0	100.0	100.0	100.0	100.0	100.00	100.0	100.0	100.0	100.0	100.0	100.0

Table 33. Percentage distribution of households by family type and average family size

	PERCENTAGE				MEAN FAMILY SIZE				NO. OF HOUSEHOLD			
	NUCLEAR		EXTENDED		NUCLEAR		EXTENDED		BOTH		Baseline	Post
	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post		
MILLEZA	80.7	76.2	19.7	23.8	5.8	6.1	6.2	6.9	5.8	6.0	109	101
BUCAYA	67.7	68.9	32.8	31.1	5.2	5.1	5.9	5.8	5.4	5.3	174	164
MARIBUYONG	89.3	77.3	10.7	22.6	5.1	5.6	5.7	6.5	5.2	5.8	103	97
BADIANG	75.3	80.9	24.7	19.1	6.1	6.0	6.6	6.8	6.2	6.2	158	147
TASTASA	60.2	60.9	39.8	39.0	5.5	5.6	7.0	4.8	5.8	5.7	131	121
BOLOLACAQ	71.4	67.1	28.6	32.9	5.2	5.2	5.6	6.7	5.3	5.7	168	155

Table 34. Average income and expenditures

	I N C O M E				D I F F E R E N C E I N M E D I A N I N C O M E	E X P E N D I T U R E				D I F F E R E N C E I N M E D I A N E X P E N D I T U R E	N
	B A S E L I N E		P O S T			B A S E L I N E		P O S T			
	Mean	Median	Mean	Median		Mean	Median	Mean	Median		
MILLEZA	3270.00	2739.50	5880.69	3449.50	710.00	2967.38	2658.59	4786.63	4499.50	1840.91	101
BUCAYA	4844.32	3473.18	6925.27	4807.19	1334.01	4644.00	3287.96	6260.25	5131.08	1843.12	163*
MARIBUYONG	3897.55	2657.30	6908.78	4832.83	2175.53	3897.55	2803.85	5551.05	4699.50	1895.65	97
BADIANG	6834.34	6332.83	7785.21	7408.59	1075.76	6151.39	5582.83	7206.98	7934.28	2351.45	147
TASTASAN	4530.00	3863.14	6788.76	5749.50	1886.36	5346.82	4658.59	6028.43	5264.21	605.62	121
BOLOLACAO	4870.75	4191.80	7287.09	5541.17	1349.37	4673.15	4002.09	6752.75	5207.83	1115.74	**

*BUCAYA
**BOLOLACAO

N = Should be 164 but one is NAP
N = 153 for INCOME ? NAP
N = 154 for EXPENDITURE 1 NAP

Consultation for Curative Care

In Milleza, prior to project implementation, traditional healers were often consulted with a magnitude of 26 percent for respiratory illnesses and 30.4 percent for diarrhea. This was followed by the private doctor and the barangay health worker. After the program implementation, traditional healers remained the leading person consulted but the percentage utilizing their services declined to 18 percent for respiratory infection and 22.2 percent for diarrhea. Lead mothers were consulted by 5 percent of all households. It has been noted that the utilization of lead mothers was rather low – less than 5 percent except in Bucaya where 17 percent of the households used the lead mothers for diarrhea management, possibly the oral rehydration therapy. In Bucaya, Badiang, Maribuyong, and Tastasan, the private physicians remained the service provider of choice. Except in Tastasan where the use of the traditional healers for respiratory infection increased from 5 to 7 percent, the other barangays manifested declines in traditional healer utilization (for example, for respiratory infections the shift was from 26 to 18 percent in Milleza; 8 to 5 percent in Bucaya; 15.8 to 15.1 percent in Badiang; 13 to 12 percent in Maribuyong; and 11 to 7 percent in Bololacao). For gastrointestinal infections, the reductions were from 30.4 to 22.2 percent in Milleza; 38.1 to 12 percent in Badiang; 36 to 6 percent in Maribuyong and 18 to 9 percent in Bololacao. There was also a decline in the utilization of the Barangay Health Worker (BHW) – 17.8 to 5.9 percent in Milleza; from 5.8 to 1 percent in Maribuyong; 6 to 1.1 percent in Tastasan; and 4.7 to 3.7 percent in Bololacao in case of respiratory infection. For gastrointestinal infection the reductions were from 30.4 to 22.2 percent in Milleza; 38.1 to 12 percent in Badiang; 5.7 to 5.8 percent in Maribuyong; and 18.2 to 8.6 percent in Bololacao. The large shift to the use of private physicians in Bucaya, Badiang, and Bololacao for respiratory illness and in Milleza, Badiang, Maribuyong, and Bololacao for gastrointestinal illnesses was notable.

Perception of the Cost of Medical Services

After the implementation of the project, more barangays felt that the cost of medical services was affordable (70 percent in Milleza, 51 percent in Bucaya, 55 percent in Badiang, 53 percent in Maribuyong, 48 percent in Tastasan, and 60 percent in Bololacao). On the other hand, from 23 to 43 percent of the households in the study barangays perceived these costs as high.

Trends in Expenditures for Medical Care

The rise in doctor's fees was observed in the median expenditures before and after the survey. While the average doctor fee ranged from P33 to P56 in the baseline survey, this rose to a range of P43 to P91 post implementation. There was no marked increase in the fees for traditional healers in the six study barangays. The same was observed for midwives. A notable drop in the expenditures on drugs was

observed – from P48 to P40 in Milleza, from P73 to P48 in Bucaya, from P96 to P75 in Maribuyong, from P82 to P66 in Bololacao.

Health Needs Perceived by the Community

A marked shift in the perceived health needs was noted during the survey interval. Whereas the lack of sufficient water and available drugs was expressed as major health concerns of the community, the proportion of households who manifested this concern during the post survey was reduced considerably. In fact, a large percentage of households didn't perceive further health needs.

While drugstores are considered drug depots, there has been an increase in the utilization of the Botica as Barangay except in Bucaya (9.1 percent). The figures were 25.2 percent in Badiang, 46.5 percent in Milleza, 42.5 percent in Bololacao, 27.2 percent in Tastasan, and 56.7 percent in Maribuyong.

The Record-Keeping System

In analyzing the data based on records, comparisons will be made between the experimental barangay and its control in terms of trends in environmental sanitation status, family planning acceptance, lactation and amenorrhoea, illness pattern, fertility and mortality. The purpose of such comparison is to demonstrate secular changes in health inputs and outcomes and incremental effect of the project on the health seeking behavior and expenditure pattern.

I. Badiang vs Batuan

Solid Waste Disposal

There were 184 households in Badiang compared to 209 in Batuan. Initially in Badiang, 66.8 percent of the households disposed of solid waste by burning and burying and 30.4 percent used the compost pit. Over time, the percentage of households that used the compost pit increased to 41.8 percent and there was a concomitant decline of the percentage of households burning and burying their solid waste to 55 percent. The use of the dump levelled off at about 3 percent. In Batuan, initially 94 percent of the households were burning and burying their waste. Over the 12-month period of the study, the percentage was reduced to 12.4 percent in August. On the other hand, 3 percent of the households in September used the compost pit and this increased to 86.1 percent by August.

Liquid Waste Disposal

Over the 12-month period of the study, there was no substantial change in the percentage of households according to their liquid waste disposal. About 28.3 percent in Badiang used the blind drainage; 66.8 percent the open field and 4.9

Table 35. Distribution of annual expenditures, in percentage

	MILLEZA				BUCAYA				BADIANG				MARIBUYONG				TASTASAN				BOLOLACAO			
	N	Base line	N	Post	N	Base line	N	Post	N	Base line	N	Post	N	Base line	N	Post	N	Base line	N	Post	N	Base line	N	Post
Food	109	63	101	70	172	65	163	74		62	146	66	102	53	97	46	129	67	120	69		61	154	61
Housing	107	8	101	6	117	5	81	6		6	143	6	100	9	97	7.32	125	6	119	6		7	152	8
Clothing	95	7	82	6	117	6	103	5		6	123	6	98	9	87	9.4	102	6	186	5		6	109	8
Education	65	8	63	8	111	7	108	8		7	98	8	73	14	64	14	87	7	79	7		8	99	8
Medical Care	101	7	71	6	136	6	71	6		6	84	6	92	7	71	6	102	6	82	6		1	74	6
Others	105	7	101	8	174	11	161	7		13	145	8	97	8	95	13	-	8	120	8		17	152	11
Median		2659		4499.5		3288		5131.08		3582		4699.5		2804		7934.28		4659		5264.21		4092		5207.83
Mean		2967		4787		4644		6260		6051		5551		3897		7207		3011		6028		3155		6753
n		109		101		174		163*		158		147		103		17		131		121		168		154*

*N's may be less than household number since some HH reported no expense.

**Table 36. Illness pattern of the population 0-6 years of age
(No. of Cases)**

	MILLEZA		BUCAYA		BADIANG		MARIBUYONG		TASTASAN		BOLOLACAO	
	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post
RESPIRATORY	169	40	91	82	127	94	87	40	69	40	107	56
GI/DIARRHEA	23	6	15	10	20	18	15	21	14	1	22	14
MEASPLES/MUMPS	15	—	2	2	3	5	12	—	21	—	4	2
OTHERS	75	21	45	35	118	27	41	14	65	31	78	36
n	518	491	792	731	810	737	454	449	609	475	580	697

**Table 37. Illness pattern of other household members
(No. of Cases)**

	MILLEZA		RUCAYA		BADIANG		MARIBUYONG		TASTASAN		BOLOLACAO	
	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post
RESPIRATORY	86	45	60	51	100	52	29	47	77	46	94	64
GI/DIARRHEA	18	3	14	5	39	7	13	9	20	3	19	7
MEASLES/MUPMS	15	3	5	2	14	6	9	5	18	6	3	4
OTHERS	1	4	8	6	13	13	6	7	11	14	16	14
n	117	120	143	141	176	172	79	100	149	131	172	187

Table 38. Percentage of HHS consulting specific health providers (for respiratory illness)

	MILLEZA		BUCAYA		BADIANG		MARIBUYONG		TASTASAN		BOLOLACAO	
	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post
RESPIRATORY:												
Private Doctor	18.3	15.29	9.1	44.6	18.9	32.88	33.3	17.82	41.9	16.28	13.1	15.4
Gov't Doctor	1.8	2.35	20.5	3.5	12.8	8.22	3.5	4.95	20.9	4.65	15.9	8.6
Midwife	9.5	8.24	23.1	5.3	24.2	6.16	26.1	9.90	9.3	4.65	16.8	28.4
B.H.W	17.8	5.88	-	-	1.5	2.05	5.8	0.99	5.8	1.16	4.7	3.7
Traditional Healer	26.0	17.65	7.7	4.8	15.8	15.07	13.0	11.88	4.7	6.98	11.2	7.4
Lead Mother	-	4.71	-	3.1	-	0.69	-	2.22	-	3.49	-	0.6

Table 39. Percentage of HHS consulting specific health providers (for GI/diarrhea)

	MILLEZA		BUCAYA		BADIANG		MARIBUYONG		TASTASAN		BOLOLACAO	
	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post
GI/DIARRHEA												
Private Doctor	21.7	22.2	26.7	16.7	9.5	29.0	21.4	29.4	52.4	50.0	13.6	39.13
Gov't Doctor	-	11.11	33.2	11.1	14.3	4.0	-	11.8	4.8	-	22.7	-
Midwife	4.4	11.11	13.3	-	23.8	12.0	14.3	20.6	4.8	-	9.1	26.1
B.H.W	13.1	11.11	-	-	-	-	7.1	-	4.8	-	9.1	-
Traditional Healer	30.4	22.22	-	11.1	38.1	12.0	35.7	5.8	-	25.0	18.2	8.6
Lead Mother	-	-	-	16.7	-	4.0	-	2.9	-	-	-	-
n	109	101	174	164	158	147	103	97	131	121	168	155

Table 40. Perception of the cost of medical services (in percentage of households)

	MILLEZA		BUÇAYA		BADIANG		MARIBUYONG		TASTASAN		BOLOLCAO	
	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post
HIGH	28.4	22.77	46.0	42.6	32.0	38.77	39.8	40.21	67.3	41.32	26.2	31.6
LOW	21.1	5.93	10.9	6.1	11.0	6.12	15.5	7.22	6.9	10.74	10.1	8.4
AFFORDABLE	46.8	70.30	45.5	51.2	57.0	55.10	41.7	52.58	25.8	47.93	63.7	60.0
DON'T KNOW	3.7	0.6					3.0					

Table 41. Median expenditure for medical care by type of health providers

	MILLEZA		BUÇAYA		BADIANG		MARIBUYONG		TASTASAN		BOLDLCAO	
	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post
Doctor's Fees	47	74	42	74	33	45	37	43	56	91	35	50
Traditional Healers	28	29	26	27	28	27	26	26	38	50	28	37
Midwife/Paltera	49	50	37	62	66	67	31	30	55	27	30	28
Drugs/Medicines	48	40	73	48	87	93	96	75	46	46	82	66
Hospitalization	125	87	125	224*	225	324**	87	25	156	750***	44	324****
Others	24	40	27	34	36	35	25	33	28	59.5	26	37
n	109	101	174	164	158	147	103	97	131	121	168	155

*n = 7

**n = 13

***n = 3

****n = 17

OTHERS = dextrose, donation, fare, injection, x-ray, laboratory tests

Table 42. Principal health needs perceived by the community

	TASTASAN		BOLOLACAO		BADIANG		BUCAYA		MARIBUYONG		MILLEZA	
	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post	Baseline	Post
Lack of H ₂ O facilities/ Supply	10.4	0.8	5.0		14.0	4.8	10.3		51.4		13.8	
Poor Environmental Sanitation			1.6		6.2	0.7	10.8		0.9		1.7	5.9
Lack of Drugs	50.0	9.1	39.5	4.5	60.0	10.2	55.0	8.5	39.4	9.2	51.2	
Lack of Food			4.6		6.1		10.2		1.9		6.9	
Insufficient Medical Services	39.6	6.6	2.3	1.9	3.7	0.7	13.7	4.2	6.4	6.2	21.4	4.9
Others		1.65		1.2				3.6				2.1
No response								0.6				
*% A.P		21.8		92.2		83.6		82.9		84.5		87.1
TOTAL	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
n	131	121	168	155	158	147	174	164	103	97	109	101

*N.A.P – Survey showed that those with NAP response don't perceive any further health needs

percent, the river. In Batuan, 80.9 percent used the open field and 19.1 percent the blind drainage.

Source of Drinking Water

Likewise there was no shift in the source of drinking water. Nearly half (47.9 percent) of the households in Badiang, drew their drinking water from the unimproved dug well, 22 percent from the improved dug well and 30 percent in shallow wells. In Batuan, the unimproved dug well was the drinking water source for 55 percent of the households and the shallow wells by 41 percent.

Toilet Facility

In Badiang, more than half of the households (54 percent) used the water sealed toilets which remained in the same proportion over time. There was a rise in the proportion of users of the Antipolo type of toilet – from 13.6 percent to 28.3 percent and a reduction in the percentage of users of pit privy (19 to 13.1 percent); cathole (8.7 to 3.1 percent); and river (4.7 to 1.2 percent). In Batuan, however, there are only two toilet services – water sealed (48 percent) and antipolo (52 percent) – which prevailed over the study period.

Immunization

The rate of immunization is rather low – in Badiang about 90.6 percent of the children were not immunized initially. Fluctuations were noted. However, it was felt that non-immunization remained at a high level. In Batuan, although



initially a large number of preschoolers was immunized, they mainly got BCG vaccines. Immunization with DPT and others remained minimal.

Family Planning Acceptance

It is interesting to note that in both the study and the control barangays, the acceptance of family planning is focused on the less effective methods, particularly rhythm. In Badiangan from January 1983 to May 1984, the percentage of pill acceptors declined from 5.6 to 4.0 percent; rhythm acceptors rare increased from 29 to 31.4 percent; condom from 8.9 to 11.3 percent; and ligation from 2.4 to 3.3 percent only. In Batuan, the percentage of pill acceptors remained at 3.6 percent and rhythm at 56.3 percent.

Weighing and Feeding Program

Both in the experimental and control communities, the extent of weighing is very low so it is difficult to ascertain the nutritional status of the preschoolers based on this program alone. No feeding program was introduced in the communities.

Food Production

Although the number of households with vegetable gardens remained the same at 89.1 percent, the percentage of households with livestock and poultry rose from 80.4 to 91.3 percent. In Batuan, all of the households have a vegetable garden as well as livestock and poultry.

Lactation, Weaning and Amenorrhea

Lactation is prevalent and weaning is confined to gruel and solids — egg yolk, bananas, camote, etc. About a fifth of the wives were amenorrheic in Badiang and a third in Batuan.

Illness Pattern

Respiratory infections remained the major cause of illness, followed by fever which may be linked to respiratory infection. A seasonal pattern emerged where increases were noted in January, February and tapering off in March followed by fluctuations in May and June. In Batuan, fever which may be linked to respiratory illnesses account for a large number of cases. No seasonality in gastrointestinal infection seemed to have emerged.

Health Service Provider

The 12-month recording of vital events witnessed a shift in the utilization of health service providers. In Badiang, in September, more than a fourth of the

Distribution of health expenditures,
Badiang (Anilao), September 1983 to
August 1984.

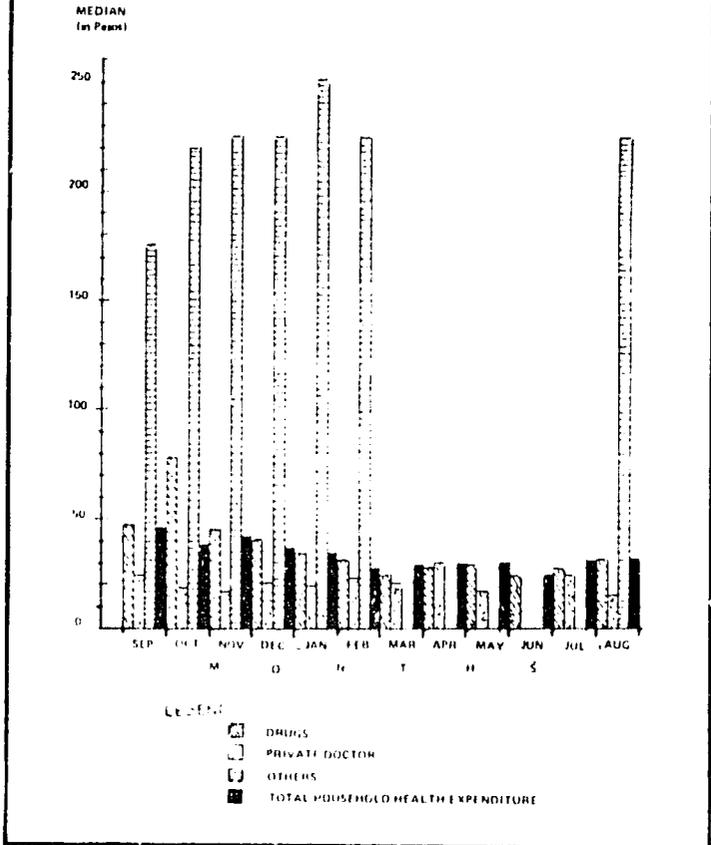


Table 43a HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

BADIANG, ANILAO	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	94.09	47.79	29.73	24.25	142.16	175.50	132.64	48.45
OCTOBER	106.45	70.63	28.50	18.83	105.50	219.25	139.78	38.83
NOVEMBER	70.28	44.60	19.25	17.17	225.50	275.50	110.68	41.69
DECEMBER	69.55	39.88	25.50	20.50	225.50	225.50	69.04	37.30
JANUARY	81.40	35.61	25.50	19.79	200.50	250.50	73.70	35.75
FEBRUARY	48.33	31.08	29.71	23.00	225.50	225.50	39.01	28.41
MARCH	32.84	24.50	15.50	20.50	-	-	33.08	28.96
APRIL	34.88	28.07	25.50	30.50	-	-	36.36	29.76
MAY	45.14	29.93	28.83	18.60	-	-	41.06	29.90
JUNE	25.50	24.50	-	-	-	-	25.50	24.50
JULY	32.84	28.67	25.50	25.50	-	-	47.16	30.75
AUGUST	42.74	31.02	15.50	15.50	75.50	25.50	40.23	31.53

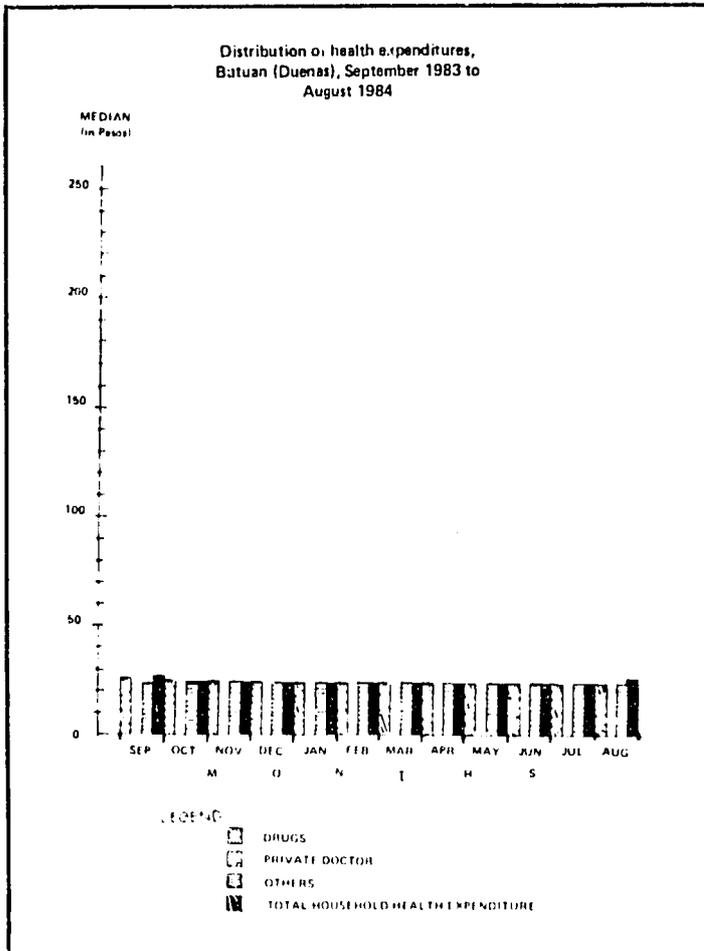


Table 43b. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

BATUAN, DUEÑAS	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	21.18	25.48	-	-	28.00	23.63	38.75	28.17
OCTOBER	25.50	24.50	-	-	26.50	24.50	25.50	24.50
NOVEMBER	25.50	24.50	-	-	26.50	24.50	25.50	24.50
DECEMBER	25.50	24.50	-	-	25.50	24.50	25.50	24.50
JANUARY	25.50	24.50	-	-	25.50	24.50	25.50	24.50
FEBRUARY	25.50	24.50	-	-	26.50	24.50	25.50	24.50
MARCH	25.50	24.50	-	-	26.50	24.50	25.50	24.50
APRIL	25.50	24.50	-	-	28.92	24.50	25.98	24.70
MAY	25.50	24.50	-	-	26.50	24.50	25.50	24.50
JUNE	25.50	24.50	-	-	26.50	24.50	25.50	24.50
JULY	25.50	24.50	-	-	26.50	24.50	25.50	24.50
AUGUST	25.50	24.50	-	-	26.50	24.50	28.44	28.08

households (26 percent) consulted the private doctor followed by the Barangay Health Worker (21.8 percent) and home management (20.8 percent). However, by August, there was a noted decline in the utilization of private doctor to 3.5 percent and home management increased by 38.6 percent. The use of the lead mothers remained at 14.7 percent in December to August of the subsequent year. In Batuan, the BHW remained the person of choice for the management of specific illnesses. Management was mainly with the use of drugs.

Health Seeking Behavior

In cases of intestinal infection in Badiang, home remedy was resorted to and the purchase of over the counter drugs. The government and private doctors, lead mother, midwife and BHW were likewise mentioned. In Batuan, the BHW was sought for all sorts of illnesses. For respiratory infection, home remedies are resorted to initially in Badiang, and notable is the increasing usage of the lead mothers.

Household Health Expenditure

Fluctuations in household health expenditures were noted in Badiang although a clear downward trend was noted in the averages (median and mean). The median expenditure for drugs was initially P47.79 which declined to P31.02 at the end of the study period. There was likewise a reduction in the fees of private physicians from a median of P24.75 per consultation to P15.50. In Batuan, the cost of drugs was P25.46 in September and P24.50 in August of the subsequent year. Most often the services are free. Overall median household health expenditure in Badiang declined from P46.45 to P31.53 although in Batuan, expenditure remained low.

Mortality and Fertility

In Badiang, over the study period, seven deaths were reported, all beyond infancy and mostly unrelated to infection. In Batuan, there were only two deaths – one due to heart failure and the other, viral in character. Badiang had 22 births, all attended by midwives; while Batuan reported 12 births which were mostly attended by hilots.

Synthesis

What were the changes that accrued to the experimental barangay that may have been attributed to the implementation of the financing schemes in the community? It will be noted that program inputs were mainly focused on two major areas: the botica sa barangay – the community-operated drug depot – and the lead mothers who were trained to provide basic health services – preventive, promotive and curative. Specific program areas where changes were noted include solid waste disposal (a shift from burning and burying to an increased use of the compost pit), livestock/poultry production, increasing practice of home management in illnesses, the increasing use of the lead mothers and decline in the cost of drugs and physi-

cian fees. In the control community, the BHW was mainly used and the drug cost was maintained sufficiently at a low level. The study period was too short to document any changes in the outcomes such as illness pattern, mortality and fertility. Despite the monthly recording of activities and outcome, no significant changes were documented due to the limited time frame.

2. Tastasan vs Barosong

Environmental Sanitation Facilities

There have been no changes in the environmental sanitation facilities in both the experimental and control barangays. In Tastasan, three out of four households (76.3 percent) disposed of their solid waste by burning and burying and almost a fifth (19.9 percent) threw them in the compost pit and it remained the same until the end of the project implementation period. In Barosong, it was mainly burning and burying. Liquid waste was disposed of mainly in the blind drainage in the two communities. Drinking water source was mainly the improved dug well (59.9 percent) in Tastasan followed by the unimproved dug well (30.2 percent). In Barosong, drinking water was mainly drawn from the unimproved dug well (55.7 percent) followed by the improved dug well (32.2 percent). The toilet was mainly water sealed in Tastasan (91.7) while in Barosong, 79.9 percent had water sealed toilets and 12.4 percent, the antipolo type. About 7.7 percent used the pit privy.

Immunization

At the start of the project period most of the children were immunized with DPT, BCG and polio. Thereafter, entries were minimal in both areas.

Family Planning Acceptance

Usage of family planning was high in Tastasan and there was no change over time. The prevalence rate was 40.4 percent with 55.4 percent using the more effective methods (pills, IUD and ligation). Prevalence of contraceptive use was lower in Barosong (17 percent in September 1983 slightly increasing to 20.4 percent in August 1984). The prevalence of use of effective methods (pills, IUD, and ligation) was 39.9 percent and the less effective method (rhythm and condom), 59.9 percent. By August of 1984, there was a slight increase in ligation acceptance from 26.6 to 31.6 percent.

Weighing and Feeding Programs

Weighing in Tastasan is done at specific time points – in September, October and April. About a fifth of the preschoolers belonged to the 2nd and 3rd degree malnourished category. There is also a feeding program in both communities. In Tastasan, participation was sustained at the level of 20 percent. However, in Barosong, it is not known if the figures reflect real changes in nutritional status since

Distribution of health expenditures,
Tastasan (Buenavista), September 1983
to August 1984

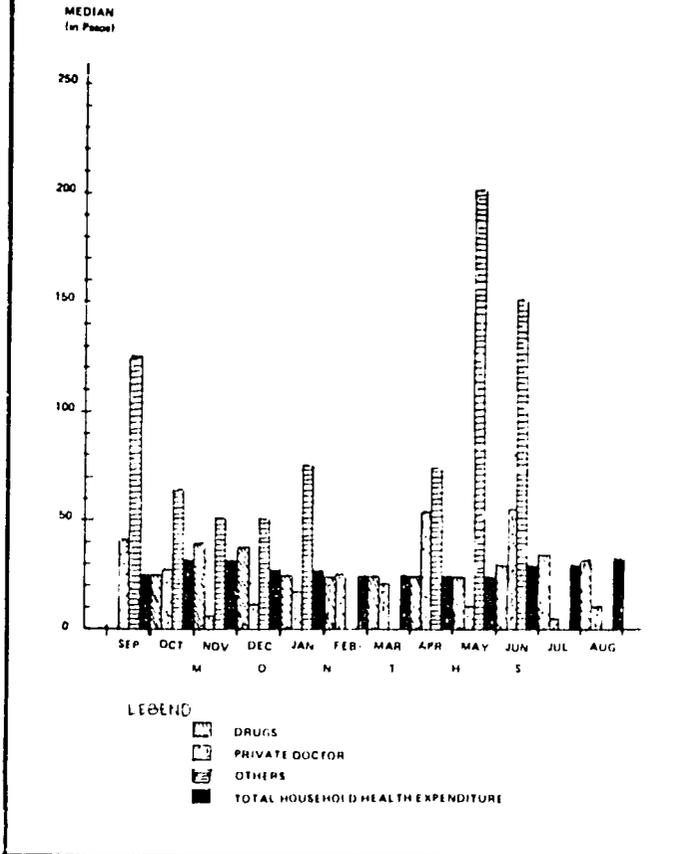


Table 43c: HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

TASTASAN, BUENAVISTA	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	-	-	38.00	40.50	125.50	125.50	25.50	24.50
OCTOBER	25.50	24.50	31.50	28.00	58.83	63.00	87.78	31.17
NOVEMBER	81.75	39.50	15.50	6.16	63.00	50.50	64.97	31.17
DECEMBER	42.17	37.00	30.50	10.50	58.83	50.50	57.32	27.00
JANUARY	25.50	24.50	21.21	18.00	96.33	75.50	31.38	27.80
FEBRUARY	25.50	24.50	23.83	25.50	-	-	25.50	24.50
MARCH	25.50	24.50	20.50	20.50	-	-	25.50	24.50
APRIL	25.50	24.50	46.50	53.00	94.54	75.50	25.50	24.50
MAY	25.50	24.50	11.75	10.50	175.50	200.50	25.50	24.50
JUNE	54.67	29.50	55.50	55.50	125.50	150.50	67.16	29.50
JULY	66.48	33.90	5.50	4.50	-	-	83.83	29.50
AUGUST	44.83	31.60	5.50	10.50	-	-	66.94	31.60

Distribution of health expenditures,
Barosong (Tugbuan), September 1983
To August 1984.

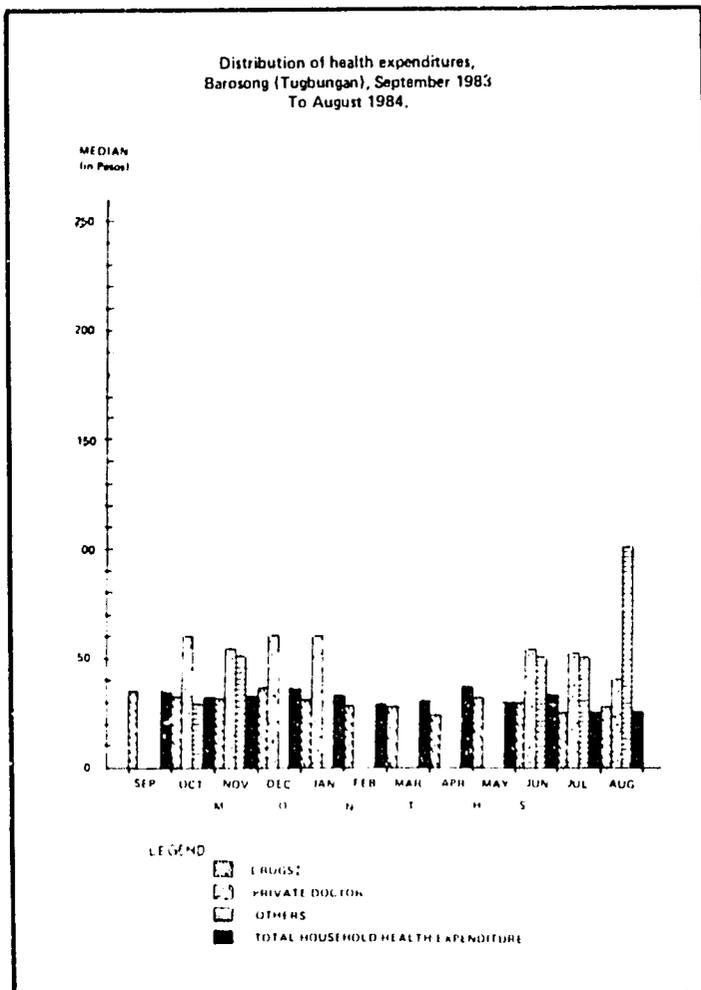


Table 43d. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

BAROSONG, TIGBUAUAN	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	68.68	36.17	-	-	-	-	68.68	35.40
OCTOBER	58.83	33.59	55.50	60.50	75.83	29.50	75.50	32.31
NOVEMBER	60.12	32.00	55.50	55.50	25.50	50.50	72.38	32.80
DECEMBER	68.36	37.00	55.50	60.50	-	-	87.40	37.00
JANUARY	49.78	30.75	55.50	60.50	-	-	67.66	33.05
FEBRUARY	37.62	28.81	-	-	-	-	51.75	29.80
MARCH	44.94	28.53	-	-	-	-	57.32	30.10
APRIL	25.50	24.50	-	-	-	-	94.73	37.74
MAY	59.43	31.30	-	-	-	-	67.16	30.80
JUNE	44.02	29.93	55.50	55.50	25.50	50.50	79.50	32.40
JULY	33.31	26.17	42.20	53.00	125.50	50.50	35.76	26.35
AUGUST	42.89	28.25	43.00	40.50	75.50	100.50	45.50	26.70

wide fluctuations occurred. Participation in feeding programs dwindled from 23 percent at the start of the project to 3.9 percent by the end.

Food Production

Most of the households (91.0 percent) in Tastasan had a vegetable garden. This proportion remained stationary throughout the study period. Likewise, almost all of the households (97.4 percent) had livestock and poultry. The percentage remained the same. Only a third of the households in Barosong had a vegetable garden but more than half (66.68 percent) had livestock and poultry.

Infant Lactation and Weaning Foods

The difficulty in categorizing infant lactation stems from its contingency on the infant's age. Early infancy predisposes to full breastfeeding and with time progression the shift to partial and bottlefeeding becomes evident. However, the scale of full breastfeeding (41-48 percent) is higher in Barosong than in Tastasan (14-40 percent). In the two communities, the intake of vegetables as weaning foods is also evident.

Amenorrhea

The disparity between the two communities in terms of the pattern of amenorrhea is marked in that nearly 10 percent of the Tastasan wives were amenorrheic during the study period compared to 38.46 percent among the Barosong women.

Illness Pattern

Fever accounted for the high percentage of illnesses in the two communities followed by respiratory infection. It seemed difficult, however, to discern any seasonal pattern in illness in the two communities although numerically, less cases were reported in Tastasan compared to Barosong.

Persons Consulted for Illness Management

The barangay health worker was the person of choice in Tastasan. However, the utilization of the BHW declined over time -- from 100 percent in September to 54 percent by August of the subsequent year. An increase in home remedies for management purposes was noted -- from 14 to 21.4 percent. Lead mothers were not used at all. In Barosong, the BHW was chosen initially by about half of the households (45.4 percent). The percentage of use declined to 30.3 percent. Home remedies, initially resorted to by 11.4 percent of the households had experienced an increase to 62.1 percent. Declines were noted in the use of government and private doctors. Management was mainly by drugs and herbs. Home remedies were resorted to in the case of intestinal tract infection and also in respiratory tract infection. For

fever, the BHW has been sought in Tastasan while in Barosong, a shift was noted from the use of the BHW to home remedies.

Household Health Expenditure

There was slight increase in median expenditure on drugs from P24.50 to P31.60 over the study period in Tastasan. However, in Barosong, there was a decline from P36 to P28. Overall median household health expenditure declined from P24.50 to P31.60 in Tastasan and a similar decline was noted in Barosong from P35.40 to P26.70.

Mortality and Fertility

There were eight deaths in Tastasan during the study period - mainly due to other causes. In Barosong, six deaths were documented. There were four births in Tastasan and 12 in Barosong. Most of them were attended by midwives.

Synthesis

The major changes during the study period in the experimental barangay were: (1) the high contraceptive prevalence rate (40.4 percent) predominated by more effective methods. This rate is almost twice that of the control barangay. (2) Feeding programs were sustained in about 20 percent of the preschoolers. (3) Vegetable garden and livestock production were consistently retained by more than a half of the households. (4) There was a notable increase in the use of home remedies. (5) Household health expenditures although fluctuating declined at the end of the period.

3 Bololacao vs Badiangan

No change in environmental sanitation facilities was noted in both the experimental and control barangays over the study period. Burning and burying of solid waste was resorted to by 65.8 percent of the households followed by the compost pit (23 percent) in Bololacao. In Badiangan, 91 to 94 percent of the households disposed of their solid waste by burning and burying. Liquid waste disposal was done in the open field from 80 to 78 percent of the households in Bololacao over time; and 20 to 22 percent use the blind drainage. In Badiangan, 98.6 percent of the households use the open field.

Half (50 percent) of the households in Bololacao use the deep well as drinking water source. The rest used the shallow wells and the improved dug wells. In Badiangan, more than half of the households (57.6 percent) used the improved dug well; and 32.2 percent, the shallow wells.

A wide variability in the type of toilet facilities was observed among the Bololacao residents - 68 percent use the water sealed toilet, 15.5 percent the antipolo type; and 14.3 percent the pit privy. In Badiangan, 87.3 percent of the households used the water sealed toilet and 12.2 percent, the antipolo type.

Immunization

Time fluctuations in immunization level was observed with nearly 38.8 percent of children vaccinated in November – predominantly DPT, BCG and polio. In Badiangan, the September report showed 69 percent of the children getting DPT, BCG and polio vaccines.

Family Planning Acceptance

Initially, family planning prevalence rate was 15.6 percent with 64.2 percent acceptors of effective methods (pills and ligation). This rose to 25.6 percent with the 73.8 percent acceptors of effective methods (pills and sterilization). The rest accepted the condom and other conventional contraceptives.

In Badiangan, contraceptive prevalence rate remained constant at 21.4 percent with 88.0 percent rhythm acceptors.

Weighing and Feeding Program

Weighing was done monthly in Bololacao with 31.4 to 25 percent of the children malnourished at the secondary level over the 12 month period. About 21.3 percent of the children participated in the feeding program. In Badiangan, sporadic weighing was done and as of June 1984, 13.6 percent were in the secondary category malnutrition. There was no feeding program in the control community.

Food Production

About 85 percent of the households had vegetable gardens. The same percentage had livestock and poultry in Bololacao. In Badiangan, 93 percent had a vegetable garden, and 89 percent livestock and poultry.

Lactation and Weaning Foods

As mentioned earlier, the pattern of lactation depends upon the age of the infant. In Bololacao, the percentage of women fully breastfeeding was reduced from 50 to 11.5 percent and shift to partial breastfeeding was noted from 50 to 88.5 percent. Weaning foods were confined to gruel and solids.

In Badiangan, the decline in the percentage breastfeeding was from 43 to 36.6 percentage and the increase in partial breastfeeders was from 51 to 59 percent. Weaning foods were gruel, solids and vegetables.

Amenorrhoea

More than a third of the wives were amenorrhoeic (37.8 percent) in Bololacao; in Badiangan the range was from 15 to 25 percent.

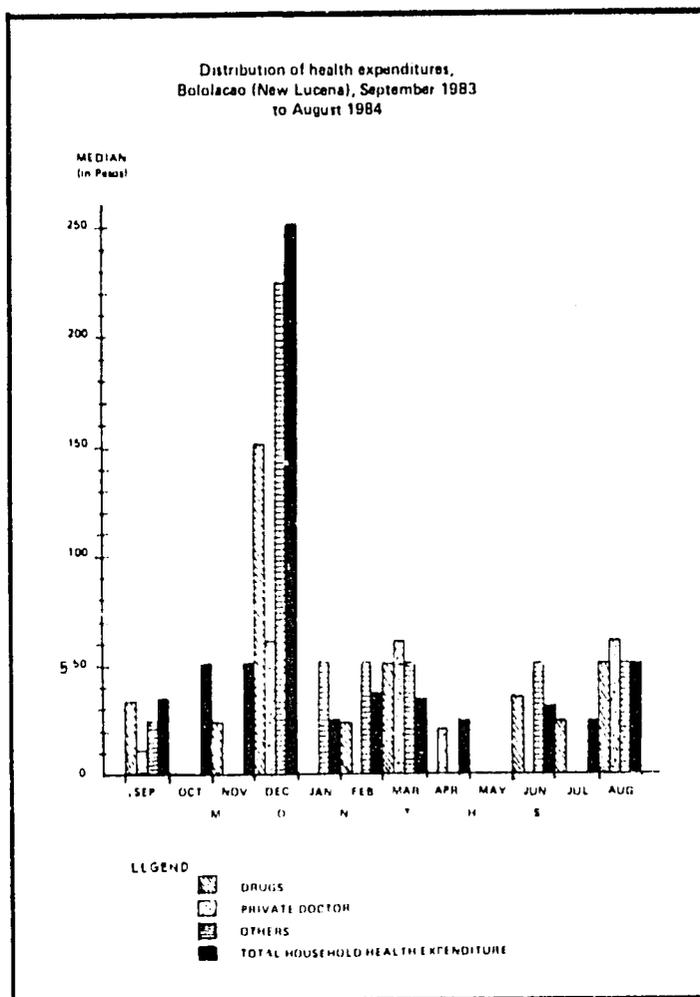


Table 43a. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

BOLOLACAO, NEW LUCENA	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	38.00	32.83	25.50	10.50	25.50	24.50	44.25	34.50
OCTOBER	-	-	-	-	-	-	25.50	50.50
NOVEMBER	125.50	24.50	-	-	-	-	200.50	50.50
DECEMBER	150.00	150.50	55.50	60.50	225.50	225.50	233.83	250.50
JANUARY	-	-	-	-	25.50	50.50	25.50	24.50
FEBRUARY	25.50	24.50	-	-	25.50	50.50	42.16	37.00
MARCH	125.50	50.50	55.50	60.50	125.50	50.50	80.50	35.21
APRIL	25.50	-	15.50	20.50	-	-	25.50	24.50
MAY	-	-	-	-	-	-	-	-
JUNE	58.83	37.00	-	-	63.00	50.50	55.50	30.8
JULY	25.50	24.50	-	-	-	-	25.50	24.50
AUGUST	50.60	50.50	55.50	60.50	75.50	50.50	100.25	50.50

Distribution of health expenditures,
Inligan (Badianan), September 1983
to August, 1984.

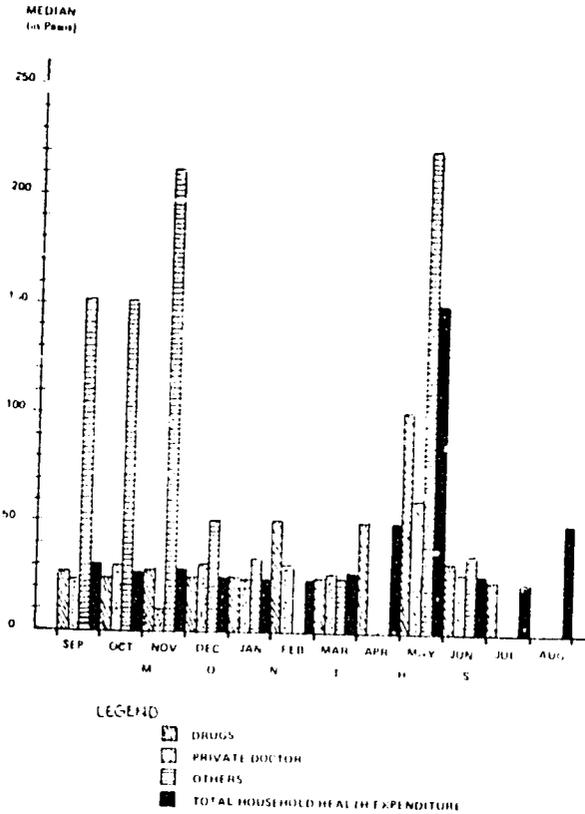


Table 43f. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

INILIGAN, BADIANGAN	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	30.19	27.09	25.50	23.50	175.50	150.50	48.47	30.30
OCTOBER	28.28	25.97	35.50	30.50	125.50	150.50	43.14	27.83
NOVEMBER	50.45	28.07	20.50	10.50	225.50	210.50	69.25	28.07
DECEMBER	29.84	25.06	13.00	30.50	125.50	50.50	40.88	26.58
JANUARY	34.07	26.04	28.83	25.50	69.25	32.83	46.33	26.77
FEBRUARY	25.50	50.50	25.50	30.50	-	-	25.50	24.50
MARCH	33.19	25.50	28.00	27.17	25.50	24.50	35.28	27.54
APRIL	75.50	50.50	-	-	-	-	75.50	50.50
MAY	100.50	100.50	55.50	60.50	225.50	210.50	225.50	150.50
JUNE	63.00	32.83	35.50	28.00	92.16	37.00	34.32	27.83
JULY	25.50	24.50	-	-	-	-	25.50	24.50
AUGUST	-	-	-	-	-	-	25.50	50.50

Illness Pattern and Management

As in other communities, fever was the most common illness reported followed by respiratory and gastro-intestinal infections. The second pattern discerned for fluctuations were noted. The midwife was most often consulted in Bololacao and Badiangan. However, in Badiangan, the government doctor was likewise utilized and the BHW to a lesser extent.

Health Expenditure Patterns

Average expenditures on drugs, although fluctuating widely, were much higher in Bololacao than in Badiangan. The median expenditure on drugs was stable at P32.83 to P50.50 in Bololacao, and the same was observed for Badiangan. Total household health expenditure in Bololacao fluctuated widely from P39.50 in September to P50.50 by August of the subsequent year. In Badiangan, the rise was similar.

Mortality and Fertility

There were 11 deaths reported in Bololacao compared to two in Badiangan. The causes were mainly non-infectious. There were 27 births reported in Bololacao compared to 16 in Badiangan.

Synthesis

Major features of the health inputs were: (1) the increase in the percentage of family planning acceptors particularly the more effective methods, (2) the presence of a feeding program catering to a fifth of the 0 - 6 years age category; (3) food production maintained at the 90 percent level, and (4) decline in the household health expenditures.

4. Milleza vs Nipa

Environmental Sanitation Facilities

There was virtually no change in the trend of usage of environmental sanitation facilities. In Milleza, 86.2 percent of the households disposed of their solid waste by burning and burying. Nearly 10 percent used the open dump. In Nipa, 92 percent disposed of their solid waste by burning and burying. Liquid waste disposal in Milleza was mainly at the open field (88 percent) followed by blind drainage (12 percent). In Nipa, the blind drainage was the major source of liquid waste disposal. The improved spring was the drinking water source in Milleza (65.5 percent) followed by the improved dug well (21.6 percent) and unimproved spring (8.6 percent). In Nipa, shallow wells were the main drinking water source. In Milleza, the water-sealed toilets were used by 68.1 percent of the households followed by the open field (17 to 21 percent). In Nipa, water-sealed toilets were used by 78 percent of the households and this increased to 100 percent over time.

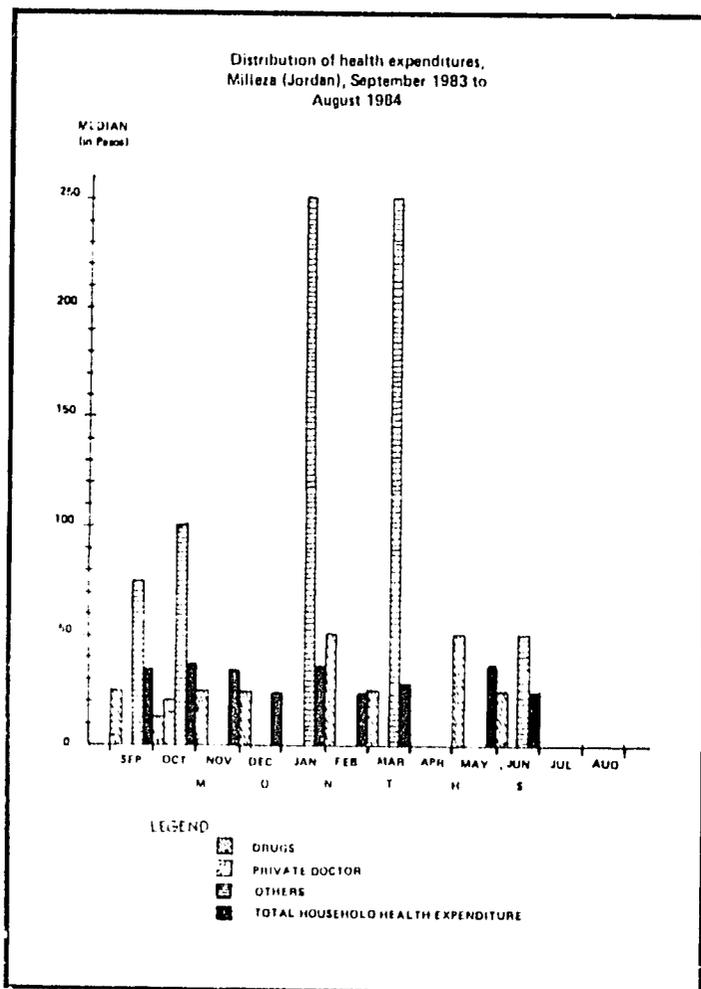


Table 43g. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

MILLEZA, JORDAN	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fees, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
	SEPTEMBER	25.50	24.50	--	--	75.50	75.50	39.78
OCTOBER	50.50	12.00	15.50	20.50	75.50	100.50	42.16	37.00
NOVEMBER	25.50	24.50	--	--	--	--	25.50	24.50
DECEMBER	25.50	24.50	--	--	--	--	25.50	24.50
JANUARY	--	--	--	--	225.50	250.50	108.83	37.00
FEBRUARY	25.50	50.50	--	--	--	--	25.50	24.50
MARCH	31.75	26.17	--	--	225.00	250.50	44.50	28.67
APRIL	--	--	--	--	--	--	--	--
MAY	25.50	50.50	--	--	--	--	--	--
JUNE	25.50	24.50	--	--	25.50	50.50	25.50	37.00
JULY	--	--	--	--	--	--	--	--
AUGUST	--	--	--	--	--	--	--	--

Distribution of health expenditures,
Nipa (Concepcion), September 1983
to August 1984.

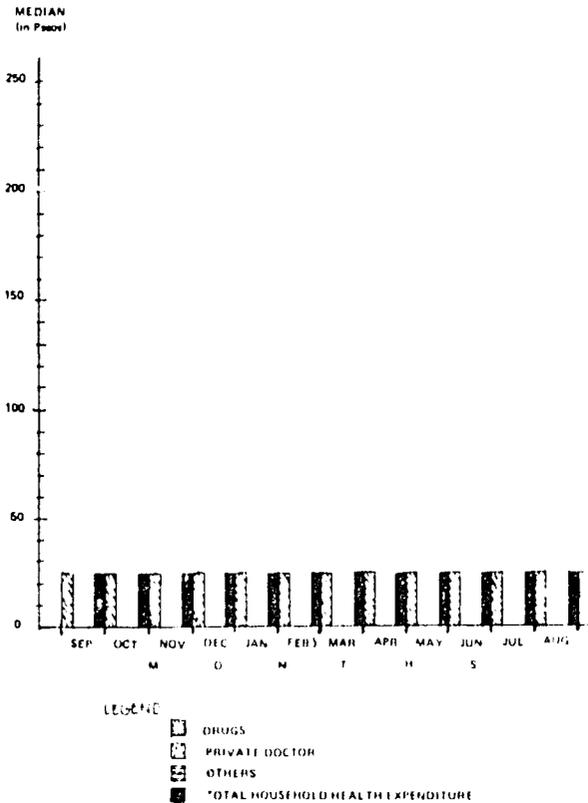


Table 43h. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

NIPA, CONCEPCION	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	25.50	24.50	--	--	--	--	25.50	24.50
OCTOBER	25.50	24.50	--	--	--	--	25.50	24.50
NOVEMBER	25.50	24.50	--	--	--	--	25.50	24.50
DECEMBER	25.50	24.50	--	--	--	--	25.50	24.50
JANUARY	25.50	24.50	--	--	--	--	25.50	24.50
FEBRUARY	25.50	24.50	--	--	--	--	25.50	24.50
MARCH	25.50	24.50	--	--	--	--	25.50	24.50
APRIL	25.50	24.50	--	--	--	--	25.50	24.50
MAY	25.50	24.50	--	--	--	--	25.50	24.50
JUNE	25.50	24.50	--	--	--	--	25.50	24.50
JULY	25.50	24.50	--	--	--	--	25.50	24.50
AUGUST	25.50	24.50	--	--	--	--	25.50	24.50

Immunization

About 30 percent of the children in Milleza were immunized in September mainly with DPT and polio. The immunization load for the rest of the year was minimal except in March where close to 20 percent got immunized mainly with DPT and BCG. In Nipa, all the children were immunized in September — 47 percent with DPT and 28 percent with DPT and BCG. For the rest of the year, the level was negligible.

Family Planning Acceptance

About 25.5 percent of the married women in the reproductive age group were family planning acceptors with only 7.1 percent of the more effective methods. The prevalence rate slightly rose to 27 percent with an upward shift in the percentage of condom acceptors and a decline in rhythm acceptors. In Nipa, however, 69 percent were family planning acceptors of mostly rhythm and condom.

Weighing and Feeding Programs

In Milleza, the weights of the preschoolers were all within the acceptable levels (normal and 1⁰). There has been an increase in the number of children weighed — from 14.4 percent in September to 51.1 percent in June of the subsequent year. There was no feeding program in Milleza. In Nipa, weighing was sporadic with a range of 4.2 percent to 22.1 percent belonging to the malnourished category. There was a reduction in the feeding program participants — from 17.4 percent to 12 percent.

Food Production

In Milleza, 60 percent of the households initially had a vegetable garden and 80 percent had livestock and poultry. In Nipa, 78 percent had a vegetable garden and only a third had livestock and poultry. The percentage of households with a vegetable garden declined to 50.4 percent by August to the subsequent year and those with livestock and poultry, 9.4 percent. In Milleza, there was no subsequent change and the 87.1 percent with livestock and poultry declined to 84.5 percent.

Infant Lactation and Weaning

Full breastfeeding percentage declined from 42 to 25 percent and partial breastfeeding from 58 to 75 percent in Milleza. In Nipa, the percentage of full breastfeeders remained constant at 21 to 22 percent. Weaning food was mainly gruel.

Amenorrhoea

The percentage of amenorrhoeic women declined from 44 to 31 percent in Milleza and from 20 to 16 percent in Nipa.

Illness Pattern and Management

Fever, respiratory tract infections and gastrointestinal diseases remained major causes of illness. The BHW was sought in most cases.

Household Health Expenditure

The median expenditure on drugs remained the same (P25.50) although fluctuations occurred in Milleza. In Nipa, the median drug expenditure (P24.50) did not change over a period of time. Overall household health expenditure declined from P34.50 to P24.50 in Milleza and remained constant in Nipa at P24.50.

Mortality and Fertility

Three deaths were recorded in Milleza and two in Nipa. There were ten births in Milleza and one in Nipa.

Synthesis

1. An increase in the number of children weighed in Milleza and all weights were within the acceptable level.
2. Household health expenditure remained constant.

5. Bucaya vs Bularan

Environmental Sanitation Facilities

The difference in the experimental and control communities in terms of solid waste disposal facilities was noted wherein 67.5 percent of the households disposed of their solid waste by burning or burying and 28 percent used the compost pit. This has prevailed in the duration of the project. In Bularan, about 48.6 percent of households disposed of their solid waste by burning and burying and 40.6 percent used the compost pit. Slight increases in the percentage of the use of these were noted in the study period. The open field remained the major liquid waste disposal facility (85.8 percent) in Bucaya and 76 percent in Bularan followed by the blind drainage with 14.2 percent and 24 percent respectively. Bucaya used the shallow wells as drinking water source (82.7 percent) followed by improved dug well (13.3 percent). In Bularan, stored rain water is the major drinking source (76.6 percent) followed by the dug well (17.7 percent). Water sealed toilets were used by 82.7 percent of the households in Bucaya and in Bularan, nearly half of the households used the water sealed toilets (49.1 percent) followed by flush toilets (18.9 percent).

Immunization

At the start of the study period, 14.4 percent of the preschoolers in Bucaya were immunized mainly with DPT, BCG and Polio. In Bularan, 56.6 percent were immunized with DPT, BCG and Polio.

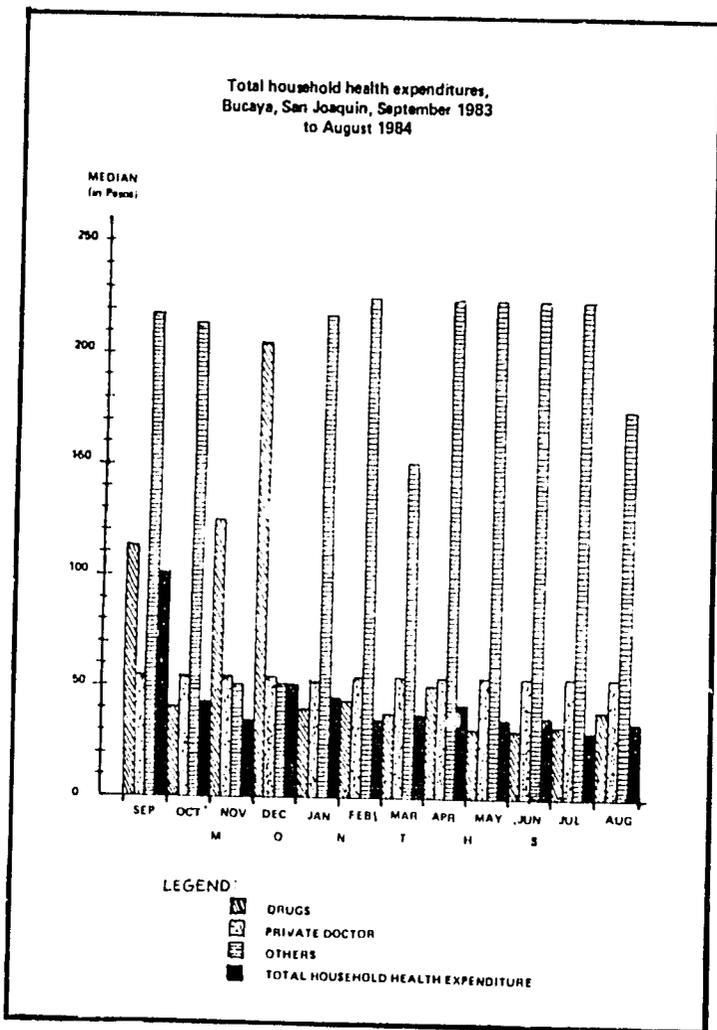


Table 43i. HOUSEHOLD HEALTH EXPENDITURE PATTE(HN (IN PESOS)

BUCAYA, SAN JOAQUIN	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	88.00	113.00	55.50	55.50	181.75	217.17	177.77	100.50
OCTOBER	83.19	40.13	55.50	55.50	158.83	213.00	104.66	42.40
NOVEMBER	125.50	125.50	55.50	55.50	125.50	50.50	258.83	38.30
DECEMBER	154.10	206.75	55.50	55.00	125.50	50.50	192.18	50.50
JANUARY	81.06	39.21	43.50	53.36	220.50	217.17	130.50	48.00
FEBRUARY	72.58	42.00	55.50	55.50	225.50	225.50	87.04	35.81
MARCH	66.68	38.14	55.50	55.50	150.50	150.50	91.41	37.00
APRIL	86.21	50.5	55.50	55.50	225.50	225.50	97.50	41.17
MAY	51.82	31.17	55.50	55.50	225.50	225.50	77.70	36.17
JUNE	48.00	30.80	55.50	55.50	225.50	225.50	86.38	37.80
JULY	57.32	32.0	55.50	55.50	225.50	225.50	61.75	30.8
AUGUST	77.35	39.21	55.50	55.50	158.83	175.00	75.50	34.50

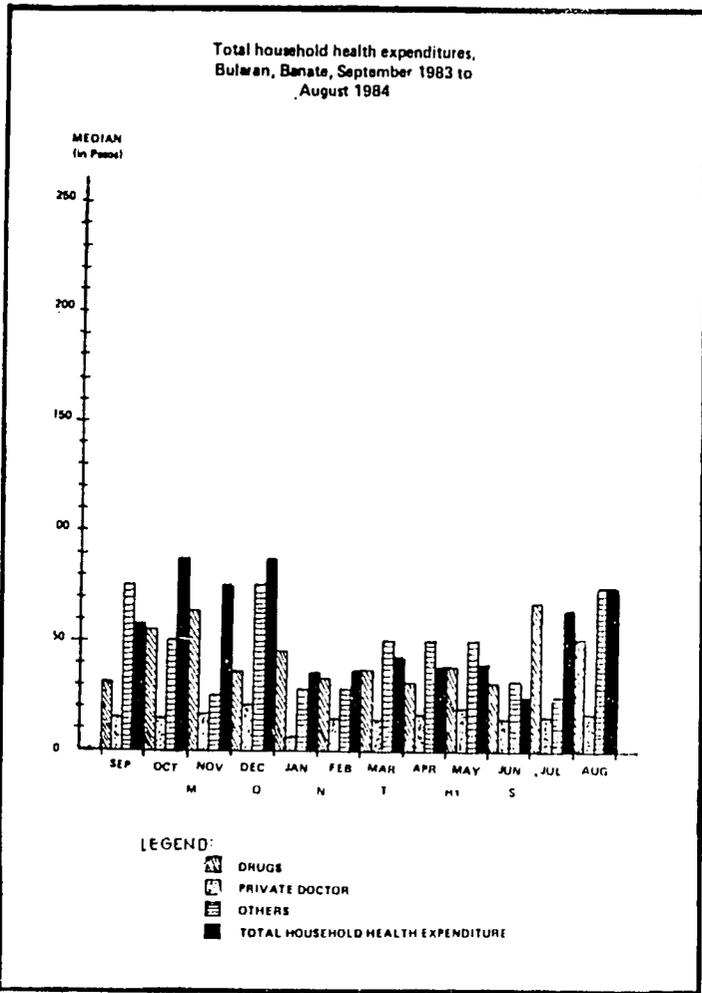


Table 43]. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

BULARAN, BANATE	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fees, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
	SEPTEMBER	83.23	31.80	15.50	15.50	75.50	75.50	92.18
OCTOBER	54.07	58.80	15.50	15.50	50.50	50.50	125.50	88.00
NOVEMBER	82.54	63.00	23.00	17.17	25.50	24.50	118.36	75.50
DECEMBER	75.50	37.00	30.50	20.50	75.50	75.50	175.50	88.00
JANUARY	66.68	48.70	10.50	5.21	31.75	28.07	88.02	38.00
FEBRUARY	40.80	32.10	17.04	15.50	39.78	28.70	64.07	37.50
MARCH	67.54	37.00	15.50	15.50	100.50	50.50	80.87	42.14
APRIL	42.17	31.10	17.81	17.00	100.50	50.50	86.57	38.40
MAY	89.05	38.30	28.23	19.80	117.18	50.50	88.31	39.70
JUNE	47.72	31.00	14.25	14.80	38.00	32.80	52.42	24.00
JULY	81.08	88.50	17.10	18.20	33.83	25.97	100.42	64.80
AUGUST	86.61	50.50	21.50	18.83	107.32	75.50	135.02	75.50

Family Planning Acceptance

Contraceptive prevalence rate was 19 percent in Bucaya with 27.2 percent using the more effective methods (pills, IUD, ligation). The same rates prevailed until the end of the period. In Bularan, 43.5 percent of the women were family planning acceptors of which 74.5 percent were users of non-effective methods (rhythm, condom and conventional contraceptives).

Weighing and Feeding

Weighing of children for nutrition assessment was limited in Bucaya. Initially, more than half (55.5 percent) of the children weighed were in the second and third degree category due to the small number of children weighed in subsequent anthropometric measurement. It would be difficult to infer on the nutritional status of the population. Participation in feeding programs fluctuated over time although at the end of the project period 26 percent participated in the program. In Bularan, almost all the preschoolers were weighed and 12 percent belonged to the malnourished category in January but declined to 4.5 percent in May. Participation in the feeding program was limited to 3.3 percent.

Food Production

About 3 out of 4 households (74.1 percent) had a vegetable garden which prevailed over time. In a similar vein, 42.6 percent of the households had livestock and poultry in Bucaya. In Bularan, only 36.6 percent had a vegetable garden and 39.4 percent had livestock and poultry.

Lactation and Weaning Foods

Breastfeeding was of a higher magnitude in Bucaya and supplementary feeding was limited to gruel and solids.

Amenorrhea

Amenorrhea range was from 10 to 20 percent in Bularan and 26 to 38 percent in Bucaya.

Illness Pattern and Management

Again, fever surfaced as the leading cause of morbidity but this might be linked to other illnesses - chronic, respiratory and gastro-intestinal followed by gastrointestinal and respiratory infection in both areas. While private physicians were sought initially, there has been a trend toward the use of home remedies. Lead mothers were used by some households to a less extent (3-8 households). As expected, drugs and herbs were mainly used. Home remedies were used most often.

Household Health Expenditure

The expenditures on drugs were much bigger in Bucaya than in Bularan

and the trend is toward a decline in Bucaya. Other household health expenses also exhibited a linear increase.

Mortality and Fertility

There were fewer deaths in Bucaya compared to one in Bularan. In Bucaya, the causes were infectious in nature. There were 23 births mostly attended to by midwives (13) and a few by hilots (8). There were five births in Bularan, 2 attended by midwives.

Synthesis

The program impact was not felt much in environmental sanitation facilities, immunization and family planning. Food production was maintained at a high level. Although the utilization of the lead mothers was minimal, there was a tendency to resort to home remedies. Declines in household health expenses were noted.

6. Maribuyong vs Poscolon

Environmental Sanitation Facilities

More than half of the households (53.7 percent in Maribuyong and 55.4 percent in Poscolon) disposed of their solid waste by burning and burying followed by the use of the compost pit (46.3 percent in Maribuyong and 36.4 percent in Poscolon). Liquid waste was disposed of in open field by 88.9 percent of the households in Maribuyong and in the blind drainage by 73.6 percent in Poscolon. The improved well was the main drinking water source of 36.1 percent of the households in Maribuyong followed by deep wells (27.1 percent). In Poscolon, the use of the shallow wells increased from 66.4 to 70 percent and deep well usage also increased from 3.6 to 4.5 percent. In Maribuyong, all of the households used the water-sealed toilets while in Poscolon, the toilet facilities were categorized into water sealed (87.3 percent), pit privy (11.8 percent) and Antipolo (1 percent).

Immunization

The extent of immunization is low in Maribuyong where 31.5 percent of the preschoolers were immunized and 90.2 percent in Poscolon. In Maribuyong and Poscolon, more of the children were immunized with DPT, BCG and Polio.

Family Planning Acceptance

There is a high rate of family planning acceptance in Maribuyong (76 percent) of which only 2.0 percent were acceptors of effective methods. By August of the next year, the percentage of effective users increased to 4 percent. In Poscolon, the rate was 78.5 percent of which 4 percent were acceptors of effective methods. This rate prevailed until the end of the project period.

Weighing and Feeding

In Maribuyong, only about 40 percent of the preschoolers were weighed at the start of the project period and the nutritional status is quite good - only 8.6

Distribution of health expenditures,
Maribuyong (Duenas), September 1983 to
August 1984.

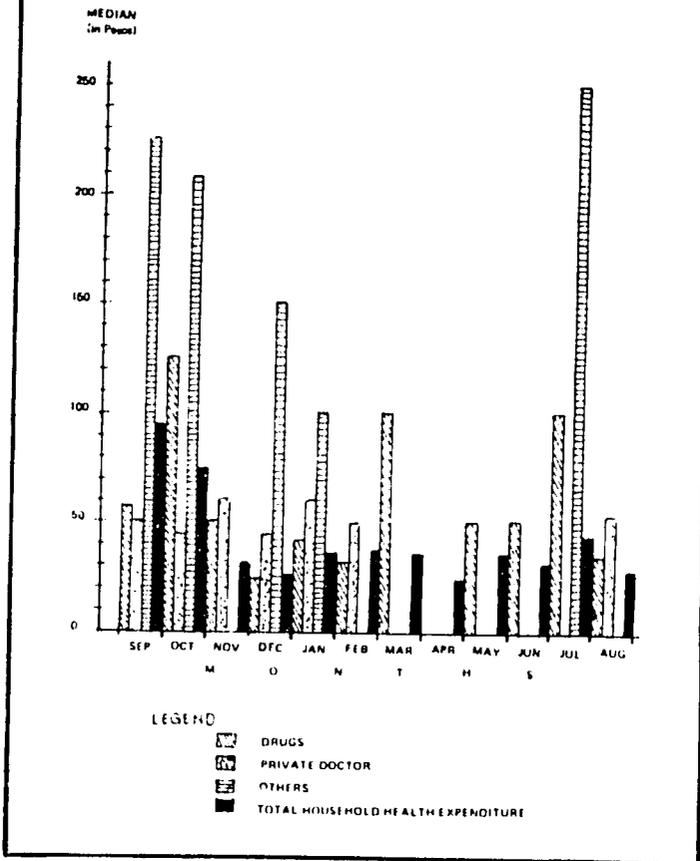


Table 43k. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

MARIBUYONG, DUEÑAS	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
	SEPTEMBER	98.83	58.83	50.50	50.50	225.50	225.50	149.64
OCTOBER	125.50	125.50	38.83	45.50	175.50	208.83	150.50	75.50
NOVEMBER	25.50	50.50	55.50	60.50	-	-	35.50	30.75
DECEMBER	25.50	24.50	45.50	45.50	125.50	150.50	38.81	27.63
JANUARY	95.50	41.17	55.50	50.50	125.50	105.50	86.81	37.00
FEBRUARY	38.00	32.83	45.50	50.50	-	-	46.92	38.30
MARCH	125.50	100.50	-	-	-	-	89.94	37.00
APRIL	-	-	-	-	-	-	25.50	24.50
MAY	50.50	50.50	-	-	-	-	42.16	37.00
JUNE	25.50	50.50	-	-	-	-	69.94	31.64
JULY	117.17	100.50	-	-	225.50	250.50	107.32	45.33
AUGUST	45.50	37.00	55.50	55.50	-	-	34.32	29.98

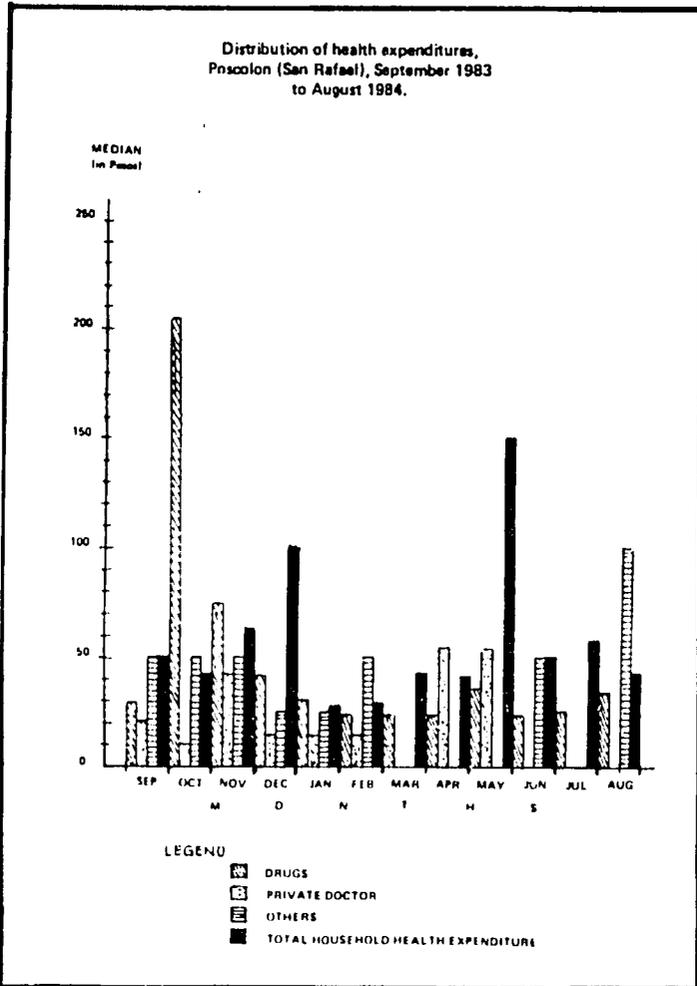


Table 43I. HOUSEHOLD HEALTH EXPENDITURE PATTERN (IN PESOS)

POSCOLON, SAN RAFAEL	DRUGS		PRIVATE DOCTOR		OTHERS (Hospitalization, fares, etc.)		TOTAL HOUSEHOLD HEALTH EXPENDITURE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
SEPTEMBER	33.83	29.50	15.50	20.50	25.50	50.50	50.50	50.50
OCTOBER	158.83	206.50	10.50	10.50	50.50	50.50	46.50	41.17
NOVEMBER	116.60	78.50	29.78	41.75	25.50	50.50	69.25	63.00
DECEMBER	106.50	41.17	15.50	15.50	25.50	24.50	126.50	100.50
JANUARY	66.50	30.75	15.50	15.50	25.50	24.50	31.06	27.83
FEBRUARY	26.50	24.50	15.50	15.50	25.50	50.50	50.50	29.50
MARCH	26.50	24.50	-	-	-	-	46.92	43.25
APRIL	26.50	24.50	55.50	66.50	-	-	106.50	41.17
MAY	64.39	37.00	55.50	66.50	-	-	190.50	150.50
JUNE	26.50	24.50	-	-	25.50	50.50	50.50	50.50
JULY	40.88	28.58	-	-	-	-	89.78	58.83
AUGUST	61.21	34.50	-	-	75.50	100.50	125.50	43.25

percent were malnourished at the secondary level. In August of the subsequent year, about 77.2 percent of the children were weighed of which 19.1 percent and 1.4 percent were malnourished at the second and tertiary levels, respectively. There was no feeding program in the community. A more active nutrition program was discussed in Poscolon where almost all of the children were weighed of which more than half (55.1 percent) were malnourished initially. By the 12th month of the project period, the percentage was reduced to 37.6 percent. The participation in the feeding program rose from 2.2 to 8.0 percent.

Food Production

Almost all households in Maribuyong and Poscolon had a vegetable garden (97.2 percent) and livestock and poultry (100 percent).

Lactation and Weaning

A wide variety of supplementary feeding was noted in Poscolon with gruel, solids, and vegetables.

Amenorrhea

Almost a third to a fifth of the wives were amenorrheic in both barangays.

Illness Patterns and Management

Fever followed by respiratory tract infection and gastro intestinal illnesses were the main causes of morbidity. Home remedies as well as the utilization of the BHW and the midwife were solicited for illness management in Maribuyong. In Poscolon, however, the BHW was used mainly followed by the government doctor and midwife.

Household Health Expenditure

Initially, a slight upward trend in drug expenditure with fluctuations in the 12-month period was noted in Maribuyong while in Poscolon the trend is upward. However, the differences are not significant. A slight downward trend in household health expenditure was noted in Maribuyong while in Poscolon it was fluctuating.

Mortality and Fertility

There was one infant death due to fever in Maribuyong. In Poscolon, there were two infant deaths – one congenital and the other respiratory. In terms of births, there were 14 in Maribuyong and 10 in Poscolon mostly attended by the hilot.

Synthesis

1. Sustenance of a high rate of family planning acceptance although of less

effective methods.

2. Improvement in the weighing program and an unsubstantial number of malnourished.
3. A high degree of food production
4. High rate of utilization of the BHW
5. Downward trend in household health expenditures.

Summary of RKS Data Analysis

There was no substantial impact of the project which may be due to the short study period and the variability in the degree of program implementation.

The following observations were noted.

1. There was no change in the environmental sanitation facilities over the project period.
2. Immunization rate was at a high level in certain communities but low in others which may not be attributed to the program
3. The experimental communities did not show any significant improvement. In fact, in certain instances, the control communities fared better than the experimental areas.
4. In certain communities, there was a high prevalence of contraceptive use but mainly confined to non-effective conventional contraception.
5. Food production was maintained at
 - a. High level
 - b. Weighing was sporadic although malnutrition is at a lower scale. Most of the communities do not have a feeding program and those who do have a small number of participants.
6. Supplementation was mainly focused on gruel with some solids and vegetables.
7. Illnesses reported were mainly fever, respiratory, and gastro-intestinal infection. There has been a predominant shift to some management which may be an indirect impact of the lead mothers.
8. Household health expenditure, particularly on drugs, declined.

SURVEY OF AWARENESS, ATTITUDE AND PARTICIPATION IN THE PROJECT

A post implementation survey was undertaken to determine the awareness, attitude and participation in the project.

A. Bololacao

Bololacao's experience is considered one of success. The knowledge, attitudes and perception of the residents regarding the project during the year of implementation was elicited during the end of project survey.

Knowledge of the Project

Of the 155 household heads interviewed 83.8 percent signified their awareness of the PRICOR Project. For 38 percent, the project was generally known as a health project while others specified certain aspects of the implementation to the exclusion of others. Of the latter group the biggest percentage referred to it as teaching them of environmental sanitation and vegetable gardening. This in fact was its first and one of two widely disseminated programs of the lead mothers. Just as common was the project being associated with the botika sa barangay (10 percent). Surprisingly, no one mentioned the project in relation to fund-raising for health purposes or the construction of the health station annex.

Participation in Health Scheme

Ninety percent said they participated in the health scheme with 94 percent of these signifying their participation in terms of the botika. When asked to specify the nature of their participation, 78 percent indicated monetary contributions while the rest mentioned donation of services.

Perceived Botika Participation

The average amount contributed by the 131 respondents who reported having done so was P6.90 and the total amount which would have been collected based on recall of respondents was P904. This figure exceeds the actual collected amount based on the lead mothers' records which reported only P717.

On those who did not contribute, the more common reason given was "no money". As for those who did not complete the 10-month contribution the reason given by 47 percent was the poor collection effort while 19 percent said they had no money. One stray reason was that anyway the botika sold the same medicine (i.e. no variation) probably indicating some frustration in their expectations.

Fifty-four percent of respondents used the botika sa barangay during the period of reference. The most frequent type of medicine bought was for fever and influenza. Purchase on credit was reported by 41.66 percent with amounts ranging from P2 to P18. Median credit amount is P6. Repayment was made within one to two weeks for the majority of borrowers. As noted in the botika re-

port, credit in Bololocao is not a problem.

Almost a third of respondents suggested that in order to improve botika operations, additional capital through continued contributions should be made. Other responses included the need for sufficient stocks of medicines, cooperation of people and payment of credit.

Service and Materials Donation

About 47 percent indicated that they donated some kind of service to the project. A common response was assistance in cooking, most likely referring to the cooking brigade during the construction of the barangay health annex.

Only a nominal number (e.g. 5 or 6) donated services in terms of cleaning surroundings, assisting the midwife, etc. Of those who did not donate, the reason given by the majority was their being very busy with household chores such that they could not make time for the community tasks. Some indicated that nobody asked for their services.

Slightly more than half of the households signified that they donated materials. Most of these were in the form of food and rice (70 percent) which again were donated for the meals during the construction of the annex.

Other types of donation mentioned were nipa, bamboo and paint. Frequent reasons given for not donating were, first, that "nobody asked them to donate" and secondly that "they couldn't afford".

Lead Mothers' Program

About 76 percent or 119 were aware of the presence of lead mothers in the barangay. The usual responses on perceived duties of the lead mother were combinations of the following reasons: teaching and overseeing the health of her assigned unit, collecting money for medicines, supervising the presence of environmental sanitation and gardens.

Seventy-eight respondents said their lead mothers had given them some kind of service. The service was in the form of giving medicine, consulting during illness, teaching on the use and cultivation of herbals as well as other health areas. The rest who did not utilize their services said that they did not need the service.

Of the few who gave suggestions on the improvement of the lead mothers program, the more common responses were the continuation of the program, and the cooperation of residents. In general, the respondents rated the adequacy of lead mothers within the average and above average range.

B. Bucaya

Bucaya's experience in health financing is considered among the more successful ones.

Knowledge of the Project

Of the 164 households interviewed, 74 percent said they were aware of the existence of the PRICOR Project. The two most common single responses, as to what their knowledge consisted of were "for health purposes" and "teaching home cleanliness and backyard gardening." Other types of responses incorporated the following individual aspects in combination, e.g. inspection of toilets, interviews, helping in illness, herbal and vegetable gardens.

Participation in Health Schemes

About 87 percent said they participated in health schemes with 93 percent of these being in terms of the botika. When probed as to the nature of their participation, almost all respondents said they gave contributions. The records on botika contributions however, showed that only 85 percent of residents actually put in some amount.

Perceived Botika Participation

The average amount contributed by the 137 who recalled having given was P2.20 although the majority said they gave only a peso. The few who did not donate said nobody collected from them. Only three said they had no money. About 77 percent said they had utilized the botika during the project period. The majority of medicine bought were for fever and flu. Only 12 percent indicated having taken out medicine on credit with many indicating repayment within two weeks or less. In Bucaya, the botika managers have not experienced problems in credit. The two major suggestions given to improve botika operations were the collection of additional contributions and the maintenance of sufficient stocks.

Service and Materials Donation

Forty-five percent indicated they donated their service for the project. The usual service reported was the cleaning of surroundings and the giving of advice on primary health care, the latter referring to work which lead mothers may have provided. The reasons given by almost half of those who did not donate was their being busy with household chores, although a good number also said nobody asked for their services.

In donation of materials, five percent said they donated materials like nipa, bamboo, food. In Bucaya, however, there was no project which required such donations on an extensive scale. Those mentioned may have been used for fencing of common gardens.

Lead Mothers' Program

Eighty percent were aware of the lead mothers' program. The common perceptions of these volunteers' duties were in terms of five areas of their work:

house visits, conduct of survey, environmental sanitation, herbal/vegetable garden, and overseeing catchment households on health matters. Forty-three percent said the lead mothers had been of service to them especially in the giving of medicine and consultation during illness. Those who did not consult with the lead mothers felt they had no need of their services. Eight respondents mentioned that they had not utilized lead mothers' services because they felt the lead mother did not do their work. The general impression on the performance of the lead mothers was positive and many expressed that they should continue their service.

C. Badiang

Badiang's health financing scheme had been beset by several problems which interfered with its smooth operations.

Knowledge of the Project

About 64 percent of 147 respondents knew of the existence of the project. Most knew the project generally as a health project which emphasized self-reliance.

Participation in Health Schemes

Upon being appraised of the project, 83 percent indicated that their participation was in the form of monetary contributions to the botika sa barangay.

Perceived Botika Participation

The average amount contributed was P4.40. The main reason given by those who did not contribute as well as those who did not complete the botika contributions was their having no money.

More than half or 63 percent of the respondents had bought medicine from their botika. The medicine purchased was mainly for fever, flu and to some extent diarrhea. Half of these households which utilized the botika reported having taken out drugs on credit. The median amount of credit was P4. While most were able to pay within two weeks, a few mentioned a month's interval. They felt that credit can be better managed by ensuring that credit is paid when it is due. Twenty-five percent articulated that it would be to the interest of the barangay if contributions to the botika could be continued.

Service and Materials Donation

About 40 percent said they donated their services to the project. These services were mainly for cleaning the surroundings and assisting in cooking.

The most common reasons given by those who did not donate services was first, that no one asked for their services and secondly, that they were busy with household chores.

Only 9 percent gave materials donation, mainly in terms of food and nipa.

Reason given was that no one asked for their donations as well as their not being able to afford.

Lead Mothers' Program

About 76 percent said they knew that lead mothers had been assigned to their puroks. The most salient awareness of the project was the lead mothers' task of collecting for selling medicine in the botika as well as the house-to-house survey on environmental sanitation and vegetable gardens. Some mentioned lead mothers as informants regarding schedules for community meetings.

About 48 percent have used the services of the lead mothers especially in terms of medicine. Only a few mentioned her as source of assistance during illness and for health aspects. The usual reason for non-utilization was that their services were not needed.

D. Maribuyong

Maribuyong's experience in health financing may be considered relatively successful.

Knowledge of the Project

About 82 percent of the 97 households interviewed had heard of the PRICOR Project. Their consciousness of it was of its being a health project which emphasized self-reliance. The more specific responses of some included environmental sanitation and vegetable garden, toilet inspections and herbal gardens. Only four mentioned herbal gardens which were actually the most visible accomplishment of the lead mothers.

Lead Mothers' Program

Only 9 percent did not know that a lead mother had been assigned to oversee health need in their purok. Those who were aware of the presence of lead mothers, saw the latter's duties chiefly as that for disseminating information regarding health, especially on herbal gardens. A few saw them as assisting the midwife. The services they had availed of from the lead mothers included advice on the use of herbals and health education. Those who did not avail of their service said they had no health problems or that their services were not needed.

Participation in the Emergency Loan Fund

Almost all who donated to the loan fund knew the purpose of the fund. The twelve individuals who did not know said either that they had not attended the meetings or they could not recall the purpose. When asked how much they

contributed to the fund, most could recall the flat rate contributions but only a few mentioned their payment on livestock/produce taxes. Apparently this was no longer in their awareness as the practice eventually disappeared. It is interesting to note that nobody recalled the raffle which was the means by which contributions were collected.

Seven respondents reported having borrowed from the fund mainly for P100 each. Only one took out P200. Three of the borrowers used the money for payment of medical services while four used it to purchase drugs. Only 35 percent anticipated borrowing from the fund within the year.

Participation in Health Schemes

When informed of what the PRICOR Project was, all respondents except one said they participated in it. Almost every one referred to monetary contributions in the emergency loan fund as their manner of participation. A few, more likely the lead mothers, said they donated their services as well. The responses elicited did not reflect the work which many residents put into their herbal gardens.

Service and Materials Donation

Only when probes were made regarding their service donations did 80 percent say they donated their services. Of these, 64 percent stated that these were in the form of maintenance of herbal gardens and cleaning of their surroundings. The rest mentioned specific aspects like assisting the health center and the midwife, assisting in cooking and giving information regarding meetings. Of the 20 respondents who did not contribute their services, the reasons cited were their being busy with household concerns and of not having been asked.

On the other hand, materials donations were extended by 66 percent. A large majority gave nipa and bamboo as fencing for their communal gardens. The reasons of those who did not donate were their perception that donation was unnecessary or that nobody asked them to. Only five said they could not afford such donation.

E. Milleza

In Milleza, the health financing scheme did not thrive.

Knowledge of the Project

Only 34 percent of the 101 households had heard of the PRICOR Project. Of these, almost 75 percent related it to self-reliance in health while the rest knew of it as the botika sa barangay, inspection of toilets and herbal gardens.

Participation in Health Schemes

When told of the components of the PRICOR Project, 92 percent said they participated in these with most of them saying they gave monetary contributions for the botika sa barangay.

Perceived Botika Participation

The average amount contributed to the project was P5.57. The two main reasons for those who were unable to complete their payments as well as those who did not pay at all were either they had no money or that collection efforts were not thorough enough.

About 72 percent had bought medicine from the botika. Most of them took out drugs for headaches and fever/flu. Twenty percent experienced buying on credit with the average credit amount of P5.11. Repayment was generally made within 15 days although three individuals said they had not yet paid back. Suggestions to improve botika operations were the increasing of stocks by continued contributions, immediate payback of credit, stock replenishment and disallowance of credit.

Service and Materials Donation

About 40 percent said they had donated their services in the project. The variety of responses regarding the nature of contributions included, in the order of frequency of response, assisting in the health center, environmental sanitation, giving advice in primary health care. Reasons given for not donating were their being busy with household chores (46 percent), nobody soliciting their services (28 percent) and the rest felt there was no need.

In the donation of materials only 19 percent said they gave something e.g. nipa, wood, paint. Those who did not donate either were not asked to or saw no need to donate.

Lead Mothers' Program

About 70 percent said they were aware that a lead mother had been assigned in their puroks. The common understanding of their duty was in terms of vegetable gardening and environmental sanitation. Also prevalent was the perception of their role as coordinators of residents and information sources. Of those who used the services of the lead mothers, the services sought were in terms of advice during illness especially on the use of herbal plants.

F. Tastasan

In Tastasan likewise, the financing scheme did not thrive.

Knowledge of the Project

Half of the 121 households had heard of the PRICOR Project although of these, 23 percent had no idea what it was. The rest knew of it in terms of health in general as well as in terms of certain activities undertaken.

About 82 percent said they participated in the Health Schemes, mainly in terms of monetary contributions to the botika. Only two or three mentioned any donation of service.

Perceived Botika Participation

The average amount contributed to the botika was P4.03. Most of the 20 percent who did not contribute at all said that nobody collected from them. The same reason was given by those who did not complete their donations. Some cited the unavailability of money.

About 58 percent of the residents had bought medicines from the botika. The single most sought after drugs were those for fever/flu. Only seven individuals took out medicine on credit, although of these, two were for amounts of P21 and slightly more.

Donation of Services and Materials

Only 31 percent and 15 percent donated services and materials, respectively. A third of the residents said their household chores kept them from putting in their service. A big number also said nobody asked them to donate at all.

Lead Mothers' Program

About 65 percent knew of the presence of the lead mothers in the community. They perceived the duties of these in terms of various health activities such as health education, collection for botika, house to house surveys, and environmental sanitation. They suggested that the lead mothers should be more active in pursuing their activities.

G. Summary of Awareness, Attitudes and Participation in the Project

Knowledge of the Project

The highest proportion of households that signified having heard of the PRICOR Project (awareness) were in the three more successful barangays: Bololacao, Maribuyong and Bucaya, all with 80 percent to 84 percent awareness. In contrast, the least successful which were Milleza and Tastasan had 33.7 percent and 49.6 percent awareness respectively. Badiang, which was likewise not too successful, had a 63.9 percent level of awareness. For all the barangays, awareness of the project was in the form of its being a health self-reliance activity, while for a few, specific aspects of the implementation were mentioned to the exclusion of the others. Regarding the latter, the oft mentioned activities were those on environ-

mental sanitation, vegetable and herbal gardening. Specific barangay health activities were mirrored in their responses. However, it was notable that in Bololacao, hardly any reference was made to the various fund raising activities undertaken for the construction of their health center annex. The same is true in Maribuyong which undertook a relatively big raffle to enable them to complete household donations for the emergency loan fund. This may be interpreted as a problem in recall or the failure of local project leaders to point out the relationship between the fund-raising activities and the purpose for which these are undertaken. So, while the fund campaign efforts in themselves were attractive to the households, their potential for realizing bigger community goals can be better played up.

**Table 44. Awareness of PRICOR Project
(in percent)**

Item	Badiang	Bucaya	Bololacao	Maribuyong	Milleza	Tastasan
Yes	63.9	80.5	83.9	82.5	33.7	49.6
No	36.1	19.5	16.1	17.5	66.3	50.4

Participation in Health Schemes

When specific components of the project are enumerated during the interview, most respondents recall participating in the schemes. The higher percentages observed in participation compared to knowledge is attributed to the tendency of individuals to take part in activities without necessarily being aware of the purpose of such. Among the barangays, Tastasan recorded the least percentage (82.6 percent) signifying participation. Even in Milleza wherein the households are widely dispersed, 92 percent reported having participated in the project. Maribuyong had the highest percentage (98.9 percent) indicating participation. Mainly, except for the lead mothers whose service donations are salient, the participation is reported in terms of monetary contributions to the botika sa barangay and in the case of Maribuyong, the emergency loan fund (Table 45)

**Table 45. Participation in schemes
(in percent)**

Item	Badiang	Bucaya	Bololacao	Maribuyong	Milliza	Tastasan
Yes	89.1	87.8	90.3	98.9	92.1	82.6
No	10.9	12.2	9.7	1.1	7.9	17.4

Perceived Botika Participation

The average amounts donated across all barangays ranged from P2.50 in Bucaya to P9.35 in Maribuyong

Table 46. Average amount contributed

Item	Badiang	Bucaya	Bololacao	Maribuyong	Milleza	Tastasan
Average	P4.40	P2.50	P7.09	P9.35	P5.57	P4.03
SD	2.56	2.86	4.27	1.89	1.02	3.32

It may be recalled that in Maribuyong, the holding of a raffle applied a subtle pressure on everyone to complete their contributions. On the other extreme, Bucaya's scheme was a voluntary single-contribution made wherein most gave one peso donations. It is interesting to note the reasons for non-completion of donations as well as for non-contribution. Whereas one might expect the lack of resources, only a few cited this as a reason except in Badiang where this was the single major reason. The most common reason given was always that nobody collected or that collection was not sustained. Other reasons given were also related to the inefficiency of collection efforts.

Botika utilization rates (as reflected in Table 47) measured in terms of the ratio of households who had said they bought medicine (from the botika) to total households indicate that Bucaya, at 77.4 percent, was relatively more patronized.

**Table 47. Utilization of Botika/Lcan/Fund
(in percent)**

Item	Badiang	Bucaya	Bololacao	Maribuyong	Milleza	Tastasan
Utilized	63.2	77.4	54.2	7.22*	72.3	57.8
Buying on Credit	63.3	12.8	22.4	N.A	20.8	42.2

*Refers to Loan Fund

This finding is supported by the sales records in Bucaya which reflect brisk stock movement. The utilization in Milleza is likewise high at 72 percent. However, due to poor management the botika was not able to take advantage of the desire of the residents to patronize the botika. As was observed, the botika always ran out of stock on needed medicines. Among the barangays, Bololacao and Tastasan

had comparatively lower utilization rates at 54 percent and 57.8 percent, probably because of their proximity to the poblacion. The loan fund in Maribuyong was used by only 7 percent of the households since many had not yet felt a need for a health loan. In this regard, casual conversations with key persons in Maribuyong surfaced the attitude of residents that only when they are unable to seek assistance from within the family circle would they borrow from the fund. This may be a reluctance to allow the public (since borrowing from the loan fund becomes a public act) to know of their inability to rely on their own resources during the emergencies.

Buying on credit is extensive in Badiang (63 percent) and likewise in Tastasan (42 percent). As noted in the case studies, Badiang lead mothers reported credit and collection as major problems in their operations. In Tastasan, credit did not grow into a problem since the barangay captain would usually advance payment so as not to jeopardize stock replenishment.

Across all the barangays, the most sought after medicine were those for fever and influenza, except in Milleza where headaches medicine was also in demand. Sales of medicine for other ailments trailed behind.

Donation of Service and Materials

Maribuyong led the barangays in the percentage of households (79 percent) who put in service hours on the community project. This was mainly in the cleaning and maintenance of their herbal gardens, which was a major activity of Maribuyong's lead mothers. Bololacao likewise had a commendable percentage (47 percent) who donated services, which were mainly in the area of cooking. This latter may refer to the food brigade during the construction of their center annex. Bucaya also registered 45.7 percent of households who put in service, chiefly for information dissemination and environmental sanitation. The other three barangays which were not too successful had lower percentages. The reasons given for non-donation of services were twofold: (a) being busy with household duties, and (b) not being asked for their services.

Donation of materials was most common in Maribuyong (66 percent) and Bololacao (54.8 percent) where the implementation plans were such that donations were called for. As to the rest, nominal donations were reported.

**Table 48. Donations of services and materials
(in percent)**

Item	Badiang	Bucaya	Bololacao	Maribuyong	Milleza	Tastasan
Services	40.1	45.7	47.09	79.4	39.6	31.4
Materials	8.9	5.5	54.8	66.0	18.9	15.7

Lead Mothers' Program

The awareness of the presence of lead mothers ranged from 65 percent in Tastasan to 80 percent in Bucaya and Maribuyong. Perceived duties of lead mothers were, in the order of frequency with which they were cited: (a) house-to-house survey on environmental sanitation and vegetables/herbal gardening, (b) collecting for the botika, (c) health education/information, (d) information on schedules of community meeting.

**Table 49. Awareness of presence of lead mothers
(in percent)**

	Badiang	Bucaya	Bololacao	Maribuyong	Milleza	Tastasan
Yes	76.2	80.5	76.8	80.4	70.3	65.3

VIII. CONCLUSIONS AND RECOMMENDATIONS

In this operations research on primary health care financing, attempts were made to involve the community at the earlier stage of needs assessment to the evaluation of the program impact. As such, the schemes were conceptualized as a response to the articulated health problems by the community, formulated and implemented by the residents themselves. In utilizing the participatory approach to financing of health services, the initial task was needs assessment through the community survey, followed by the formulation of strategies selected by the community and its eventual evaluation.

The following conclusions and recommendations can be drawn from the project.

1. It is feasible to evolve a health care financing scheme that focuses on community participation.
2. Such efficient operation hinges on a number of factors: the cultural milieu in which the project is operating, the level of awareness and recognition of the importance of the project, the degree of community interest, leadership and structural support, level of community organization, and efficient management.
3. In societies that are agricultural and operative on a non-monetary economy, alternatives to financial contributions should be explored as findings from the study revealed that drawing minimal financial contributions is difficult.
4. Communities attempting to achieve self-reliance in primary health care delivery or financing should be given adequate structural support both from the service providers and the political leaders. They cannot operate in vacuo. The results of the study indicate that lack of supervision and delays in the provision

of supplies and funds may dampen the interest and enthusiasm of the residents in the operations of their project.

5. Adequate operations of specific health care inputs such as the drugstore can be carried out by the community provided that sufficient orientation is given to them in the inventory of drugs, management of supplies, price mark-up, replenishment and record-keeping.

6. Likewise, the potential beneficiaries (lead mothers) of the health services could be tapped as providers given adequate training, supplies, supervision, and backstop support. The prospects along this line are great in the light of the potential capability of these mothers to provide basic preventive, promotive and curative care at minimal cost.

7. Sufficient lag time should be given for the communities to mull over their health problems and plan on the strategies that they select. Otherwise, the inability to internalize the issues might deter the efficient operations of the program.

8. Lead mothers should be given a longer period of training for a wide variety of service and subsequently provided with the necessary backstop support to ensure the smooth operations of programs.

9. Much as volume and type of activities are measures of the providers' performance, a better measure of effectiveness would be household coverage such that the impact of the health programs could be perceptible. This is the first step in approaching community participation in health care financing on a systematic basis. The lessons drawn from these case studies could serve as a guide to health planners as to which program components to modify or strengthen to ensure the maximization of the impact of primary health care through the participatory approach.

APPENDICES

THE RESEARCH DISSEMINATION WORKSHOP

As a means of linking this research to the decision-making process in the area of health, the investigators presented the study before concerned regional and provincial level decision makers, planners and academicians in health and health-related ministries and disciplines. The study was presented in terms of its philosophy and objectives, planning, implementation and the evaluation of outcomes. After an open forum wherein the participants addressed their questions, small groups were formed to discuss the issues arising from the study, such as: implementation problems in the botika sa barangay, the lead mothers' program, financial contribution, community involvement in planning and implementation, sustainability of schemes. From the workshop, a set of recommendations on how best to tap the community efforts in terms of support mechanisms and their mobilization emerged.

The highlights of the recommendations of each group are reported below.

GROUP I

On the Botika sa Barangay:

1. Adoption of a more entrepreneurial approach wherein a cooperative management system will be applied. The manager will be chosen by the community residents and receive an incentive for his work.
2. Capital will be generated through either a single raffle or on a one time flat rate contribution. Indirect taxation measures will be adopted.
3. Institution of a profit-sharing mechanism among the members of the cooperative.
4. After some success in operating the barangay botika, outlets outside the barangay may be considered.
5. Credit collection could be improved by accepting non-cash payment of credit e.g. farm produce or livestock, which can be converted into cash through the local market.

On the Lead Mothers' Program:

Lead mothers must be officially sanctioned as BHW's by the Ministry of Health which will provide adequate training and supervision. They should be given ample time to familiarize themselves with their roles and functions in the community. In order to maximize community involvement, each lead mother would be in charge of small groups or clusters of households within the barangay.

One suggested form of incentive to be given to lead mothers is the privilege of purchasing drugs sold at the Botika sa Barangay at discount prices.

GROUP II

The discussion of the second group focused on the management of the botika, the selection of botika managers, and the involvement of the Ministry of Health and the Provincial Development Staff. Comparisons were made between the MOH implemented botikas and those in the study.

1. The MOH must conduct a more regular supervision and follow-up of the operations of the botika, as a measure to prevent decapitalization through credit.
2. Credit problems may be minimized by using a guarantor. Credit ceilings may also be imposed, using contributions as a basis.
3. Close scrutiny should be given to the choice of drugs ensuring that these are what are needed by the community. Information on the generic drugs and the brand names should be provided, so consumers may opt for cheaper though equivalent drugs.
4. Incentives for botika members should be devised such as 5 percent discounts on purchases.
5. The selection process for choosing botika managers should be improved. Project planners may need to have more intimate information on prospective choices.
6. The botika operation should elicit the support and supervision of the BHW.

GROUP III

In a brief but concise discussion of how to sustain the Botika sa Barangay operations, the group recommended that the botika could be expanded into a diversified cooperative system wherein prime commodities such as soap, cooking oil, sugar, etc. could be sold aside from the over-the-counter drugs.

Branches may be established in the other barangays of the municipalities so as to take advantage of economies of scale e.g. in the purchase of stocks.

B. Income and Expenditure

1. In the past year, how much did your household earn and what were the sources of your income? (Sang nagligad nga tuig, pila ang kinita-an sang panimalay kag sa diin naghalin ang amo nga kinita-an?)

Salary (Suweldo)	Amount (Kantidad)	State months when Income was Realized (Ihambal ang bulan kon san-o natuman ang kinita-an)
A. Cash		
Sale of Farm Produce (Kinita-an sa Pagbaligya sang Produkto sa Uma)		
Wage from Labor (Suhol sa pagpangabudlay)		
Others, specify (Iban pa, Ihambal isa-isa)		
TOTAL		
B. In Kind, specify the qty. in standard units		

1. b. Do you think that your income will remain the same, increase, or decrease this year? (Sa imo pagbanta, magalugang ayhan ukon maganubo ukon amo man gihapon ang imo kinita-an sa subong nga tuig?)

- Same
- Increase
- Decrease

Reasons for Increase/Decrease (Kabangsanang sang Pagtaas/Pagubos)

2. How much did your household spend and how was the expenditure allocated in the past year? (Pila gid ang gingasto sa kinahanglanon sa panimalay sang nagligad nga tuig?)

Expenditure Allocation (Kag-stuhanan sa balay)	Amount (Kantidad)
Food (pagka-on)	
Housing (incl. water sanitation)	
Clothing (Pagbita)	
Education (Edukasyon)	
Medical Care (Ikaayong lawas)	
Others, specify (Iban pa, Ihambal)	

3. In Medical Care, what was the breakdown of your expenses? (Sa pagpabalong, pila ang imo gingasto sa niga masunod?)

Health Expenditure Allocation (Gastos Para sa Ikaayong Lawas)	Amount (Kantidad)
Health Provider's fee (Ang nagapamulong)	
Medicine, drugs (Bulong)	
Hospitalization (Bayad sa Hospital)	
Immunization (Bakuna)	
Others, Specify (Iban pa, Ihambal)	

c. Illness Experience in the Household and Community (Mga masakit nga naayon sa panimalay kag barangay)

There are _____ children 0-6 years of age in your household. What illnesses did they experience in the past year that merited medical attention?

(Pila ka biog ang imo kabataan nga nagatad san 0-6 ka tuig? Ano nga masakit ang ila naayon sang nagligad nga tuig nga nagakinahanglan sang atensyon sang manugbu- ng?)

Children 0-6 Years of Age (Kabataan nga yara sa 0-6 gingagad)

Name (Ngalan)	Illness Experienced (Balat-an)	Indicate Months of Occurrence (Ihamul kon san-o masami nagaabot/ how many times)	Person (s) Attending (Sin-o ang nagtatap) (Outside)	Management (Ano ang ginhimo sa Pagtatap/ Pagtatap)	Outcome (Resulta)	Expenses (Gastos)
1.						
2.						
3.						
4.						
5.						

2. Were there other members of the household who got sick in the past year and needed medical attention?
 May iban pa bala nga miembro sang pamilya nga nagmasakit sang nagligad nga tulog kag nagekinahanglan sang atensyon sang manuebulong?

Name (Ngalan)	Illness Experience (Balat-an nga naagyan)	Person (s) Attending (Sin-o ang nagtatap)	Management (Ano ang ginhimo sa Pagtatap/ Pagtatap)	Outcome (Resulta)	Expenses (Gastos)
1.					
2.					
3.					
4.					
5.					
6.					

3. Were there persons who died in the household in the past year?
 (May miembro bala sang pamilya nga napatay sang nagligad nga tulog?)

Name (Ngalan)	Age at Death (Edad sang napatay)	Cause of Death (Ginhalian sang kamatayan)	Nature of Health Attendance (Prior) (Klasa sang Pagtatap bag-o napatay)
1.			
2.			
3.			
4.			

4. What are the more common health needs in the barangay? (List according to priority)
 (Ano ang masami nga kinahanglanon sa ikasyong lawas nga yara sa barangay? (sulat suno sa kabug-aton sang amo nga problema)
 How can these needs be solved?
 (Sa ano nga paagi nga ini nga mga problema masolusar?)

Needs	Solutions/Needs Met	Needs	Needs were Met
1.			
2.			
3.			
4.			
5.			

5. Who decides on who and where to seek consultation for a sick member of your family?
 (Sin-o ang gahatag sang desisyon kon diin kag kay sin-o ipakonekta ang nagamasakit nga miembro sang pamilya?)

6. Before seeking consultation, do you first do some home remedies?
 (Bag-o ka magpakonekta, ginhatagan mo bala sang pamulong-bulong sa panimatay?)
 _____ No (Indi) _____ Yes (Huo)

8. 1. If Yes: Type of Illness
 Kon hu, Klasa sang balatan

Home Remedy Given
 (Pamulong-bulong nga ginhatag sa eridong balay)

1. _____

2. _____

3. _____
 4. _____

7. Is the cost of getting medical services
 (Ang imo bala ginbeyad sa serbisyong pagpabalung)

_____ High (Mahal)
 _____ Low (Barato)
 _____ Just Enough (Hustuhan lang)

8. What are your opinions regarding the current provisions of health services?
 (Ano ang maalling ninyo nahanungod sa pagtatap sa maayo nga panglawason sa mga misaunod?)

Types of Providers	Negative (Indi Maayo)	Positive (Maayo)	Comments (Komentar)
Traditional Healers (Tumandok nga manugbulong)			
BHW			
Nurse			
Doctors			
Others			

D. Perception, Awareness and Utilization of Health Facilities in the Community
 (Panghangod, Pagtalupangod, ...ng paggamit sa mga gagamiton sa ikaayong lawas sa Barangay)

1. What health resources are available in your community? Have you used them? For what problems?
 Were you satisfied with the services provided? What problems did you encounter in their utilization? How accessible are they?
 (Ano nga mga serbisyong nahanungod sa ikaayong lawas ang yara sa barangay? Nani, ...-hit ka bala sa mga ita-erbisyo? Sa ano nga problema? ...-santo ka sa pagtatap/serbisyo nga ginahatag? Ano nga mga problema ang nauapata mo sa paggamit sa ita-erbisyo mo bala madali-dali, matawag o nakaduhan kun kinahanglan?)

Name	Mentioned (Check)	Used/Not Used If not, why not? If yes, when was the last time	Specific Problems for w/c Services were utilized	Satisfaction with Usage	Problems encountered in the utilization of services	Average Amount Paid	Accessibility
Brgy. Health Center							
BHW's							
Midwives							
Doctors							
Nurses							
Traditional Healers							
Brgy. Nutrition Workers							
Brgy. Technicians for Health							
Others specify							

2. Which of the above services do you utilize the most and why? Which of the services do you utilize the least and why?
 (Ano nga serbisyong ang pinna ninyo ginagamit kang mga-a? Ano ang mga serbisyong nga talaga lang ginagamit kang mga-a?)

Services Used Most (Serbisyong nga pinna ginagamit)	Reasons (Rasones)	Services Used Least (Serbisyong nga ginagamit sa pinakadag)	Reasons (Rasones)
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	

3. Where do you procure your medicines and how much do you usually pay for them?
 (Dilin ka nagkuha sa mga bulung kang pila ang imo ginbeyad?)

Medicine Type (Klase)	Source (Ginhalian)	Amount of Payment
1.		
2.		
3.		
4.		

4. Where do most people in the barangay go for their health problems and why?
(Dim katabanan sa inyo sa barangay nagakadto para sa kinahanglanon sa ikaayong lawas? Nga-a?)

Health Problems (Problema sa Ikaayong Lawas)	Person(s) Attending (Sin-o ang nagatatap)	Reasons (Kabangnanan)
1.		
2.		
3.		

5. Where do you usually go for the following problems? What is the usual management? and approximately how much do you spend all in all?
(Sa diin kamo masama nagakadto sa mga masunod nga problema? Ano ang ginhiho sa pagtatap/pagbulong? kag pila ang gingasto mo sa kabuluhan?)

Health Problems	Person(s) Sought	Date of Last Visit	Management	Amount spent
Pre Natal Consultation				
Delivery				
Infant Illnesses				
Diarrhea				
Respiratory Diseases				
Mumps, Measles				
Family Planning Service				
Others, specify				
Immunization				
Nutritional Problems				

5.1 Do you have to go far to seek medical care?
(Nagakadto ka gid bala sa malayo para magpabulong?)

- Yes (huo)
- No (indi)

6.2 Distance ----- (in km.)
(Distansya)

6.3 Travel Time Spent ----- (hours/minutes)
(Pila ka oras ka makaabot)

7. How adequate are the health resources in the community to meet the people's needs?
(Ano ka bastanta ang mga bagay subong sang doktor, nurses, midwife, kag iban pa nga parte sa ikaayong lawas sa inyo barangay para matuman/matatap ang kinahanglanon sang mga pumuluho diri?)

-----	Very Adequate (Tama gid ka bastanta)	-----	Inadequate (Indi Bastante)
-----	Adequate (Bastante)	-----	Very Inadequate (Tama gid ka kulang)
-----	So-so (Hustohan lang)		

7.1 If inadequate, what are the needs that have to be met and how can these needs be met?
(Kon kulang, ano ang kinahanglanon nga dapat pa matatap kag sa ano nga pasgi ini matuman?)

Needs that have to be met	How can these needs be met?
1.	
2.	
3.	
4.	
5.	

E. Potential Capability to Participate in Health Financing Schemes
(Ang ikasarang sang Pumuluho sa Pagpasekop sa Finansiyal nga plann nahangungod sa ikaayong lawas)

1. At present, the health facilities available to the community is not adequate as would be desired. If schemes are set to draw from people's participation in health financing schemes, are you in favor of it?
(Sa subong, ang facilidades para sa ikaayong lawas kulang sa kinahanglanon sang mga pumuluho (Kon may mga padihot o pasgi para sa pagpasigap sa finansiyal nga programa sa ikaayong lawas, pabor ka man hata sini?)

- Yes (huo)
- No (indi)

2. Would you be willing to participate in such a program/scheme?
(Gusto mo man bala magpasakop sa sini nga plano?)

----- Yes (Huo)
----- No (Indi)

3. What would be the best way to get the cooperation of your barangay to look/identify a workable scheme?
(Sa imo panghuhuna ano ang pinakamaayo nga paagi para magkuha sang pagpasakop/partisipasyon sang pumuluho sa pagpangita sang plano nga mahimu masunod/magustuhan nila?)

4. In the past there have been schemes developed in other areas to finance community health programs. Which of these do you think would be viable in your barangay?

(Sang nagligad nga tug, may mga programa nga gintukod para sa pagpauusag sa programa sa ikaayong lewas. Sa imo pagbanta, diin sa mga plano nga ini ang puweste himu-on sa inyo barangay?)

SCHEMES	VIABLE	NOT VIABLE	REASON (S)
Fee for Service (Bayad sa serbisyo)			
Flat rate contribution (Pararaho nga kontribusyon)			
Health Insurance (Pagueguro)			
Donation of Materials (Materyales)			
Donation of Services (Serbisyo)			
Participation in Income Generating Activities for Health Care Support - implementar sang programa para sa paguportar san ikaayong lewas			

5. Are you willing to participate in any health financing schemes?

(Gusto mo man bala magpasakop sa sini nga plano sang kagastuhanan para sa ikaayong lewas?)

----- Yes (Huo)
----- No (Indi)

6. If Yes: (Kon huw)

For the different schemes mentioned, indicate the inputs that respondent is willing to defray including amount for fees and timing if deemed applicable. Then, rank the schemes from the one most like (1) to the least liked.

(Sa mga masunod nga palihot, ano ang imo maarrangan sa paghulag sa kagastuhanan subong sang balayan kag kon ano gusto mo magbayad. Ilista halin sa pinakamagustuhanan tubud sa indi nagustuhan.)

SCHEMES	NATURE/AMOUNT OF CONTRIBUTION	TIME FRAME MONTHLY, HARVEST MONTHS, ETC.	RANK
Fee for service			
Flat rate			
Health Insurance			
Donation of Materials			
Donation of Services			
Income Generating Activities (for Health Needs)			

7. For those intending to donate services, which areas would be willing to participate in and how much time can you provide for these?

(Sa mga may gusto maghatag sang ita serbisyo, sa ano nga bagay gusto mo magpasakop kag pila ka oras ang imo maliatag?)

Areas	Time Allocation _____ per week
a. Health Education _____	(Hours)
b. Contraceptive referral and Supply Distribution _____	
c. Weighing and Feeding Program _____	
d. Immunization Campaign _____	Days during the week _____
e. Record Keeping, Identification of Targets _____	
f. Other (Specify) _____	

8. What income generating activities could the community undertake to finance health schemes? How could the income be utilized?

(Sa ano nga paagi kamo makaupot ukon makakita sang kwarta sa paguportar sang programa para sa ikaayong lewas? Paano ita paguuseron/pagamiton?)

List of Activities	Nature of Utilization for Health Schemes
_____	_____

5.

9. In which health areas should the contribution to the health schemes be directed?
(Sa diin nga bahin/parte sang ikanyong lawas pagsamahon ukon pagatagan sang prioridad sang kontribusyon sa imo nga plano?)

Items	Check	Rank
BHW's salary		
Purchase of Drugs		
Construction of toilets, sewage, water facilities		
Purchase of Contraceptive Supplies		
Assistance Food Production		
Assistance Feeding Program		

10. Are you a member of any social/civic organization in your community?
(Miembro ka bela sang mga organisasyon sa imo barangay?)

- Yes (Huo)
- No (Indi)

Organization	Activities

11. How often do you get in touch with the following? (per quarter)
(Nagapakitagot ka bela prime sa mga masunod?)

- 1. Barangay Health Worker
- 2. Barangay Captain

Are you presently involved in income generating activities?
(Sa sibong nagapatakop ka bela sa mga hilikutan nga makahatag sa imo sang dugang nga kinitaan?)

- Yes (Huo)
- No (Indi)

If Yes: Nature of Income Generating Activities and Amount Realized
(Kon hu, ano ang klase sang hilikutan nga makwartahan kag ang kantidad nga makita?)

Income Generating Activities	Amount

2. How much did your household spend and how was the expenditure allocated in the past year? (June 1983 - May 1984) Amount _____
 (Pala gid ang gingasto sa kinahanglanon sa panimalay sang nagligad nga tuig? (Kantidad)

Expenditure Allocation (Kagastuhanan sa balay)	Amount (Kantidad)
FOOD (Pagkaon)	
HOUSING (incl. environmental sanitation)	
CLOTHING (PAGBISTE)	
EDUCATION (Edukasyon)	
MEDICAL CARE (Ikaayong lawas)	
OTHERS, SPECIFY (Iban pa, ihambal)	

3. In Medical Care, what was the breakdown of your expenses?
 (Sa pagbabulong, pala ang inyo gingasto sa mga maunod?)

HEALTH EXPENDITURE ALLOCATION (GASTOS PARA SA IKAAYONG LAWAS)	AMOUNT (KANTIDAD)
Health Provider's Fee (Ang nagapamulong)	
Medicine, Drugs (Bulong)	
Hospitalization (Bayar sa Ospital)	
Immunization (Bakuna)	
Others, Specify (Iban pa, ihambal)	

C. ILLNESS EXPERIENCE IN THE HOUSEHOLD AND COMMUNITY
 (Mga masakit nga naagyan sa panimalay kag barangay)

There are _____ children) - 6 years of age in your household. What illnesses did they experience in the past year that merited medical attention?
 (Pala ka bilang ang imo kabata an nga naga edad sang 0 - 6 ka tuig? Ano nga masakit ang ila naagyan sang nagligad nga tuig nga nagakimahanglan sang atensyon sang manugbulong?)

Children 0 - 6 Years of Age (Kabata an nga yara sa 0 - 6 nga edad)

NAME (NGALAN)	ILLNESSES EXPERIENCED (BALATI AN)	Indicate Months of Occurrence (Ihambal kon san o mesari nagabot)	PERSON(S) ATTENDING (SIN O ANG NAGTATAP)	MANAGEMENT (Ano ang ginimo sa Pagtatap/ Pagtapa)	OUTCOME (RESULTA)	EXPENSE (GASTO)
1.						
2.						
3.						
4.						

2. Were there other members of the household who got sick in the past year and needed medical attention?
 (May iban pa bala nga miembro sang pamilya nga nagmasakit sang nagligad nga tuig kag nagakimahanglan sang atensyon sang manugbulong?)

NAME (NGALAN)	ILLNESSES EXPERIENCED (BALATI AN NGA NAAGYAN)	PERSON(S) ATTENDING (SIN O ANG NAGTATAP)	MANAGEMENT (ANO ANG GINHIMO NGA PAGTATAP/ PAGTAPNA)	OUTCOME (RESULTA)	EXPENSE (GASTOS)
1.					
2.					
3.					
4.					

3. Were there persons who died in the household in the past year?
 (May miembro bala sang pamilya nga napatay sang nagligad nga tuig?)

NAME (NGALAN)	AGE AT DEATH (Edad sang napatay)	CAUSE OF DEATH (Ginhalian sang kamatayon)	NATURE OF HEALTH ATTENDANCE (Prior) (Klase sang pagtatap bag-o mapatay)
1.			
2.			

3. _____
 4. _____

4. What are the more common health problems in the barangay? (List according to priority)
 (Ano ang masamang mga problema sa ikayong lawas nga yara sa barangay? (Ikuha suno sa kabug-aton sang amo nga problema)

How can these problems be solved?
 (Sa ano nga paagi nga ini nga mga problema masolva?)

PROBLEMS (Mga Problema)	SOLUTIONS (Mga Solusyon sa mga Problema)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

5. Who decides on who and where to seek consultation for a sick member of your family?
 (Sino ang ginhatag desisyon kon din kag kay sino ipakonsulta ang nagkasakit nga miembro sang pamilya?)

6. Before seeking consultation, do you first do some home remedies?
 (Bag-o ka magpakonsulta, ginhatagan mo bala sang pamulog-bulong sa panimalay?)

Yes (Huo) _____ No (Indi) _____

6.1.

If Yes: Type of Illness (Kon hu, kiese sang belastan)	Home Remedy Given (Pamulong-bulong nga ginhatag sa sulod sang balay)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

7. Is the cost of getting medical services
 (Ang imo bala ginbayad sa serbisyong pagpahulong)

_____ High (Mahal)
 _____ Low (Barato)
 _____ Just Enough (Hustuhan lang)

D. PERCEPTION, AWARENESS AND UTILIZATION OF HEALTH FACILITIES IN THE COMMUNITY
 (Paghango, Pagtalupangod, kag Paggamit sang mga palamiton sa ikayong lawas sa barangay)

1. What health resources are available in your community? Have you used them in the past year? For what problems? Were you satisfied with the services provided? What problems did you encounter in their utilization? How accessible are they?
 (Ano nga mga bagay subong abri sang doktor, nurses, BHW, midwife, bulong kag iban pa nahangngod sa ikayong lawas nga yara sa barangay? Nakagamit ka bala sang ila serbisyong? Sa ano nga problema? Kontento ka sa pagtatap/serbisyong nga ginhatag? Ano nga mga problema ang nangagata mo sa paggamit sa ila? Serang mo bala madali-dali, matawag, o makadtuon kon kinahanglanon?)

NAME	Mentioned (Check)	Used/Not Used If not, why not? If yes, when was the last time	Specific Problems for w/c services were utilized	Satisfaction with Usage	Problems Encountered in the Utilization of Services	Accessibility
Dty. Health Center	_____	_____	_____	_____	_____	_____
BHW's	_____	_____	_____	_____	_____	_____
Midwife	_____	_____	_____	_____	_____	_____
Doctors	_____	_____	_____	_____	_____	_____
Nurses	_____	_____	_____	_____	_____	_____
Traditional Healers	_____	_____	_____	_____	_____	_____
Dty. Nutrition Scholars	_____	_____	_____	_____	_____	_____
Dty. Technician for Health	_____	_____	_____	_____	_____	_____
Lead Mothers	_____	_____	_____	_____	_____	_____
OTHERS Specify	_____	_____	_____	_____	_____	_____

2. In the past year, what medicine did you buy for yourself and your family? Where did you obtain this, and how much did you pay?
 (Sang naghad nga tuig, ano nga mga bulong ang imo ginbakal para sa imo kag sa imo pamilya? Sa din mo ginkuha ini kag pila ang imo ginbayad?)

MEDICINE	SOURCE (GINHALINAN)	AMOUNT OF PAYMENT
1. _____	_____	_____
2. _____	_____	_____

4.

5. In the past year, did you encounter the following problems? If yes, where did you go? What is the usual management and approximately how much do you spend all in all?
 (Sang nagkad nga tuig, nakaakap/inaiya ka bala sang mga maunod nga mga problema? Kon huo, sa din ika v nagkado?
 Ano ang ginhiwa sa pagtatap/pagbulong? kag pila ang gingasto mo sa kabilugan?)

HEALTH PROBLEMS	CHECK	PERSON(S) SOUGHT	DATE OF LAST VISIT	MANAGEMENT	AMOUNT SPENT
Pre Natal Consultation					
Delivery					
Family Planning Service/ *Referral					
Immunization Deferral					
Nutritional Problems/ Rehabilitation					
Environmental Sanitation					
Oral Rehydration Therapy					

6. Do you have to go far to seek medical care?
 (Nagkaddto ka gid hale sa malayo para magpahulong?)

Yes _____ No _____

7. How adequate are the health resources in the community to meet the people's needs?
 (Ano ka bastante ang mga bayay subong subong abt sang doktor, nurses, midwife kag than pa nga mga parte sa ikaayong lawas sa inyo barangay para matuman matatapi ang kinahanglanon sang mga pumulayo diri?)

Very Adequate (Tama ka bastante) _____ Inadequate (Indi bastante) _____
 Adequate (Bastante) _____ Very Inadequate (Tama gid ka kulang) _____
 So so _____

8. If inadequate, what are the needs that have to be met and how can these needs be met?
 (Kon kulang, ano ang kinahanglanon nga dapat matatapi kag sa anong mga paraqi ini matuman?)

Needs that have to be met	How can these needs be met?
1	
2	
3	
4	

1. PARTICIPATION IN HEALTH SCHEMES

Have you heard of the PRICOR Project? _____

1. Have you heard of the PRICOR Project?
 (Nakabala ka man bala sang PRICOR Project?)

Yes _____ No _____

2. If yes, what do you know of it?
 (Kon huo, ano ang imo nahibal an parte-qi?)

3. In your PHICOR Project, the barangay is implementing the Botika sa Barangay/Emergency Loan Fund and the Lead Mothers Project. Are you participating in any of these?

(Sa inyo PRICOR Project, ang barangay nagtukod sang Botika sa Barangay/Emergency Loan Fund (only Maribuyong) kag and Lead Mothers Project. Nagpapakop ka man bala sa isa unang isa?)

Yes _____ No _____

2. If yes, which one? _____ Lead Mothers _____ Botika sa Barangay/Emergency Loan Fund
 (Kon huo sa din?)

3. If yes, what is the nature of your participation?
 (Kon huo, paano ikaw nakapagibahin?)

2.2.1 Have you contributed any amount to your project? _____ Yes _____ No _____
 (Nakaamot ka man bala sa imong proyekto?)

If yes, how much? _____
 (Kon huo, pila?)

If no, why not? _____
 (Kon wala, nga wala?)

If you did not give for the entire months as planned, why not?
 (Kon wala ikaw makahatag sang kabilugan nga kantidad subong sang ginkaaratan, nga wala?)

2.2.2 Did you donate any service to the barangay for the purpose of primary health care?
(Nakahatag ka man bala sang imo serbisyo sa barangay para sa PHC o kon sa ikayong lawas sang ka nunidad?)

----- Yes ----- No

If yes, what and how long?
(Kon huo, ano nga klase sang serbisyo kag ano ang kadugayon?)

If no, why not?
(Kon wala, nga wala?)

2.2.3 Have you donated any materials to assist any primary health care activity?
(Nakahatag ka man bala sang materyales para ibulig sa mga aktibidades sang primary health care?)

----- Yes ----- No

If yes, what and in what quantity?
(Kon huo, ano kag ano kadamo?)

If no, why not?
(Kon wala nga wala?)

F. LEAD MOTHERS

1. Do you know that a lead mother has been assigned in your purok to assist you in your health needs?
(Nakahibalo ka bala nga may Lead Mother nga natuon sa inyo purok para mabuligan kamo sa inyo mga nga kinahanglanon sa ikayong lawas?)

----- Yes ----- No

1.1 If yes, who is your lead mother?
(Kon huo, sino ang inyo lead mother?)

1.2 What do you perceive her work to be?
(Ano sa pamityagon mo ang inyo trabaho?)

2. Has your lead mother been of any service to you?
(Nakasertibyo man bala ang inyo lead mother sa inyo?)

----- Yes ----- No

2.1 If yes, what?
(Kon huo, ano?)

2.2 If no, why not?
(Kon wala, nga wala?)

3. Have you encountered difficulties with your lead mothers?
(Nakaeksperyensya ka bala sang problema sa inyo lead mother?)

----- Yes ----- No

3.1 If yes, what?
(Kon huo, ano?)

4. If you are to rate the performance of lead mothers, how would you rate them?
(Ano sa paghante mo ang kalidad sang serbisyo nga ginhatag sang inyo lead mothers?)

----- Very Adequate (Tama ka bastante) ----- Inadequate (Indi bastante)
----- Adequate (bastante) ----- Very Inadequate (Tama gid ka kulang)
----- So so (Hustuhan lang)

5. What is your suggestion to improve the performance of lead mothers?
(Ano ang sugang mo matugla para mapasanyog ang serbisyo sang Lead Mother?)

G. BOTIKA SA BAHANGAY

1. Have you bought medicines from the PHICOR Botika sa Barangay?
(Nakabakal ka man sang bulong sa inyo PHICOR Botika sa Barangay?)

----- Yes ----- No

1.1 If yes, how many times and when medicines?
(Kon huo, pila ka beses kag ano nga mga bulong?)

1.2 Did you ever buy medicines on credit?
(Nakaangi ka bala utang sa Botika sa Barangay?)

----- Yes ----- No

1.2.1 If yes, how much and how long did it take you to pay?
(Kon huo, pila kag ano kadugay kag nabayaran mo in?)

2. It has been observed that buying on credit is common in your barangay. What suggestion do you have to minimize this?
(Nakabitawan nga kinaandan sa inyo barangay ang pag-utang nang bulong sa botika. Ano ang imo arang matugda sa paghahanagan sa ini?)

3. What is your suggestion to improve the operations of your botika?
(Ano ang imo maramkendam para mapasanyog ang pagpatak sa inyo Botika sa Barangay?)

H. FOR MARIBYONG EMERGENCY LOAN FUND

1. Do you know what the Emergency Loan Fund (ELF) is for?
(Nakahibalo ka bala kon para sa ano ang Emergency Loan Fund?)

1.1 If yes, what?
(Kon hoo, ano?)

1.2 If no, why not?
(Kon wala, ngaa wala?)

2. Have you experienced borrowing from the emergency loan fund?
(Nakaagil ka bala hulam sa Emergency Loan Fund?)

----- Yes ----- No

2.1 If no, why not?
(Kon wala, ngaa wala?)

2.2 If yes, how much?
(Kon hoo, pila ang imo ginhulam?)

2.3 What did you use the money for? (Probe Breakdown)
(Sa ano mo gongemil ang imo ginhulam nga kuarta?)

2.4 Do you anticipate borrowing from the fund within the year?
(Nagapapabot ka bala nga makahulam ikaw sa pundo sa subong nga tuig?)

----- Yes ----- No

2.4.1 If yes, for what?
(Kon hoo, para sa ano?)

I. OTHERS

1. What other schemes do you recommend to be incorporated in the present one? And how can this be implemented?
(Ano pa ang iban nga proyekto ang puede mo maramkendam para idugang sa subong nga mga proyekto? Pano mo ini lga-implementar?)

2. How often do you get in touch with the following? (3 months)
(Ka pila ikaw makapag-angut sa mga maunod? Kado tatlo ka bulan)

1. Barangay Health Worker -----

2. Barangay Canteen -----

3. Lead Mother -----

PUSH PROJECT
Monthly Household Health Record
Calendar Year 198__

BHW HF-2 _____

BHW: _____ HH No. _____

Date (Initial Survey) _____ HH Head: _____

Barangay: _____

Purok/Sitio _____

Municipality: _____

Direct Preventive Activity	Targets (Names)	Baseline (Initial)		January	February	March	April	May	June	July	August	September	October	November	December
		Age	Status												
A. ENVIRONMENTAL															
SANITATION															
1) Sewerage – Solid Waste															
Liquid Waste															
2) Water Source (for drinking purposes)															
3) Toilet Facility															
B. IMMUNIZATION (0-6 and pregnant women)															
	1.														
	2.														
(indicate type, date of immunization and expected date of next immunization)	3.														
	4.														
C. FAMILY PLANNING (MCRA)															
	1.														
(See instructions)	2.														
	3.														
D. NUTRITION															
1. Weighing (10-6)	1.														
(Weight and level of nutrition)	2.														
	3.														
2. Feeding Program (0-6)	1.														
(Indicate if participant or not)	2.														
	3.														
3. Food Production (garden/ livestock)															
4. Infant Lactation and Weaning Pattern	1.														
	2.														
5. Amenorrhea	1.														
(See instructions)	2.														

II. Vital Information

	Individuals	Age	January	February	March	April	May	June	July	August	September	October	November	December
A. MORBIDITY														
	1.													
(Describe illness, management, attending person, outcome)	2.													
	3.													
	4.													
	5.													
	6.													
	7.													
	.													
B. MORTALITY														
	1.													
(Indicate cause of death)	2.													
	3.													
C. BIRTHS														
	1.													
(Date of birth, sex, outcome)	2.													
	3.													
D. MIGRATION (Expected Duration)														
	1.													
a) IN	1.													
b) OUT	2.													
E. HOUSEHOLD HEALTH EXPENDITURES														
F. REMARKS														

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