

Area/Program- Based Health Planning in the Philippines



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Monograph No. 2

*Area/Program-
Based Health
Planning
in the
Philippines*

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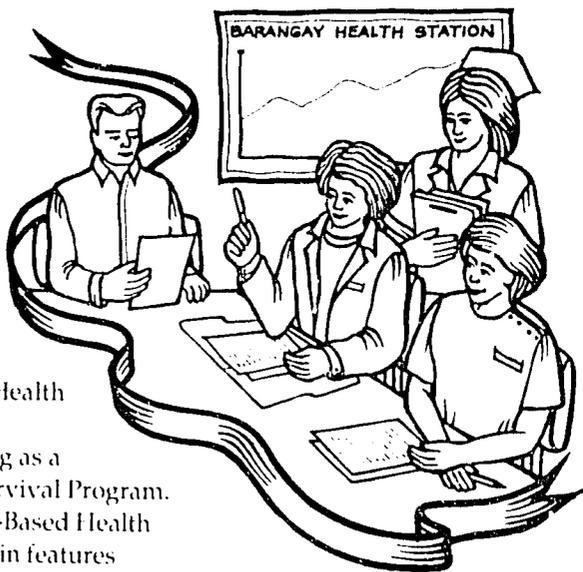
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List of acronyms used

APBHP	Area/Program-Based Health Planning
BHS	Barangay Health Station
DOH	Department of Health
EPI	Expanded Program on Immunization
FHSIS	Field Health Services Information System
FIC	Fully Immunized Child
IPS	Internal Planning Service
LGC	Local Government Code
LGU	Local Government Unit
MHO	Municipal Health Officer
MOOE	Maintenance and Other Operating Expenses
NGO	Non-Government Organization
PHO	Provincial Health Officer
RHU	Rural Health Unit
RITM	Research Institute for Tropical Medicine
USAID	United States Agency for International Development

Executive Summary



Beginning in 1989 the Philippine Department of Health (DOH) developed a new approach to health planning as a key element in its Child Survival Program. Known as "Area/Program-Based Health Planning" (APBHP), its main features include the following:

- It is **decentralized** in that midwives and nurses from Barangay Health Stations (BHS) and Rural Health Units (RHU) actively participate in the planning process.
- It is **data-based**, relying on the Field Health Services Information System (FHSIS) to provide the most important inputs.
- It **targets** particular **geographic units**, such as barangays, which have low levels of coverage for key programs.
- It also **targets** particular **programs** which are performing poorly in a number of barangays.

It can be said without exaggeration that APBHP revolutionized health planning in the Philippines. An APBHP Manual (now in its 4th edition) has been widely disseminated and health workers at all levels have been trained in the APBHP approach. Annual plans meeting quality standards are produced by all 75 provinces and 60 chartered cities.

The APBHP methodology anticipated the fact that health services in the Philippines would be devolved to Local Government Units (LGU). In

addition, augmentation funding is made available to provinces and cities to implement their health plans on a decentralized basis.

The success of the Area/Program-Based Health Planning approach can be explained by a number of factors, including strong leadership from top management of the DOH, continued funding from and close collaboration with the principal donor — USAID, and the commitment to develop and use a powerful planning tool on the part of thousands of midwives, nurses, and doctors throughout the country.

But APBHP in the Philippines has had its share of setbacks and problems; it has not been an unmitigated success. The problems in implementation have included:

- APBHP is very time-consuming for midwives to do every year, given all of their other responsibilities.
- Actual copies of local health plans have often not been available to implementors.
- Augmentation funds from the Central Office often arrive in the provinces very late in the calendar year.

What lessons have been learned from this experience?

1. A clear, focused health plan with **measurable/feasible targets** makes everyone's job easier — front-line health worker, supervisor, and program manager.
2. In order to develop a sustainable, institutionalized approach to health planning (which replaces the previous system), a comprehensive long-term strategy is required. **There is no quick fix.**
3. **Leadership is required** from senior management to help generate the momentum required by the adoption of a new planning methodology.
4. When a health system decentralizes, a new health planning approach **must meet the needs of both health workers and local government officials.**

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Introduction

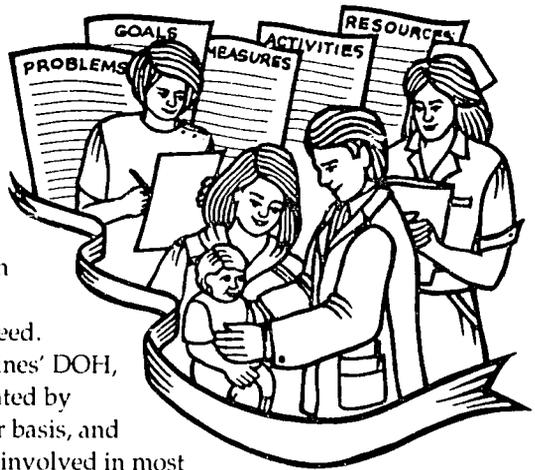
Health planning is an art as well as a science, and often, there is a wide gap between the content of health plans — what is supposed to happen — and the execution — what actually does happen. For one thing, health planners work with incomplete and frequently inaccurate data, and they rarely know with any precision what sort of health budget will be available for the period being planned. Furthermore, the unexpected always happens — be it a political change, an epidemic, or some natural disaster — so that implementation of planned health programs varies, sometimes radically, from what had been anticipated.

Given this gap between plan and execution, it has been observed that what really counts is not the plan itself but the process that planners go through in creating the plan. As health planners go through the steps of creating a plan, they inevitably learn a great deal about priorities and about the obstacles to improving the health status of the population.

With the collapse of centralized, planned economies throughout the world and the trend towards rapid decentralization and devolution, what is the status of planning in the Philippines and that of health planning in particular? Beginning in 1989 the Philippines' Department of Health (DOH) undertook an entirely new approach to health planning — quite different from anything that had ever been done before in the Philippines, and distinct from the planning approaches developed by most other countries. What was this unique Philippine way of doing health planning? What has been the Filipino experience with this new planning methodology and what lessons can be learned from it? This paper will try to answer these questions.

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What is APBHP?



Area/Program-Based Health Planning was developed, beginning in 1989, to meet a need. For many years in the Philippines' DOH, health plans had been formulated by provinces, but not on a regular basis, and only province-level staff were involved in most cases. The usual practice was for provincial health staff to develop operational plans for each of their health programs, without involving local health workers at the district or municipal levels. These plans were "optional" and were not regularly submitted for approval to regional or central levels. The plans were usually quite general, were not data-based, and did not clearly identify which geographical areas had low coverage levels or which programs were performing poorly in a large number of barangays.

By 1989 it had become abundantly clear to health managers in the DOH that the existing health planning methodology was not meeting the needs of health workers at every level.

- At the **Barangay** and **Municipality** levels, health workers were not involved in health planning at all, and possessed no tools that would enable them to identify particular programs or particular barangays needing special attention.
- At the **Province** level, health plans were dutifully written but were based on last year's plan rather than being "data-based".

- At the **Regional** and **Central** levels, health plans were not nearly as focused or targeted as they should have been, and as a result were not good “road maps” for determining appropriate strategies for getting where they needed to go.

An important idea behind Area/Program-Based Health Planning was the empowerment of health workers at the local level — including midwives, nurses, and doctors — by enabling them to make health plans based on their own local priorities. In particular, the methodology developed for Area/Program-Based Health Planning (APBHP) provided a means whereby a midwife could determine which barangays in her catchment area had low coverage levels for major problems — and thus needed more time and effort on her part to raise coverage levels — and which barangays had relatively high coverage levels — thereby needing less of her attention. In addition, the APBHP methodology allowed the midwife — and other health workers — to determine which health programs were performing poorly in a number of barangays, thus indicating which programs needed priority attention. It should now be clear why this planning approach is indeed “area/program-based”. It is **area**-based in that each geographical unit — usually the barangay — is assessed according to how well health programs are performing in that particular area. It is **program**-based in that each program is examined according to how it is performing in a number of barangays.

APBHP is not limited to identifying priority programs and geographical units. The methodology includes a sequence of steps that allows the planner to identify the main constraints to effective health service delivery and to determine what can be done to eliminate those constraints. The word “planner” includes midwives, supervising public health nurses, and doctors at the municipality and provincial levels. The major function of planners at higher levels (regional and national) is to consolidate plans from lower levels. The major steps in this process can be summarized as follows:

1. **Problem Analysis.** This involves using selected program parameters to assess and analyze performance or lack of performance. For example, for the Expanded Program on Immunization (EPI), a provincial health officer may choose the parameter “Fully Immunized Child” or FIC, meaning the percentage of children on their first birthday who are fully immunized with the six (6) EPI antigens. The planner then determines a “cut-off point” below which program performance is considered unsatisfactory. A typical cut-off point for the FIC parameter is 85%. This means that any geographical unit — such as a barangay — with an FIC below 85% would be considered a poorly

performing area needing additional attention and resources. When performance is consistently below the cut-off point in a number of areas, the planner determines the causes of the inadequate performance or low coverage. Each province chooses its own parameters and cut-off points, which are applied consistently throughout the province.

2. Goal Setting. The provincial planner decides on targets or goals for each health program being implemented and for each activity needed to achieve program targets. For EPI, for example, the provincial target is set higher than the cut-off point. For the FIC parameter, where the cut-off point was 85%, the planner may choose a target or goal of say, 90%.

3. Formulation of Measures. The planner identifies the most important measures necessary and sufficient to achieve the targets or goals specified for each program. These measures can come from program guidelines, usually issued by the Central Office in Manila, or from the planners' own imagination and insight. Measures are normally selected at the municipality level.

4. Activity Planning. The municipality-level planner as well as barangay-based midwives decide what activities and tasks are required to carry out the necessary measures that have already been decided. These activities and tasks are assigned to individuals so that clear lines of responsibility are drawn.

5. Resource Planning. The planner, such as the Provincial Health Officer or PHO, computes, estimates, consolidates, and summarizes the personnel, logistical, financial and other resource requirements needed to perform all the requisite activities and tasks.

In order to make these steps easier for the planner to accomplish, the Internal Planning Service (IPS) of the DOH Central Office in Manila has written and distributed a set of guidelines entitled, "Area/Program-Based Health Planning Manual". This comprehensive guide includes worksheets which make it relatively easy for those developing health plans to follow the steps, identify programs and geographical areas needing particular attention, as well as identify the goals, measures, and activities needed to remedy the situation. Selected worksheets taken from the APBHP Manual are included at the end of this paper. (See Appendix A.)

The sequence of planning steps is initially carried out by the midwife, and the area covered is her Barangay Health Station (BHS) catchment area. At the Rural Health Unit (RHU), the doctor and public health nurse consolidate the plans of the different BHS catchment areas into a single municipality health plan. Municipality plans are further consolidated at the district level, and

district plans are in turn consolidated at the province level. The objective of this series of consolidations is to eliminate redundancy and overlap, and to produce consolidated plans that are easy to use and that reflect a coordinated approach so that resources are used as efficiently as possible.

This development of the APBHP approach occurred over a two-year period, involving senior management in the DOH, especially the Chief of Staff; outside consultants; as well as active involvement of the DOH at all levels, from the Internal Planning Service to BHS midwives. The APBHP methodology was field-tested in Quezon province in 1990, and based on that experience the Manual was developed (now in its 4th revised edition). A series of workshops was held throughout the country so that health workers could be trained in the APBHP approach. By 1992 nearly every health worker in the country had experience with APBHP and were using it to raise coverage levels and increase the impact of such programs as EPI, the Control of Diarrheal Disease, the Control of Acute Respiratory Infections, Maternal Care, Family Planning and Nutrition.

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Advantages and disadvantages of APBHP in the Philippine experience

When one compares APBHP as practiced in the Philippines since 1990 with health planning as it occurred in the country before 1990, or with how health planning is conducted in other countries, certain advantages and disadvantages emerge.

These advantages and disadvantages of the APBHP approach can be divided into two categories: those that relate to its planning **methodology** or its conceptual aspects and those that relate to its actual **implementation**.

Advantages of the APBHP methodology:

1. APBHP represents a useful approach for devolved health units, such as municipalities, which can be applied to other sectors besides health. Agriculture, for example, can use the area/program based approach by identifying which barangays have low rice yields and which agricultural programs are performing poorly in a large number of barangays. Mayors may also find the approach helpful.

2. The methodology of APBHP requires inter-sectoral collaboration, including involvement of other government organizations, NGOs, and the private sector. Such close cooperation at the local level is essential for effective service delivery, especially in the era of devolution.



Advantages of the APBHP approach based on actual implementation:

1. There is active involvement in health planning at all levels of the system, from midwives up to provincial and regional staff.
2. At this point, 1993, there has been three years worth of experience with APBHP. Familiarity with how APBHP works is widespread among health workers; a readable manual exists as an aid to plan preparation; most midwives, nurses, and doctors, both in the field and in the Central Office, are supportive.
3. APBHP has been effective as a means of identifying weak areas and programs and in strengthening them.

Disadvantages of the APBHP methodology:

1. The APBHP approach is very time-consuming, especially for midwives who must obtain detailed coverage data for every health program in each of the barangays in their catchment areas. This data-collecting can take two weeks of full-time work and is repeated every year.
2. The planning guidelines do not place a limit on the level of funding for the plans made by local health staff. As a result, the total resources required to implement the plans at different levels often far exceeds the resources actually available. This in turn leads to frustration since many if not most plan activities can never be carried out. Often, the plans simply represent a fantasy of what health officials would like to happen rather than a feasible set of tasks that can actually be accomplished.

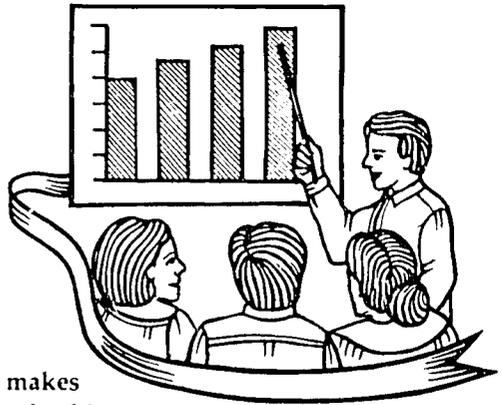
Disadvantages of the APBHP approach based on actual implementation:

1. In actual practice, few midwives, nurses, or rural health physicians have access to a copy of their local plan, once the annual plans are submitted. They either have to depend on an occasional visit to the Provincial Health Office where copies of the plans are available, or end up implementing their plan based on memory.
2. There have been difficulties in the distribution of funds to enable the provinces to implement their plans. Mainly because of the slowness in the government's budget approval process, donor funds made available from the Central Office in Manila to augment Philippine government funds often arrive in November or December in the provinces. While augmentation funds are supposed to be spent by December 31 of each calendar year, it is actually possible to roll over unspent donor funds to the next calendar year. However, many provincial health offices do not know how to do this in practice and instead, they return unspent funds to the treasury.

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Lessons learned from the Philippine experience with health planning

Several lessons have been learned from the Philippine experience in health planning which are relevant to other countries. Four of these lessons seem of particular significance:



1. A clear, focused health plan with *measurable/feasible targets* makes everyone's job easier — front-line health worker, supervisor, and program manager.

Although in the Philippines there is sometimes a tendency to focus too much on achieving targets — that is, focusing just on the numbers — with not enough emphasis on the means of reaching them, there is definite value in defining measurable/feasible objectives. As a result of setting quantifiable, clearly defined targets, health workers at all levels are able to determine how well they are doing and whether they need to change their operational strategy to do better. The targets enable health workers, including the midwives, to assess their own performance as they go along, and this is invaluable.

Now that health services in the Philippines are being devolved to local government units, the experience of APBHP at the local level will make it relatively easy for midwives and nurses to make their own municipality health plans, based on their own data, with meaningful targets. A basic

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lesson is this: as the nations of the world increasingly decentralize the management of services, the importance of **local** capability in planning and managing those services will become greater and greater.

2. In order to develop and install a new and sustainable, institutionalized approach to health planning, a comprehensive long-term strategy is required. *There is no quick fix.*

It is tempting to simplify health planning to the point where health staff can do it in a spontaneous, rapid way. But if a totally different and more systematic approach to planning is desired, there must be a comprehensive long-term strategy to implement it, including training, manual development, supervision, regular feedback, monitoring, and technical assistance as needed. Appendix B contains a checklist developed by the Internal Planning Service (IPS) of the DOH, based in Manila, which allows planners to determine if they are including all the elements of a "quality" plan.

3. *Leadership is required from senior management to help generate the momentum required by the adoption of a new planning methodology.*

In most ministries of health around the world, health planning approaches are typically a habit of long-standing on the part of health staff, and old habits die hard. To overcome inertia and resistance to change, strong support from top management is essential. Support from management, however, is by itself not sufficient for ensuring the adoption and effectiveness of a new approach; the new approach itself must be useful to health staff in the first place and must meet their needs.

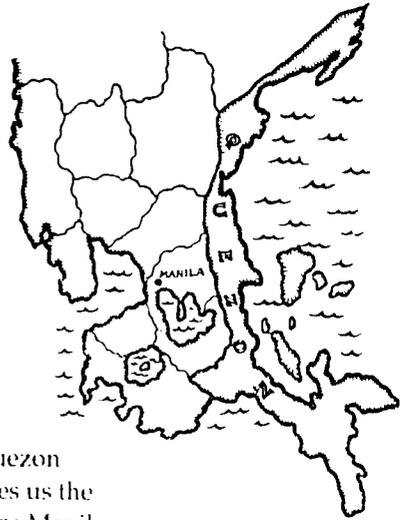
4. *When a health system decentralizes, a new health planning approach must meet the needs of both health workers and local government officials.*

A devolved health system, such as the Philippines has introduced in 1993, means that health workers at the local level are no longer employed by the national Department of Health but instead are responsible to local politicians — mayors and governors. A new health planning approach may meet the needs of local health workers but may be unacceptable to local government officials. For example, an elaborate planning methodology, which is time-consuming, may alienate the local mayor who may receive complaints that the midwife is too busy planning to be able to see patients. Under such circumstances, a simplified approach may be necessary.

The impact of APBHP at the local level

What happened in Quezon province?

The experience of Quezon province regarding APBHP is unique because it was the first province to use the new planning methodology. APBHP was "field-tested" in Quezon in late 1989 before it was tried out in the rest of the country. Why was Quezon chosen to be first? Looking at the map gives us the answer — Quezon is not too far from Metro Manila, about a three hours' drive, thus allowing easy access for careful observation. Also, Quezon's geography includes island municipalities, a long coastline, remote mountain areas, and areas with "peace and order" problems — a true microcosm of the Philippines. In addition, Quezon was known for its innovative programs in health service delivery, such as the Bondoc Peninsula Health Project, which was begun in 1987.



In December 1989 about forty participants from Quezon province, including all the Municipal Health Officers and a number of provincial level staff, were trained in the APBHP methodology in a 3-day workshop at the Research Institute for Tropical Medicine (RITM), located near Manila. Participants all seem to recall the same three things from that workshop:

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- The APBHP approach was at first confusing because it was so different from the approach that they were used to.
- By the end of the second day, the APBHP approach was much clearer, after they had practiced the methodology by going through it step-by-step.
- The third day was disrupted by an attempted coup which took place quite near the RITM but which failed to overthrow the Aquino government.

A brief follow-up training session took place in Quezon province in February 1990. Midwives and nurses from the different municipalities of the province were trained and were then asked to prepare a health plan for 1991. This is something they had never been asked to do before. Previously, the midwives and nurses had been given targets to achieve; these targets were based on a formula originating from the DOH in Manila. The targets were for specific programs for each municipality, and there was no targeting whatsoever at the barangay level. Now, in early 1990, they were being asked to prepare a complete plan for their municipality, other than hospital-based activities. They had to review their data for each barangay and determine which of the 4 or 5 barangays in their catchment area had low coverage levels for important programs, and which programs were performing poorly in most of their barangays. This would allow them to identify barangays and programs needing special attention, so that the midwives would be able to prioritize their time and their use of resources. In addition, this new plan required an analysis of their goals, the constraints that they faced, and how these constraints could be overcome. It was a daunting task, but the midwives had no choice but to make the plan.

Looking back on those days in early 1990, the midwives now remember how hard they worked and how much their husbands complained. Some of the husbands, apparently, were suspicious of their wives' explanation that many late nights in a row were required for preparing a plan. Some husbands even suspected that these late nights were occupying their spouses for yet another purpose altogether....

But somehow, after 2 to 3 weeks poring over their register books and target-client lists, the midwives were finally able to generate the data needed for the municipality plans. Now the baton was passed to the supervising public health nurses and the Municipal Health Officer, usually a doctor, who needed to take the barangay- and program-specific data and produce a municipality plan for 1991. This was also new for them, but they managed to do it.

The next step was for all of the municipality plans to somehow be "consolidated" into a single provincial health plan. Making annual plans

was not new for the Quezon provincial health staff. For years they had been producing plans, but they had been fairly simple and did not require any data from the barangay or even municipality levels. All they had needed to do was to write a brief "situational analysis", compute their targets for specific health programs based on formulas from Manila, and estimate their budgetary requirements for achieving their targets — usually last year's budget plus 10%. Although Quezon provincial health staff had involved Municipal Health Officers (MHOs) since 1984 in their health plans, the requirements for the APBHP approach were far greater than what they were used to. It had to be a team effort and it needed the involvement of people outside of DOH, such as individuals working for NGOs and local government officials.

According to Quezon province health staff, the 1991 APBH Plan represented a revolutionary change not only in the way they planned but also in the way they managed health programs. For example, under the "old" system, most mayors thought of health programs as synonymous with hospitals and "medical missions" — that is, sending out medical teams to rural areas to give out free medicines. With APBHP, the mayors in Quezon began to understand that health involved much more than hospitals and missions; likewise, NGOs began to see health services provided by the DOH as being more "development-oriented" than had been true in the past.

Given this very positive experience, what were the main difficulties encountered in Quezon Province in developing the APBHP approach?

- The process was very time-consuming, especially for midwives and nurses, as compared with health planning in the past. An opportunity cost was also involved — the time devoted by midwives to health planning was time taken away from seeing and attending to mothers and children or implementing public health programs.

- Because the APBHP methodology places no limits on the amount of money or resources that can be requested as part of the plan, Quezon's provincial health plan requested far more than was actually available. This led to some frustration since the approved plans required a great deal of scaling back to adjust to the resources that are actually available. Quezon health staff would have preferred to have been told the approximate amount of funds available **prior** to working on their plan.

- The other source of frustration for health officials in Quezon was the fact that augmentation funds for implementing their plan came very late in the year to be of much use. This problem was not due to the APBHP methodology, however, but rather to bureaucratic delays within the Philippine government system.

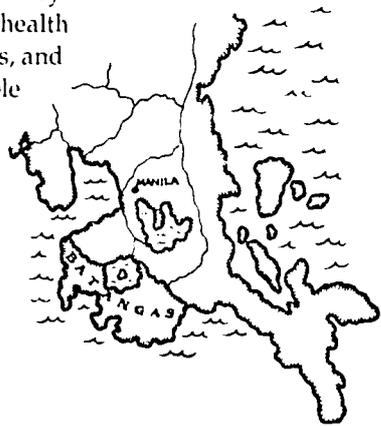
What will happen to APBHP in Quezon now that the DOH has devolved health services to the local level?

1. Quezon provincial and municipality-level health staff were unanimous in saying that they will continue using the APBHP methodology even if it was no longer required by the central office in Manila.

2. With devolution, decisions on how money will be spent will be made by local government officials, especially governors, mayors and provincial and municipal councils, instead of by DOH central or regional staff. Will local government officials choose to allocate substantial resources to low-profile, often invisible public health programs or will they instead focus on politically more advantageous targets such as hospitals and handing out drugs? If health planners have anything to say about this decision, public health programs will do very well. In Quezon province the current governor is said to be very supportive of health programs, both curative as well as preventive/promotive. Who knows what his successor will do?

3. Quezon province health staff insist that they are much more likely to continue with the APBHP approach if the methodology is simplified and made less time-consuming, especially for midwives. They point out that determining which barangays and which programs are of highest priority is something the midwives and nurses should do every year, but that it is not necessary for them to go through the entire problem-analysis component of APBHP every year as well. Except for the few health problems that changed during the previous year, the health problem-analysis assumptions already made should only be written from scratch every third year or so. This would reduce the planning workload with virtually no detrimental effect on the quality of the plan itself.

4. Finally, Quezon health workers say that they need to improve the day-to-day use of local health plans as a practical tool for midwives, nurses, and doctors, as well as expand the range of people outside of government who should be involved in the health planning process.



The experience of Batangas

In order to determine whether Quezon's experience with APBHP was "typical", interviews were conducted in a second province — Batangas. Like Quezon, this

province of 1.2 million people is located in the Southern Tagalog region of Luzon. In other respects, however, it differs considerably from its neighbor province, being topographically much less diverse. To an amazing degree, the experience of Batangas with APBHP has paralleled that of Quezon. However, Batangas staff were able to identify some unique experiences, both positive and negative. For example:

- Several MHOs were surprised at the disparities in program performance between different barangays in their municipality. Some were even “shamed” into visiting those poorly-performing areas for the first time. The adage “out of sight, out of mind” had applied until the APBHP data clearly showed just how bad things were.

- In Batangas, the health staff complained that in addition to APBHP they had **other** plans they had to produce, so-called “medium-term” plans and “strategic plans”. They felt that there was a lot of overlap and too much emphasis on planning at the expense of implementation.

All in all, the experience of APBHP was very positive in both Quezon and Batangas. Whether this new approach to health planning will continue in some form in the era of decentralized control and devolution still remains to be seen.

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The sustainability of APBHP in the Philippines

For APBHP to be sustained, it must effectively contend with recent major developments in the Philippine government, particularly devolution and the implementation of the Local Government Code.



The DOH is aware of the fact that under the Local Government Code (LGC) governors and mayors will be responsible for health matters and may choose not to continue using the APBHP approach. What can the DOH do to ensure the continuation of decentralized planning? The DOH has already taken or is about to take several positive steps to support APBHP at the local level as devolution takes full effect in 1993:

1. Health staff from every province and nearly every municipality have received training in APBHP and virtually all of them are committed to this approach. The DOH plans to intensify its efforts to “market” APBHP to Local Government Units (LGUs). An operations research study, with the collaboration of the University of the Philippines College of Public Health, will begin in 1993 and will determine how the DOH can most effectively support APBHP in provinces and cities.

2. DOH field offices — formerly regional offices — will also vigorously promote APBHP in provinces, cities, and municipalities. DOH field office staff can support DOH representatives on the Local Health Boards to make sure APBHP is understood and its value appreciated.

3. The proposed “Guidelines for the Management by LGUs of a Health Care Delivery System After Devolution” (Chapter 7, Section 22 “Directions for Health Planning”) states that municipal and provincial health units “shall submit their operational health plans by the second week of January prior to the year of implementation of the plan, **following the standard set in the Area/Program-Based Health Planning Manual of the DOH**”. These guidelines require that the APBHP approach be followed by all provinces and municipalities.

4. Maintenance and Other Operating Expenses (MOOE) augmentation funds can be made available to provinces, cities, and municipalities contingent upon submission of decentralized health plans. This can be a potent means of ensuring continuation of APBHP.

5. The Core Group, managed by the Internal Planning Service, consists of about 25 DOH Central Office staff who have been trained in APBHP and in process consulting skills. The members of the Core Group frequently provide technical assistance in health planning to local health officials and LGUs. Funding for this technical assistance has been provided by donors, and DOH senior management for its part has expressed its intention to continue Core Group activities.

The DOH is confident that these measures will assure the approach of decentralized health planning — using the APBHP approach — for the foreseeable future.

“Next steps” for APBHP in the Philippines

In light of recent developments in the Philippines, a number of “next steps” are suggested in order to increase the effectiveness of health planning at all levels:



1. Develop and field-test a simplified Area/Program-Based Planning approach appropriate to Local Government Units.
2. Orient mayors and local health board members regarding APBHP and how the methodology can be useful to other sectors.
3. Facilitate closer integration of health planning and financial planning — budgetting — at all levels. Link field health services planning — APBHP — with hospital planning.
4. Strengthen the capability of planners at province level and below.
5. Continue the “Core Group” of DOH staff trained as consultants to local officials as a means to support Local Government Units in health planning.
6. Make a formal evaluation of APBHP to determine its impact and to identify which of its components are of greatest importance.

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Conclusion

The Philippine experience with Area/Program-Based Health Planning has been a very positive one with important lessons learned along the way. The challenge now is to inform local government officials at provincial and municipal levels that a simplified version of the APBHP can meet their needs very satisfactorily. If they are not convinced that it is to **everyone's** advantage to implement APBHP, then it is likely that over time many midwives, nurses, and physicians at the local level will gradually stop making plans which are area- and program-based. This would be most unfortunate since the area/program-based approach is a powerful tool that enables health workers to focus on the highest priority problems.



Appendix A

The Area/Program-Based Health Planning Manual consists of a step-by-step guide to developing a comprehensive health plan for each administrative level -- municipality, province, region and national. An important component of each plan is a set of worksheets and tables filled out by health planners which helps them clarify the plan's inputs and outputs as well as priority areas and programs. This Appendix includes a sample of these worksheets and tables taken from the APBHP Manual published by the Philippine Department of Health in 1992. In some cases the worksheets and tables are partially filled in order to provide a typical example.

Area/Program-Based Health Planning in the Philippines

**Worksheet 1.1.
Priority Health Problems Analysis, Year 1991**

Name of Office _____
Address _____

Column 1	Column 2	Column 3	Column 4
Priority Health Problems	DOH Controlled Causes/Factors	Causes/Factors Outside DOH Control	DOH Program Responsive to
1. Respiratory Tract Infection Pneumonia Bronchitis Influenza	-- lack of trained personnel for ARI program	-- poor housing -- overcrowding -- lack of proper education	CARI
2. Tuberculosis	-- low case finding and treatment -- negative attitude of personnel regarding sputum collection	-- lack of community participation	NTP
3. Diarrhea	-- poor environmental sanitation practices	-- poor source of water supply -- religious practices -- poor eating habits	CDD ES
4. CVA			
5. Malignancies			
6. Tetanus Neonatorum			
7. Deaths related to pregnancy			
8. Renal Disease			
9. Accidents			
10. Liver Diseases			

N B. To be accomplished at all levels except BHS (RHU, DHO, CHO, IPHO, RHO).

Area/Program-Based Health Planning in the Philippines

Worksheet 1.2 Statement of Area Program-Specific Problems, Year 1991

Name of Office _____
Address _____

	1			2			3			4			5			6		
Program Parameter	IFI			CDD			MC			BF			FP					
	FC			ORS			Pre-natal care coverage			Exclusive BF 1-months			New Acceptors					
Cut Off Point	30%			10%			80%			60%			70%					
Sub-Unit	Data	Status	Rank	Data	Status	Rank	Data	Status	Rank	Data	Status	Rank	Data	Status	Rank			
Magsaysay	68%	✓	C	10%	✓	B	68%	✓	B	56%	✓	B	44%	✓	C			
Quezon	84%	✓	B	11%	✓	B	100%	✓	A	60%	✓	B	75%	✓	B			
Quinto	87%	✓	A	23%	✓	A	69%	✓	B	99%	✓	A	100%	✓	A			
Laurel	100%	✓	A	12%	✓	A	83%	✓	A	86%	✓	A	98%	✓	A			
Marces	82%	✓	A	9%	✓	C	58%	✓	C	29%	✓	C	77%	✓	B			
Macapagal	77%	✓	C	11%	✓	B	68%	✓	B	65%	✓	B	50%	✓	C			
Aquino	77%	✓	B	19%	✓	B	84%	✓	B	76%	✓	B	56%	✓	B			
Amambato	79%	✓	C	8%	✓	C	75%	✓	B	10%	✓	C	53%	✓	B			

Worksheet 1.2 (Continuation) Statement of Area Program-Specific Problems, Year 1991

Name of Office _____
Address _____

	9			10			11			12			13			14	
AD	IDA			IDD			MRP			NTP			Malaria API				
of cases	No. % of cases			No. % of			2nd and 3rd degree malnutrition rate			No. % of sputum + identified			5/1,000			Total Number of Cs	
VAC	70%			100%			20%			30%			5/1,000				
of 1	Status	Rank	Data	Status	Rank	Data	Status	Rank	Data	Status	Rank	Data	Status	Rank	Data		
✓	B	95%	✓	B	100%	✓	A	25%	✓	C	26%	✓	B	NE	✓	3	
✓	C	33%	✓	C	100%	✓	A	17%	✓	B	14%	✓	C	3%	✓	A	3
✓	A	96%	✓	A	100%	✓	A	10%	✓	A	14%	✓	C	NE	✓	1	
✓	A	100%	✓	A	100%	✓	A	13%	✓	B	68%	✓	A	7%	✓	C	1
✓	B	24%	✓	C	45%	✓	A	20%	✓	B	27%	✓	B	4%	✓	B	5
✓	B	76%	✓	B	18%	✓	A	27%	✓	C	29%	✓	B	NE	✓	3	
✓	B	61%	✓	B	100%	✓	A	24%	✓	B	12%	✓	C	NE	✓	1	
✓	C	65%	✓	B	100%	✓	A	8%	✓	A	28%	✓	B	7%	✓	C	6
✓	C	77%	✓	B	91%	✓	C	13%	✓	B	15%	✓	A	5%	✓	B	2
✓	B	35%	✓	B	88%	✓	C	25%	✓	C	23%	✓	B	NE	✓	4	
4	5			3			4			8			2				

Legend : ND - No Data, NE - Non-endemic

Area/Program-Based Health Planning in the Philippines

Worksheet 2.1.
Analysis of Program-Specific Problems and Statement of Program and Operational Goals,
by Program and by Field Sub-Unit/Area, Year 1993

Name of Office _____

Address _____

1 Area Programs	2 Rank	3 Statement of the Problem	4 Causes of the Problem	5 Statement of Goals	
				Program Goal	Operational
RHU Aginaldo NTP	6 Cs	Low sputum (+) identified (14%)	Inadequate skills on case-finding, sputum collection, smearing and staining techniques Negative attitude of personnel regarding sputum collection	To increase % of sputum (+) identified from 14% in 1991 to 70% in 1993.	To improve of RHMs case-finding sputum smearing staining techniques
EPI					
etc. RHU Marcos CDD etc.	5 Cs		Lack of cold chain facilities		To ensure adequate cold chain facilities.
RHU Roxas EPI	4 Cs				

N.B. To be accomplished at all levels except regional (BHS, RHU, DHO, CHO, IPHO).

Area/Program-Based Health Planning in the Philippines

Worksheet 3.1.
Operational Plan for Activities Requiring Augmentation, by Program, by Area, 1993

Name of Office : DHO Presidente
Address : Iloilo Province

1	2	3	4	5	6	7	8	9	
Area/ Programs	Operational Goals	Measures	Activities	Targets	Locus of Respon- sibility	Schedule	Resource Requirem		
							Item Quantity	Unit Cost	
RHU Aguinaldo / NTP	To improve KAS of RHMs on casefinding, sputum collection, smearing and staining techniques.	Retraining of RHMs on sputum collection, smearing and staining techniques.	1. Conference with COH	5 RHMs	RHP	3/93 2nd week	RHP	Time	---
			2. Conference with RHMs		RHP	3/93 4th week	RHP	Time	---
			3. Prepare schedule and venue		PHN	3/93 4th week	PHN	Time	---
			4. Prepare training needs		PHN	3/93 4th week	PHN	Time	---
			5. Actual conduct of training		NTP Coordi- nator	4/93	Snacks (2/day) and lunch	P20.00/ snack and P50.00/	P2

Worksheet 3.1. (Continuation)
Operational Plan for Activities Requiring Augmentation, by Program, by Area, 1993

Name of Office : DHO Presidente
Address : Iloilo Province

1	2	3	4	5	6	7	8	9	10	11
Area/ Programs	Operational Goals	Measures	Activities	Targets	Locus of Respon- sibility	Schedule	Resource Requirement			Source of Funds
							Item/ Quantity	Unit Cost	Total Cost	
RHU Aguinaldo / NTP	To improve masterlisting.	Active participa- tion of BHWs and TBAs.	1. Review TCL	---	RHM	weekly	---	---	---	---
			2. Update TCL	---	RHM	weekly	---	---	---	---
			3. Conduct conference with 200 BHWs and TBAs	four (4) confer- ences	EPI Coordi- nator	quarterly	Snacks for 200 persons	P10.00	P8,000.00	CSP
							8 record books	P45.00	P360.00	CSP
							36 books	---	P64.80	CSP

Area/Program-Based Health Planning in the Philippines

**Worksheet 3.3.
Operational Plan for Basic Program and other Regular Support Activities, by Area, 1993**

Name of Office : DHO Presidente

Address : Iloilo Province

Population : 239, 413

Program/ Activities	Targets by Area									
	RHU Mags	RHU Quez	RHU Quir	RHU Laur	RHU Marc	RHU Maca	RHU Aqui	RHU Aqui	RHU Carc	RHU Rota
	1. NTP / Casefinding : Sputum Microscopy	1232	1000	875	946	1500	1260	1345	1730	1490

**Worksheet 3.3. (Continuation)
Operational Plan for Basic Program and other Regular Support Activities, by Area, 1993**

Name of Office : DHO Presidente

Address : Iloilo Province

Population : 239, 413

Program/ Activities	Person/ Office Responsible	Resource Requirement			Source of Fund
		Item/ Quantity	Unit Cost	Total Cost	
1. NTP / Casefinding : Sputum Microscopy	MHO	Sputum cup (24,650)	P00.49	P12,078.50	GOP
		Glass slide (24, 650)	P00.59	P14,543.50	GOP
		Reagents for staining and examining			
		Basic fuchsin powder	P00.15	P3,697.50	GOP
		Ethyl alcohol	P00.09	P2,218.50	GOP
		Ethanol crystal	P00.15	P3,697.50	GOP
		Methylene blue	P00.05	P1,232.50	GOP
		Sulfuric acid	P00.08	P1,972.00	GOP
		Cedar wood oil	P00.08	P1,972.00	GOP
Xylene	P00.05	P1,232.50	GOP		

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Area/Program-Based Health Planning in the Philippines

Table 1.
Summary of Performance Targets, by Program and by Area

Province / City _____

Year _____

Program	Parameter	Performance Targets, by Area (%)						Overall Target (%)
		DHO Proper	RHU	RHU	RHU	RHU	Etc.	
1. EPI	FIC	95%	85%	92%	92%	90%		90%
2. CDD								
3. Maternal Care								
4. CARI								
5. UFC								
6. Breastfeeding								
7. MRP								
8. Vit. A Def. Prev. & Control								
9. Micronutrient Supp (IDD & IDA)								
10. Fam. Planning								
11. NTP								
12. Malaria control								
13. Schisto control								
14. Leprosy control								
15. Dental Health								
16. Env. Sanitation								
17. Others								
18								
19								
20								

N.B. To be accomplished by BHS, RHU, DHO, CHO, PHO and RHO.
Source of data: Worksheet 2.1

Appendix B

The Area/Program-Based Health Planning Manual also includes a form developed by the Internal Planning Service of the DOH. The form enables health planners to determine if their health plan has the elements of a “quality” plan.



Area/Program-Based Health Planning in the Philippines

**Attachment 1
Evaluation Checklist
Provincial / City Health Plan**

Province _____
Year _____

Date Started : _____
Date Completed : _____

Instructions : Rate all the sub-items by encircling one of the numbers at the right of each. The lowest rating is 1, and the highest rating is 5.

Item 1. Completeness of the Plan (20%)	Item 2. Validity and Timeliness of Data (15%)								
<p>Sub-item 1. Describes briefly the health status and other relevant data needed to define priority health problems. 1 2 3 4 5</p> <p>Sub-item 2. Analyzes the causes and factors contributing to the occurrence of health problems. 1 2 3 4 5</p> <p>Sub-item 3. Presents a summary of performance parameters and cut off points. 1 2 3 4 5</p> <p>Sub-item 4. Contains a summary list of problematic programs and problematic areas. 1 2 3 4 5</p> <p>Sub-item 5. Presents a summary description of strategic measures to be implemented and pursued during the year. 1 2 3 4 5</p> <p>Sub-item 6. Provides a list of specific activities and work targets for the year. 1 2 3 4 5</p> <p>Sub-item 7. Provides cost estimates, including sources of funds, and a total as appropriated from each source. 1 2 3 4 5</p> <p>Sub-item 8. Contains budget summary by programs and by sub-units. 1 2 3 4 5</p> <p>Sub-item 9. Contains Work-Items (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15) including the coordination, timing, and other supporting documents to explain and justify the targets and costs. 1 2 3 4 5</p> <p>Sub-item 10. Others, specify. 1 2 3 4 5</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Sub-item 1. Data or information are derived from the locality.</td> <td style="width: 20%; text-align: center;">1 2 3</td> </tr> <tr> <td>Sub-item 2. Available data or information support/affirm feasibility of target set.</td> <td style="text-align: center;">1 2 3</td> </tr> <tr> <td>Sub-item 3. Data or information are clearly and logically presented.</td> <td style="text-align: center;">1 2</td> </tr> <tr> <td>Sub-item 4. Others, specify.</td> <td style="text-align: center;">1 2</td> </tr> </table> <p>(a) Ratings Total for Item 2 : _____ (b) Number of Sub-items in Item 2 : _____</p> <p>Divide (a) by (b) to get (c) Average Rating for Item 2 : _____</p>	Sub-item 1. Data or information are derived from the locality.	1 2 3	Sub-item 2. Available data or information support/affirm feasibility of target set.	1 2 3	Sub-item 3. Data or information are clearly and logically presented.	1 2	Sub-item 4. Others, specify.	1 2
Sub-item 1. Data or information are derived from the locality.	1 2 3								
Sub-item 2. Available data or information support/affirm feasibility of target set.	1 2 3								
Sub-item 3. Data or information are clearly and logically presented.	1 2								
Sub-item 4. Others, specify.	1 2								
<p>(a) Ratings Total for Item 1 : _____ (b) Number of Sub-items in Item 1 : _____</p>									

Area/Program-Based Health Planning in the Philippines

Attachment 1 (continuation)
Evaluation Checklist
Provincial / City Health Plan

Item 3. Basic Approaches, Measures and Activities (20%)					Item 4. Impact on Health Problems (15%).				
Sub-item 1 Selection of parameters conform with 7 criteria	1	2	3	4	5	Sub-item 1. Proposed specific measures and activities are effective in controlling the major problems	1	2	3
Sub-item 2 Areas and programs are properly stratified	1	2	3	4	5	Sub-item 2. Activities and targets are proportionate to the perceived needs of the community.	1	2	3
Sub-item 3 Problems are identified and underlying causes are analyzed (program and non program)	1	2	3	4	5	Sub-item 3. Others, specify:	1	2	3
Sub-item 4 Measures and activities are supportive to the identified goals and are valid and feasible.	1	2	3	4	5	(a) Ratings Total for Item 4 : _____ (b) Number of Sub-items in Item 4 : _____			
Sub-item 5 Activities listed are realistic and implementable in the time frame of the plan	1	2	3	4	5	Divide (a) by (b) to get (c) Average Rating for Item 4 : _____			
Sub-item 6 Activities and targets requiring substantial increases on financial and material support are identified and costed	1	2	3	4	5	Item 5. Funding Priorities (15%).			
Sub-item 7 Resource requirements per activity are costed and funding sources are indicated	1	2	3	4	5	Sub-item 1. Funding requirement are consistent with priority health problems	1	2	
Sub-item 8 Others, specify	1	2	3	4	5	Sub-item 2. Clearly states which program or interventions merit highest consideration	1	2	
(a) Ratings Total for Item 3 : _____ (b) Number of Sub-items in Item 3 : _____									

Attachment 1 (continuation)
Evaluation Checklist
Provincial / City Health Plan

Item 6. Involvement of Other Agencies/Sectors (15%).					Assessment Scoring and Rating				
Sub-item 1 Indication of other agency involvement in the plan, e.g., endorsement, letter of invitation, etc	1	2	3	4	5	(Average Rating for Item 1 _____) x (0.20) = Score for Item 1 = _____			
Sub-item 2 Indication of other agency participation during pre-planning and planning activities in the plan, e.g. consultative workshop, community diagnosis	1	2	3	4	5	(Average Rating for Item 2 _____) x (0.15) = Score for Item 2 = _____			
Sub-item 3 Indication in the plan, the involvement of Provincial Department including	1	2	3	4	5	(Average Rating for Item 3 _____) x (0.20) = Score for Item 3 = _____			
						(Average Rating for Item 4 _____) x (0.15) = Score for Item 4 = _____			
						(Average Rating for Item 5 _____) x (0.15) = Score for Item 5 = _____			

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