JAPAN INTERNATIONAL COOPERATION AGENCY(JICA)

DEPARTMENT OF HEALTH, REPUBLIC OF THE PHILIPPINES

BASELINE, PROJECT FINDING AND PREPARATION STUDY FOR JICA'S ASSISTANCE IN HEALTH SECTOR IN THE PHILIPPINES

FINAL REPORT

DECEMBER 2004

SYSTEM SCIENCE CONSULTANTS INC.

This Report contains the recommendation of projects,
which the Study Team has identified and prepared,
based on its own analysis of data and information.

The recommendation is therefore
strictly of the consultants' opinion and not of JICA's.

Baseline, Proejct Finding and Preparation Study

For

JICA's Assistance in Health Secotr in the Philippines

Final Report

Composition of Final Report

1. Final Report	This Volume
2. Final Report Summary	Separete Volume
3. Final Report (Baseline Data)	Separate Volume

PREFACE

The government of Japan formulated the “Country Assistance Plan (CAP) for the Philippines (2000)” and set directions of its assistance in accordance with the “Medium-Term Philippine Development Plan”formulated by the government of the Philippines. The CAP focused on four priority areas including “Mitigaion of disparities (alleviate poverty and mitigate regional disparities), as one of the priority issues of which, “Improvement of health care services” was selected to be solved.

The health sector working team of the Japanese ODA Task Force has discussed structures of programs and prepared “Japan’s ODA Basic Policy to the Philippines Health Sector “ in July 2004. In line with the policy, Japan International Cooperation Agency (JICA) has conduct this study in order to promote fomulation of projects..

JICA selected and dispatched the study team headed by Mr. Shuji Noguchi of System Science Consultants Inc. from September 2004 to December 2004. The team held discussions and interviews with the officials and organizations concered of the Philippines and Japan, and made a comprehensive analysis of data including statistics and indicators, current situations and issues extracted though workshops and the result of field surveys. Upon returning to Japan, the team conducted further studies and prepared this final report.

I hope that this report will be a useful basis for JICA’s assistance in Health Sector of the Philippines. Finally, I wish to express my sincere appreciation to the officials concerned of the Government of the Republic of the Philippines for thier close cooperation extended to the team.

December, 2004

Eiryo SUMIDA
Vice-President
Japan International Cooperation Agency

Letter of Transmittal

We have completed and are very much pleased to submit herewith the Report of Baseline, Project Finding and Preparation Study (the Study) for JICA's Assistance in Health Sector in the Philippines.

This Report has been prepared by the consultants' team (the Study Team) of System Science Consultants, Inc., based on the contract with the Japan International Cooperation Agency (JICA), for the Baseline, Project Finding and Preparation Study (the Study) for JICA's Assistance in Health Sector in the Philippines.

This Report gives first the overview of health sector in the Philippines including current health status, health sector development policies, achievement of sector reforms and donor's assistance along with the government policy, and next describes the health situation specifically in 3 Regions of Cordillera Administration Region (CAR), Bicol (Region V) and Eastern Visayas (Region VIII). Finally, the Report presents the outline of projects which were identified and designed for the JICA's assistance in the health sector of 3 Regions, based on the analysis of information obtained through the field visits and baseline data.

During the course of data and information collection, the Study Team was given full support and guidance from the offices of Department of Health (DOH), at central, Regional and Provincial levels, as well as the other government offices inclusive of LGUs, NEDA, DOF NSCB, PHIC, and the health facilities of hospitals, RHUs and BHSs in 3 Regions. The Team was also provided by actively supporting donors with valuable information of their activities and advices based on their learning. The Team would like to express firstly, its sincere gratitude and appreciation to Honorable Undersecretary Atty. Alexander A. Padilla, and all the officers of LGU, DOH, NEDA, DOF NSCB, PHIC, and also special thanks to the representatives and friends of international and bilateral donors assisting the Philippines in the health sector.

This Report contains the recommendation of projects, which the Study Team has identified and prepared, based on its own analysis of data and information. The recommendation is therefore strictly of the consultants' opinion and not of JICA's.

Again we thank to all parties supporting our Study, and expect that the outputs of the Study would be of assistance to the further promotion of the Philippines health sector reform and the future development assistance of JICA.

December 2004

System Science Consultants Inc.
Study Team
Team Leader

COLLECTION OF PHOTOGRAPHS

Workshop at DOH, Metro Manila on Oct. 15, 2004

Workshop at DOH, Metro Manila on Oct. 15, 2004

Workshop at CHD, Baguio on Oct. 19, 2004

Workshop at CHD, Baguio on Oct. 19, 2004

Workshop at CHD, Legaspi on Oct. 26, 2004

Workshop at CHD, Legaspi on Oct. 26, 2004

COLLECTION OF PHOTOGRAPHS

Workshop at CHD, Tacloban on Nov. 3, 2004

Workshop at CHD, Tacloban on Nov. 3, 2004

Flora District Hospital in Apayao Province, CAR

Accreditation by PHIC (Primary Level)
at Flora District Hospital, Apayao Province, CAR

Far North Luzon General Hospital & Training Center in Apayao Province, CAR

Medicare Community Hospital in Abra Province, CAR

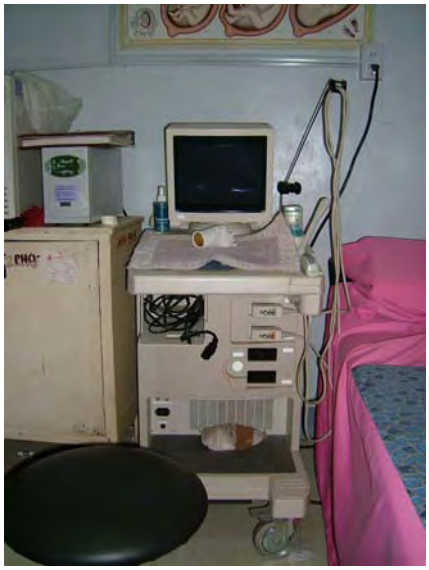
COLLECTION OF PHOTOGRAPHS

X-ray Machine donated by Japan's Grant Aid (1992) at Abra Provincial Hospital, CAR

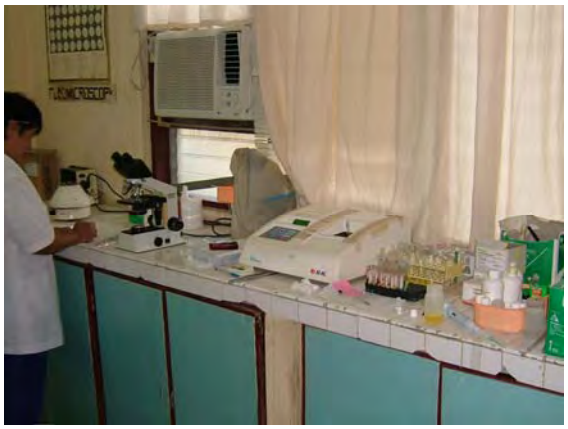
Naguey BHS in Benguet Province, CAR

Old delivery Table at Pantao District Hospital, Albay Province, Region V

BHS in Masbate Province, Region V



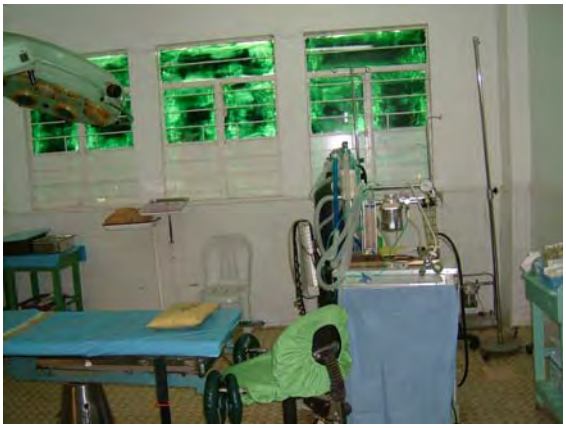
Ultrasound Machine donated by UNICEF at Masbate Provincial Hospital, Region V



Laboratory at Masbate Prpvincial Hospital, Region V

COLLECTION OF PHOTOGRAPHS

Health Center (RHU) in Tacloban City, Region VIII



Surgical Room at Leyte Provincial Hospital In Northern Leyte, Region VIII

Biliran Provincial Hospital, Biliran Province, Region VIII

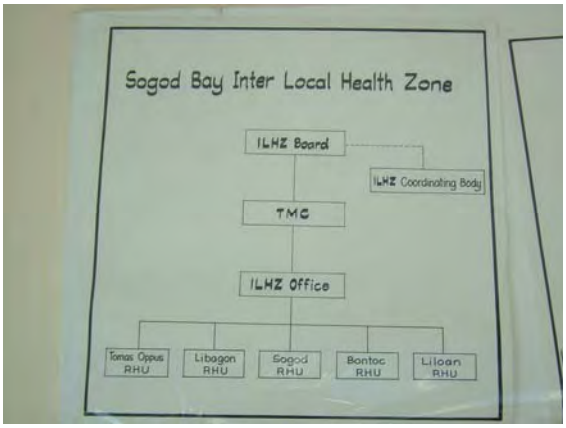
Emergency Room at Biliran Provincial Hospital

Sogod District Hospital, Southern Leyte, RegionVIII

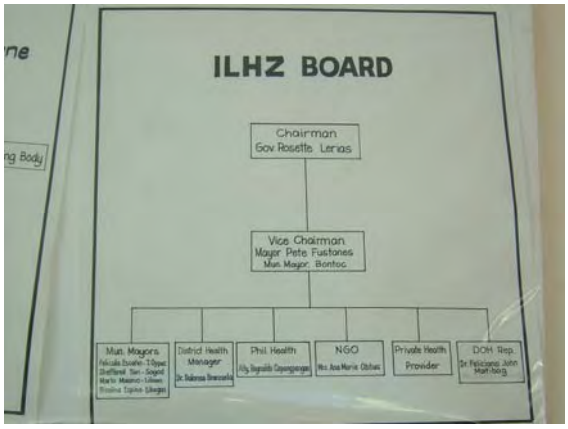
Sogod RHU in the same premise of Sogod District Hospital

COLLECTION OF PHOTOGRAPHS

Inter-Local Health Zone (ILHZ) Office
at Sogod District Hospital

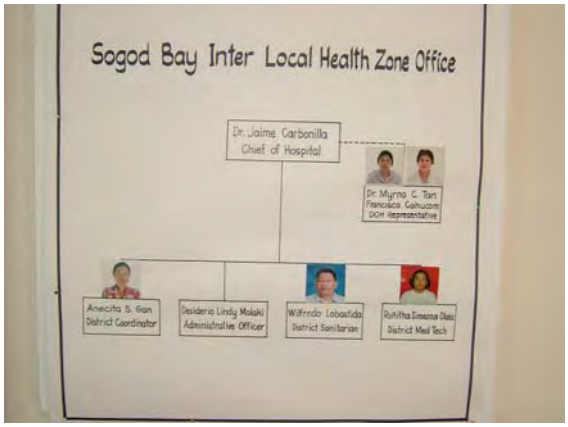


ILHZ Overall Organization Chart, Sogod Bay



ILHZ Board Organization Chart, Sogod Bay

TMC (Technical Management Committee)
Organization Chart, Sogod Bay



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LIST OF ACRONYMS

ADB	-	Asian Development Bank
AusAID	-	Australian Agency for International Development
BEmOC	-	Basic Emergency Obstetric Care
BFAD	-	Bureau of Food and Drugs
BHDT	-	Bureau of Health Devices and Technology
BIHC	-	Bureau of International Health Cooperation
BHS	-	Barangay Health Unit
BHW	-	Barangay Health Worker
BLHD	-	Bureau of Local Health and Development
CAR	-	Cordillera Autonomous Region
CBHP	-	Community Based Health Program
CBMIS	-	Community Based Monitoring and Information System
CBR	-	Crude Birth Rate
CDF	-	Countrywide Development Fund
CDR	-	Crude Death Rate
CEmOC	-	Comprehensive Emergency Obstetric Care
CFEH	-	Center for Family and Environmental Health
CHD	-	Center of Health and Development
CHO	-	City Health Office
CHW	-	Community Health Worker
CIDA	-	Canadian International Development Agency
CIDD	-	Center for Infectious and Degenerative Diseases
COA	-	Commission on Audit
CPG	-	Clinical Practice Guidelines
CPH	-	Community Primary Hospitals
CS	-	Convergence Site
CVD	-	Cardio Vascular Disease
DA	-	Department of Agriculture
DBM	-	Department of Budget and Management
DENR	-	Department of Environment and Natural Resources
DH	-	District Hospital
DHB	-	District Health Board
DHS	-	District Health System
DOF	-	Department of Finance
DOH	-	Department of Health
DSWD	-	Department of Social Welfare and Development
EmOC	-	Emergency Obstetric Care
EPI	-	Expanded Program on Immunization
EU	-	European Union
FHSIS	-	Field Health Service Information System
FP	-	Family Planning
GFATM	-	Grobal Fund to Fight AIDS, Tuberculosis and Malaria
GIDA	-	Geographically Isolated and Disadvantage Areas
GOP	-	Government of the Philippines
GTZ	-	Geslleschaft für Tecnische Zusammenarbeit (German Technical Cooperation)
HDI	-	Human Development Index
HDB	-	Health District Board

HIV/AIDS	-	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HP	-	Health Passport
HPDPB	-	Health Policy Development and Planning Bureau
HR	-	Hospital Reform
HRP	-	Health Reform Program
HSDP	-	Health Sector Development Project
HMIS	-	Health Management Information System
HSRA	-	Health Sector Reform Agenda
HSRP	-	Health Sector Reform Project
HSRP-MU	-	Health Sector Reform Project Management Unit
HSRTAP	-	Health Sector Reform Technical Assistance Project
ICHSP	-	Integrated Community Health Service Project
IEC	-	Information Education Campaign
IHIS	-	Integrated Hospital Information System
IMR	-	Infant Mortality Rate
ILHZ	-	Inter Local Health Zone
IPHO	-	Integrated Provincial Health Office
JICA	-	Japan International Cooperation Agency
JBIC	-	Japan Bank for International Cooperation
KfW	-	Kreditanstalt fur Wideraufbau
LCE	-	Local Chief Executive
LGUs	-	Local Government Units
LHAD	-	Local Health Assistance Division
LHS	-	Local Health System
MCH	-	Maternal and Child Health
MHO	-	Municipal Health Office
MMR	-	Maternal Mortality Rate
MPDC	-	Municipal Planning and Development Council
MOA	-	Memorandum of Agreement
NCDPC	-	National Center for Diseases Prevention and Control
NCHFD	-	National Center for Health Facility Development
NCR	-	National Capital Region
NEC	-	National Epidemiology Center
NEDA	-	National Economic Development Authority
NGO(s)	-	Non-Governmental Organizations
NSCB	-	National Statistical Coordination Board
NSO	-	National Statistics Office
OFW	-	Overseas Filipino Workers
OPD	-	Out-patient Department
OWWA	-	Overseas Worker’s Welfare Agency
PH	-	Provincial Hospital
PHIC/PhilHealth	-	Philippine Health Insurance Corporation
PHN	-	Public Health Nurse
PHO	-	Provincial Health Office
POPCOM	-	Population Commission
PPHP	-	Priority Public Health Program
QA	-	Quality Assurance
RHU	-	Rural Health Unit
SS	-	Sentrong Sigla
STI	-	Sexually Transmitted Infection

TB	-	Tuberculosis
TBDOTS	-	Tuberculosis Daily Observation Treatment, Short-course
TMC	-	Technical Management Committee
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Populations Fund
UNICEF	-	United Nations Children’s Fund
USAID	-	United States Agency for International Development
WB	-	World Bank
WHO	-	World Health Organization

Baseline, Project Finding and Preparation Study
for
JICA's Assistance in Health Sector in the Philippines

Final Report

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Chapter 1 Objective and Activities of the Study

1.1 Japan's ODA Basic Policy to the Philippines Health Sector

In July 2004, "Japan's ODA Basic Policy to the Philippines Health Sector" was prepared by the Japan's ODA Task Force. The outline of the basic policy is as follows.

(1) Objective

Improvement of health status in the Philippines and alleviation of cross-boarder public health risks such as infectious diseases.

(2) Priory issues

a. To strengthen the infectious diseases control

- Infectious diseases with significant economic and social impact such as tuberculosis
- Public health crisis such as SARS and avian flu epidemic

b. To improve maternal and child health

- Reduction of maternal and child mortality
- Improvement of health status of women and child

c. To improve local health system

- Improvement of physical and financial access to and quality of health services

d. To reduce risk factors of lifestyle related disease

- Analysis of present situation and continued dialogue for future direction of assistance

(3) Priority geographical area

Discussion will be continued to identify specific geographical areas with low health status to mitigate disparities in parallel with assistance to national level.

1.2 Objective of the Study

The objective of the Study is to facilitate identification and formulation of technical assistance project(s) by JICA, which could contribute to control of infectious diseases, improvement of mother and child health, reduction of risk factors for life-style diseases, and strengthening of rural health systems, either combined or separately, with geographical attention in CAR, Region V and Region VIII, in line with the "Japan's ODA Basic Policy to the Philippines Health Sector" announced in July 2004 with the initiative of ODA Task Force of Japan.

1.3 Activities of the Study

(1) Overall situation analysis of current health sector in the Philippines including donor assistance.
(2) Collection and analysis of baseline data on health status and health services.
(3) Collection and analysis of baseline data on public health facilities in 3 Regions.
(4) Collection and analysis of baseline data on Inter-Local Health Zone (ILHZ) in 3 Regions.
(5) Collection and analysis of information on priority public health programs in 3 Regions.
(6) Review of pending proposals
(7) Identification and formulation of possible technical assistance project(s).

The Study approach, schedule and team members are shown in Annexes A and B.

For collecting information of DOH policy and programs together with the achievements, a workshop was held in Manila on October 15, 2004 with the attendance of Undersecretary of Health, Mr. Alexander A. Padillia. The division chiefs of DOH, their staffs and a PHIC representative also attended. The Study Team presented the Inception Report to DOH and explained the activities and approach of the Study, while the division chiefs of DOH and the PHIC representative outlined their activities and accomplishments.

In Manila, the Study Team collected data and information from NEDA, DOF, NSCB, PHIC, as well as bilateral donors and international agencies.

In order to study the actual condition in 3 Regions, the Team conducted a survey in Baguio, Apayao, Alba and Benguet of CAR, Legaspi, Camarines Sur, Naga, Albay and Masbate of Region V, and Tacloban, Leyte, Biliran, Eastern Samar and Southern Leyte of Region VIII. During the field survey, data and information were collected from LGUs, hospitals, RHUs and BHSs. Respective governors, mayors, LGU officers, provincial and municipal health officers were interviewed, DOH-Representatives, doctors, nurses, midwives and other health workers. The survey focused on the progress of organization and operation in Inter-Local Health Zone (ILHZ) of each Province. List of major interviewees is presented in Annex C.

At each capital of the three Regions, PCM workshops were held; on October 19 at Baguio, October 26 at Legaspi, and November 3 at Tacloban. The workshop was intended to identify the problems and objectives by stakeholders in the health sector, in each province of the Region. The details of workshop are shown in Annex L.

All data and information collected in Manila and in the field surveys were cross checked with the baseline data, which formed the basis of analysis for project identification. In the project identification, the Study Team has reviewed and considered the following pending proposals.

(1) Japan's Grant Aid for "Establishing and Sustaining Health Facilities as Centers for Wellness" submitted by DOH, Center for Health Development, CAR, dated August 19, 2002
(2) Japan's Grant Aid for "Urgent Strengthening of Health Delivery and Referral System in Eastern Visayas" submitted by DOH, dated May 2002
(3) Japan's Grant Aid for "Bicol Health Services Delivery Enhancement Project" submitted by DOH, Center for Health Development, Bicol, April 2003
(The proposal has not been endorsed by NEDA-ICC (Investment Coordination Committee) as of the date of this Report.)
(4) Technical Cooperation for "Strengthening the Management and Delivery of Integrated

MCH Services in Selected ILHZs in the Philippines" submitted by DOH, dated February 28, 2004

(5) Project type technical cooperation program (PTTCP) for "Community Health Promotion Project in the Province of Benguet", submitted by the Province of Benguet, dated May 2001 and currently being studied by JICA experts

Projects identified in the Study has been designed with due consideration of the above proposal in view of their objective, relevance, effectiveness, efficiency and sustainability.

Chapter 2 Health Sector in the Philippines

2.1 Demography

The total population of the Philippines, which was 36.7 million in 1970, has continued growth at an annual rate of more than 2% to reach 76.5 million in 2000 (National Statistical Office (NSO), 2001, Census of Population and Housing 2000). The National Statistics Coordination Board (NSCB) has estimated that the population will maintain an annual growth rate of close to 2% in the future, to reach 86.2 million in 2005 and 96.8 million in 2010. The level of population growth rate in the Philippines is relatively high and the population density is the highest in comparison to the neighboring countries. The population growth rate at this level could have an enormous influence on the Philippines economy, when the annual GDP growth rate in real terms has remained at 3-4%. The rate of the population under 15 years is particularly high (37.5%), with a lower rate of the population 60 years and over (5.5%). The urban population accounts for 61.0% of the total population, which could be one of major causes of high incidence of infectious diseases such as tuberculosis and rabies, endemic to the poor in urban areas (Table 2-1)[1].

Table 2-1 Comparative demographic indicators, The Philippines and neighboring countries (UN medium variant)

	Total Population[a] (mil)	Population Density[a] (km^2)	Urban Population[c] (%)	Population under 15 years[a] (%)	Population 60 years and over[a] (%)	Total Fertility Rate[a]	Population Growth Rate[a] (%)	Life Expectancy[b] (men/women)
	2003	2003	2003	2000	2000	00-05	95-00	2002
Philippines	79.9	267	61	37.5	5.5	3.2	2.03	65/72
Indonesia	219.8	115	44	30.9	7.6	2.4	1.4	65/68
Malaysia	24,4	74	59	33.7	6.5	2.7	2.44	70/75
Thailand	62.8	122	20	26.3	8.4	1.9	1.04	69/73
Vietnam	81.3	245	25	33.4	7.5	2.3	1.40	67/72

Source： a; United Nations (2003), World Population Prospects, the 2002 Revision
b; WHO (2003), World Health Report 2003
c; United Nations (2004), World Population Prospects, the 2003 Revision

Although the total fertility rate (TFR) shows a decreasing trend in comparison to neighboring nations, which have experienced a rapid demographic transition, the rate of decline is still slow and the level is still high (refer Table 2.1). NSO estimated TFR in 1996 was 3.7 (NSO, 1999, National Demographic and Health Survey 1998: NDHS98) and 3.5 in 2003 (NSO, 2004, National Demographic and Health Survey 2003: NDHS03). TFR is 3.2 for the years 2000-2005 according to the 2002 revision of UN medium variant. It shows a significant decrease from 6.0 for the years

[1] Figures appearing in the main text and those in the tables do not match, because those in the main texts are cited from data published by the government agencies in the Philippines and those in tables are cited from standardized data published by international organizations for comparison to neighboring countries.

1970-75. Nevertheless, TFR indicates a difference of about one compared to Indonesia and Vietnam and about 1.5 compared to Thailand. The total wanted fertility rate, which excludes all unwanted births, was estimated at 2.5 in 2003 (NSO, 2004, NDHS03). This means that, on an average, women in the Philippines are giving birth to one more child than desired in their lifetimes. It also suggests that, with the expansion of quality reproductive health services, there is a room for reducing fertility rate based on reproductive rights, desire and free choice of individuals.

In addition to the above-mentioned population growth rate it can be mentioned that maternal mortality, infant mortality and under-five mortality remain at high level. Infant mortality rate was estimated at 30 and under-five mortality rate was estimated at 42 in 2003 (NSO, 2004, NDHS03). Although these mortality rates in the Philippines are on the decrease, these are not rapidly improving comparing to the neighboring countries which have achieved a more considerable improvement of mortality rates in the past 30 years (Table 2-2). Further efforts are required to achieve the Millennium Development Goals (MDGs), particularly in reducing children under five mortality rate by two-third by 2015 (Goal 4) and in reducing maternal mortality rate by three-quarters by 2015 (Goal 5).

Table 2-2 Comparative mortality indicators, The Philippines and neighboring countries

	Under 5 Mortality Rate[a] (per 1,000 live birth)		Infant Mortality Rate[a] (per 1,000 live births)		Maternal Mortality Rate (per 100,000 live births)	
	1970	2001	1970	2001	1990[b]	2000[c]
Philippines	90	38	60	29	280	200
Indonesia	172	45	104	33	650	230
Malaysia	63	8	46	8	80	41
Thailand	102	28	74	24	200	44
Vietnam	157	38	112	30	160	130

Source: a; UNICEF(2003), State of the World's Children, New York
b; WHO/UNICEF(1996), Revised 1990 Estimates of Maternal Mortality: A new Approach by WHO and UNICEF, Geneva
c; WHO/UNICEF/UNFPA(2003), Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA, Geneva

2.2 Health Status

2.2.1 Present Situation

Epidemiologic transition is rapidly underway in the Philippines; chronic diseases and life-style related diseases are the major diseases burden instead of infectious diseases and malnutrition. Although the mortality rate among children is on the decline, there are still a large number of children who die every year from preventable diseases such as respiratory infection, diarrhea and malnutrition. (Table 2-3)

Table 2-3 Top ten causes of mortality in the Philippines in 1998

Adult	Number	Per 100,000	Under 5	Number	Per 100,000
Heart diseases	55,830	76.3	Pneumonia	3,450	45.46
Vascular diseases	41,380	56.6	Diarrhea	1,251	16.48
Pneumonia	33,709	46.1	Unknown	655	8.63
Malignant Neoplasm	32,090	43.9	Congenital anomaly	621	8.18
Accident	29,874	40.8	Dengue fever	492	6.48
Tuberculosis	28,041	38.3	Sepsis	485	6.39
Chronic pulmonary diseases	14,228	19.5	Accident	450	5.93
Diabetes mellitus	8,819	12.1	Meningitis	386	5.09
Respiratory diseases	7,516	10.3	Measles	339	4.47
Renal diseases	7,453	10.2	Chronic pulmonary diseases	313	4.12

Source：Philippine Health Statistics, DOH web site accessed Oct., 2004

Regarding the double burden of disease, due to changes in risk factors in life style such as the over nutrition and smoking behavior, there are concerns that the problems will become more serious in the future. According to the 1998 National Nutrition Survey (NNS98) conducted by the Food and Nutrition Research Institute of Department of Science and Technology (DOST-FNRI), the prevalence of overweight (BMI of 125 or higher) among adults of 20 years and over has increased from 16.6% in 1993 to 20.2% in 1998, showing a rising tendency. The consumption rate of tobacco products among adults is the highest among the neighboring countries in the years 1992 to 2000 (United Nations Development Programme (UNDP), 2003, Human Development Report 2003). Although there has been a decrease among men of 15 - 24 years old (from 40.4% to 37.3%), it has been an increase among women of 15 – 24 years old from 4.2% to 6.3%. As chronic and life-style related diseases require longer treatment periods and higher medical costs, it is a concern that cost allocation to curative care could become larger in health expenditures, that will exert even greater pressure on resource distribution for public health services and preventive care. Although it will become more important for the people to control the daily life style to reduce the disease risks, the role of health service providers would have to be reviewed. Volunteer workers and midwives could be partners for health advisors.

The problem of under nutrition has a major negative effect on the health of children and mothers. Mortalities and poor health status among children due to infectious diseases and those among women due to pregnancy and delivery are often caused by under nutrition such as

anemia and lack of immunity. In particular, the prevalence of low birth weight (birth weight less than 2.5kg) in the Philippines is markedly higher than in neighboring countries (Table 2-4), and it is caused by under nutrition of mothers during their pregnancy. The problem of under nutrition during childhood (especially low birth weights) is known to be risk factors for a variety of malnutrition (obesity, etc.) and chronic diseases (diabetes, diseases of the heart, etc.) in later stages of life. Dealing with the problem of under nutrition of mothers and children in the Philippines might be one of an effective measure to deal with "double burden of diseases".

Table 2-4 Comparative nutrition status of the children, The Philippines and neighboring countries

%

	Low birth weight 1995-2000	*Stunting (0-5 year-old) 1995-2000*	*Under weight (0-5 year-old) 1995-2000*	*Wasting (0-5 year-old) 1995-2000*
Philippines	18	30	28	6
Indonesia	9	-	26	-
Malaysia	9	-	18	-
Thailand	7	16	19	6
Vietnam	9	36	33	6

Note: - Low birth weight - Less than 2,500 grams.
- Stunting (Moderate and severe): below minus two standard deviations from median height for age of reference population.
- Underweight (Moderate and severe): below minus two standard deviations from median weight for age of reference population
- Wasting (Moderate and severe): below minus two standard deviations from median weight for height of reference population.

Source : UNUCEF (2003), The State of the World's Children 2003

2.2.2 Infectious Diseases

(1) Tuberculosis

Tuberculosis is one of the most important infectious diseases in the Philippines and it is ranked as the sixth among all the total causes of mortality. According to WHO estimate in 2004 (WHO Report 2004: Global Tuberculosis Control), there are 251,000 new cases of tuberculosis every year in the Philippines. This ranks the Philippines as the eighth in the world in terms of the magnitude. WHO has listed Philippines is one of the 22 high-burden countries to tuberculosis. The estimated incidence per 100,000 populations is the third highest in Asia after Cambodia and Afghanistan and eleventh among the 22 high-burden countries (Table 2-5).

Table 2-5 Comparative tuberculosis incidence estimates and mortality caused by tuberculosis, The Philippines and neighboring countries

	New TB cases[a] (1000s) 2002	*Incidence[a] (per 100,000) 2002*	*Mortality rate[b] (per 100,000) 2001*
Philippines	251	320	56
Indonesia	557	256	68
Thailand	80	128	18
Vietnam	155	192	23

Source: a; WHO (2004), WHO Report 2004: Global Tuberculosis Control, Geneva
b; UNDP (2003), Human Development Report 2003, New York

(2) HIV/AIDS

Fortunately, the prevalence of HIV/AIDS is still low in the Philippines based on WHO classification. According to HIV/AIDS registration data of the Department of Health (DOH), the annual number of registered new seropositive cases till 1989 was less than 40 cases. In 1993, it exceeded 100 cases a year, and in 1998 it was 189 cases, and in 2003 with 193 cases; thus showing an increasing tendency. Since 1984, when HIV/AIDS registration was started, a cumulative total of 642 cases of infection were reported up to 2003; of that figure, 44% (250 persons) had died by the year 2003 (DOH, 2004, The 2003 Technical Report of the National HIV/AIDS/STI Surveillance System). Nevertheless, according to an estimate by UNAIDS, the number of persons infected with HIV is 9,400 persons, which indicates the prevalence of less than 0.1% for the general adult population (UNAIDS, 2002, The Report on the Global HIV/AIDS Epidemic 2002). However, according to a recent review by WHO and the DOH (WHO/DOH, 2002, Consensus Report on STI, HIV and AIDS Epidemiology), the number of infected persons was estimated at 6,002 cases in 2001. In the Philippines, a sentinel survey targeting the vulnerable groups in the major urban areas has been undertaken since 1993. The results of the survey up to 2001 as shown in Table 2-6 show that it remains at low prevalence even among the vulnerable groups.

Table 2-6 HIV prevalence among vulnerable groups in sentinel sites (1997-2001)

Vulnerable groups	*HIV prevalence*
Registered Female Sex Worker	1～3%
Female Sex Worker (freelance)	1% or less
Men Having Sex with Men	1～3%（surveyed only in Cebu and Quezon City）
Injecting Drug Users	1～3%（surveyed only in Cebu City）

Source: WHO/DOH (2002), Consensus Report on STI, HIV and AIDS Epidemiology

Nevertheless, according to DOH, 52% of women in the latest registered cases were housewives. The sentinel survey and various studies show that sexually transmitted infections such as syphilis, bacterial vaginitis, chlamydia, gonorrhea, etc. are on the increase. Particularly, in the case of chlamydia and gonorrhea, prevalence among young population is high. In order to maintain the present low infection rate of HIV/AIDS, preventive measures such as

information campaigns and reproductive health education aimed at young population will be of importance in the future. One of the recommended options for preventing the wide spread of HIV/AIDS, which are proved effective in the other Asian country, is to promote IEC and condom use focusing on the high risk groups such as sex workers and drug users.

(3) Malaria

As for malaria, the incidence per 100,000 persons in the year 2000 was 15, the mortality rate per 100,000 persons was 2 among all age groups, and it is estimated as 3 among children under-five years. There are differences among the provinces and 80% of all the malaria incidences are in 22 of the 79 provinces. These 22 provinces are mainly clustered in northern part of Luzon Island (CAR and Region 2), Palawan Island (Region 4), and Mindanao (Region 9, 10, 11, ARMM and Caraga) (Table 2-7).

Table 2-7 Comparative malaria status, The Philippines and neighboring countries in 2000

	Incidence rate (per 100,000)	*Mortality: total (per 100,000)*	*Mortality : under five (per 100,000)*
Philippines	15	2	3
Indonesia	920	1	0
Malaysia	57	1	1
Thailand	130	8	9
Vietnam	95	9	1

Source: UNDP (2003), Human Development Report 2003, New York

(4) Other Diseases

In addition to tuberculosis, malaria and HIV/AIDS, which are recognized as global issues, other infectious diseases considered serious by the DOH include rabies, dengue fever, filariasis, schistosomiasis, water and food-borne diseases and leprosy, and the new infectious disease as SARS (sever acute respiratory syndrome). As for rabies, according to international comparison statistics published by WHO, there is a marked delay in countermeasures compared to neighboring countries.

2.2.3 Life style related diseases

Seeding the top ten causes of mortality include heart diseases, vascular diseases, pneumonia, etc., the life style of Filipino like smoking and eating habit should be changed not to hamper the peoples health. IEC and campaign for for healthy life style are to be promoted.

2.2.4 Regional Differences

In the Philippines the health status in regard to the regional differences and differences according to socioeconomic status are extremely large; therefore, the national average does not represent the real situation in whole country. In particular, as presented in the table below, infant mortality rates and maternal mortality rates show large differences among the provinces

and regions. One of the causes is the gap in quality and quantity of the health services provided among the areas. As a result of the Local Government Code enacted in 1991, large part of executive powers has been devolved to local government units (LGUs) in health sector; however, the LGUs do not have the sufficient financial and human resources and systems to carry out public administration. These problems and issues cause the regional gap of quality and quantity of healthcare services and access to the services.

Table 2-8 Regional differences on TFR, child mortality and maternal mortality

	*TFR[*1] (women age 15-49 years)* *2003*	*Neonatal mortality rate[*1]* *(per 1,000 live births)* *2003*	*Infant mortality rate[*1]* *(per 1,000 live births)* *2003*	*Under-5 mortality rate[*1]* *(per 1,000 live births)* *2003*	*Maternal mortality rate[*2]* *(per 1,000 live births)* *1995*
Philippines	3.5	13	30	42	180
NCR	2.8	15	24	31	119
CAR	3.8	6	14	34	193
Region I	3.8	19	29	39	161
Region II	3.4	17	28	35	191
Region III	3.1	15	25	31	171
Region IVa	3.2	17	25	31	139
Region IVb	5.0	18	44	68	-
Region V	4.3	19	28	43	166
Region VI	4.0	22	39	50	184
Region VII	3.6	18	28	39	158
Region VIII	4.6	24	36	57	190
Region IX	4.2	6	27	43	200
Region X	3.8	24	38	49	225
Region XI	3.1	18	38	49	160
Region XII	4.2	15	27	37	187
Caraga	4.1	21	35	49	-
ARMM	4.2	18	41	72	320

Source: *1: NSO (2004), National Demographic and Health Survey 2003
*2: NSCB (2004), 2004 Philippine Statistical Yearbook
(estimate by NSCB Technical Working Group on Maternal and Child Mortality)

Differences of health status according to socioeconomic status are also large as shown in the following table. TFR shows negative associations with wealth quintiles, i.e., women in wealthier household have fewer children than those in poorer households. Mortality rates of infant and children in the lowest quintile are more than twice as high as those in the wealthiest ones.

Table 2-9 Differences on TFR and child mortality according to wealth index quintiles[2] in 2003

Wealth quintiles	*TFR*	*Infant mortality rate*	*Under-5 mortality rate*
Lowest	6.5	48.8	79.8
Second	4.7	39.2	60.5
Third	3.6	33.7	49.7
Forth	2.9	24.9	33.4
Highest	2.1	20.9	29.2

source： NSO (2004), National Demographic and Health Survey 2003

2.3 Health expenditures and finance

2.3.1 Present Situation

According to the National Health Account for 2004 (NSCB, 2004), the Filipinos spent a total of 115.4 billion pesos (1,435 pesos per person) in 2002 for health expenses; a decrease by 1% of the total budget compared to the previous year. In comparison with the GNP, the figure has been decreasing from 3.5% in 1997, to 3.3% in 2001 and to 2.7% in 2002. A breakdown to source of funds shows 14.5% from the central government and 15.4% from the local governments, therefore the total of about 30% of health expenditure is covered by the government fund. A decrease of the proportion of central government expenditure and an increase in the local governments' expenditure is a major trend in the health finances in the Philippines, since the enactment of the Local Government Code. The proportion of the local government expenditure exceeded to that of central government's in 2001. Although the total budget of central and local governments had decreased by 18% in 2002compared to the previous year, the financial source from social insurance increased 14%.

The share of private sector expenditure is the largest (59.5%), which includes out-of-pocket expenditure (47.5%) borne by individuals. Although it is not as high as in Indonesia and Vietnam, health expenditure burden on individuals in the Philippines is one of the serious issues.

Table 2-10 Comparative national health accounts, The Philippines and neighboring countries (2001)

	Total expenditure on health as % of GDP	*Per capita total expenditure on health (international dollar)*	*General government expenditure on health as % of total expenditure on*	*Social security expenditure on health as % of general government expenditure on*	*External resources for health as % of total expenditure on health*	*Out-of pocket expenditure as % of total expenditure of health*

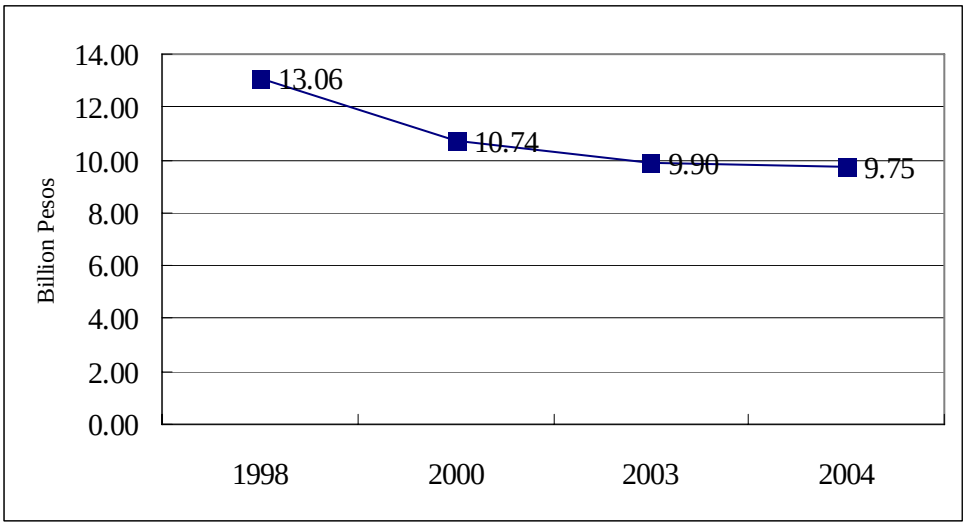
[2] A wealth index was constructed by assigning a weight or factor score to each household asset including household's ownership of a number of consumer items, such as radio, television, or car, as well as on dwelling characteristics and sanitation facilities, through principal components analysis. These scores were summed by household, and individuals were ranked according to the total score of the household in which they resided. The sample was then divided into quintiles—five groups with the same number of individuals each.

			health	*health*		
Philippines	3.3	169	45.2	17.2	3.5	42.9
Indonesia	2.4	77	25.1	7.5	6.5	68.8
Malaysia	3.8	345	53.7	1.1	0.0	43.0
Thailand	3.7	254	57.1	26.8	0.1	36.5
Vietnam	5.1	134	28.5	10.9	2.6	62.6

Source: WHO (2003), World Health Report 2003, Geneva

The total budget of the Department of Health (DOH) was 9.75 billion pesos (approx. 20 billion yen) in 2004. About 70% of total budget (6.76 billion pesos) was allotted to expenses for national hospitals, 1.37 billion pesos (14.1%) for public health programs, and 1.62 billion pesos (16.7%) for the food and drugs regulation, healthcare facilities and medical equipment regulation.

As for budgets in the local government units (LGUs) (province, city, municipality), the medical treatment (operation cost for public hospital, etc.) accounted for 7.88 billion pesos (31.6%), the public health services {mainly for personal expenses at Rural Health Units (RHUs), Health Centers and Barangay Health Stations (BHSs)} which came to 10.73 billion pesos (43.0%), and the other items amounted to 6.33 billion pesos (25.4%). This suggests that the actual budget allotted to public health programs is still limited. The budget for public health of the DOH has been declining for the last 5 years as shown in the table below. Many of the provincial governments, to which hospitals have been devolved as a result of decentralization, are already spending 30% of the total budget on health sector. It is difficult for them to increase the budget for health sector under current situation, therefore, financial sources other than the public finances such as health insurance system are necessary.



Source : DOH web site, accessed Nov. 2004

Figure 2-1 Budget for DOH from 1998 to 2004

2.3.2 Health insurance

The Philippine Health Insurance Corporation (PHIC), established as an agency of DOH based on the Republic Act (RA) 7875 in 1995, is intended to integrate the existing public health insurance systems. PHIC is expected to expand the social security coverage in health sector and support the financial resource for healthcare services to solve the budget constraint as described in the previous section (2.3.1).

Table 2-11 Number of beneficiaries, target and method of premium payment of national health insurance

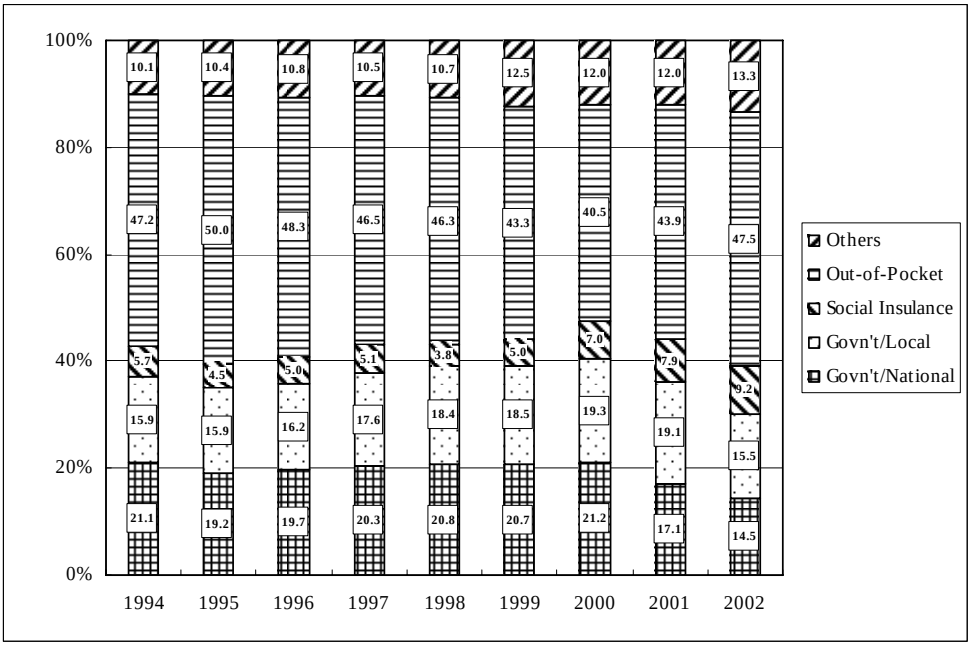
Programs	*Membership households (1,000)*	*Beneficiaries (1,000)*	*Target and method of premium payment*
Employed	7,580	30,786	Target: Employees in public and private organizations/ agencies/ companies. Premium payment is equally shared between employers and employees. The amount varies in accordance with salary of members. (The Premium scale is under review to increase the sealing of salary standards, because the current system is advantageous to the rich.)
Individual	560	2,743	Target: independent entrepreneurs including OFW (overseas Filipino workers) Premium payment is made by the member themselves. The annual premium amount is 1,200 pesos per household.
Non-paying	110	153	Target: The retired who had paid premium for more than 10 years. Premium is free.
Sponsored	6,180	30,189	Target: Indigents identified by LGUs Premium payment is shared between national government and LGUs based on memorandum of agreement. (Initial shares for LGUs vary from 10% to 50% in accordance with their income class, and 50% each in the end.) The annual premium amount is 1,200 pesos per household.

Source: 2004 mid-term report, Philippines Health Insurance Corp., 2004

As shown in the above table, premium collection systems vary among the programs. The government of the Philippines is focusing on expansion of the coverage in the sponsored program with the aim to cover 25% of total population. The membership, which was 1.75 million (estimated beneficiaries was 8.74 million persons) in 2003, had increased rapidly to 6.18 million (estimated beneficiaries was 30 million persons) as of the end of June 2004, according to an interim report for the year 2004. The total coverage ratio has also reached about 77% in June of 2004. Such rapid increase has achieved by the promotion campaign of the President, prior to the last presidential elections in May 2004, which provided membership card for indigents with one year free insurance premiums. Therefore, though achievement was remarkable, there is a concern about financial sustainability of such a rapid increase. As for

individually-paying, PHIC introduced a new scheme to increase the enrollment, the PhilHealth Organized Groups Interface (POGI) in 2003. Under this scheme, individual paying members enroll through the organized group such as cooperatives.

Data on changes over the years in total health expenditure and the share of finances shows that, since the establishment of PHIC in 1995, the outlays by PHIC have shown a marked increase, although the percentage it occupies in total health expenditures is still low at 9.2% as shown in the figure below. With the PHIC Insurance coverage remaining at low level, the national and local government fiscal support has been shaply declining in the increasing trend. As the PHIC insurance, especially for the sponsored package for the indigents, needs financial support of local government, after the rapid increase of coverage due to the promotion campaign for the last presidential election, is critical, even under the financial constraint of the government.



Source : NSCB (2003), 2003 Philippine National Health Account

Figure 2-2 Share of total health expenditure from 1994 to 2002

About 1,700 hospitals have obtained license from the DOH; of which about 1,500 facilities (public and private) have been accredited by PHIC. The facilities that have not yet been accredited are often located in inaccessible areas. In addition, about 400 rural health units have obtained PHIC accreditation.

Benefit payments to health facilities by PHIC are only made to accredited facilities by PHIC. Benefit payment consists of the following major packages.

Table 2-12 Benefit payment packages of PHIC

Package	**Outline of the package**
Benefit package	Hospitals are reimbursed the following costs for inpatients and outpatients with unit rates set by PHIC in accordance with the hospital category which is identified in accreditation; - Room and board, drugs and medicines, X-ray, laboratory, professional fees, operating room, surgeon & anesthesiologist and surgical family planning
Additional benefit package	- TB package Accredited DOTS centers are reimbursed the costs for TB medicines, professional fees and the routine laboratory tests with unit rates set by PHIC. - Normal spontaneous deliveries package Accredited hospitals, lying-in clinics and midwife clinics are reimbursed for the costs for the necessary prenatal services and deliveries of 1st and 2nd deliveries with unit rates set by PHIC. (It will be expanded to 4th delivery near future.) - Dialysis Accredited free-standing dialysis clinics are reimbursed for dialysis treatment with unit rates set by PHIC. - SARS package under consideration
Outpatient diagnosis package	Accredited RHUs receive capitation (300 pesos per year per sponsored member in the catchments area) for provision of services including consultations, urinalysis, chest x-ray, sputum microscopy, complete blood count, etc.

Source: PHIC (2000), The revised implementing rules and regulations of the national health insurance act of 1995 (Republic Act 7875)
PHIC (2003), Philippine Health Insurance Corporation Annual Report 2003
Interview at PHIC head office

As a result of accomplishment of HSRA, 25% of government hospitals have achieved full income retention and increased hospital income by 2003, however, only 30% of PHIC reimbursements were received by the government hospitals.(Hearing from DOH and PHIC head office)

2.4 Healthcare service providers

2.4.1 Health facilities

The facilities under the direct management of the DOH are 72 as shown in the following table and most of which are located in the national and/or provincial capitals.

Most of the provincial/ district/ community hospitals are managed by the provincial governments and that includes the costs of purchasing consumable supplies, maintenance/management costs of facilities, personnel costs and pharmaceuticals. As a general rule, the municipal governments manage the RHU (Rural Health Units) and the municipal governments or Barangay (villages) manage the BHS (Barangay Health Stations).

Therefore, the local government units are responsible for the provision of healthcare services in the front line.

Table 2-13 Public health facilities

Category	Number (As of 2003)	Administrative body or ownership
DOH retained hospitals	72 in total	DOH
Specialty Hospitals	4	
Lung Center of the Philippines		
National Kidney & Transplant Institute		
Philippines Children's Medical Center		
Philippine Heart Center		
Special Hospitals	7	
Research Institutes	2	
Medical Centers	22	
Regional Hospitals	19	
District Hospitals	6	
Sanitaria Hospitals	8	
Extension Hospitals	4	
Provincial/ District/ Community Hospitals	590	Provincial Government
Rural Health Units (RHUs)	1,879	Municipal Government
Barangay Health Stations (BHSs)	15,343	Municipal Government

Source: DOH website (http://www.doh.go.ph) accessed in December 2004

According to the Website of DOH, the public health facilities in the Philippines were composed of 662 government hospitals including DOH retained hospitals in 2003, 1,879 Rural Health Units (RHU) (2001), and 15,343 Barangay Health Stations (BHS). In addition there are 1,077 private hospitals.

The following table shows the distribution of licensed government and private hospitals by service capacity of health care. The licensed government hospitals were 661 and the licensed private hospitals were 1057 in 2003. About 40% of tertiary hospitals are located in NCR. There are no hospitals with a capacity for second level referral in CAR, Region II, VI and ARMM. About 70% of all the hospitals in Region XI are private primary hospitals or infirmary. In CAR, 60% of government hospitals are infirmary, it is 55% in Region V and 69% in Region VIII.

Table 2-14 Distribution of Licensed Government and Private Hospitals by Service Capability[*1] of Health Care as of 2003

Regend: G=Government Hospital; P=Private Hospital

Region	Birthing Home		Primary	Infirmary		Secondary	First Level Referral Hospital		Second Level Referral Hosp.		Third Level Referral Hosp.		Psychiatric Care Fac.	Total	
	G	P	P	G	P	P	G	P	G	P	G	P	P	G	P
NCR	3	11	0	7	21	0	15	51	4	10	25	31	5	54	129
CAR	0	0	0	18	10	0	11	8	0	0	1	1	1	30	20
Region 1	0	0	0	18	48	1	13	27	0	3	6	5	0	37	84
Region 2	0	1	0	20	28	0	15	15	0	0	2	1	0	37	45
Region 3	0	2	1	12	36	3	34	75	2	14	5	5	1	53	137
Region 4	0	3	0	47	52	1	45	90	3	23	2	8	0	97	177
Region 5	0	4	39	27	0	2	16	19	4	5	2	3	0	49	72
Region 6	0	0	0	20	5	0	29	5	0	0	4	9	0	53	19
Region 7	0	0	16	36	0	15	19	0	1	9	4	6	0	60	46
Region 8	0	2	0	34	12	0	13	10	1	1	1	1	1	49	27
Region 9	0	0	19	17	2	1	7	14	0	3	1	1	0	25	40
Region 10	0	0	7	17	33	2	8	15	3	3	2	5	0	30	65
Region 11	0	0	68	11	1	16	4	1	2	4	1	3	0	18	93
Region 12	0	0	1	14	41	1	7	22	1	4	1	3	0	23	72
CARAGA	0	0	0	23	19	0	8	3	3	2	1	1	0	35	25
ARMM	0	0	6	6	0	0	6	0	0	0	0	0	0	12	6
Total	3	23	157	327	308	42	250	355	24	81	58	83	8	662	1,057

Note: *1: Administrative Order 70-A-s., 2002-Service Capability

- Birthing Home - A health facility that provided maternity service on pre-natal and post-natal care, normal spontaneous delivery, and care of newly born babies
- Infirmary - A health facility that provided emergency treatment and care to the sick and injured, as well as clinical care and management to mothers and newborn babies
- First Level Referral Hospital - Non-departmentalized hospital that provided clinical care and management on the prevalent diseases in the locality
- Second Level Referral Hospital – Departmentalized hospital that provides clinical care and management on the prevalent diseases in the locality, as well as particular forms of treatment, surgical procedure and intensive care.
- Third Level Referral Hospitals - Teaching and training hospitals that provides clinical care and management on the prevalent diseases in the locality, as well as specialized and sub-specialized forms of treatment, surgical procedures and intensive care.
- Psychiatric Care Facility – It includes mental and custodial psychiatric care facilities.

Source: DOH website (http://www.doh.go.ph) accessed in December 2004

One of the major problems in the public health sector in the Philippines is the over utilization of large-scale hospitals and the under utilization of the smaller hospitals. For example, in Apayao Province in CAR, the bed occupancy rate in Far North Hospital (DOH retained hospital) is 135% in 2003, while it is only 14% in the neighboring district hospital. In Bicol Medical Center (DOH retained hospital), it is about 130% in 2003, while those in the neighboring district hospitals are around 10~40%. Even the DOH retained hospitals are licensed on tertiary level; many patients even with slight illness come directly to these hospitals. This situation is caused by insufficient human resources, especially specialists, and lack of specific equipment and facilities in the district hospitals. Lack of integrated planning for healthcare facilities improvement is also one of the reasons of mal-distribution of

healthcare services. This causes disorderly upgrading of RHUs to infirmaries by municipal governments or establishment of new district hospitals by politicians.

Hospital management rationalization as an autonomous facility for maximizing the limited resources has been proposed as solution to such problems in HSRA (Health Sector Reform Agenda) as described in the later section. As described in previous section (2.3.1), many of the provincial governments are in a situation where more than 30% of their local government budgets are allocated to health expenses including personnel, and maintenance and operation expenses. Hospital rationalization is, therefore, one of the preferable options for LGUs to improve finances as well as fiscal and managerial autonomy of the hospitals. Nevertheless, it involves intervention or disturbances from opponents such as municipal governments where the hospitals to be closed and/or political opposition is active. Such plans would thus require strong leadership of provincial governors.

2.4.2 Certification Systems（Sentrong Sigla; SS）

Along with the rationalization of hospitals and the trend towards fiscal and managerial autonomy mentioned in the previous section (2.4.1), an improvement in the capability of the facilities in the front line (especially Rural Health Units) to provide basic healthcare services has been proposed to improve efficiencies in the services delivery systems in the public health sector. The certification system, Sentrong Sigla (SS), which is been promoted by the DOH as part of Health Sector Reform Agenda (HSRA) as described in the later section, aims to improve and maintain the quality of healthcare services, especially in primary level services provided in Rural Health Units.

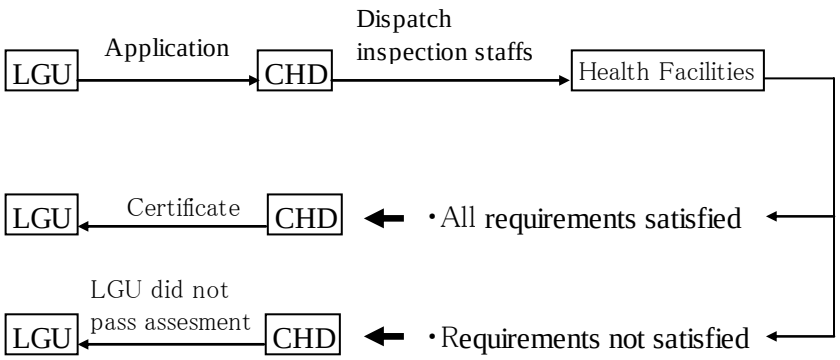
(1) The Sentrong Sigla certification is composed of three levels in Phase II.

Level 1: Basic certification	Minimum input, processes and output standards for integrated public health services for 4 core programs, facility systems, regulatory functions and basic curative services
Level 2: Specialty Award	Second level quality standards for selected core public health programs
Level 3: Awards for Excellence	Maintaining level 2 standards for the 4 core public health programs and Level 2 facility systems for at least 3 consecutive year

*4 core public programs

1) Safe Motherhood & Family Planning
2) Child Care
3) Prevention and Control of Infectious Disease
4) Promotion of Healthy Life Style

(2) The Sentrong Sigla certification is issued according to the following procedure.



Note:
If the non-fulfilled parts are improved and meet the requirement within 6 months, the certificate is issued thereupon, or otherwise new application must be submitted when LGU wants to apply to SS certificate.

Figure 2-4 Procedure of Sentrong Sigla Certification

(3) Inspection items for procedure of Sentrong Sigla certification

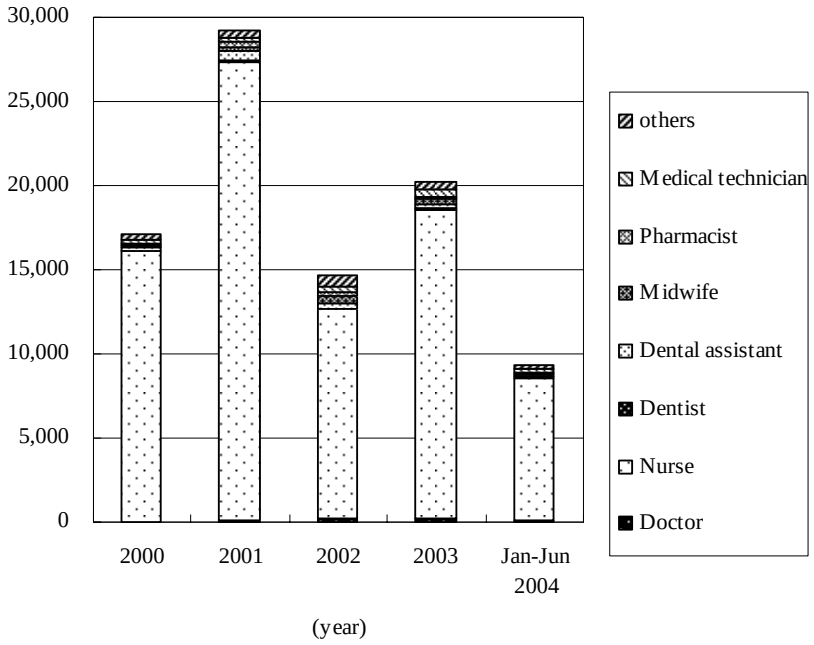
1) Resources (basic condition of facilities, electricity, supply and drain water, number of staff, materials, etc.), 13 items
2) Nature of health service activities (observation/survey of materials), 17 items
3) Nature of health service activities (interview), 11 items
4) Random detailed investigation on 6 items
   (Facility and Standards: 1 item, Integrated Public Health: 1 item,
   Curative Care and Regulatory: 4 items)

2.4.3 Health Workers

According to the National Statistics Coordination Board (NSCB), there were a total of 2,957 physicians, 1,958 dentists, 4,819 nurses and 16,612 midwives in the health service delivering system in the public sector as of 2001. In the villages, about 300,000 volunteers known as Barangay Health Workers (BHW) are working for various activities for primary health care services. The number of doctors including not registered doctors per 100,000 populations is estimated at 123 persons including in the private sector. Although this is not a small number, it remains rather difficult to grasp on the number of doctors that is actually working. There is a manpower shortage in terms of doctors and nurses in the rural and remote areas due to mal-distribution among the localities.

The Philippine government has been promoting overseas deployment as a means to obtain foreign currencies. The following figure shows the number of registered overseas Filipino workers (OFWs) deployed in the health sector abroad. Some 15,000 to 30,000 health workers

are contracted to work abroad every year.



Source: Philippines Overseas Workers Association

Figure 2-3 Number of registered health workers deployed in abroad (2000 – Jun 2004)

2.5 Health sector development policy

2.5.1 Decentralization

With the enforcement of the Local Government Code of 1991 since 1992, the authority to provide public health and primary care services have been devolved from DOH to Local Government Units (LGUs), along with the transfer of personnel in the local health offices and health facilities, records, assets, equipment, drugs, supplies, and materials in the above facilities. The set-up of governmental organizations and their respective responsibilities and functions in the health sector are shown below.

Administration Disposition	Number	Administrative Body for Health Sector
Central Government	1	Department of Health (DOH)
└ Region	17	Center for Health Development (CHD) (ARMM-DOH for ARMM region)
Province	79	Provincial Government Provincial Health Office (PHO) Provincial Health Board Health Committee of Sangguniang Panlalawigan
├ Component City	83	City Government City Health Office (CHO) City Health Board Health Committee of Sangguniang Panlungsod
└ Barangay	*1	(No administrative agency for health sector)
└ Municipality	1,499	Municipal Government Municipal Health Office (MHO) Municipal Health Board Health Committee of Sangguniang Bayan
└ Barangay	*1	(No administrative agency for health sector)
Highly Urbanized City	27	City Government City Health Office (CHO) City Health Board Health Committee of Sangguniang Panlungsod
└ Barangay	*1	(No administrative agency for health sector)
Independent Component City	5	City Government City Health Office (CHO) City Health Board Health Committee of Sangguniang Panlungsod
└ Barangay	*1	(No administrative agency for health sector)

*1: Total no. of Barangays is 41,972.

Source : NSCB Home Page

Figure 2-5 Administrative System in the Philippines

The Department of Health (DOH) controls the central administration and the Center for Health Developments (CHDs) in 17 regions. The main roles and responsibilities and organizational structure of the DOH are as follows.

［Role and responsibility of DOH］

- Health research and development
- Health surveillance and information system
- Resource generation for priority health services
- Technical assistance and logistics support to local health services
- Human resources capability building on health
- Health promotion and advocacy
- Direct service delivery for specialized health care
- Health care financing
- Health emergency preparedness and response
- Monitoring, assessment and evaluation of the health situation
- Quality assurance for health care
- Networking for sectoral actions on health

Source: DOH, National Objectives for Health 1999 - 2004

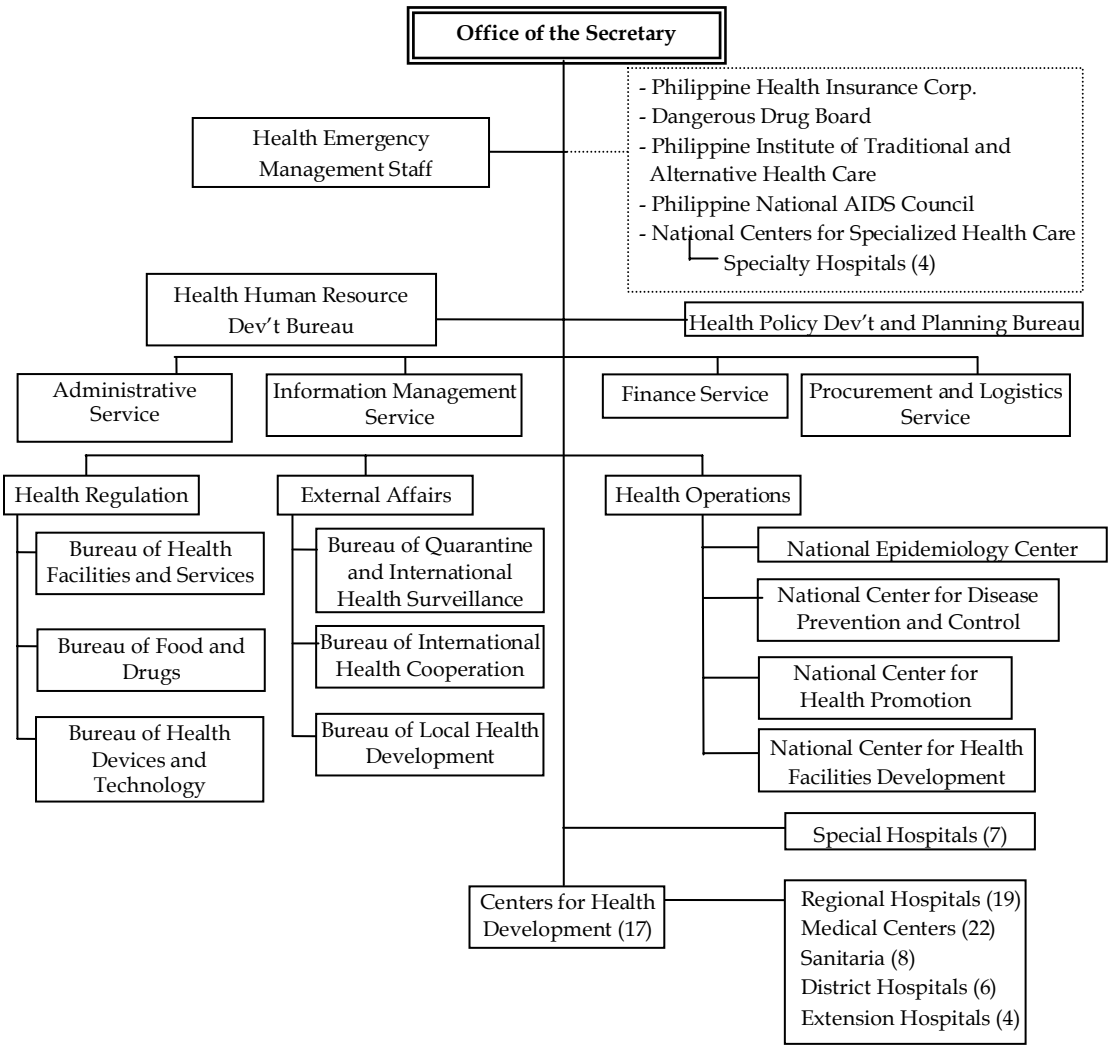


Figure 2-6 Organization of Department of Health

In accordance with policies and guidelines determined by DOH, CHD provides technical

and managerial information, technical and fiscal assistance to LGUs to supervise the implementation of health policy and programs. The organizational structure of CHD is shown below.

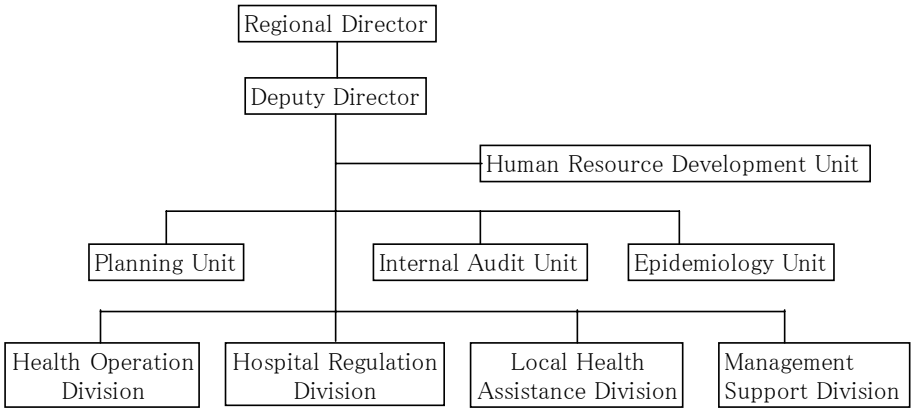


Figure 2-7 Organization of Center for Health Development

As a result of the Local Government Code enacted in 1991, large part of executive powers has been devolved to local government units (LGUs) in health sector as mentioned in the previous section (2.2.3). The main roles and responsibilities of the Local Government Units (LGUs) are as shown below.

［Roles and responsibility of LGUs］

- Formulation and enforcement of local ordinances related to health, nutrition, sanitation and other health-related concerns.
- Implementation of the following healthcare services in accordance with national policies, standards and regulations;
  - Public health programs and project on –
    - (i) Primary health care;
    - (ii) Maternal and child health care;
    - (iii) Dental health;
    - (iv) Family planning
    - (v) Nutrition
    - (vi) Environmental health;
    - (vii) Communicable and non-communicable diseases control; and
    - (viii) Such other public health programs and projects as appropriate to the need to the community.
  - Primary health services, otherwise known as basic health services, comprise the services delivered at health centers or rural health units and barangay health stations.
  - Secondary health services are medical services provided by some rural health units, infirmaries, district hospitals, and out-patient departments of provincial hospitals.
  - Tertiary health services include medical and surgical diagnostic, treatment and rehabilitative care undertaken usually by medical specialists in a hospital setting.

- Operation and maintenance of local health facilities (e.g., district and provincial hospitals under the provincial government; rural health units, health centers and barangay health stations under municipal or city government.
- Health human resources capability building.

Source: DOH, Rules and Regulation Implementing the Local Government Code of 1991
DOH, National Objectives for Health 1999 - 2004

DOH dispatches representatives to LGUs aiming to liaise with the DOH and CHD, provide technical assistance, and monitor and supervise the LGUs activities in health sector as shown in the following figure.

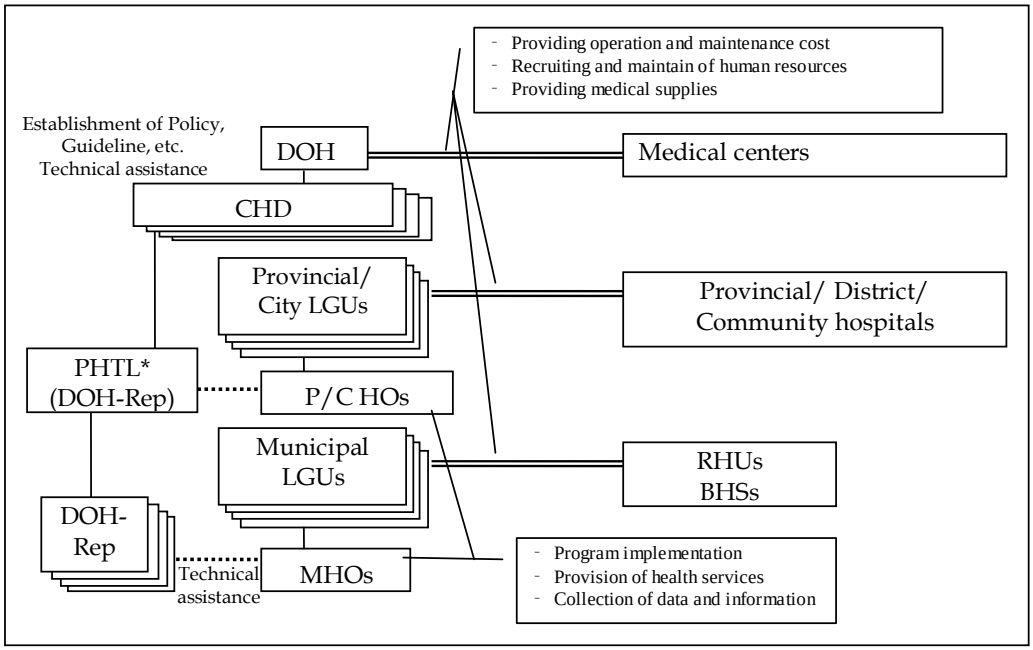


Figure 2-8 Health policy implementation systems after devolution

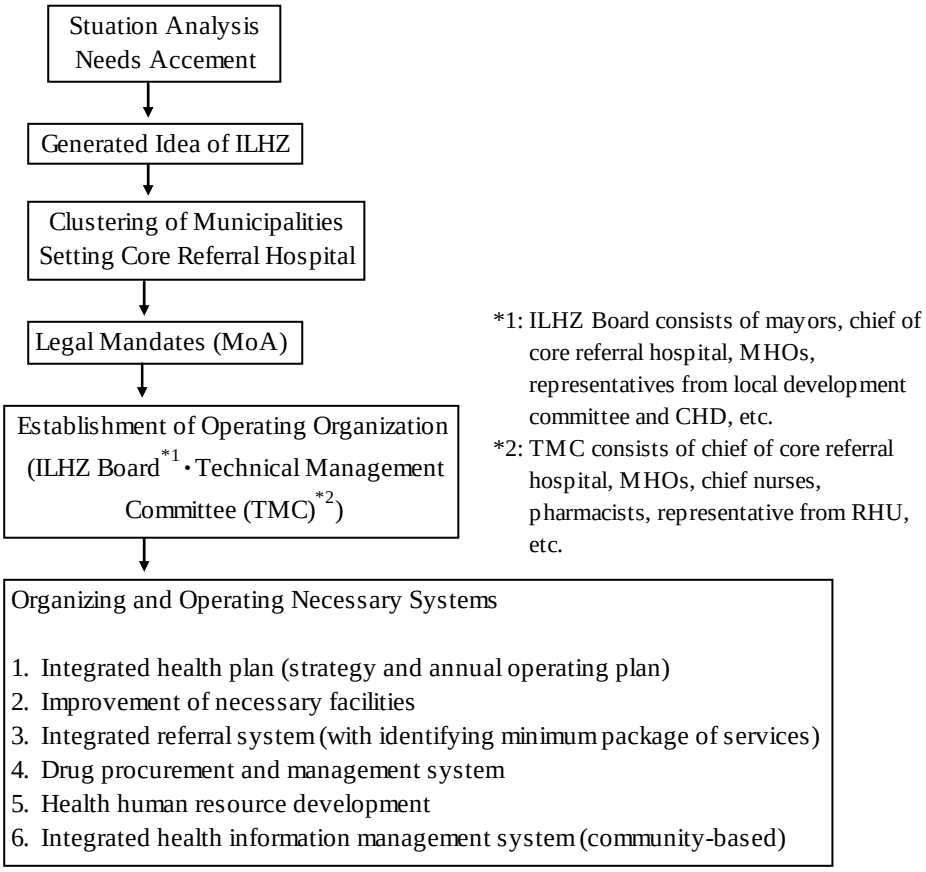
As a result of decentralization, there are regional differences in the health services due to the situation shown below, that lead to negative effects.

- Average population per city/municipality is less than 55,000 when the total population of the country is divided by the number of cities/municipalities, which is actually too small unit to function as one independent administrative body.
- Financial and human resources in local governments are generally limited, and effective and efficient resource management has not been practiced. It could affect negatively on the health service.
- The different quality and quantity of resources among the municipalities causing the regional gap in the health service.
- Coordination between central and local governments is not well functioning, in terms of reporting, monitoring, supervision, evaluation, and feed back.

2.5.2 Inter-Local Health Zone (ILHZ)

In order to solve the above concern, the cluster system of LGUs has been developing to mutually support and complement each other in providing healthcare services. This has been promoted since 1999 in the form of Inter-Local Health Zone (ILHZ) as a part of Health Sector Reform Agenda (HSRA) as described in the later section. In this system, several LGUs (municipalities and cities) in catchment area of a one core hospital establish a district health system to provide healthcare services efficiently. The district hospital, provincial hospital, or private hospita under the jurisdiction of the provincial government is shared as a core referral hospital in the ILHZ.

The general flow up to the founding of the ILHZ, in accordance with the handbook of DOH, is as follows.



Source: DOH (2002), A Handbook on Inter-Local Health Zones – District Health System in a Developed Setting,

Figure 2-9 Flow for organizing ILHZ

The DOH presently considers that the ILHZ is functioning when the following three systems are in operation in accordance with the report from CHDs based on the regular accomplishment reports from DOH-reps.

1) System for establishing the integrated strategic health planning
2) Integrated referral system identifying minimum package of services in each facilities (RHUs and hospitals)
3) Integrated health information management system

However, at present, definition of functioning ILHZs varies, in realty, among the regions or even among the provinces. Common perception and criteria for the “functioning ILHZ” is under consideration in DOH.

2.5.3 Information Management System

Data and information in health sector are gathered from routine reports from Barangay to provincial level and from various surveys. The major information systems and surveys related to health sector are as follows.

- Field Health Services Information System (FHSIS)
(National Epidemiology Center, Department of Health (NEC-DOH))

Data on demographic baseline, environmental health, fertility and mortality is reported monthly from rural health midwives in BHSs to public health nurses in RHUs/ Main Health Centers (MHCs). Fertility and mortality data is based on their accomplishment report and Local Civil Registration. RHUs/MHCs also receive data on notifiable diseases from all hospitals in the municipality/city. RHUs/MHCs consolidate the received data and report it to provincial health office and mayor quarterly and annually. Provincial health offices consolidate and computerize the data and submit it to the Centers for Health Development (CHD) quarterly.

After decentralization, DOH modified the system and focused on minimum indicators for smooth coordination with LGUs for information management system. In the previous system, the monthly report consisted of 24 pages, and about 500 indicators were collected. Currently, BHSs submit half a page of monthly report and RHUs submit 3 pages of quarterly report. Although LGUs can include additional data, it is not necessarily reported to DOH.

- Hospital Information System
(National Center for Health Facilities Development, DOH)

DOH retained hospital submits annual statistical reports on treatment cases and health care services provided in the hospitals. The data included are bed occupancy rate, total admissions, total discharges, hospital drugs, average length of stay, leading causes of discharges and leading causes of hospital deaths.

- National Epidemic Sentinel Surveillance System (NESSS)
(NEC-DOH)

About 200 sentinel hospitals submit reports on annual hospital active surveillance on 14 infectious diseases including EPI preventable diseases.

- National HVI/AIDS Sentinel Surveillance System (NHSSS)
  (NEC-DOH)

  Annual active surveillance is carried out on the high-risk groups (Registered Female Sex Worker, Female Sex Worker (freelance), Men Having Sex with Men and Injecting Drug Users) in 10 sentinel sites (cities of Angeles, Baguio, Cagayan De Oro, Cebu, Davao, General Santos, Iloilo, Pasay, Quezon and Zamboanga). The surveillance is composed of HIV serological surveillance and behavioral sentinel surveillance.

- National Demographic and Health Survey (NDHS)
  (Demographic and Social Statistics Division, National Statistics Office (DSSD-NSO))

  The survey is carried out every 5 years. Subjects are all female members of 15-49 years old in the sample household in the Labor Force Survey. The survey items include basic demography, fertility, family planning, infant and child death, maternal and child health, infant breastfeeding and supplementation and general health (infectious diseases, life-style related diseases, environmental health, traditional medicine and health facility utilization).

- Maternal and Child Health Survey and Family Planning Survey
  (NSO)

  The surveys are carried out every year except the year of National Demographic and Health Survey (NDHS). Subjects are 15-49 year-old women in the sample household in the Labor Force Survey, who have under-5 year-old children. The maternal and child health survey includes the data on maternal and child care (prenatal care, supplementation, immunization, etc.) and infant feeding and supplementation. The family planning survey includes the data on usage of family planning methods, source of contraceptive supply and high-risk fertility behavior.

Such data and information are important not only for the decision-making in policy and program planning but also for planning, monitoring and evaluation of donor's support, as well as for immediate countermeasures in case of epidemics of infectious diseases. Nevertheless, particularly since decentralization, schedule of data collection and under reporting is one of the major concerns in information management system in the health sector. As for the report-based information system such as FHSIS, the report preparation and submission are, sometimes, not carried out on regular basis because of time constraint of field health workers, and lack of management and supervision. As for sentinel surveillance, the data and information collected in the survey are not immediately analyzed and disseminated to users due to difficulty in data

collection caused by time-consuming and expensive process. It sometimes takes three years or more before survey results are released. Representativeness of the sample has also to be considered in the sentinel surveillance. For example, the geographic representation of sentinel hospitals in NESSS varies among the regions; in some regions, the data are obtained only from the hospitals in the province where CHD is located, while those are obtained from all the public and private hospitals in the other regions.

It has also been pointed out on the reliability of the indices mentioned in the Millennium Development Goals, particularly regarding maternal mortality rates and infant mortality rates. According to the National Statistics Office, these items should be added to the 2005 census to improve the reliability of data. However, implementation was cancelled for 2005 due to budget limitations.

2.5.4 Health Sector Reform Agenda (HSRA)

Health Sector Reform Agenda (HSRA) has been implemented by DOH since 1999 as a policy framework aiming to establish effective and efficient health system in current decentralization framework. HSRA involves a total promotion of reforms in the following five areas: hospital reforms, local health system reforms, public health reforms, health regulation reforms, and health financing reforms, as shown in the following table.

Table 2-13 Overview of Health Sector Reform Agenda

Five areas of health sector reform	*Departments and Agencies under DOH*	*Objectives*
Hospital Reforms	National Center for Health Facility Development (NCHFD)	Realize the improvement and efficiency of health service, and to reduce the financial burden of MOH through autonomy or self-dependent.
Local Health System Reforms	Bureau of Local Health Development (BLHD)	Promote the development of local health system by convincing local government units (LGUs) of a specific health zone or catchments area to network, cooperate and share functional health facilities and services among themselves
Public Health Reforms	National Center for Disease Prevention and Control (NCDPC)	Provide DOH with critical capacities to effectively perform its technical leadership in disease prevention and control through sustained funding for priority public health programs and effective local public health delivery system
Health Regulation Reforms	Bureau of Food and Drugs (BFAD) Bureau of Health Devices and Technology (BHDT)	Ensure the good quality and affordability of health products, pharmaceuticals, devices and facilities through the strengthening of DOH's regulatory mandate and the upgrading of its capacities to implement the same
Health Financing Reforms	Philippine Health Insurance Corp. (PHIC)	Expand the coverage of the National Health Insurance Programs (NHP) to effectively reduce the financial burden of health care of individual families through social risk-pooling and provide greater leverage with respect to the value-for-money benefit spending of health insurance

	funds generated.

Source: DOH (2003), Implementing the Health Sector Reform Agenda in the Philippines

The five reform areas are assigned to the responsible bureaus at the central level for implementation as shown in the above table. Health Policy Development and Planning Bureau (HPDPB) takes overall coordination and monitoring. HSRA convergence sites have been selected, where integrated package of HSRA is intended to be implemented. The resources necessary to ensure success in implementation such as technical and financial assistance of DOH are to be prioritized for the convergence sites.

In accordance with Administrative Order 37 of 2001, 65 provinces and cities as presented in Annex D were selected according to the following conditions in order to cover 30% of the total population. (Annex D)

- The governors and mayors have commitments on health sector reforms.
- The positive impact is expected to expand to the surrounding provinces.
- LGUs have a hand actively in programs of the DOH and PHIC (DOTS program, SS certification, PHIC sponsored program, etc.).

Nevertheless, due to limitations of budget and human resources, actual assistance from DOH has been limited to providing aid to a single Inter-Local Health Zone (ILHZ) per province in average. As a result, only 31 convergence sites have been initially organized by 2003.

Viewing the recent progress of ILHZ organization over the Regions, DOH revised its guidelines for selection standards and implementation of HSRA in the convergence sites by Administrative Order 174, 2004. The selection criteria in for convergence sites in the revised guidelines are as follows:

- Willingness of LGU to participate within the Health Sector Reform Agenda considering factors such as willingness to provide required counterpart resources, to enter into formal agreements between the LGUs including the private sector for networking, resources sharing and other inter-LGU Management Systems.
- Presence of local initiatives or start-up activities relevant to HSRA strategies, e.g., development of ILHZ, fiscal autonomy in local health facilities, improvements in enrollment of poor sponsored sector, drug management systems, etc.
- Relatively high level feasibility of success and sustainability considering factors such as capacity to enter loans, capacity to absorb investments and sustain the reform process
- Availability of funds from the government and external sources for capital investment requirements

The expected roles of the DOH, Centers for Health Development (CHDs), local government

units (LGUs), civil society and donors are mentioned in AO 174 as follows:

Department of Health (Central Office)

- Develop systems, policies and guidelines that will facilitate the implementation of HSRA, including the monitoring and evaluation of reform strategies.
- Develop the capacity of the CHD personnel in assisting the LGUs in implementing the HSRA at the local level

Center for Health Development

- Facilitate the implementation of procedural guidelines in the convergence sites, from ground working and situational analysis to finalizing the commitments of the key players (DOH, LGU, PHIC, private sector, NGOs, etc.,)
- Provide technical assistance to LGUs in selecting reform strategies
- Assist the LGUs in coordinating the actual implementation of the chosen reform strategies

Local Government Units

- Organize themselves into Inter-Local Health Zones that will manage the implementation of reform strategies
- Pass the necessary local legislation (ordinances, resolution, etc.,) to implement the reform strategies
- Provide the counterpart funds for implementing their investment plan

Civil Society

- Assist the LGUs in achieving their health objective
- Identify the health needs of the people and bring to the attention of the ILHZ managers
- Enhance accountability and transparency of ILHZ management

Donor Agencies

- Provide financial and technical assistance according to the investment plan developed for the convergence site

Health Sector Reform Agenda is being shared as a basic framework of health policies in the Philippines among the donors. United States Agency for International Development (USAID) involved in the initial stage with technical assistance for introducing the basic concept and implementing HSRA in the selected seven provinces and one city nationwide. Following this, German Technical Cooperation (GTZ) started technical assistance in Region VIII. In their assistance program, one ILHZ has been created in Southern Leyte province and there are plans

to expand to the other ILHZs in the Southern Leyte, and to start similar programs in Biliran and Eastern Samar provinces in 2005 as described in the later section (3.3). The World Bank is planning projects in four provinces and the ADB is also planning projects in five provinces for HSRA implementation support.

2.6 Donors' activities

In the Philippines, many donors are involved in health sector. To promote collaboration and coordination among the donors assisting health sector in the Philippines, informal donor meetings have been held regularly. The major donors attending these meetings and their activities are as shown in the table below. With progress of decentralization, almost all of the donors select LGUs as their targets, carrying out their support that will have an impact on both the central and the local governments. In accordance with the framework of HSRA promoted by the DOH, donors' supports are also requested by DOH to be prioritized to the convergence sites with a package assisting the successful implementation of HSRA.

Table 2-14 Major Donors Activities in Health Sector

Donor	Support of public health programs and NGO support, etc.	Support of Health Sector Reform Agenda
Bilateral		
GTZ		Support for HSRA implementation including social heath insurance, pharmacy financing system, implementing of local health system reform, hospital reform, training for health workers in RHU for curative care, laboratory services and pharmacy, and baseline monitoring system.
USAID	Local Enhancement and Development for Health (LEAD for Health): Support in improving capability of LGUs (municipal government) to procure and distribute commodities required for implementation of public health programs such as reproductive health, infectious diseases control (TB and HIV/AIDS) and maternal and child health (micronutrient supply): targets are 146 LGUs in initial fiscal year, with end figure of 530 LGUs.	
AusAID	Community–based malaria control, providing funds to UNICEF Country Program.	
CIDA	Tuberculosis control with NGO support.	
Multilateral		
WHO	TB prevention and care, malaria and parasitic disease control, expanded program on immunization (EPI) and maternal and child health.	

Donor	Support of public health programs and NGO support, etc.	Support of Health Sector Reform Agenda
UNFPA	Community empowerment and capability building of service providers for maternal heath, family planning, STI and violence against women (3 municipalities x 10 provinces) with 6th country program.	
UNICEF	Child-friendly movement including adolescent maternal health, under nutrition and micronutrient deficiency elimination and child health and sanitation under 6th country program (2005~2009) in 19 provinces and 5 cities.	
ADB	Women's health, tuberculosis control, integrated management of child illness (IMCI), and sexually transmitted infection (STI)	HSDP (Health Sector Development Project) aiming to support for HSRA implementation with emphasis on capability building and infrastructure improvement in selected 5 provinces, and program loan for HSRA.
EU		HSRA implementation support including technical assistance and budget support for DOH and LGUs.
World Bank	Providing facilities and equipment required for women's health and safe motherhood (introduction of programs in keeping with health sector reforms and Basic Emergency Obstetric Care (BEmOC) for primary facilities). Support of early childhood development. -WHSMP2: SM, FP, STI/HIV, ARH -ECCD	Health Sector Reform Project (HSRP) aiming to support of HSRA implementation including capability building for DOH, PHIC and LGUs in convergence sites.

Source: Interview survey with donors, DOH and CHDs

Among the varieties of assistance to health sector reform, there are ones for organization strengthening and capacity building in line with the MOH strcture, ones to include the building cinstruction and equipment procurement for sector reform, and the others. For the specific program support, may supports are extended for organization strengthening and capacity building for LGU and other parties concerned. The sturucture and capability of parties concerned in the health sector reform of the Philippines is expected.

As to the target site, there are donors such as NFPA and USAID which are focusing on the specific sites at the level of province and municipality, and others such as UNICEF which are supporting vertically from central level down to community level on the specific program. Although major concern is addressed to the importance of capacity building of LGUs because of the policy of national decentralization, supporting to improve the capcity of MOH and its Regional office are becoming more important among the donors.

Outline of activities and programs of major donors in health sector in the Philippines are as follows;

(1) WHO (World Health Organization)

WHO established a Philippine Representative Office in the DOH compound in 2002 to strengthen close cooperation with DOH. WHO provides the support programs through DOH and CHDs to LGUs with providing technical assistance to central and regional levels.

(2) The World Bank

Regarding support for the budgetary planning for HSRA implementation, the World Bank particularly recommends to allocate the budget for promotion of accreditation of PHIC and for establishment of the Drug Revolving Fund.

Management of program implementation at the provinces and cities is carried out via the DOH. In order to avoid an excessive burden on the DOH and the LGUs, one project is implemented per one province.

(3) EU (European Union)

Regarding support for HSRA implementation, framework and target areas of the projects are to be identified in early 2005. The EU also plans budget support for the DOH regarding improvement of primary facilities, and conducting technical assistance for capability building for policy implementation and donor coordination.

(4) UNFPA (United Nations Funds for Population)

In the 6th Country Program (2005-2009), target communities have been selected, considering the poverty situation. Program implementation was basically carried out by local governments and NGOs with the regular monitoring of program officer.

(5) GTZ (German Technical Cooperation)

GTZ has been making efforts to support HSRA implementation since 1999 and basically does not include the support for particular public health programs. Their geographical target is Region VIII. GTZ has offices in the DOH and CHD Region VIII and dispatch project coordinators to the target provinces during the period of implementation monitoring (See Chapter 3 regarding project implementation systems and contents). The support strategy and framework are identified through negotiation between GTZ and the recipient, by selecting from the list of overall support components based on the local needs and financial capabilities.

(6) USAID (United States Agency for International Development)

Regarding LEAD for Health, target LGUs were selected according to poverty and health indices, in consultation with regional technical assistance team consisting of CHD, PHIC regional office and POPCOM. Commitment of LGUs was also confirmed in project areas

identification. At the level of the DOH, technical working groups consisting of representatives from the DOH bureaus are organized to provide technical assistance for planning, monitoring and preparation of guideline. Field coordinators dispatched to CHDs cover maximum 30 municipalities. Service Institution/Organization (SIO) with selected members from NGOs, institutes and universities supervises and monitors the project implementation. Project strategy and component are to be identified by SIO and LGUs, selecting from the list of overall support components based on the local needs.

(7) UNICEF (United Nations Children's Fund)

UNICEF is preparing the 6th Country Program (2005-2009) including health sector. The focal areas are adolescent and maternal health, under nutrition and micronutrient deficiency elimination and control, and child health and sanitation in the health sector.

(8) ADB (Asian Development Bank)

ADB is preparing the HSDP (Health Sector Development Project) in 5 provinces, with the budget of approximately US$42 million. In addition to the above HSDP, ADB is studying the support in the fields of tuberculosis, reproductive health (women's health), child health (IMCI), STI and HIV/AIDS.

2.7 Japan's ODA

2.7.1 Japanese Assistance in the Past

Japanese government has been providing the assistance in the forms of grant aid and technical assistance in the health sector of the Philippines.

Assistance for priority public health issues has been carried out selectively with emphasis on the following; maternal and child health (improving EPI related diseases control such as polio and measles, strengthening maternal and child healthcare services in the particular program areas), infectious diseases control (improving tuberculosis and malaria control, improving prevention of HIV/AIDS and other STIs, improving schistosomiasis control, emergency countermeasures against SARS and other new infectious diseases, strengthening research functions for infectious diseases). As for improvement of hospitals and local health facilities, Japan has contributed to establish the outpatient division and to supply equipment to top referral hospitals located in the three main cities of Manila, Cebu and Davao, and also to supply euipment to top referral hospitals (total of 71 hospitals). It has also contributed to the construction of provincial hospitals with equipment, and as well as equipment for RHUs and BHSs in that province (Benguet Province). Other achievements include upgrading of

equipment and facilities of public health service providers including RHUs and BHSs in Region III.

In the area of health policy and regulations, Japan has continued support for the Bureau of Food and Drugs (BFAD).

Table 2-15 Major cooperation projects undertaken by Japanese Government in health Sector in the Philippines (as of Oct., 2003)

Project	Period	Scheme
Maternal and Child Health		
The project for measles control	2002	Grant Aid。
The project for poliomyelitis control	1967.5 - 1974.3	Project-type technical cooperation
Family planning	1974.7 – 1989.3	Project-type technical cooperation
Maternal and child health and family planning	1992.4 – 1997.3	Project-type technical cooperation
Maternal and child health and family planning, II	1997.4 – 2002.3	Project-type technical cooperation
UNFPA multi-bi cooperation	1996 - 2003	Medical equipment supply
Infectious Diseases Prevention		
1.Tuberculoses		
Project for establishment of the National Tuberculosis Reference Laboratory	2000	Grant Aid
The public health development project	1992.9 – 1997.8	Project-type technical cooperation
Tuberculosis control project in the Philippines	1997.9 – 2002.8	Project-type technical cooperation
Quality tuberculosis control programme	2002.9 – 2007.8	Project-type technical cooperation
2.HIV/AIDS		
The project for prevention and control of AIDS	1996.7 – 2001.6	Project-type technical cooperation
3.Malaria		
Malaria control	1997	Grant Aid
4.Other infectious diseases		
The Research Institute for Tropical Medicine	1979	Grant Aid
Improvement and expansion of the Research Institute for Tropical Medicine	1987	Grant Aid
Cholera eradication project	1967.11 – 1977.3	Project-type technical cooperation
Schistosomiasis research	1972.8 – 1981.3	Project-type technical cooperation
The Research Institute for Tropical Medicine	1980.10 – 1988.3	Project-type technical cooperation
Anti-SARS measures	2002	Medical equipment supply
Health facilities and equipment		
Equipment supply for regional hospitals equipment upgrading	1983	Grant Aid
Equipment supply for upgrading medical equipment of the National Cancer Center	1984	Grant Aid
Equipment supply for the upgrading medical equipment of the Philippine Children's Hospital	1986	Grant Aid
Construction of the out-patient department of the Philippine General Hospital	1987	Grant Aid
Equipment supply for the upgrading medical equipment of the Philippine Health Center	1987	Grant Aid
Project for the equipment upgrading of 21 provincial hospitals	1988	Grant Aid

Project	Period	Scheme
Project for upgrading medical equipment of 21 provincial hospitals	1991	Grant Aid
Project of the improvement of the facilities of the out-patient department of the Vincente Sotto Memorial Medical Center	1993	Grant Aid
Improvement of Health System of Benguet	1998, 1999	Grant Aid
Project for upgrading of facilities and equipment in Selected field health units	1999	Grant Aid
Project for construction and equipping of the Davao Medical Center	2000, 2001	Grant Aid
Health policy and regulation		
Equipment supply for the establishment of the Food and Drugs Laboratory	1985, 1986	Grant Aid
Food and Drugs Laboratory	1986.7 – 1993.7	Project-type technical cooperation
The project for preparation and publication of the Philippine Pharmacopeias	1999.3 – 2002.2	Project-type technical cooperation
The project for preparation and publication of the Philippine Pharmacopeias	2002.4 – 2005.4	Project-type technical cooperation

Source: ODA White Papers, Ministry of Foreign Affairs
JICA Annual Reports, JICA

Chapter 3 Baseline and Findings of Field Survey in 3 Regions

3.1 Cordillera Administrative Region (CAR)

3.1.1 Demography

The Cordillera Administrative Region (CAR) is located in northern part of Luzon Island with the land area of 18,293m^2. The region is composed of the Provinces of Abra, Apayao, Benguet, Ifugao, Kalinga, Mountain Province and the highly urbanized City of Baguio. The region's topography is dominated by mountains, a third of which are 1,000 meters above sea level. Road network within the region is not well developed. As the large part of inter provincial roads is unpaved mountainous roads, people has to take detours through other regions to go to neighbor provinces/ city.

The basic demographic data in each province/ city is shown in the following table.

Table 3-1 Demography of each province/ city in CAR

	*No. of Cities*1*	*No. of Municipalities*1*	*No. of Barangays*1*	*Total Population*3*	*No. of Households*3*	*Annual Pop. Growth rate*2*	*Poverty Incidence Rate in Population*4*	**Income class*5**
Year	2004	2004	2004	2002	2002	2001-02	2000	
Abra	0	27	303	215,441	40,237	1.27	58.6	4
Apayao	0	7	133	96,659	61,558	2.79	19.2	4
Benguet	0	13	269	353,752	17,528	1.83	45.1	3
Baguio City	-	0	*a)	302,104	61,142	n.a.	n.a.	1
Ifugao	0	11	175	173,975	30,858	1.27	58.6	4
Kalinga	0	8	152	177,065	27,192	2.79	19.2	3
Mt. Province	0	10	144	147,471	30,296	1.83	45.1	5
Total in CAR	1	76	1,176	1,466,467	268,811	2.19	38.0	

Note: a) Data is included to Benguet.

Source: *1- 2004 Philippine Statistical Yearbook, NSCB, 2004
*2- 1995 Census-Based Population Projection, Vol II, NSO,1997
*3- Field Health Service Information System, National Epidemiology Center - DOH, 2002
*4- Provincial Poverty Statistics, 2000, NSCB
*5- Questionnaire Survey on Provincial Health Offices

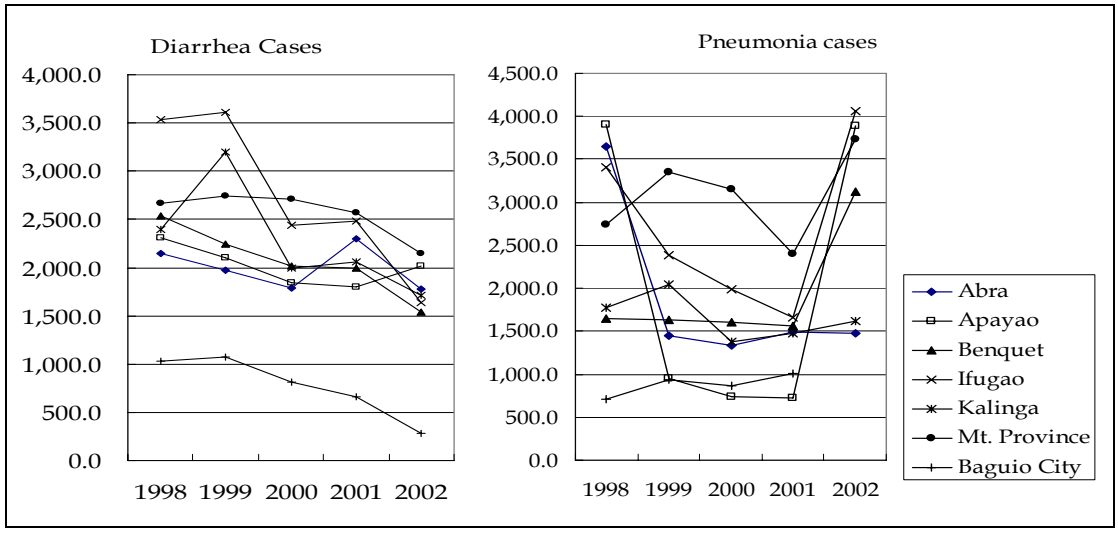
3.1.2 Health Status

(1) General

Life expectancy in CAR is projected at 64.19 for men and 69.18 for women in 2002. Benguet has the longest life expectancy (66.40 for men and 71.85 for women) which approach towards the national average (66.93 for men and 72.18 for women), while those in Ifugao (60.66 for men and 67.24 for women) are the shortest. There is a difference of approximately by 5 years between them.

As shown in Table E-1.1 in Annex E, the major causes of morbidity in 2003 are infectious diseases or water and/or food-borne diseases, such as respiratory infectious diseases, diarrhea and parasitism. Major causes of mortality in the provinces include life-style related diseases, such as vascular diseases and cancer. However, pneumonia is still the major cause of mortality, especially among the children and elderly people. Tuberculosis is also common in these provinces. Therefore, the causes of mortality show that double burden of diseases might be affecting the health status in the region.

The following figures show reported incidence of diarrhea and pneumonia per 100,000 persons in the recent 5 years (1998 – 2002). The reported incidence of diarrhea has decreased since 1998 as shown in Table E-2 in Annex E, and the average of the 5 years is 1,947 per 100,000 populations, however this is higher than the national average (1,119 per 100,000 populations). It is the highest in Ifugao (2,742 per 100,000 populations) and the lowest in Abra (1,993 per 100,000 populations) among the provinces. According to the result of National Demographic and Health Survey 2003 (NSO, 2004: NDHS03), among the children under five years, diarrhea prevalence[3] was 20.4%. Only 33.1% of those children were taken to a health facility to seek care.



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-1 Reported Diarrhea and pneumonia cases in CAR (1998 – 2002) (per 100,000 population)

Reported incidence of pneumonia per 100,000 populations in CAR has increased since 1999 as shown in Table E-3 in Annex E, and the average of the recent 5 years (1998 – 2002) is 1,856 per 100,000 populations and it is twice of the national average (874 per 100,000 populations). It is the highest in Mountain Province (3,076 per 100,000 populations) and the lowest in

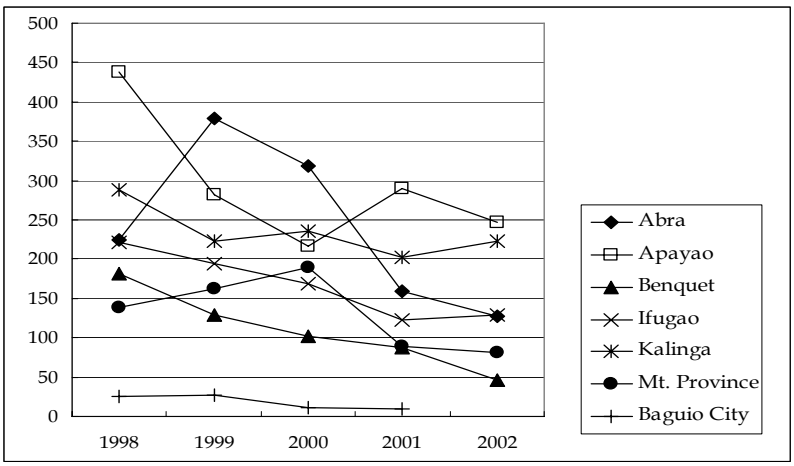
[3] The percentage of the children with diarrhea in the two weeks proceeding the survey period of NDHS03 (from June 16 to September 3, 2003).

Kalinga (1,655 per 100,000 populations). According to the results of NDHS03, among the children under five years, prevalence of acute respiratory infection (ARI) and fever[4] were 16.9% and 23.9%, respectively, and only 50.2% of those children received the treatment. ARI and fever are some of the major direct causes of pneumonia, therefore, the above percentage of low care-seeking for ARI and fever might affect on its high incidence.

One of the major causes of diarrhea and respiratory infection are environmental conditions such as lack of safe water and sanitary toilet (Table E-4 and 5 in Annex E). In CAR, 93.8% of household have access to safe water supply and the rates are nearly 100% in Mountain Province, however, households with access to safe water supply in Apayao are 67.0% in 2002. Households with sanitary toilet represent 73.2% of total households in CAR in 2002. On the provincial level, it is the highest in Apayao (80.1%), and the lowest in Kalinga (49.6%) in 2002.

(2) Infectious diseases

As described in the previous section, tuberculosis is one of the major causes of mortality in CAR. Reported incidence of tuberculosis per 100,000 populations in CAR has decreased since 1998 as shown in Table E-6 in Annex E. The following figure shows tuberculosis reported incidence in provinces for the 5 years (1998 – 2002). The average of the 5 years is 147 per 100,000 populations and it is lower than the national average (177 per 100,000 populations). In Apayao, it is the highest in CAR (295 per 100,000 populations) and the third cause of mortality in the province in 2003. In Kalinga, the situation had not improved during the five years (1998 – 2002), and the average is 235 per 100,000 persons.



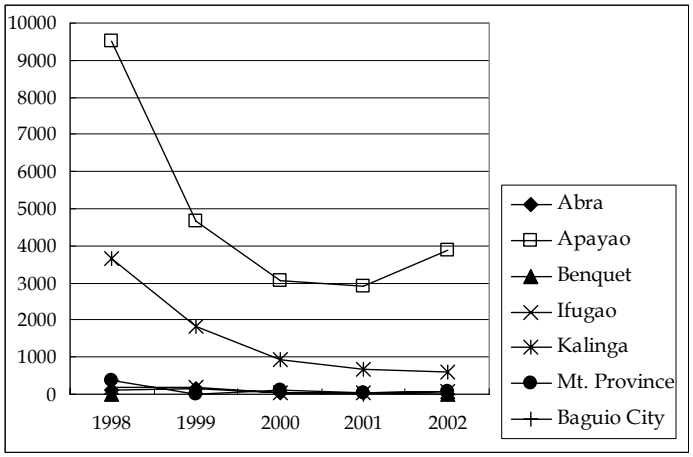
Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-2 Reported TB incidence in CAR (1998 – 2002) (per 100,000 population)

Malaria is endemic in five provinces especially in Abra and Apayao except Benguet and

[4] The percentage of the children with symptoms of ARI and fever in the two weeks proceeding the survey period of NDHS03 (from June 16 to September 3, 2003).

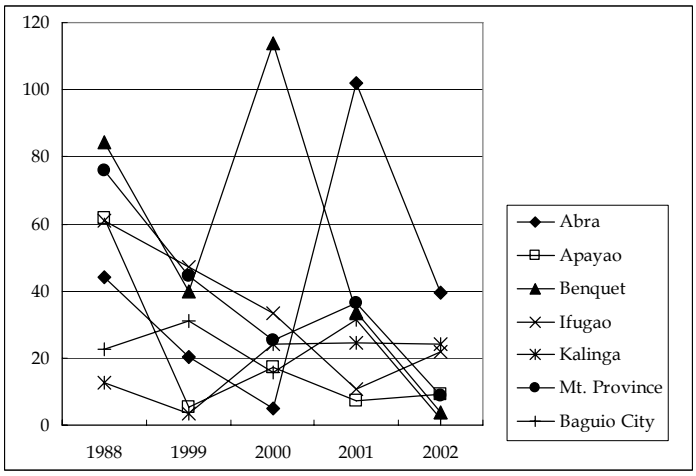
Baguio City. The average of reported incidence of Malaria per 100,000 persons in CAR is 545.1 per 100,000 persons and much higher than the national average (71.4 per 100,000 persons) for the recent 5 years (1998 – 2002). As shown in the following figure, malaria reported incidence in Apayao sharply decreased from 1998 to 2001 though having increased in 2002. (Table E-7 in Annex E) The average of the recent 5 years is the highest in Apayao (4,800 per 100,000 populations).



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-3 Reported malaria incidence in CAR (1998 – 2002) (per 100,000 persons)

The average of reported incidence of Measles is 35 per 100,000 populations for the recent 5 years in CAR. It is higher than the national average (28 per 100,000 populations). As shown in the following figure, the changes in each province are not stable for the 5 years. In Benguet, it is the highest (55 per 100,000 persons) and it is the lowest in Kalinga (18 per 100,000 persons). (Table E-8 in Annex E)



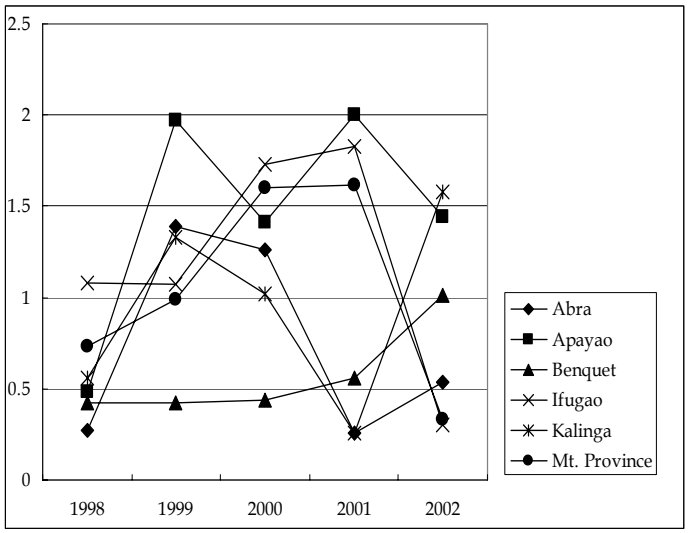
Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-4 Reported measles incidence in CAR (1998 – 2002) (per 100,000 population)

(3) Women's health

1) Health status

Total number of reported maternal death in CAR is 22 in 2002 as shown in Table E-10 in Annex E. Changes of the maternal mortality rates per 1,000 live births are shown in the following figure. The average of maternal mortality rate for the recent 5 years (1998 – 2002) is 0.80 per persons in CAR and it is higher than the national average (0.65 per 1,000 live births). In Apayao, it is the highest (1.46 per 1,000 live births) and also high in Ifugao, it is 1.2 per 1,000 live births.



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-5 Reported maternal mortality rate in CAR (1998 – 2002) (per 1,000 live births)

According to "Philippine Nutrition Facts & Figures 2001[5]" (Food and Nutrition Research Institute, Department of Science and Technology (DOST-FNRI), 2001), prevalence of vitamin A deficiency is 6.3% among pregnant women and 1.2% in lactating women in CAR. (Table E-11 in Annex E) However, the prevalence varies among provinces. Abra and Kalinga have high prevalence among pregnant women, 11.9% and 21.5%, respectively. Prevalence of anemia among pregnant women in CAR is 39.8%, especially, Kalinga, Apayao and Mountain Province have high rate of about 45%. About 55% of lactating women in Ifugao and Kalinga are anemia (Table E-12 in Annex E).

Total Fertility Rate (TFR) in CAR is estimated at 3.8 and it is higher than the national average (3.5), however, wanted fertility rate is estimated at 2.7 in 2003 (NSO, 2004, NDHS03). On the average, women in CAR have one more child than their desired number of children in their lifetime.

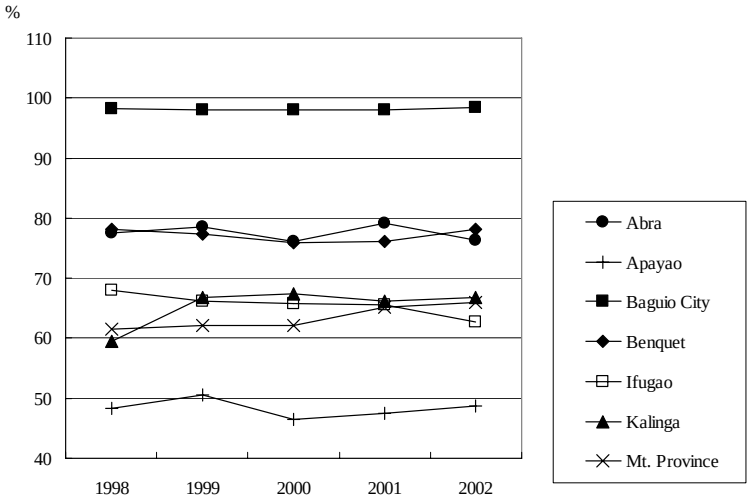
[5] The report based on 1993 and 1998 national nutrition surveys.

2) Health services

In CAR, 54.5% among the women who had a live birth for the last 5 years had antenatal care by doctors during the pregnancy for the most recent birth, 31.5% of them had it by nurses/ midwives, and 2.9% by Traditional Birth Attendant. Percentage of antenatal care by doctor is higher than the national average (38.1%). About 30% of pregnant women had tetanus toxoid injections twice during their pregnancy; however, 35.6% of them never had the injection (NSO, 2004, NDHS03).

The most popular place of delivery in CAR is home. Fifty five percent of women delivered their children in home and 38.6% of women delivered in government hospitals, and 6.2% in private hospitals or clinics. Regarding delivery in government hospital, the percentage is higher than the national average (NSO, 2004, NDHS03).

According to the result of NDHS03, 40.7% of the most recent deliveries for the last 5 years were attended by doctor and 18.9% by nurses and/or midwives in the 5 years. And 24.4% of deliveries were attended by relatives and/or friends in CAR. Comparing to the national average (2.4%), percentage of delivery attended by such neither skilled nor trained personnel is much higher. The following figure shows the percentage of deliveries attended by skilled health personnel including doctor, midwife and nurse in each province for the recent 5 years (1998 – 2002) according to Field Health Services Information Systems (FHSIS) by DOH. The average of percentage of the recent 5 years is the highest in Abra (78%) and the lowest in Apayao (48%) among the provinces. (Data is presented in Table E-13, 14 and 15 in Annex E.)



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-6 Deliveries attended by skilled health personnel in CAR (1998 – 2002)

Seven percent of the most recent deliveries for the last five years were caesarean section according to the data in NDHS03. It is the almost same as the national average (7.3%). On the delivery, 33.8% of babies were not weighed their birth weight. The data in NDHS03 also

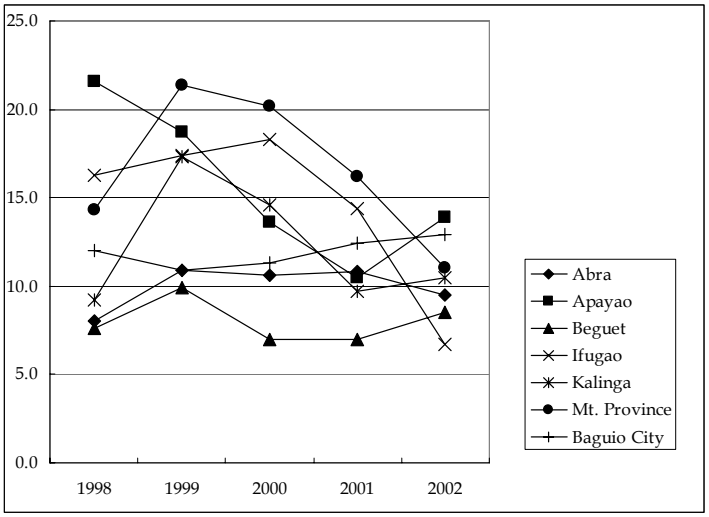
shows 16.7% of babies were born with low birth weight (under 2.5kg).

Regarding family planning, 40% of married women used modern contraceptive method in 2002 and condom users were only 4%. Pill and female sterilization were popular among modern method users (Table E-16 in Annex E).

(4) Children's health

1) Health status

Child mortality rates are estimated at 6 for neonatal mortality, 14 for infant mortality and 34 for under 5 mortality in CAR in 2003 (per 1,000 live births) (NSO, 2004, NDHS03). These are lower than the national average (neonatal mortality rate; 13, infant mortality rate; 30 and under five mortality rate; 42). According to DOH, total reported number of infant death in CAR is 307 and infant mortality rate is 10.3 per 1,000 live births in 2002 as shown in Table E-17 in Annex E. The average of the recent 5 years (1998 – 2002) is 11.88 per 1,000 live births. Changes of the infant mortality rates per 1,000 live births are shown in the following figure. The average of the recent 5 years is higher in Mountain Province (16.6 per 1,000 live births), Apayao (15.7 per 1,000 live births) and Kalinga (12.3 per 1,000 live births). The rates have been generally decreasing except in Apayao and Benguet.

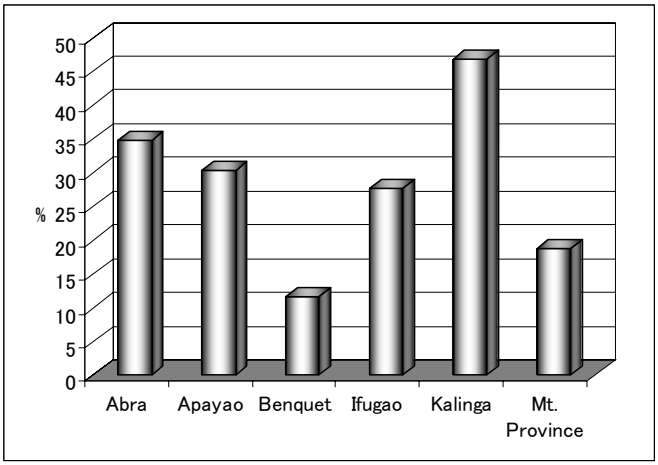


Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-7 Reported infant mortality rate in CAR (1998 – 2002) (per 1,000 live births)

The following figure shows the percentage of underweight children by the weight-for-age classification of NCHS (USA's National Center for Health Statistics)/ WHO[6] (Table -21 in Annex E). It is 26.7% in CAR and is lower than the national average. It is higher in Kalinga (46.9%) and Abra (34.8%).

[6] Cut-off point of NCHS (USA's National Center for Health Statistics)/ WHO standards for weight-for-age are; Underweight: Less than - 2SD, Normal: - 2SD to +2SD, and Overweight: more than +2SD



Source: Philippine Nutrition Facts & Figures 2001, DOST, 2001

Figure 3-8 Percentage of underweight 0-5 year-old children in CAR

Prevalence of vitamin A deficiency among 6 months to 5 years old children in CAR is 6.3%. It is the highest in Abra (14.0%) and the lowest in Benguet (0.7%) (Table E-19 in Annex E). Reported incidence of anemia among 6 months to 5years old children in CAR is 25.4%. It is the highest in Kalinga (36.4%) and the lowest in Mountain Province (12.3%) (Table E-20 in Annex E).

2) Health services

Percentage of fully immunized children among 12-23 months old[7] is 67.4% in CAR in 2003 (NSO, 2004, NDHS03). According to DOH, the percentage of reported fully immunized children among 9-11 months old have decreased since 1999 and it is 79.4% in 2002 as shown in Table E-18 in Annex E and the average of the recent 5 years (1998 – 2002) is 83.5. It is the lowest in Mountain Province (68.7%) among the provinces in 2002.

(5) Life-style related diseases

Cancer is one of major causes of mortality in CAR (Table E-1.1 in Annex E). However, only 54 cases are reported in "Field Health Service Information System, 2002" although more than 200 cases are reported in previous years as shown in Table E-22 in Annex E. Reported incidence of hypertension is high in Benguet (1,767.9 per 100,000), Mountain Province (1,227.4 per 100,000) and Abra (1,052.7 per 100,000) (Table E-23 in Annex E).

3.1.3 Health Services and Facilities

According to the data of Field Health Services Information System (FHSIS) attached in Annex F-1-1, F-1-2 and F-1-3, there is a total of 60 hospitals in CAR. Out of 60 hospitals, DOH operates 5 hospitals, Baguio General Hospital and Medical Center in Baguio City, Fort

[7] Percentage of children age 12-23 months received BCG, DTPx3, Poliox3 and Measles.

Del Pilar Station Hospitals in Baguio City, Luis Hora Memorial Regional Hospital in Bauko, Mountain Province, Far North Luzon General Hospital and Training Center in Luna, Apayao, and Conner District Hospital in Conner, Apayao.

In addition, there are 4 provintial hospitals, 29 district, municipal or community hospitals and 22 private hospitals. There are 88 rural health units and 551 barangay health stations with their own buildings.

The common problems and bottlenecks identified in connection with the facilities through field survey in CAR, later in Region V and VIII are indicated below.

a. Poor road condition, unavailability of public transportation for patient, far distance between health facilities and resident area
b. Dilapidated facilities and equipment: Need to repair or replace at some health facilities.
c. Poor water supply and drainage: Especially BHS.
d. Poor hygiene condition at some health facilities: Comfort room, patient wards
e. Shortage of equipment: Shortage in minimal equipment for getting Sentrong Sigla Certification and PHIC Accreditation (Details are attached in Annex G.1, G.2, H.1, H.2, and I)
f. Poor maintenance system for facilities and equipment
g. Shortage of staff and income for expansion/improvement of facilities and equipment

Following problems are identified in the present situation of health facilities in CAR.

(1) Many primary level hospitals

There are many local primary hospitals in the region. The patients receiving the primary health care service at RHU/BHS are referred to the secondary hospital in the same area, whenever necessary. This situation, however, makes it difficult for ILHZ referral system to function according to the health care needs. Such secondary hospitals of primary level are often under-utilized, due to unavailability of required services. The main reasons why such hospitals remain on the primary level, are dilapidated equipment and lack of health personnel. One of the options to improve the situation is to rationalize the hospitals to maintain only one second level hospital in the ILHZ, considering the road condition and accessibility to the hospital.

(2) Few PHIC accredited RHUs

In addition to the financial support of municipal office, benefit payment by PHIC is another possible financial income to RHU. However, RHUs, which are certified by Sentrong Sigla and PHIC accredited for benefit payment, are still 22% of all RHUs. It is encouraged to

improve RHUs to get PHIC accreditation to be able to claim benefit payment. Among the provinces in CAR, 9 RHUs in Ifugao are PHIC accredited and, less than 3 RHUs in the other provinces.

(3) Regional Gap

There are observed regional gap in the Region. Viewing the status of SS certification of RHUs, for example, Ifgao, Benguet, Baguio City have large number of RHUs having SS certification compared with others including Abra, Apayao, Kalinga and Mt. Province.

Table 3-2 Health Facilities by Province/City in CAR

Province/City		Abra	Apayao	**Benguet**	**Ifugao**	Kalinga	Mt. Province	**Buaguio City**	TOTAL	Rate
Non-LGU Hospitals	Accredited by PHIC (Tertiary)	0	0	**0**	**0**	0	0	**1**	1	20.0%
	Accredited by PHIC (Secobdary)	0	0	**0**	**0**	0	1	**1**	2	40.0%
	Accredited by PHIC (Primary)	0	0	**0**	**0**	0	0	**0**	0	0.0%
	Non accredited	0	2	**0**	**0**	0	0	**0**	2	40.0%
	Total	0	2	**0**	**0**	0	1	**2**	5	
LGU Hospitals	Accredited by PHIC (Tertiary)	0	0	**0**	**0**	0	0	**0**	0	0.0%
	Accredited by PHIC (Secobdary)	1	0	**2**	**1**	1	2	**0**	7	21.2%
	Accredited by PHIC (Primary)	4	5	**4**	**5**	4	3	**0**	25	75.8%
	Non accredited	0	0	**0**	**1**	0	0	**0**	1	3.0%
	Total	5	5	**6**	**7**	5	5	**0**	33	
Private Hospital	Accredited by PHIC	5	0	**3**	**1**	4	1	**4**	18	81.8%
	Non accredited	0	1	**0**	**0**	1	0	**2**	4	18.2%
	Total	5	1	**3**	**1**	5	1	**6**	22	
RHUs*	Accredited by PHIC	1	1	**1**	**9**	3	3	**1**	19	21.6%
	SS Certified	9	4	**11**	**9**	4	7	**8**	52	59.1%
	Non SS certified	18	3	**2**	**2**	8	3	**0**	36	40.9%
	Total	27	7	**13**	**11**	12	10	**8**	88	
	Municipality	27	7	**13**	**11**	8	10	-	76	
BHSs	SS Certified	1	0	**0**	**0**	0	0	**0**	1	0.2%
	Non certified	87	48	**140**	**94**	87	86	**8**	550	99.8%
	Total	88	48	**140**	**94**	87	86	**8**	551	
	Barangay/ BHS	3.48	2.77	**1.92**	**1.86**	2.01	1.67	-	2.13	
	BHWs/BHS	15.7	10.7	**8.7**	**6.7**	8.8	10	**10**		

* Total = (SS Certified) + (Non SS Certified)

BOLD: Convergence Site

Source: Licensing, Regulations and Enforcement Division, CHD-CAR, PHIC

With regard to the referral system inside of functioning ILHZ, health facilities are as follows.

Table 3-3 ILHZ and health facilities in CAR

Province	Name of ILHZ	No. of LGUs	No. of Hospitals	No. of RHUs
Abra	La Paz DH	4	1	4
	Bukay DH	4	1	4
Apayao	Amma Jabsac DH & Far North DH	2	2	2
	Flora DH	2	2	2
Benguet	Kabayan DH	2	1	2
	Atok DH	4	2	4
	Kapangan Medicare CH	2	1	2
Ifugao	Ifugao PH	5	2	5
	Potia DH	2	2	2
	Mayoyao DH	2	2	2
	Hungduan DH	1	1	3
Kalinga	Western Kalinga DH	1	1	1
Mt. Province	Paracelis DH	1	1	1
	Bontoc GH	3	1	3
	Barling DH	2	2	2
	Besao DH	2	1	2
	Luis Hora Memorial PH	3	1	3

Source: Licensing. Regulations and Enforcement Division, CHD-CAR, PHIC

3.1.4 Health Financing

(1) Expenditure on health services in provincial government

The maintenance and other operating expenses for health sector in each provincial government in 2003 are shown in the following table.

Table 3-4 Health related maintenance and other operating expenses in each province in CAR (2003)

Unit: million pesos

	Total of Personal Services Expenses	Maintenance and Other Operating Expenses (MOOE)				Total Expenses
		Total of MOOE	Medical, Dental & Lab. Supplies Expense	Hospitals & Health Center Maintenance	Others	
Abra	144,459,028	132,140,146 (100.00%)	32,285,835 (24.43%)	105,228 (0.08%)	99,749,083 (75.49%)	276,599,174
Apayao	111,687,713	104,472,236 (100.00%)	7,012,564 (6.71%)	536,391 (0.51%)	96,923,281 (92.78%)	216,159,949
Benguet	197,540,194	153,812,275 (100.00%)	8,335,824 (5.42%)	495,892 (0.32%)	144,980,559 (94.26%)	351,352,470
Ifugao	139,046,481	48,872,877 (100.00%)	4,790,342 (9.80%)	90,745 (0.19%)	43,991,791 (90.01%)	187,919,358
Kalinga	164,097,793	56,674,740 (100.00%)	8,231,779 (14.52%)	Not Available	48,442,961 (85.48%)	220,772,533
Mountain Province	156,072,898	18,520,613 (100.00%)	342,321 (1.85%)	51,298 (0.28%)	18,126,994 (97.87%)	174,593,510

Source: Commission on Audit (COA)

Expenses spent on the maintenance of health facilities is generally below 1% of the total MOOE in each province. The expenses on the medical, dental and laboratory supplies vary among the provinces. Abra and Kalinga spend around 15~25% of MOOE, while other provinces did less than 10%.

According to provincial and municipal health officers and health facility staff, there are difficulties to maintain necessary equipment and facilities and to hire required number of necessary health workers to meet the standard, especially doctors, because of budget constraint. In one of RHUs in Abra, the construction works have not been completed because municipal government did not allocate the budget, and financial assistance from DOH was not provided.

Flora District Hospital in Apayao Province cannot maintain facilities and equipment installed in a ADB supported project due to lack of operational fund. According to the provincial health officer, budget constraint is caused also by many patients who do not want to pay the charges because of their perception that the public hospital's service is free.

(2) Health insurance

The following table shows the number of PHIC member households in each province/ city. Coverage in CAR is 89% in 2004. Because coverage is calculated using population in 2000 as denominator, the figures in Baguio City and Mountain Province exceed 100%. However, in Apayao, it was the lowest (66%) and enrollment of individual members is also the least in the region.

Table 3-5 Number of PHIC member households and coverage in each province/ city - CAR (as of September 2004)

	Employed	*Individual*	*Non-paying*	*Sponsored*	*Total*	**Coverage***
Abra	6,535	5,290	292	26,624	38,741	92.5%
Apayao	2,669	171	17	9,876	12,733	65.5%
Benguet	17,983	6,963	607	23,408	48,961	74.2%
Baguio City	33,628	14,604	1,530	10,395	60,157	119.2%
Ifugao	4,543	912	137	20,334	25,926	80.2%
Kalinga	4,716	1,831	99	21,842	28,488	81.9%
Mt. Province	5,264	3,136	290	20,065	28,755	102.4%
Total in CAR	75,338	32,907	2,972	132,544	243,761	89.3%

*Coverage=total member x 5 (average number of household member)/ total population in 2000

Source: PHIC CAR office

According to PHIC CAR office, as LGU portions for the sponsored program for the year 2004 in many of the municipalities in CAR were supported by congress men and/or governors, it was one of the major concerns as to how these LGUs could find funding source for the following year. According to PHIC CAR office, 60% of LGUs will face financial constrains after financial support from those politicians is phased out.

The premium collection status for each program and claims status for benefit payment are shown in the table below. As members can select either central or regional offices to pay their premiums, the regional offices cannot monitor all the premiums paid by members in the region. Even for the members paying their premium to the regional office, PHIC CAR office has not been monitoring premium collection rate against the target, because they have no reliable

membership database and target calculation system.

Table 3-6 Premium collection and claims paid status in CAR (2001 – Sep. 2004)

(Thousand pesos)

	2001		*2002*		*2003*		**Jan-Sep 2004**	
	Collected	Paid	Collected	Paid	Collected	Paid	Collected	Paid
Employed (Gov)	32,100	82,765	33,781	85,790	60,595	76,750	45,612	48,439
Employed (Priv)	50,572	70,120	59,410	72,102	63,163	70,005	54,332	62,671
Individually paying	7,220	6,836	13,942	9,712	15,512	24,563	12,959	45,072
Sponsored	*	*	*	*	10,790	3,036	10,581	10,526
Total	89,892	159,721	107,133	167,604	150,060	174,354	123,484	166,708

*No data available on collected and paid amount for sponsored program for 2001 and 2002

Source: PHIC CAR office

The paid amount for the period from January to September 2004 is already reaching the total amount of the previous year. Especially for the sponsored program, paid amount for the period from January to September is 10,526 thousand pesos, which is three times as high as the total amount of 2003 (3,036 thousand pesos). Membership in the sponsored program increased rapidly because of the national campaign for enhancement of enrolment of sponsored program held several months before the election in May 2004. Utilization of that membership in health facilities has therefore rapidly increased accordingly. As for the individual paying program, paid amount for the above period is almost twice as high as the total amount paid in 2003 (24,563 thousand pesos).

3.1.5 Local Health Systems

CHD–CAR has been providing technical assistance such as orientation and facilitation for stakeholders including governors, mayors, local health officers and health service providers to organize and to operate ILHZs. Financial support is also provided from 1999 to 2002, but it has been terminated since 2003 due to lack of budget.

As mentioned in Chapter 2, conditions of “functioning” ILHZs vary among the regions, and in accordance with Local Health Assistance Division (LHAD) of CHD-CAR, the conditions of “functioning” Inter-Local Health Zone (ILHZ) are as follows.

- Having regular meeting in accordance with their plan and submit the record of discussion to CHD.
- Integrated health plan has been established.

Three conditions defined by DOH (integrated health planning, integrated referral system and integrated information management system) to judge “functioning” ILHZ in their guidebook have not been applied yet. However, CHD-CAR is considering applying them in the near future in accordance with progress of organization and functioning of ILHZs.

The following table presents the situation of ILHZs in each province. Detailed data on the organized ILHZs, such as population, number of health facilities and functioning systems are presented in Annex K-1.

Table 3-7 Situation of Inter-Local Health Zones (ILHZs) in CAR (as of October 2004)

Legend: figure= year of MOA signed
name of core-referral hospital
- name of municipality

Province	*No.*	*Under planning*	*No.*	*Organized but not functioning*	*No.*	**Functioning**
Total in CAR	1		5		17	
Abra (Total No. of municipalities: 27)	1	no core-referral hospital[a] San Quintin Pidigan Langiden	1	2001 Villacisiosa Medicare Hospital [b] - Pilar - San Isidro - Villaviciosa	2	1999 La Paz DH (District Hospital)[b, c] - La Paz - Danglas - Lagayan 2000 Bucay DH [b, c] - Bucay - Daguioman - Bucloc - Sallapadan
No. of LGUs		3 (11%)		3 (11%)		7 (26%)
Remarks	a: DOH-reps are having orientation to mayors but PHO seems not agree to the ILHZ concept. b: Motivation of members is low, because budget allocation for health sector by provincial government is not appropriate. c: Integrated planning, referral and information management systems are functioning.					
Apayao (Total No. of municipalities: 7)	0		1	2000 Kabugao DH[d] - Kabugao	2	1999 Amma Jabsac DH & Far North Hospital[e] - Luna - Pudtol 2001 Flora DH[f] - Flora - Sta. Marcela
No. of LGUs		0 (0%)		1 (14%)		4 (57%)
Remarks	d: 75% of residents live in mountainous areas and do not utilize health facilities frequently. e: Integrated planning system is well functioning. Although Far North Hospital is DOH retained hospital, it provides technical assistance and commodities for public health activities in ILHZ. f: Although integrated planning system is functioning, it is not so active according to CHD.					
Benguet (CS[*1]) (Total No. of municipalities: 13)	0		1	2003 Benguet GH (General Hospital) - La Trinidad - Itogon - Sablan - Tuba - Tublay	3	1999 Kabayan DH[g] - Bokod - Kabayan 2000 Atok DH[g] - Atok - Bakun - Buguias - Mankayan 2001 Kapangan Medicare Community Hospital (CH) [g] - Kapangan - Kibungan:

Province	*No.*	*Under planning*	*No.*	*Organized but not functioning*	*No.*	**Functioning**
No. of LGUs	0 (0%)		5 (38%)		8 (30%)	
Remarks	g: Integrated planning system is functioning.					
Ifugao (CS[*1]) (Total No. of municipalities: 11)	0		0		4	2000 Ifugao PH (Provincial Hospital) [h] - Asipulo - Banawe - Hingyon - Kiangan - Lagawe 1999 Potia DH[i] - Alfonso Lista - Aguinaldo* 2001 Mayoyao DH[i] - Aguinaldo*(same as the avobe) - Mayoyao 2003 Hungduan DH[j] - Hunguan
No. of LGUs	0 (0%)		0 (0%)		9 (82%)	
Remarks	h: Integrated referral and planning systems are functioning. i: The 2 ILHZs will be integrated in year 2004. Referral, planning and information management system are functioning. j: Referral system is functioning.					
Kalinga (Total No. of municipalities: 8)	0		2	1999 Kalinga DH[k] - Tabuk - Rizal - Tanudan 2001 Pinukpuk DH - Pinukpuk	1	2000 Western Kalinga DH[l] - Balbalan * Tinglayan involves in ILHZ in Mt. Province.
No. of LGUs	0 (0%)		4 (50%)		2 (25%)	
Remarks	k: No secretariat and common fund for necessary activities such as meeting. l: Mayor is providing hospital operation fund. Referral, planning and information management systems are well functioning					
Mt. Province (Total No. of municipalities: 10)	0		0		5	1999 Paracelis DH - Paracelis 2000 Bontoc GH[m] - Bontoc - Sadanga - Tinglayan (in Kalinga) 2001 Barling DH[n] - Barlig - Natonin 2002 Besao DH[n] - Besaoo - Sagada 2002 Luis Hora Memorial Regional Hospital[n] - Bauko - Sabangan - Tadian
No. of LGUs	0 (0%)		0 (0%)		10 (100%)	
Remarks	m: Tinglayan in Kalinga province joins to the ILHZ because of geographical condition. Referral and planning systems are functioning n: Referral, planning and information management systems are well functioning					

Province	*No.*	*Under planning*	*No.*	*Organized but not functioning*	*No.*	**Functioning**
	- ILHZs are generally well functioning with limited support from CHD because of good understanding of mayors and health service providers.					

*1: CS= Convergence Site
Source: hearing from and questionnaire survey on PHOs, and hearing from DOH-reps and LHAD of CHD-CAR

In terms of progress of ILHZ organization, there are no differences between convergence sites and no-convergence sites, because CHD have been facilitating and monitoring all the provinces simultaneously in almost the same manner. However, political influence seems to have affected on organizing and/or functioning of some ILHZs. The major reasons why ILHZs are not functioning are: Local Chief Executive (LCE)'s little support including late fulfillment of commitment, inappropriate budget allocation, non-attendance of regular meetings, low utilization of health facilities, insufficient logistic coordination among the participating LGUs, and tribal conflict. Some LGUs have to organize ILHZs that are geographically isolated and/or are not accessible to neighboring LGUs.

According to CHD-CAR, key factors for successful operation of ILHZs are LCE's commitments and political will, based on the perception of importance of health sector, the capability of municipal health planning officer and the capability to persuade stakeholders, especially LCEs, from the technical point of view of DOH representatives and CHD staff to the stakeholders, especially to LCEs. However, even after an ILHZ has been organized, CHD has sometimes to start from the orientation again in case that governor or mayor is changed after the election.

3.1.6 Donor's Activities

The following table shows on-going and future donor's activities in CAR.

In hard-to-reach provinces such as Apayao, Abra and Kalinga, it seems to be also difficult for donors' assistance programs to reach.

Table 3-8 Donor's current activities and future plans in CAR (as of October 2004)

	Assistance for public health programs	***Assistance for HSRA Implementation***
Abra		
Apayao	Grobal fund: Malaria	
Benguet	Spanish Gov.: TB USAID: LEAD (Local Enhancement and Development) for Health[*1] (2004~: 3 municipalities) (2005~: all municipalities)	
Baguio	WHO: HIV/STI prevention EU: HIV/AIDS (NGO support) USAID: LEAD for Health[*1] (all municipalities)	
Ifugao	UNFPA: Community empowerment and capability building of service providers for maternal heath, family planning, STI and VAW[*2] (Lagawe, Asipulo and Tinoc) Spanish Gov.: TB	ADB: HSDP (Health Sector Development Project) (loan)
Kalinga	Global fund: Malaria	*EU: Health Sector Reform*[*4]
Mountain	Spanish Gov.: TB UNICEF: Child-friendly movement[*3] UNFPA: Community empowerment and capability building of service providers for maternal heath, family planning, STI and VAW[*2] (Paracelis, Sagada and Bontoc)	*EU: Health Sector Reform*[*4]

*1: Capability building for procurement and distribution of health commodity for municipal/ city governments.
*2: Community empowerment and capability building of health workers for selected 3 municipalities.
*3: Under 6th country program (2005~2009). Major activities include adolescent maternal health, under nutrition and micronutrient deficiency elimination and child health and sanitation.
*4: *It is under study and not committed.*

Source: hearing from DOH, donors and CHD-CAR

Even in the public health program support, donors provide necessary capability building and/or institutional strengthening support related to the subject programs.

Regarding target areas, some donors provide support directly to the municipal governments including field health workers and/or communities, and some provide integrated support from central (DOH) to Barangay levels including LGUs, local health officers and field health service providers.

3.1.7 Findings from the Regional Workshop

The regional workshop was held as follows;

Date: 19 October 2004 8:00~16:00

Place: CHD-CAR

Participants: representatives from CHD-CAR, provincial health offices, hospital, PHIC regional office and NEDA regional office

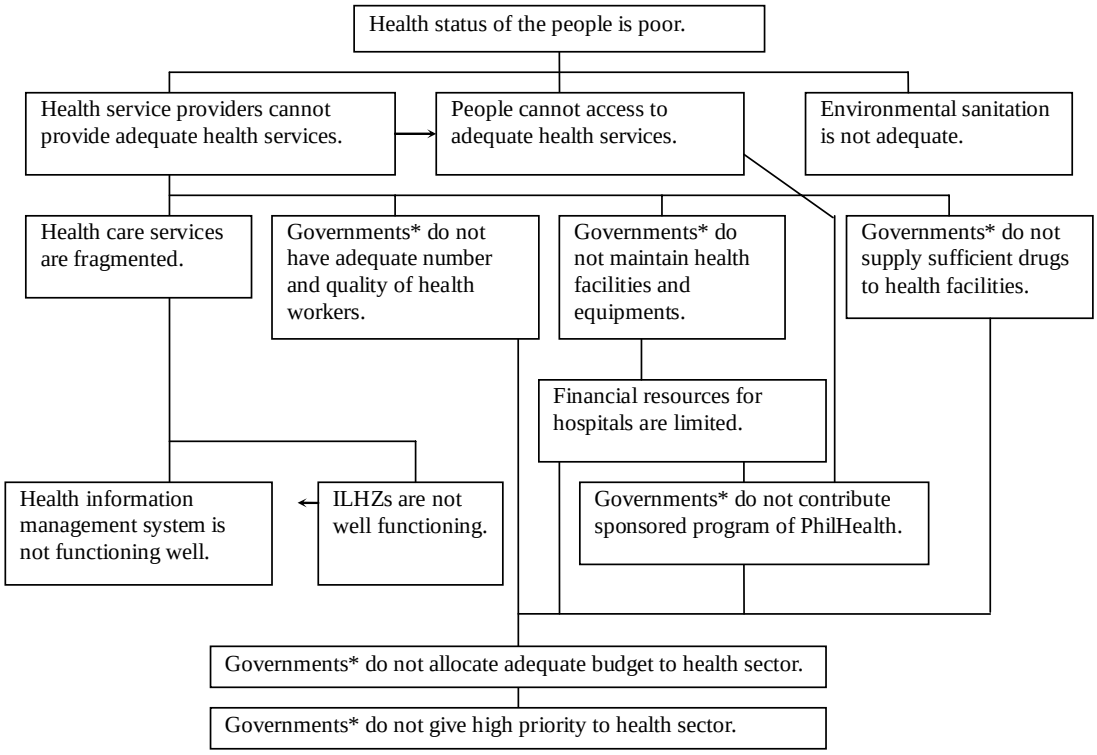
List of participants, detailed records of discussion and products of the workshop are presented in Annex L.

Participants were divided into 4 groups, i.e., CHD, Provincial Health Office, hospital and PHIC. Problem and alternative solution identifications in each group are shown in the Annex L, which are summarized as follows.

(1) Problems

The following figure presents integrated summary of identified problem tree.

Most of groups set “poor health status” as a core problem and “availability of the health services” as major direct causes. Further, what they identified as the root causes are lower priority of health in LGUs and fragmentation of health service providing system.



*=”Governments” include provincial and municipal governments in this context.

Figure 3-9 Summarized problem tree of health sector in CAR

(2) Alternative solution

The alternative solutions identified by the participants to improve the above situation are summarized in the following strategies. Direct and indirect linkage was found among alternative solutions identified in each group. Generally, they suggested to review and to analyze the current situation for establishing and strengthening health service delivery system to be accessible.

1) Improvement of quality of health services

- Reviewing condition and situation of existing facilities, manpower and ILHZ.
- Identifying priority for upgrading and procurement of health facilities and equipments, and health human resources development.
- Improving regulatory function for medicines and health facilities.
- Strengthening activities to organize ILHZs and to install necessary systems to be functioning well.
- Enhancing monitoring and evaluation function of CHD.

2) Improvement of accessibility to the health services

- Enhancing the activities of PHIC to facilitate LGUs, maintain reliable membership database system and increase enrolment especially of individual paying members.
- Reviewing and strengthening of referral system

3.2 Region V (Bicol)

3.2.1 Demography

Region V or Bicol Region, with the land area of 17,622km^2, is located at the southeast tip of Luzon Island. The region is composed of 6 provinces namely Albay, Camarines Norte, Camarines Sur, Catanduanes, Masbate and Sorsogon. It has three independent cities namely Naga and Iriga cities in Camarines Sur and Legaspi city in Albay. Two thirds of the region's land area are made up of the island provinces of Masbate and Catanduanes. The region is generally mountainous and hilly with a few stretches of plains and numerous bay and gulfs characterize the coastal areas.

The basic demographic data in each province/ city is shown in the following table.

Table 3-9 Demography of each province/ city in Region V

	*No. of Cities*1*	*No. of Municipalities*1*	*No. of Barangays*1*	*Total Population*2*	*No. of Households*3*	*Annual Pop. Growth rate*1*	*Poverty Incidence Rate in Population*4*	**Income class *5**
Year	2004	2004	2004	2002	2002	2001-02	2000	
Albay	3	15	720	1,150,057	198,446	1.86	47.8	1
Camarines Norte	0	12	282	524,811	92,093	2.49	57.3	3
Camarines Sur	2	35	1,063	1,663,619	307,381	1.95	48.7	1
Catanduanes	0	11	315	231,652	36,984	1.87	53.2	3
Masbate	1	20	550	702,940	131,660	0.76	70.9	2
Sorsogon	1	14	541	644,300	84,716	0.95	51.4	2
Total in Region V	7	107	3,471	4,917,361	775,728	1.68	56.2	

Source: *1- 2004 Philippine Statistical Yearbook, NSCB, 2004
*2- 1995 Census-Based Population Projection, Vol II, NSO,1997
*3- Field Health Service Information System, National Epidemiology Center - DOH, 2002
*4- Provincial Poverty Statistics, 2000, NSCB
*5- Questionnaire Survey on Provincial Health Offices

3.2.2 Health Status

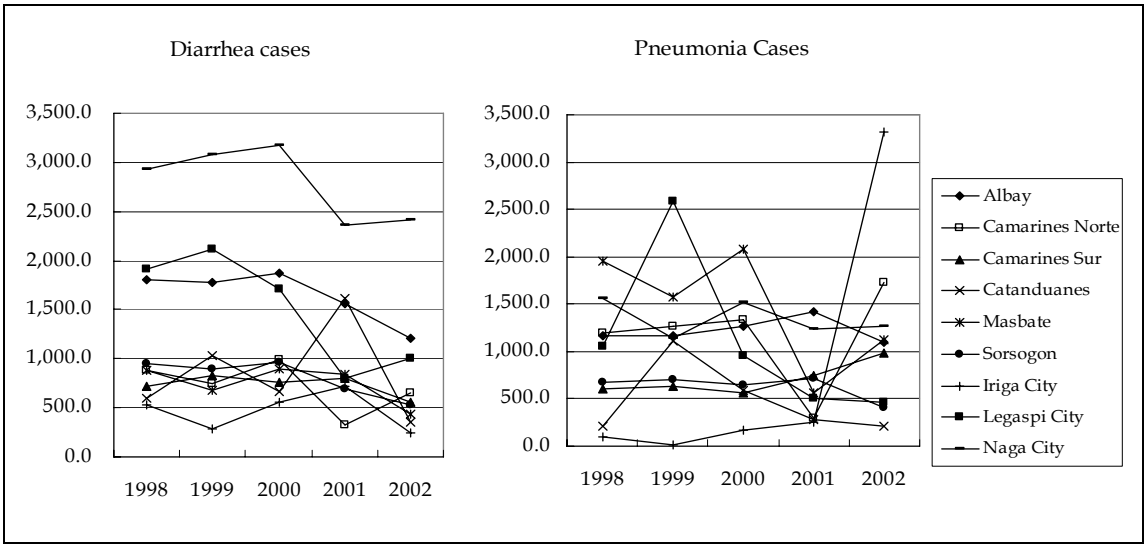
(1) General

Life expectancy in Region V is projected at 66.38 for men and 71.53 for women in 2002, which are higher than the national average (66.93 for men and 72.18 for women). The difference between the province of the longest life expectancy (Camarines Sur: 68.23 for men and 73.27 for women) and the one of the shortest (Camarines Norte: 64.44 for men and 68.83 for women) is about 4 years.

As shown in Table E-1.2 in Annex E, major causes of morbidity are infectious diseases and food and/or water borne diseases, such as respiratory infections, diarrhea and parasitism. Major causes of mortality over the provinces in 2003 are vascular diseases, tuberculosis, wound and respiratory diseases including pneumonia. Therefore, burden of infectious diseases is still high

in the Region V.

The following figure shows reported incidence of diarrhea and pneumonia in the recent 5 years (1998 – 2002). Reported incidence of diarrhea per 100,000 persons in Region V has decreased since 1999 (Table E-2 in Annex E). Although diarrhea cases have decreased in each province, the average of reported incidence of the 5 years in Albay is the highest among the provinces (1,645 per 100,000). According to the National Demographic and Health Survey 2003 (NSO, 2004: NDHS03), among the children under five years, diarrhea prevalence[8] was 11.4%, and only 25.9% of those children were taken to a health facility to seek care.



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-10 Reported incidence of diarrhea and pneumonia cases in Region V (1998 – 2002) (per 100,000 population)

The average of reported incidence of pneumonia of the recent 5 years (1998 – 2002) in Region V is 981 per 100,000 persons (Table E-3 in Annex E). It is the highest in Masbate (1,460 per 100,000 persons) and the lowest in Catanduanes (480 per 100,000 persons). According to the results of NDHS03, among the children under five years, prevalence of acute respiratory infection (ARI) and fever[9] were 9.6% and 25.6%, respectively and only 38.2% of those children received the treatment. ARI and fever are some of the major direct causes of pneumonia, therefore, the above percentage of low care seeking for ARI and fever might have affects on its high incidence.

One of the major causes of diarrhea and respiratory infection are environmental conditions such as lack of safe water and sanitary toilet (Table E-4 and 5 in Annex E). Overall 81.6% of

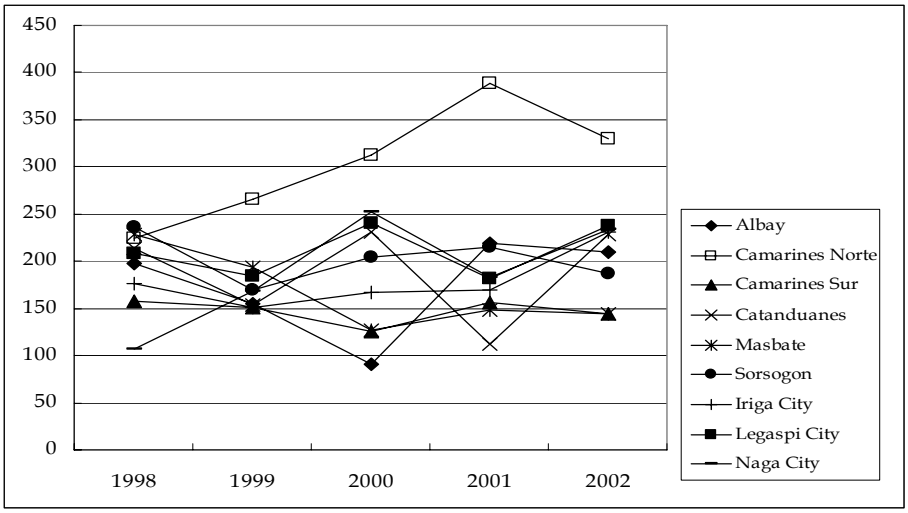
[8] The percentage of the children with diarrhea in the two weeks proceeding the survey period of NDHS03 (from June 16 to September 3, 2003).

[9] The percentage of the children with symptoms of ARI and fever in the two weeks proceeding the survey period of NDHS03 (from June 16 to September 3, 2003).

the households in Region V have access to safe water supply; however, in Masbate, about 50% of households have access to safe water supply, while almost 100% coverage is noticed in Sorsogon and Catanduanes in 2002. Households with sanitary toilet represent 49.3% of total households in Region V in 2002, 92.6% in Sorsogon, and only 39.7% in Masbate in 2002.

(2) Infectious diseases

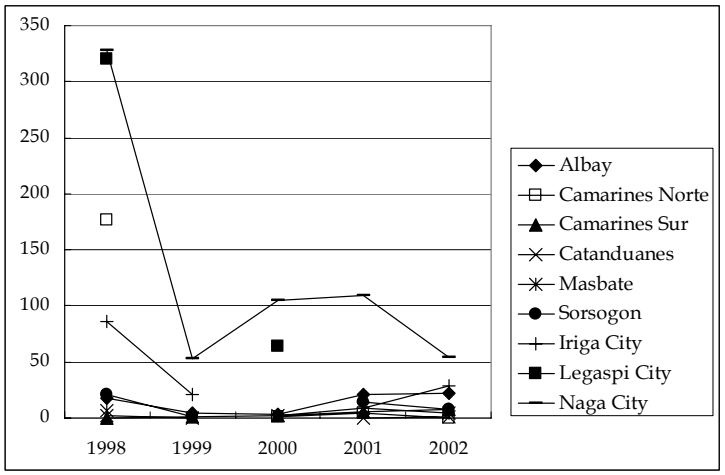
As described in the previous section, tuberculosis is one of major causes of mortality in Region V. The following figure shows reported incidence of tuberculosis per 100,000 persons. The average of reported incidence for the recent 5 years (1998 – 2002) in Camarines Norte is the highest (304 per 100,000 persons) and it is also high in Sorsogon (203 per 100,000 persons). In other provinces, the situations have not improved for five years of 1998 – 2002. (Table E-6 in Annex E)



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-11 Reported TB incidence in region V (1998 – 2002) (per 100,000 population)

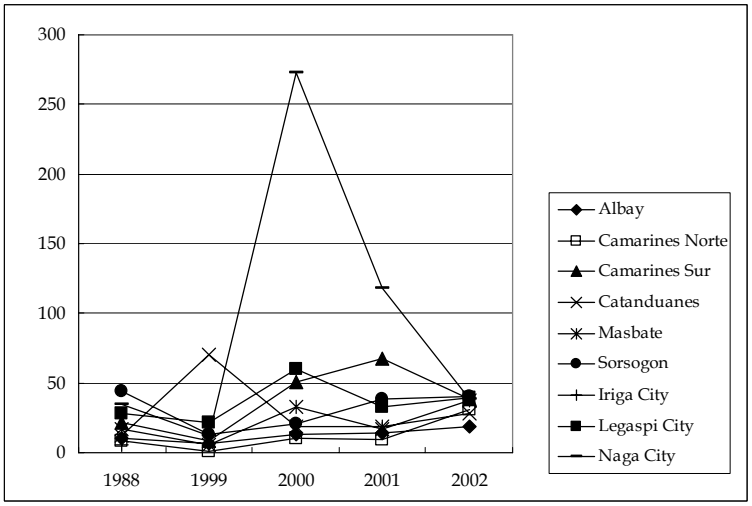
The average of reported incidence of dengue cases of the recent 5 years (1998 – 2002) in Region V is 17 per 100,000 persons (Table E-9 in Annex E). It has been on the high level in Legaspi and Naga Cities for five years (the average of reported incidence is 192 and 130 per 100,000 persons, respectively). The figures in Camarines Sur, Catanduanes and Masbate are less than 10.



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-12 Reported dengue incidence in Region V (1998 – 2002) (per 100,000 population)

Reported incidence of Measles in Region V has increased since 1998 as shown in Table E-7 in Annex E and the average of the recent 5 years (1998 – 2002) is 28 per 100,000 persons. It is the highest in Naga City (95 per 100,000 persons). Among provinces, it is the highest in Sorsogon (31 per 100,000 persons).



Source: Field Health Services Information System, DOH, 1998 - 2002

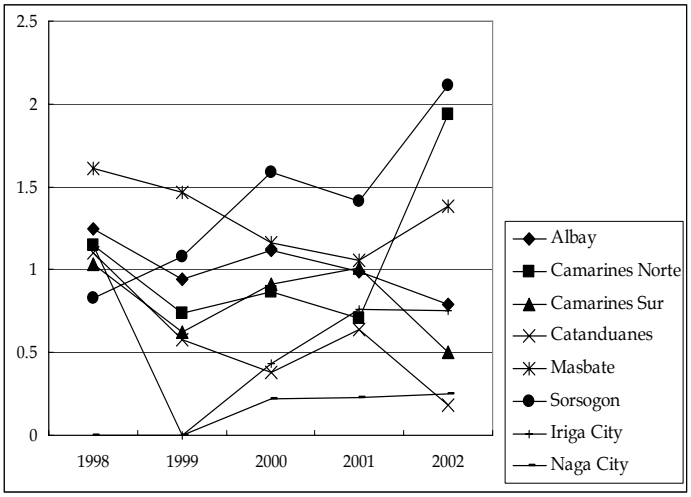
Figure 3-13 Reported measles incidence in Region V (1998 – 2002) (per 100,000 population)

(3) Women's health

1) Health status

Total number of reported maternal death in Region V is 116 in 2002 (1.1 per 1,000 live births) as shown in Table E-10 in Annex E. Changes of the maternal mortality rate per 1,000 live births are shown in the following figure. The average of maternal mortality rate for the recent 5 years (1998 – 2002) is 1.00 per persons in Region V and it is higher than the national average (0.65 per 1,000 live births). In Sorsogon, it is the highest (1.41 per 1,000 live births)

and also high in Masbate at 1.34 per 1,000 live births.



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-14 Reported maternal death rate in Region V (1998 – 2002) (per 1,000 live births)

According to "Philippine Nutrition Facts & Figures 2001[10]" (Food and Nutrition Research Institute, Department of Science and Technology (DOST-FNRI), 2001), prevalence of vitamin A deficiency is 4.9% among pregnant women and 2.6% in lactating women in Region V (Table E-11 in Annex E). Camarines Norte, Catanduanes and Sorsogon have high prevalence among pregnant women, around 12%.

Prevalence of anemia among pregnant women in Region V is 64.4%, especially, Catanduanes had 73.5% and Camarines Sur, Masbate and Sorsogon have the rates around 60%. More than 60% of lactating women in Camarines Norte and Masbate has anemia (Table E-12 in Annex E).

Total Fertility Rate (TFR) in Region V is estimated at 4.3 and it is higher than the national average (3.5); however, wanted fertility rate is estimated at 2.6 in 2003 (NSO, 2004, NDHS03). On the average, women in Region V have almost 2 more child than their desired number of children in their lifetime.

2) Health services

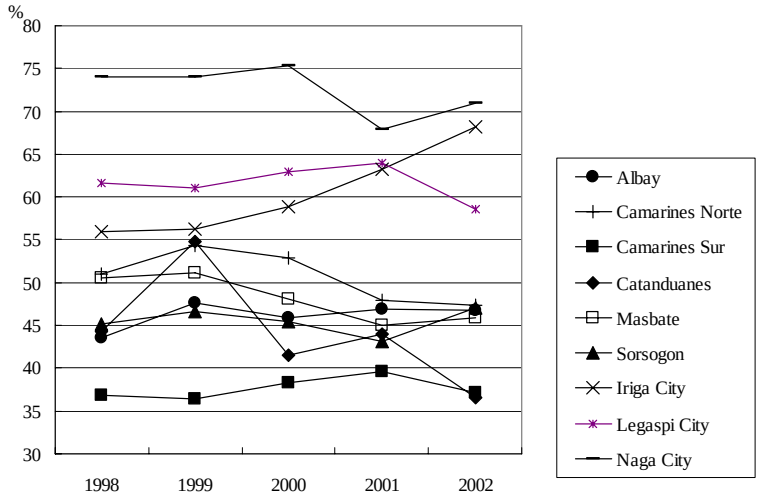
In Region V, 30.0% among the women who had a live birth for the last 5 years had antenatal care by doctors during the pregnancy for the most recent birth, 55.6% of them had it by nurses/ midwives, and 8.6% by Traditional Birth Attendant. Percentage of antenatal care by nurses/ midwives is higher than the national average (49.5%). About 29.1% of pregnant women had tetanus toxoid injections twice during their pregnancy; however 34.6% of them never had the

[10] The report based on 1993 and 1998 national nutrition surveys.

injection. (NSO, 2004, NDHS03)

The most popular place of delivery in Region V is home. Seventy six percent of women delivered their children in home, and only 15.7% of women delivered in government hospitals, and 5.5% in private hospitals or clinics. (NSO, 2004, NDHS03)

According to the result of NDHS03, for the last 5 years 19.5% of the most recent deliveries were attended by doctors and 28.3% by nurses and/or midwives. Some 50.2% of deliveries were attended by Traditional Birth Attendant (TBA), which means that 1 out of 2 deliveries attended by TBA; it is higher when compared to the national average (37.1%). The following figure shows the percentage of deliveries attended by skilled health personnel including doctor, midwife and nurse in each province for the recent 5 years (1998 – 2002) according to Field Health Services Information Systems (FHSIS) by DOH. The average of percentage of the recent 5 years is the lowest in Camarines Sur (38%) and those are around 45% in other provinces. (Data is presented in Table E-13, 14 and 15 in Annex E.)



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-15 Deliveries attended by skilled health personnel in Region V (1998 – 2002)

Six percent of the most recent deliveries for the last five years were caesarean section in accordance with the data in NDHS03. On the delivery, 42.5% of babies were not weighed their birth weight. The data in NDHS03 also shows 11.1% of babies were born with low birth weight (under 2.5kg).

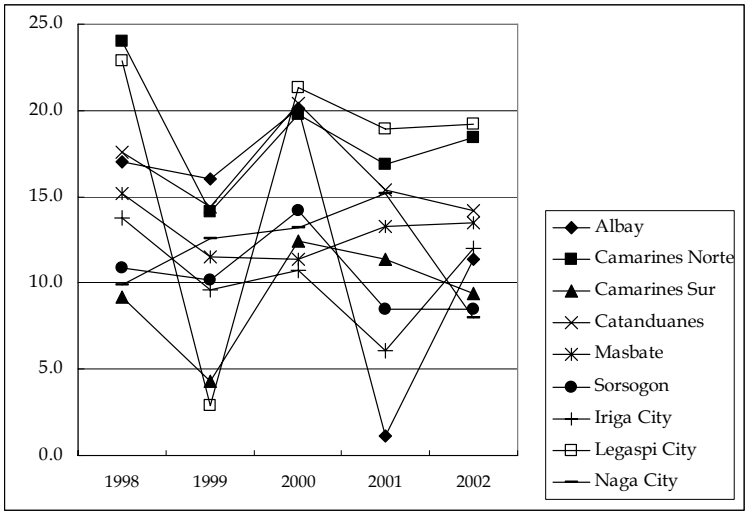
Regarding family planning, less than 30% of married women used modern contraceptive method in 2002 and condom users were less than 1%. Pill and female sterilization were popular among modern method users. (Table E-16 in Annex E)

(4) Children's health

1) Health status

Child mortality rates are estimated at 19 for neonatal mortality, 28 for infant mortality and

43 for under 5 mortality in Region V in 2003 (per 1,000 live births) (NSO, 2004, NDHS03). These rates are almost same as the national average (neonatal mortality rate 13, infant mortality rate 30 and under five mortality rate 42). According to DOH, total reported number of infant death in Region V is 1,280 and infant mortality rate is 11.7 per 1,000 live births in 2002 as shown in Table E-17 in Annex E. The average of the recent 5 years (1998 – 2002) is 12.3 per 1,000 live births. Changes of the infant death rates per 1,000 live births are shown in the following figure. The average of the recent 5 years is higher in Camarines Norte (18.6 per 1,000 live births) and Catanduanes (16.4 per 1,000 live births).

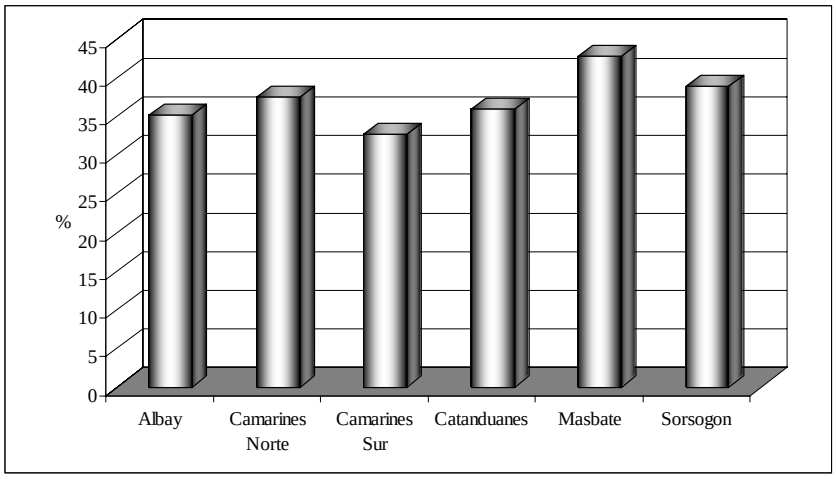


Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-16 Reported infant mortality rate in Region V (1998 – 2002) (per 1,000 live births)

The following figure shows the percentage of underweight children by the weight-for-age classification of NCHS (USA's National Center for Health Statistics)/ WHO[11] (Table E - 18 in Annex E). Thirty six percent (36%) of 0-5 year-old children in Region V are underweight; it is the highest in Masbate (43%).

[11] Cut-off point of NCHS (USA's National Center for Health Statistics)/ WHO standards for weight-for-age are; Underweight: Less than - 2SD, Normal: - 2SD to +2SD, and Overweight: more than +2SD



Source: Philippine Nutrition Facts & Figures 2001, DOST, 2001

Figure 3-17 Percentage of underweight 0-5 year-old children in Region V

In Region V, prevalence of vitamin A deficiency among 6 months to 5 years old children is 7.5 (Table E-19 in Annex E), and for anemia, it is 34.3%. These rates are the highest in Masbate; vitamin A deficiency is 19.0% and anemia is 56.2% (Table E-20 in Annex E).

2) Health services

Percentage of fully immunized children among 12-23 months old[12] is 64.7% in Region V in 2003. (NSO, 2004, NDHS03). According to DOH, the percentage of reported fully immunized children among 9-11 months old children decreased from 87.0% in 2000 to 74.4% in 2002 as shown in Table E-21 in Annex E. It is the highest in Albay (83.8%) and the lowest in Catanduanes (45.2%) in provinces in 2002.

(5) Life-style related diseases

Diabetes Mellitus is one of top causes of mortality in Legaspi, Naga and Iriga Cities as shown in Table E-1.2 in Annex E. Cancer or neoplasm is also the major causes of mortality in all the provinces except Masbate. Reported incidence of hypertension is high in Albay (952 per 100,000), Catanduanes (766 per 100,000) and Sorsogon (617 per 100,000) as shown in table E-23 in Annex E.

3.2.3 Health Services and Facilities

According to the data of Field Health Services Information System (FHSIS), as shown in the Annex F-2-1, F-2-2 and F-2-3, there is a total of 136 hospitals in Region V. Out of 134 hospitals, 3 are DOH operated hospitals, namely Bicol Regional Training and Teaching Hospital in Legaspi City, Albay, Bicol Sanitarium in Cabuso, Camarines Sur, and Bicol Medical Center in Naga City, Camarines Sur. In addition to DOH hospitals, there are 3

[12] Percentage of children age 12-23 months received BCG, DTPx3, Poliox3 and Meales.

provincial hospitals and 47 district, municipal or community hospitals, and 81 private hospitals. The total number of RHU and BHS is 127 and 1,007, respectively.

The specific problems in connection with the health facilities in this Region are as follows.

(1) Many primary level hospitals

In this Region also, there are number of hospital of primary level, which makes it difficult for ILHZ to operate the referral system according to the patient's needs. Besides, Region V has comparatively more hospitals than in the other 2 Regions. It is recommendable, therefore, to review the need of each hospital services, and to study the rationalization of hospitals to have one secondary level hospital.

(2) Many RHUs, which have not accredited by PHIC

PHIC benefit payment is another possible income to RHU, in addition to the financial support of municipal office. However, RHUs, which are certified by Sentrong Sigla and accredited by PHIC for benefit payment, are still at 43% of all RHUs. It is encouraged to improve RHUs to get PHIC accreditation to be able to claim for benefit payment of PHIC. Among the provinces in this Region, almost all of RHUs in Sorsogon are PHIC accredited, while in Masbate only 3 of 21 RHUs are accredited.

(3) Too many health facilities

In this region, there are too many health facilities in comparison to the number of municipalities. Consolidation of small-scale facilities is needed as a measure for dealing with this problem.

Table 3-10 Health Facilities by Province in Region V

Province/City		Albay	Camarines Norte	Camarines Sur	**Catanduanes**	Masbate	**Sorogon**	TOTAL	Rate
Non-LGU Hospitals	Accredited by PHIC (Tertiary)	1	0	1	**0**	0	**0**	2	66.7%
	Accredited by PHIC (Secobdary)	0	0	0	**0**	0	**0**	0	0.0%
	Accredited by PHIC (Primary)	0	0	1	**0**	0	**0**	1	33.3%
	Non accredited	0	0	0	**0**	0	**0**	0	0.0%
	Total	1	0	2	**0**	0	**0**	3	
LGU Hospitals	Accredited by PHIC (Tertiary)	0	1	1	**1**	1	**0**	4	8.0%
	Accredited by PHIC (Secobdary)	2	1	1	**1**	0	**1**	6	12.0%
	Accredited by PHIC (Primary)	5	0	6	**5**	5	**7**	28	56.0%
	Non accredited	1	1	5	**0**	3	**2**	12	24.0%
	Total	8	3	13	**7**	9	**10**	50	
Private Hospital	Accredited by PHIC	27	9	13	**2**	7	**6**	64	79.0%
	Non accredited	6	0	7	**0**	4	**0**	17	21.0%
	Total	33	9	20	**2**	11	**6**	81	
RHUs*	Accredited by PHIC	9	11	10	**7**	3	**14**	54	42.5%
	SS Certified	11	14	19	**10**	11	**16**	81	63.8%
	Non SS certified	10	2	23	**1**	10	**0**	46	36.2%
	Total	21	16	42	**11**	21	**16**	127	
	Municipality	15	12	35	**11**	20	**14**	107	
BHSs	SS Certified	0	0	0	**0**	0	**4**	4	0.4%
	Non certified	181	111	323	**49**	173	**166**	1003	99.6%
	Total	181	111	323	**49**	173	**170**	1007	
	Barangay/ BHS	3.98	2.54	3.29	**6.43**	3.18	**3.18**	3.45	
	BHWs/BHS	15.7	8.6	11.2	**40**	10.4	**8.9**		

* Total = (SS Certified) + (Non SS Certified)

BOLD: Convergence Site

Source: Licensing. Regulations and Enforcement Division, CHD-Region V, PHIC

Regarding the referral system inside of functioning ILHZ, health facilities are as follows.

Table 3-11 ILHZ and health facilities in Region V

Province	Name of ILHZ	No. of LGUs	No. of Hospitals	No. of RHUs
Camarines Norte	Labo DH	5	2	7
	Camarines Norte PH	7	1	9
Camarines Sur	Ragay DH	3	1	3
Sorsogon	Bulan DH	4	3	4
	Gubat DH	4	2	4
	Donsol DH	2	1	2
	Sorsogon DH	5	3	5

Source: Licensing, Regulations and Enforcement Division, CHD-Region V, PHIC

3.2.4 Health Financing

(1) Expenditure on health service in provincial government

The maintenance and other operating expenses for health sector in each provincial government in 2003 are shown in the following table.

Table 3-3 Health related maintenance and other operating expenses in each province in Region V (2003)

Unit: million pesos

	Total of Personal Services Expenses	Maintenance and Other Operating Expenses (MOOE)				Total Expenses
		Total of MOOE	Medical, Dental & Lab. Supplies Expense	Hospitals & Health Center Maintenance	Others	
Albay	213,994,145	159,659,840 (100.00%)	38,256 (0.02%)	1,336,941 (0.84%)	158,284,643 (99.14%)	373,653,985
Camarines Norte	149,122,114	115,554,061 (100.00%)	2,303,405 (1.99%)	852,028 (0.74%)	112,398,628 (97.27%)	264,676,175
Camarines Sur	305,391,161	164,979,394 (100.00%)	8,111,903 (4.92%)	494,859 (0.30%)	156,372,632 (94.78%)	470,370,554
Sorsogon	196,300,175	129,178,427 (100.01%)	15,547,815 (12.04%)	1,377,923 (1.07%)	112,252,688 (86.90%)	325,478,601
Masbate	198,453,245	63,959,644 (100.00%)	15,507,815 (24.25%)	3,447,395 (5.39%)	45,004,434 (70.36%)	262,412,889
Catanduanes	149,473,145	88,876,485 (100.00%)	2,173,423 (2.45%)	Not available	86,703,063 (97.55%)	238,349,631

Source: Commission on Audit (COA)

Expenditures on the maintenance of health facilities are generally under 1% in each province, except in Masbate. Expenditures on medical, dental and laboratory supplies varies among the provinces; Sorsogon and Masbate had spent around 10~25% of MOOE, while the other provinces had spent less than 5%, and Albay in particular had spent only 0.02%.

Provincial and municipal health officers and health facility staff indicates that they have difficulties to maintain necessary equipment and facilities and to hire appropriate health workers, especially doctors, as the budget is inadequate.

According to NEDA Regional Office, however, LGUs generally places low priority to health sector after devolution and decrease in budget allocation. For example, according to representative from Catanduanes, the provincial government has not allocated adequate budget

to improve provincial government hospitals to be core referral in ILHZs.

(2) Health insurance

The following table shows the number of PHIC member households in each province. Coverage ratio is 77.3% in the Region V and it is the highest in Camarines Norte, more than 100%, and the lowest in Sorsogon (60.8%).

Table 3-4 Number of PHIC member households and coverage in each province in Region V (as of September 2004)

	Employed	*Individual*	*Non-paying*	*Sponsored*	*Total*	**Coverage**
Albay	51,077	18,273	2,067	128,424	199,841	86.9%
Camarines Norte	14,796	7,650	739	72,775	95,960	101.7%
Camarines Sur	52,506	17,730	1,286	181,140	252,662	76.0%
Catanduanes	8,381	1,534	479	28,444	38,838	86.7%
Masbate	14,096	2,358	355	76,658	93,467	62.8%
Sorsogon	20,541	6,626	485	56,442	84,094	60.8%
Total in Region V	161,397	54,171	5,411	543,883	764,862	77.3%

Note: *Coverage=total member x 5 (average number of household member)/ total population in 2000

Source: PHIC Region V office

PHIC Region V office has started to negotiate with mayors for contribution to sponsored program for the next year, i.e., financial support after phasing out of special program mentioned in 3.1.4. According to the office, all the municipalities in Camarines Norte, Catanduanes and Sorsogon have already agreed to continue contribution. However, it depends on the perception of mayors rather than on financial status of LGUs, as LGUs of high income class tend to be passive.

The premium collection status for each program and claims status for benefit payment are shown in the table below.

Table 3-5 Premium collection and claims paid status in Region V (2001 – Jun. 2004)

(Thousand pesos)

	2001	*2002*	*2003*		**Jan-Jun 2004**	
	Collected	Collected	Collected	Paid	Collected	Paid
Employed (Gov)	93,049	109,961	106,748	168,095	60,589	94,391
Employed (Priv)	64,855	71,573	76,474	138,912	44,842	82,969
Individually paying	16,646	15,785	17,309	*2	11,207	*2
Sponsored	*1	*1	*1	44,155	*1	39,446
Total	174,550	197,319	200,531	351,162	116,638	216,806

*1: No data available on collected amount for sponsored program.

*2: No data available on paid amount for individually paying program.

Source: PHIC Region V office

The paid amount for the sponsored program during the period from January to June 2004 is 10,526 thousand pesos, which is almost 90% of the total amount of 2003. Membership in the

sponsored program increased rapidly because of the national campaign for enhancement of enrolment of sponsored program that was held in several months before the election (May 2004). Utilization of PHIC members in health facilities therefore has increased rapidly. As it was found that total paid amount for employed program exceeded the amount of premium collected in 2003, PHIC Region V office began to monitor collection rate, from 2004, against estimated target. The monitored results showed that the government sector had the worst collection rate as of June 2004.

Although private hospitals and clinics increased their claim amounts recently, PHIC office do not have enough staff to investigate and verify these claims.

3.2.5 Local Health Systems

CHD Region V has been providing technical assistance such as orientation and facilitation to stakeholders including governors, mayors, local health officers and health service providers to form a consensus among them and to organize ILHZs. After the consensus of LCEs, approval of Local Legislative Board is also necessary to regulate the ILHZ. In spite of continuous effort of CHD, DOH-rep (DOH representatives) and PHO (Provincial Health Officer), it has been difficult to organize ILHZs in most of the cases, because of LCEs' unconcern and low priority of implementation of HSRA.

As mentioned in Chapter 2, the quality and the level of "functioning" vary among the regions or even among the provinces. According to Local Health Assistance Division (LHAD) of CHD Region V, conditions of "functioning" Inter-Local Health Zone (ILHZ) are as follows.

- Integrated health plan has been established.
- Integrated referral system is functioning
- Integrated management of health information system is functioning

The following table presents the situation of ILHZs in each province. Detailed data on the organized ILHZs, such as population, number of health facilities and functioning systems are presented in Annex K-2.

Table 3-6 Situation of Inter-Local Health Zones (ILHZs) in Region V (as of October 2004)

Legend: figure= year of MOA signed
(for planning ILHZ, year of planned)
name of core-referral hospital
- name of municipality

	No. *Under planning*	*No.* *Organized but not functioning*	*No.* **Functioning**
Total in Region V	7	2	6
Albay (Total No. of municipalities: 15 cities: 3)	0	2 2000 Josefina Belmonte Memorial DH[a] - Jovellar - Oas	0

	No. *Under planning*	*No.* *Organized but not functioning*	*No.* **Functioning**
		- Ligao - Libon - Polangui - Guinobatan 2002 Ziga Memorial DH[a] - Tiwi - Malinao - Tabaco City - Bacacay - Malilipot - Sto. Dmingo	
No. of LGUs	0 (0%)	11 municipalities and 1 city (67%)	0 (0%)
Remarks	a: Chief of hospital (chairperson of TMC) was changed and it has been difficult for him/her to call all the mayors to the meeting since then. Integrated planning system is functioning.		
Camarines Norte (Total No. of municipalities: 12)	0	0	2 2000 Labo DH[c] - Sta.Elena - Jose Panganiban - Panacale - Labo - Capalonga 2004 Camarines Norte PH[b] - Basud - Mercedes - Daet - San Lorenzo - San Vincente - Talisay - Vizons
No. of LGUs	0 (0%)	0 (0%)	12 (100%)
Remarks	b: Orientation for LGU officials & health personnel has been given. MOA is under review. Two-way referral, planning and information management systems are generally functioning. c: Two-way referral system, planning and integrated information management systems have been functioning. But it's not reported to CHD. - Generally, LCEs agree on the concept of ILHZ and are supportive. Both two ILHZs have regular meeting.		
Camarines Sur (Total No. of municipalities: 35 cities: 2)	0	0	2 2000 Ragay DH - Lupi - Ragay - Del Gallego 2003 Dr. Niloo Roa Memorial Foundation Hospital (Private)[d] - Naga City - Calabanga - Magarao - Canaman - Bombon - Milaor - Gainza - Pamplona

	No. *Under planning*	*No.* *Organized but not functioning*	*No.* **Functioning**
			- Pasacao - San Fernando - Ocampo - Bula - Pili - Camaligan - Minalabac
No. of LGUs	0 (0%)	0 (0%)	17 municipalities and 1 city (49%)
Remarks	d: Orientation for MHOs and municipal planning officer has been conducted. Some of municipalities are reviewing to participate. Negotiation is being done to affirm core-referral hospital. - For all ILHZs: MOA isn't signed by the governor because he does not agree to the concept of ILHZ. However, planning, referral and information management systems are functioning.		
Catanduanes (CS[*1]) (Total No. of municipalities: 11)	0	4 2000 Pandan DH[e] - Pandan - Caramoran 2001 Viga DH[f] - Pangabinan - Viga - Bagamanoc 2001 Virac PH[e] - Virac - San Andres - San Miguel 2001 Bato Matenity and Childrens Hospital - Bato - Baras - Gigmoto	0
No. of LGUs	0 (0%)	11 (100%)	0 (0%)
Remarks	e: It will be functioning near future. f: No meeting has been held after election because 1 new mayor does not agree to the concept of ILHZ. For all ILHZs; Training on integrated planning and orientation on referral systems conducted and finalizing referral manual. Core-referral hospitals have not been improved because LGU has not allocated enough budgets.		
Masbate (Total No. of municipalities: 20 city: 1)	2 2004 Ticao DH[g] - San Fernando - San Jacinto - Batuan - Monreal 2004 Masbate PH[h] - Masbate City - Mobo - Uson - Cawayan - Balud - Mandaon - Milagros - Arory - Baleno - Dimasalang	1 2000 Cataingan DH[i] - Cataingan - Palanas - Placer - Espelanza	0

	No.	*Under planning*	*No.*	*Organized but not functioning*	*No.*	**Functioning**
No. of LGUs		13 municipalities and 1 city (67%)		4 (19%)		0 (0%)
Remarks	g: Orientation for LGU officials was given. MOA is under review. h: Orientation for health personnel has been given. i: New chief of hospital is not much cooperative. Mayors are passive to contribute to common fund. Integrated planning system is functioning.					
Sorsogon (CS*1) (Total No. of municipalities: 14 City: 1)	0		0		4	2000 Bulan DH - Bulan - Irosin - Matnog - Sta.Magdalena 2000 Gubat DH[j] - Gubat - Prieto Diaz - Bulusan - Barcelona 2000 Donsol DH - Donsol - Pilar 2000 Sorsogon DH - Sorsogon City - Castilla - Casiguran - Magallanes - Juban
No. of LGUs		0 (0%)		0 (0%)		14 municipalities and 1 city (100%)
Remarks	j: Training on Local Health Information Management System (LHIMS) has been given. Common drug management system between 2 municipalities is functioning. - All ILHZs: planning, referral and information management systems are functioning. - Although all mayors involved in ILHZs have committed to contribute to common fund, some of Local Health Board did not approve. - TMCs have been organized in all ILHZs and have meetings. They have established strategic plan.					

*1: CS= Convergence Site

Source: hearing from and questionnaire survey on PHOs, and hearing from DOH-reps and LHAD of CHD-Region V

According to CHD Region V, the key factors for successful operation of ILHZs are capability of Technical Management Committee (TMC), especially leadership, and capability to persuade stakeholders from the technical point of view of the chairperson (it is usually chief of core referral hospital.). However, even after an ILHZ has been organized, CHD has to start sometimes from the orientation again, in case governor or mayor is changed after the election.

Common drug procurement system is functioning at only one (1) ILHZ (among 2 municipalities) in Sorsogon. However, according to CHD, it is generally difficult to integrate drug procurement system, because each LGU has already established their own system and they have close connection sometime with drug suppliers.

3.2.6 Donor's Activities

The following table shows on-going and future donor's activities in Region V.

Even in the public health program support, donors provide necessary capability building and/or institutional strengthening support related to the subject programs. However, no support focusing on institutional /capability development for HSRA has been given or planned yet.

Regarding target areas, some donors provide support directly to municipal governments including field health workers and/or communities. UNICEF provides integrated support from central (DOH) to Barangay levels including LGUs, local health officers and field health service providers.

According to NEDA Regional Office, some municipal governments could not receive foreign assistance program, because they could not provide counterpart fund and staff for the health sector.

Table 3-7 Donor's current activities and future plans in Region V (as of October 2004)

	Assistance for public health programs	**Assistance for HSRA Implementation**
Albay	USAID: LEAD (Local Enhancement and Development) for Health*1 (2005~) (all municipalities) EU: HIV/AIDS (NGO support)	
Camarines Norte	UNICEF: Child-friendly movement*2	
Camarines Sur		
Catanduanes	USAID: LEAD for Health*1 (2005~) (all municipalities)	
Masbate	UNICEF: Child-friendly movement*2 UNFPA: Community empowerment and capability building of service providers for maternal heath, family planning, STI and VAW*3 (Dimasalang, Palanas and Placer)	
Sorsogon	World Bank: Women's Health and Safe Motherhood Project Phase 2 (WHSMP2) USAID: LEAD for Health*1 (2004~) (all municipalities) EU: HIV/AIDS (NGO support)	
Legaspi City	WHO: Public-private DOTS strategy	
Iriga City		
Naga City		

*1: Capability building for procurement and distribution of health commodity for municipal/ city governments.
*2: Under 6th country program (2005~2009). Major activities include adolescent maternal health, under nutrition and micronutrient deficiency elimination and child health and sanitation.
*3: Community empowerment and capability building of health workers for selected 3 municipalities.
*4: *It is planning as a target site.*

Source: hearing from DOH, donors and CHD-Region V

3.2.7 Findings from the Regional Workshop

The regional workshop was held as follows;

Date: 26 October 2004 8:00~16:00

Place: CHD-Region V

Participants: representatives from CHD-Region V, provincial, city and municipal health offices, hospital, PHIC regional office and NEDA regional office

List of participants, detailed records of discussion and products of the workshop are presented in Annex L.

Participants were divided into 4 groups, i.e., CHD, Provincial, City and Municipal Health Offices, DOH retained hospital and LGU hospital. Problem and alternative solutions identified in each group are shown in the Annex L, which are summarized as follows.

(1) Problems

CHD group identified the core problem in the public health services and the other three (3) groups identified problems in the hospital. The participants, especially CHD and provincial health staff analyzed and indicated that the fragmentation of health services after devolution and political intention had affected the quality of health services. In addition as the quality of district hospital services is not maintained, people do not believe in the public hospitals.

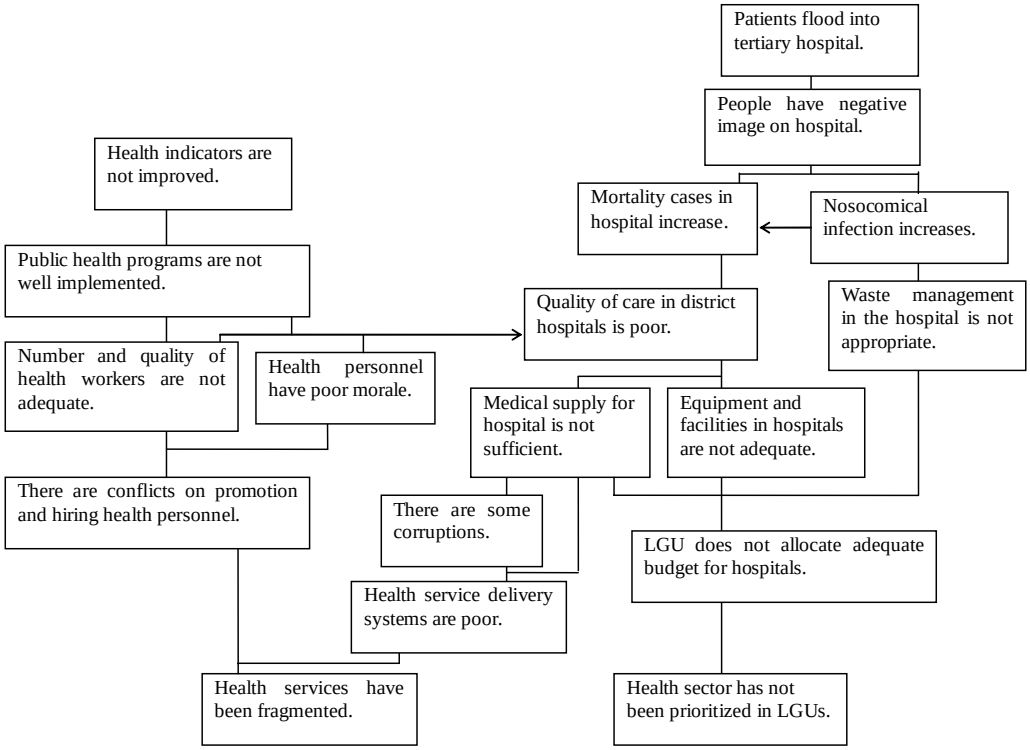


Figure 3-18 Summarized problem tree of health sector in Region V

(2) Alternative solutions

The alternative solutions identified by the participants to improve the above situation are summarized in the following strategies. The participants suggested beginning with ensuring support for health sector from LGUs to allocate adequate budget to improve health facilities and equipment and to maintain health care service providers, as well as the need for external financial support to construct new facilities. However, it was difficult for them to consider practical strategies to utilize and maintain the new and upgraded facilities and equipment.

1) Ensuring support from LGUs, especially provincial government
   - To have constant dialogue with Local Chief Executives (LCEs), DOH and related organizations.

2) Improvement of health facilities and equipment
   - To improve income generating capability of health facilities.
   - To construct new health centers and/or to upgrade equipment in health facilities to increase income from PHIC and from the patient for pay ward.

3) Improvement of capability for public health program implementation
   - To integrate and improve health service delivery system in ILHZ by constructing new research and training center, mobilizing community in health service planning and implementation, and modifying procurement system.
   - To maintain adequate health manpower.
   - To functionalize referral system by improving quality of services in RHUs

3.3 Region VIII (Eastern Visayas)

3.3.1 Demography

Region VIII is located in the easternmost border of the Philippine Archipelago. Its two main islands, Leyte and Samar are connected by San Juanico Bridge. The region consists of six provinces, i.e., Northern Layte, Biliran, Southern Leyte, Western Samar, Eastern Samar and Northern Samar. Its land areas are 21,435km^2 and relatively flat terrain. Near and along its coasts, and mountainous areas are located in the middle portion of both islands.

The basic demographic data in each province/ city is shown in the following table.

Table 3-8 Demography of each province/ city in Region VIII

	*No. of Cities *1*	*No. of Municipalities*1*	*No. of Barangays* 1*	*Total Population *2*	*No. of House-holds*3*	*Annual Pop. Growth rate*2*	*Poverty Prevalence Rate in Population *4*	**Income class*5**
Year	2004	2004	2004	2002	2002	2001-02	2000	
Biliran	0	8	132	154,022	28,161	2.14	45.1	4
Eastern Samar	0	23	597	410,544	73,242	1.70	57.1	2
Northern Samar	0	24	569	1,771,024	90,188	1.74	50.4	2
Western Samar	1	25	951	519,455	123,258	2.01	48.0	2
Northern Leyte	2	41	1,641	678,827	325,668	2.21	41.9	1
Southern Leyte	1	18	500	368,552	72,734	2.08	37.7	3
Total in Region VIII	4	139	4,390	3,902,407	713,251	2.04	45.4	

Source: *1- 2004 Philippine Statistical Yearbook, NSCB, 2004
*2- 1995 Census-Based Population Projection, Vol II, NSO,1997
*3- Field Health Service Information System, National Epidemiology Center - DOH, 2002
*4- Provincial Poverty Statistics, 2000, NSCB
*5- Questionnaire Survey on Provincial Health Offices

3.3.2 Health Status

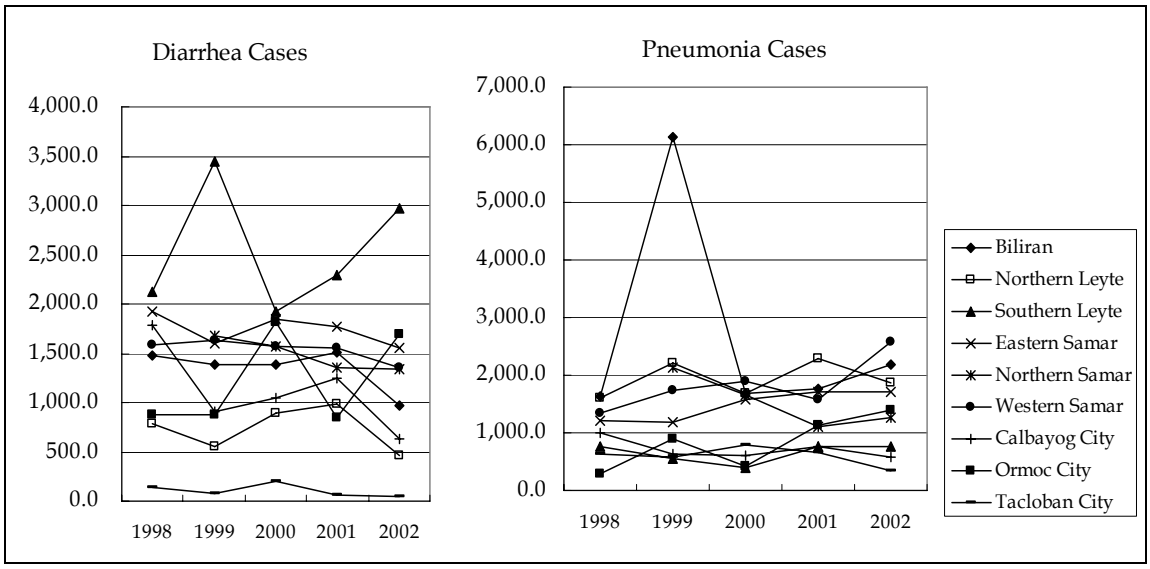
(1) General

Life expectancy in Region VIII was projected at 64.45 for men and 68.50 for women in 2002. The difference between the province of the longest life expectancy (Biliran and Northern Leyte: 66.03 for men and 70.61 for women) and the one of the shortest (Western Samar: 62.10 for men and 65.22 for women) is about 5 years.

As shown in Table E-1.3 in Annex E, major causes of morbidity in 2003 are respiratory diseases, especially pneumonia, tuberculosis, diarrhea and parasitism. Major causes of mortality in each province are pneumonia and other respiratory diseases, vascular diseases and tuberculosis. Therefore, burden of infectious diseases is still high in the Region VIII.

The following figure shows reported incidence of diarrhea and pneumonia in the recent 5 years (1998 – 2002). Reported incidence of diarrhea per 100,000 persons in Region VIII has decreased since 1998 (Table E-2 in Annex E) and the average of the 5 years is 1,240 per

100,000 population. In Southern Leyte, it is the highest among the provinces (2,552 per 100,000). According to the result of National Demographic and Health Survey 2003 (NSO, 2004: NDHS03), among the children under five years, diarrhea prevalence[13] was 9.8% and it is under the national average (10.6%). However, only 43.5% of those children were taken to a health facility to seek care.



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-19 Reported incidence of diarrhea and pneumonia in Region VIII (1998 – 2002) (per 100,000 persons)

Reported incidence of pneumonia per 100,000 persons has increased since 1998 (Table E-4 in Annex E). The average of the recent 5 years (1998 – 2002) in Region VIII is 1,553 per 100,000 persons. It is the highest in Biliran (2,683 per 100,000 persons) and the lowest in Southern Leyte (648 per 100,000 persons). According to the results of NDHS03, among the children under five years, prevalence of acute respiratory infection (ARI) and fever[14] were 15.6% and 27.4%, respectively and 51.9% of these children received the treatment. ARI and fever are some of the major direct causes of pneumonia, therefore, the above percentage of low care seeking for ARI and fever might have affects on its high incidence.

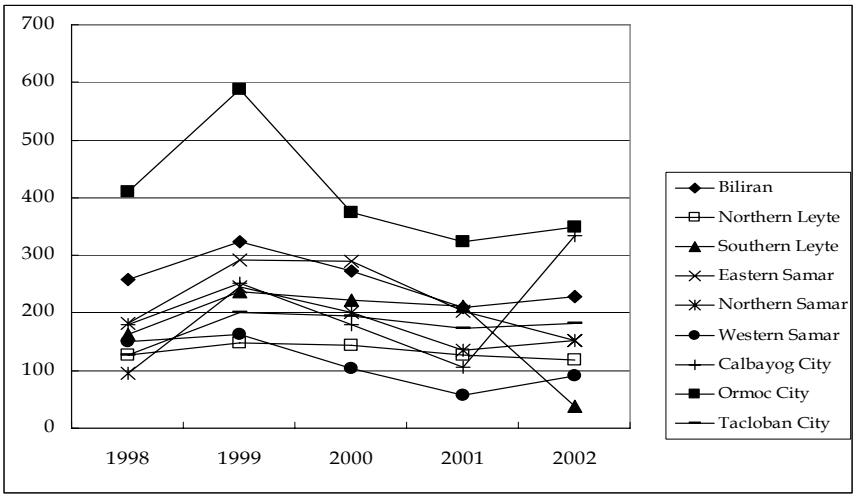
Most of diarrhea and respiratory infection cases are caused by environmental conditions such as lack of safe water and sanitary toilet (Table E-4 and 5 in Annex E). In Region VIII, 88.2% of household have access to safe water supply. It is more than 100% in Southern Leyte and the lowest in Northern Leyte (82.0%). Households with sanitary toilet represent 66.3% of total households in Region VIII. It is 83.5% in Southern Leyte, while 44.4% in Western Samar in 2002.

[13] The percentage of the children with diarrhea in the two weeks proceeding the survey period of NDHS03 (from June 16 to September 3, 2003).

[14] The percentage of the children with symptoms of ARI and fever in the two weeks proceeding the survey period of NDHS03 (from June 16 to September 3, 2003).

(2) Infectious diseases

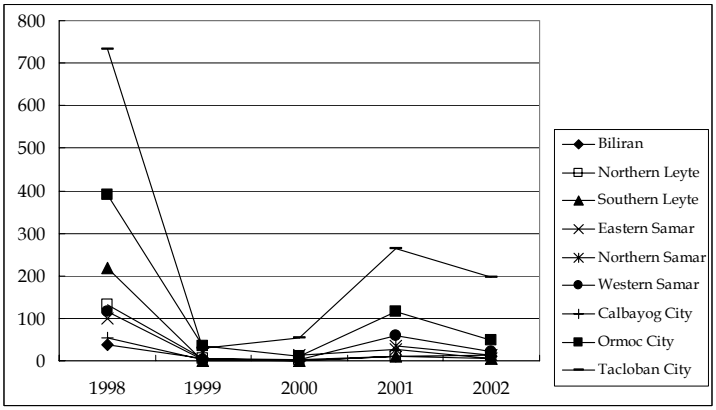
As described in the previous section, tuberculosis is one of the major causes of morbidity and mortality in Region VIII. Reported tuberculosis incidence per 100,000 persons in Region VIII increased since 1999 as shown in Table E-6 in Annex E, and the average of the recent 5 years (1998 – 2002) is 170 per 100,000 persons. This is lower than the national average (177 per 100,000 persons). It is higher in Biliran (258 per 100,000 persons) and in Eastern Samar (223 per 100,000 persons).



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-20 Reported incidence of TB in Region VIII (1998 – 2002) (per 100,000 population)

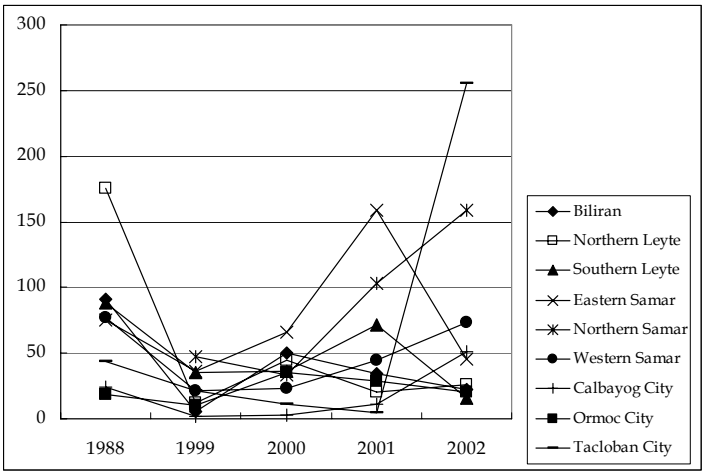
The average of reported incidence of dengue cases of the recent 5 years (1998 – 2002) in Region VIII is 51 per 100,000 persons (Table E-9 in Annex E), and it is twice as high as the national average (26 per 100,000 persons). Among the provinces, the range of the average of the recent 5 years is 13 (in Biliran) to 47 (in Southern Leyte). However, those are considerably high in Ormoc and Tacloban cities, 120 and 256 per 100,000 persons, respectively.



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-21 Reported incidence of dengue in Region VIII (1998 – 2002) (per 100,000 population)

Reported incidence of Measles in Region VIII has decreased since 1998 as shown in Table E-7 in Annex E and the average of the recent 5 years (1998 – 2002) is 58 per 100,000 persons. This is higher than the national average (28 per 100,000 persons). It is higher in Northern Samar (86 per 100,000 persons) and in Eastern Samar (76 per 100,000 persons) among the provinces.



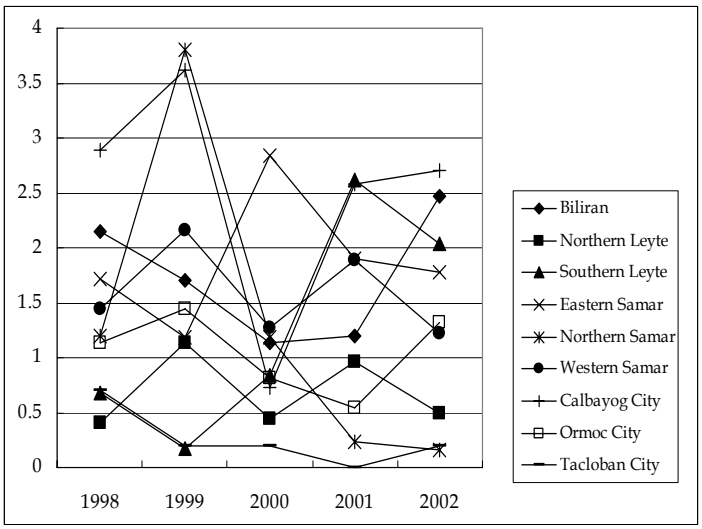
Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-22 Reported incidence of measles in Region VIII (1998 – 2002) (per 100,000 population)

(3) Women's health

1) Health status

Total number of reported maternal death in Region VIII is 83 (1.0 per 1,000 live births) in 2002 as shown in Table E-10 in Annex E. Changes of the maternal mortality rate per 1,000 live births are shown in the following figure. The average of maternal mortality rate for the recent 5 years (1998 – 2002) is 1.10 per 1,000 live births in Region VIII and it is higher than the national average (0.65 per 1,000 live births). In Biliran and Eastern Samar, the rates are higher (1.7 and 1.9 per 1,000 live births, respectively).



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-23 Reported maternal mortality rate in Region VIII (1998 – 2002) (per 1,000 live births)

According to "Philippine Nutrition Facts & Figures 2001[15]" (Food and Nutrition Research Institute, Department of Science and Technology (DOST-FNRI), 2001), prevalence of vitamin A deficiency is 9.2% among pregnant women and 4.3% in lactating women in Region VIII (Table E-11 in Annex E). Western Samar has high prevalence among pregnant and lactating women, 25.1% and 13.9%, respectively.

Prevalence of anemia among pregnant women in Region VIII is 61.7%, especially, Eastern Samar shows 84.2% and Southern Leyte and Western Samar show more than 60%. (Table E-12 in Annex E) According to rural health midwives working in City Health Centers in Tacloban City, they have not been able to provide iron tablet to pregnant women due to insufficient supply from LGU. They advise pregnant women to buy it in private pharmacies.

Total Fertility Rate (TFR) in Region VIII is estimated at 4.6 and it is higher than the national average (3.5), however, wanted fertility rate is estimated at 2.9 in 2003 (NSO, 2004, NDHS03). On the average, women in Region VIII have almost 2 more child than their desired number of children in their lifetimes.

2) Health services

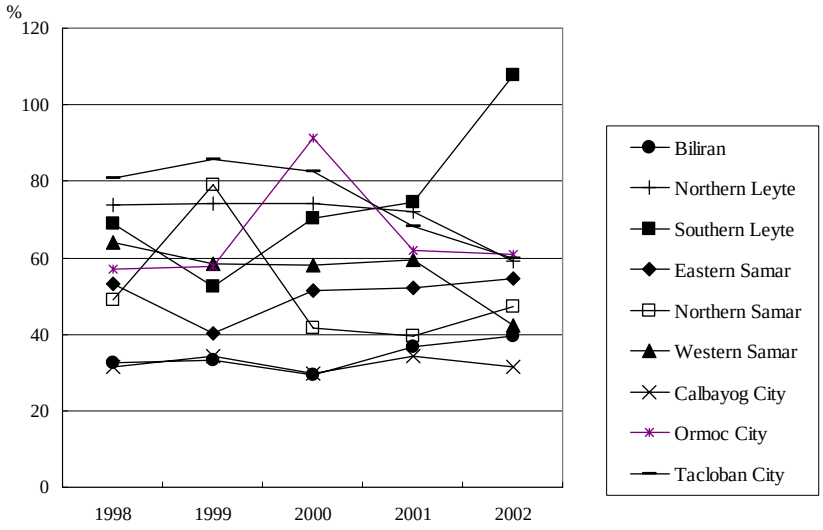
In Region VII, 19.1% among the women who had a live birth for the last 5 years had antenatal care by doctors during the pregnancy for the most recent birth, 60.0% of them had it by nurses/ midwives, and 17.9% by Traditional Birth Attendant (TBA). Percentage of antenatal care by TBA is considerably higher than the national average (6.5%). About 35.1% of pregnant women had tetanus toxoid injections twice during their pregnancy; however 33.9% of them

[15] The report based on 1993 and 1998 national nutrition surveys.

never had the injection (NSO, 2004, NDHS03).

The most popular place of delivery in Region VIII is home. Seventy nine percent of women delivered their children in home and only 14.7% of women delivered in government hospitals, and 5.3% in private hospitals or clinics (NSO, 2004, NDHS03).

According to the result of NDHS03, 16.4% of the most recent deliveries for the last 5 years were attended by doctor and 19.6% by nurses and/or midwives in the 5 years. And 62.3% of deliveries were attended by Traditional Birth Attendant (TBA). It means that more than 1 out of 2 deliveries attended by TBA. Comparing to the national average (37.1%), it is higher. The following figure shows the change of the percentage of deliveries attended by skilled health personnel including doctor, midwife and nurse in each province for the recent 5 years (1998 – 2002) according to Field Health Services Information Systems (FHSIS) by DOH. The average of percentage of the recent 5 years is the lowest in Biliran (34%) among the provinces. Those are more than 70% in Southern Leyte and Northern Leyte, and around 50% in other provinces. (Data is presented in Table E-13, 14 and 15 in Annex E.)



Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-24 Deliveries attended by skilled health personnel in Region VIII (1998 – 2002)

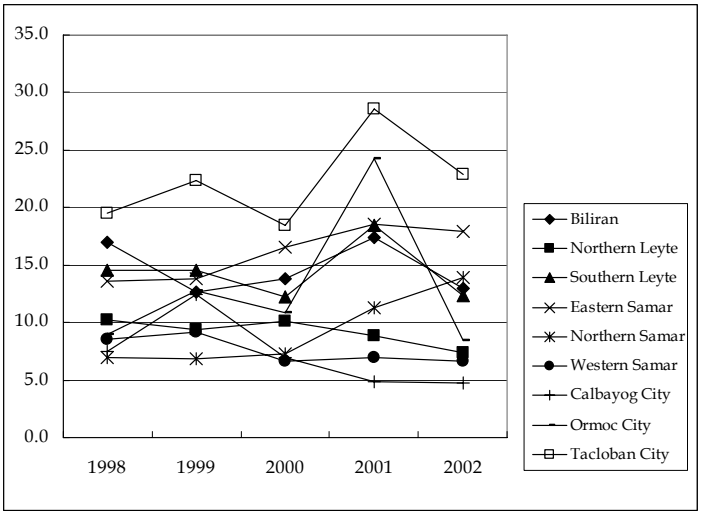
Regarding family planning, less than 30% of married women used modern contraceptive method in 2002 and condom users were 1.7%. Pill and female sterilization were popular among modern method users (Table E-16 in Annex E).

(4) Children's health

1) Health status

Child mortality rates are estimated at 24 for neonatal mortality, 36 for infant mortality and 57 for under 5 mortality in Region VIII in 2003 (per 1,000 live births) (NSO, 2004, NDHS03). These rates are higher than the national average (neonatal mortality rate; 13, infant mortality

rate; 30 and under five mortality rate; 42). According to DOH, total reported number of infant death in Region VIII is 915 and infant mortality rate is 11.0 per 1,000 live births in 2002 as shown in Table E-17 in Annex E. The average of the recent 5 years (1998 – 2002) is 11.3 per 1,000 live births. Changes of the infant death rates per 1,000 live births are shown in the following figure. The average of the recent 5 years is the highest in Southern Leyte (24.8 per 1,000 live births) and lower in Northern Leyte and Western Samar (6.3 and 7.6 per 1,000 live births, respectively).

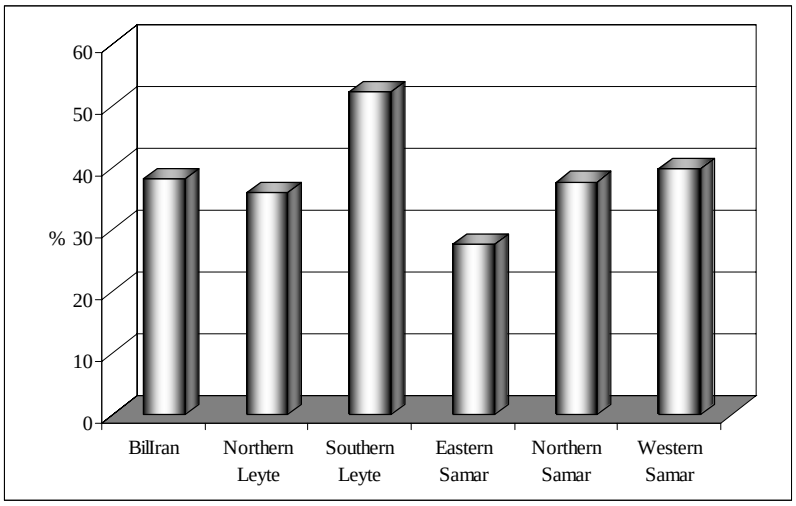


Source: Field Health Services Information System, DOH, 1998 - 2002

Figure 3-25 Reported infant mortality rate in Region VIII (1998 – 2002) (per 1,000 live births)

The following figure shows the percentage of underweight children by the weight-for-age classification of NCHS (USA's National Center for Health Statistics)/ WHO[16] (Table E - 18 in Annex E). Thirty eight percent of 0-5 year-old children in Region VIII are underweight. The percentage is the highest in Southern Leyte (52.3%) and the lowest in Eastern Samar (27.5%).

[16] Cut-off point of NCHS (USA's National Center for Health Statistics)/ WHO standards for weight-for-age are; Underweight: Less than - 2SD, Normal: - 2SD to +2SD, and Overweight: more than +2SD



Source: Philippine Nutrition Facts & Figures 2001, DOST, 2001

Figure 3-26 Percentage of underweight 0-5 year-old children in Region VIII

Prevalence of vitamin A deficiency and anemia among 6 month-old to 5 year-old children in Region VIII is 10.4% and 47.3%, respectively. It is the highest in Western Samar (27.3% and 59.1%). Prevalence of vitamin A deficiency is the lowest in Northern Samar (2.2%). Prevalence of anemia is the lowest in Biliran (36.4%) (Table E-19 and 20 in Annex E).

2) Health services

Percentage of fully immunized children among 12-23 months old[17] is 70.3% in Region VIII in 2003 (NSO, 2004, NDHS03). According to DOH, the percentage of reported fully immunized children among 9-11 month-old ones has decreased from 88.3% in 1998 to 67.8% in 2002 as shown in Table E-21 in Annex E. It is the highest in Eastern Samar (82.4%) and the lowest in Western Samar (53.7%) among the provinces in 2002.

(5) Life-style related diseases

Cancer is one of the top ten causes of mortality in all the provinces as described in previous section, except Western Samar[18] in 2003. However, the reported cases seem to be fewer in FHSIS, 96 cancer cases were reported in 2002 (Table E-22). Reported incidence of hypertension is the highest in Southern Leyte (2,231 per 100,000) (Table E-23).

3.3.3 Health Services and Facilities

According to the data of Field Health Services Information System (FHSIS), as shown in the Annex F-3-1, F-3-2 and F-3-3, there is a total of 76 hospitals in Region VIII. Out of 76 hospitals, 2 are DOH operated hospitals; namely Schistosomiasis Hospital in Palo City, Eastern Visayas Regional Medical Center in Tacloban City. In addition to DOH hospitals, there are 4

[17] Percentage of children age 12-23 months received BCG, DTPx3, Poliox3 and Meales.
[18] No data was provided by provincial health office.

provincial hospitals and 42 district, municipal or community hospitals, and 28 private hospitals. The total number of RHU and BHS is 139 and 556, respectively.

The specific problems in connection with the health facilities in this Region are as follows.

(1) Most conspicuous feature of this region is that accreditation and certification of health facilities are completed in Biliran and Southern Leyte, and this attributed to the support to health sector by GTZ.

(2) Provincial difference

While the health facilities are exceedingly developed or completed in Biliran and Southern Leyte, re-arrangement and disposal of the facilities are underway in other provinces.

Table 3-18 Health Facilities by Province in Region VIII

Province/City		**Biliran**	**Eastern Samar**	Northern Samar	Western Samar	Northern Leyte	**Southern Leyte**	TOTAL	Rate
Non-LGU Hospitals	Accredited by PHIC (Tertiary)	**0**	**0**	0	0	1	**0**	1	50.0%
	Accredited by PHIC (Secobdary)	**0**	**0**	0	0	0	**0**	0	0.0%
	Accredited by PHIC (Primary)	**0**	**0**	0	0	1	**0**	1	50.0%
	Non accredited	**0**	**0**	0	0	0	**0**	0	0.0%
	Total	**0**	**0**	0	0	2	**0**	2	
LGU Hospitals	Accredited by PHIC (Tertiary)	**0**	**0**	0	0	0	**1**	1	2.2%
	Accredited by PHIC (Secobdary)	**1**	**2**	2	2	5	**1**	13	28.3%
	Accredited by PHIC (Primary)	**0**	**10**	6	2	5	**5**	28	60.9%
	Non accredited	**0**	**0**	0	2	2	**0**	4	8.7%
	Total	**1**	**12**	8	6	12	**7**	46	
Private Hospital	Accredited by PHIC	**0**	**6**	1	2	9	**1**	19	67.9%
	Non accredited	**0**	**0**	2	1	3	**3**	9	32.1%
	Total	**0**	**6**	3	3	12	**4**	28	
RHUs*	Accredited by PHIC	**8**	**11**	7	2	10	**19**	57	36.8%
	SS Certified	**8**	**13**	8	7	22	**19**	77	49.7%
	Non SS certified	**0**	**13**	16	20	29	**0**	78	50.3%
	Total	**8**	**26**	24	27	51	**19**	155	
	Municipality	**8**	**23**	24	25	41	**18**	139	
BHSs	SS Certified	**1**	**0**	0	0	0	**4**	5	0.6%
	Non certified	**34**	**106**	129	122	289	**104**	784	99.4%
	Total	**35**	**106**	129	122	289	**108**	789	
	Barangay/ BHS	**3.77**	**5.63**	4.41	7.80	5.68	**4.63**	5.56	
	BHWs/BHS	**32**	**20.4**	18.2	23.40	18.3	**16**		

* Total = (SS Certified) + (Non SS Certified)

BOLD: Convergence Site

Source: Licensing. Regulations and Enforcement Division, CHD-Region V, PHIC

Regarding the referral system within the functioning of ILHZ, health facilities are as follows.

Table 3-19 ILHZ and health facilities in Refion VIII

Province	Name of ILHZ	No. of LGUs	No. of Hospitals	No. of RHUs
Biliran	Nacal PH	8	1	8
Eastern Samar	Borongan PH	5	1	6
	Balngiga PH	4	2	4
	Taft DH	4	3	4
	Guiuan DH	5	1	6
Southern Leyte	Sogod DH	5	2	5
	Maasin PH	5	2	6
	Pacific DH	6	2	6
	Panaon DH	3	1	3

Source: Licensing. Regulations and Enforcement Division, CHD-Region V, PHIC

3.3.4 Health Financing

(1) Expenditure on health service in provincial government

The maintenance and other operating expenses for health sector in each provincial government in 2003 are shown in the following table.

Table 3-20 Health related maintenance and other operating expenses in each province in Region VIII (2003)

Unit: million pesos

	Total of Personal Services Expenses	Maintenance and Other Operating Expenses (MOOE)				Total Expenses
		Total of MOOE	Medical, Dental & Lab. Supplies Expense	Hospitals & Health Center Maintenance	Others	
Biliran	75,683,788	40,258,168 (100.00%)	8,094,708 (20.11%)	656,364 (1.63%)	31,507,096 (78.26%)	115,941,956
Eastern Samar	219,471,384	49,809,304 (100.00%)	10,364,928 (20.81%)	272,519 (0.55%)	39,171,858 (78.64%)	269,280,689
Northern Leyte	423,176,718	199,612,054 (100.00%)	Not Available	626,691 (0.31%)	198,985,362 (99.69%)	622,788,772
Northern Samar	254,099,006	86,343,674 (100.00%)	Not Available	126,221 (0.15%)	86,217,454 (99.85%)	340,442,680
Western Samar	Not Available					
Southern Leyte	169,666,253	72,227,116 (100.00%)	10,102,387 (13.99%)	36,503 (0.05%)	62,088,226 (85.96%)	241,893,369

Source: Commission on Audit (COA)

Expenditures on the maintenance of health facilities are generally under 1% in each province except in Biliran. Regarding medical, dental and laboratory supplies, although data for 3 of 6 provinces is not available, Biliran, Eastern Samar and Southern Leyte had spent around 10-25% of MOOE.

Provincial and municipal health officers and health facility staff revealed, however, that the budget does not cover the payment of necessary expenses for maintaining necessary equipment and facilities and for hiring appropriate health workers, especially doctors.

Budget allocation is affected by priority setting by LGUs and commitment of LCEs. According to CHD and provincial health officers, provincial governments of Biliran, Eastern

Samar and Southern Leyte have given high priority to health sector, while health facilities in Western Samar have not been well maintained because of low priority set by the governor for health sector. Therefore, patients from Western Samar are flowing into Eastern Visayas Regional Medical Center. Provincial government of Northern Leyte expects to transfer Ormoc District Hospital to Ormoc City due to lack of budget, while Ormoc City does not accept it.

(2) Health insurance

The following table shows the membership status of PHIC in each province. Coverage ratio in Region VIII is 85.5%. It is the highest in Northern Leyte (94.4%) and the lowest in Northern Samar (64.1%) as of October 2004.

Table 3-21 PHIC membership status in each province in Region VIII (as of September 2004)

	Employed	*Individual*	*Non-paying*	*Sponsored*	*Total*	**Coverage**
Biliran	3,856	2,144	235	18,210	24,445	83.7%
Eastern Samar	10,523	3,182	900	49,471	64,076	83.0%
Northern Samar	9,656	2,350	403	56,003	68,412	64.1%
Western Samar	14,361	4,050	607	69,728	88,746	85.7%
Northern Leyte	63,289	19,957	3,747	158,857	245,850	94.4%
Southern Leyte	12,217	2,691	784	40,201	55,893	88.9%
Total in Region VIII	113,632	34,374	6,676	392,470	547,422	85.5%

Note: *Coverage=total member x 5 (average number of household member)/ total population in 2000

Source: PHIC Region VIII office

According to PHIC Regional Office, LGUs contribute to sponsored program without large amount of external financial supports such as congress men or private funds, and all provincial governments, except in Western Samar that provides financial support to municipal governments. The PHIC Regional Office has given orientation on LGUs' contribution to sponsored program for the next year to PHO, MHO and LCEs. Both provincial and municipal governments in the region, especially Biliran and Southern Leyte are cooperative to sponsored program.

The premium collection status for each program and claims status for benefit payment are shown in the table below.

Table 3-22 Premium collection and claims paid status in Region VIII (2001 – Sep. 2004)

(Thousand pesos)

	2001		*2002*		*2003*		**Jan-Sep 2004**	
	Collected	Paid	Collected	Paid	Collected	Paid	Collected	Paid
Employed (Gov)	96,795	120,773	126,098	114,662	136,368	116,705	116,551	109,505
Employed (Priv)	39,323	60,715	45,962	59,999	54,939	66,072	45,626	67,079
Individually paying	7,246	*1	9,352	*1	11,264	*1	12,027	*1
Sponsored	3,007	5,311	9,577	6,737	17,646	10,664	15,859	31,792

Total	146,370	186,800	190,989	181,398	220,217	193,442	190,064	208,376

*1: Paid amount for individual paying program is included to private employed program.

Source: PHIC Region VIII office

The paid amount for the sponsored program during the period from January to September 2004 is 31,792 thousand pesos, which is almost 3 times of total amount of 2003 (10,664 thousand pesos). Membership of the sponsored program increased rapidly, because of the national campaign for enhancement of enrolment of sponsored program held in several months before the election (May 2004). Utilization of membership in health facilities has rapidly increased accordingly. Total paid amount during the period of Jan. – Sep. 2004 also exceeded the amount of collected premium.

PHIC Region VIII office has been monitoring collection rate against the estimated target since 2002. According to them, total collection rate has been decreasing; 154% in 2002, 91% in 2003 and 83% as of September 2004 due to decreasing of collection rate in employment program. The latest collection rate in employment programs (both government and private) is 78%, while 171% in the sponsored program.

3.3.5 Local Health Systems

(1) Ovevall ILHZ situation

CHD Region VIII has been assisted by GTZ for HSRA implementation including organizing and operating of ILHZs for 3 years as described in later section (3.3.6). Both CHD and GTZ concentrated their support to convergence sites, i.e., Southern Leyte, Biliran and Eastern Samar, and then to expand to the other area. CHD's support include facilitating the stakeholders such as local chief executives, PHOs and MHOs to organize ILHZ, to establish the necessary systems support, providing technical assistance to prepare the manuals and supervising the implementation of their activities. However, CHD's support for non-convergence sites has not been progressed because of the budget constraints, according to Local Health Assistance Division (LHAD).

Regarding the activities for ILHZs, the CHD started from a pilot site, Sogod ILHZ in Southern Leyte, and it is going to expand their support to the other ILHZs of the province, simultaneously initializing the activities in Biliran and Eastern Samar.

As mentioned in Chapter 2, conditions of "functioning" ILHZs vary among the regions, and according to Local Health Assistance Division (LHAD) of CHD Region VIII, conditions of "functioning" Inter-Local Health Zone (ILHZ) are as follows.

For all ILHZs;

- Integrated health plan has been established.
- Integrated referral system is functioning
- Integrated management of health information system is functioning

In addition to the above conditions, following are also required for ILHZs in convergence sites;

- Integrated drug management system based on RDIF has been established
- Common human resources management system has been established.
- Integrated health care financing has been established.

The following table presents the situation of ILHZs in each province and data on population and health facilities and functioning systems in ILHZs for which MoA has been signed are presented in Annex K-3.

Table 3-23 Situation of Inter-Local Health Zones (ILHZs) in Region VIII (as of October 2004)

Legend: figure= year of MOA signed
name of core-referral hospital
- name of municipality

	No.	*Under planning*	*No.*	*Organized but not functioning*	*No.*	**Functioning**
Total in Region VIII	4		0		9	
Biliran (CS*) (Total No. of municipalities: 8)	0		0		1	2003 Naval PH[a] - Biliran - Naval - Almeria - Lulaba - Cabncagayan - Kawayang - Caibiran - Maripipi
No. of LGUs		0 (0%)		0 (0%)		8 (100%)
Remarks	a: Referral , integrated health planning and information management systems are functioning.					
Eastern Samar (CS*) (Total No. of municipalities: 23)	2	Oeas DH[b] - Oeas - Snaslog - San Palicayso - Jipapad - Daloes Anteche DH[b] - Anteche	0		4	2004 Borongan PH[c] - Paorongan - San Juan - Maydelong - Balangkayan - Dointe 2004 Balngiga PH[c] - Balangiqui - Lawaab - Giporlos - Quinapondan 2004 Taft DH[c] - Taft - Sulat - Canavid - Dolores 2004 Guiuan DH[c] - Guian - Mercedes - Heinani - Salcedo - San Mearthur

	No.	*Under planning*	*No.*	*Organized but not functioning*	*No.*	**Functioning**
No. of LGUs		6 (26%)		0 (0%)		17 (74%)
Remarks	b: Orientation for LCEs has held in October 2004. c: Referral, integrated health planning and information management systems have been introduced.					
Northern Samar (Total No. of municipalities: 24)	3	(core-referral is not identified) - Gamay - Mapanas - Lapinig Capul DH - Capul - San Vicente Biri DH - Biri	0		0	
No. of LGUs		6 (25%)		0 (0%)		0 (0%)
Remarks	- Orientation for to all the municipalities was given in October 2004; but, only 6 municipalities listed above sent their representatives.					
Western Samar (Total No. of municipalities: 25 City: 1)	2	Calbayog DH - Calbayog City - Sta. Margarita - Sto. Nino - Almagro - Tagapulan Gandara DH - Gandara - Matuguinao - San Jorge - Pansanghan	0		0	
No. of LGUs		8 municipalities and 1 city (35%)		0 (0%)		0 (0%)
Remarks	- Orientation for LCEs was held in October 2004.					
Northern Leyte (Total No. of municipalities: 41 Cities: 2)	1	Leyte PH - Tacloban City - Palo - Tolosa - Duulag - Tanauan - Pastrana - Santa Fe - Alangalang - Babatangon	0		0	
No. of LGUs		8 municipalities and 1 city (21%)		0 (0%)		0 (0%)
Remarks	- Orientation for LCEs has been completed.					

	No.	*Under planning*	*No.*	*Organized but not functioning*	*No.*	**Functioning**
Southern Leyte (CS*) (Total No. of municipalities: 18 City: 1)	0		0		4	2003 Sogod DH[d] - Sogod City - Bontoc - Libagon - Liloan - Ceppun 2003 Maasin PH[e] - Maasin - Macrohon - Padre Burgos - Malitbog - Limasawa 2003 Pacific DH[f] - Silago - Hinunangon - Hinundayan - Anahawan - San Juan - St. Bernard 2003 Panaon DH[g] - San Francisco - Pintuyan - San Ricardo
No. of LGUs	0 (0%)		0 (0%)			18 municipalities and 1 city (100%)
Remarks	d: Planning (both strategic and annual operational), information and drug management (for 3 municipalities) are functioning and referral manual is under finalization and training. e: Integrated planning, referral and information management systems are functioning. f: Integrated planning and referral systems, and common financing among some LGUs are functioning. g: Integrated planning, referral and information management systems, and common financing among some LGUs are functioning					

*1: CS= Convergence Site

Source: hearing from and questionnaire survey on PHOs, and hearing from DOH-reps and LHAD of CHD-Region VIII

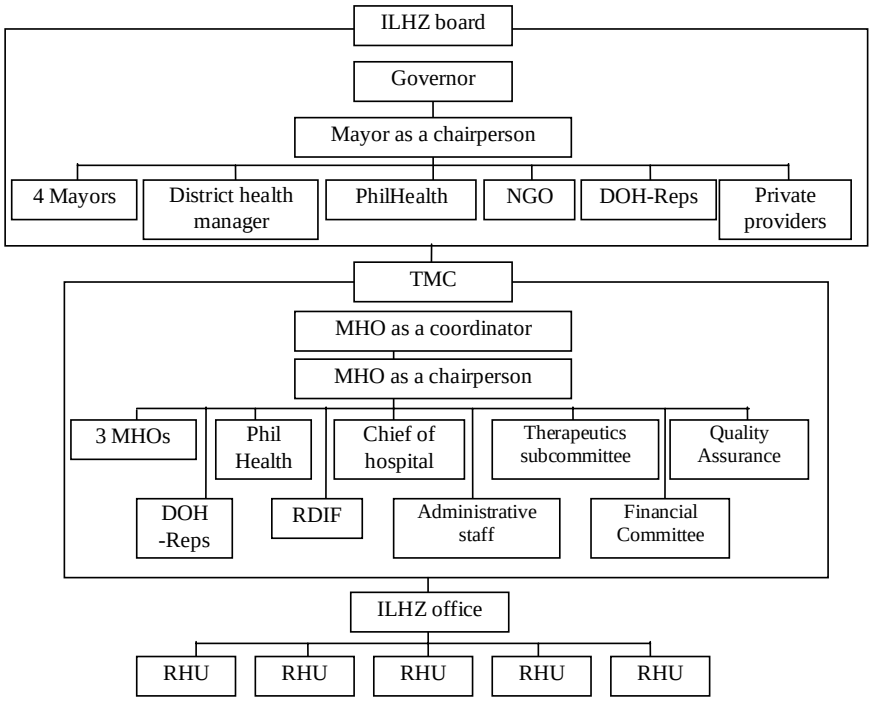
According to CHD Region VIII, the ideal number of municipalities in ILHZ is 5 to 6, because it is easy to manage. Based on their experiences, if more than 7 LGUs are involved in one ILHZ, it would be difficult to arrange meeting, to form consensus and to operate the activities. CHD staff have been attending meeting of ILHZs since the initial stage to keep close communication with the stakeholders such as mayors, governors, local health officers and DOH-Reps.

(2) Sogod Bay ILHZ

Memorandum of Agreement among the 5 LGUs and provincial government was signed in December 2003. Integrated strategic health plan has been established and annual operational plan for 2005 is being finalized. Integrated management of health information system focusing on baseline and monitoring is also functioning. Manual on integrated referral system is being

finalized through the training seminar. Drug management system with "Revolving Drug Insurance Fund (RDIF)[19]" is being operated in pilot sites in 3 municipalities.

Overall organization of the ILHZ is shown below.



Source: Sogod Bay ILHZ Office

Figure 3-27 Organization of Sogod Bay Inter-Local Health Zone

Major products developed for the ILHZ are as follows;

- Improving hospital performance/ reform
- Quality management of hospital and RHUs
- Baseline and monitoring system
- Referral system
- Revolving drug insurance fund
- Making drug accessible/ health plus outlets and pooled procurement
- Family/ reproductive health package
- Implementation of PHIC indigent package
- Social Health Insurance/ Social Marketing Scheme to increase informal sector enrollment
- Developing modules of cooperation with PHIC and organized groups for informal sector

[19] RDIF is a drug management system involving accredited private pharmacies, and is operated with the financial support of LGUs. It aims to provide appropriate medicines to sponsored program members of PHIC. LGUs contribute P200/family/year from total capitation fund of PHIC (total is P300/family/year) to the drug fund. RHU/ hospitals issue drug coupon to sponsored program members to get medicines in accredited pharmacies. Pharmacies must agree to uniform pricing of essential drugs for sponsored program patients defined by the RDIF committee.

CHD and provincial health office had initiated and organized the ILHZ in 2001 with the support of GTZ. CHD spent almost a year to facilitate and persuade local chief executives such as mayors, although the governor of Southern Leyte has been very supportive and expressing strong commitment to the health sector reform.

CHD and the provincial health office are planning to expand their support to organize ILHZs in other areas in Southern Leyte based on the experience.

3.3.6 Donor's Activities

The following table shows on-going and future activities of donors in Region VIII.

Donors provide, even in the public health program, the necessary capability building and/or institutional strengthening support related to the subject programs.

Regarding target areas, some donors provide support directly to municipal governments including field health workers and/or communities, while some provide integrated support from central (DOH) to Baranguay levels including LGUs, local health officers and field health service providers.

Table 3-24 Donor's current activities and future plans in Region VIII (as of October 2004)

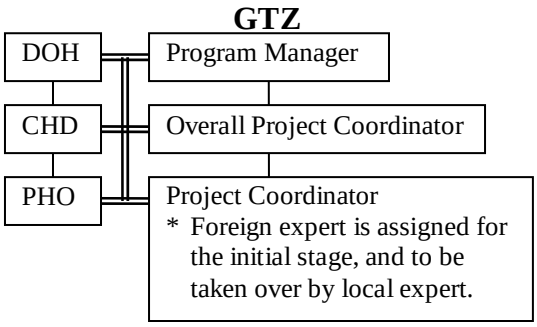
	Assistance for public health programs	**Assistance for HSRA Implementation**
Biliran	USAID: LEAD (Local Enhancement and Development) for Health*1 (all municipalities)	GTZ: Local Health System Development (LHSD) (2004~) KfW: LHSD (infrastructure) *2 EU: HSRA*2
Eastern Samar	USAID: LEAD for Health*1 (2005~: 12 municipalities) (2006~: all municipalities) UNICEF: Child-friendly movement*3 UNFPA: Community empowerment and capability building of service providers for maternal heath, family planning, STI and VAW*4 (Maydolong, Sulat and Liorente)	GTZ: LHSD (2005~) KfW: LHSD (infrastructure) *2 EU: HSRA*2
Northern Samar	UNICEF: Child-friendly movement*3	
Western Samar		
Northern Leyte	USAID: LEAD for Health*1 (2005~: 15 municipalities and Tacloban and Ormoc)) (2006~: all municipalities)	
Southern Leyte	USAID: LEAD for Health*1 (2005~: 11 municipalities) (2006~: all municipalities)	GTZ: LHSD (2001~) KfW: LHSD (infrastructure) *2 EU: HSRA*2

*1: Capability building for procurement and distribution of health commodity for municipal/ city governments.
*2: *It is planning as a target site.*
*3: Under 6th country program (2005~2009). Major activities include adolescent maternal health, under nutrition and micronutrient deficiency elimination and child health and sanitation.
*4: Community empowerment and capability building of health workers for selected 3 municipalities.

Source: hearing from DOH, donors and CHD-Region VIII

(1) Local Health System Development (LHSD) by German Technical Cooperation (GTZ)

Since 2001, GTZ has been providing integrated support for implementation of Health Sector Reform Agenda (HSRA) in Region VIII. As presented in the following figure, GTZ dispatched their experts from central to provincial level to enhance close coordination among central, regional and provincial stakeholders.



Source: Hearing from GTZ and CHD VIII

Figure 3-28 Organization for ILHD implementation support

Initially, GTZ provided technical assistance for capability building of DOH to strengthen planning and implementation of policy/programs that are to be implemented by CHD on the components below.

- Implementing of local health system reform
- Hospital reform
- Training for health workers in RHU for curative care
- Laboratory services and pharmacy
- Baseline monitoring system

Then, GTZ initiated activities in the selected pilot site, Sogod Bay ILHZ in Southern Leyte. In selection of the pilot site, commitment and attitude of governors are primarily considered along with other factors for project feasibility. GTZ's program is expanded to Biliran in 2003 and planned to be expanded to Eastern Samar in 2005.

3.3.7 Findings from the Regional Workshop

The regional workshop was held as follows.

Date: 3 November 2004 8:00~16:00

Place: CHD-Region VIII

Participants: representatives from CHD-Region VIII, provincial, city and municipal health offices, hospitals, PHIC regional office and NEDA regional office, and mayors

List of participants, detail records of discussion and products of the workshop are presented in Annex L.

Participants were divided into 4 groups, i.e., provincial group including provincial health officers and DOH-Reps, regional group including CHD, PHIC and NEDA, mayors group from convergence sites and mayors group from non-convergence sites. Problem and alternative solutions identifications in each group are shown in the Annex L, which are summarized as follows.

(1) Problems

Convergence site mayors group was expected to identify different problems from non-convergence site mayors group because the processes of health sector reform are advanced. However, no specific differences were found between the groups.

The participants identified that environmental sanitation and accessibility to health services are affecting the health status in the region. Accessibility to health services depends on availability of health service providers which are health facilities, medicines, health workers and systems, and its availability is strongly affected by financial limitation.

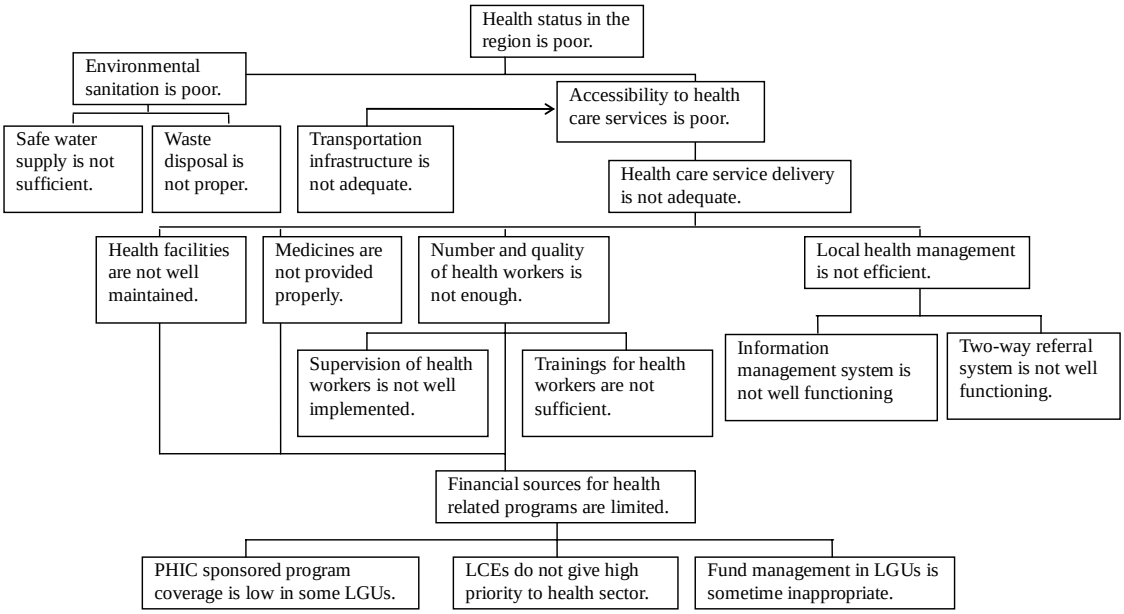


Figure 3-29 Summarized problem tree of health sector in Region VIII

(2) Alternative solutions

The alternative solutions identified by participants to improve the above situation are summarized in the following strategies.

1) Enhancing health care financing

- Maximizing existing local resources in communities, government and non-government organizations.
- Establishing cost sharing system in ILHZ.

- Encouraging RHUs and hospitals to be accredited by PHIC and to maintain the accreditation.
- Encouraging people to enroll PHIC programs with introducing possible premium discount options.
- Encouraging LGUs and private donors to contribute sponsored program of PHIC.

2) Enhancing local health service delivery system

- Organizing and functionalizing ILHZs.
- Developing and utilizing referral system.
- Designing and implementing integrated health information system.
- Encouraging community to participate in health planning and implementation process.
- Establishing cost effective drug procurement system.
- Developing and utilizing training, monitoring and supervising system for health human resources development.

Chapter 4 Project identification and formulation

4.1 Basic framework for project formulation

As having been explained in the pervious section, the needs for health service lies in mother and child health and various infectious diseases, as well as in life style related diseases. It is important therefore that the technical assistance with appropriate approaches be focused to these areas. MOH as well raises mother and child health, infectious disease control and activities for life stele related diseases as the core programs for the quality control of RHU/BHS level services(Sentrong Sigla).

Particularly, the data of health status and health service featured by MMR, IMR, ratio of delivery attended by trained health personnel and ratio of fully immunized children show that there are comparatively larger needs in the mother and child health care in 3 Regions. In addition, various infectious diseases are prevailing over the country. Although prevailing infectious disease varies from area to area, a country-wide standard approach to efficiently and effectively control each infectious disease should be introduced depending on the local needs. As to the life style related diseases, it will be one of the important approaches to implement the preventive measures such as IEC and campaign for improving the life style including smoking and eating habit, possibly giving negative effect to the health, as well as to study the variations of risk factors in the poverty and the positive effects of preventive measures.

When the assistance is provided in the fields of mother and child health, various infectious disease control and life style related disease, which are listed as priority areas for Japan's ODA Basic Policy in the health sector, it is important to concentrate the program inputs in the standardized and cost effective approach, so as to obtain the maximum impact with the limited resources. To be specifically speaking, technical guidelines for the various programs should be prepared on the national level, and health service should be improved at each level by utilizing the standard module, so that the program imputes and activities will be provided equally throughout the country. In other words, the assistance should be extended in the direction of "vertical integration" of various programs.

While, the major public health service providers are Municipalities administrating RHU and BHS, and District and Provincial governments administrating district hospital, provincial hospital and city general hospital, as a result of devolution progress since 1991. Sustainable improvement of public health services and programs therefore need health system strengthening at each level of LGU, and various programs should be easily integrated into such district health systems. This district health systems development may be called a sort of "horizontal integration".

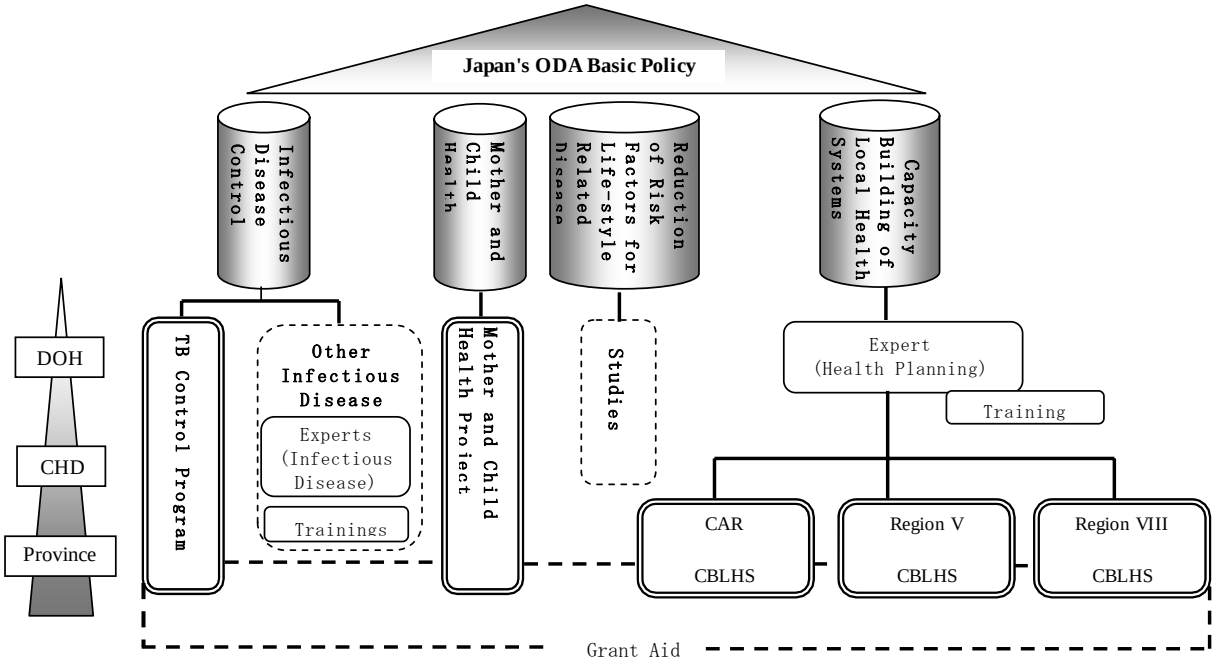
In reality, municipalities having RHU and BHS in general allocate more than 10% of their total budget to the health sector, and 80% to 90% out of such health budget is spent for the salaries for the health workers. Only less than Pesos1,000,000 annually is allocated for purchasing drugs, maintenance of facilities, service outreach and service improvement such as training and education of the staff. While, most of the Provincial government having district and provincial hospital allocate the budget of approximately 30% of their total budget to the health sector, and around 90% of its budget spent for the hospital medical service. Therefore only several millions of Pesos annually can be allocated to the public health service.

In these situation, it is necessary that the efforts be made for maximizing the available resource by making use of alternative resources and for effectively utilizing the limited resources by cooperating and sharing the resources among LGUs, for the quality improvement of public health services. Specifically, it is important to secure additional financial resources for the public health services on the municipal and provincial levels by expanding the health insurance coverage and by improving hospital management by financial autonomy, and to improve the efficiency of health service by sharing the limited resources (sharing the human resources, common drug procurement, etc.) through the establishment and operation of ILHZ. Namely, this implies the actual implementation of HSLA on the district level of the country.

Through this combination approach of continuing the assistance of “vertical integration” which has been extended in the public health including tuberculosis control, mother and child health, and of starting the assistance of “horizontal integration” including the Local Health System Capacity Strengthening Project, JICA would be able to extend their assistance more comprehensively with better balance in the health sector of the Philippines.

It is considered reasonable and recommended therefore that technical assistance to support specific programs, expert advisory service and/or training should be provided to the need of mother and child health, infectious disease control and reduction of life style related disease, and system development technical support (HSRA System Development Support Technical Assistance) be provided simultaneously to the need of various systems development required to function ILHZs.

For the technical assistance for mother and child health, JICA expert is studying the project at present based on the request of Philippine Government, and the project which is considered to be matured should be implemented in the form of Public Health Program Support Technical Assistance to be mentioned later. For various infectious disease control and reduction of life style related disease risks should be implemented in the forms of JICA Expert and/or training service based on the specific needs.



(NOTE) CBLHS:Capacity Building Project for Local Health Systems

Framework of Recommended Assistance in line with Japan's ODA Basic Policy

4.2 Project outline

(1) Typical TOR for Program Support Technical Assistance to mother and child health care

Typical TOR for the Program Support Technical Assistance to mother and childhood is as follows, and the project is temporarily titled "Strengthening the Delivery of Quality Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC) in Selected Health Zones (ILHZ)".

1	Project Title	Strengthening the Delivery of Quality Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC) in Selected Inter-Local Health Zones (ILHZ)
2	Type of Assistance	Technical Assistance
3	Implementing Agency	NCDPC/DOH, together with selected provincial/municipal governments
4	Overall Goal	To reduce maternal and infant(particularly neonatal) mortality in target ILHZs
5	Project Purpose	To strengthen capacity of selected inter-local health zones in two (or three?) regions to provide quality pregnancy, childbirth, postnatal and newborn care in a sustainable manner, with supportive technical and policy guidance from DOH.
6	Objectives	1. To strengthen DOH capacity for technical guidance and program monitoring for quality PCPNC. 1-1. To consolidate technical and policy guidelines on quality PCPNC. 1-2. To establish effective training system for quality PCPNC. 1-3. To improve progress monitoring and supervision for quality PCPNC. 2. To strengthen service delivery capacity of selected ILHZs (provincial and

		municipal governments) for quality PCPNC. 2-1. To create baseline data for PCPNC planning in selected ILHZs. 2-2. To ensure commitment from local chief executives (LCEs) and health care providers for quality PCPNC in selected ILHZs. 2-3. To formulate rational development plan for quality PCPNC as integral part of provincial health development plan in selected ILHZs. 2-4. To improve health care provider skills to ensure quality PCPNC delivery in selected ILHZs. 3. To strengthen supportive environment in communities in selected ILHZs for quality PCPNC. 3-1. To create awareness among communities about the need for quality PCPNC in selected ILHZs. 3-2. To create community support for quality PCPNC in selected ILHZs.
7	Activities	1-1. To consolidate technical and policy guidelines on quality PCPNC. (1) Review and revision of existing technical guidelines (2) Review and revision of existing policy guidelines 1-2. To establish effective training system for quality PCPNC (1) Selection of candidate institutions for BEmOC training (2) Training of trainors (TOT) for selected institutions (3) Provision of essential training equipment for selected institutions (4) Facilitation of regular implementation of BEmOC training (5) Review and revision of existing training modules and materials 1-3. To improve progress monitoring, supervision and dissemination of quality PCPNC (1) Development of standardized monitoring indicators (2) Periodical data collection and dissemination of lessons learned (3) Development of supervisory manuals for PHOs 2-1. To create baseline data for PCPNC planning in selected ILHZs (1) Situation analysis using EmOC assessment tool (2) Travel distance, accessibility and catchment analysis of health facilities (3) Maternal death review 2-2. To ensure commitment from local chief executives (LCEs) and health care providers for PCPNC in selected ILHZs (1) LCEs orientaion and advocacy (2) Advocacy for PhilHealth maternity package accreditation of hospitals and RHUs (3) Study tours and other exchange programs among ILHZs 2-3. To formulate rational development plan for quality PCPNC as integral part of provincial health development plan in selected ILHZs (1) Review of integrated provincial health development plan (or HSRA implementation plan) and ILHZs formulation plan (2) Identification of potential CEmOC and BEmOC facilities (3) Formulation of training plan, according to the level of facilities (4) Identification of non-emergency obstetric care training institutions/trainors in the area 2-4. To improve health care provider skills to ensure quality PCPNC delivery in selected ILHZs (1) BEmOC training for selected referral facility staff (2)Non-emergency obstetric care training for first-line facility staff (3)Periodical monitoring visits to service delivery points and on-site supervision, including management support 3-1. To create awareness among communities about the need for quality

	PCPNC in selected ILHZs (in partnership with NGOs or JOCV) (1) Community diagnosis using participatory methodologies (2) Community IEC campaign 3-2. To create community support for quality PCPNC in selected ILHZs (1) Community mobilization (eg., organized support for mothers, community financing and resource sharing for emergency transportation, etc.) (2) Involvement of BHWs and TBAs in the delivey of non-emergency obstetric care and community referral

(2) Typical TOR for HSRA System Development Support Technical Assistance

Typical TOR for the project of HSRA System Development Support Technical Assistance is as follows, and the project is temporarily titled "Local Health System Capacity Strengthening Project".

"Activities" listed in the TOR covers the entire activities normally required for the establishment of district health service system, and should be selected for implementation depending on the local specific needs. The core component in the "Activities" is the improvement of local health system institutions, where the specific systems to be improved should also be selected.

1	Project Title	Local Health System Capacity Strengthening Project
2	Type of Assistance	Technical Assistance
3	Implementing Agency	CHDs/DOH, together with selected provincial/municipal governments
4	Overall Goal	People, who are most in need, can access good quality of affordable health services
5	Project Purpose	To strengthen local health system for effective, efficient, equitable and sustainable health service delivery through the HSRA implementation.
6	Objectives	(1) To create baseline data for rational decision making. (2) To ensure commitment from LCEs and other all stakeholders including health workers on the HSRA and the Project itself (3) To formulate integrated provincial health development plan. (4) To improve local health system institutions. (5) To improve local health system infrastructure. (6) To improve priority public health service quality and coverage. (7)To improve progress monitoring and on-site supervision. (8) To ensure sustainability of good practices
7	Activities	1. To create baseline data for rational decision making (1) Facility (SS certification, PhilHealth accreditation, DOH license, staff, travel time and catchment population, census reports including level of utilization, etc.) (2) Skills level (training needs assessment) (3)Financial capacity (direct subsidy, PhilHealth, community health insurance etc.) (4) Procurement system (index drug price, etc.) (5) Health services outside facilities such as Botica Binhi, drug stores, TBAs, community health activities (6) Demographic, economic and socio-cultural profiles (7) Mortality and morbidity reports (Epidemiology) (8) Political affiliation of LGUs (9) Rapid assessment in communities to identify their needs

2. To ensure commitment from LCEs and other all stakeholders including health workers on the HSRA
   (1) Orientation and advocacy targeting LCEs
   (2)Study tours and other exchange programs with advanced convergence sites
   (3) Health summit
   (4) Promotion of supportive local legal mandates
   (5) MOA signed by LCEs
   (6) Community mobilization

3. To formulate integrated provincial health development plan.
(1)Convergence workshop
(2)Special planning of ILHZs and health facilities, rational identification of strategic facilities for upgrading
(3) HRD planning
(4) Development of integrated health planning system

4. To improve local health system institutions.
   (1)ILHZ development, with functioning ILHZ board and technical management board, resource sharing, clear financial mechanism and private sector involvement through MOA and issuance of an Executive Order or Resolution on the organization of the ILHZ
   (2)Health insurance coverage expansion (eg. enrollment by organized groups, social marketing, IEC activities for beneficiaries) and promotion of PhilHealth accreditation (OP, maternity and DOTs center) of health facilities
   (3)Hospital and RHU management improvement through training and fiscal autonomy promotion through user fees, income retention, improvement of billing and collection system and patient classification, invitation of private doctors etc.
   (4)Health facility quality improvement through functioning quality assurance committee, 5S activities etc.
   (5)Drug management and procurement improvement through establishment of therapeutic committee and development of provincial drug formulary, PDI, bulk procurement, cooperative pharmacy, Revolving Drug Insurance Funds(RDIF), Health Plus, revolving funds, Botica Binhi
   (6)Development and establishment of two-way referral system from communities to hospitals and referral manual, and training on the referral system
   (7)ILHZ management information system through simplification of recording and reporting system

5. To improve local health system infrastructure for Sentrong Sigla and PhilHealth accreditations.
(1)Development of unified inventory and provision of essential equipment
(2)Repair and renovation of facilities

6. To improve priority public health service quality and coverage, such as follows.
   (1) EPI & cold-chain management
   (2) ECCD including growth/development monitoring and counseling
   (3) Micronutrient supplementation
   (4) IMCI
   (5) IMPAC (PCPNC)
   (6) FP
   (7) DOTS
   (8) Environmental and sanitation program

	(9)Others (Control measures for endemic diseases such as malaria, filariasis, rabies, STHs, HIV/STIs, IEC for health promotion, etc.) (10)Development of integrated manuals for health workers in RHUs and BHSs by using the current manuals2) 7. To improve progress monitoring and on-site supervision (1) Development of monitoring indicators (2) Improvement of periodical data collection by using the current system2) and dissemination and feedback, including lessons learned (3) Periodical monitoring visits to service delivery points and on-site supervision 8. To ensure sustainability of good practices (1) Legal mandate through Executive Orders and Resolutions (2)Establishment/development of momentum through proper and timely implementation of the above activities, which cannot be reversed

Note:

(1) When JICA provides technical assistance mentioned above, JICA should provide a technical support simultaneously to DOH Central Office on project monitoring, supervision, evaluation and feed back the result to the policy implementation.

(2) Assistance for equipment procurement and/or building construction should be considered only in the areas, where technical assistance is provided for ILHZ(s) system development.

4.3 Project site selection

The identified projects, which are Public Health Program Support Technical Assistance, JICA Expert, training service, and HSRA System Development Support Technical Assistance to support the development of various systems for functional ILHZs, should be implemented at the site(s) which should be selected as follows.

The project site(s) should be the Province(s) in each Region of CAR, V, and VIII, and be finally decided upon consultation between JICA and DOH, with due consideration on the following criteria for project site selection.

PROJECT TYPES	CRITERIA
Program Support Technical Assistance (Vertical Integration)	**1. Needs must be larger than the other area on the following respects;** ① Comparatively poorer health status (By indicators of MMR, IMR, and others) ② Comparatively lower level of service(By indicators of percentage of delivery attended by skilled health personnel, percentage of fully immunized children and others) **2. The efforts must have been made to improve the health service on the following respects ;**

	① Comparatively higher coverage ratio of PHIC insurance and higher expenditure ratio on health in total MOOE ② Comparatively more PHIC accredited health facilities, higher bed occupancy rates, and better ratio of health workers against population ③ Having ILHZ(s) organized with MOA **3. There must be donor coordination;** ① Other donor is not providing assistance in the subject program
HSRA System Development Support Technical Assistance (Horizontal Integration)	1.① to 2.③:Same as above **2. There must be donor coordination;** ① Other donor is not providing assistance for HSRA support and possibly in program support(Other donor is providing assistance in specific program)


JICA